STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505416	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadview Center	13023 Greenwood Avenue North Seattle, WA 98133

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on interview and record review, the facility failed to ensure shower preferences were reasonably accommodated for 2 of 6 residents (Residents 2 & 3), reviewed for preferences. This failure placed the residents at risk of unmet care needs and a diminished quality of life.Findings included… Review of the facility's undated policy titled, “Dignity,” showed, “The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs. This begins with the initial admission and continues throughout the resident's facility stay.” The policy further showed residents were supported in exercising their rights and allowed them to choose when to sleep, eat and conduct activities of daily living (ADL). RESIDENT 2Review of Resident 2's “Shower Preference Questionnaire,” dated 07/03/2023 and another one dated 05/30/2024, showed Resident 2 preferred a shower in the morning twice a week. Review of Resident 2's care plan printed on 09/09/2025, did not show Resident 2's shower preferences. Review of Resident 2's Electronic Health Record (EHR), under task- ADL Bathing/Showering, showed Resident 2 was scheduled for a shower on Thursday evenings and as needed. The task further showed Resident 2 did not receive a shower twice a week in the morning per their preference. In an interview and joint record review on 09/10/2025 at 1:20 PM, Staff E, Resident Care Manager, stated a resident was asked about their shower preferences upon admission. A joint record review of Resident 2's “Shower Preference Questionnaire,” dated 07/03/2023 showed Resident 2 preferred a shower in the morning twice a week. Additional joint record review of Resident 2's EHR showed Resident 2 was scheduled for showers every Thursday once a week and as needed. Staff E stated that if the facility could accommodate the residents' preferences, they would try to honor them. When asked if the facility was currently honoring Resident 2's shower preferences, Staff E stated, “How it is does not reflect it now. ” In an interview and joint record review on 09/15/2025 at 4:59 PM, Staff B, Director of Nursing, stated the facility was not honoring Resident 2's shower preferences and that they should have. Joint record review of Resident 2's “Shower Preference Questionnaire,” showed a new questionnaire was completed and dated 09/15/2025 with the same shower preferences. Staff B stated that Resident 2's shower schedule had been updated to Tuesdays and Thursdays during the day. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/16/2025 at 2:11 PM, Staff C, Administrator, stated they would expect to honor resident's shower preferences “within reason.” Staff C further stated that a shower twice a week seemed like a “reasonable” request. RESIDENT 3Review of Resident 3's care plan for preferences dated 12/02/2019 and revised on 01/07/2025 showed Resident 3 preferred bed baths. In an interview on 09/08/2025 on 3:27 PM, Resident 3 stated, “I prefer bed baths, and I prefer to get them two times a week. A long time ago I was asked if I would like to take showers or bed baths. I chose bed baths because I don't like getting out of bed to take a shower. I told the staff I would like to receive two bed baths a week in the evening. Review of Resident 3's EHR, under task- ADL Bathing/Showering, showed Resident 3 was scheduled for a shower/bath every Sunday and Thursday evening and as needed. The task further showed Resident 3 did not receive bed baths two times a week from 08/13/2025 to 08/25/2025. In an interview and joint record review on 09/11/2025 at 2:43 PM Staff E RCM stated, we recently went to interview and update all the residents shower preferences and care planned their choices, I know Resident 3 preferred bed baths. In a joint record review of Resident 3's EHR under task showed Resident 3 did not receive bed baths two times a week per Resident 3's preference from 08/13/2025 to 08/25/2025. Staff E also stated Resident 3 refused at times and that all refusals should be documented. Further joint review of the task record dated 08/13/2025 to 08/25/2025 with Staff E did not show documented refusals of the bed baths, Staff E then stated Resident 3 did not receive two showers per week during this time. In an interview and joint record review on 09/11/2025 at 3:20 PM with Staff B stated, the task record showed Resident 3 preferred bed baths two times per week and did not receive two times a week from 08/13/2025 to 08/25/2025. Staff B then stated Resident 3's preference for two bed baths per week was not honored. In an interview on 09/15/2025 at 4:01 PM Staff C stated, “I expect the Resident's preferences to be honored for showers and bed baths.” Reference: (WAC) 388-97 0860 (2) .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct a thorough investigation and/or include a corrective action to prevent reoccurrence of an incident for 3 of 4 residents (Resident 4, 1 & 2), reviewed for abuse investigations. This failure placed the resident at risk for repeated incidents and unidentified abuse.Findings included… Review of the facility's policy titled, “Abuse Investigation and Reporting,” dated 10/01/2021, showed that all reports of abuse, neglect and mistreatment were thoroughly investigated by “facility management.” Review of the Nursing Home Guidelines, The Purple Book, Sixth Edition, dated October 2015, showed, A thorough investigation is a systematic collection and review of evidence/information that describes and explains an event or a series of events . Federal law requires the nursing home to do a thorough investigation of the incident. In order for a facility to provide evidence of the thoroughness of the investigation the information must be recorded.” It further showed that “the investigation is done to determine, as far as possible: what occurred; and to make necessary changes to the provision of care and services to prevent reoccurrence…The investigation should end with the identification of who was involved in the incident and what, when, where, why and how the incident happened during the probable or reasonable cause.” RESIDENT 4Review of a face sheet showed Resident 4 admitted to the facility on [DATE] with diagnosis that included anxiety disorder (feeling of constant worrying), hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body), and dementia (impaired thinking and memory). Review of the facility's compiled documents titled, “Investigative Summary, [Resident 4], dated 08/26/2025, showed it was completed by Staff B, Director of Nursing. It showed that the facility was made aware of an allegation of abuse on 08/21/2025. The contents of the investigation included the investigation summary and staff statements from Staff U, Certified Nursing Assistant (CNA) and Staff V, CNA, did not show that the investigation ended with the identification of when the alleged incident happened. Further review of Resident 4's investigative summary documents showed resident interviews were completed on 08/26/2025 by Staff W, Social Worker. Review of interviews completed with Residents 8, 18, 19, 20, 21, 22 and 23 showed that these residents answered, “Yes,” to the question, “Do you have concerns about your safety?” It did not show documentation of Staff W completing a follow-up regarding residents' concern about their safety. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 09/10/2025 at 3:52 PM, Staff B stated that Staff W did not “ask” the resident interview questions on 08/26/2025 correctly for Residents 8, 18, 19, 20, 21, 22 and 23. Staff B further stated that there was “follow-up” completed with residents who answered, “Yes” to having safety concerns. A joint record review of the documents provided by Staff B showed, “8/26 [2025] – f/u [follow-up] on safety concerns question. Resident had no safety concerns, [Staff B initials]” was documented on the back of the resident interview forms for Resident 8, 18, 19, 20, 21, 22 and 23. When asked who completed the follow-up with the residents, Staff B stated, “I asked either the [Nurse Unit Manager] or Social Worker, I don't [do not] remember.” When asked if they expected Staff W to have completed an immediate follow-up with the residents while conducting the interviews, Staff B stated “Yes.” When asked if they expected staff who were tasked with investigation interviews would be trained to conduct interviews correctly, Staff B stated, “Yes.” When asked if Staff W completed the investigation interviews correctly, Staff B stated, “based on this [resident interview forms], no.” Review of a quarterly Minimum Data Set (MDS – an assessment tool) dated 06/05/2025 showed that Resident 22 had a Brief Interview for Mental Status (BIMS – short test used to check how well a person's memory and thinking skills are working) score of four. This indicated severe cognitive impairment (major trouble with memory, thinking, and understanding). Review of a quarterly MDS dated [DATE] showed that a BIMS was not attempted with Resident 23 due to “resident is rarely/never understood.” In an interview on 09/11/2025 at 10:34 AM, Staff W stated that they were trained on the facility's process for investigating allegations of abuse and that, “I know how to do it and I've [I have] read the [facility] policies.” When asked how investigation resident interviews were conducted, Staff W stated that “Questions are printed on a document that is taken to the resident to be used for the interview, the resident is asked to sign the interview form afterwards.” Staff W stated that they wrote up the resident interview questions used for Resident 4's investigation on 