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	06/06/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to inform a resident and/or their representative about risks and benefits of positioning a bed against the wall for 1 of 3 residents (Resident 93), reviewed for accidents. The failure to conduct an assessment, evaluation and/or providing information regarding bed positioning prevented the resident and/or their representative to exercise their right to make an informed decision. Findings included . Review of the undated facility's policy titled, Resident Rights, showed, The Resident has the right to be fully informed of, and participate in, his or her treatment including: the right to be fully informed in a language that he or she can understand of his or her total health status, including but not limited to his or her medical condition. The policy further showed, The Resident has a right to be fully informed in advance about care and treatment and any changes in that care or treatment that may affect the Resident's well-being. Review of a face sheet printed on 06/02/2025 showed Resident 93 was admitted to the facility on [DATE] with diagnosis that included dementia (memory impairment and/or decline). Review of the quarterly minimum data set (an assessment tool) dated 04/03/2025 showed Resident 93 had severe cognitive impairment. Further review of the MDS assessment showed Resident 93 was unable to walk and had limited range of motion in both lower legs. Review of the facility's Electronic Health Record (EHR) did not show Resident 93 was assessed, evaluated or informed about the risk and benefits of positioning their bed against the wall. Observation on 05/30/2025 at 8:56 AM, showed Resident 93's bed was positioned against the wall. In a follow-up observation on 06/02/2025 at 10:54 AM and on 06/03/2025 at 9:02 AM, Resident 93 was lying in bed, and their bed was positioned against the wall. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 06/04/2025 at 1:29 PM, Staff J, Registered Nurse (RN), stated that Resident 93's bed was positioned against the wall. Staff J stated that there should be a [physician] order if the bed is against the wall. A joint record review of the EHR did not show a physician order about Resident 93's bed position. Further joint record review of the EHR did not show Resident 93 was assessed, evaluated or informed regarding the risks and benefits of having their bed positioned against the wall. Staff J stated that they did not know if Resident 93's representative had been informed about Resident 93's bed position. In an interview and joint record review on 06/04/2025 at 2:11 PM, Staff E, RN Unit Manager, stated that they were aware that Resident 93's bed was positioned against the wall. A joint record review of the EHR did not show Resident 93 had been assessed, evaluated, and/or informed about risks/benefits of having their bed positioned against the wall. Staff E stated that they were not able to assess, evaluate and inform Resident 93 and/or their representative about the risks and benefits of positioning their bed against the wall. In an interview on 06/05/2025 at 2:51 PM, Staff B, Director of Nursing, stated they expected Resident 93 and/or their representative to have been assessed, evaluated and informed about risks and benefits of having their bed positioned against the wall. Reference: (WAC) 388-97-0260(2) (a-d) .

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident choices/preferences regarding shower/bathing were honored for 2 of 3 residents (Residents 41 & 10), reviewed for Activities of Daily Living (ADLs). This failure placed the residents at risk of being unable to exercise their rights, not having their choices/preferences honored, and a diminished quality of life. Findings included . Review of the facility's undated policy titled, Resident Rights, showed, The Resident has a right to a dignified existence, self-determination . The policy further showed that, The Resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice . Review of the facility's undated policy titled, Shower/Tub Bath, showed that residents would be offered at least two full baths or showers per week. The policy further showed that resident preference for type and frequency of baths would be taken into consideration and honored. RESIDENT 41 Review of a quarterly Minimum Data Set (MDS-an assessment tool) dated 04/17/2025, showed Resident 41 had moderate cognitive impairment, and shower/bathing was not attempted due to environmental limitations. The MDS assessment further showed that it was very important for Resident 41 to choose between a tub bath, shower, bed bath, or sponge bath. Review of the ADL care plan initiated on 08/02/2022 showed Resident 41 preferred