STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505042	A. Building B. Wing	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballard Center	820 Northwest 95th Street Seattle, WA 98117

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39651 Based on interview and record review, the facility failed to ensure residents are free from abuse (physical) for 1 of 6 residents (Resident 1) reviewed for abuse and neglect. This failure placed Resident 1 at risk for ongoing pain and placed other residents at risk for harm and injury. Findings included . The Code of Federal Regulation (CFR) define abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Resident 1 was a long-term resident of the facility. A review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] and 08/10/21 showed the resident had intact cognition and needed one-person physical assistance from staff for mobility including locomotion on and off the unit. A review of the facility's incident and accident log for July 2021 showed that on 07/16/2021 at unknown time, Resident 1 was involved on a resident-to-resident altercation with another resident (Resident 2). The incident log showed the facility had substantiated abuse related to the incident. A review of the facility's incident investigation report, dated 07/16/2021, showed Resident 1 reported the incident to Staff Z, Social Services Assistant (SSA), on 07/16/2021 (unknown time) that on 07/15/2021 around 8:00 PM, she began calling for her aide due to needing additional help with something, but was unable to locate her call light. Resident 1 stated that her roommate walked to the left side of her bed and placed her hand on Resident 1's right breast and began to apply pressure as hard as possible to inflict pain on her. Resident 1 states she felt the pain for about an hour following the altercation. The incident investigation also showed that Resident 2 reported to Staff Z, SSA on 07/16/2021 (unknown time) that on 07/15/21 at 8:00 PM, Resident 2 stated Resident 1 made her mad because she was yelling. Resident 2 reported, So I placed her phone on her chest and pressed down a little bit because I was mad at her. Per the investigation report, Staff Z then asked Resident 2 if she purposely inflicted pain on Resident 1, and that Resident 2 responded, Yea, just a little bit, but I don't think it hurt her that much. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505042	A. Building B. Wing	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballard Center	820 Northwest 95th Street Seattle, WA 98117

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 2's quarterly MDS assessment, dated 06/07/2021, showed the resident had mild cognitive impairment and was independent with locomotion and ambulation on and off the unit. On 08/31/2021 at 11:00 AM, Resident 1 stated that her previous roommate (Resident 2), caused her pain by pressing the phone really hard on her chest. Resident 1 stated that she could not recall the specific date of the incident and why Resident 2 came to her side of the room very upset. According to Resident 1, she had been waiting for staff to assist her with something and she had waited long enough, at least 30 minutes. No one came, so she started calling (yelling) for help. Resident 1 further stated that she was initially shocked and afraid immediately after the incident but felt better after the room change. On 08/31/2021 at 11:35 AM, Resident 2 stated she remembered what happened between her and Resident 1. Resident 2 stated that her previous roommate (Resident 1) was very loud the night of the incident and had been calling and yelling for help so she came to her side of the bed, grabbed her phone, and placed it on her chest. According to Resident 2, Resident 1 was yelling for almost half an hour, and that she was not able to sleep, Yes, I pushed it on her chest because I was mad and to make her quit. Resident 2 stated, she did not think it was that hard, as she only wanted her to feel a little pain. On 08/31/2021 at 11:45 AM, the Director of Nursing (DNS) stated that there was a resident-to-resident physical altercation between Resident 1 and Resident 2. The DNS stated the facility had substantiated abuse after completing an investigation of the incident. Reference: WAC 388-97-0640(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505042	A. Building B. Wing	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballard Center	820 Northwest 95th Street Seattle, WA 98117