08/26/2025. A joint record review of resident interview forms dated 08/26/2025 for Residents 8, 18, 19, 20, 21, 22 and 23 showed that these residents answered “Yes,” to the question, “Do you have concerns about your safety?” Staff W stated that they asked the question incorrectly. When asked if they were asked by Staff B to complete a follow-up for the resident interviews for Residents 8, 18, 19, 20, 21, 22 and 23. Staff W stated, “I didn't [did not] follow up because I didn't know I made the error. [Staff B] saw it and I don't [do not] know if [Staff B] followed up.” When asked how residents were selected for resident interviews, Staff W stated they selected residents based on their cognition (ability to remember and understand things) and those who have knowledge of the staff identified in an investigation. Staff W stated that residents who could not be interviewed due to poor cognition would require their representative to be interviewed. Staff W stated that they referred to the BIMS score in MDS assessments to determine a resident's ability to be interviewed. A joint record review of Resident 22 and 23's interview questionnaires completed on 08/26/2025 showed signatures from both residents. Staff W stated that they should have interviewed Resident 22 and 23's representatives and that these residents should not have been interviewed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/15/2025 at 2:42 PM, Staff B stated that the facility referred to the BIMS score to determine a resident's cognition and ability to be interviewed. Staff B was asked if Resident 22 and 23 were appropriate to be interviewed [by Staff W] on 08/26/2025 and Staff B stated, “I don't [do not] have an answer for that.” Staff B stated that the facility followed guidance from the Purple Book for completing investigations. When asked if Resident 4's investigation determine the specific date and/or time of the alleged incident, Staff B stated, “I don't [do no] have an answer.” Review of the facility's policy titled, “Abuse,” revised on 10/20/2022, showed the organization would maintain protocols and procedures to identify, correct and intervene in situations in which abuse, neglect, mistreatment and/or misappropriation of resident property is more likely to occur. This would include analysis of the assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors. The policy showed that if an alleged allegation was verified appropriate corrective action must be taken. The policy further showed that resident's plan of care would be revised to reflect interventions to minimize reoccurrence and to treat any injury or harm identified through assessment of the resident. RESIDENT 1 & RESIDENT 2 INCIDENTReview of Resident 1 and Resident 2's investigation dated 08/22/2025, showed a Resident-to-Resident Investigation was completed. The “Summary of Events, ” showed that on 08/22/2025 administration was notified that Resident 1 was attempting to push another resident back to their room, when Resident 2 tried to intervene. The summary showed that “In intervening, [Resident 1] became agitated and scratched and hit [Resident 2's] arms.” The investigation showed that the residents were immediately separated. The investigation further showed witness statements that saw Resident 1 “holding (in squeeze form),” Resident 2's arm and stopped once they saw the staff member and “yelled” at them in sign language. Further review of the investigation showed a care plan for Resident 1 and Resident 2. The investigation and care plans did not show a new or revised intervention was addressed or evaluated to prevent reoccurrence from the incident that occurred between Resident 1 and Resident 2 on 08/22/2025. On 09/05/2025 at 9:47 AM, Resident 2 stated that a “deaf” person (Resident 1) grabbed their friend's wheelchair and yelled at them (Resident 2) and said, “no, no, no.” Resident 2 stated that they did not know that they (Resident 1) were “deaf,” and did not know what they were saying, and they grabbed Resident 2's arm. Resident 2 lifted her left sleeve up to show three circular shaped bruises on their left forearm, indicating where Resident 1 had grabbed them. Resident 2 stated, “she [Resident 1] makes me nervous.” Resident 2 stated that staff heard her and Resident 1 yelling and separated them. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 09/15/2025 at 11:36 AM, Staff E, Registered Nurse Unit Manager, stated the purpose of an investigation was to determine the cause of the incident and make a plan to correct the incident to prevent reoccurrence. Staff E stated that on 08/22/2025, they were informed by a nurse that Resident 1 grabbed Resident 2's arm and that had caused bruising. When asked what corrective action was taken related to the incident, Staff E stated, “separate the residents,” and “more supervision I guess, and don't [do not] sit them next to each other in the dining room.” When asked how staff would know what corrective action was taken, Staff E stated staff would know through verbal nursing report and alert charting (communication tool used for monitoring a resident's change of condition). When asked if they would expect the resident's care plan to reflect their behaviors, Staff E stated, “Yeah I guess it should, at that time [Resident 2] preferred to eat in her room,” and that “[Resident 2] still didn't [did not] want to see [Resident 1] I guess.” Staff E stated that Resident 1 could get “easily agitated” if you did not understand them and had a history of grabbing staff. A joint record review of Resident 1's mood and behavior care plan revised on 06/28/2024, showed Resident 1 had a behavior of grabbing staff, pushing them and locking them in an office. When asked if there was anything in Resident 1's care plan that addressed grabbing other residents, Staff E stated that they did not see any and that grabbing another resident would be a behavior, and that Staff E “could add that. ” Staff E further stated that it was important to add Resident 1's behaviors in their care plan so that staff were aware. A joint record review of Resident 2's care plan printed on 09/15/2025, showed no care plan monitoring or interventions that addressed how Resident 2 would be protected from potential reoccurrence of the 08/22/2025 incident with Resident 1. Staff E further stated that there were no interventions. On 09/15/2025 at 4:59 PM, Staff B stated on 08/22/2025 the immediate action was to separate Resident 1 and Resident 2. When asked what the corrective action was, Staff B stated to keep Resident 1 and Resident 2 separated. When asked how the staff were aware of this, Staff B stated the kitchen and nursing staff had been “told,” and there was no documentation of that. Staff B further stated that they would expect Resident 1's behavior of grabbing another resident to be in their care plan. When asked if they would expect there to be a care plan or intervention for Resident 2 to address what happened on 08/22/2025 and how the facility would protect Resident 2, Staff B stated, “I don't [do not] have an answer for that. ” On 09/16/2025 at 2:00 PM, Staff C, Administrator, stated the purpose of an investigation was to keep residents safe, find out the root cause of why the incident occurred, and prevent it from happening in the future. When asked if abuse or neglect was substantiated on the investigation for the incident on 08/22/2025 between Resident 1 and Resident 2, Staff C stated that the abuse was physical. When asked what corrective action was taken based on the investigation, Staff C stated that Resident 1 and Resident 2 were placed on alert and separated and were interviewed on whether they felt safe. When asked if there were any new/revised interventions as part of the investigation for Resident 1 and Resident 2's care plan, Staff C stated, “I could not find any other interventions, other than being separated.” Reference: (WAC) 388-97-0640 (6)(a)

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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. (continued on next page)

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F 0656 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 develop care plans for 2 of 2 residents (Residents 8 & 4), reviewed for comprehensive care plans. The failure to develop care plans for assistive device use, independent community outings, and refusal of incontinent care (toileting assistance) placed the residents at risk for unmet care needs and a diminished quality of life. Findings included .Review of the facility's undated policy titled, Care Planning - Comprehensive Person-Centered, showed, A person-centered comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs shall be developed for each resident. It showed that Comprehensive Care Plan meant an interdisciplinary communication tool developed after completion of a comprehensive MDS [Minimum Data Set - an assessment tool] and review of the Care Area Assessments. It showed, The resident will receive the services and/or items included in the plan of care, and any services that would otherwise be required but are not provided due to the resident's exercise of right to refuse treatment. It further showed that the comprehensive care plan will Incorporate identified problem areas.Incorporate risk factors associated with identified problems.promote resident safety.RESIDENT 8Review of a face sheet showed Resident 8 initially admitted to the facility on [DATE] with diagnosis that included generalized (not specific) muscle weakness and a history of person injured in unspecified motor-vehicle accident. It further showed that Resident 8 readmitted to the facility on [DATE].Review of an initial admission nursing progress note dated 07/01/2025 showed that Resident 8 Arrived in electric