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	04/16/2026

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

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure annual Minimum Data Set (MDS - an assessment tool) were completed within 14 days of the ARD (Assessment Reference Date) for 3 of 26 residents (Residents 18, 100 & 2), reviewed for comprehensive assessments. This failure placed the residents at risk for delayed and/or unmet care needs, and a diminished quality of life.Findings included . Review of the Resident Assessment Instrument (RAI) 3.0 User's Manual (a guide directing staff on how to accurately assess the status of residents), Version 1.20.1, dated October 2025, showed that the completion date of the annual MDS assessment must be no later than 14 days after the ARD (ARD plus 14 calendar days). The MDS RAI manual further showed that the admission assessment must be completed by the end of day 14, counting the date of admission to the nursing home as day one. RESIDENT 18Review of Resident 18's annual MDS dated [DATE] showed that it was completed on 10/27/2025 (six days late). RESIDENT 100Review of Resident 100's annual MDS dated [DATE] showed that it was completed on 01/29/2026 (seven days late). In an interview and joint record review on 04/14/2026 at 12:31 PM, Staff D, MDS Coordinator, stated that the facility followed the RAI manual for MDS assessment completion. A joint record review of Resident 18's annual MDS dated [DATE] showed that it was completed on 10/27/2025. A joint record review of Resident 100's annual MDS dated [DATE] showed it was completed on 01/29/2026. Staff D stated that Resident 18's and Resident 100's annual MDS assessments were completed late, and it should have been completed within 14 days. In an interview on 04/15/2026 at 8:35 AM, Staff B, Director of Nursing, stated that the facility would follow the RAI manual as guidance for MDS completion, and stated they expected MDS assessments to be completed timely and accurately. RESIDENT 2Review of Resident 2's face sheet printed on 04/10/2026 showed that Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's admission MDS dated [DATE], showed that it was completed on 01/05/2026 (11 days late). A joint record review and interview on 04/15/2026 at 6:03 PM with Staff D, showed the RAI manual revealed that an admission MDS was to be completed on day 14 of admission. A joint record review of (continued on next page)

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

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 2's admission MDS dated [DATE] showed that it was completed on 01/05/2026. Staff D stated that the MDS was not completed timely and that it should have been completed by 12/25/2025. In an interview on 04/16/2026 at 4:57 PM, Staff B stated that they expected MDS assessments to be completed accurately and timely. Reference: (WAC) 388-97-1000(1)(b)(3)(a) .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident assessments were completed accurately for 9 of 32 residents (Residents 49, 100, 14, 13, 66,19, 3, 10 & 71), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessment was marked on the MDS regarding weights, PASRR [Preadmission Screen and Resident Review], insulin injections (medication used to manage blood sugar levels), Serious Mental Illness (SMI), diagnosis, weight loss, medication, and Bilevel Positive Airway Pressure (BiPAP - a noninvasive ventilator that helps people breathe easier by delivering pressurized air through a mask) placed the residents at risk for unidentified and/or unmet care needs, and a diminished quality of life.Findings included . According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.20.1, dated October 2025, showed, .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. RESIDENT 49Review of the RAI manual showed, The measurement of weight is one guide for determining nutritional status. check the medical record and enter the weight taken within 30 days of the Assessment Reference Date (ARD or assessment period) of this assessment. If a resident cannot be weighed, for example because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code (- [dash]) and document rationale on the resident's medical record. Review of the annual MDS dated [DATE] showed that Resident 49's weight was recorded as 202.2 pounds (lbs. – a unit of measurement). Review of the Weight and Vitals Summary record printed on 04/09/2026 showed that Resident 49's last weight was taken 08/01/2024 and it was 202.2 lbs. In an interview and joint record review on 04/14/2026 at 12:37 PM, Staff D, MDS Coordinator, stated that the facility used the RAI manual for MDS assessment completion. Staff D stated that they used Resident 49's last weight record to document weights in MDS. A joint record review of the annual MDS dated [DATE] showed Resident 49's weight was recorded as 202.2 lbs. A joint record review of Resident 49's Electronic Health Record (EHR- under weights/vitals) showed their last weight was taken on 08/01/2024 and it was 202.2 lbs. Staff D stated they used the weight taken on 08/01/2024 for the annual MDS dated [DATE]. Staff D further stated that the weight recorded on the MDS was not obtained within 30 days of the ARD. RESIDENT 100The RAI manual directed, Code 1, yes: if PASRR Level