| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505416 | A. Building<br>B. Wing | 12/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Broadview Center | 13023 Greenwood Avenue North<br>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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>(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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 3 residents (Resident 1) was adequately monitored for a change in level of consciousness and decreased oxygen saturation (level of oxygen present in the blood), reviewed for quality of care. Additionally, the facility failed to promptly initiate oxygen therapy and to offer prompt transfer to a hospital for evaluation of change of condition. These failures placed the resident at risk of a delay with a higher level of care and associated complications.Findings included.Review of the facility's policy titled Change in a Resident's Condition, dated [DATE], showed that a significant change in the resident's condition was A deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications. It showed that nursing staff would notify the medical provider of significant change in the resident's physical, mental or psychosocial status, need to transfer the resident to a hospital, and that prior to notifying the medical provider, the nurse will make detailed observations and gather relevant and pertinent information for the medical provider. It also showed that nursing staff would notify the resident's representative when there is a significant change in the resident's physical, mental, or psychosocial status and when it was necessary to transfer the resident to a hospital. It further showed, The nurse/designee will record in the resident's medical record information relative to changes in the resident's medical/mental condition status.Review of a hospital Discharge summary dated [DATE] showed Resident 1 was hospitalized on [DATE] due to a fracture (broken bone) to her left leg and that Resident 1 was subsequently discharged to a skilled nursing facility for rehabilitation.Review of hospital nursing progress notes dated [DATE] through [DATE] showed Resident 1 was neurologically (related to the brain, nerves and nervous system) assessed to be alert and oriented x 4 [means a person is awake, aware, and able to correctly answer questions about four key things: person, place, time, and situation]. It further showed that Resident 1's oxygen saturation levels were read at room air (non-use of oxygen therapy):-96% (percent) on [DATE].-97% on [DATE].-98% on [DATE].-96% on [DATE].Review of a face sheet showed Resident 1 admitted to the facility on [DATE] with diagnoses that included subsequent encounter for closed fracture with routine healing, muscle weakness, and altered mental status.Review of an admission nursing progress note, dated [DATE] at 7:13 PM, showed Resident 1 was Alert and oriented x 4, able to verbalize needs clear. Reported mild pain up on movement.hears adequately. It further showed Resident 1 was Full Code [A medical term used in nursing homes to indicate the resident wishes for emergency treatments to include cardiopulmonary resuscitation, defibrillation (using electric shocks to restart the heart), and hospital transfer to be evaluated for intubation (putting a tube in the airway to help with breathing), ventilation (life support) and medications (drugs to restart or stabilize the heart)].Review of a document titled POLST (Portable Orders for Life Sustaining Treatment), showed it was completed and signed by Resident 1 on [DATE]. It showed their elected level of medical interventions was Full treatment [primary goal is prolonging life by all medically effective means], It further showed that full treatment included transfer to a hospital if indicated.Review of a nursing progress note dated [DATE] at 11:44 PM, showed Resident 1 was alert and oriented and able to make needs known.[Resident 1] states that she was given lots of medication prior to arriving and her stomach was bothering her.rating pain 4-5/10 [resident rated pain from a scale of one to ten], [Resident 1] refused offer of oxycodone [narcotic (controlled) pain medication]. It further showed an oxygen saturation reading of 96% on room air.Review of a medical provider encounter note dated [DATE] showed Resident 1 was seen by their attending medical provider after nursing reported a change in condition. It showed, Patient [resident] demonstrates significantly altered mental status with inability to respond appropriately to questions, excessive somnolence (sleepiness or drowsiness) and poor interaction. It also showed treatment plan for reduce sedating medications due to excessive drowsiness and altered mental status and monitor mental status closely. It further showed Resident 1's oxygen saturation reading on [DATE] at 3:42 PM was at 90% room air.Review of a nursing progress note dated [DATE] at 4:41 PM, written by Staff C, Registered Nurse (RN), showed Cognitive status assessed. Resident is cognitively impaired, and Behavior/mood evaluated and the resident is noted to be uncooperative.Review of a document titled, SBAR [Situation, Background, Appearance, Review and Notify] Communication Form, showed it was completed by Staff D, RN, on [DATE] at 5:50 PM. It showed that Resident 1 was noted to have altered level of consciousness, labored or rapid breathing, shortness of breath and other respiratory changes and an oxygen saturation level reading of 88% on room air. It further showed that the Primary Care Clinician was notified at |