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	10/07/2021

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39651 Based on observation, interview, and record review, the facility failed to ensure systems were in place for staff following and implementing abuse and neglect policies & procedures for reporting, investigation, and protection for 16 of 16 residents (Resident 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 and 16) reviewed for abuse and neglect. These failures caused harm to Resident 1, 2, 3, 4, 5, 6 and 10 and placed other residents in the likelihood of serious harm and injury from abuse and neglect. The facility's failure to act and initiate immediate interventions to protect residents from further harm related to potential abuse and neglect and the failure to timely investigate abuse and neglect allegations constituted a situation of an immediate jeopardy (IJ) related to CFR 483.12 - F607 - Develop/Implement Abuse/Neglect Policies. The IJ was identified and communicated to the facility on [DATE]. Findings included . A review of the facility's policy titled, Abuse Prohibition Policy and Procedure dated 02/23/2021, showed the facility prohibited abuse and neglect. The policy also showed that the facility would implement abuse prohibition through the following: Prevention of occurrences, Identification of possible incidents or allegations which need investigation, Investigation of incidents and allegation, Protection of residents during the investigations, and Reporting of incidents, investigations and the facility's response to the results of their investigations. The policy directed facility staff to: A. Identifying, correcting, and intervening in situations in which abuse, neglect and/or misappropriation of patient property is more likely to occur. B. The notified supervisor will report the suspected abuse immediately to the Center Executive Director (Administrator) or designee and other officials in accordance with state law. If the resident sustains serious bodily injury, the employee who forms the suspicion or witnesses the incident must report no later than two (2) hours after forming the suspicion. C. The employee alleged to have committed the act of abuse will be immediately removed from duty, pending the investigation. (continued on next page)

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

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

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	D. If the suspected abuse is resident to resident, the resident who has in any way threatened or attacked another will be removed from setting or situation and an investigation will be completed. E. Report allegations of abuse and neglect no later than 2 hours after the allegation was made if the event results in serious bodily injury. Serious bodily injury is reportable. Only an investigation can rule out abuse, neglect or mistreatment. F. Notify local law enforcement, Ombudsman, Licensing District Office, Licensing Boards, Registries and other agencies as required. G. Initiate an investigation within 2 hours of an allegation of abuse that focuses on whether abuse or neglect occurred and to what extent; clinical examination for signs of injuries, if indicated, causative factors, Interventions to prevent further injury. H. The Center will protect patients from further harm during an investigation. Provide the patient with a safe environment by identifying persons with whom he/she feels safe and conditions that would feel safe. I. The Administrator or designee will take all necessary corrective action depending on the result of the investigation and Report findings of all completed investigation within (5) working days to the licensing District office. PHYSICAL ABUSE ALLEGATION Resident 1 was a long-term care resident of the facility. The resident's diagnoses list included left-sided paralysis (loss of the ability to move) and lack of proper nutrition. A review of the resident's 5 Day Minimum Data Set (MDS) assessment, dated 09/04/2021, showed the resident had intact cognition and needed 2-person extensive assistance with bed mobility and dressing. On 09/28/2021 at 12:50 PM, Resident 1 stated she was physically abused and feared a particular staff member, Staff C, Nursing Assistant Certified (NAC). Resident 1 stated that about 1-2 weeks ago (could not recall the exact date), Staff C forcefully yanked and manhandled her in bed while she was receiving personal care. Resident 1 also stated that Staff C grabbed her right arm/wrist area so hard that it caused her severe pain and had left bruising to the area. According to Resident 1, she told Staff C that she was terrified by her [Staff C] and that she did not want her [Staff C] to care for me anymore. Resident 1 further stated that Staff C had continued to come into her room and provide her meal trays after the incident. Resident 1 stated that this continued to occur even after she reported the incident of abuse to several staff members and told the facility's administration that she no longer feels safe to be around Staff C. Observation showed that Resident 1 had 2 or 3 fading/scattered light purple bruises (approximately) on her right wrist. Resident 1 stated she had lost sleep and appetite because of her fear that Staff C would just enter her room and hurt her again, especially when she's asleep. Resident 1 stated that Staff C neglected her and had retaliated against her by removing her dinner tray even before she started eating, and by not placing her call button where she could easily reach it and call for help. Resident 1 stated that these incidents of removing her meals and call light out of her reach occurred almost every day after she had reported the allegation of physical abuse to the facility. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 09/28/2021 at 1:15 PM, Staff B Director of Nursing (DNS) stated she was aware of the allegation of physical abuse involving Resident 1 dated 09/17/2021. Staff B also stated that Resident 1's description of the alleged perpetrator matched a staff member (Staff C, NAC) but Resident 1 was not able to identify the name of the alleged staff member. However, Staff B stated that the investigation was not completed at this time and that the facility had not suspended (removed from duty) any staff member, including Staff C, related to the allegation of physical abuse reported by Resident 1. On 09/28/2021 at 1:25 PM, Staff D, Social Services Director (SSD) stated she was aware of the allegation of physical abuse reported by Resident 1. Staff D stated that Resident 1 reported the allegation on 09/17/2021 early afternoon (not sure of the exact time) and provided a description of the alleged staff member. Staff D also stated that Resident 1's description of the alleged staff member matched the description of a particular staff member, Staff C, who was scheduled to work that afternoon shift immediately after the allegation was made (on 09/17/2021). According to Staff D, they immediately interviewed other residents in the unit on the same day to see whether other residents had any issues or concerns with Staff C. Staff D said they also reported the allegation to the state agency, and the facility Administration (Staff A, Administrator and Staff B, DNS). However, Staff D stated that the facility did not suspend any staff member related to the allegation, and that Staff C continued to work with residents, including Resident 1, without the facility completing the investigation and ruling out abuse and or neglect. Review of the daily staffing schedule from 9/17/2021 through 9/28/21? showed that Staff C was remained on the resident care schedule. Additionally, a review of Staff and personnel files showed no staff was suspended related to the allegation until the incident was investigated by the surveyor on 09/28/21. On 09/28/2021 at 1:30 PM, both Staff A, Administrator, and Staff B, DNS, stated they were not aware of the specific details of the incident. Staff A stated she was out of the facility when the incident happened and Staff B also stated that she was working as a nurse on the cart (medication/treatment nurse) when the incident happened, and that neither of them followed-up with the investigation. Both Staff A and Staff B stated that residents should have been protected from potential abuse (or on-going abuse), investigations should have been completed timely within 5 days of the incident and that the alleged staff member (Staff C NAC) should have been suspended pending the result of the investigation. Both Staff A and Staff B stated they knew that the investigation was not complete and offered no explanation as to why the facility's abuse and neglect policies and procedures were not followed to ensure Resident 1 and other residents of the facility received immediate protection from abuse so as to not be subjected to on-going abuse or neglect after the allegation was made and during an investigation. A review of the facility's daily staff schedule and Resident 1's clinical records for September 2021 showed Staff C continued to work with Resident 1 as her primary caregiver and worked with other residents after the allegation of physical abuse was reported to the facility. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 09/28/2021 at 1:45 PM during a meeting with Staff A and Staff B, Resident 1 stated and reiterated the allegation of physical abuse that she said she experienced from Staff C, NAC. Resident 1 stated that she was fearful and did not feel safe around Staff C, especially when Staff C came to her room every evening to deliver her meal and food tray. Both Staff A and Staff B were not able to state or provide evidence on what action(s) (if any) was taken by the facility to protect Resident 1 and other residents from a similar situation. Additionally, both Staff A and Staff B were not able to provide evidence that the facility had thoroughly investigated the incident for abuse and/or neglect, and whether the incident was reported to law enforcement agency as needed and required. On 09/28/2021 at 3:15 PM, Staff C stated that Resident 1 told her about 1-2 weeks ago that Resident 1 did not want Staff C to take care of her anymore for something that Staff C did. Staff C stated she continued working with residents, including Resident 1, but mostly just served meal trays to Resident 1 because the resident would refuse care from her, even if Staff C offered to provide care. Staff C further stated the facility was aware of the allegation made against her by Resident 1, but Staff C did not receive any instructions on what to do or whether she was to totally avoid and remove herself from providing any care to Resident 1 or not. The facility's lack of action and the failure to protect Resident 1 after the allegation of physical abuse caused harm to Resident 1 in the form of fear and psychosocial harm. Additionally, Resident 1 said she continued to experience on-going abuse, neglect and/or retaliation from Staff C. These failures caused serious harm to Resident 1 and placed other residents in the likelihood of serious harm and injury from ongoing abuse and neglect. NEGLECT ALLEGATION RESIDENT 2 Resident 2 was a long long-term care resident of the facility. The resident's diagnoses list included stroke, muscle weakness and left limb amputation. A review of the resident's Quarterly MDS assessment, dated 09/24/2021, showed the resident had intact cognition and needed 2-person assistance with bed mobility and transfers. A review of Resident 2's care plan, dated 04/06/2021, showed the resident required a mechanical lift device (Hoyer Lift) with 2 staff person assistance for transfers. A review of a nursing progress note completed by Staff E, Licensed Practical Nurse (LPN), dated 09/19/2021, showed that on 09/18/2021 at 3:40 PM, Resident 2's caregiver Staff F, NAC reported that Resident 2 had a fall while being transferred from the wheelchair to bed. Staff E completed an assessment immediately after the incident and noted the following injuries: A. Purple bruise on the left lower back area, 40 centimeter (cm) in length by 12 cm wide. B. Left lower back abrasion, 11cm in length by 0.5cm wide. C. Abrasion on the left buttocks area, 3cm in length x 0.5cm wide. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 09/28/2021 at 2:30 PM, Resident 2 stated that he remembered the incident occurred about 1 week ago when he fell out of the mechanical lift device while being transferred from the wheelchair to bed. Resident 2 stated Staff F, NAC, transferred him by herself using the mechanical lift device when he [Resident 2] suddenly slid off the sling. Resident 2 stated that Staff F attempted to hold him up while she lowered him to the floor. According to Resident 2, the resident landed on his back, but did not hit his head, Luckily, I just bruised myself and bled a little. Resident 2 further stated that staff usually transferred him by only 1 person, instead of 2 persons, because there was not enough staff available when the resident needed to be transferred to and from the bed. On 09/28/2021 at 1:15 PM, Staff B, DNS, stated that the incident occurred because Staff F, NAC used the mechanical lift device alone and attempted to self-transfer Resident 2 without the second person for safety and as directed by the resident's care plan. However, Staff B stated that the incident investigation was not completed at this time, and that the facility was still investigating the incident. Staff B was not able to state and provide evidence on what action(s) (if any) was taken by the facility to protect Resident 2 and other residents from a similar situation. Additionally, Staff B was not able to provide evidence that the facility had thoroughly investigated the incident for abuse and/or neglect, or whether the incident was reported to the state agency as required. A review of the state agency's hotline reports from 09/01/2021 to 09/28/2021 showed this incident was not called in and/or reported to the state hotline. On 10/01/2021 at 1:10 PM, Staff F, NAC, stated she knew Resident 2 required 2 staff person for safe transfers and when using a mechanical lift, but she was not able to locate and/or get any help from other staff to assist her with transfer, so she attempted to transfer Resident 2 from wheelchair to bed by herself. Staff F stated that during the transfer, Resident 2 slid off the sling, so she lowered the resident to the ground immediately. According to Staff F, she immediately called in the nurse to help assist with the situation and to check on Resident 2. Staff F further stated that Resident 2 was assessed by Staff E, LPN after the incident and the resident was found with a huge bruise on his back, skin tear and abrasions on his back after the incident. The facility's failure to ensure staff followed and implemented Resident 2's care plan directives caused harm and injury to Resident 2. Additionally, the facility's failure to timely investigate and implement timely interventions based on the root cause of the incident placed Resident 2 and other residents of the facility in the likelihood of serious injury, harm and serious impairment related to ongoing staff neglect. RESIDENT 10 Resident 10 was a long-term care resident of the facility. The resident's diagnoses list included stroke with left sided paralysis/weakness. A review of the resident's Quarterly MDS assessment, dated 09/18/2021, showed the resident had intact cognition and needed one person assistance with bed mobility and transfers. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 09/28/2021 at 1:20 PM, Staff B, DNS, stated Resident 10 made an allegation of neglect about a staff member (Staff I, NAC) on 09/15/2021. Staff B said Resident 10 reported on 09/17/2021 that on 09/15/2021, day shift - no specified time, Resident 10 did not receive peri-care, her brief was not changed, and she had stayed in bed all day because Staff I did not provide the care and refused to get her up in bed. Staff B also stated that the investigation of the allegeation was not complete at this time, and that Staff I was not suspended during the investigation. Staff B offered no explanation as to why the facility's abuse and neglect policy was not implemented or why Staff I was not suspended pending the result of the investigation. On 09/28/2021 at 3:05 PM, Resident 10 stated Staff I, NAC refused to clean her and get her up from bed few weeks ago. The resident was not able to recall exact date and time. Resident 10 stated that she ended up staying in bed the entire day and did not receive peri-care from 6:00 AM till about 3:00 PM. According to Resident 10, she had a bowel movement and was sitting in her own urine for hours. Resident 10 stated, I was very angry and upset because I have bad rash and open sores on my bottom and private area. Resident 10 also stated that she reported her concern to the nurses and the social worker, but they didn't care. Resident 10 stated that Staff I was back to working with her and was never sorry for what she did. Resident 10 added that Staff I was blaming me instead because she said that I refused. Resident 10 stated, I never refuse. I always want to get up from bed. Resident also stated, I felt attacked because I was being blamed for what happened. Resident 10 stated the facility was shorthanded and she would always wait for hours to be changed or be transferred from wheelchair to bed. You wonder why most residents here complain about not getting help? Go figure. Resident 10 stated, It was embarrassing and humiliating to be in your own waste for hours. A review of Resident 10's clinical records and skin assessment, dated 09/20/2021, showed the following new skin injury/wound(s) were identified: Rash to bilateral groin area and left buttocks/left upper rear thigh Moisture associated skin damage (MASD). The facility's failure and lack of action to protect Resident 10 and other residents of the facility, and the failure to timely investigate the allegation of abuse/neglect caused harm to Resident 10 in the form of anger/psychosocial harm and contributed to the development of new skin breakdown/conditions. A reasonable person would feel humiliated and embarrassed when left sitting in their own urine and waste as described by Resident 10. RESIDENT 11 Resident 11 was a long-term care resident of the facility. The resident's diagnoses list included stroke with left sided weakness. A review of the resident's Quarterly MDS assessment, dated 08/09/2021, showed the resident had impaired cognition and needed 1 person assistance with transfers and personal hygiene. On 09/28/2021 at 1:20 PM, Staff B, DNS stated that Resident 11 made an allegation of abuse and rough handling on 09/17/2021 against Staff J, NAC. Staff B stated Resident 11 was not sure about the specific date and time, but she said it was few weeks ago around 09/17/2021. Staff B stated that Staff J came to the resident's room to give her a shower, but during the transfer, Staff J pushed her hard into the shower chair causing the resident pain and soreness on the back. Staff B stated Resident 11 ended up refusing the shower because of what happened. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Staff B also stated that the investigation was not complete at this time, and that Staff J was not suspended during the investigation. Staff B offered no explanation as to why the facility's abuse and neglect policy was not implemented and why Staff J was not suspended pending the result of the investigation. On 09/29/2021 at 10:30 AM, Resident 11 stated she remembered what happened between her and Staff J, NAC. Resident 11 stated that few weeks ago (was not able to recall the date and time), Staff J offered to give her a shower. However, Resident 11 stated that when she transferred from the bed to the shower chair, Staff J shoved her and pushed her hard enough to cause her severe back pain. Resident 11 stated that she asked Staff J why was he so rough? and told Staff J that she will be filing a complaint against him. According to Resident 11, Staff J responded by saying go ahead, so she decided to not let Staff J give her a shower because of the incident. Resident 11 stated she reported the incident to several facility staff including nurses and social workers. However, Resident 11 stated Staff J continued to come into her room and from time to time, asked her if she would like a bath or shower. According to Resident 11, she does not feel comfortable around Staff J and that she would always refuse to have Staff J give her a shower because of the incident. On 09/29/2021 at 11:00 AM, both Staff A, Administrator and Staff B, DNS stated they were not aware of Resident 11's preference of not wanting Staff J, NAC to offer and provide her a shower and/or bath due to the allegation of abuse reported on 09/17/2021. RESIDENT 12 Resident 12 was a long-term care resident of the facility. The resident's diagnoses list included obesity and muscle weakness. A review of the resident's Quarterly MDS assessment, dated 07/30/2021, showed the resident had intact cognition and needed 1-to-2-person assistance with bed mobility and transfers. On 09/28/2021 at 1:20 PM, Staff B, DNS stated that Resident 12 made an allegation of neglect on 09/14/2021 about Staff H, NAC. Staff B stated that Resident 12 reported that there was a delay in care and with the amount of time it took staff to respond to his call light, but Resident 12 was not able to provide a specific date and time. Staff B was not able to provide additional information related to the investigation, such as the specific details of the incident, witness statements and/or interview including any supporting documents on what action was taken (if any) to protect the resident and other residents of the facility. Staff B stated the incident investigation was not complete at this time. AVOIDABLE ACCIDENTS (FALLS) RESIDENT 3 Resident 3 was a long-term care resident of the facility. The resident's diagnoses list included Parkinson's disease (a movement disorder) and dementia (memory problem). A review of the resident's Quarterly MDS assessment, dated 09/14/2021, showed the resident had impaired cognition and needed 2 person staff assistance with bed mobility and transfers. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of Resident 3's care plan, dated 10/08/2019 and revised on 09/30/2021, showed the resident was at risk for falls due to cognitive loss, lack of safety awareness, impaired mobility and current medical diagnoses. A review of a report submitted to the state agency on 09/27/2021 showed that Resident 3 had fallen at least 3 times within the last month. The concern report also showed that Resident 3 told this family member that He hit his head very hard on the floor and his hip. He said he laid on the hard cold floor and waited for someone to come find him. It took so long that he fell back to sleep. The report showed the resident sustained injuries including a gash (a deep wound or cut) on his head and a laceration on his arm. On 09/28/2021 at 1:20 PM, Staff B, DNS, stated that Resident 3 had fallen out of bed on 09/15/2021 and 09/24/2021. Staff B stated that both fall incidents were unwitnessed, but the resident and staff reported that Resident 3 had rolled out of bed on both occasions resulting in injury. Staff B stated that on 09/15/2021 fall, Resident 3 sustained a head laceration with abrasions to the right side of the head, and bruised right elbow measured at 3cm long by 3cm wide. During the fall on 09/24/2021, Resident 3 sustained a skin tear on his right elbow measured at 6cm long by 5cm wide. Staff B stated that the incident investigation for Resident 3 on both falls were not completed at this time, and that the facility was still investigating the incident. Staff B was not able to state and provide evidence on what action(s) (if any) was taken by the facility to protect Resident 3 and other residents from a similar situation. Additionally, Staff B was not able to provide evidence that the facility had thoroughly investigated the incident for abuse and/or neglect, and whether the incident was reported to the state agency as required. On 09/29/2021 at 12:30 PM, Resident 3 stated he had recently fallen out of bed at least 2 times that he could remember. Resident 3 stated that he rolled out off bed on both occasions because the bed was too small and slippery. According to Resident 3, he always slides to either side of the bed a lot and also it was impossible to get any staff member here to help you. Resident 3 further stated he had waited hours, maybe 1-3 hours before somebody found him on the floor on both occasions. Resident 3 stated he hit his head hard that he had lost consciousness and suffered several lacerations on his head and elbows. Resident 3 stated he had requested to get something done to his bed or mattress but there has been no follow-up made to his request and he was afraid that he would fall out of bed again soon. Resident 3 was observed on a regular size bed with a low air loss mattress. Resident 3 was positioned close to the edge of the bed with his head leaning on the right side. There was no safety device to keep the resident at the center of the bed and minimize risk of him sliding on the side. Resident 3 stated he was not able to reposition himself in bed independently. RESIDENT 4 Resident 4 was a long-term care resident of the facility. The resident's diagnoses list included heart problems and dementia (memory problem). A review of the resident's Significant Change MDS assessment, dated 09/14/2021, showed the resident had impaired cognition and needed one person assistance with bed mobility and toilet use. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of Resident 4's care plan, dated 04/10/2021 and revised on 09/21/2021, showed Resident 4 was at risk for falls due to cognitive loss and lack of safety awareness. The care plan directed facility staff to: ensure left side fall mat is in place at all times while resident lying/resting in bed. On 09/28/2021 at 1:20 PM, Staff B, DNS, stated Resident 4 fell on [DATE] and sustained injuries including a bruise on the face (left cheek area), multiple lacerations to the left lower extremities, and skin tears to the left elbow and left foot. Staff B stated the incident was not witnessed, but the resident reported that she was trying to use the bathroom when the incident happened. Staff B stated that the incident investigation for Resident 4 was not complete at this time, and that the facility was still investigating the incident. Staff B was not able to state and provide evidence on what action(s) (if any) was taken by the facility to protect Resident 4 and other residents from a similar situation. Additionally, Staff B was not able to provide evidence that the facility had thoroughly investigated the incident for abuse and/or neglect, and whether the incident was reported to the state agency as required. On 09/29/2021 at 12:35 PM, Resident 4 stated that she fell and rolled out of bed last week, but could not recall the exact date and time, and hit her head and face hard. Resident 4 stated she also injured her left arm and blood was all over. According to the Resident 4, she needed to use the bathroom at the time of the incident, and she called for help, but no one came for hours so she decided to get up by herself. Resident 4 further stated, she had waited for a very long time on the floor calling for help before she received help from any staff member. Observation showed the resident lying on a regular/standard size bed and mattress with no other safety device in place. There was no fall matt on the floor, as directed by the plan of care. The facility's failure to act and protect Resident 3 and Resident 4 from further injuries from falls, the failure to timely investigate and identify the root cause, and implement timely interventions caused harm and injury to Resident 3 and 4. Additionally, these failures placed Resident 3 and Resident 4 in the likelihood of serious harm and injury, impairment and/or death related to avoidable accidents. RESIDENT 9 Resident 9 was a long-term care resident of the facility. The resident's diagnoses list included Cerebral Palsy (movement disorder) and muscle weakness. A review of the resident's Quarterly MDS assessment, dated 08/19/2021, showed the resident had impaired cognition and needed 2-person extensive assistance with bed mobility and transfer. A review of Resident 9's care plan, dated 03/01/2016 and revised on 04/13/2020, showed the resident was at risk for falls due to her current medical conditions. On 09/28/2021 at 1:20 PM, Staff B, DNS, stated Resident 9 fell on [DATE] at approximately 5:00 PM. Staff B stated the incident was not witnessed and the resident did not suffer any injury. However, Staff B stated that she does not have the specific details of the incident including what action was taken (if any) to minimize the risk of the incident because the investigation was not complete at this time. (continued on next page)

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	505042	A. Building B. Wing	10/07/2021

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

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of a nursing progress note, dated 09/16/2021, showed that at 5:00 PM, Resident 9 was found lying face down, right next to her bed. The note documented, Res (resident) apparently slid down from her wheelchair onto floor. Prior to incident res was offered by CNA to be put in bed as she looked sleepy but refused . PRN (as needed) Tylenol (pain/fever medication) and routine Norco (narcotic pain medication) given for discomfort from fall. On 09/28/2021 at 3:00 PM, Resident 9 stated that a few days ago (did not know the exact date and time) she fell asleep while in the wheelchair and fell forward. Resident 9 stated she wanted to go back to bed, but there was no staff member around to put her back to bed. The resident stated she hit her head hard on the floor and had waited a long time for any staff to found her and assist her. Observation of Resident 9 did not show any injury related to the fall. The facility's failure to address the root cause of the incident and the failure to timely investigate and implement interventions to minimize the risk of reoccurrence of the incident placed Resident 9 at increased risk of harm and injury related to fall. RESIDENT 15 Resident 15 was admitted to the facility on [DATE] for rehabilitation therapy. The resident's diagnoses list included history of repeated falls and muscle weakness. A review of the resident's Admission MDS assessment, dated 08/27/2021, showed the resident had intact cognition and needed 1 person assistance with bed mobility and transfers. On 09/28/2021 at 1:20 PM, Staff B, DNS, stated that Resident 15 had a fall on 09/21/2021. However, Staff B was not able to provide additional information about the incident and stated that the investigation was not complete at this time. On 09/28/2021 at 3:30 PM, Resident 15 stated he had a fall on 09/21/21, but could not recall the time. Resident 15 stated he tried to get some clothes from his drawer, but he became dizzy and lightheaded. Resident 15 also stated that he landed on his right side, and hit the wall before hitting the ground. According to Resident 15, there was no staff member present and/or around when the incident happened, but he was able to crawl back in bed. Resident 15 further stated that he had an on-going problem with being lightheaded and dizzy, so he would appreciate if somebody from the facility could help him figure out a way to how to minimize the risk of falling and possibly getting injured. RESIDENT 16 Resident 16 was a long-term care resident of the facility. The resident's diagnoses list included stroke and dementia (memory problem). A review of the resident's Annual MDS assessment, dated 07/01/2021, showed the resident had impaired cognition and needed two staff person with bed mobility and toileting needs. On 09/28/2021 at 1:20 PM, Staff B, DNS, stated that Resident 16 had a fall on 09/21/2021. Staff B stated that the incident was unwitnessed, and the resident was found on his knees in the room leaning on his bed. However, Staff B was not able to provide additional information about the incident and stated that the investigation was not complete at this time. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 09/29/2021 at 9:30 AM, Staff B, DNS, stated she was still gathering information about Resident 16's fall, but said the resident was found to have incontinent (lack of voluntary control) episodes of bowel and bladder at the time of the incident. However, Staff B was not able to provide any additional information regarding when the resident last received incontinent care and who assisted, and whether the resident's care plan was followed, and/or if the [TRUNCATED]

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F 0835 Level of Harm - Actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39651 Based on interview and record review, the facility Administration failed to effectively manage the facility in compliance with state and federal regulatory requirements. The facility Administration failed to ensure compliance related to the development and implementation of effective policies and procedures on timely investigation and immediate protection of residents from abuse and neglect. The facility Administration also failed to timely investigate incidents and accidents to immediately protect the resident(s) from harm and to minimize the risk of reoccurrence of the same incident/accident. These failures caused harm to Resident 1, 2, 3, 4, 5, 6 and 10 and placed the other residents at risk for harm related to ongoing abuse and neglect. An immediate Jeopardy (IJ) related to CFR 483.12 - F607 - Develop/Implement Abuse/Neglect Policies was identified and communicated to the facility on [DATE]. Findings included . A review of the facility's accident and incident reporting log for the month of September 2021 showed 17 incomplete investigation that were not investigated timely to ensure that residents involved with each incident and accidents were protected and received timely and effective interventions to minimize the risk of serious harm, injury, and further reoccurrence of the accidents/incidents. The facility failed to implement written abuse and neglect policies and procedures related to the required and timely investigation, resident protection, and/or reporting to the state agency/other agency as required for the following incidents and accidents: A. Resident 1 - Physical Abuse allegation dated 09/17/2021. B. Resident 2 - Neglect (substantiated) dated 09/18/2021. C. Resident 10 - Neglect allegation dated 09/15/2021. D. Resident 11 - Physical Abuse allegation/rough handling dated 09/17/2021. E. Resident 12 - Neglect allegation dated 09/14/2021. F. Resident 7 - Unexpected death at the facility on 09/16/2021. G. Resident 3 - Fall with injuries dated 09/15/2021 and 09/24/2021. H. Resident 4 - Fall with injuries dated 09/15/2021. I. Resident 5 - In-house acquired (developed in the facility) stage IV pressure ulcer/injury. J. Resident 6 - In-house acquired stage IV pressure ulcer/injury. K. Resident 8 - Elopement on 09/10/2021 and 09/12/2021. (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Some	L. Resident 13 and Resident 14 - Resident-to-Resident altercation on 09/16/2021. M. Resident 9 - Fall dated 09/16/2021. N. Resident 15 - Fall on 09/21/2021. O. Resident 16 - Fall on 09/21/2021. On 09/29/2021 at 12:50 PM, both Staff A, Administrator and Staff B, Director of Nursing (DNS) stated those sixteen investigations were not followed-up on and completed timely so as to ensure those residents were safe, and that timely and effective interventions were put in place to minimize the risk of recurring abuse and neglect incidents. Both Staff A and Staff B offered no explanation as to why the facility's written policies and procedures were not followed to ensure resident safety and protection from abuse and neglect. Reference: (WAC) 388-97-1620(1)

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F 0837 Level of Harm - Actual harm Residents Affected - Some	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 operation. The governing body failed to ensure the facility implemented abuse and neglect policies and procedures related to resident protection, reporting and investigation of allegations of abuse, neglect, and accidents/incidents for 16 of 16 residents (Resident 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 and 16) reviewed for abuse and neglect. Additionally, the facility failed to effectively implement corrective actions for the deficiencies cited on previous abbreviated surveys' Statement of Deficiencies, dated 07/12/2021, 08/17/2021, and 09/15/2021. These failures caused harm to Resident 1, 2, 3, 4, 5, 6 and 10 and placed other residents at risk of harm and injury from abuse and neglect. 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. The facility showed continued noncompliance for the following Federal Regulatory requirements after the facility alleged to be back in substantial compliance prior to the start of the current abbreviated survey. The Governing Body failed to ensure the facility administration implemented their plan of corrections and sustained compliance as alleged on the written plan of correction submitted on 07/27/2021, 09/09/2021, and 10/08/2021. The continued noncompliance resulted to an Immediate Jeopardy (IJ) situation related to CFR 483.12 - F607 - Develop/Implement Abuse/Neglect Policies, a repeat citation from 08/17/2021. 1. CFR 483.25 - F689 - Free of Accident Hazards/Supervision/Devices. - Scope and Severity of pattern Immediate Jeopardy to resident health and safety (K). 2. CFR 483.25 - F684 - Quality of Care - Scope and Severity of isolated actual harm that is not immediate jeopardy (G). 3. CFR 483.25 - F686 - Treatment/Services to Prevent/Heal Pressure Ulcers - Scope and Severity of isolated actual harm that is not immediate jeopardy (G). 4. CFR 483.70 - F835 - Administration - Scope and Severity of isolated actual harm that is not immediate jeopardy (G). 5. CFR 483.70 - F837 - Governing Body - Scope and Severity of isolated actual harm that is not immediate jeopardy (G). (continued on next page)

