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	05/20/2024

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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to inform a resident and/or their representative of risks and benefits before installation/use of a transfer pole for 1 of 2 residents (Resident 27), reviewed for accidents. This failure placed the resident at risk for not being fully informed before making decisions regarding their health care, alternative treatment options, and the right to refuse care. Findings included . Resident 27 admitted to the facility on [DATE]. Review of the annual Minimum Data Set (an assessment tool) dated 02/22/2024, showed Resident 27 was independent for lying to sitting and for sit to stand. Review of Resident 27's activities of daily living care plan printed on 05/14/2024, showed an intervention for safety devices, which included use of a transfer pole. Review of Resident 27's electronic health record showed no documentation that Resident 27 had been provided risks and benefits for their use of a transfer pole. Observation and interview on 05/14/2024 at 10:05 AM, showed Resident 27 had a transfer pole next to the left side of their bed. The pole ran from the floor and was secured to the ceiling wall. Resident 27 stated they used the transfer pole every day to lift up and move around. On 05/17/2024 at 9:41 PM, Staff Q, Certified Nursing Assistant, stated Resident 27 used the transfer pole to help them move in bed and for transferring out of bed. On 05/17/2024 at 1:26 PM, Staff U, Registered Nurse, stated Resident 27 used the transfer pole to help them get up. Staff U stated they did not know if there needed to be consent prior to use of a transfer pole. On 05/17/2024 at 1:32 PM, Staff N, Charge Nurse, stated that before a transfer pole was installed in a resident's room, there should be an assessment done by therapy and consent should be obtained from the resident and/or their representative. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/20/2024 at 12:58 PM, Staff T, Rehab Manager, stated that prior to a resident using a transfer pole, they should get verbal consent from the resident and/or their representative. Staff T stated Resident 27 used the transfer pole to transfer independently. When asked if there was documentation that Resident 27 was provided risks and benefits of using a transfer pole, Staff T stated, verbal consent is fine. On 05/20/2024 at 2:44 PM, Staff B, Assistant Director of Nursing, stated that a transfer pole was considered an assistive device and they expected there to be documentation that risks and benefits were provided prior to using one for a resident. Reference: (WAC) 388-97-0260 (2) (a-d)

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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** 47680 Based on interview and record review, the facility failed to ensure allegations of abuse were reported to the State Agency for 2 of 2 residents (Residents 3 & 25), reviewed for abuse allegations. This failure placed the residents at risk for potential unidentified abuse and lack of protection from abuse. Findings included . Review of the facility's policy titled, Prevention of Abuse and Neglect of Residents and Clients, updated in January 2018, showed that the facility prohibits and prevents abuse, neglect, involuntary seclusion, misappropriation of property of all residents and clients. The policy further showed that the Administrator On Call (AOC) will be responsible for investigating all alleged incidents of abandonment, abuse, neglect, or mistreatment, including injuries of unknown source and misappropriation of resident property. The AOC will utilize the State's Nursing Home Guidelines for Incident, Identification, Investigation and Reporting. Review of the Nursing Home Guidelines, The Purple Book, dated October 2015 (sixth edition) showed, For the purposes of reporting abuse, abandonment, neglect, financial exploitation, sexual assault and physical assault, a nursing home employee (or other mandated reporter) is required to make a report if he or she has reasonable cause to believe the incident occurred. Examples of reasonable cause may include: the individual observes the incident or hears the victim state it happened; or the individual hears about an incident from a permissive reporter who has direct knowledge of the incident. It further showed, Federal law requires the facility to report all allegations of abuse or neglect. This would include taking seriously any allegation from residents or others with a history of making allegations. RESIDENT 3 Resident 3 admitted to the facility on [DATE]. On 05/14/2024 at 11:51 AM, Resident 3 stated that an unknown female staff that worked at night was mean and said mean things. Resident 3 further stated that a week ago, an unknown female staff hit them on their right rib while they were in bed, showing an elbow in motion. Resident 3 stated they wanted to report it, but they did not. Resident 3 stated that the unknown female staff did it once and that no one else had done that to them. On 05/14/2024 at 12:43 PM, Staff A, Administrator, was informed of Resident 3's abuse allegation. Staff A stated they would start an investigation right away. Review of Resident 3's investigation report dated 05/15/2024 did not show that Resident 3's abuse allegation was reported to the State Agency. RESIDENT 25 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 25 admitted to the facility on [DATE]. Review of the Resident Council Minutes dated 02/20/2024 showed, Staff O, Director of Nursing (DON), and Staff B, Assistant DON were provided the following resident feedback, Resident states nurses are rough during changes and requested the nurses to be gentler during care. The Resident Council Minutes further showed the response, Thank you for the feedback; we'll include an increased awareness in our huddles. Review of the facility's February 2024 incident reporting log showed no documentation that Resident 25's allegation of rough care was reported to the State Agency or investigated. Review of Resident 25's investigation report dated 05/15/2024 did not show the allegation of rough care was reported to the State Agency. On 05/15/2024 at 3:54 PM, Staff E, Recreational Therapist, stated that they helped facilitate the resident council meetings and typed out the minutes. Staff E stated that they emailed the department heads the information they received in the resident council meeting. Staff E stated if residents brought up abuse during the meeting, they would report it and follow their reporting process. Staff E stated that complaints of rough care came up during a nursing category and that they informed Staff O. Staff E stated that Staff O was already aware and believed they were working with Resident 25 who voiced the concern. Staff E further stated that they did not report Resident 25's concern to the State Agency and that they had reported it to Staff O. On 05/15/2024 at 4:21 PM, Staff A was informed that a resident (unidentified) had made a complaint that nurses were rough with care was documented in the resident council minutes. Staff A stated that they had just spoken to Staff E about it and that they were having Staff E and Staff B start another investigation. On 05/20/2024 at 9:27 AM, Staff B stated that if they knew or suspected abuse or if a resident reported abuse, they would call it in to the State Agency. Staff B stated that they did not report Resident 3 or Resident 25's allegation to the State Agency and that Staff A does the reporting. Staff B further stated that if abuse allegations were reported to the State Agency, it would be part of the investigation report. On 05/20/2024 at 2:19 PM, Staff B stated that Resident 25's complaint of rough care was treated as a complaint of care and that it was addressed by speaking to staff to be gentle and attentive. Staff B stated that there was no report to the State Agency and/or an investigation completed after speaking with Resident 25 because they did not consider it abuse. In an interview and joint record review on 05/20/2024 at 2:32 PM, Staff A stated when reporting to the State Agency they followed a workflow provided by the State that had very clear lines (when to report). Staff A stated that if an abuse allegation potentially happened and if it was still in question, they would report it to the State Agency. Staff A further stated that it depended on the situation, if it was emergent or urgent and/or justified, they would report it. Staff A stated that if a resident was not feeling safe and reported staff was rough with them, they would report to the State Agency. Staff A stated Resident 3 and Resident 25's allegations were not called in to the State Agency and in retrospect they should have been. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: (WAC) 388-97-0640 (5)(a)

