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	06/29/2026

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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(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 2 of 6 residents (Resident 3 and 5), reviewed for abuse investigations. These failures placed the residents at increased risk of injury, emotional distress and a diminished 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 infliction 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 inflict injury or harm.<RESIDENT 3>Review of an incident investigation report dated 06/01/2026, showed that nursing staff heard [a] commotion in [the] dining room and witnessed [Resident 4] having an argument with [Resident 3] and that Resident 4 moved her hand toward [Resident 3]'s face making contact.Review of the nursing progress note dated 06/01/2026 showed that Resident 3 and Resident 4 had resident to resident physical incident.In an interview on 06/11/2026 at 2:37 PM, Resident 3 stated, Yes when asked if they had an altercation with a resident. Resident 3 stated that they could not remember the resident's name but she hit me like this [with an open hand to their right temple area]. She was bragging about something but then she hit me.In an interview on 06/11/2026 at 3:01 PM, Resident 4 stated that they had an argument with Resident 3 when they were in the dining room. Resident 4 stated that Resident 3 was picking with everybody and that they asked Resident 3 if they [want to] get slapped? Resident 4 stated that Resident 3 raised her hand and when she raised her hand, I slapped her.In an interview on 06/12/2026 at 9:08 AM, Resident 7 stated that they were sitting with Resident 3 and Resident 4 in the dining room. Resident 7 stated that Resident 4 and Resident 3 were arguing with each other and that Resident 4 stood up and slapped Resident 3.In an interview on 06/12/2026 at 9:37 AM, Staff D, Registered Nurse, stated that they were in the hallway when they heard noises coming from the dining room. Staff D stated that when they got to the dining room, they saw Staff C, Certified Nursing Assistant, trying to intervene between Resident 3 and Resident 4. Staff D stated that Staff C told them that Resident 4 slapped Resident 3. In an interview on 06/12/2026 at 9:43 AM, Staff C stated that they heard a commotion in the dining room and saw Resident 4 swung her hand and smacked her [Resident 3]. Staff C further stated, I saw the altercation as it happened and I separated them. <RESIDENT 5>Review of an incident investigation report dated 06/03/2026, showed that Residents 5, 6 and 8 were in the dining room talking to each other. The investigation report showed that Staff E, Certified Nursing Assistant (CNA) heard Resident 5 with an elevated voice and witnessed Resident 6 grabbed Resident 5's right forearm. The investigation report further showed that Resident 5 sustained two new superficial (outer skin) bruises on her right arm.red/purple in color.Review of the nursing progress note dated 06/03/2026, showed Resident 5 had a bruise and complained of pain to their right forearm.An observation and interview on 06/11/2026 at 4:44 PM, showed Resident 5 was propelling around the unit in their wheelchair. When asked to be interviewed, Resident 5 stated, I have no time for that. Come back next time.In a follow-up interview and observation on 06/12/2026 at 11:42 AM, Resident 5 (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated, Oh, I am going to tell you something when asked to show their right forearm. Resident 5 pulled up their right sleeve and showed a pale bluish discoloration on their right forearm. Resident 5 stated, Someone grabbed my arm so tight and it turned blue. When asked if they knew the person who grabbed their right arm, Resident 5 stated, I don't remember but he grabbed my arm and I screamed.An observation and interview on 06/12/2026 at 8:48 AM, showed Resident 6 had difficulty speaking and used gestures/nodding to communicate. Resident 6's facial expression showed their eyebrows drawn together and declined further questions when asked related to the altercation with Resident 5.In an interview on 06/12/2026 at 11:12 AM, Resident 8 stated that they were in the dining room with Resident 6 when Resident 5 yelled at them and said that we were going to jail because we were holding hands. [Resident 6] then wheeled over to [Resident 5] and grabbed her arm, and she screamed like bloody murder. And people came over. In a phone interview on 06/23/2026 at 11:04 AM, Staff E, CNA, stated that they were in the dining room and saw the incident. Staff E stated that Resident 5 said something and [Resident 6] took a swing, [and] he hit her in the right arm. He was like holding her [right] arm. It happened really fast and I separated them. In an interview on 06/23/2026 at 11:42 AM, Staff B, Director of Nursing, stated that they investigated two separate resident-to-resident altercations that resulted to physical abuse for Resident 3 and Resident 5. Staff B stated that Resident 5 sustained superficial bruises on their right forearm. Staff B further stated that they considered resident-to-resident altercation as a form of abuse and that they expected residents to be free from abuse. Reference WAC: 388-97-0640(1).

