STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505469	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terraces at Skyline	715 9th Avenue Seattle, WA 98104

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 - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45146 Based on interview and record review, the facility failed to ensure incident of unexpected death was investigated timely for 1 of 2 residents (Resident 1), reviewed for abuse/neglect investigations. This failure placed the residents at risk for repeated incidents, unidentified abuse/neglect, and a diminished quality of life. Findings included . Review of the Nursing Home Guidelines, The Purple Book, Sixth Edition, dated October 2015, showed, A thorough investigation is a systematic collection and review of evidence/information that describes and explains an event or a series of events. It seeks to determine if abuse, neglect, abandonment personal and/or financial exploitation or misappropriation of resident property occurred, and how to prevent further occurrences . All incidents require thorough investigation and reporting, as necessary, according to state and federal regulations . The facility must immediately begin the investigation in order to collect accurate data related to the incident. Any delay in starting the investigation can cause valuable information to be either lost or altered. The reporting guideline of the purple book further showed that unexpected death not related to abuse/neglect but suspicious should be reported and logged on the incident log within 5 days. Review of the facility's policy titled, Abuse / Neglect - Identifying and Reporting, reviewed on 03/06/2025, showed, An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. The immediate response time is outlined in the Washington State Guidelines Purple Book for Skilled Nursing . Review of the electronic health record showed Resident 1 was admitted to the facility on [DATE] and passed away on 04/18/2025. Review of the online incident report form dated 04/24/2025 showed that Staff B, Interim Director of Nursing, reported Resident 1's unexpected death. Review of the facility's April 2025 incident reporting log provided by the facility on 05/07/2025 showed Resident 1's unexpected death was not logged on the incident log. Review of the facility's May 2025 incident reporting log provided by the facility on 05/22/2025 showed Resident 1's unexpected death was logged on 05/07/2025, 19 days after the incident. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/07/2025 at 12:06 PM, Staff A, Director of Health Services, stated that Resident 1's unexpected death was not investigated or logged on the incident reporting log. In an interview on 05/22/2025 at 11:49 AM, Staff B stated that Resident 1's unexpected death reporting and investigation were not completed timely. In an interview on 05/22/2025 at 12:51 PM, Staff A stated that Resident 1's unexpected death incident was reported late and was not investigated timely. Staff A further stated that the incident was logged late on the incident log. Reference: (WAC) 388-97-0640 (5)(a)(6)(a)