II [refers to the evaluation process conducted after a Level I screening indicates a possible serious mental illness or Intellectual Disability (ID) to ensure that individuals receive appropriate care and support based on their specific needs and conditions] screening determined that the resident has a serious mental illness and/or ID/DD [Developmental Disabilities] or related condition, and continue to A1510, Level II Preadmission (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Screening and Resident Review (PASRR) Conditions. Review of the annual MDS dated [DATE] showed that Section A1500 (PASRR) showed Resident 100 was marked no for state Level II PASRR. Review of the Level II PASRR dated 02/03/2026 showed Resident 100 had a Level II PASRR determination (eligible for behavioral services). During a joint record review and interview on 04/14/2026 at 12:31 PM with Staff D showed Resident 100's annual MDS dated [DATE] was marked not considered by the state Level II PASRR. Staff D stated that the MDS was marked No for the Level II PASRR and it should have been marked, Yes. In an interview on 04/15/2026 at 8:35 AM, Staff B, Director of Nursing, stated that they expected MDS assessments to have been completed timely and accurately. RESIDENT 14Review of Resident 14's annual MDS dated [DATE], showed that Resident 14 was marked No, in Section A (A1500- PASRR). Review of Resident 14's PASRR level II dated 11/12/2020, showed that Resident 14 had a Level II PASRR determination. In a joint record review and interview on 04/14/2026 at 12:32 PM with Staff D, showed that Resident 14's annual MDS dated [DATE] was marked No, in Section A1500. A joint record review of Resident 14's PASRR level II dated 11/12/2020, showed that Resident 14 had a Level II PASRR determination. Staff D stated that Resident 14's annual MDS was not marked accurately. In an interview on 04/15/2026 at 8:25 AM, Staff B stated that they expected Resident 14's annual MDS to have been completed accurately. RESIDENT 13Review of the RAI Manual showed, .Count the number of days that the resident received any type of injection while a resident of the nursing home. Record the number of days that any type of injection. was received in Item N0300 [injections received during the seven [7] day look back period]. Enter in Item N0350A [insulin injections]. Review of Resident 13's quarterly MDS dated [DATE] showed it was marked for 7 injections in Section N0300 and 0 [zero] days for insulin injections in Section N0350A. Review of Resident 13's March 2026 Medication Administration Record (MAR) showed that Resident 13 was given insulin injections for 6 [six] days (03/19/2026, 03/20/2026, 03/22/2026, 03/23/2026, 03/24/2026 and 03/25/2026) during the look back period. A joint record review and interview on 04/15/2026 at 5:48 PM with Staff D, showed Resident 13's MDS dated [DATE] was marked for seven injections and zero insulin injections. A joint record review of March 2026 MAR showed that Resident 13 was given insulin injections for six days during the look back period. Staff D stated that Resident 13's MDS was not accurate and that it should have been marked for six injections and six insulin injections. In an interview on 04/16/2026 at 4:57 PM, Staff B stated that they expected MDS assessments to have been completed accurately and timely. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESIDENT 66 Review of the RAI manual coding instructions showed that if the resident had been diagnosed with SMI to code it in Section A1510A. Review of the admission record printed on 04/09/2026 showed Resident 66 had a diagnosis of Major Depressive Disorder (MDD-persistent feelings of sadness, loss of interest). Review of the annual MDS dated [DATE] showed Resident 66's MDS under Section A1510A was not marked for SMI. Review of a behavioral progress note dated 01/02/2026 showed Resident 66 had a diagnosis of MDD and had been undergoing mental health visits. A joint record review interview on 04/15/2026 at 3:59 PM with Staff D, showed Resident 66's annual MDS dated [DATE] showed Section A1510A was not marked for SMI. A joint record review of Resident 66's EHR (admission record and physician's order) showed a diagnosis of MDD. When asked if SMI should have been marked, Staff D stated that they would consult with Staff O, MDS Nurse. A joint record review and phone interview on 04/15/2026 at 5:02 PM with Staff O, showed Section A1510A on Resident 66's annual MDS dated [DATE] was not marked for SMI. Staff O stated that Resident 66 had MDD and had mental health visits. When asked if SMI should have been marked, Staff O stated, Yes. RESIDENT 19 Review of the RAI Manual coding instructions showed, Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Review of the quarterly MDS dated [DATE] showed Resident 19's MDS under Section I (Active Diagnoses) was not marked for anxiety disorder (having intense, excessive and persistent worry and fear about everything). Review of the March 2026 MAR showed Resident 19 was receiving medication for anxiety during the observation period. Review of a physician progress note dated 03/23/2026 showed Resident 19 had a diagnosis of anxiety disorder. A joint record review and interview on 04/15/2026 at 4:42 PM with Staff D, showed Resident 19's quarterly MDS dated [DATE] was not marked for anxiety disorder. A joint record review of the March 2026 MAR showed Resident 19 was taking medication for anxiety. Staff D stated that Resident 19's quarterly MDS was not accurate and that anxiety disorder should have been coded. In an interview on 04/16/2026 at 1:19 PM, Staff B stated that they expected staff to follow MDS coding per regulation. Staff B further stated that Resident 66's SMI and Resident 19's anxiety disorder should have been marked in their MDS. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESIDENT 3The RAI showed, 10% [percent – standardized scale of 100] weight loss in 180 days.start with the resident's weight closest to 180 days ago and multiply it by 90 [or 90%]. The resulting figure represents a 10% loss from the weight 180 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has a lost 10% or more body weight. Review of Resident 3's quarterly MDS dated [DATE], showed that Resident 3 was marked, No or unknown, under Section K (K0300 - Loss of 5% or more in the last month or loss of 10% or more in the last 6 months). Review of Resident 3's September 2025 through March 2026 weights showed 147.4 lbs on 09/02/2025 and 132 lbs. on 03/01/2026. The weights further showed a 10.45% weight loss in the last 6 months. A joint record and interview on 04/14/2026 at 12:32 PM with Staff D, showed Resident 3's quarterly MDS dated [DATE], was marked, No or unknown, under Section K0300. A joint record review of Resident 3's September 2025 through March 2026 weights showed a weight of 147.4 lbs on 09/02/2025 and a weight of 132 lbs. on 03/01/2026. Staff D stated that Resident 3's quarterly MDS was not marked accurately and that it should have been marked, Yes [Loss of 5% or more in the last month or loss of 10% or more in the last 6 months]. In an interview on 04/15/2026 at 8:25 AM, Staff B stated that they expected Resident 3's quarterly MDS to have been completed accurately. RESIDENT 10The RAI showed, Check if an opioid [medication to treat moderate to severe pain] medication was taken by the resident at any time during the 7-day look-back period. Check if there is an indication noted for all opioid medications taken by the resident any time during the observation period. Review of Resident 10's significant change MDS dated [DATE], showed that Resident 10 was marked Is taking and Indication noted, under Section N (N0415H- Opioid). Review of Resident 10's October 2025 MAR showed that Resident 10 did not receive an opioid during the MDS look back period. In a joint record review and interview on 04/14/2026 at 12:32 PM with Staff D, showed that Resident 10's significant change MDS dated [DATE] was marked Is taking and Indication noted, under Section N (N0415H-Opioid). Staff D stated that Resident 10's significant change MDS was not marked accurately. In an interview on 04/15/2026 at 8:25 AM, Staff B stated that they expected Resident 10's significant change MDS to have been completed accurately. RESIDENT 71The RAI showed, Code any type of CPAP [Continuous Positive Airway Pressure – a device that treats sleep apnea [disorder where breathing repeatedly stops and starts while sleeping] by blowing a steady stream of air into a mask worn over the nose or mouth] or BiPAP use during the first three days of admission. Review of Resident 71's admission/5day MDS dated [DATE], showed that Resident 71 was marked CPAP under Section O0110G3. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 71's March 2026 physician orders showed that Resident 71 was prescribed a BiPAP machine. Review of Resident 71's March 2026 Treatment Administration Record showed Resident 71 used a BiPAP during the look back period. In a joint record review and interview on 04/14/2026 at 12:32 PM with Staff D, showed Resident 71's admission/5day MDS dated [DATE] was marked CPAP in Section O0110G3. A joint record review of Resident 71's March 2026 physician orders showed that Resident 71 used a BiPAP. Staff D stated that Resident 71 used a BiPAP and that their admission/5day MDS was not marked accurately. In an interview on 04/15/2026 at 8:25 AM, Staff B stated that they expected Resident 71's admission/5day MDS to have been completed accurately. Reference: (WAC) 388-97-1000(1)(b) .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, the facility failed to ensure the care plan was revised accurately to reflect changes related to use of hearing devices for 1 of 2 resident (Resident 66), reviewed for care planning. This failure placed resident at risk for unidentified and unmet care needs, and a diminished quality of life.:Findings included. Review of the facility's policy, titled, Care Plan Comprehensive, dated 08/25/2021, showed, Assessments of resident are ongoing, and care plans are reviewed and revised as information about the resident and the resident condition change. Review of the comprehensive care plan printed on 04/10/2026 showed Resident 66 had impaired communication as evidenced by hard of hearing. Further review of Resident 66's impaired communication care plan showed the following interventions that were created between 2018 to 2022 and did not show they were revised to reflect Resident 66's status:- Ensure batteries are working in pocket talker-[Resident 66] has bilateral hearing aids.-Plug in [Resident 66's] hearing aids every night-[Resident 66] also has a pocket talker available to assist with hearing verbal communication. An observation and interview on 04/08/2026 at 8:39 AM, showed Resident 66 had hearing difficulty and did not have hearing aids and/or pocket talker. Resident 66 stated that they had not used a pocket talker or worn hearing aids. In an interview and observation on 04/14/2026 at 2:29 PM, Staff S, Certified Nursing Assistant, stated that Resident 66 had hearing difficulty. Staff S stated that they did not see Resident 66 worn hearing aids and/or had a pocket talker. Staff S went and looked around Resident 66's room and stated that they did not see any hearing devices. In an interview on 04/14/2026 at 2:42 PM, Staff E, Registered Nurse, stated that Resident 66 had hearing difficulty. Staff E stated that they did not see Resident 66 used hearing aids or a pocket talker. In an interview and joint record review on 04/15/2026 at 2:52 PM, Staff C, Assistant Director of Nursing, stated that they would review residents' care plans during their Interdisciplinary Team meeting and would revise care plans if there were changes in residents' care or status. A joint record review of Resident 66's comprehensive care plan showed interventions that included use of hearing aids and a pocket talker. Staff C was informed about Resident 66 not using hearing aids or a pocket talker and when asked about it, Staff C stated that they may need to review more. In an interview on 04/16/2026 at 10:43 AM, Staff B, Director of Nursing, stated that they expected Resident 66's comprehensive care plan to have been reviewed and revised to reflect their status. Reference: (WAC) 388-97-1020 (5)(b).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Infection Prevention and Control Program (IPCP) policies and procedures were reviewed annually as required. In addition, the facility failed to ensure hand hygiene was performed after removal of Personal Protective Equipment (PPE - gloves and gown), disinfect shared medical equipment after resident use, ensure proper PPE and/or Enhanced Barrier Precautions [EBP-specialized infection control measures used to prevent the spread of specific infections) were followed for 3 of 8 staff (Staff P, Staff L & Staff M), reviewed for infection control. These failures placed residents, visitors, and staff at an increased risk for infection and related complications. Findings included. Review of the facility's policy titled, Infection Prevention and Control Program, dated 09/18/2023, showed, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The policy showed, The program is reviewed annually and updated as necessary. The policy further showed that infection prevention included ensuring staff adherence to proper techniques and procedures and following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC). IPCP ANNUAL REVIEW Review of the IPCP policies and procedures showed that they have not been reviewed at least annually. The Infection Prevention and Control Program and Antibiotic Stewardship were dated 09/18/2023 and the Water Management Program was dated 06/24/2021 and these policies did not show that they were reviewed annually. In an interview and joint record review on 04/16/2026 at 1:20 PM, Staff B, Director of Nursing, stated that they were not sure when the policies were reviewed. Staff B stated, The corporate does the review of the policies. A joint record review of the IPCP, antibiotic stewardship and the water management program showed they were not reviewed at least annually. Staff B stated that they would follow up with the corporate office, and informed Staff A, Administrator, during the interview. HAND HYGIENE STAFF P Review of the facility's policy titled, Handwashing/ Hand Hygiene, dated 09/18/2023, showed, This facility considers hand hygiene the primary means to prevent the spread of infections. The policy further showed that hand hygiene would be performed after removing personal protective equipment. Observation on 04/15/2026 at 8:08 AM, showed Staff P, Certified Nursing Assistant (CNA), performed hand hygiene, put on a gown and a pair of clean gloves, carried a breakfast meal tray and entered room [ROOM NUMBER] (a TBP [specialized infection control measures used to prevent the spread of specific infections] room). At 8:11 AM, Staff P [already removed their gloves and gown] and exited room [ROOM NUMBER]'s room. Staff P did not perform hand hygiene after removing their PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/15/2026 at 8:21 AM, Staff P stated that they delivered and set up the breakfast tray to the resident in room [ROOM NUMBER]. When asked if they were expected to perform hand hygiene after removing their PPE, Staff P stated, Yes. Staff P further stated, Oh, I missed that [hand hygiene]. No, I did not sanitize my hands. In an interview on 04/15/2026 at 8:27 AM, Staff I, Licensed Practical Nurse, stated that staff were expected to perform hand hygiene after removing their PPE. Staff I further stated, Staff should hand wash or use hand sanitizer. In an interview on 04/16/2026 at 2:57 PM, Staff B stated that they expected staff to perform hand hygiene after removing their PPE. MEDICAL EQUIPMENT CLEANINGSTAFF LReview of the facility's policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised in September 2022 showed, Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC (Centers for Disease Control and Prevention) recommendations for disinfection and OSHA [Occupational Safety and Health Administration] Bloodborne Pathogens [germs in human blood that can cause disease in humans] Standard. Observation on 04/10/2026 at 7:40 AM, showed that Staff L, Registered Nurse, removed a digital blood pressure cuff from the medication cart and entered Resident 110's room to check the resident's blood pressure and heart rate (vital signs). After checking the resident's vital signs, Staff L left the room, performed hand hygiene, and placed the blood pressure cuff on the medication cart. Further observation showed Staff L stored the cuff in the medication cart drawer without cleaning or disinfecting it after use. In an interview on 04/10/2026 at 8:13 AM, Staff L stated that blood pressure cuffs should be cleaned between resident use. Staff L further stated that they did not clean the blood pressure cuff after using it on Resident 110 and stated that it should have been cleaned. EBPSTAFF MReview of the facility's policy titled, Enhanced Standard/Barrier Precaution, revised on 02/21/2025, showed, Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant (to at least one drug in three or more different classes of antimicrobial agents, making infections harder to treat) organisms that employs targeted gown and glove use during high contact resident care activities. The policy showed the facility would make PPE available near or outside of the resident's room. The policy further showed that residents with indwelling urinary catheters (a flexible tube inserted into the bladder to drain urine) would benefit from EBP and changing linens and briefs were considered high contact resident care activities. Review of the order summary report printed on 04/14/2026 showed that Resident 110 had an order for indwelling urinary catheters with an order start date of 04/08/2026. Observation on 04/10/2026 at 9:16 AM, showed that there was no EBP signage or PPE cart available near or outside of Resident 110's room. Observation showed Staff M, CNA, entered Resident 110's room, performed hand hygiene and applied gloves. Further observation showed Staff M provided incontinence care for Resident 110 and changed the resident's bed linens. Staff M did not wear a gown during high contact resident care activity as required. In an interview on 04/10/2026 at 9:34 AM, Staff M stated that residents with indwelling catheters (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would require EBP, including the use of gown and gloves during incontinence care. Staff M stated that Resident 110 was a new admission, and there was no EBP signage or PPE cart outside the door. Staff M further stated that they should have worn a gown before providing incontinent care. In an interview on 04/15/2026 at 8:26 AM, Staff B stated that staff were expected to clean and sanitize blood pressure cuffs after each use before storing them. Staff B stated that for residents on EBP, an EBP sign would be posted on the door, and a PPE cart would be available. Staff B further stated that gloves and gowns should be worn during high-contact care activities of residents on EBP. Reference: (WAC) 388-97-1320 (1)(a)(c) (5)(c).

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	04/16/2026

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Ballard Center	820 Northwest 95th Street Seattle, WA 98117

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to ensure pneumococcal vaccine (used to prevent pneumonia [a lung infection]) was administered for 1 of 5 residents (Resident 19), reviewed for pneumococcal immunization. This failure placed the resident at risk for acquiring, transmitting, and/or experiencing potential complications from pneumococcal disease.Findings included. Review of the facility's policy titled, Pneumococcal Vaccine, revised in October 2023, showed that all residents would be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. The policy further showed, Pneumococcal vaccines are administered to residents.per our facility's physician-approved pneumococcal vaccination protocol. Review of the Vaccine Informed Consent dated 10/02/2025 showed Resident 19 had signed to receive a pneumococcal vaccine. Review of Resident 19's Electronic Health Record (EHR-immunization record, progress/clinical notes and treatment record) did not show Resident 19 was administered their pneumococcal vaccine. In an interview and joint record review on 04/14/2026 at 4:24 PM, Staff B, Director of Nursing, stated that residents who had signed consents for immunization would be administered their vaccines. A joint record review of the vaccine consent dated 10/02/2025 showed Resident 19 signed to receive a pneumococcal vaccine. Further joint record review of the EHR did not show Resident 19 received their pneumococcal vaccine. Staff B stated that they would inquire more and would provide information regarding Resident 19's pneumococcal immunization. In a follow up interview on 04/16/2026 at 10:50 AM, Staff B stated that they could not find any record to show Resident 19 received the pneumococcal vaccine. Reference: (WAC) 388-97-1340(2).