wheelchair. Review of the admission MDS dated [DATE] showed that Resident 8 was coded to have impairment (limitation that interfered with daily functions or placed resident at risk of injury in the last seven days) to both lower extremities and that Resident 8 used a motorized wheelchair as a mobility device. It further showed that Resident 8 was cognitively intact with a BIMS score of 15. In an interview and observation on 09/09/2025 at 1:04 PM, Resident 8 stated that they went out to the community un-supervised and that they used their motorized wheelchair to visit family and to get food. An observation of Resident 8's room showed a parked motorized wheelchair. In a follow-up interview on 09/11/2025 at 11:29 AM, Resident 8 stated that they independently used their motorized wheelchair outside of the facility 3 to 4 days out of the week. Review of a comprehensive care plan printed on 09/05/2025 did not show documentation of Resident 8's use of a motorized wheelchair. Further review did not show documentation of Resident 8's preference and/or ability for independent community outings. In an interview on 09/11/2025 at 11:47 AM, Staff J, Certified Nursing Assistant (CNA), did not identify Resident 8 when asked to identify Unit 700 residents who used a motorized wheelchair.In an interview on 09/11/2025 at 11:52 AM, Staff I, Licensed Practical Nurse (LPN), stated nobody used a motorized wheelchair in Unit 700. When asked if Resident 8 used a motorized wheelchair, Staff I stated, Oh yes, you're [you are] right, and that most of the time [Resident 8 stayed in their] room and Resident 8 had not left their room lately. When asked if Resident 8 left the facility using their motorized wheelchair, Staff I stated [Resident 8] does, and that Resident 8 had not gone out in the last 3 weeks] due to an incident where Resident 8 bumped [themselves] in the store.In an interview and joint record review on 09/12/2025 at 11:20 AM, Staff H, LPN Unit Manager, stated that Resident 8 was alert and oriented and could sign in and out of the facility for community outings. Staff H stated that leaving the facility independently posed a risk to residents' safety to include cars, accidents, and falls. When asked if Resident 8 was identified by nursing to be at risk for falls and accidents, Staff H stated, Yes. A joint record review of Resident 8's comprehensive care plan did not show a care plan for Resident 8 leaving the facility independently and that Staff H expected there to be a care plan. When asked if assistive devices and equipment were important to be included in a resident's care plan, Staff H stated, yes, we include wheelchairs and walkers and that motorized wheelchairs were considered an assistive device. Joint record review of Resident 8's care plan did not show documentation of Resident's 8's use of a motorized wheelchair. Staff H stated that wheelchair was mentioned, but it doesn't [does not] say electric wheelchair. It should be there. When asked if Resident 8's safety interventions related to their use of a motorized wheelchair were identified and included in their care plan, Staff H stated, It should be there.In an interview on 09/12/2025 at 2:08 PM, Staff B, Director of Nursing, was asked if leaving the facility independently posed a risk to residents, Staff B stated, not necessarily if the resident was mobile. When asked if residents who were mobile could be at risk for accidents and hazards, Staff B stated, Yes. When asked if Resident 8's care plan included safety interventions related to leaving the

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure bathing/showers were consistently provided for 4 of 6 residents (Residents 2, 6, 3 & 5), reviewed for activities of daily living (ADL). This failure placed the residents at risk for poor hygiene, unmet care needs, decreased self-esteem, and a diminished quality of life.Findings included . Review of the facility's policy titled, “Activities of Daily Living (ADLs),” dated 10/01/2021, showed, “Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.” The policy showed if a resident refused care the resident and/or representative would be informed of the risks and benefits, offered an alternative intervention to minimize further decline, and the refusal and information would be documented in the resident's clinical record. The policy further showed each resident would receive a tub or shower baths as often as needed, but not less than twice weekly or as required by law. RESIDENT 2Review of the ADL self-care needs care plan initiated on 04/14/2025, showed Resident 2 required extensive assistance by one staff with bathing/showering. Review of Resident 2's Electronic Health Record (EHR), under task- ADL Bathing/Showering, showed they were scheduled for a shower on Thursday evenings and as needed. The task showed a lookback of 30 days from 08/12/2025 to 09/10/2025. The task showed two showers were given during this time: one on 08/22/2025 and on 09/01/2025. The task further showed documentation for the remaining days were documented as, “Not Applicable,” and did not show whether Resident 2 was offered a shower or if they declined a shower. Review of Resident 2's progress notes from 08/12/2025 to 09/10/2025 did not show whether Resident 2 was offered a shower or if they declined a shower during the time. RESIDENT 6Review of Resident 6's face sheet printed on 09/05/2025 showed they admitted to the facility on [DATE]. Review of a care plan printed on 09/16/2025 did not show the amount of assistance Resident 6 required with their showers/bathing. Review of Resident 6's EHR, under task- “*GG- Shower/Bathe Self Every Thursday day shifts and PRN [as needed],” showed Resident 6 was scheduled for a shower on Thursday. The task showed a lookback of 30 days from 08/26/2025 to 09/04/2025. The task showed one shower was given during this time: on 09/03/2025 (11 days after their admission). The task further showed documentation for the remaining days were documented as, “Not Applicable,” and did not show whether Resident 6 was offered a shower or if they declined a shower. Review of Resident 6's progress notes did not show whether Resident 6 was offered a shower or if they declined a shower during the time from 08/22/2025 to 09/08/2025. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A joint record review and interview on 09/10/2025 at 1:20 PM, with Staff E, Unit Manager Registered Nurse, showed Resident 2's EHR under task- ADL Bathing/Showering revealed two showers on 08/22/2025 and on 09/01/2025 were given during a lookback of 30 days from 08/12/2025 to 09/10/2025. The task further showed documentation for the remaining days were documented as, “Not Applicable.” When asked if there was documentation to show whether Resident 2 was offered or refused a shower on the remaining days, Staff E stated, “I don't [do not] see it here.” When asked if there was any documentation to show whether Resident 6 was offered or declined a shower Staff E stated, “If there is no documentation then it means that it was not done. They [staff] should have offered a shower.” Staff E further stated it was important for a resident to be offered or receive a shower/bath for their dignity and comfort. On 09/11/2025 at 3:19 PM, Staff B, Director of Nursing, stated they would expect staff to document whether a resident received or refused their shower, and that “Not Applicable” documentation did not show whether a resident was offered a shower. When asked when Resident 6 received their first shower, Staff B stated, “It looks like due to documentation,” on 09/03/2025. When asked how many days Resident 6 went without a shower Staff B stated, “From 08/22/2025 to 09/03/2025.” Staff B stated that Resident 6 should have been offered a shower/bath prior to 09/03/2025. RESIDENT 3Review of a care plan for “Activity of Daily Living,” revised on 01/07/2025 showed Resident 3 required limited assistance of one staff member with bathing/showering. The care plan further showed Resident 3 preferred to take bed baths. Review of Resident 3's EHR, under task- ADL Bathing/Showering, showed Resident 3 was scheduled for a shower/bath every Sunday and Thursday evening and as needed. The task further showed Resident 3 did not receive bed baths from 08/13/2025 to 08/25/2025. Review of Resident 3's progress notes did not show whether Resident 3 was offered a bed bath or if they declined a bed bath during the time from 08/13/2025 to 08/25/2025. In an interview and joint record review on 09/11/2025 at 2:43 PM. Staff E stated Resident 3 was scheduled to receive two bed baths a week. A joint record review of Resident 3's EHR under task did not show that Resident 3 received bed baths from 08/13/2025 to 08/25/2025. Staff E stated refusals should be documented. Further joint review of the task record dated 08/13/2025 to 08/25/2025 with Staff E showed no documented refusals of the bed baths and did not show that Resident 3 received bed baths during the time of 08/13/2025 to 08/25/2025. RESIDENT 5Review of a care plan for bathing, initiated on 08/13/2025 showed Resident 5 was dependent on staff for bathing. Review of Resident 5' s EHR, under task-ADL Bathing/Showering, showed Resident 5 was scheduled for a shower/bath every Monday evening and as needed. The task further showed Resident 5 received one shower on 08/26/2025 during the time frame of 08/12/2025 to 09/08/2025. Review of Resident 5' s nursing progress notes dated 08/12/2025 to 09/08/2025 showed no documental refusals of showers. (continued on next page)

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	505416	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadview Center	13023 Greenwood Avenue North Seattle, WA 98133