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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 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** 47680 Based on interview and record review, the facility failed to ensure allegation of abuse was thoroughly investigated for 1 of 2 residents (Resident 25), reviewed for abuse investigation. This failure placed the resident at risk for repeated incidents, unidentified abuse, and a diminished quality of life. Findings included . Review of the facility's policy titled, Prevention of Abuse and Neglect of Residents and Clients, updated January 2018, showed that the facility prohibits and prevents abuse, neglect, involuntary seclusion, misappropriation of property of all residents and clients. The policy further showed that the Administrator On Call (AOC) will be responsible for investigating all alleged incidents of abandonment, abuse, neglect, or mistreatment, including injuries of unknown source and misappropriation of resident property. The AOC will utilize the State's Nursing Home Guidelines for Incident, Identification, Investigation and Reporting. Review of the Nursing Home Guidelines, The Purple Book, dated October 2015 (sixth edition) showed, 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. Resident 25 admitted to the facility on [DATE]. Review of the Resident Council Minutes dated 02/20/2024 showed, Staff O, Director of Nursing (DON), and Staff B, Assistant DON, were provided the following resident feedback, Resident states nurses are rough during changes and requested the nurses to be gentler during care. The Resident Council Minutes further showed the response, Thank you for the feedback; we'll include an increased awareness in our huddles. Review of the facility's February 2024 incident reporting log showed no documentation that Resident 25's allegation of rough care was investigated. Review of the facility's February 2024 grievance log showed no documentation that Resident 25's allegation of rough care was logged. On 05/15/2024 at 3:54 PM, Staff E, Recreational Therapist, stated that they helped facilitate the resident council meetings and typed out the minutes. Staff E stated that they emailed the department heads the information they received in the resident council meeting. Staff E stated if residents brought up abuse during the meeting, they would report it and follow their reporting process. Staff E stated that complaints of rough care came up during a nursing category and that they informed Staff O. Staff E stated that Staff O was already aware and believed they were working with Resident 25 who voiced the concern. Staff E further stated that they did not report Resident 25's concern to the State Agency and that they had reported it to Staff O. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/15/2024 at 4:21 PM, Staff A was informed that a resident (unidentified) had made a complaint that nurses were rough with care was documented in the resident council minutes. Staff A stated that they had just spoken to Staff E about it and that they were having Staff E and Staff B start another investigation. In an interview and joint record review on 05/20/2024 at 9:27 AM, Staff B stated that they had five days to complete an abuse allegation investigation and that they completed investigations along with Staff O. Joint record review of the February 2024 resident council minutes showed nurses are rough during changes. Staff B stated that they were not aware and that they were just informed of the allegation when the administrator reported it to them on 05/15/2024. Review of Resident 25's investigation report dated 05/15/2024 did not show that other residents and staff were interviewed. On 05/20/2024 at 2:19 PM, Staff B stated that Resident 25's complaint with rough care was treated as a complaint of care and that it was addressed by speaking to staff to be gentle and attentive. Staff B stated that there was no report to the State Agency and/or an investigation completed after speaking with Resident 25 because they did not consider it abuse. In an interview and joint record review on 05/20/2024 at 2:32 PM, Staff A stated their abuse allegation process would be to complete a patient safety assessment and complete an investigation. Staff A stated the leadership team would receive the investigation, follow up with additional information, interview as needed, follow up with appropriate people, and speaking with staff if necessary. Staff A stated Resident 25's investigation report dated 05/15/2024 was a little bit on the brief side and would say it was an abbreviated investigation. Joint record review of Resident 25's investigation report did not show residents and/or staff were interviewed. Staff A further stated that they expected Resident 25's investigation report to be thorough. Reference: (WAC) 388-97-0640 (6)(a)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on interview and record review, the facility failed to provide a written notice of transfer/discharge to the resident and/or their representative describing the reason for transfers for 1 of 1 resident (Resident 10), reviewed for hospitalization . This failure placed the resident at risk for not having an opportunity to make an informed decision about transfers/discharges. Findings included . Resident 10 admitted to the facility on [DATE]. Review of Resident 10's clinical record showed Resident 10 was transferred to the hospital for further evaluation on 03/19/2024 and on 05/04/2024. Further review of Resident 10's clinical record showed no documentation that Resident 10 and/or their representative had been provided written notification of transfer to the hospital. On 05/16/2024 at 10:29 AM, Staff N, Charge Nurse, stated that when a resident transferred to the hospital, they notified residents and/or their representatives by phone. Staff N stated that it was not their policy to notify residents and/or their representatives in writing. Staff N further stated that there was no written documentation provided to Resident 10 and/or their representative for their hospitalization s on 03/19/2024 and on 05/04/2024. On 05/16/2024 at 1:52 PM, Staff K, Social Worker, stated that they call the families but did not provide written documentation to residents and/or their representatives when a resident was transferred to the hospital. On 05/20/2024 at 1:18 PM, Staff B, Assistant Director of Nursing, stated that they expected staff to provide notification to residents and/or their representatives when transferred to hospital generally by phone and that nothing written is provided. On 05/20/2024 at 1:18 PM, Staff A, Administrator, stated that the nurse will call them (residents' representatives) when a resident transferred to the hospital. When asked if they expected to staff to provide written notification or transfer to the hospital, Staff A stated they would need to double check about that. Reference: (WAC) 388-97-0120 (2)(a)(c)(d)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on interview and record review, the facility failed to ensure a bed-hold notice was provided at the time of transfer to the hospital for 1 of 1 resident (Resident 10), reviewed for hospitalization . This failure placed the resident at risk of lack of knowledge regarding their right to hold their bed while in the hospital. Findings included . Review of the facility's policy titled, Bed Hold and Return Notice for hospitalization of Social/Therapeutic Leave, updated in January 2018, showed, At the time of hospitalization , clinical staff will . ask the resident to sign a copy of the policy to be placed in their medical record. Give a copy of the policy to the resident. Resident 10 admitted to the facility on [DATE]. Review of the progress notes dated 05/04/2024, showed Resident 10 was transferred to the hospital for further evaluation. Review of Resident 10's Electric Health Record (EHR) did not show documentation that a bed-hold notice was provided to Resident 10 and/or their representative. In an interview and joint record review on 05/16/2024 at 10:29 AM with Staff N, Charge Nurse, stated they expected there to be a bed-hold notice for every time they (residents) go to the hospital. Joint record review of Resident 10's EHR showed no documentation that a bed-hold was provided to Resident 10 and/or their representative. Staff N stated that there should have been one. Joint record review and interview on 05/16/2024 at 1:52 PM with Staff K, Social Worker, showed no documentation that a bed-hold was provided to Resident 10 and/or their representative. Staff K stated there should be one for Resident 10's hospitalization on [DATE]. On 05/20/2024 at 11:11 AM, Staff B, Assistant Director of Nursing, stated that they expected a bed-hold to be provided to residents and/or their representatives when being transferred to the hospital. Reference: (WAC) 388-97-0120 (4)(a)(b)(c)

