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	09/13/2022

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 39651 Based on interview and record review, the facility failed to provide adequate supervision and implement the care plan for 1 of 3 residents (Resident 1) reviewed for avoidable accidents and supervision. Additionally, the facility failed to develop written policies and procedures related to the use of Motorized Wheelchairs (MW) and conduct a comprehensive assessment to ensure that residents were safe to operate a MW for 13 of 13 residents (Residents 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 & 14) reviewed for devices. These failures caused serious injury and serious harm to Resident 1 who sustained a hip fracture and was hospitalized related to a MW incident with Resident 2. The facility's lack of policies and an effective system in ensuring that residents were assessed prior to the use of a MW increased the likelihood of serious injuries and serious harm to the residents of the facility. The facility also failed to provide adequate supervision and implement written policies and procedures related to elopement and initiate timely/appropriate interventions to minimize the risk of elopement incident for 3 of 4 residents (Residents 1, 15 & 16) reviewed for elopement. These failures resulted to an actual elopement incident of Resident 1 who was found at the facility's parking lot alone and unsupervised by staff for an unknown duration, placing the resident at risk for harm/injury. The facility's failure to provide adequate supervision to high-risk residents and the lack of an effective system to ensure that residents were safe prior to the use of a MW constituted a situation of an Immediate Jeopardy (IJ) on 09/09/2022. The facility was notified of the IJ on 09/09/2022 at 1:00 PM. An onsite survey was conducted on 09/12/2022 and verified the removal of the IJ related to CFR 483.25 - F689 - Free of Accident Hazards/Supervision/Devices. The remaining noncompliance was found to be an isolated deficiency that constitute actual harm to the resident [Resident 1] that was not an IJ. Findings included . FAILURE TO PROVIDE ADEQUATE SUPERVISION and RESIDENT TO RESIDENT INCIDENT (continued on next page)

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

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident 1 was a long-term care resident of the facility. The resident's diagnoses list included dementia (memory problem), bipolar disorder (extreme mood swings) and anxiety disorder. A review of Resident 1's annual Minimum Data Set (MDS) assessment dated [DATE] showed the resident had impaired cognition and required one person staff assistance with activities of daily living (ADL's). A review of Resident 1's care plan dated 08/25/2022 showed that Resident 1 was a high risk for elopement and unsafe wandering due to increase confusion and history of attempting to leave the facility without staff supervision. The care plan directed the facility staff to observe the resident frequently while ambulating in the hallway and to provide redirection when needed. A review of the facility's incident reporting log for September 2022 showed that on 09/06/2022 at 5:00 PM, Resident 1 was involved in a resident-to-resident altercation with Resident 2 that resulted to a fall incident with substantial injury (hip fracture) to Resident 1. The incident log showed that Resident 1 required medical treatment and was admitted the hospital because of the incident. On 09/08/2022 at 11:30 AM, Staff A, Administrator, Staff B, Director of Nursing, and Staff C, Nurse Consultant, confirmed and stated that Resident 1 and Resident 2 had an altercation on 09/06/2022. Staff C stated that Resident 1 sustained a left hip fracture from the incident that required surgery. Both Staff B and Staff C stated the resident had substantiated physical abuse due to Resident 2's intent to harm Resident 1 with the use of his MW. According to Staff A, Staff B, and Staff C, the incident between Resident 1 and Resident 2 was witnessed by a staff member [Staff D, Nursing Assistant Certified] who tried to separate the residents and had asked Resident 2 to move his MW backwards but instead run through Resident 1 that resulted in a fall. However, both Staff B and Staff C stated that there was no staff member present to supervise and provide redirection to Resident 1 prior to the altercation as directed by Resident 1's care plan. On 09/08/2022 at 2:00 PM, Staff D stated she witnessed the incident between Resident 1 and Resident 2. Staff D stated that she was on a resident room providing resident care when she heard a loud banging noise in the hallway. When she responded, she saw Resident 2 already screaming and telling Resident 1 to move out of his way, so she immediately intervened. Staff D stated she only saw Resident 1 hitting the wall with his walker but Resident 2 claimed that he was hit by Resident 1 using his walker and would not move out of his way. According to Staff D, she had asked Resident 2 to move his MW backward instead so he can maneuver and drive away from Resident 1 but instead, Resident 2 forced his way through towards Resident 1 causing Resident 1 to fall on to the ground. Staff D stated that there was no other staff member present when the incident happened, so she called for help, and that's when Staff E, Licensed Practical Nurse, and other staff members came to the scene to assist Resident 1 on the floor. Staff D further stated that the impact to Resident 1 was so strong that when he landed on the ground, he was not able to move and complained of severe pain to his hip and back area. On 09/08/2022 at 2:30 PM, Staff E stated during a phone interview that he was the nurse on duty on 09/06/2022 when the incident between Resident 1 and Resident 2 happened. Staff E stated they did not witness the incident and by the time he arrived, Resident 1 was already on the floor. Staff E stated he was busy providing care to other residents when the incident happened and did not notice either Resident 1 and/or Resident 2 prior to the incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 09/08/2022 at 2:45 PM, Resident 2 stated that Resident 1 was on his way and would not move even after telling him More than 5 times to get out of my way. Resident 2 also stated that Resident 1 would not only wander in the hallways and to other resident rooms but also was angry and agitated at times. According to Resident 2, Resident 1 was agitated at the time of the incident and when he asked for him to move, he started hitting him with his walker, so he had no choice but to defend himself. Resident 2 stated he was very angry, upset, and at the same time helpless and worried about his safety so he could have lost control of his MW and run through Resident 1. Resident 2 further stated that the incident could have been avoided if staff had intervened and redirected Resident 1 away from him because he was very confused and a very angry man. On 09/08/2022 at 3:10 PM, Staff A, Staff B, and Staff C stated that Resident 1 was care planned to be redirected frequently by staff while ambulating in the hallway but was not able to provide an explanation as to why no staff member was present to provide supervision and/or redirection to Resident 1 while he was ambulating in the hallway and prior to getting too close to Resident 2. According to Staff C, the other staff on duty could have been providing care to other residents at the facility and was not aware of Resident 1's whereabouts prior to the incident. A review of the hospital record dated 09/07/2022 showed that Resident 1 was admitted to the hospital with a left hip fracture that required an operation to repair the fracture. LACK OF AN EFFECTIVE SYSTEM AND POLICY RELATED TO THE USE OF MW A review of Resident 2's clinical records including nursing progress notes, medical diagnoses and care plans dated 04/07/2022 with a revision date of 06/20/2022 showed that Resident 2 had always expressed frustrations towards others, was always irritable approximately 60% of the time and had history of physical aggressions towards other residents and/or staff. A review of Resident 2's most recent MW assessment dated [DATE] showed that the resident was physically able to operate the MW independently. However, the assessment only assessed Resident 2's physical ability and did not have any information whether the facility had assessed and/or considered Resident 2's safety use of MW related to aggressive behaviors towards others. On 09/08/2022 at 3:25 PM, Staff A stated that Resident 2's MW evaluation did not include an assessment regarding his mental health conditions and/or current behavioral concerns. According to Staff A, the facility did not have a policy regarding the use of MWs prior to the incident between Resident 1 and Resident 2. Staff A stated that the facility was currently working on re-assessing and re-evaluating current residents on MW's (including Resident 2) to ensure that each resident on MW were not just assessed physically but also mentally and that behaviors and other mental health conditions were reviewed and considered to ensure the safety of not just the resident operating the MW but also the residents around them. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the facility's list of current residents using MWs showed that all 13 of 13 residents (Residents 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 & 14) that were using MW's did not have a current comprehensive assessment that included information whether the resident's current mental health and/or behavioral issues/concerns were reviewed and/or considered to determine the residents safety to operate the MW and the safety of other residents around them. Three residents' (Residents 3, 4 & 5) clinical records including nursing progress notes, care plans and documented behaviors from 01/01/2021 to 09/09/2022 showed that each resident had a significant mental health condition and/or current behaviors that increased the risk of unsafe operation and use of MW's. Resident 3, Resident 4, and Resident 5 had documented history of behaviors and accidents/incidents involving the use of MW's. Resident 3's nursing progress notes and therapy evaluation dated 06/18/2021 showed that Resident 3 had a history of running over and hitting other residents using her MW on purpose. Resident 4's nursing progress notes and care plan dated 08/01/2021 showed that Resident 4 had a history of increased agitation towards others and had a documented behavior of traumatic attention seeking behavior that included driving his MW at a very high speed. Resident 5's clinical records including nursing progress notes and care plan dated 04/01/2022 and 05/01/2022 showed the resident had history of angry outburst and threatening behaviors towards other residents, poor impulse control, and history of several resident-to-resident altercations in the past. On 09/09/2022 at 10:45 AM, Staff A, Staff B, Staff C, and Staff G, Physical Therapy Consultant, they all stated that the facility did not have a system and policy for the use of MWs prior to the incident between Resident 1 and Resident 2. Staff C stated that the facility was working on completing comprehensive assessments for each resident on MWs including Resident 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 & 14. Both Staff A and Staff C stated and acknowledged the increased risk of accidents/incidents including the likelihood of serious harm and serious injury related to the use of MWs for those residents (and the residents around them) without a current MW assessment. ELOPEMENT INCIDENT A review of the facility's elopement policy dated 03/22/2022 showed that residents will be evaluated for elopement risk upon admission, re-admission, quarterly, and with a change in condition. The policy directed the facility staff to develop an interdisciplinary elopement prevention and person-centered care plan for those residents identified to be at high risk for elopement to minimize the risk of elopement incident. A review of the facility's incident reporting log for August 2022 showed that Resident 1 had an elopement incident on 08/25/2022. The incident log showed that Resident 1 was found outside the facility near the facility's parking lot. A review of the incident investigation report summary dated 08/25/2022 showed that on 08/25/2022 at 8:28 AM, Resident 1 was found by a staff member [Staff F, Registered Nurse] outside the facility in the parking lot heading towards the street. The incident report showed that Staff F immediately intervened and assisted the resident back to the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 09/09/2022 at 11:30 AM, Staff F stated that the elopement incident of Resident 1 happened on 08/25/2022 at approximately 6:00 PM and not 8:28 AM. Staff F stated that she was on her way home when she saw Resident 1 in the parking lot alone. According to Staff F, she immediately helped and assessed the resident back to the facility and notified the nurse on duty, including the physician, Staff A, and Staff B. According to Staff F, she was not sure who was assigned to watch and supervise the resident at the time of the incident, and she was not sure why Resident 1 manage to leave the facility without any staff knowledge. Staff F further stated that Resident 1 was a high risk for elopement since admission to the facility due to his dementia, poor memory/cognition, and his ability to ambulate independently without staff assistance. A review of Resident 1's clinical records including nursing progress notes and care plans from 01/01/2022 to 09/09/2022 showed the facility did not initiate appropriate timely interventions to minimize the risk of elopement for Resident 1. Additionally, there was no elopement care plan developed prior to the elopement incident on 08/25/2022. On 09/09/2022 at 11:00 AM, Staff B and Staff C stated the facility did not consider Resident 1 to be at high risk for elopement prior to the incident on 08/25/2022 because Resident 1 had not attempted to leave the facility in the past. However, Staff C stated that Resident 1 had dementia and had been wandering throughout the facility [cognitively impaired and independently mobile] increasing his risk of elopement. Additionally, both Staff B and Staff C were not able to provide important details of the elopement incident, including who were the staff that were supposed to supervise and/or assigned to care for Resident 1 at the time of the incident. Both Staff B and Staff C stated they did not know when the last time was a staff person provided care to Resident 1 or had seen Resident 1 prior to the elopement incident. According to Staff B, she also made a mistake with the investigation because the elopement incident happened on 08/25/2022 at approximately 6:00 PM and not at 8:28 AM as listed on the investigation summary report. Staff B and Staff C were not able to provide an answer on how long Resident 1 was outside the facility without any staff supervision and what the resident was doing prior to the elopement incident. On 09/09/2022 at 11:30 AM, Staff A stated that Resident 1 was a high risk for elopement and should have been care planned with preventative measures including the need for increased supervision and/or the use of a wander guard alert system to minimize the risk of elopement. Staff A also stated that the incident investigation for Resident 1 would be re-investigated to ensure that all pertinent information was included and that the root cause of the elopement incident would be addressed with appropriate interventions. Similar findings were applicable to Resident 15 and 16. RESIDENT 15 Resident 15 was a long-term care resident of the facility. The resident's diagnoses list included schizoaffective disorder (mental and mood disorder). A review of Resident 15's quarterly MDS assessment dated [DATE] showed the resident had impaired cognition and needed supervision with ambulation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 09/08/2022 at 10:30 AM, 09/09/2022 at 8:30 AM, and 09/09/2022 at 12:45 PM, Resident 15 was observed wandering at the nurse's station, activities area, unit's 200, 300 and 400 hallways, up to the front reception area close to the entrance/exit doors without staff supervision. A review of Resident 15's elopement assessment dated [DATE] showed the resident was a high risk for elopement due to his current medical conditions and prior history of elopement. The clinical records showed no recent elopement risk assessment completed for Resident 15 as directed by the facility' elopement policy. RESIDENT 16 Resident 16 was a long-term care resident at the facility. The resident's diagnoses list included Alzheimer's disease (memory problem). A review of Resident 16's quarterly MDS assessment dated [DATE] showed the resident had impaired cognition and needed supervision with locomotion (moving from one place to another) on and off the unit. On 09/08/2022 at 10:15 AM, 09/09/2022 at 8:25 AM, and 09/09/2022 at 12:50 PM, Resident 16 was observed wandering at the nurse's station, unit's 200, 300 (near exit doors) and 400 hallways, up to the front reception area without staff supervision. A review of Resident 16's elopement assessment dated [DATE] showed the resident was a high risk for elopement due to his current medical conditions and prior history of elopement. The clinical records showed no recent elopement risk assessment completed for Resident 16 as directed by the facility' elopement policy. On 09/09/2022 at 11:45 AM, Staff A, Staff B, and Staff C stated they were not aware that Resident 15 and Resident 16 did not have current elopement assessments and that both residents remained high risks for elopement due to their current conditions and history of elopement in the past. Reference: (WAC) 388-97-1060 (3)(g)