to have a shower two times a week. Review of the May 2025 ADL Task showed Resident 41 had received bed baths on 05/09/2025, on 05/30/2025 and on 05/31/2025. The May 2025 ADL task showed Resident 41 had received tub baths on 05/08/2025 and on 05/19/2025, and from 05/11/2025 to 05/17/2025, Resident 41 did not have a shower for a week. The May 2025 ADL records did not show Resident 41 refused a shower. In an interview on 05/29/2025 at 12:38 PM, Resident 41 stated, There [are] not enough staff. Resident 41 further stated they prefer showering twice a week, but I never got it more than once a week. In an interview on 06/03/2025 at 10:23 AM, Staff K, Certified Nursing Assistant (CNA), stated that Resident 41 liked to have a shower twice a week but now gets [shower/bath] once a week because there is no regular shower aide. In an interview and joint record review on 06/03/2025 at 10:41 AM, Staff L, Licensed Practical Nurse, stated Resident 41 preferred to have showers. A joint record review of the ADL care plan showed Resident 41 preferred shower two times a week. A joint record review of the May 2025 ADL Task showed Resident 41 received three bed baths, two tub baths for the month of May 2025. Further joint review of the May 2025 ADL task did not show Resident 41 refused a shower from 05/11/2025 to 05/17/2025. Staff L stated that Resident 41's shower preferences and care plan should have been followed. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 06/03/2025 at 11:16 AM, Staff D, Registered Nurse [RN] Unit Manager (RNUM), stated that they considered and followed residents' shower/bathing preferences and their care plan. A joint record review of Resident 41's ADL care plan showed Resident 41 preferred shower two times a week. A joint record review of the May 2025 ADL task showed Resident 41 did not have a shower from 05/11/2025 to 05/17/2025. Resident 41 was given bed baths or tub baths instead of showers two times a week. Further joint record review of the May 2025 ADL task did not show Resident 41 refused a shower. Staff D stated that they expected staff to have followed Resident 41's shower preferences and care plan. RESIDENT 10 Review of a significant change MDS dated [DATE], showed Resident 10 had intact cognition. The MDS assessment further showed that it was very important for Resident 10 to choose between a tub bath, shower, bed bath, or sponge bath. Review of the comprehensive care plan revised on 01/07/2025, showed Resident 10 preferred a bath twice a week. Review of the May 2025 ADL task showed Resident 10 did not have a bath and/or shower from 05/11/2025 to 05/17/2025 and had a tub bath once from 05/18/2025 to 05/24/2025. Further joint record review of the May 2025 ADL task did not show Resident 10 refused a shower. In an interview on 05/30/2025 at 10:24 AM, Resident 10 stated, I used to get two showers a week. I used to soak my legs, but I [did not] get showers or bath like I used to. Resident 10 further stated that with [current management] shower aides were given floor work assignment. In an interview on 06/03/2025 at 10:04 AM, Staff I, CNA, stated that Resident 10 preferred shower or bath two times a week. Staff I stated that Resident 10 usually gets [shower/bath] two times a week at the time of [previous management] but now it [shower/bath] is once a week. In an interview and joint record review on 06/03/2025 at 1:41 PM, Staff J, RN, stated that Resident 10 preferred shower/bath two times a week. A joint record review of the ADL care plan showed Resident 10 preferred a tub bath two times a week. A joint record review of the May 2025 ADL task showed Resident 10 did not have a shower/bath from 05/11/2025 to 05/17/2025 and had a tub bath from 05/18/2025 to 05/24/2025. Staff J stated that Resident 10's care plan should have been followed, and their [twice a week] bathing preferences honored. A joint record review and interview on 06/03/2025 at 2:43 PM with Staff D, showed Resident 10's ADL care plan included their preference for a twice a week tub bath. A joint record review of the May 2025 ADL task showed Resident 10 did not have a shower/tub bath from 05/11/2025 to 05/17/2025 and had a bath 05/18/2025 to 05/24/2025. Staff D stated that they expected staff to have followed Resident 10's care plan and honored their [twice a week] shower/bathing preferences. In an interview on 06/04/2025 at 2:42 PM, Staff B, Director of Nursing, stated that they expected staff to have followed Resident 41 and Resident 10's care plan and should have honored their shower/bathing preferences. Staff B further stated that they expected Resident 41 and Resident 10 to have received shower and/or bathing two times a week. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: (WAC) 388-97-0900 (1) .