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 09/11/2025 at 2:58 PM, Staff E stated Resident 5 was scheduled to receive a shower once a week, on Monday. A joint record review with Staff E of Resident 5's EHR under task, showed that Resident 5 received one shower on 08/26/2025 during the time frame of 08/12/2025 to 09/08/2025. Staff E stated refusals should be documented, further joint review of the task record dated 08/12/2025 to 09/08/2025 with Staff E showed no documented refusals of the showers, Staff E then stated the documentation showed that Resident 5 received one shower during the time of 08/12/2025 to 09/08/2025. In an interview and joint record review on 09/11/2025 at 3:28 PM, Staff B stated the task record showed Resident 5 received a shower on 08/26/2025, and nothing else was documented about a shower for Resident 5 during the time frame of 08/12/2025 to 09/08/2025. In an interview on 09/15/2025 at 4:01 PM, Staff C, Administrator, stated, “If Resident 3 or Resident 5 refused care like bed baths or showers it should be documented as a refusal, otherwise the expectation was for Resident 3 and Resident 5 to receive bed baths and showers as scheduled, and as needed.” Reference: (WAC) 388-97-1060 (2)(c)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 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 ensure monitoring for latent (hidden or not active yet) signs of injury and prompt medical evaluation for treatment was provided in accordance with professional standards of practice for 1 of 1 resident (Resident 8), reviewed for change of condition. These failures disallowed an opportunity to promptly evaluate the resident for a change in condition, which resulted in a delay of medical services, and placed the resident at risk for adverse consequences, related complications, and a diminished quality of life.Findings included.Review of the facility's policy titled, Change in a Resident's Condition, dated 10/01/2021, showed that the facility will promptly notify the resident's physician/practitioner of changes in the resident's medical/mental condition and/or status.The nurse will notify the resident's Attending Physician/practitioner or physician on call when there has been an accident or incident involving the resident.The nurse/designee will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Review of the facility's policy titled, Charting and Documentation, dated 10/01/2021, showed that All services provided to the resident.or changes in the resident's medical, physical, functional, or psychological condition, will be documented in the resident's medical record.The following information is to be documented in the resident medical record. Events, incidents, or accidents involving the resident.Review of a face sheet showed Resident 8 initially admitted to the facility on [DATE] with diagnosis that included generalized (not specific) muscle weakness and cauda equina syndrome (medical condition that affects the bundle of nerves at the bottom of the spinal cord).Review of an admission MDS dated [DATE] showed that Resident 8 was cognitively intact with a Brief Interview for Mental Status (BIMS -a cognitive screening tool) score of 15 (highest possible score). It further showed that Resident 8 used a motorized wheelchair for mobility.In an interview on 09/11/2025 at 11:29 AM, Resident 8 stated that on 08/21/2025, they used their motorized wheelchair at a clothing store when they injured their right foot. Resident 8 further stated that the tip of their right Ankle-Foot Orthosis (AFO-type of brace designed to support the ankle and foot) got caught on a store display while maneuvering down a narrow isle, which caused their right leg to flip around. When asked if they returned to the facility independently after the incident, Resident 8 stated, Yes, and that they initially reported the incident to a Physical Therapist (PT) to take a look at my leg and that Resident 8 felt like they sprained their right ankle. Resident 8 further stated that a Certified Nursing Assistant (CNA) later helped them take off their right AFO which resulted in Resident 8 having pain. Resident 8 stated that the CNA notified the Nurse. Review of a nursing progress note dated 08/21/2025 at 8:00 PM, showed Resident 8 was given oxycodone (strong pain medication) 10 mg (milligrams-a unit of measurement) that was instructed to be given every six hours as needed for severe pain. Review of a nursing progress note dated 08/21/2025 at 8:54 PM, showed [Resident 8] reported pain at around 8 pm [8:00 PM] on right ankle and wants oxycodone, [Resident 8] stated, I pumped my right ankle on my power w/c [wheelchair] while out for shopping to [a clothing store] this morning. It showed, [Resident 8] unable to move [their] leg r/t [related to] paralyze. [Resident 8] placed on a/c [alert charting - communication tool used for monitoring a resident's change of condition] for monitor. It further showed that the medical provider was notified via communication book and that Report given to incoming nurse.Review of a nursing progress notes showed Resident 8 was given additional doses of oxycodone 10 mg for severe pain on the following dates and times:- On 08/21/2025 at 11:03 PM- On 08/22/2025 at 3:07 PMReview of Resident 8's nursing progress notes did not show documentation of alert charting and/or medical provider assessment of Resident 8's complaint of right ankle pain on 08/22/2025, 08/23/2025 and on 08/24/2025 [three days following Resident's 8 change of condition].Review of Resident 8's August 2025 Medication Administration Record showed that Resident 8 was documented to receive non-pharmacological pain interventions on the following dates and nursing shifts:-On 08/21/2025, Rest for all shifts and Cold/Ice during the evening and night shifts.-On 08/22/2025, Rest for all shifts and Cold/Ice during the day and evening shifts.-On 08/23/2025, Rest for all shifts and Cold/Ice during the day and evening shifts. -On 08/24/2025, Rest for the day and evening shifts and Cold/Ice during the day and evening shifts. -On 08/25/2025, Rest for the day and evening shifts.Review of a medical provider's encounter note dated 08/25/2025 showed Resident 8 was assessed for a chief complaint of right ankle sprain. It showed that mechanism for Resident 8's complaint of right ankle pain was that ankle twisted at [a clothing store] when [their AFO] brace caught on display edge. It further showed that Resident 8 reported a pain score of eight out

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 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/replace a pressure relieving bed mattress (Dolphin Mattress-a type of mattress that alternated fluid through the mattress) as recommended by the wound consultant to prevent and protect skin/wounds from further breaking down for 1 or 3 residents (Resident 3), reviewed for pressure ulcers. This failure placed the resident at risk for related medical complications, a decrease in healing potential, and a diminished quality of life.Findings included.Review of the National Pressure Injury Advisory Panel (NPIAP - leading expert in pressure injuries/wounds), dated February 2025, defined pressure injury stages as follows: -Stage 4 Pressure Injury is a full-thickness loss of skin and tissue with exposed or directly palpable fascia (layer of tissue covering the muscle), muscle, tendon (a cord or band of dense, tough, inelastic, white, fibrous tissue, serving to connect a muscle with a bone or part), ligament (a tough fibrous band of connective tissue that supports internal organs and holds bones together at the joints. It connects bones to other bones and helps hold organs in place), cartilage (a strong, flexible connective tissue that protects the joints and bones acting as a shock absorber throughout the body) or bone in the ulcer. Slough (is non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture) and/or eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like) may be visible.Review of the facility's undated Pressure Injury and Prevention Management Policy showed, If a referral is made to a wound consultant, the wound consultant will provide timely and accurate information to the facility on the status of the pressure ulcer/injury and will provide recommendation for change in treatment and care of the pressure ulcer/injury.Review of the quarterly Minimum Data Set assessment (MDS-an assessment tool) dated 07/28/2025 showed Resident 3 readmitted to the facility on [DATE]. Further review of the MDS dated [DATE] showed Resident 3 required assistance with bed mobility and transfers.Review of the Electronic Health Record (EHR) showed Resident 3 had history of pressure injuries that included Stage 4 pressure injuries to the right and left hip and Osteomyelitis (bone infection) of the right femur (leg), the EHR further showed the Stage 4 pressure injuries and Osteomyelitis had a chronic (long) history of healing and reopening.Review of a physician order in the EHR dated 03/20/2025 showed Resident 3 had orders to be followed by a wound care clinic outside of the facility.Review of a wound care clinic notes dated 08/28/2025, showed Resident 3's mattress was not sufficiently offloading pressure, and Resident 3 needed a Dolphin Mattress to prevent and protect skin/wounds from further breaking down.In an interview on 08/26/2025 at 12:13 PM, Collateral Contact 1 (CC1), stated, We made several phone calls and sent so many recommendations to the nursing staff at the facility to please arrange to get this Dolphin Mattress for Resident 3. We informed them that the current mattress that they replaced with when the Dolphin Mattress broke was not sufficient for offloading pressure. CC1 stated Resident 3 had a long history of pressure injuries and that they recommended this mattress to prevent and assist in