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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** 47218 Based on interview and record review, the facility failed to ensure admission Minimum Data Set (MDS) assessments were completed within 14 days of admission for 2 of 14 residents (Residents 1 & 25) and failed to complete annual MDS assessments within 14 days from the ARD (Assessment Reference Date) for 2 of 14 residents (Residents 27 & 3), reviewed for comprehensive assessments. These failures 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 1.18.11, revised in October 2023, showed that, at a minimum, facilities are required to complete a comprehensive assessment of each resident within 14 calendar days after admission to the facility (admitted + [plus] 13 days), when there is a significant change in the resident's status, and not less than once every 12 months (within 366 days) while a resident. The annual MDS assessment should be completed no later than 14 days from the ARD (ARD + [plus] 14 days). The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS and ends at 11:59 PM on the day of the Assessment Reference Date (ARD or assessment period). RESIDENT 1 Resident 1 admitted to the facility on [DATE]. Review of Resident 1's admission MDS with an ARD of 03/04/2024, showed it was completed on 05/03/2024 (54 days late). On 05/20/2024 at 2:57 PM, Staff D, MDS Coordinator, stated they used the RAI manual for MDS assessment completion. A joint record review and interview on 05/20/2024 at 3:24 PM with Staff D, showed Resident 1's admission MDS dated [DATE] was completed on 05/03/2024. Staff D stated Resident 1's admission MDS was completed late. On 05/20/2024 at 3:33 PM, Staff B, Assistant Director of Nursing, stated they expected MDS assessments to be completed timely. 46912 RESIDENT 25 Resident 25 admitted to the facility on [DATE]. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 25's admission MDS with an ARD of 12/22/2023, showed it was completed on 04/11/2024 (105 days late). RESIDENT 27 Resident 27 admitted to the facility on [DATE]. Review Resident 27's annual MDS with an ARD of 02/22/2024, showed it was completed on 05/01/2024 (69 days late). On 05/20/2024 at 2:58 PM, Staff D stated that the MDS should be completed 14 days after the ARD. Staff D stated that Resident 25 and Resident 27's MDS assessments were completed late. On 05/20/2024 at 3:33 PM, Staff B stated that they expected the MDS to be completed timely. 47680 RESIDENT 3 Resident 3 admitted to the facility on [DATE]. Review of Resident 3's annual MDS with an ARD of 01/05/2024, showed it was completed on 04/16/2024 (88 days late). Joint record review and interview on 05/16/2024 at 2:26 PM with Staff D, showed Resident 3's annual MDS was completed late. Staff D stated that Resident 3's annual MDS should have been completed within 14 days from the ARD. On 05/16/2024 at 4:17 PM, Staff B stated that Resident 3's annual MDS should have been completed timely. Reference: (WAC) 388-97-1000 (5)(a)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49619 Based on interview and record review, the facility failed to ensure quarterly Minimum Data Set (MDS) assessments were conducted timely within 14 days from the Assessment Reference Date (ARD or assessment period) for 8 of 12 residents (Residents 2, 5, 19, 6, 3, 22, 25 & 18), reviewed for quarterly MDS assessments. This failure placed the residents at risk for delayed and/or unidentified care needs. 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 1.18.11, dated October 2023, showed a quarterly assessment is considered timely if the MDS completion date (Item Z0500B) must be no later than 14 days after the ARD (ARD + [plus] 14 days). RESIDENT 2 Resident 2 admitted to the facility on [DATE]. Review of Resident 2's quarterly MDS with an ARD of 01/02/2024, showed it was completed on 04/11/2024 (86 days late). Review of Resident 2's quarterly MDS with an ARD of 04/03/2024, showed it was completed on 05/08/2024 (21 days late). During an interview and joint record review on 05/16/2024 at 3:18 PM, Staff D, MDS Coordinator, stated they followed the RAI manual and had 14 days to complete an MDS assessment after the ARD. Joint record review of Resident 2's quarterly MDS assessments dated 01/02/2024 and 04/03/2024, showed they had been completed more than 14 days past the ARD. Staff D stated that the MDS assessments were late and that they should not have been completed late. On 05/20/2024 at 3:33 PM, Staff B, Assistant Director of Nursing, stated they expected the MDS assessments to be completed timely. 46912 RESIDENT 5 Resident 5 admitted to the facility on [DATE]. Review of Resident 5's quarterly MDS with an ARD of 01/02/2024, showed it was completed on 04/10/2024 (99 days late). Review of Resident 5's quarterly MDS with an ARD of 04/03/2024, showed it was completed on 05/07/2024 (33 days late). (continued on next page)