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a plan for discharge and to notify a resident and/or their representative of a discharge in writing for 1 of 3 residents (Resident 1), reviewed for discharge process. This failure placed the resident and their representative at risk of not having an opportunity to make an informed decision about the discharge and about their rights to appeal the discharge. Findings included.Review of the facility's policy titled, Discharge Planning, dated 10/01/2021, showed that The facility will develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care.The facility's discharge planning process must be consistent with the discharge rights for all individuals, including skilled and long-term care residents, regardless of source of payment.Review of a face sheet showed Resident 1 admitted to the facility on [DATE] with diagnosis that included sepsis (a life-threatening reaction to an infection), a history of repeated falls, and abnormality of gait (the way a person walks) and mobility.Review of Resident 1's care plan for rehabilitation, revised on 01/14/2026, showed that [Resident 1] has been admitted to the facility to rehabilitation and requires assistance with activities of daily living [ADL] due to recent hospitalization for sepsis with altered mental status [confusion] and overall decline in functional abilities. Further review of Resident 1's comprehensive care plan did not show a care plan or goals related to discharge planning. Review of Resident 1's comprehensive care plan also showed a closed (retired) date of 02/03/2026 due to discharge from the facility.Review of Resident 1's Electronic Health Record (EHR) under the census section showed his discharge date of 01/30/2026. Further review showed private pay as Resident 1's billed primary payer from 01/24/2026 through 01/29/2026.Review of a medical provider progress note dated 01/21/2026 showed that Resident 1 was documented to have discharge planning issues and that He is currently min [minimal] to max [maximal] assist with most ADL, not able to stand without breaks, continuing confusion. Recommendation is 24-hour assistance.Review of a document titled Notice of Medicare Non-Coverage, signed by Resident 1's representative on 01/22/2026, showed that Resident 1's skilled services were scheduled to end on 01/24/2026. Further review indicated that financial liability would begin on 01/25/2026 and that Resident 1 had the right to file an appeal the termination of skilled services.Review of a progress note dated 01/23/2026 showed that Resident 1 filed an appeal. Further review showed that the note was authored by Staff F, Social Worker.Review of a progress note dated 01/24/2026, authored by Staff F, showed Received notice [Resident 1] lost his appeal, LCD [last covered day] remains 01/24/2026.Review of a progress note dated 02/09/2026 showed documentation that Resident 1 won his redetermination appeal.Review of a scanned document in Resident 1's EHR, dated 02/07/2026, showed that An independent reconsideration peer reviewer determined that termination of skilled services 01/24/2026 was issued incorrectly. Further review showed that The determination was based on the following information:- [Resident 1 required] complete assistance to move from bed to a chair. - [Resident 1 was] unable to walk-The plan for your care after leaving the skilled nursing facility is not documented in your medical record.In an interview on 06/10/2026 at 2:31 PM, Resident 1's representative was asked the circumstances of Resident 1's discharge from the facility on 01/30/2026, Resident 1's representative stated, We were told that Medicare would stop paying [Name of Resident 1's health insurance] within three days and so we just had to scramble to find an adult family home [AFH - a house in the community staffed by caregivers who provide 24-hour support], we hardly knew what that was.we had to do it in a very big hurry and then they said we had to pay [the facility]. Resident 1's representative further stated, He wasn't [was not] ready to leave, we felt rushed. We felt like we had no choice, and that We wouldn't [would not] have chosen to go to the AFH, we felt like he wasn't [was not] ready at that time.In an (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview and joint record review on 06/11/2026 at 1:27 PM, Staff F was asked if residents and/or their representatives were issued a notice when the facility transferred or discharged residents out of the facility, and that Staff F stated, We don't [do not] have documents that state the purpose of the discharge or any kind of notice. I usually just notify them verbally. A joint record review of a facility document titled Nursing Home Transfer or Discharge Notice showed that Written notice of transfer or discharge, and the reasons for the