healing of pressure injuries.Observation on 09/08/2025 at 2:21 PM, Resident 3 had a MATT-EASY AIR mattress [a type of mattress that alternated air through the mattress] on their bed that was not the Dolphin Mattress as CC1 recommended in the wound care note dated 08/28/2025. In an interview on 09/09/2025 at 11:36 AM, CC2 stated the difference between the two mattresses were that the Dolphin Mattress functioned by alternating fluid in the mattress to relieve pressure and MATT-EASY AIR mattress functioned by alternating air to relieve pressure. CC2 further stated that the Dolphin Mattress was highly recommended for pressure reduction, healing, and prevention of pressure ulcers.In an interview on 09/15/2025 at 1:37 PM, Staff E, Registered Nurse, Unit Manager, stated that when Resident 3 returned from the wound care clinic the orders and recommendations were faxed over and that they noted the new orders and recommendations and made sure all were taken care of. Staff E stated that the Dolphin Mattress broke, and they informed the previous administration staff about the recommendation for it. Staff E stated that the MATT-EASY AIR mattress was ordered and placed on Resident 3's bed on 08/05/2025 despite the wound care recommendations for Dolphin Mattress. Staff E further stated the Dolphin Mattress was never replaced and had informed the previous administration regarding Resident 3's multiple wound care notes that recommended the Dolphin Mattress.In an interview on 09/15/2025 at 3:29 PM, Staff B, Director of Nursing, stated, I know the previous Administrator was working with our corporation to get the Dolphin Mattress replaced, I am not sure, but I think they did not want to pay to fix or replace the bed, so another mattress was ordered for Resident 3.In an interview on 09/16/2025 at 5:11 PM, Staff C, Administrator, stated that the

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on observation, interview, and record review, the facility failed to provide adequate assessment and supervision for electronic cigarette use and ensure safe storage of smoking materials for 1 of 1 resident (Resident 7) that constituted an Immediate Jeopardy (IJ) and failed to supervise and restrain a pet (dog) for 1 of 1 staff (Staff F), reviewed for accident/hazards. Resident 9 experienced harm when they sustained a laceration (cut) on the back of their head when a staff member's dog was unleashed, wandered under the table in the dining room, startled the resident who fell backwards in their wheelchair hitting their head and required transport to the hospital for further evaluation. These failures placed the residents at risk for significant safety hazards including explosion and/or fire related to the electronic cigarette battery, avoidable accidents, bodily injury, and other negative outcomes. An IJ was identified, and the facility was notified of the noncompliance on 09/05/2025. The IJ was determined to have begun on 09/05/2025 when the facility failed to adequately assess Resident 7 for smoking and to ensure safe storage of smoking materials. The IJ was removed on 09/08/2025 when an on-site inspection confirmed the facility implemented their removal plan by removing the smoking materials in Resident 7's room for safe storage, completed a smoking assessment and updated Resident 7's care plan with the facility providing supervised vaping, completed interviews and observations of all residents and their rooms to ensure smoking materials were stored safely, and all residents and/or resident representatives, and staff were educated on the facility's non-smoking policy. Findings included . RESIDENT 7Review of the facility's policy titled, “Smoking Prohibited,” dated 10/01/2021, showed that smoking or vaping by residents was prohibited within the facility and on the grounds of the facility. It showed that vaping referred to the use of electronic nicotine delivery system or electronic smoking devices such as e-cigarettes [or E-cigar]. It further showed that residents may not keep smoking materials in their rooms and that if a resident had smoking materials, they were to be given to the “nurse” for secure storage. Review of a face sheet showed Resident 7 admitted to the facility on [DATE] with diagnosis that included stroke (caused by a blocked blood vessel in the brain), unsteadiness on feet and need for assistance with personal care. Review of a quarterly Minimum Data Set (MDS – an assessment tool), dated 08/25/2025 showed Resident 7 was cognitively intact (a person's thinking and memory are working well) with a Brief Interview for Mental Status (BIMS -a cognitive screening tool) score of 15 (highest possible score). Review of a document titled, admission Nursing Collection, dated 07/09/2025, showed that a “Smoking Safety Screen” was completed for Resident 7. It further showed that Resident 7 was identified to “use tobacco products” upon admission to the facility. Review of Resident 7's care plan titled, “Tobacco Use,” dated 07/14/2025, showed that Resident 7 “preferred” to smoke cigarettes, cigar, pipes, and via electronic delivery systems, including electronic cigarettes and vape pen. It showed that the care plan goal was, “The resident will smoke safely thru the review period.” It further showed a care plan intervention for the facility to complete a smoking assessment as needed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident 7's Electronic Health Records (EHR) did not show documentation of a completed smoking assessment. Review of a nursing progress note dated 07/10/2025, showed that Resident 7 “request to smoke vapes, on routine nicotine (smoking cessation) patch” and that “Staff educate [Resident 7] that no smoking is allowed in the facility.” Review of July 2025 Medication Administration Record (MAR) showed that Resident 7 refused their nicotine patch on eight occasions from July 10, 2025, through July 31, 2025. Review of August 2025 MAR showed that Resident7 refused their nicotine patch every day from 08/01/2025 through 08/19/2025. It further showed that Resident 7 physician's order for routine nicotine patch was discontinued on 08/19/2025. An observation and interview on 09/05/2025 at 10:30 AM showed Resident 7 was lying in bed, holding a slim, rectangular device, which they raised to their mouth before exhaling a cloud of white, odorless vapor. When asked if Resident 7 was vaping, Resident 7 stated, “Yes” and that they were aware that residents were not allowed to use a vape within the facility. When asked if Resident 7 independently stored and charged the battery of their vape device, Resident 7 stated, “Yes.” Resident further stated that their vape device was a “Juul [brand name].” A follow up observation and interview on 09/05/2025 at 12:10 PM, showed Resident 7 was sitting upright on the side of their bed and used their vape pen while watching television. Resident 7 stated that the facility knew about their use of a vape device and that Resident 7 refused nicotine patches that were offered by the facility. When asked how often they vaped, Resident 7 stated, “not that often, I would say, three times a day,” and that they vaped unsupervised in their room. When asked if staff had ever seen Resident 7 used their vape inside the facility, Resident 7 stated, “Yes,” and that “They (Staff) don't [do not] pay attention to it, they're [they are] working.” In an interview and joint record review on 09/05/2025 at 12:19 PM, Staff D, Registered Nurse (RN), was asked if there were residents that smoked in the facility, Staff D stated, “I know [Resident 7] uses e-cigarettes.” Staff D stated that residents were not allowed to smoke within the facility and that they did not know if residents could vape within the facility. Staff D stated that they saw Resident 7 vaping in the facility “once in a while,” and that Staff D last saw Resident 7 vaping in the facility on 09/05/2025. When asked what their action was after observing Resident 7 vaping in the facility, Staff D stated that they “reminded [Resident 7] of the risks for “hypertension [high blood pressure] and heart problems.” When asked if they offered to safely store Resident 7's vape device, Staff D stated that Resident 7's vape was their “own supply” and that they had not been told “how to keep or safe keep those e-cigarettes.” When asked if residents were allowed to smoke outside of the facility, Staff D stated, “Yes, it's [it is] open, there's [there is] a patio.” Staff D then stated that they were not “aware” that Resident 7 needed to be supervised for smoking because Staff D did not “know about e-cigarettes.” Staff D further stated that they were “not sure” if the facility had a smoking policy that included vape devices. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview and joint record review on 09/05/2025 at 1:15 PM, Staff E, RN, Unit Manager, stated that the facility was a non-smoking facility, which meant that residents were not allowed to smoke within the facility and within the facility premises. Staff E stated that they were “not sure” if the facility's non-smoking policy included the use of vaping devices. When asked what the facility's process was when smoking materials were identified within the facility, Staff E stated that they would “clarify with the Director of Nursing [DON]” if they could “confiscate” the smoking materials and “keep in a safe place away from the resident.” A joint record review of Resident 7's EHR showed a Tobacco Use Care Plan, dated 07/14/2025, that listed an intervention to complete a smoking assessment as needed. Staff E stated that Resident 7 was screened for tobacco use on admission and that they did not see documentation of a completed smoking assessment. When asked what the purpose was of completing a smoking assessment, Staff E further stated that they had “no idea,” and that they had not completed a smoking assessment before because the facility was a “non-smoking facility. ” When asked if Resident 7 should have been assessed for smoking, Staff E stated that they would “clarify it with the DON.” In an interview on 09/05/2025 at 1:32 PM, Staff B, DON, stated that the facility had a smoking policy and that they were “not sure” if the policy included the use of vape devices. When asked if vape devices were considered smoking materials, Staff B stated, “Yes,” and that they “believed” there were no residents that had vape devices “in-house.” Staff B stated that they expected that smoking materials would be “kept in the nurses' station” accessible only to staff. Staff B stated that vape devices posed “fire hazards” and that vape devices would be considered smoking materials. Staff B further stated that if a resident was observed using e-cigarettes and/or vape devices that they would expect staff to “right away” educate the resident on the associated risks, intervene to stop the activity, and secure any smoking materials. Staff B stated that the reason for removing the smoking supplies from a resident's procession was for “safety reasons, safe storage, and to keep everybody safe.” When asked if a smoking assessment should be completed for a resident identified on admit having used tobacco, Staff B stated that they expected there would be an “evaluation that is followed up on by nursing [staff].” When asked if Resident 7 should have been assessed for smoking, Staff B stated that they would “have to look into it.” In an interview on 09/05/2025 at 2:20 PM with Staff B, and Staff A, Interim Administrator, Staff B stated that they were “under the impression” that the facility had a designated smoking area in the “courtyard,” and that they would “get the determination of that.” Staff A clarified that the facility was a “non-smoking facility.” Record review of Resident 7's EHR showed a progress note signed by Staff D on 09/05/2025 at 3:11 PM, showed “This writer saw [Resident 7] has E-cigar in her room,” and that Staff B was notified. Record review of Resident 7's EHR showed a progress note signed by Staff B on 09/05/2025 at 3:41 PM, showed “Smoking Evaluation completed.” RESIDENT 9 Review of the Pet, Animal Policy, revised in January 2025 showed, Personal Pet Visits:The following rules and restrictions apply to personal pet visits:a. A staff member, volunteer, or other designated individual must always accompany animals at all times. b. Animals must be on a leash and/or restrained while in the facility. Safety Precautions: Animals will not be allowed in food preparation areas, dining areas, bathrooms or treatment areas. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the quarterly MDS dated [DATE] showed Resident 9 was admitted to the facility on [DATE] with a diagnosis list that included dementia (impaired memory) and required partial to moderate assistance for transfers and mobility. The MDS further showed the resident used a wheelchair. Review of the incident investigation dated 08/04/2025 showed Resident 9 was eating breakfast in the dining room when a dog entered the dining room and crawled under the table that Resident 9 sat at in their wheelchair to eat breakfast. The investigation showed Resident 9 was startled and they lifted both feet up which caused the wheelchair to tip backwards with Resident 9 in the wheelchair. A licensed nurse (LN) found Resident 9 on the floor, on their back. The LN assessed the resident and found a laceration (cut) on their head that measured 1.0 centimeters (cm-a unit of measurement) by 0.5 cm. Resident 9 complained of pain when the area was touched. First Aide was performed to clean the cut, and pressure was applied to the area to control the bleeding. Resident 9 required extensive assistance from staff to be transferred from the floor to their wheelchair. Resident 9 was transported to the local hospital for assessment and evaluation of their head and pain on 08/04/2025 and returned to the facility the same day. A computed tomography (CT-imaging to create detailed images of the body) scan was completed and was negative for any traumatic injury of the head or neck. The incident investigation dated 08/04/2025 further showed a LN (Staff M, Licensed Practical Nurse - LPN) observed the dog come into the dining room from the gym (therapy room) and go between Resident 9 and another resident that sat at the table, the dog then went under the table between the two residents, when Resident 9 screamed “help.” Staff M walked towards Resident 9's table, the dog barked and Resident 9's wheelchair flipped back, and Resident 9 was found on their back. The investigation then stated it seemed like the dog was stuck under the table and could not figure their way out from the table. In an interview on 08/15/2025 at 12:45 PM Staff F, Rehabilitation Director, stated, “the dog went into the dining room, he (the dog) was eating crumbs that fell on the floor under the table and got stuck in the wheelchair. He should have been on his leash; this accident would not have happened. They sent Resident 9 to the hospital. The rules were broken and Resident 9 got harmed because the dog was not on a leash. He (the dog) got tangled up in their wheelchair and tipped it over. Resident 9 would not have been hurt if he (the dog) was on a leash, we would have been able to stop him from going under the table, getting tangled up in the wheelchair and tipping it over. It was a broken policy, the policy said 100% the dogs need to be on a leash, always and he was not.” In an interview on 08/15/2025 at 1:29 PM, Staff L, Speech Therapist, stated that they went to the gym, the door was left open, and the dog went to the dining room from the gym, then they heard a loud bang that came from the dining room, and went to see what the noise was and saw Resident 9 on the floor, with the back of their head bleeding. The dog was not on a leash; he (the dog) smelled food that came from the dining room and went to get some food. The dog was not on a leash while he was in the gym or in the dining room. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadview Center	13023 Greenwood Avenue North Seattle, WA 98133

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 09/15/2025 at 11:59 PM Staff M stated, “I was in the dining room, Resident 9 was sitting in their wheelchair at the table eating breakfast when the dog went under the table, Resident 9 tried to move their legs away from the dog, fell backwards and hit the back of their head on the floor. There was blood from a cut on the back of their head, Resident 9 was frightened. The dog was not on a leash, the dog should not be in a resident area, especially not in the dining room when the residents eat. The dog was not on a leash when I saw the dog come from the gym (therapy) room. The dog was by itself. There was nobody with the dog when it entered the dining room. This accident could have been avoided if the dog had been on a leash with someone supervising and holding the leash to prevent the dog from going under the table. Resident 9 would not have fallen backwards in their wheelchair and cut the back of their head because the dog would not have been under the table.” In an interview on 09/15/2025 at 12:30 PM, Staff N, Registered Nurse, Unit Manager, stated, “all dogs were supposed to always be on leashes and supervised when they were in the facility. Staff N further stated if the dog had been on a leash, Resident 9 would not have been harmed on 08/04/2025 when the dog went under the dining room table and Resident 9 fell backwards in their wheelchair and cut the back of their head. ” In interview on 09/15/2025 at 3:29 PM, Staff B stated Resident 9's accident on 08/04/2025 could have been avoided if the dog was on a leash, Resident 9 would not have injured the back of their head when they fell backwards in their wheelchair. In an interview on 09/15/2025 at 4:01 PM, Staff C, Administrator, stated, “I think the dog got in the way and tripped Resident 9. I am not sure about that, but per policy the dog should have been on a leash. This would not have happened if the dog was on a leash.” Reference: (WAC) 388-97-1060(3)(g)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the daily nurse staffing form was accurately completed with actual hours worked for each shift for 7 of 10 days (09/01/2025, 09/02/2025, 09/03/2025, 09/04/2025, 09/05/2025, 09/09/2025 & 09/10/2025), reviewed for sufficient and competent staffing. This failure placed the residents and residents' representatives at risk of not being fully informed of the current staffing levels. Findings included .Review of the nursing staff posting forms dated 09/01/2025, 09/02/2025, 09/03/2025, 09/04/2025, 09/05/2025, 09/09/2025 and 09/10/2025 did not show actual nursing hours worked. In an interview on 09/16/2025 at 3:46 PM, Staff O, Receptionist stated the nurse staffing form was posted every morning for day shift and then the evening and night shift was added to the form in the afternoon. Staff O further stated, I never do the actual hours worked. I just put up the staff hours that the nursing staff were scheduled to work. I never seen the actual hours worked completed on the form. The nursing forms were given to the staffing coordinator to save and file.In an interview on 09/16/2025 at 3:52 PM, Staff P, Staffing Coordinator, stated that the previous administration staff would fill in the actual hours worked on the nursing staff posting forms the next day. It was never done on the same day, so you would not know the actual hours worked until the next day or later if they did not get filled out.In an interview on 09/16/2025 at 5:10 PM Staff C, Administrator, stated the actual nursing hours should be posted on the same day to inform visitors and residents of the actual nursing hours worked.No Reference WAC .