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on interview and record review, the facility failed to ensure the survey result binder included the recent recertification survey results and associated plan of correction for 2 of 3 years (November 2022 and February 2023), reviewed for availability of survey reports. This failure prevented residents, their representatives, and visitors from exercising their right to review past survey results and the facility's plan of correction. Findings included . Review of the facility's undated policy titled, Examination of Survey Results, showed, A copy of the most recent and three preceding years of standard surveys, including any subsequent extended surveys, follow-up revisit reports, complaint surveys, etc., along with state-approved plans of correction of noted deficiencies, are accessible in an area frequented by residents, resident representatives, and visitors. A review of a binder labelled, Annual Recertification Survey on 05/29/2025 at 10:18 AM, on 05/30/2025 at 2:17 PM, and on 06/02/2025 at 2:05 PM, showed the binder contained the 2024 annual recertification survey results and associated plan of correction. Further review of the binder showed that the 2022 and 2023 recertification survey results and their associated plan of correction for 11/03/2022 and 02/20/2023 were not the binder. During a joint record review and interview on 06/02/2025 at 2:17 PM with Staff B, Director of Nursing, showed that the binder contained the 2024 recertification survey and its associated plan of correction. Further review of the binder showed the 2022 and 2023 survey results were not included in the binder. Staff B stated the binder should have the 2022 and 2023 survey results and their associated plan of correction and made accessible to residents and their representatives. In an interview on 06/02/2025 at 2:23 PM, Staff A, Administrator, stated they were responsible for maintaining and updating the recertification survey results binder. Staff A further stated that the 2022 and 2023 survey results were missing and that they were required to maintain the previous three-year survey result and its associated plan of correction. Reference: (WAC) 388-97-0480(1)(a)(c)(4) (5)(a) .

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain and/or renew guardianship papers, and/or failed to offer assistance in formulating an Advance Directive (a written document describing a resident's wishes for care if they became incapacitated such as a living will or Durable Power of Attorney [DPOA] for health care) for 3 of 4 residents (Residents 43, 77 & 102), reviewed for Advance Directives. These failures placed the residents and/or their representatives at risk of losing their right to have their preferences honored to receive care according to their choice. Findings included . Review of the facility's policy titled, Advance Directives, dated [DATE], showed, Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so . If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative. It further showed, If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. RESIDENT 43 Review of the annual Minimum Data Set (an assessment tool) dated [DATE] showed Resident 43 readmitted to the facility on [DATE] and had a diagnosis of unspecified intellectual disabilities (a condition that involves limitations on intelligence, learning and everyday abilities necessary to live independently). In an interview on [DATE] at 10:30 AM, Resident 43 stated that they had a guardian. Review of Resident 43's guardian and conservator (an individual appointed by the court to look after the well-being of a minor or a person who is mentally incapacitated due to an illness or accident) papers showed an expiration date of [DATE]. In an interview and joint record review on [DATE] at 2:01 PM, Staff F, Social Worker, stated that Social Workers and Staff S, Business Office Manager, managed the residents' guardianship papers and that Social Workers initiated it. Staff F stated that the Business Office ensured guardianship papers were up to date and that sometimes they would keep an eye on them but were not high on their list. Staff F stated that if the guardianship papers were expired, they would try to get an updated copy. A joint record review of Resident 43's guardianship papers showed an expiration date of [DATE]. Staff F stated that they may be able to get an updated copy from Resident 43's representative. Staff F stated that they usually checked on it for their assigned residents and that they were not sure who was responsible in ensuring the guardianship papers were up to date and ensuring the current copy was in the residents' Electronic Health Record (EHR). Staff F further stated that if residents' had an updated guardianship paper, they should have had a copy in their EHR. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 3:27 PM, Staff S stated that guardianship lawyers ensured that residents' guardianship papers were up to date and that the guardianship lawyers were the ones that were on top of it. When asked who ensured the guardianship papers were up to date in the residents' EHR, Staff S stated that no one was assigned to it. In an interview on [DATE] at 3:41 PM, Staff A, Administrator, stated that they did not know who ensured updated guardianship papers were in the residents' EHR and that they would have to refer to their policy. Staff A further stated that they expected guardianship papers to be up to date in Resident 43' EHR. RESIDENT 77 Review of a face sheet printed on [DATE] showed Resident 77 was admitted to the facility on [DATE]. Review of the quarterly minimum data set (an assessment tool) dated [DATE] showed Resident 77 had intact cognition. Review of Resident 77's EHR did not show documentation for advance directives. Further review of the EHR did not show documentation that an advance directive was discussed and/or offered to Resident 77. In an interview and joint record review on [DATE] at 2:15 PM, Staff F stated, if they [residents] have [advance directive] we ask them to send it to us to have it uploaded to our system. Staff F stated that they offered assistance for residents who chose to have an advance directive. A joint record review of Resident 77's EHR did not show advance directive was discussed and/or offered to Resident 77. Staff F stated, I don't [do not] see any documentation that it was discussed or offered to [Resident 77] and that it should have been discussed and offered to the resident. In an interview on [DATE] at 1:55 PM, Staff A stated that they expected staff to discuss or offer advance directive to Resident 77 upon their admission to the facility. RESIDENT 102 Review of a face sheet printed on [DATE] showed Resident 102 admitted to the facility on [DATE]. In an interview and joint record review on [DATE] at 12:51 PM, Staff O, Social Worker, stated that the facility followed a process in which they offer residents the opportunity to establish an advance directive if they did not have one. Staff O stated that Resident 102 was their own decision-maker and did not have an advance directive. Staff O stated that they spoke with Resident 102's collateral contact, and they were interested in serving as the resident's DPOA (a legal document that allows an appointed agent to make decisions on behalf of the principal, even if the principal becomes incapacitated). A joint record review of Resident 102's EHR showed no documentation that advance directive was discussed with the resident's collateral contact. Staff O stated that they did not document the conversation they had with Resident 102's collateral contact. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 8:22 AM, Resident 102 stated that they were their own decision maker. Resident 102 stated that they wanted to designate DPOA for their health care decisions. Resident 102 stated that the facility did not request a copy of advance directive if they had or offered them the option to establish one. Resident 102 stated that with their procedure appointment on [DATE] approaching, they were expected to have an advance directive in place. Resident 102 stated that they would be interested in having advance directive if they were given the opportunity. In an interview on [DATE] at 2:02 PM, Staff A stated that residents should be given an opportunity to delegate to DPOA upon admission and ensure their care preferences were documented. Staff A stated that these directives must be easily accessible to staff when needed. Staff A stated that Resident 102 should have been offered the option to establish an advance directive, and that Staff O should have documented all discussions they had regarding Resident 102's advance directive. Reference: (WAC) 388-97-0280 (3)(a)(d) .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure privacy and confidentiality of medical information were maintained during a medical provider visit for 2 of 3 residents (Resident 42 & 51), reviewed for confidentiality of records. This failure placed the residents at risk for having their medical and personal information not kept confidential and a diminished quality of life. Findings included . Review of the facility's undated policy titled, Attending Physician Responsibilities, showed that, The Physician/NPP [Non-Physician Practitioner], will maintain a courteous and professional level of interaction with facility residents. RESIDENT 42 An observation on 06/04/2025 at 1:02 PM, showed several residents were gathered in the Memory Care Unit (MCU) Television (TV) room area and that Staff U, Advanced Registered Nurse Practitioner, was interacting with Resident 42. It further showed that Staff U asked about specific medical conditions and discussed medical laboratory results with Resident 42, while Resident 42 was in the company of other residents. In an interview on 06/04/2025 at 1:22 PM, Staff G, Registered Nurse, stated that she observed Staff U visiting with Resident 42 while in the company of other residents. Staff G further stated that Staff U did not provide privacy during the visit with Resident 42 and that they should have taken them to their room for privacy. In an interview on 06/04/2025 at 1:50 PM, Staff B, Director of Nursing, stated that they considered the MCU TV room as a common area and that they expected provider visits would be conducted in private. RESIDENT 51 An observation on 06/04/2025 at 1:02 PM, showed Staff U visited with Resident 51 while they were seated on a bench that was placed between the MCU nurse's station and MCU dining room. It showed that Resident 51 was asked about specific medical conditions and that Resident 51 pushed away when Staff U attempted to place a stethoscope on their chest. In an interview on 06/04/2025 at 1:22 PM, Staff G stated that she observed Staff U visiting with Resident 51 near the nurse's station. Staff G further stated that Staff U did not provide privacy during the visit with Resident 51 and that they should have taken them to their room for privacy. In an interview on 06/04/2025 at 1:50 PM, Staff B, Director of Nursing, stated that they expected provider visits would be conducted in private. Reference (WAC): 388-97-0360 (1)(b)(e) .

