STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505476	A. Building B. Wing	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bailey-Boushay House	2720 East Madison Seattle, WA 98112

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary supervision and follow the safety care plan for 1 of 1 resident (Resident 1), reviewed for accident hazards. This failure placed the resident at risk for injury, and a diminished quality of life.Findings included.Review of the facility's policy titled, Workplace Violence and Prevention Policy, dated May 2020, showed that the facility is committed to providing a secure environment to protect the safety and well-being of everyone in the building and its premises.Review of the facility's policy titled, Development, Review, and Revisions of Care Plans, dated June 2025, showed that residents' comprehensive care plan was developed and implemented to attain or maintain their highest practicable physical, mental, and psychological well-being.Resident 1 admitted to the facility on [DATE] with diagnosis that included dementia (loss of thinking, remembering and reasoning skills) with agitation (restlessness).Review of the comprehensive care plan printed on 07/16/2025 showed Resident 1 had severe cognitive impairment and required redirection or supervision. Further review of the care plan showed staff would accompany [Resident 1] down [first floor], or phone down [inform] to security in the absence of available staff.Review of the nursing progress note dated 06/23/2025 showed Resident 1 signed out of the unit and was hit in the face by an outpatient individual during a verbal exchange at the first-floor lobby. Further review of the nursing progress note did not show Resident 1 was accompanied and/or a security person informed that Resident 1 was not accompanied by staff when they went down to the lobby. Review of the facility's investigation report completed on 06/29/2025 showed Resident 1 was given access to the elevator and was not accompanied or supervised by staff when Resident 1 went down to the first floor. Further review of the investigation report did not show that a security person was informed Resident 1 was not accompanied by staff.In an interview on 07/16/2025 at 11:31 AM, Resident 1 stated that they did not recall being slapped in the face by an individual.In an interview and joint record review on 07/16/2025 at 12:34 PM, Staff C, Infection Preventionist/Charge Nurse stated that Resident 1 had a staff assigned to them daily to ensure their safety. A joint review of Resident 1's safety care plan showed staff will accompany [Resident 1] down or phone down to security in the absence of available staff. Staff C stated Resident 1 was not accompanied by a staff when Resident 1 signed out of the unit to go to the first floor. Staff C further stated that Resident 1's care plan was not followed and that Resident 1 did not receive the necessary supervision from staff.In an interview on 07/16/2025 at 1:26 PM, Staff B, Assistant Director of Nursing, stated that Resident 1 had assigned staff to go with them to provide safety. When asked if Resident 1 was accompanied by a staff member when the incident happened, Staff B stated no. Staff B stated they expected staff to have accompanied Resident 1 or they should have called security [person]. Staff B stated that staff did not provide supervision and Resident 1's care plan was not followed.In an interview on 07/16/2025 at 1:43 PM, Staff A, Director of Nursing, stated that they expected staff to have followed Resident 1's care plan. Staff A stated that security personnel had not been informed that Resident 1 was not accompanied by staff. Staff A stated that Resident 1 did not receive necessary supervision and that the incident could have been prevented if [Resident 1] was with staff. Reference: (WAC) 388-97-1060 (3)(g).