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 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 interview and record review, the facility failed to ensure 2 of 2 residents (Residents 3 and 17) were free from significant medication errors. The failure to provide intravenous (IV- administered through a vein) antibiotic medications (to treat infection) placed the residents at risk for a decline in their medical condition, a life-threatening infection, and a diminished quality of life.Findings included .RESIDENT 3Review of the quarterly Minimum Data Set (MDS-an assessment tool) dated 07/28/2025 showed Resident 3 was readmitted to the facility on [DATE] and had intact thinking.In an interview on 09/08/2025 at 2:32 PM, Resident 3 stated, a few weeks ago I missed the antibiotic [medication] I was supposed to take for the infection in my wounds and bone, it was an IV the nurses told me they did not have it and that they were trying to get it delivered from the pharmacy. After I missed a few doses, I started to feel like I had a fever and chills. When the aides took my temperature, it was normal, but I still felt like I had a fever and chills from missing the antibiotics.Review of August 2025 Medication Administration Record (MAR) in the Electronic Health Record (EHR) showed orders for Meropenem (antibiotic-medication used to treat infection) 1 gram (gm-a unit of measurement) IV every 8 hours for Pelvic (hip) Osteomyelitis (bone infection) with a date to start on 07/28/2025 and a date to stop on 08/28/2025. Further review of the MAR dated 08/24/2025 at 2:00 PM and at 10:00 PM and on 08/25/2025 at 6:00 AM and at 2:00 PM, showed the medication was not administered. Medication Meropenem 1 gm IV was not administered four times from 08/24/2025 to 08/25/2025.Review of the nursing progress notes in the EHR dated 08/24/2025 showed Resident 4 missed doses of Meropenem 1 gm IV at 2:00 PM, 10:00 PM and on 08/25/2025 at 6:00 AM and 2:00PM.RESIDENT 17Review of the admission MDS dated [DATE] showed Resident 17 was admitted to the facility on [DATE]. Review of a nursing admission progress note in the EHR dated 08/22/2025 showed Resident 17 admitted to the facility with right hip peri-prosthetic joint infection (an infection that occurred around the replaced right hip joint) and had a suspected joint infection and was admitted to the facility for intravenous antibiotic therapy. Review of the physician's orders in the EHR dated 08/23/2025 showed orders for Daptomycin (medication used to treat infection) IV 500 milligrams (mg-unit of measurement) at 10:00 AM for infection for 41 days and Ertapenem 1 gram IV at 10:00 AM for 6 weeks. Review of the MAR dated 08/23/2025 showed Daptomycin IV use 500 mg at 10:00 AM for infection or Ertapenem 1 gram IV at 10:00 AM was not administered to Resident 17.Review of a progress note in the EHR dated 08/23/2025 showed Resident 17 was transferred to a local hospital at 12:50 PM due to the pharmacy's inability to deliver the residents IV antibiotic medications. In an interview on 09/12/2025 at 1:31PM Staff D, Registered Nurse (RN), stated, we don't know where to get IV medications anymore, there has been a change, we don't know who to call. The pharmacy here doesn't do IVs anymore. They won't deliver IV medication here now. If I had a resident that had physicians orders for IV medication, I would have to ask the Director of Nursing Services (DNS) what to do. In an interview on 09/12/2025 at 1:46 PM Staff T, RN stated, the pharmacy does not do IVs, they will deliver all the other medications, just not the IVs. I don't know who to call if I get IV medication delivered here for the residents if they need it. I would have to ask the DNS; it's not the same pharmacy that we had for IVs, the pharmacy we have now will deliver all other medications, just not IVs.In an interview on 09/15/2025 at 1:07 PM Staff E, RN, Unit Manager stated, the previous pharmacy was called to deliver the IV antibiotic medication for Resident 3, and we were told they did not deliver IV medication to the facility anymore because their contract ended with the facility. Resident 3 missed three or four doses of their antibiotic IV. We informed the physician, and they wanted Resident 3 to be monitored here at the facility. I think Resident 17 was transported back to the hospital because we could not get their IV medication here. We have a new pharmacy that will bring IV medication to the facility now.In an interview on 09/15/2025 at 3:29 PM Staff B, DNS, stated there was an issue with the previous pharmacy when they stopped delivering IV medication to the facility. We notified the physician of Resident 3 when the IV antibiotic medication (Meropenem) was not administered, the physician ordered for the resident to be monitored in the facility. Staff B stated Resident 3 missed three or four doses of the IV antibiotic. Staff B stated there was another resident, Resident 17 was admitted to the facility and had to be transported back to the hospital the day after they were admitted because Resident 17 had physician orders for antibiotic IV's and they could not get the IV antibiotic medication delivered from the pharmacy to the facility. Staff B stated Resident 17 missed two doses of antibiotic medication before they were transported back to the hospital the day after admission. Staff B further stated those were significant

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure foods were served at proper temperature for 1 of 7 nursing units (Transitional Care Unit [TCU]), and 4 of 4 residents (Residents 3, 5, 6 & 16), reviewed for food temperatures and palatability. This failure placed the residents at risk for decreased nutritional intake, weight loss, and a diminished quality of life. Findings included .FOOD TEMPERATURES-TCUDuring a joint observation and interview on 09/10/2025 at 12:11 PM, Staff Q, Dietary Manager, used the facility's kitchen thermometer to check the temperatures of the meal that was delivered to the TCU. The plate that had food on it was removed from a plastic tray; the serving plate sat on a round plate warmer and was covered with a round plastic top that covered the entire plate. Staff Q stated, the meal being served was baked beans, hamburgers, corn on the cob and chicken noodle soup. The following food items' temperature were noted as follows:-Baked beans temperature showed 133 degrees Fahrenheit (F-a unit of measurement),-Hamburger patty's temperature showed 124 degrees F-Corn on the cob's temperature showed 113 degrees F-Chicken noodle soup's temperature showed 105 degrees FInterview on 09/10/2025 at 12:18 PM, Staff Q stated the baked beans, hamburger patty, corn on the cob and the chicken noodle soup should have tested at 140 degrees F, and the temperatures were low for the food that was tested. Staff Q stated that when the food leaves the kitchen, the temperature should remain at 140 degrees F for up to forty minutes. Staff Q further stated the food did not hold the temperature for forty minutes and that the temperatures of the meal that was just tested left the kitchen less than ten minutes ago.FOOD TEMPERATURES AND PALATIBILITYRESIDENT 3Review of the quarterly Minimum Data Set (MDS-an assessment tool) dated 07/28/2025 showed the resident did not have impaired thinking or problems with their memory.In an interview on 09/08/2025 at 2:21 PM, Resident 3 stated, the food is always cold; to get a good meal I have to get it from outside of here and delivered to me. I haven't done it yet. I am trying to get all that figured out now.RESIDENT 5Review of the quarterly MDS dated [DATE] showed the resident did not have impaired thinking or problems with memory.In an interview on 09/09/2025 at 1:21 PM, Resident 5 stated that the food is cold, and it tastes terrible. I have chicken noodle soup with my lunch every day and it is always cold; I eat it anyway because it helps my stomach to feel better. I wish I could at least have it warm, the whole lunch would taste better if it was at least warm.RESIDENT 6Review of the admission MDS dated [DATE] showed the resident did not have impaired thinking or problems with their memory.In an interview on 09/09/2025 at 1:14 PM, Resident 6 stated, every meal is served lukewarm to cold, breakfast, lunch and dinner. A nice warm bowl of oatmeal in the mornings would be so nice. I sometimes don't eat because the food is always served lukewarm to cold.RESIDENT 16Review of the admission MDS dated [DATE] showed the resident did not have impaired thinking or problems with their memory.In an interview on 09/09/2025 at 1:16 PM, Resident 16 stated, the food should never be served cold, that is not right. Every meal is served cold. It tastes terrible.In an interview on 09/12/2025 at 12:23 PM, Staff Q stated, I am aware that there were some residents that complained of their meals being served cold and not tasting good. I thought the food being placed on a warm plate, covered with a lid and placed in a closed food cart for delivery to the nursing units would help the meals to keep the temperatures at 140 degrees F when brought to the nursing units and served to the residents.In an interview on 09/15/2025 at 3:29 PM with Staff B, Director of Nursing Services, stated they knew the previous Administrator and the dietary manager were working together to resolve the residents' complaints about cold food and the food not tasting good, and that they were not sure of the outcome.In an interview on 09/16/2025 at 5:03 PM, Staff C, Administrator, stated the residents should have meals served at the proper temperatures.Reference: (WAC) 388-97-1100 (2).