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** RESIDENT 98 Review of a face sheet printed on 06/05/2025 showed Resident 98 was admitted to the facility on [DATE]. Review of Resident 98's EHR showed a physician's order initiating an antidepressant (a drug used to treat mental health condition that causes a persistent feeling of sadness and loss of interest in activities, significantly impacting daily life) 7.5 milligrams (mg- unit of measurement) on 05/15/2025, and a dose increased to 15 mg on 05/20/2025. Review of Resident 98's May 2025 MAR, printed on 06/04/2025 did not show monitoring or documentation for target behaviors and potential adverse side effects. A joint record review and interview on 06/04/2025 at 10:52 AM with Staff D, showed Resident 98 had been taking an antidepressant since 05/15/2025. Staff D stated that adverse side effects and target behaviors were not monitored or documented and that they should have. In an interview on 06/06/2025 at 11:27 AM, Staff B stated it was their expectation that any resident taking antidepressants should have been monitored for adverse side effects and target behaviors and documented in the MAR. Staff B further stated this was missing in Resident 98's records. Review of a face sheet printed on 06/04/2025 showed Resident 54 was admitted to the facility on [DATE]. Review of the May 2025 physician's order summary report showed that Resident 54 had been on antipsychotic medication since 10/26/2023. Review of Resident 54's Abnormal Involuntary Movement Scale (AIMS- an assessment tool used to evaluate involuntary movements) assessment showed it was completed late on 09/25/2024 (two months and 10 days late). Review of a Consultant Pharmacist's Medication Regimen Review dated 04/02/2025 showed, Please consider document AIMS assessment every 6 [six] months since he is taking Quetiapine [antipsychotic medication] routinely so the facility may stay compliant. Last AIMS was on 9-25-24 [09/25/2024]. In an interview and joint record review on 06/04/2025 at 10:35 AM, Staff E, RNUM, stated that Resident 54 was on antipsychotic medication. Staff E stated that residents on antipsychotic medication should have had an AIMS assessment completed every three to six months. A joint record review showed that Resident 54's last AIMS assessment was completed on 09/25/2024. Staff E stated that Resident 54's AIMS assessment was overdue and should have been completed within six months. In an interview on 06/04/2025 at 1:36 PM, Staff B stated that residents on antipsychotic medication were expected to have an AIMS assessment completed every six months and as needed. Staff B further stated that Resident 54's AIMS assessment was late and should have been completed within six months. (continued on next page)

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	505416	A. Building B. Wing	06/06/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference: (WAC) 388-97-1060 (3)(k)(i)(4) Based on interview and record review, the facility failed to ensure adequate monitoring was in place for psychotropic (drugs that affects how the brain works, and causes changes in mood, awareness, thoughts, feelings or behavior) medication management for 3 of 5 residents (Resident 6, 90 & 98), and failed to timely assess involuntary movements associated with psychotropic drug use for 1 of 3 residents (Resident 54), reviewed for unnecessary medications. These failures placed the residents at risk for unmet care needs, adverse side effects, and a diminished quality of life. Findings included . Review of the facility's undated policy titled, Antipsychotic Medication [used to treat mental health symptoms], showed that nursing staff will observe and document information regarding the effectiveness of any interventions, including antipsychotic medications. It further showed that nursing staff would monitor for and report to the attending physician, side effects and adverse consequences, to include involuntary movements associated with antipsychotic drug use. RESIDENT 6 Review of a face sheet printed on 06/05/2025, showed that Resident 6 readmitted to the facility on [DATE]. Review of Resident 6's Electronic Health Record (EHR) showed a physician's order for an antipsychotic medication that started on 08/15/2024. Further review did not show monitoring for side effects related to antipsychotic medication use. Review of Resident 6's Medication Administration Record (MAR) for May 2025, printed on 06/02/2025, did not show documentation of monitoring of side effects related to antipsychotic medication use. In an interview and joint record review on 06/04/2025 at 10:53 AM, Staff D, Registered Nurse [RN] Unit Manager (RNUM), stated that the facility monitored for side effects and target behaviors related to psychotropic drug use and that they expected to see documentation of monitoring in the MAR and in the physician's orders. A joint record review of Resident 6's EHR showed a physician's order for antipsychotic medication that started on 08/15/2024. Further joint record review of Resident 6's EHR did not show documentation of monitoring side effects related to antipsychotic medication use in the physician's orders, in May 2025 and in June 2025 MAR. Staff D stated that, I don't see it, I will put that in. Staff D further stated that they expected monitoring would have been in place. In an interview on 06/06/2025 at 11:48 AM, Staff B, Director of Nursing, stated that they expected residents who were prescribed psychotropic medications would have monitoring of side effects documented in the physician's orders and in the MAR. RESIDENT 90 Review of a face sheet printed on 06/05/2025, showed that Resident 90 was admitted to the facility on [DATE]. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident's 90's physician orders, printed on 06/03/2025, showed an order for an antipsychotic medication that was started on 07/18/2024. Further review did not show monitoring of side effects or target behaviors (observable behaviors that are intended to be addressed by medication) related to antipsychotic medication use. A joint record review and interview on 06/04/2025 at 11:03 AM with Staff D showed a physician's order for antipsychotic medication that started on 07/18/2024 in Resident 90's EHR. Further joint record review did not show documentation of monitoring side effects and target behaviors related to antipsychotic medication use in the physician's orders, in May 2025 MAR, and in June 2025 MAR. Staff D stated that they did not see documentation and that they expected monitoring for side effects and target behaviors would have been in place. In an interview on 06/06/2025 at 11:48 AM, Staff B stated that they expected residents who were prescribed psychotropic medications would have monitoring of side effects and target behaviors documented in the physician's orders and in the MAR.

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	505416	A. Building B. Wing	06/06/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 for 1 of 2 residents (Resident 101), reviewed for abuse investigations. This failure placed the residents at risk for repeated incidents, unidentified abuse, and inappropriate corrective actions. Findings included . 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. It seeks to determine if abuse, neglect, abandonment personal and/or financial exploitation or misappropriation of resident property occurred, and how to prevent further occurrences .All incidents require thorough investigation and reporting, as necessary, according to state and federal regulations. All such investigations attempt to determine if such injury or allegation of injury results from abuse or neglect. Review of the facility's policy titled, Abuse, revised on 10/20/2022, showed, This organization recognizes and respects that each resident has the right to be free from abuse, neglect, misappropriation of resident's property, and exploitation .Designated staff will immediately review and investigate all allegations or observations of abuse. Review of a face sheet printed on 06/02/2025 showed Resident 101 admitted to the facility on [DATE]. In an interview on 05/29/2025 at 8:42 AM, Resident 101 stated, They're not providing the necessary resources to take care of us and that they would run out of trash bags, briefs, moisturizers and wipes. Resident 101 further stated that they thought this was a form of elderly abuse. Review of Resident 101's investigation report dated 05/29/2025 showed, Actions Taken: -Reported to State Agency -Administrator [Staff A]/Director of Nursing [Staff B] notified -Interview of resident -Care plan revision -Review of supply invoices which shows that supplies are being ordered regularly -Resident room and supply rooms checked and are fully stocked. Further review of the investigation report showed that interviews with other residents and staff members were not conducted. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/06/2025 at 10:21 AM, Staff A stated that they would report and investigate abuse/neglect allegations. Staff A stated that they and Staff B completed the investigations. Staff A reviewed Resident 101's investigation report and stated that they did not see documentation that other residents and staff were interviewed. Staff A stated, No, I'm not seeing it in the summary of events. When asked if the investigation was completed thoroughly, Staff A stated, we could have done more and that their usual format would be to interview other residents and staff members. Staff A further stated, We should have done a more thorough investigation like we usually do. Reference: (WAC) 388-97-0640 (6)(a) .

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely complete a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS-an assessment tool) for 1 of 3 residents (Resident 76), reviewed for SCSA. This failure placed the residents at risk for delayed care planning, unmet care needs, and diminished quality of life. Findings included . