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	08/16/2022

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

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39651 Based on interview and record review, the facility failed to prevent physical abuse for 1 of 3 residents (Resident 1) reviewed for abuse and neglect. As a result of this failure, Resident 1 suffered physical injury, pain, and experienced psychosocial harm including refusal to take her medications, not wanting and/or refusing to eat, and it affected her sleep and mood. Findings included . The Code of Federal Regulations (CFR) define abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. According to the [NAME] State Reporting Guidelines for Nursing Homes (Purple Book) dated October 2015, Abuse is the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. Resident 1 was a long-term care resident of the facility. The resident's diagnoses list included stroke with left sided weakness and depression. Review of Resident 1's quarterly Minimum Data Set (MDS) assessment dated [DATE] showed the resident had mild cognitive impairment and needed two-person extensive assistance for bed mobility and transfer. Review of the facility's August 2022 incident reporting log (IRL) showed Resident 1 was involved in a resident-to-resident altercation with another resident (Resident 2) on 08/01/2022. The IRL showed that the incident had resulted injuries to both Resident 1 and Resident 2. (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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 08/07/2022 at 10:30 AM, Resident 1 stated she was able to recall the physical altercation incident in detail. Resident 1 stated that Resident 2 rushed towards her at the smoking area and started hitting her and slapping her on the face. Resident 1 stated, this assault was witnessed by other residents who were also shocked why Resident 2 was being physical aggressive towards her. Resident 1 also stated she was hit on the face several times and her back area when she tried to leave the scene. According to Resident 1, she tried to defend herself and cover her face but was not able to because the left side of her body was paralyzed. Resident 1 stated she felt unsafe and did not feel comfortable around Resident 2. Resident 1 stated her face and back area were sore from the incident and that Resident 2's assault left red marks on her cheek. Resident 1 also stated that she was hurt and was treated badly and repeatedly by this resident (Resident 2) in the past. Resident 1 further stated that the incident affected her mood negatively, had affected her sleep and was not able to eat even days after the incident. Resident 1 stated, I am still mad and angry about the situation and wanted to get even with Resident 2. A review of Resident 1's clinical records including meal monitors and nursing/social services notes from 08/01/2022 to 08/03/2022 showed that Resident 1 sustained physical injuries (redness to the face/cheeks area) and exhibited probable signs of psychosocial harm related to the physical altercation incident in the form of refusal to take her medications and not wanting and/or refusal to eat. A review of the facility incident investigation report dated 08/01/2022 showed that the incident between Resident 1 and Resident 2 was witnessed by another resident (Resident 3). The incident report also showed that Resident 3 was trying to intervene and stop Resident 2 from hitting Resident 1, but Resident 2 also turned to Resident 3 and started hitting Resident 3 with a walker. A review of the written statement provided by Resident 3 dated 08/01/2022 showed Resident 2 came out with the intent to start a fight. She (Resident 2) started ramming Resident 1 with her walker. Resident 1 was being slapped in the face and the head area. Resident 1 tried to hold up arm in defense. Then she (Resident 2) rammed me with her walker when I tried to intervene. The statement went on and showed, She (Resident 2) continued to verbally abuse Resident 1 by calling her a fat w****. These even transpired over 20 minutes. On 08/17/2022 at 11:05 AM, Resident 2 stated she remembered having a physical altercation with Resident 1. Resident 2 stated Resident 1 and another resident (could not recall who) were taking a long time to smoke so she confronted them about it. According to Resident 2, she decided to take matters into her own hands when Resident 1 did not listen to her, so she hit and slapped her on the face. Resident 2 added, she deserves what she got and I'm not sorry. Resident 2 showed the scratch that she sustained on her face (left side) related to the incident. Resident 2 reported pain to the area when it was newer but denied any pain during the interview. A review of Resident 2's quarterly MDS assessment dated [DATE] showed that Resident 2 had intact cognition and was independent with locomotion (moving to one place to another) on and off the unit. A review of Resident 2's clinical records including nursing/social services notes from 08/01/2022 to 08/03/2022 showed that Resident 2 sustained physical injuries (scratch to the left side of the face/cheeks area) and exhibited probable signs of psychosocial harm related to the physical altercation incident in the form of withdrawal and attention seeking behaviors. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 08/17/202 at 11:35 AM, Resident 3 stated that Resident 2 came out to the smoking area to start a fight and assaulted Resident 1. Resident 3 stated that Resident 2 started slapping Resident 1 on the face and head, and even her when she tried to intervene. According to Resident 3, Resident 1 was defenseless because she could not use her arm and only tried to cover her face. Resident 1's face was so red because she was slapped and hit several times. When I tried to stop Resident 2, she then turned on me and started hitting me with her walker. Resident 3 further stated that there was a staff member that came right away to intervene but even after that, Resident 2 still called Resident 1 all kind of names, such as B**** and Fat w****. On 08/17/2022 at 1:00 PM, both Staff A, Administrator and Staff B, Interim Director of Nursing stated and confirmed the physical and verbal altercation between Resident 1 and Resident 2 that happened on 08/01/2022 at around 2:00 PM. Both Staff A and Staff B stated that both residents had sustained and documented injuries from the incident and acknowledged that they should have scheduled their smoking time differently to separate them and that the facility had revised both the resident's care plans (including smoking care plan) to minimize the risk of the reoccurrence of the incident. Reference: (WAC) 388-97-0640 (1)