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39651 Based on observation, interview and record review, the facility failed to develop and implement an effective policy and procedure(s) related to serving hot beverages, failed to provide adequate supervision, and failed to implement the plan of care for 1 of 3 residents (Resident 1) reviewed for avoidable accidents and supervision. These failures caused serious harm and injury to Resident 1 who sustained a second-degree burn and experienced pain and placed other residents of the facility in the likelihood of serious harm and injury related to the unsafe temperature of hot beverages served. The facility's failure to ensure an effective policy and procedures related to serving hot beverages were in place to minimize risks and protect residents from avoidable accidents and the failure to provide adequate supervision to Resident 1, caused serious injury/harm and constituted a situation of an Immediate Jeopardy (IJ) related to CFR 483.25 - F689 - Free of Accident Hazards/Supervision/Devices. The IJ was identified and communicated to the facility on [DATE]. Additionally, the facility failed to provide adequate supervision and implement the plan of care to minimize the risk of avoidable accidents (falls) for 2 of 3 residents (Residents 3 and 4) reviewed for falls. These failures caused harm to Resident 3 and Resident 4 who sustained multiple bone fractures, pain, and diminished quality of life. Findings included . Resident 1 was a long-term resident in the facility. The resident's diagnoses list included generalized muscle weakness and lower body paraplegia (loss of the ability to move the lower body). A review of the resident's quarterly Minimum Data Set (MDS) assessment, dated 08/10/2021, showed the resident required extensive staff assistance with bed mobility and supervision (oversight, encouragement or cuing) and set-up with eating. A review of the resident's care plan, dated 06/19/2020 and revised on 04/01/2021, showed Resident 1 was at risk for decreased ability to perform activities of daily living (ADL) including bed mobility and eating. The care plan directed the facility staff to: A. Provide cuing for safety and sequencing to maximize current level of function. B. Eating - Set up assistance, then indirect supervision. HOT WATER TEMPERATURE/UNSAFE HOT BEVERAGES A review of a facility incident report, dated 08/29/2021, showed that on 08/29/2021 at 7:30 AM, Resident 1 had an unwitnessed incident that resulted in an injury (burn). The incident investigation showed that Resident 1 reported to the nurse aide [Staff Y, Nursing Assistant Certified (NAC)] that she had spilled hot tea on herself while attempting to drink it. The incident report also showed that no staff member was present when the incident had occurred. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505042	A. Building B. Wing	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballard Center	820 Northwest 95th Street Seattle, WA 98117

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The incident investigation report concluded that the root cause of the incident was that the facility did not implement policies and procedures related to safe delivery of hot beverages to the resident. The conclusion also indicated that a contributing factor to the incident was that Resident 1's care plan directed staff to provide indirect supervision which was not clear to staff. The incident investigation report showed that Resident 1 sustained a second-degree burn (a burn injury involving the first 2 layers of the skin) related to the incident, and the facility had implemented corrective actions immediately after the incident to ensure hot beverages were not delivered to residents at a temperature greater than 150 degrees Fahrenheit (F). On 08/31/2021 at 10:20 AM, Staff W, Dietary Manager (DM) and Staff X, Dietary Aide (DA) both stated that the facility had no written policies and procedures in place related to the safe delivery of hot beverages to the residents. Staff W and Staff X stated that there was no hot water temperature testing or screening being done prior to the incident, and that there was no system as to how to make sure that hot beverages were served at a safe temperature to the residents. Both Staff W and Staff X stated that Staff A, Administrator, and Staff C, Regional Dietary Manager (RDM), had recently provided staff education (08/30/2021) to make sure that hot beverages leaving the kitchen and being served to the residents did not exceed 150 F. On 08/31/2021 at 10:30 AM, Staff A, Administrator and Staff B, Director of Nursing (DNS) both stated the facility had no written policies and procedures in place related to the safe delivery of hot beverages to the residents. Both Staff A and Staff B stated that the facility had just started checking hot beverage temperatures yesterday (08/30/2021) at lunch time and that dietary staff had been educated to ensure that hot beverages leaving the kitchen and served to the residents did not exceed 150 F. Observation on 08/31/2021 at 10:55 AM showed Resident 1 had a partial thickness burn (a burn injury involving the first 2 layers of the skin) on her left upper arm extending to the left shoulder. The wound was measured at approximately 10 centimeters (cm) in length and 10 cm wide. The burn site was red with open areas and the