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	505476	A. Building B. Wing	05/20/2024

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/20/2024 at 2:58 PM, Staff D stated that the MDS should be completed 14 days after the ARD. Staff D stated Resident 5's MDS assessments were late. On 05/20/2024 at 3:33 PM, Staff B stated that they expected the MDS to be completed timely. 47218 RESIDENT 19 Resident 19 admitted to the facility on [DATE]. Review of Resident 19's quarterly MDS with an ARD of 03/12/2024, showed it was completed on 04/09/2024 (14 days late). A joint record review and interview on 05/20/2024 at 3:21 PM with Staff D, showed Resident 19's quarterly MDS dated [DATE] was completed on 04/09/2024. Staff D stated Resident 19's MDS was late and that it should have been completed within 14 days from the ARD. RESIDENT 6 Resident 6 readmitted to the facility on [DATE]. Review of Resident 6's quarterly MDS assessment with an ARD of 02/24/2024, showed it was completed on 05/02/2024 (54 days late). A joint record review and interview on 05/20/2024 at 3:23 PM with Staff D, showed Resident 6's quarterly MDS dated [DATE] was completed on 05/02/2024. Staff D stated Resident 6's MDS was completed late and that it should have been completed within 14 days from the ARD. On 05/20/2024 at 3:33PM, Staff B stated that the facility follows the RAI manual for MDS completion. Staff B further stated they expected the MDS assessments to be completed timely. 47680 RESIDENT 3 Resident 3 admitted to the facility on [DATE]. Review of Resident 3's quarterly MDS with an ARD of 04/05/2024, showed it was completed on 05/08/2024 (19 days late). Joint record review and interview on 05/16/2024 at 2:26 PM with Staff D, showed that the quarterly MDS dated [DATE] was completed late. Staff D stated that the quarterly MDS should have been completed within 14 days from the ARD. RESIDENT 22 Resident 22 admitted to the facility on [DATE]. (continued on next page)

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	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 22's quarterly MDS with an ARD of 01/08/2024, showed it was completed on 04/16/2024 (85 days late). Review of another quarterly MDS with an ARD of 04/09/2024 showed it was completed on 5/07/2024 (14 days late). Joint record review and interview on 05/16/2024 at 2:31 PM with Staff D, showed that Resident 22's quarterly MDS with an ARD of 01/08/2024 and 04/09/2024 were completed late. Staff D stated that Resident 22's quarterly MDS assessments should have been completed within 14 days from the ARD. On 05/16/2024 at 4:17 PM, Staff B stated Resident 3 and Resident 22's quarterly MDS assessments should have been completed timely. 48298 RESIDENT 25 Resident 25 admitted to the facility on [DATE]. Review of Resident 25's quarterly MDS with an ARD of 03/23/2024, showed it was completed on 05/06/2024 (44 days late). Joint record review and interview on 05/20/2024 at 3:10 PM with Staff D, showed Resident 25's quarterly MDS was completed late. Staff D stated that it should have been completed within 14 days from the ARD. RESIDENT 18 Resident 18 admitted to the facility on [DATE]. Review of Resident 18's quarterly MDS with an ARD of 03/13/2024, showed it was completed on 04/09/2024 (19 days late). Joint record review and interview on 05/20/2024 at 3:10 PM with Staff D, showed Resident 18's quarterly MDS was completed late. Staff D stated that it should have been completed within 14 days from the ARD. On 05/20/2024 at 3:33 PM with Staff B stated they expected MDS assessments to be completed timely. Reference: (WAC) 388-97-1000 (4)(a)

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	505476	A. Building B. Wing	05/20/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298 Based on observation, interview and record review, the facility failed to accurately assess 1 of 14 residents (Resident 25), reviewed for Minimum Data Set (MDS - an assessment tool). The failure to ensure accurate assessments regarding tube feeding (the delivery of nutrients through a feeding tube [a device that delivers liquid nutrition] directly into the stomach) and fall incidents placed the resident at risk for unidentified 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 1.18.11, dated October 2023, showed Accuracy of Assessment means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate RAI (i. e., comprehensive, quarterly, annual, significant change in status). It further showed instructions to code feeding tubes and/or hydration (intake of adequate fluid to meet body's need) and falls that occurred during the assessment period. The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS assessment and ends at 11:59 PM on the day of the Assessment Reference Date (ARD or assessment period). Resident 25 admitted to the facility on [DATE] with multiple diagnoses that included dysphagia (difficulty in swallowing). TUBE FEEDING Review of Resident 25's quarterly MDS with an ARD of 03/23/2024, showed tube feeding was coded. Review of Resident 25's February 2024 Medication Administration Record (MAR), February 2024 physician orders, and nursing progress notes dated 02/08/2024 showed Resident 25's tube feeding was discontinued on 02/08/2024 and that their feeding tube was maintained for medication administration only. Review of the March 2024 MAR and nursing progress notes showed Resident 25 had not received nutrition and/or hydration through their tube feeding. Observation and interview on 05/14/2024 at 11:26 AM, showed Resident 25 had a feeding tube on their stomach covered with a dressing. Resident 25 stated that they received their food and water by mouth. Resident 25 further stated that they used adaptive utensils (specialized devices designed to make eating easier) and was assisted by staff during mealtimes. FALL INCIDENTS Review of Resident 25's quarterly MDS dated [DATE], showed fall was not coded. (continued on next page)

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	505476	A. Building B. Wing	05/20/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's March 2024 incident reporting log showed Resident 25 had two fall incidents on 03/18/2024. Review of the nursing progress notes dated 03/18/2024 showed Resident 25 had two near falls from a wheelchair, the first while outside and the second while in the elevator. A joint record review and interview on 05/20/2024 at 3:10 PM with Staff D, MDS Coordinator, showed Resident 25's quarterly MDS was coded for tube feeding and was not coded for falls. Staff D stated they followed the RAI manual in completing an MDS. Staff D stated Resident 25's tube feeding should not have been coded and the fall incidents should have been coded in their quarterly MDS. Staff D further stated, I will modify (Resident 25's) quarterly MDS. On 05/20/2024 at 3:33 PM, Staff B, Assistant Director of Nursing, stated they expected staff to complete MDS assessments accurately. Reference: (WAC) 388-97-1000 (1)(b)