move, must be provide to the resident and the resident's representative, in a language and manner they understand. Further review of the document showed Appeal Rights - You have the right to appeal this discharge or transfer by making a request for a hearing.You have the right to remain in the facility until the appeal is decided, if the hearing request is received on or before the proposed date of transfer/discharge, or the day you are actually transferred/discharged . Staff F stated Yes, it [Notice of transfer or discharge form] does look familiar, I have not been completing this. A joint record review of Resident 1's EHR did not show a completed notice of transfer or discharge issued to Resident 1 and/or their representative. Staff F stated, I do not see one for him, and that I would expect to see it in [Resident 1's EHR] if it was completed.In an interview on 06/11/2026 at 2:03 PM, Staff B, Director of Nursing, stated that the facility's process for issuing notices of transfers or discharge to residents was that there is a written notice. For non-emergency discharges we do provide that written notice.In a follow-up interview on 06/23/2026 at 12:05 PM, Staff B stated, There should have been a discharge notice issued [to Resident 1 and his representative] and that it would have informed the resident of their right to appeal that discharge.In an interview on 06/23/2026 at 12:13 PM, Staff A, Administrator, stated that the facility followed the process of issuing written notices of transfer or discharge to residents, and that these notices inform residents of their right to appeal. When asked about the facility's policy, Staff A stated, Every discharge or transfer would have that notice issued. Whether that's [that is] happening or not, I don't [do not] know if that's been happening. When asked how resident care and services were continued during an ongoing appeal, Staff A stated, We keep them on skilled services until we know that they have exhausted all of their chances to appeal.Reference: (WAC) 388-97-0120 (2) (a-c).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure hand hygiene/glove use practices and/or Enhanced Barrier Precautions (EBP- precaution to protect residents from Multidrug-Resistant Organism [MDRO-a germ that is resistant to medications that treat infections]) practices were followed for 5 of 6 Staff (Staff G, H, J, K, & L), reviewed for infection control. These failures placed the residents, visitors, and staff at an increased risk of infection and related complications. Findings included.Review of the facility's undated policy titled, Hand Hygiene, showed, The facility promotes hand hygiene as a simple and effective method for preventing the spread of infections. Glove use is not a substitute for hand hygiene. The policy showed, All staff are responsible for following hand hygiene procedures: . b. Before and after having direct contact with a resident's intact skin. c. After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings. e. When hands move from a contaminated-body site to a clean body site during resident care f. Before and after wearing gloves. The policy further showed an alcohol-based hand sanitizer should be used, Before moving from work on a soiled body site to a clean body site on the same resident iv. After touching a resident or the resident's immediate environment v. After contact with blood, body fluids or contaminated surfaces vi. Immediately after removing gloves.Review of the Centers for Disease Control and Prevention (CDC) online document titled, Implementation of Personal Protective Equipment (PPE [gown and gloves]) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 04/02/2024, showed, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. The document further showed, Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include:.Changing briefs or assisting with toileting.Device care or use:.urinary catheter [flexible tube inserted into the bladder that drains urine].Review of Resident 9's physician orders printed on 06/24/2026 showed an order for Enhanced Barrier Precautions r/t [related to] indwelling urinary catheter, bilateral [both] lower leg wound. Ensure precautions in place, educate resident/visitors of infection control.Observation on 06/24/2026 at 9:30 AM, showed an EBP signage outside Resident 9's room.