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the facility assessment (document describing resident population and needs to determine staff and other resources necessary to competently care for residents) included a completed facility-based and community-based risk assessment, the facility resources to include a list of medical and non-medical equipment description, and contracts, memorandums of understanding and other agreements with third parties to provide services or equipment to the facility both during normal and emergency situations. This failure placed the residents at risk for unmet care needs. Findings included .Review of the facility's policy titled, Facility Assessment, dated 10/01/2025, showed that A facility assessment is conducted annually to determine and update the capacity to meet the needs of and competently care for the residents during day-to-day operations.Review of the facility's document titled Facility Assessment, dated 07/10/2025, did not show inclusion of a completed facility-based and community-based risk assessment, a list of medical and non-medical equipment description and contracts, memorandums of understanding and other agreements with third parties to provide services or equipment to the facility both during normal and emergency situations. It further showed that [Facility name] does not admit active COVID-19 patients. In an interview on 09/16/2025 at 4:15 PM with Staff A, Interim Administrator, and Staff C, Administrator, Staff C stated the facility could admit active COVID-19 residents and that the facility assessment needed to be updated to reflect that. Joint record review of the facility assessment dated [DATE] showed that a list of medical and non-medical equipment description was referred to be outlined in Appendix 1. It further showed that contracts, memorandums of understanding and other agreements with third parties to provide services or equipment to the facility both during normal and emergency situations were referred to be outlined in Appendix 2. Staff C and Staff A stated, No, we can't [cannot] find it [documentation of Appendix 1 and 2]. When asked if the facility assessment included a completed facility-based and community-based risk assessment, Staff C stated, No, but I can include it. No associated WAC.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on interview and record review, the facility failed to employ a qualified social worker that met the educational requirements and supervised social work experience for one year in a health care setting for 4 of 4 social workers (Staff L, M, N & O), reviewed for social worker qualifications. This failure placed the residents at risk for unmet social services care needs, and a diminished quality of life.Findings included . Review of the Facility Assessment, updated on 07/10/2025, showed the facility was licensed to provide care for 211 residents.STAFF LReview of the facility staff list showed Staff L, Social Worker, was hired on 12/23/2024 and was employed per diem (works on an as-needed basis).STAFF MReview of the facility staff list showed Staff M, Social Worker, was hired on 08/04/2025 and was employed full time.On 09/16/2025 at 5:46 PM, Staff M stated that the facility was licensed to hold over 200 beds (or residents). When asked how many social workers were employed in the facility Staff M stated there were three full-time social workers, and that Staff L was per diem and was not at the facility every day. Staff M stated that they had a master's degree in theology (provides an advanced academic study of a religion from academic, historical, and philosophical perspectives, and can prepare individuals for various careers in ministry, teaching, and further doctoral studies). Staff M stated that they did not have a degree in social work or in a human service field. When asked if they met the qualifications for a social worker in a facility with over 120 licensed beds, Staff M stated, I guess not, further stating Theology dealt with Christian studies and was not a human service field. STAFF NReview of the facility staff list showed Staff N, Social Worker, was hired on 12/23/2024 and was employed full time.On 09/16/2025 at 6:24 PM, Staff N stated that they had been employed with the previous company and had worked at the facility for three years. Staff N stated that they had an associate's degree and did not have a bachelor's degree in social work or in a human services field. When asked if they met the qualifications for a social worker in a facility with over 120 licensed beds, Staff N stated, I do not have it at this time.STAFF OReview of the facility staff list showed Staff O, Social Worker, was hired on 08/19/2025 and was employed full time.Review of an email exchange with Staff C, Administrator, on 09/16/2025 (2:47 PM) showed a request for the facility's social workers' certifications/qualifications. Another email exchange on 09/16/2025 (7:08 PM) with Staff C, Staff A, Interim Administrator, and Staff B, Director of Nursing, showed an additional request for completed documents for the facility's social worker(s) certifications/qualifications.In an interview on 09/16/2025 at 7:29 PM with Staff A and Staff C, Staff A stated the facility was licensed for 211 beds. Staff A stated the facility employed three full time social workers and that Staff L was per diem or as needed/ on-call. Staff C stated that they would expect to have a qualified social worker that met the requirements for their facility. When asked if they were familiar with the required qualifications for a social worker for the facility, Staff C stated, well apparently not as well as I should be. Staff C stated that Staff M had a master's degree in theology and was not applicable to social work or a human service field. Staff C further stated that Staff N had certifications [was not provided], and that they had been reaching out to Staff O all day and had not got back to me.An additional email exchange with Staff C on 09/17/2025 (10:02 AM) showed a request for all the facility's employed social worker's certifications/qualifications/degrees, any resume showing at least one year experience working as a social worker in a healthcare setting, and the facility's job requirements and description or policy for a social worker. The facility did not provide qualifications for Staff L, Staff M, Staff N, or Staff O or a job description or policy for a social worker as requested.In a follow-up email on 09/17/2025 at 11:56 AM, from Staff A showed they were unable to get any information regarding the 3rd social workers [Staff O] qualifications.Reference: (WAC) 388-97-0960 (2)(a)(b).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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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 0880 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 ensure aerosol contact precautions (safety steps used to keep germs from spreading) that included keeping the door closed at all times and proper use of Personal Protective Equipment (PPE - gown, gloves, N95 [respirator -medical face mask that filters out at least 95% of tiny particles in the air] and face shield) were followed for 2 of 2 staff (Staff X & Z), reviewed for infection control. This failure placed the residents, staff, and visitors at risk for facility acquired or healthcare-associated infections and related complications.Findings included.Review of the facility's undated policy titled, Coronavirus Disease (COVID-19) [respiratory disease caused by a virus]-Infection Prevention and Control Measures, showed This facility follows infection prevention and control (IPC) practices recommended by the Centers for Disease Control and Prevention to prevent the transmission of COVID-19 within the facility, It further showed that IPC measures to address COVID-19 included identifying and managing ill residents.optimizing engineering controls [keeping isolation room doors closed] and indoor air quality.STAFF XReview of the facility document titled, admission Nursing Collection Tool, dated 09/12/2025, showed Resident 24 tested positive for COVID and required isolation precautions [or aerosol contact precautions] and appropriate PPE per policy. It further showed that Resident 24 admitted to the facility's Transitional Care [TCU, room [ROOM NUMBER]].Review of an admission Nursing Collection Tool, dated 09/13/2025, showed that Resident 25 tested positive for COVID and required isolation precautions and appropriate PPE per policy. It further showed that Resident 24 admitted to the Transitional Care [TCU, room [ROOM NUMBER]].Observation on 09/15/2025 at 3:32 PM, showed a sign posted on the closed double-door entrance to the TCU that indicated, All staff and visitors, N95 is required beyond this point. It further showed that an aerosol contact precaution sign was posted on room [ROOM NUMBER]'s door and that the door was not closed. In an interview and joint record review on 09/15/2025 at 3:37 PM, Staff X, Nursing Assistant Certified (NAC), stated that the double doors to the TCU were kept closed because Resident 24 and Resident 25 were positive with COVID-19. A joint record review of the aerosol contact precaution sign posted on room [ROOM NUMBER]'s door indicated that the door remains closed. Staff X stated, It [room [ROOM NUMBER]'s door] should be closed. In an interview on 09/15/2025 at 3:39 PM, Staff Y, Licensed Practical Nurse (LPN), stated that Resident 24 and 25 were on aerosol contact precautions for COVID-19. Staff Y stated that both residents were located in room [ROOM NUMBER] and that the door should be closed all the time. In an interview on 09/15/2025 at 4:35 PM, Staff N, Registered Nurse Unit Manager, stated that the facility admitted residents who tested positive for COVID-19 and that Residents 24 and Resident 25 were admitted to the facility with active COVID-19. Staff N stated that they expected staff to wear appropriate PPE and kept isolation door rooms closed when aerosol contact precautions were implemented. STAFF ZObservation on 09/16/2025 at 10:03 AM showed room [ROOM NUMBER]'s door was open and that Staff Z, NAC, was inside the room with a resident. It further showed Staff Z exited room [ROOM NUMBER] wearing a surgical mask. It did not show Staff Z used appropriate PPE according to aerosol contact precautions (N95, gown, mask, eye protection and gloves). In an interview on 09/16/2025 at 10:08 AM, Staff Z, NAC, stated that they entered room [ROOM NUMBER] to remove used glasses [for drinking]. A joint observation of the aerosol contact sign posted on the door of room [ROOM NUMBER] showed instructions to keep the door closed and for staff to wear appropriate PPE. Staff Z stated they should have worn appropriate PPE and kept room [ROOM NUMBER]'s door closed. In an interview on 09/16/2025 at 10:15 AM, Staff M, LPN, stated they expected staff would follow precautions indicated on the aerosol contact precaution sign when it was posted and that staff would wear N95 while working in the TCU. In an interview on 09/16/2025 at 3:30 PM, Staff B, Director of Nursing, stated that the facility admitted residents with active COVID-19 infection. Staff B stated that they expected staff would wear appropriate PPE to include N95 mask on the COVID Unit [TCU]. Staff B further stated that they expected room doors would remain closed as much as possible, when aerosol contact precautions were indicated. Reference: (WAC) 388-97-1320 1(a)2(a).