STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505500	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bellevue Post Acute	2424 156th Avenue Northeast Bellevue, WA 98007

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to provide written notice of transfer/discharge to the resident and/or their representative and failed to notify the Office of the State Long Term Care Ombudsman (an advocate for residents of nursing homes who protect and promote resident rights under federal and state law and regulations), describing the reason for transfer/discharge for 1 of 2 resident (Resident 2), reviewed for discharges. These failures placed the resident at risk for not having opportunities to make informed decisions about transfer/discharge.Findings included.Review of the facility's policy titled, Transfer or Discharge Notice, revised in March 2021, showed that Residents and/or representatives are notified in writing, and in a language and format they understand. It showed that the resident and/or representative are notified of the specific reason for the transfer or discharge, date of the transfer or discharge, the location of where they are being transferred or discharged , and an explanation of the resident's rights to appeal the transfer or discharge. It further showed that A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman.Review of the Electronic Health Record (EHR-progress notes, assessments, and attachments) from 07/18/2025 to 07/28/2025, showed that Resident 2 was discharged from the facility on 07/28/2025. Further review of Resident 2's EHR showed no documentation that a written notice of transfer or discharge was provided to Resident 2 and/or their representative and to the Office of the State Long-Term Care Ombudsman.In an interview and joint record review on 08/12/2025 at 12:15 PM, Staff G, Social Services Director, stated that they had started in this role last week and was unsure if a transfer/discharge notice was provided to residents and/or their representatives. A joint record review of Resident 2's EHR showed no documentation that Resident 2 and/or their representative had been provided with written notification of discharge. Staff G stated that they don't [do not] see a form. Staff G further stated that we're [we are] supposed to send [transfer/discharge notice] to the ombudsman, but I'm [I am] not sure the process here.In an interview on 08/12/2025 at 1:55 PM, Staff C, Charge Nurse, stated that providing the transfer/discharge notice to residents and/or their representatives was a new policy with the new company. We haven't [have not] been doing that. Staff C further stated that they don't [do not] send anything to the ombudsman.A joint record review and interview on 08/12/2025 at 2:55 PM with Staff B, Regional Nurse Consultant, showed Resident 2's EHR had no documentation that Resident 2 and/or their representative had been provided with written notification of transfer or discharge. Staff B stated, I don't [do not] see one [transfer/discharge notice]. Should have one. Staff B stated that I don't know how they [the facility] have been doing it but moving forward they will be doing it [notifying the Office of the State Long Term Care Ombudsman] weekly.In an interview on 08/12/2025 at 3:32 PM, Staff A, Administrator, stated that they expected that a transfer/discharge notice would be given to residents and/or their representatives when discharging from the facility. Staff A further stated that it's a regulation to send notification of transfer/discharges to the Office of the State Long Term Care Ombudsman and I would expect that 100 percent.Reference: (WAC) 388-97-0120 (2) (a-d).

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

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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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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	505500	A. Building B. Wing	08/12/2025

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Bellevue Post Acute	2424 156th Avenue Northeast Bellevue, WA 98007

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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 adequate supervision and accurately assess risk of elopement for 1 of 1 resident (Resident 1), reviewed for accident hazards. This failure placed the resident at risk for elopement, falls, and injury.Findings included.Review of the facility's policy titled, Wandering and Elopements, revised in September 2022, showed, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.Review of the admission Minimum Data Set (an assessment tool), dated 07/21/2025, showed that Resident 1 was admitted to the facility on [DATE] with diagnoses that included dementia (a group of conditions characterized by impairment with brain functions, such as memory loss and judgement). It further showed in Section E (Behavior), that Resident 1 wandered 1 [one] to 3 [three] days during the seven-day look back period.Review of the Electronic Health Record (EHR-assessments, attachments, progress notes) from 07/15/2025 to 08/05/2025, showed no documentation that an elopement risk assessment was completed for Resident 1.Review of a physician progress note, dated 07/15/2025, showed, Nursing staff reported patient [resident] has been confused, wondering [wandering] in the hallways.Review of a nursing progress note, dated 07/20/2025, showed Resident [Resident 1] alert and oriented to self, she is very confused and forgetful. She is high risk for fall, as she is impulsive and ambulates [walks] without her walker or wheelchair.Review of the investigation report dated 07/22/2025, showed on 07/22/2025, the facility became aware that a patient [Resident 1] had left the facility without notifying staff. Facility became aware of the incident as a passerby had called it in, and the police showed up to assess the situation.patient had no injuries. During the incident, the patient was redirectable but agitated due to a relapse in memory and cognitive function. It further showed that Staff E, Receptionist, was the evening receptionist and stated that they left around 7:00 PM to 7:05 PM, locked the front door before she left so no one could get in. She states she did not put the poll [pole] in the runner on the bottom of the door.Review of the nursing progress note, dated 07/23/2025, showed that Resident 1 left the building and was found across the street by police officers. A joint observation and interview on 08/05/2025 at 1:56 PM, Staff D, Maintenance Director, showed the front entrance of the facility had two sets of sliding glass doors. Staff D stated that the front door gets locked at 7:00 PM from the outside on the weekdays and 6:00 PM on weekends. Staff D stated the front door was not locked from the inside, so people could leave the facility. Staff D stated that the process was to put a wooden pole in the track of the sliding door and pull a red caution tape across from one wall to the other in front of the sliding door. Staff D further stated that a wander guard system (a wearable device that tracks movement and triggers an alarm when a resident nears a restricted area) was now in place, it's [it has] been up for two weeks, after the lady [Resident 1] left and she went out the front door.An observation and interview on 08/05/2025 at 2:15 PM, Staff E, showed that the front desk was located across from the facility entrance/exit. Staff E stated that there was always someone at the front desk. Staff E stated that they left the faciity on weekdays at 7 [7:00 PM] and weekends at 6 [6:00 PM]. Staff E stated that the process when they left for the day was to lock the front door and put the pole down [in the track of the sliding door], been doing that for a couple weeks, the red tape is new. Staff E stated, I was advised not to put the stick [pole] down. I didn't [did not] put the stick down because I was told by my boss [Staff R, Revenue Cycle Manager] not to do it because a family member kept pushing it [the sliding door off the track].In an interview on 08/05/2025 at 2:31 PM, Staff R stated that they oversee the receptionists and that locking up the facility after hours included locking the door, locked to come in the facility, but not to go out. Staff R stated that lately we've [we have] been told to put the stick down, about a week and a half ago.In a phone interview on 08/06/2025 at 1:26 PM, Resident 1's representative stated that Resident 1 has trouble in hospitals and other facilities and loves her freedom. They further stated that she was able to just walk out [of the facility].In an interview and joint record review on 08/12/2025 at 2:55 PM, Staff B, Regional Nurse Consultant, stated that they expected staff to prevent elopement by completing an elopement risk assessment, put preventions in place and put in a care plan. A joint record review of Resident 1's EHR showed an elopement risk assessment was not completed. Staff B stated that it was not done. A joint record review of the investigation report dated 07/22/2025, showed no wander guard system was in place prior to Resident 1 leaving the facility. Staff B stated, there is a wander guard system in place now and an elopement assessment now populates for every admission.In an interview on 08/12/2025 at 3:32 PM, Staff A, Administrator, was asked what precautions were in place when Resident