surrounding skin was swollen. According to the resident, the burn area was painful to touch. On 08/31/2021 at 11:00 AM, Resident 1 stated that she was having breakfast when the incident happened. The resident stated the hot tea might have spilled because she was not sitting upright, and the head of the bed was not high enough when she was drinking. The resident also stated she tended to lean on her left side because of her weakness and contractures (permanent tightening of the muscles), and that there was no staff member near her to cue or supervise her when the incident happened. The resident further stated the facility served hot water and her tea was very hot on a daily basis, and she was not sure as to why the hot drinks had to be extremely hot. Observation on 08/31/2021 at 12:40 PM showed two residents in the dining room (Resident 5 and Resident 6), having lunch with hot beverages served at the table. Both residents stated their hot water, and the coffee were too hot to drink, and they were letting it cool down before they can drink the beverages. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505042	A. Building B. Wing	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballard Center	820 Northwest 95th Street Seattle, WA 98117

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A joint observation on 08/31/2021 at 12:45 PM with Staff C, Regional Dietary Manager (RDM) showed the temperatures of the hot water and hot coffee served in the main dining room were recorded as 166.0 F. Additionally, 5 of 6 beverage carts that had come out of the kitchen with beverages for residents to drink (located close to the nurse station and clean utility room) showed the recorded temperatures of the hot water was 162.0 to 173.1 degrees F, and the recorded temperatures of the coffee was 147.3 to 163.0 degrees F. On 08/31/2021 at 1:00 PM, Staff C, RDM, stated that kitchen and dietary staff had received education and training on 08/30/2021 regarding this issue and she was not sure why the kitchen and dietary staff had continued to serve hot beverages at unsafe temperature level of more than 150 F. Staff C stated the hot water and coffee temperatures should have been taken in the kitchen and brought down to a safe level [120 F to 150 F] if necessary before leaving the kitchen for residents to drink. Although the facility took steps to train and educate staff related to the safe delivery of and serving hot beverages to the residents, the facility failed to ensure staff continued to implement the steps of checking the temperatures of hot beverages and serving the hot beverages at a safe temperature level. This failure increased the likelihood of serious harm and injury related to the unsafe temperature of hot beverages served to the residents. On 08/31/2021 at 1:45 PM, both Staff A, Administrator, and Staff B, DNS, stated that kitchen and dietary staff had received education and training on 08/30/2021 regarding safe delivery of hot beverages to the residents and they were not sure why the kitchen and dietary staff had continued to serve hot beverages at unsafe level of more than 150 F to the residents. Staff A and Staff B both stated that they would immediately re-educate and re-train dietary staff to ensure the safe delivery of hot beverages to the residents. FAILURE TO PROVIDE ADEQUATE SUPERVISION On 08/31/2021 at 11:00 AM, Resident 1 stated that there was no staff member present when the burn incident occurred. The resident also stated that she did not receive any additional staff assistance or supervision during meals, other than delivering her food. The resident further stated that staff did not provide any kind of cuing during meals. On 08/31/2021 at 11:05 AM, Resident 1's roommate stated that she was in the room when the incident happened. The roommate said that Resident 1 often leaned on her left side when she ate and drank, and that Resident 1 would often call for help, but no one will come. The roommate further stated that staff do not check on either her or Resident 1 during meals because the staff were busy, and the facility was mostly understaffed almost everyday. On 08/31/2021 at 11:30 AM, Staff Y, Nursing Assistant Certified (NAC), stated that he did not witness Resident 1's incident and he was not in the room when the incident happened. Staff Y stated that Resident 1 was independent with eating and only needed set-up assistance with eating and drinking. Staff Y was not aware of the care-planned direction for indirect supervision while eating for Resident 1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505042	A. Building B. Wing	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballard Center	820 Northwest 95th Street Seattle, WA 98117

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/31/2021 at 11:36 AM, during a joint interview with Staff J (NAC), Staff K (NAC), Staff L (NAC), and Staff M (NAC), the staff gave different responses as to what indirect supervision meant, either that indirect supervision meant Resident 1 should have been supervised within line of sight or that it meant that Resident 1 should not be left alone in the room due to the need for supervision. On 08/31/2021 at 11:45 AM, Staff B, DNS, stated that Resident 1's care plan showed the resident needed cuing for safety, set-up assistance with eating, and indirect supervision from staff. Staff B also stated that staff were not clear as to what indirect supervision meant, and that she had to update Resident 1's care plan to clarify this intervention. FALLS WITH MAJOR INJURY RESIDENT 3 Resident 3 was a long-term resident of the facility. The resident's diagnoses list included respiratory/breathing problems and seizure disorder. A review of Resident 3's annual MDS assessment, dated 06/24/2021, showed the resident had intact cognition and needed 1 person staff assistance with transfers and toilet use. A review of Resident 3's care plan, dated 06/2018, showed Resident 3 was at risk for falls related to impaired mobility, generalized weakness, lack of safety awareness and current use of high-risk medications. The care plan directed facility staff to anticipate needs and frequently check on the resident. The Activities of Daily Living (ADL) care plan, dated 06/2018 and recently revised on 06/24/21, showed the resident requires 1-person limited assistance when the resident allows, for oxygen tubing management. Review of an incident investigation report, dated 08/02/2021, showed Resident 3 had a non-witnessed fall on the night of 07/31/2021, when the resident had rushed to the bathroom and fell . The incident report showed Resident 3 reported the incident to Staff N, NAC on the morning of 08/01/2021. Staff N immediately reported the incident to the nurse on duty, Staff D, Licensed Practical Nurse (LPN). However, no follow-up or action(s) were taken to address the fall until 08/02/2021, when another nurse noticed a bruise on Resident 3's left back. The incident investigation report also indicated that Resident 3 also had changes in his medical condition between 08/02/2021 to 08/08/2021. The resident received antibiotic treatment, fluids therapy and several medication changes related to the worsening of his chronic respiratory disease. On 08/09/2021, a chest x-ray was ordered and showed a left lower lung collapse with numerous posterior (back) left rib fractures, 5th rib fracture in at least 2 places. Cannot exclude flail chest [a serious condition that results from having two or three ribs that are broken in two or more places mostly due to a crushing injury]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505042	A. Building B. Wing	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballard Center	820 Northwest 95th Street Seattle, WA 98117

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 09/08/2021 at 9:15 AM, Resident 3 stated that he remembered what happened when he fell and broke his ribs. The resident stated he needed to use the bathroom to urinate and have a bowel movement. Resident stated he felt dizzy and lightheaded at the time, so he called for staff assistance and pressed his call light. However, Resident 3 stated he had waited for a long time (at least 45 to 60 minutes according to the resident) but no staff member came. Resident 3 stated that he tried shouting for help, which was very difficult due to his lung problems. Resident 3 stated that after waiting for almost an hour, he decided to go to the bathroom because he did not want to have a bowel movement in bed. According to Resident 3, he fell and landed on one of the bedside tables or a trash bin, directly hitting his back and rib cage. Resident 3 added, That is why I called for assistance, but nobody came. Resident 3 also stated he reported the incident the following morning (08/01/2021) to an aide (Staff N, NAC). However, Resident 3 stated that he did not get any help or attention related to his fall until 08/02/2021. Resident 3 stated that he felt sharp pain immediately after the fall and he knew he may have fractured his ribs, but no one seems to believe me. Resident 3 stated it was harder to breath and the rib fractures caused him more pain and discomfort than usual. Resident 3 said that staff did not check on him frequently or on a regular basis. According to Resident 3, the only time he would see a staff member was when they delivered his meals and medications, Staff don't come even if you call them. The resident further stated that the incident could have been avoided if a staff member had come to help and assist him to the bathroom. On 09/08/2021 at 10:00 AM, Staff B, DNS, stated there was a delay in communication to the physician that Resident 3 had a fall and a delay in the management of the fall injury for at least 24 hours. Staff B stated that Resident 3's care plan intervention showed frequent checks, which meant staff should