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	05/14/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to prevent physical abuse for 1 of 8 residents (Resident 1), reviewed for abuse investigations. Resident 2 initiated physical aggression towards Resident 1 by grabbing her left wrist causing unwanted physical contact, swelling and bruising. This failure placed residents at an increased risk of injury, emotional distress and a reduced quality of life.Findings included.Review of the facility's policy titled, Abuse, reviewed on 10/20/2022, showed This organization recognizes and respects that each resident has the right to be free from abuse. It further showed that abuse was defined as the willful inflection of injury.Instances of abuse of all residents, irrespective of any mental or physical condition, can cause physical harm, pain or mental anguish.Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to infect injury or harm.Review of an incident summary, dated 04/19/2026 at 7:15 PM, showed that nursing staff witnessed [Resident 2] agitated and initiated physical aggression to [Resident 1] by grabbing her left wrist causing a superficial bruise.It further showed documentation of Resident 1's statement which showed, [Resident 1] was in the middle of the hallway and I was not able to go through so I asked her politely to move so that we can go through.[Resident 2] then got upset and grabbed/pulled my left wrist. It further showed that the incident between Resident 1 and 2 was witnessed by staff.Review of Resident 1's document titled, Skin Observation Weekly (Licensed Nurse, dated 04/16/2026, showed that Resident 1 was assessed to have no bruises, or other skin conditions four days before the incident.Review of Resident 1's skin observation weekly document, dated 04/23/2026, showed that Resident 1 was assessed to have left dorsal bruise fading four days after the incident.Review of Resident 1's Treatment Administration Record dated April 2026, showed an order to Monitor bruise to left dorsal hand until resolved, every shift skin monitoring until resolved, and that this order was initiated on 04/20/2026.In an interview on 05/08/2026 at 12:51 PM, Resident 1 was asked about the 04/19/2025 incident involving her and Resident 2, and Resident 1 stated, My friend and I take the wheelchair up and down the hallway sometimes just to exercise on our own.[Resident 2] was sitting in the middle of the isle and I asked her to please move and she told me to move and then she grabbed my left wrist by her bare hands.This [Resident 1's left wrist] was swollen, big, black and blue. Resident 1 further stated that the swelling and bruising to her left wrist was painful in the beginning.In an interview on 05/14/2026 at 12:55 PM, Staff C, Licensed Practical Nurse, stated that staff were trained on abuse and neglect, including physical abuse. Staff C further stated that resident-to-resident altercations can constitute abuse, noting that there are two kinds, sometimes verbal and even physical contact.In an interview on 05/14/2026 at 1:10 PM, Staff D, Certified Nursing Assistant, stated she was trained on abuse and neglect, including physical abuse. Staff D further explained that an example of physical abuse included somebody hitting another person.In an interview on 05/14/2026 at 1:38 PM with Staff A, Administrator, and Staff B, Director of Nursing, Staff B stated that the facility's policy on abuse defined what was considered physical abuse. Staff A stated that physical abuse was unwanted touch from one person to another. Staff A further stated that the facility followed the Purple Book, Nursing Home Guidelines [a guidance manual for nursing homes focused on abuse and neglect prevention, (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident identification, investigation procedures, and reporting requirements]. When asked if Resident 1 sustained a physical injury as a direct result of the resident-to-resident incident involving Resident 2 on 04/19/2026, Staff B stated, Yes. Staff B further stated, I don't [do not] think it was intentional, rather it was a reaction by [Resident 2].Reference: (WAC) 388-97-0640(1).