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	505476	A. Building B. Wing	05/20/2024

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on interview and record review, the facility failed to ensure the Level 1 Pre-Admission Screening and Resident Review (PASRR- an assessment used to identify people referred to nursing facilities with Serious Mental Illness (SMI), intellectual disabilities, or related conditions are not inappropriately placed in nursing homes for long term care) accurately reflected the current diagnosis for 1 of 5 residents (Resident 3), reviewed for PASRR. This failure placed the resident at risk for inappropriate placement and/or not receiving timely and necessary services to meet mental health care needs. Findings included . Resident 3 admitted to the facility on [DATE] with diagnoses that included anxiety (feeling anxious) and unspecified psychosis (collection of symptoms that affect the mind, where there has been some loss of contact with reality) not due to a substance or known physiological (anything that has to do with the body and its systems) condition. Review of Resident 3's Level 1 PASRR dated 01/11/2022 showed no mental disorders were marked on the form. In an interview and joint record review on 05/17/2024 at 10:45 AM, Staff H, Admissions, stated that the hospital were responsible to complete the PASRRs. Staff H stated that when they worked on resident admissions, they would ask the hospital social worker for a PASRR and if the resident needed a level two, the hospital social worker made the referrals. Staff H stated that they ensured the PASRR forms were accurate. If they received a PASRR that was missing something (incorrect), they would call the social worker back to correct it. Staff H stated that if the resident admitted to the facility with an incorrect PASRR, they would correct it, and it would be their job to fill out a new PASRR. Joint record review of Resident 3's PASRR form dated 01/11/2022, showed it was not marked for SMI. Staff H stated that they were not aware that the PASRR form was inaccurate. Staff H further stated that they should have contacted the hospital social worker and had Resident 3's PASRR form corrected. On 05/17/2024 at 11:50 AM, Staff B, Assistant Director of Nursing, stated they expected the PASRR form to be completed accurately and expected Admissions to follow up with the hospital for incorrect PASRRs. Reference: (WAC) 388-97-1975(1)

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	505476	A. Building B. Wing	05/20/2024

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298 Based on interview and record review, the facility failed to provide a copy of the baseline care plan (preliminary care plan) to the residents and/or their representatives for 2 of 2 residents (Residents 230 & 29), reviewed for baseline care plan. This failure resulted in the residents not being informed of their initial plan for delivery of care services and placed the residents at risk for unmet care needs. Findings included . Review of the facility's policy titled, Care Planning-Inpatient, dated February 2018, showed that the preliminary care plan will be completed within 48 hours of admission. It further showed that the resident or their representative will receive a copy of the preliminary care plan and that staff will document in the resident's medical record that the copy of the preliminary care plan was given to the resident or their representative. RESIDENT 230 Resident 230 admitted to the facility on [DATE]. Review of Resident 230's Electronic Health Record (EHR) did not show a copy of the baseline care plan was provided to the resident and/or their representative. Review of the nursing progress notes dated 05/06/2024, showed Staff K, Care Manager (CM), reviewed the baseline care plan with Resident 230 and their representative. Further review of Staff K's progress note showed no documentation that a copy was provided to Resident 230 and/or their representative. On 05/20/2024 at 4:42 PM, Staff K stated they did not offer and/or provide baseline care plans to the residents and/or their representatives and that they only offer/provide a copy of the comprehensive care plan during care conference meetings. 47218 RESIDENT 29 Resident 29 admitted to the facility on [DATE]. Review of the EHR did not show a copy of the baseline care plan was provided to Resident 29. Review of the nursing progress notes dated 04/18/2024, showed Staff V, CM, reviewed the baseline care plan with Resident 29. Further review of the progress notes showed no documentation that a copy of the baseline care plan was offered and/or provided to Resident 29. (continued on next page)

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	505476	A. Building B. Wing	05/20/2024

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/20/2024 at 4:42 PM, Staff K stated they did not offer and/or provide baseline care plans to the residents and/or their representatives and that they only offer/provide a copy of the comprehensive care plan during care conference meetings. On 05/20/2024 at 5:05 PM, Staff B, Assistant Director of Nursing, stated they expected staff to follow the facility's policy of providing a copy of the baseline care plan to the residents and/or their representatives. Reference (WAC) 388-97-1020(3) Reference (WAC) 388-97-1020(3)

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	505476	A. Building B. Wing	05/20/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218 Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for 1 of 2 residents (Resident 1), reviewed for care plans. The failure to develop a care plan for oxygen care/management placed the resident at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy titled, Care Planning - Inpatient, dated February 2018, showed that the facility will have a care plan that directs the care of each resident. The comprehensive care plan will include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs. Resident 1 admitted to the facility on [DATE]. Review of Resident 1's physician orders with a start date of 04/06/2024, showed an order for oxygen 0-6L [zero to six Liters - unit of measurement) O2 [oxygen] by NC [nasal cannula - flexible tubing that sits inside the nose and delivers oxygen] as needed for comfort. Review of Resident 1's comprehensive care plan printed on 05/14/2024 did not show a care plan for oxygen care/management. A joint record review and interview on 05/15/2024 at 3:50 PM with Staff M, Registered Nurse, showed Resident 1 did not have a care plan for oxygen care/management. Staff M stated Resident 1 should have had an oxygen care plan in place when they were started on oxygen. On 05/17/2024 at 1:55 PM, Staff N, Charge Nurse, stated they expected to see a care plan for oxygen on residents receiving oxygen. Staff N stated Resident 1 should have had an oxygen care plan when they were started on oxygen. On 05/17/2024 at 2:07 PM, Staff B, Assistant Director of Nursing, stated Resident 1 should have had an oxygen care plan in place when they started their oxygen treatment. Reference: (WAC) 388097-1020 (1)(2)(a)

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	505476	A. Building B. Wing	05/20/2024

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on observation, interview, and record review, the facility failed to revise comprehensive care plans for 2 of 13 residents (Residents 15 & 25), reviewed for care plan revision. The failure to revise care plans for denture use, tube feeding (the delivery of nutrients through a feeding tube [a device that delivers liquid nutrition] directly into the stomach), and failure to conduct an interdisciplinary (different areas of expertise) review placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy titled, Care Planning, dated February 2018, showed that the comprehensive care plan will be reviewed every three months, or more frequently if there is a change in status. The policy further showed, The comprehensive care plan will be revised based on the changing goals, preferences, and needs of the resident. RESIDENT 15 Resident 15 admitted to the facility on [DATE]. Review of the oral and dental health care plan printed on 5/15/2024, showed Resident 15 had full upper and lower dentures. The care plan further showed, Assist to place in the morning, removal at night, and manage denture care including soaking & [and] rinsing. Observations on 05/15/2024 at 9:31 AM, on 05/16/2024 at 9:46 AM and at 12:43 PM, showed Resident 15 was not wearing dentures. On 05/16/2024 at 9:46 AM, Resident 15 stated they were not wearing dentures and that they lost them. On 05/16/2024 at 12:45 PM, Staff E, Recreational Therapist, stated that they assisted Resident 15 with their lunch and that Resident 15 was not wearing dentures. Staff E further stated that Resident 15 did not wear dentures. In an interview, joint record review, and joint observation on 05/16/2024 at 1:26 PM, Staff G, Certified Nursing Assistant (CNA), stated that they looked at the care plan and Kardex (care guide for CNAs) on how to care for residents. Joint record review of Resident 15's care plan showed they had full upper/lower dentures and to assist with denture care. Staff G stated that Resident 15 did not have dentures that they knew of. Joint observation showed that Resident 15 was not wearing dentures. Staff G stated the care plan was incorrect and that Resident 15's care plan had to be revised. On 05/16/2024 at 2:10 PM, Staff D, Minimum Data Set (MDS) Coordinator, stated that care plans were revised annually, quarterly, and as needed. Staff D further stated that Resident 15's dental care plan should have been revised. (continued on next page)

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	505476	A. Building B. Wing	05/20/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/16/2024 at 4:15 PM, Staff B, Assistant Director of Nursing, stated they expected care plans to be revised routinely and that Resident 15's dental care plan should have been revised. 48298 RESIDENT 25 Resident 25 admitted to the facility on [DATE]. Review of the physician orders and nursing progress notes dated 02/08/2024, showed Resident 25's tube feeding was discontinued on 02/08/2024 and that their tube feeding would be maintained for medication administration only. Review of the nutrition and hydration comprehensive care plan printed on 05/14/2024, showed Resident 25 had enteral nutrition (tube feeding) and a written goal to tolerate intake of at least 50% [percent] estimated needs enterally [via tube feeding] in the next 90 days. Observation and interview on 05/14/2024 at 11:26 AM, showed Resident 25 had a tube feeding on their abdomen covered with a dressing. Resident 25 stated they received their food and water by mouth. Resident 25 further stated that they used adaptive utensils (specialized devices designed to make eating easier) and was assisted by staff during mealtimes. A joint record review and interview on 05/20/2024 at 3:10 PM with Staff D, showed Resident 25's comprehensive nutrition and hydration care plan had a goal for tube feeding intake. Staff D stated that the care plan should have been revised to reflect Resident 25's change in status from tube feeding to oral (by mouth) intake of food and water. On 05/20/2024 at 3:33 PM, Staff B stated they expected staff to follow the facility's policy on care plan review and revision. Reference: (WAC) 388-97-1020 (5)(b)

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	05/20/2024

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to ensure an assessment was completed prior to use of a transfer pole (a type of assistive device for transferring in and out of bed) for 1 of 2 residents (Resident 27), reviewed for accident hazards. The failure to assess for safe use of transfer pole placed the resident at risk for accidents, injury, and other negative outcomes. Findings included . Resident 27 admitted to the facility on [DATE]. Review of the annual Minimum Data Set (an assessment tool) dated 02/22/2024, showed Resident 27 was independent for lying to sitting and sit to stand. Review of the fall care plan printed on 05/14/2024, showed an intervention to, Observe and monitor for [Resident 27's] continued ability to use this pole as an assistive device with transfers. Review of Resident 27's electronic health record showed no documentation that Resident 27 had been assessed for safe use of their transfer pole. Observation and interview on 05/14/2024 on 10:05 AM, showed Resident 27 had a transfer pole next to the left side of their bed. The pole ran from the floor and was secured to the ceiling wall. Resident 27 stated they used the transfer pole every day to lift up and move around and it's unstable. On 05/17/2024 at 9:41 PM, Staff Q, Certified Nursing Assistant (CNA), stated that Resident 27 used the transfer pole to help them move in bed and for transferring out of bed. During a joint observation and interview on 05/17/2024 at 12:40 PM, Staff P, CNA, showed Resident 27's transfer pole was movable. Staff P stated, I think it needs to be a little firmer. On 05/17/2024 at 2:35 PM, Staff S, Physical Medicine Aide, stated that Staff T, Rehab Manager, was responsible for assessing residents for safety prior to the use of transfer poles and then I install them. On 05/20/2024 at 12:58 PM, Staff T stated that there was not a formal assessment done for use of transfer poles. Staff T stated, it's an assistive device and an assessment is not needed for assistive devices. Staff T stated there was no documentation that Resident 27 had been assessed for safe use of their transfer pole. On 05/20/2024 at 2:44 PM, Staff B, Assistant Director of Nursing, stated that a transfer pole was considered an assistive device and that they expected the Rehab department to assess residents for safety prior to using them. (continued on next page)

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	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/20/2024 at 3:58 PM, Staff B stated there should have been an assessment done prior to Resident 27 using the transfer pole. When asked if there was any documentation to show Resident 27 had been assessed for use of their transfer pole, Staff B stated, I've given you all the documentation they had. Reference: (WAC) 388-97-1060 (3)(g)

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	05/20/2024

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview and record review, the facility failed to ensure appropriate treatment and services related to tube feeding (the delivery of nutrients through a tube directly into the stomach to provide nutrition for those who cannot obtain nutrition by mouth, are unable to safely swallow, or need nutritional supplementation) were followed for 1 of 1 resident (Resident 10), reviewed for tube feeding management. The failure to check the gastric residual volumes (GRV - fluid/contents that remain undigested in the stomach) prior to tube feeding administration placed the resident at risk for medical complications and a diminished quality of life. Findings included . Review of the facility's policy titled, Care and Treatment of Feeding Tubes, revised on 11/28/2022, showed it is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. Resident 10 admitted to the facility on [DATE]. Review of the significant change in status Minimum Data Set (an assessment tool) dated 04/16/2024, showed Resident 10 had a feeding tube. Review of Resident 10's feeding tube care plan revised on 05/04/2024, showed, verify appropriate placement of the tube [feeding] and check the residual [GRV] for tolerance. During a joint observation and interview on 05/16/2024 at 10:04 AM showed Staff U, Registered Nurse, was connecting Resident 10's feeding tube to their enteral formula (liquid nutritional products used for tube feeding). Staff U did not check for GRV prior to connecting Resident 10 to their enteral (tube feeding) formula. Staff U stated that they checked the GRV this morning before giving meds [medications]. On 05/17/2024 at 1:40 PM, Staff N, Charge Nurse, stated that they expected staff to check the GRV each time connecting residents to their enteral formula. On 05/20/2024 at 11:11 AM, Staff B, Assistant Director of Nursing, stated that they expected staff to check the GRV prior to connecting residents to their enteral formula. Reference: (WAC) 388-97-1060 (3)(f)

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	505476	A. Building B. Wing	05/20/2024

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

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49619 Based on interview and record review, the facility failed to ensure Abnormal Involuntary Movement Scale assessments (AIMS- a rating scale that measures involuntary movements known as tardive dyskinesia [uncontrollable facial, oral, trunk and extremity movements]) were conducted timely for 3 of 5 residents (Residents 20, 6 & 3), reviewed for unnecessary medications. This failure placed the residents at risk for receiving unnecessary medications, adverse side effects, and a diminished quality of life. Findings included . Review of the facility's policy titled, Antipsychotic [used to treat psychotic (a collection of symptoms that affect the mind) disorders) Medication Use, revised in September 2021, showed that residents receiving an antipsychotic medication should have an AIMS assessment completed on admission, quarterly, with a significant change in condition, change in antipsychotic medication, or as needed. RESIDENT 20 Resident 20 to the facility on [DATE]. Review of Resident 20's physician's order summary report printed on 05/17/2024, showed an order for Quetiapine (or Seroquel, an antipsychotic medication) 25 milligram (mg-unit of measurement) tablet one time a day for restlessness and agitation. On 05/20/2024 at 8:55 AM, Staff C, Advanced Registered Nurse Practitioner, stated that they were responsible for completing AIMS assessments. Staff C stated that Resident 20 did not have an AIMS assessment prior to 05/16/2024, and that there should have been one. During an interview and joint record review on 05/20/2024 at 1:39 PM, Staff B, Assistant Director of Nursing, stated that AIMS assessments should be done quarterly. Joint record review of Resident 20's Electronic Health Record (EHR) showed no AIMS assessment completed prior to 05/16/2024. Staff B stated that Resident 20 should have had an AIMS assessment and that it had not been done. 47218 RESIDENT 6 Resident 6 readmitted to the facility on [DATE]. Review of the physician's order summary report printed on 05/14/2024, showed Resident 6 was taking Seroquel oral tablet 700 mg daily for anxiety (feeling anxious) related to dementia (a syndrome of cognitive decline that affects memory, thinking and daily activities) with behavioral disturbances. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing progress notes from 01/05/2024 to 05/19/2024, did not show Resident 6 had an AIMS assessment completed. Review of the EHR under the assessments tab from 01/02/2024 to 05/11/2024, did not show Resident 6 had an AIMS assessment completed. Review of the physician's orders dated 04/25/2024 did not show Resident 6 was monitored for antipsychotic medication side effects related to tardive dyskinesia and/or Extrapyramidal Symptoms (EPS - side effects of antipsychotic medication that can cause movement and muscle control problems throughout the body). Review of the high-risk medications care plan printed on 05/14/2024, did not show Resident 6 was being monitored for antipsychotic medication side effects related to tardive dyskinesia and/or EPS. A joint record review and interview on 05/20/2024 at 8:55 AM with Staff C, showed Resident 6 was taking Seroquel 700 mg daily for anxiety related to dementia with behavioral disturbance. Staff C stated that Resident 6 had progressive multifocal leukoencephalopathy (a rare viral disease characterized by progressive damage or inflammation of the white matter of the brain at multiple locations) and history of outbursts of aggressive behavior towards self and their environment. Staff C further stated that Resident 6 did not have an AIMS assessment done since March of 2023 and that there should have been an AIMS assessment completed quarterly. 47680 RESIDENT 3 Resident 3 admitted to the facility on [DATE]. Review of Resident 3's physician orders dated 12/07/2023, showed an order for Olanzapine (antipsychotic medication) give 15 mg by mouth at bedtime for unspecified psychosis (collection of symptoms that affect the mind, where there has been some loss of contact with reality) not due to a substance or known physiological condition (anything that has to do with the body and its systems) and neurocognitive (group of conditions that frequently lead to impaired mental function) disorder with Lewy Bodies (a brain disease that affects thinking, movement, behavior and mood). Review of Resident 3's EHR assessments did not show AIMS assessments were completed. On 05/20/2024 at 8:59 AM, Staff C stated that AIMS were done quarterly. Staff C further stated that Resident 3 did not have an AIMS completed and that they should have had one. On 05/20/2024 at 2:03 PM, Staff B stated they expected AIMS assessments to be completed. Reference: (WAC) 388-97-1060(4)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218 Based on observation, interview, and record review, the facility failed to ensure expired food items were discarded appropriately in accordance with professional standards of food safety for 1 of 1 kitchen (Kitchen Dry Foods Storage Area), reviewed for food service. The failure to discard expired food items placed the residents at risk for food borne illness (caused by the ingestion of contaminated food or beverages), cross contamination, and a diminished quality of life. Findings included . Review of the facility's policy titled, Food Safety Requirements, dated [DATE], showed the food will be stored, prepared, distributed and served in accordance with professional standards for food service safety. Joint observation and interview on [DATE] at 8:16 AM with Staff L, Food Services Manager, showed the Kitchen Dry Foods Storage Area had four packages of small size tortillas with an expiration date of [DATE] and six packages of large size tortillas with an expiration date of [DATE]. Staff L stated the tortillas were expired and that they should have been discarded by the expiration date. On [DATE] at 1:55 PM, Staff A, Administrator, stated they expected food items to be discarded by their expiration date and that the expired tortillas in the kitchen should have been discarded or thrown away. Reference (WAC) [DATE] (3)

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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. 46912 Based on observation, interview, and record review, the facility failed to ensure the facility's water management program included a flow diagram to assess or monitor the potential growth of Legionella (a water-borne bacteria that can cause pneumonia [a lung infection]) or other waterborne pathogens (an organism that can cause disease), and failed to ensure Enhanced Barrier Precautions (EBP- precaution to protect residents from Multidrug-Resistant Organism [MDRO-a germ that is resistant to medications that treat infections]) practices were followed for 1 of 7 residents (Resident 23), reviewed for infection control. These failures placed the residents at risk for facility acquired or healthcare-associated infections and related complications. Findings included . Review of the facility's policy titled, Water Management Policy, 198.00, revised in November 2021, showed to reduce the risk for health care associated infections from water sources through a protective program that includes systematic building management and infection control principles. Review of the online Centers for Disease Control and Prevention (CDC) toolkit titled, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings, Version 1.1, dated 06/24/2021, showed that there are seven elements of a Water Management Program, which includes to describe the building water systems using text and flow diagrams. It further showed, In addition to developing a written description of your building water systems, you should develop a process flow diagram and Once you have developed your process flow diagram, identify where potentially hazardous conditions could occur in your building water systems. Review of the facility's Water Quality Management Plan, revised in March 2018, did not show a flow diagram of their building water systems. On 05/17/2024 at 2:07 PM, Staff R, Facilities Manager, stated that the water management plan did not include a flow diagram. On 05/20/2024 at 1:18 PM, Staff A, Administrator, stated that Staff R was responsible for the water management program and I have not seen a flow diagram. 47680 Review of the online CDC website article titled, Implementation of Personal Protective Equipment [PPE - e.g. , gown and gloves] Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms, dated 04/02/2024, showed when implementing EBP, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. To accomplish this: Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE. It further showed EBP signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves. RESIDENT 23 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 23's physician orders dated 5/14/2024, showed EBP for high-contact care activities for Dressing, bathing or showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use every shift for history of MDRO. Gloves and gown prior to high-contact care activity. Change PPE before caring for another resident. Multiple observations on 05/14/2024 at 1:58 PM, on 05/15/2024 at 8:11 AM, on 05/16/2024 at 9:40 AM, on 05/17/2024 at 8:55 AM and on 05/20/2024 at 9:08 AM, showed no EBP signage on Resident 23's door. During an interview and joint observation on 05/20/2024 at 12:09 PM with Staff G, Certified Nursing Assistant, stated they assisted Resident 23 with changing their linens and that they would not use a gown. Staff G further stated that Resident 23 was not on EBP. Joint observation of Resident 23's door did not show an EBP signage. Staff G stated if Resident 23 was on EBP, they would have a signage on their door, and EBP precautions would be communicated through email and in the resident's care plan. During an interview and joint observation on 05/20/2024 at 12:41 PM with Staff F, Registered Nurse, stated that residents on EBP would have an EBP signage placed by the side of their door and would be communicated to staff through the signage, morning shift report, verbal report/conversations and through email. Staff F stated that Resident 23 was on EBP. Joint observation of Resident 23's door did not show an EBP signage. Staff F stated that they did not see an EBP signage on Resident 23's door and that they should have had one. Staff F further stated that staff should be wearing PPE when providing Resident 23 with high contact care. On 05/20/2024 at 2:09 PM, Staff B, Assistant Director of Nursing, stated they expected residents on EBP to have a signage (on their door) and that it would be in their care plan. Staff B further stated that they expected staff to follow EBP and apply [use] PPE. Reference: (WAC) 388-97-1320 (1)(a)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on interview and record review, the facility failed to ensure residents received education regarding the potential risks and benefits when offering pneumonia vaccine (use to prevent pneumonia [lung infection]) for 2 of 5 residents (Residents 3 & 20), reviewed for immunizations. This failure placed the residents and/or their representatives at risk of not being fully informed of the risks and benefits before making decisions about their pneumonia immunizations. Findings included . Review of the facility's policy dated, Influenza and Pneumococcal Immunizations, reviewed in March 2023, showed for pneumococcal immunizations each resident, or the resident's legal representative, will be provided education regarding the benefits and potential side effects and possible medical contraindications of the immunization. RESIDENT 3 Resident 3 admitted to the facility on [DATE]. Review of the immunization record for Resident 3 showed they received a dose of Pneumococcal Conjugate Vaccine (PCV20-vaccine that protects against 20 types of bacteria that cause pneumonia) on 04/13/2023. Review of the Electronic Health Record (EHR) showed no documentation that Resident 3 was provided risks and benefits for receiving the pneumococcal vaccine. RESIDENT 20 Resident 20 admitted to the facility on [DATE]. Review of the immunization record for Resident 20 showed they received a dose of PCV20 on 04/13/2023. Review of the EHR showed no documentation that Resident 20 was provided risks and benefits for receiving the pneumococcal vaccine. On 05/17/2024 at 9:57 AM, Staff C, Infection Preventionist, stated they could not find if there was documentation that risks and benefits were provided to Residents 3 and 20. On 05/20/2024 at 11:11 AM, Staff B, Assistant Director of Nursing, stated they expected that risks and benefits of pneumonia vaccinations were provided to residents and there should be documentation that a resident was either given the vaccination or if they declined it. Reference: (WAC) 388-97-1340 (2) .