<STAFF G>In an observation on 06/24/2026 at 9:47 AM, Staff G, Certified Nursing Assistant (CNA), entered Resident 9's room wearing a gown and gloves. Staff G cleaned Resident 9's kidney basin (kidney-shaped tray used to catch bodily fluids) that contained oral secretions from their oral care, Staff G then removed their gloves and applied new gloves. Staff G touched Resident 9's belongings including their bed, control, and cables, removed their gloves and applied new gloves. Staff G did peri-care (cleaning of private parts) on Resident 9's front side including catheter care, then they removed their gloves and applied new gloves to clean Resident 9's bowel movement (BM). Staff G removed their gloves and applied new gloves and then touched Resident 9's pillow and blanket, and assisted Resident 9 with putting a new gown on. Staff G did not do hand hygiene in between glove use. On 06/24/2026 at 10:18 AM, Staff G stated that they would do hand hygiene before and after a task. Staff G stated that they would change their gloves in between tasks and it was a part of hand hygiene. When asked if hand hygiene should be performed after glove removal, Staff G stated, I may need to be guided. Staff G stated hand hygiene was important to avoid spreading diseases and for infection control.<STAFF H>In an observation on 06/25/2026 at 9:57 AM, Staff H, CNA, entered Resident 9's room wearing a gown and gloves. Staff H unfasted Resident 9's brief and performed peri-care on Resident 9 using wet wipes. Staff H assisted Resident 9 to roll towards them and held onto Resident 9's hand. Staff H applied barrier cream to Resident 9's skin and then applied a new brief to Resident 9. Staff H touched Resident 9's bedding, bedside table, and their gown. Staff H did not change their gloves after performing peri-care on Resident 9 or do hand hygiene.On 06/25/2026 at 10:34 AM, Staff H stated that hand hygiene was performed before and after care, removing gloves, between meal trays, and before removing or applying PPE. Staff H stated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gloves should be changed between dirty to clean tasks. Staff H further stated they should have changed their gloves in between dirty to clean tasks for Resident 9's care and done hand hygiene in between glove use.On 06/25/2026 at 11:13 AM, Staff I, Licensed Practical Nurse (LPN), stated hand hygiene should be performed after glove removal. Staff I further stated (Staff H) should have removed their gloves after peri-care on Resident 9 and done hand hygiene and applied a new pair of gloves. <STAFF J>In an observation and interview on 06/29/2026 at 10:04 AM, Staff J, CNA, entered Resident 9's room wearing a gown and applied two pairs of gloves inside the room. Staff J unfastened Resident 9's brief, did peri-care and then removed their top gloves. Staff J then cleaned Resident 9's BM, and removed the soiled brief and then their gloves. Staff J applied new gloves and continued to wipe Resident 9 and applied a new brief. Staff J assisted Resident 9 get positioned in bed and touched their bed control, sheets, and pillow. Staff J then grabbed the dirty trash bag and removed their gloves and applied new gloves to empty Resident 9's catheter bag (used to collect urine). Staff J removed their gown and gloves and then touched Resident 9's bedside table to move it next to their bed. Staff J did not do hand hygiene in between glove use. Staff J stated hand hygiene should be performed after cleaning a resident's BM, after using gloves, and when leaving a resident's room.<STAFF K AND STAFF L>In an observation on 06/29/2026 at 10:32 AM, Staff K, LPN, and Staff L, CNA, entered Resident 9's room and applied gloves. Staff K unfasted Resident 9's brief and positioned them on their side and applied gel medication to Resident 9's back. Staff K removed their gloves, applied new gloves and applied skin prep (used to protect skin) to Resident 9's bottom. Staff L cleaned Resident 9's BM and then performed peri-care and catheter care on Resident 9. Both staff did not wear a gown while performing care for Resident 9. Staff K did not do hand hygiene in between glove use. Staff L did not remove their gloves after cleaning Resident 9's BM or do hand hygiene prior to performing catheter care on Resident 9.On 06/29/2026 at 10:46 AM, Staff K stated that Resident 9 was on EBP due to their catheter. Staff K stated that gloves were important when providing care and that a gown could also be worn according to the precaution. Staff K stated that hand hygiene should be done before and after caring for a resident, and after removing their gloves. Staff K further stated that Staff L should have removed their gloves and done hand hygiene before doing catheter care on Resident 9.On 06/29/2026 at 11:00 AM, Staff L stated that they should have followed EBP signage for Resident 9 and worn a gown while performing care. Staff L stated that they performed hand hygiene when exiting a resident room. Staff L stated that wiping Resident 9's BM first and then performing catheter care with the same pair of gloves put Resident 9 at risk of a urinary tract infection.On 06/29/2026 at 11:30 AM, Staff B, Director of Nursing, stated they expected staff to follow their hand hygiene policy and follow EBP signage outside a resident's room.Reference WAC 388-97-1320(1)(a)(c).