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	03/25/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to log an allegation of unprofessional conduct on the facility's reporting log for 1 of 5 residents (Resident 3), reviewed for incident investigations. This failure placed the residents at risk of unidentified abuse and a diminished quality of life. Findings included. Review of the Nursing Home Guidelines, The Purple Book, Sixth Edition, dated October 2015, showed reporting guidelines for nursing homes for an allegation of staff to resident abuse indicated to log the allegation on the facility's reporting (Department of Social and Health Services) log within five days. Review of the quarterly Minimum Data Set assessment (a required assessment tool) dated 02/10/2026 showed the resident was readmitted to the facility on [DATE]. The MDS further showed Resident 3 did not have problems with their memory or thinking. Review of the facility's incident investigation form dated 02/19/2026 showed Resident 3 complained that a staff member [Staff C, Recreation Assistant) called them [Resident 3] a derogatory name while they were speaking. Resident 3 stated that Staff C claimed it was said in a joking manner, however, they [Resident 3] did not take it that way. Resident 3 said that they called Staff C a derogatory name in retaliation. Further review of the incident investigation showed the allegation was substantiated when Staff C said they called Resident 3 a derogatory name. Review of the facility's incident log dated 02/03/2026 to 02/28/2026 did not show that the incident of verbal abuse was logged for the 02/19/2026 incident. A joint record review and interview on 03/25/2026 at 4:50 PM with Staff A, Director of Nursing Services, showed the facility's reporting log dated 02/03/2026 to 02/28/2026 did not show the verbal abuse incident that occurred on 02/19/2026 was logged on the incident report log. Staff A stated that they expected all incident investigations to be logged on the facility's reporting log within five days of the incident. Reference: (WAC) 388-97-0640 (5)(a) .

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	03/25/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete thorough and timely investigations for 3 of 5 residents (Residents 1, 3 & 4), reviewed for abuse/incident investigations. This failure placed the residents at risk for unidentified abuse, repeated incidents and a diminished quality of life.Findings included.Review of the Nursing Home Guidelines, The Purple Book, Sixth Edition, dated October 2025, showed, The facility must have evidence that all alleged violations are thoroughly investigated. The guidelines showed the results of all investigations must be reported to the administrator or their designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.Review of the facility's Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigation policy, dated September 2022 showed all allegations are thoroughly investigated and conduct interviews with other residents to whom the accused employee provides care or services.STAFF TO RESIDENT INCIDENT INVESTIGATIONSRESIDENT 1 Review of the quarterly Minimum Data Set assessment (MDS-an assessment tool) dated 01/08/2026 showed Resident 1 was readmitted to the facility on [DATE]. The MDS further showed Resident 1 had intact thinking and memory.Review of the facility incident investigation form dated 02/16/2026 showed another resident [Resident 2] reported that they witnessed Resident 1 being abused by a staff member.Review of the incident investigation dated 02/16/2026 showed an undated interview form with Resident 1, they denied that a staff member had touched them inappropriately since they had been a resident at the facility. The investigation further showed six other interview forms that did not have names or dates on the forms. The six forms had resident room numbers documented on the forms. Further review of the incident investigation form showed the summary/conclusion of the incident was dated 03/17/2026, this date was past the five working days of the allegation that was reported [by Resident 2] that Resident 1 had been abused by a staff member.In an interview on 03/25/2026 at 5:04 PM Staff B, Assistant Director of Nursing Services, stated they did the incident investigation for the allegation that was reported by Resident 2 on 02/16/2026. Staff B further stated that they did not conclude or summarize that abuse or neglect had not occurred for the incident until 03/17/2026, almost a month later.In an interview on 03/25/2025 at 5:26 PM Staff A, Director of Nursing Services, stated that all resident interviews should be dated on the date the interviews were conducted as part of the investigation. Staff A stated that part of a complete investigation would include resident names and the date the interview was completed. Staff A further stated that their expectation was that all investigations be completed and concluded within five working days, and the investigation for the allegation of abuse for Resident 1 was about a month past the five-day requirement.RESIDENT 3Review of the quarterly MDS dated [DATE] showed Resident 3 was readmitted to the facility on [DATE] and had intact thinking and memory.Review of an incident investigation dated 02/19/2026 showed Resident 3 complained that a staff member [Staff C, Recreation Assistant] called them a derogatory name while in a conversation with Staff C, and the staff member said they were joking, however, Resident 3 did not see it that way and called them a derogatory name in retaliation.Further review of the investigation dated 02/19/2026 showed there was a miscommunication between Resident 3 and Staff C, it was concluded that the staff member called Resident 3 a derogatory name while they communicated on 02/19/2026. The investigation showed five other interview forms that did not have names or dates on the forms. The five forms had resident room numbers documented on the forms.In an interview on 03/25/2025 at 5:37 PM Staff A stated that all resident interviews should be dated on the date the interviews were conducted as part of the investigation to make the investigation complete. Staff A stated the residents interviewed should have names on the forms, not just the room numbers. Staff A stated that if the residents changed rooms or were discharged it could be difficult to track which resident was (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	03/25/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interviewed. Staff A further stated that a complete investigation would include the names of the residents that were interviewed and the date the interview was completed.FALL INCIDENT INVESTIGATIONRESIDENT 4Review of the quarterly MDS assessment dated [DATE] showed Resident 4 was admitted to the facility on [DATE] and had a diagnosis of a stroke (blood flow to part of the brain is blocked) which caused partial/total loss of voluntary function on the right side of their body. The MDS further showed Resident 4 had problems with thinking and memory and was dependent on staff for all transfers and mobility.Review of an unwitnessed fall incident investigation dated 03/09/2026 showed Resident 4 was seen by their roommate [Resident 5] getting up from their bed, heading towards a chair in their room, then Resident 4 stumbled towards the chair [the investigation did not state where the resident landed]. The fall incident investigation was unclear whether the resident hit their head or not because the resident was nonverbal. The resident was assessed for pain/injuries, and none were found. Further review of the unwitnessed fall incident investigation did not show staff interviews.In an interview on 03/25/2026 at 3:48 PM, Staff D, Registered Nurse, stated that they must do staff interviews, especially if a resident falls as it would help to complete the investigation to know what the resident was doing prior to the fall, when was the resident last seen by staff, what was their behavior like, or had they been trying to get out of bed. Staff D stated the assigned nursing assistant should be the first one interviewed, then any other staff that may have seen the resident or had contact with the resident, and the answers to these questions would help to complete the investigation and find out the possible cause of the fall and maybe prevent the resident from falling again.In an interview on 03/25/2026 at 3:58 PM Staff E, Licensed Practical Nurse/Unit Manager, stated they completed the unwitnessed fall incident investigation dated 03/09/2026. Staff E stated staff interviews should be conducted for falls, the assigned nursing assistant and any staff that may have seen or had contact with the resident prior to the fall should be interviewed. Staff E further stated that staff interviews should have been included in the investigation for Resident 4.In an interview on 03/25/2026 at 5:45 PM, Staff A stated that it was their expectation for staff interviews to be completed for resident fall incidents. Staff A further stated that the fall incident dated 03/09/2026 for Resident 4 did not have staff interviews and was an incomplete incident investigation.Reference: (WAC) 388-97-0640 (6)(a).