check the resident more than every 2 hours, but this instruction was not clear to staff. Staff B further stated that it was not clear as to when the resident was last seen by a staff member and whether he received any care or services from a staff member before the incident. On 09/08/2021 at 10:30 AM to 11:30 AM, interviews with Staff N NAC, Staff L NAC, Staff M NAC, and Staff D LPN showed the staff had different understanding of what frequent checks meant related to resident supervision. Staff L and Staff M stated that frequent checks meant to check the resident at least every 30 minutes or sometimes every 15-30 minutes. Staff N and Staff D stated that the meaning of frequent checks varied and could be interpreted as to check the resident often or at least every 30 minutes and/or every time staff walked by the resident's room. RESIDENT 4 Resident 4 was admitted to the facility on [DATE] for rehabilitation therapy. The resident's diagnoses list included history of repeated falls and orthostatic hypotension (sudden drop in blood pressure). A review of Resident 4's MDS assessment, dated 07/14/2021, showed the resident had intact cognition, needed one person assistance with bed mobility, and two person staff assistance with transfers and toileting needs. A review of Resident 4's care plan, dated 07/08/2021, showed the resident required staff assistance with ADLs including bed mobility, transfers, ambulation and toileting. The care plan also showed Resident 4 had several fall incidents in the facility. The care plan directed facility staff to do frequent visual checks while in bed d/t (due to) impulsiveness. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505042	A. Building B. Wing	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballard Center	820 Northwest 95th Street Seattle, WA 98117

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident 4's clinical records and the facility's incident reporting log from 07/2021 to 09/05/2021 showed Resident 4 had 5 falls (07/21/2021, 08/02/2021, 08/07/2021, 08/10/2021 and 08/24/2021) while at the facility. During the fall that occurred on 08/24/2021 at 8:00 AM, Resident 4 sustained a laceration (deep cut) on his left elbow and was sent out to the hospital for further evaluation and treatment. On 09/08/2021 at 10:30 AM, Resident 4 stated that he remembered what happened on his last fall on 08/24/2021. Resident 4 stated he wanted to use the bathroom to urinate, so he called for help using the call light. Resident 4 stated, I waited and waited, but no one came. According to Resident 4, he waited an hour, but he couldn't hold it anymore, so he decided to use the bathroom on his own. Resident 4 added that he knew he was supposed to have a staff member when he got up to use the toilet, but he felt he had no choice. Resident 4 said to ask his roommate about it, as his roommate also knew what happened. Resident 4 stated that the fall could have been avoided if staff had been present to help him and supervise him when he got up from bed to use the bathroom. On 09/08/2021 at 10:40 AM, Resident 4's roommate stated that Resident 4 had waited patiently for staff to came and help him, but there was no staff around to help him. Resident 4's roommate stated he also had experienced an hour wait (sometimes longer) to get help from staff. On 09/08/2021 at 10:45 AM, Staff L, NAC, stated that he was familiar with Resident 4's care and care plan. Staff L stated Resident 4 required assistance and increased supervision from staff, at least every 15 minutes. However, Staff L stated that most of the time it was not possible to provide that amount of supervision, especially in the early morning get-up times and during mealtimes (6:00 AM to 9:00 AM and 11:30 AM to 1:00 PM). A review of the fall incident investigation report, dated 08/24/2021, showed Resident 4 had a history of multiple falls in the past and his care plan required him to have 1 person staff assistance with transfers, ambulation, and dressing. The incident report also showed the resident was last toileted and received care from staff at around 7:00 AM (1 hour before the incident). However, the incident investigation was missing key information as to what was the root cause of the incident and whether staff had followed the resident's care plan and provided the necessary care and services to minimize risk of the incident. On 09/08/2021 at 11:00 AM, Staff B, DNS, stated that Resident 4's fall on 08/24/21 was not witnessed by staff. Staff B also stated Resident 4's care plan showed he required extensive assistance from staff and frequent visual checks, which meant staff should be providing increased supervision of at least every 30 minutes to every one to two hours. However, Staff B also stated that the phrase frequent checks was not clear to staff as to how often they should be checking and providing supervision to the resident. Staff B further stated the incident