

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/28/2025
NAME OF PROVIDER OR SUPPLIER  Ballard Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>35787</p> <p>Based on interview and record review, the facility failed to timely initiate and/or investigate an allegation of neglect for 1 of 3 residents (Resident 1), reviewed for abuse/neglect investigation. This failure placed the resident at risk for potential unidentified neglect and lack of protection from abuse/neglect.</p> <p>Findings included .</p> <p>Review of the Nursing Home Guidelines, The Purple Book, revised in 2015, showed that all alleged incidents of abuse, neglect, abandonment, mistreatment, injuries of unknown source, personal and/or financial exploitation, or misappropriation of resident property must be thoroughly investigated.</p> <p>Review of the facility's undated policy titled, Abuse Investigating and Reporting, showed all reports of resident abuse, neglect, exploitation and misappropriation of resident property shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management.</p> <p>Review of the quarterly Minimum Data Set (an assessment tool) dated 03/06/2025 showed Resident 1 was cognitively intact.</p> <p>Review of the complaint hotline form dated 02/27/2025, showed Staff F, Social Services, submitted to the state agency that the facility received communication from an outside agency that Resident 1 reported to them that they had multiple concerns with the facility. It further showed that in the communication, Resident 1 stated multiple issues of negligence, falls, and disrespectful language.</p> <p>In an interview on 03/27/2025 at 1:01 PM, Staff F stated that the outside agency emailed me and it was something that Resident 1 reported to them, and I submitted a report to the online incident reporting line. We had a care conference with Resident 1, and I completed grievance forms when I was informed about the multiple concerns, the negligence, the falls and the disrespectful language. I think I told the Director of Nursing Services (DNS) that was here at the time, not the one that is here now. I did not tell the Administrator. I did not start an investigation, I did a care conference with Resident 1 and started the grievances, I thought that would be enough.</p> <p>In an interview on 03/27/2025 at 4:40 PM, Staff B stated, I was not here during that time; an allegation of neglect should have been thoroughly investigated.</p> <p>(continued on next page)</p>		

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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 03/27/2025 at 4:43 PM, Staff G, Regional Nurse Consultant, stated the investigation would have been placed in a red folder when the investigation was complete. Staff G further stated, I did not see one.</p> <p>In an interview on 03/27/2025 at 4:51 PM, Staff A, Administrator, stated they managed the allegations and the investigations of abuse/neglect in the facility and that an allegation of neglect for Resident 1 was not reported to them or investigated.</p> <p>Reference: (WAC) 388-97-0640 (6)(a)(b)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35787</b></p> <p>Based on interview and record review, the facility failed to timely develop a care plan for lice (insects that live on the human body and hair that can be transmitted through contact with an infected person or their belongings like clothing and /or bedding) infestation for 1 of 1 resident (Resident 2), reviewed for infection control. This failure placed the residents, staff, and visitors at increased risk for further infestation, and unmet care needs.</p> <p>Findings included .</p> <p>Review of the readmit Advanced Registered Nurse Practitioner (ARNP) progress note dated 03/04/2025, showed Resident 2 was readmitted to the facility that day, with orders for permethrin (treatment for lice) external liquid apply to hair and scalp one time.</p> <p>Review of Resident 2's care plan, initiated on 03/24/2025 [20 days later since the date of admission], showed, Resident 2 was on contact precautions for head Lice.</p> <p>In an interview on 3/27/2025 at 4:54 PM, Staff B, Interim Director of Nursing Services, stated that the care plan for Resident 2's head lice and treatment started on 03/24/2025 and that the care plan should have been started when they readmitted to the facility on [DATE].</p> <p>Reference (WAC): 388-97-1020 (5)(b)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>35787</p> <p>Based on observation, interview, and record review, the facility failed to ensure contact precautions (set of safeguards used to prevent the spread of infection transmitted through direct or indirect contact with a resident or their environment) signage was placed on the outside of the room for 1 of 1 Resident (Resident 2), reviewed for infection control. This failure placed the residents, staff, and visitors at increased risk of further infestation of lice (insects that live on the human body and hair that can be transmitted through contact with an infected person or their belongings like clothing and /or bedding) and related complications.</p> <p>Findings included .</p> <p>Review of the facility's undated policy titled, Isolation-Categories of Transmission Based Precautions, showed when a resident is placed on transmission-based precautions, appropriate notification is placed on the entrance door so that personnel and visitors are aware of the need and the type of precaution. The policy further showed the signage informed the staff of instructions for use of personal protective equipment (PPE-gown and gloves).</p> <p>Review of the quarterly Minimum Data Set (an assessment tool) dated 12/30/2024 showed Resident 2 was cognitively intact.</p> <p>Review of a nursing progress note in Resident 2's Electronic Health Record (EHR) dated 03/04/2025, showed Resident 2 requested to go to the local hospital for treatment of abdominal pain, nausea, and vomiting that was not relieved with medication. The progress notes further showed Resident 2 was transported to the local emergency department by emergency transport that day.</p> <p>Review of the hospital record dated 03/04/2025 showed Resident 2 was shown to have pediculosis (infestation of lice) and needed permethrin (a topical medication used to treat lice) treatment before going to have a scan.</p> <p>Review of the readmit Advanced Registered Nurse Practitioner (ARNP) progress note dated 03/04/2025, showed Resident 2 was readmitted to the facility that day, with orders for permethrin external liquid apply to hair and scalp one time for lice until 03/21/2024.</p> <p>In a joint observation and interview on 03/24/2025 at 3:06 PM, Staff C, Registered Nurse, stated the contact precautions sign should still be on the outside of Resident 2's room to inform staff and visitors that they needed to wear a gown and gloves before they entered Resident 2's room. Staff C stated that they did not know why the contact precautions sign was removed because Resident 2 still had symptoms of having lice when they had ongoing itching of their scalp, hair, arms and legs. Staff C further stated they were going to inform the physician that Resident 2 continued to have persistent itching of their scalp, and hair even after the last treatment was applied.</p> <p>In an interview on 03/24/2024 at 3:13 PM with Staff D, ARNP, stated Resident 2 should still be on contact precautions because they still had something in their hair that looked like lice. Staff D further stated that Resident 2 got treated in the hospital for lice and that they ordered additional treatments for the lice when Resident 2 returned to the facility from the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 03/24/2024 at 3:33 PM, Staff E, Infection Preventionist, stated Resident 2 should still be on contact precaution.</p> <p>In an interview on 03/24/2024 at 3:38 PM, Resident 2 stated their scalp still itched all the time and that they had picked their skin so bad from itching that it bled at times. Resident 2 further stated that they had been treated at the hospital for lice and that they needed additional treatments at the facility to get rid of the lice and stop the itching.</p> <p>In an interview on 03/24/2024 at 3:44 PM, Staff B, Interim Director of Nursing Services, stated the contact precaution sign was up for Resident 2 earlier that day and that they were not sure why it was removed.</p> <p>Reference: (WAC) 388-97-1320 (1)(a)</p>		