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F 0837 Level of Harm - Actual harm Residents Affected - Some	6. CFR 483.12 - F600 - Free from Abuse and Neglect - Scope and Severity of isolated no actual harm, with potential for more than minimal harm. 7. CFR 483.12 - F607 - Develop/Implement Abuse/Neglect Policies - Scope and Severity of isolated no actual harm, with potential for more than minimal harm. 8. CFR 483.12 - F609 - Reporting of Alleged Violations - Scope and Severity of isolated no actual harm, with potential for more than minimal harm. 9. CFR 483.12 - F610 Investigate/Prevent/Correct Alleged Violation - Scope and Severity of isolated no actual harm, with potential for more than minimal harm. The following accidents, incidents, and allegations of abuse and neglect were not reviewed and investigated timely to ensure residents were protected during an on-going investigation as directed by the facility's abuse and neglect policy: A. Resident 1 - Physical Abuse allegation dated 09/17/2021. B. Resident 2 - Neglect (substantiated) dated 09/18/2021. C. Resident 10 - Neglect allegation dated 09/15/2021. D. Resident 11 - Physical Abuse allegation/rough handling dated 09/17/2021. E. Resident 12 - Neglect allegation dated 09/14/2021. F. Resident 7 - Unexpected death at the facility on 09/16/2021. G. Resident 3 - Fall with injuries dated 09/15/2021 and 09/24/2021. H. Resident 4 - Fall with injuries dated 09/15/2021. I. Resident 5 - In-house acquired (developed in the facility) stage IV pressure ulcer/injury. J. Resident 6 - In-house acquired stage IV pressure ulcer/injury. K. Resident 8 - Elopement on 09/10/2021 and 09/12/2021. L. Resident 13 and Resident 14 - Resident-to-Resident altercation on 09/16/2021. M. Resident 9 - Fall dated 09/16/2021. N. Resident 15 - Fall on 09/21/2021. O. Resident 16 - Fall on 09/21/2021. (continued on next page)

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F 0837 Level of Harm - Actual harm Residents Affected - Some	On 10/04/2021 at 11:25 AM, Staff Z, [NAME] President of Operations (VPO) stated he was not aware that the facility was behind in completing the required and timely investigations of allegations of abuse and neglect, including other accidents and incidents as required by the state and federal regulations. Staff Z also stated that during his visits to the facility, he did not review the facility's record/incident and accident logs to ensure that the facility administration was up to date in conducting investigations and ensuring residents were protected during the investigation process as directed by the facility's abuse and neglect policy. According to Staff A, he also reviewed the facility's written plan of correction for the recent citations (as detailed above). However, Staff Z stated he did not review specific records (including open and current accidents, incidents, allegations of abuse and neglect) and would only review what he thought would be appropriate for him to check based on his credentials/qualifications. Staff Z further stated the facility Administration did not communicate and reach out to the Governing Body about the need for help in making sure that the facility was up to date with investigations and were implementing the plan of corrections as required. Reference: WAC 388-97-1620 (2)(c)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 39651 Based on interview and record review, the facility failed to ensure a consistent Quality Assurance and Performance Improvement (QAPI) Program, failed to put forth effort of good faith attempts to identify and correct own identified deficiencies, and failed to develop/implement effective plans of action to sustain compliance for previous deficiencies. Failure to recognize deficiencies in care and services that were identified during survey and/or for previously cited deficiencies placed all residents at risk for ongoing unmet needs and a diminished quality of life. Findings included . Review of the facility's Quality Assurance and Performance Improvement (QAPI) Plan, dated 01/31/2018, showed that the QAPI program was on-going, integrated date driven and comprehensive addressing all aspects of care, quality of life and resident-centered rights and choices; Improvement activities and Performance Improvement Projects are the structure and means through which identified problem areas are addressed with data analysis, process improvements and ongoing monitoring, whenever necessary using an interdisciplinary team; Assess, evaluate and identify potential improvement opportunities based on: All current regulatory on-site assessments, including plan of corrections, both state/federal surveys and peer surveys. Include a review of the plan of correction; Adverse events since past meetings including prevention opportunities, investigations and corrective actions; Potential issues identified through . family comments, resident requests . grievances. On 10/04/2021 at 11:25 AM, Staff Z, [NAME] President of Operations (VPO) stated he attended the facility's QAPI committee meeting on a regular basis. However, Staff Z was not able to provide an explanation as to why the QAPI committee was not aware and/or did not identify the quality deficiencies related to CFR 483.12 - F607 - Develop/Implement Abuse/Neglect Policies that resulted in an Immediate Jeopardy situation on 09/29/2021, a repeat citation from 08/17/2021. On 10/06/2021 at 10:35 AM, Staff A, Administrator and Staff B, Director of Nursing (DNS) stated the facility's QAPI committee meeting was held monthly. Both the staff member stated that the QAPI committee was not aware and did not identify quality deficiencies related to the areas of abuse and neglect allegations, accidents and incidents including timely investigations and need for resident protection and follow-ups. Both Staff A and Staff B stated the QAPI committee should have been aware of these issues, but did not provide an explanation as to why the committee was not involved and/or made aware of the lack of timely investigations of accidents, incidents, and abuse and neglect allegations. Reference WAC 388-97-1760(1)(2)