investigation did not contain information as to whether the incident was avoidable or not because the incident report submitted to her was missing information about the details of the incident, including lack of witness statements and interviews from the resident and his roommate. On 08/31/2021 at 11:36 AM and again on 09/08/21 at 11:30 AM, during joint interviews with Staff J NAC, Staff K NAC, Staff L NAC, and Staff M NAC, the staff gave different responses as to what frequent visual checks meant in terms of resident supervision, such as frequent checks meant staff were to check residents every 30 minutes, frequent checks meant check every time they passed the resident's room, or that frequent checks meant staff were to check the resident at least every 2 hours. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505042	A. Building B. Wing	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballard Center	820 Northwest 95th Street Seattle, WA 98117

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident 4's clinical records showed the resident's fall on 08/24/2021 resulted in multiple injuries, including fracture of multiple ribs of the right side and a closed traumatic Pneumothorax (a collapsed lung). On 09/08/2021 at 11:45 AM, Resident 4 stated his injury from the fall caused him increased pain, affected his ability to breath normally, and affected his ability to enjoy his day and have quality sleep at night. Reference: (WAC) 388-97-1060(3)(g)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505042	A. Building B. Wing	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballard Center	820 Northwest 95th Street Seattle, WA 98117

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 39651 Based on interview and record review, the Administration failed to effectively manage the facility in compliance with state and federal regulatory requirements. The administration failed to ensure compliance related to the development and implementation of an effective policy and procedures related to the safe delivery of hot beverages to the residents, and failed to ensure staff provided adequate supervision for 3 of 4 residents (Residents 1, 3 and 4) reviewed for accident hazards, supervision, and devices. These failures caused serious harm to Resident 1, 3 and 4 and resulted in an Immediate Jeopardy (IJ) situation on 08/31/2021. Additionally, the facility administration failed to ensure staff followed and implemented an effective, on-going system to safeguard resident's property from misappropriation and potential drug misuse/diversion for Resident 3. These failures placed residents of the facility at risk for harm, injury, and abuse and/or neglect. Findings included . On 08/31/2021, an IJ situation was identified related to CFR 483.25 - F689 - Free of Accident Hazards/Supervision/Devices. RESIDENT 1 (BURN) The facility failed to develop and implement an effective policy and procedure related to the safe delivery and serving of hot beverages to the residents that resulted in serious injury and harm to Resident 1 who sustained a second-degree burn (a burn injury involving the first 2 layers of the skin) on 08/29/2021. A review of the facility incident report dated 08/29/2021 showed that Resident 1 had spilled hot tea on herself while attempting to drink it. The incident report also showed that no staff member was present to supervise the resident when the incident had occurred. The incident investigation report concluded that the root cause of the incident was due to the facility's failure to implement policies and procedures related to safe delivery of hot beverages to the resident. The conclusion also included information that a contributing factor to the incident was related to Resident 1's care plan that was directing staff to provide indirect supervision which was not a clear direction to staff. On 08/31/2021 at 1:45 PM, Staff A, Administrator, and Staff B, Director of Nursing (DNS) both stated that it was the facility's administration's responsibility to ensure that an effective policy and procedure was in place related to the safe delivery of hot beverages to the residents. Staff A stated she was not sure as to why the kitchen staff did not have a policy in place at the time of the incident that resulted in a serious burn injury for Resident 1 by accidentally spilling hot beverage to herself at unknown temperature. RESIDENT 3 and RESIDENT 4 (FALL WITH MAJOR INJURIES) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505042	A. Building B. Wing	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballard Center	820 Northwest 95th Street Seattle, WA 98117

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Actual harm Residents Affected - Few	The facility failed to provide adequate supervision and implement the resident's plan of care to minimize the risk of avoidable accidents (falls) for Resident 3 and Resident 4. These failures caused harm to Resident 3 and Resident 4 who sustained multiple bone fractures, pain, and diminished quality of life. Resident 3 had a non-witnessed fall on 07/31/2021 and sustained a left lower lung collapse with multiple rib fractures and potentially a flail chest (a serious and life-threatening condition resulting from having two or three ribs that were broken in two or more places mostly due to a crushing injury). On 09/08/2021 at 9:15 AM, Resident 3 stated that the incident could have been avoided if a staff member had come to help and assist him to the bathroom. Resident 4 had a non-witnessed fall on 08/24/2021 and sustained multiple injuries including fracture of multiple ribs of the right side and a closed traumatic Pneumothorax (a collapsed lung). On 09/08/2021 at 10:30 AM, Resident 4 stated the incident could have been avoided if staff were present to assist and supervise him when he got up from the bed to use the bathroom. On 09/08/2021 at 11:00 AM, Staff B, DNS stated that both Resident 3 and Resident 4's fall incidents were not witnessed. Staff B stated she was not aware of the specific circumstances of the incidents, in that both Resident 3 and Resident 4 reported that they did not receive timely assistance and supervision from staff. ABUSE ALLEGATION (MISAAPROPRIATION - NARCOTIC PAIN MEDICATION) A review of the incident report for Resident 3 dated 08/29/2021 showed that an entire medication card (bingo card) of Oxycodone (a narcotic pain medication) 10 milligram (mg) tablet went missing on 08/28/2021. The incident investigation report concluded that the root cause of the incident was due to the facility staff's failure to follow and implement the facility's written policy and procedures related to the proper accounting of controlled narcotic medications. The incident report showed that staff did not conduct an end of shift narcotic count for an unknown period of time. On 09/08/2021 at 12:05 PM, Staff B, DNS stated she was not aware and not sure as to why some nurses were not counting narcotics at the end of each shift. Staff B, DNS stated that she was responsible for ensuring that nurses followed and implement written policies and procedures in safeguarding residents' medications, including controlled substances. Reference: (WAC) 388-97-1620(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505042	A. Building B. Wing	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballard Center	820 Northwest 95th Street Seattle, WA 98117

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Actual harm Residents Affected - Few	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 39651 Based on interview and record review, the governing body failed to provide adequate oversight and monitoring of the facility's administration and its operation. The governing body failed to ensure the facility had a policy in place to ensure compliance related to a safe delivery of hot beverages and minimize the risk/hazards to residents. These failures caused serious harm and injury to Resident 1 and resulted in an Immediate Jeopardy (IJ) situation on 08/31/2021. Additionally, these failures also placed residents of the facility at risk for harm and injuries. Findings Included . A review of an undated policy titled, Governing Body, showed the governing body was legally responsible for establishing and implementing policies regarding the management and operation of the facility. A review of the facility incident report, dated 08/29/2021 showed that Resident 1 had spilled hot tea on herself while attempting to drink it. The incident investigation report concluded that the root cause of the incident was due to the facility's failure to implement policies and procedures related to safe delivery of hot beverages to the resident. On 08/31/2021 at 1:45 PM, both Staff A Administrator and Staff B Director of Nursing (DNS) stated that it was the facility administration's responsibility to ensure that an effective policy and procedure was in place related to the safe delivery of hot beverages to the residents. Staff A stated she was not sure as to why the kitchen staff did not have a policy in place at the time of the incident that resulted to Resident 1 getting burned by accidentally spilling hot beverage on herself at unknown temperature. On 09/01/2021 at 4:40 PM, Staff AA, [NAME] President of Operations, stated that he was not sure as to why there was no policy being implemented at the facility related to the safe delivery of hot beverages to the residents. Staff AA also stated that there could have been a policy, but he was not sure what could have happened as to why there was none in place at the time of the incident. According to Staff AA, the lack of policy and procedure related to the safe delivery of hot beverages could have been the result of the management turnover in the kitchen and dietary staff, but the issue should have been identified. Reference: WAC 388-97-1620(2)(c)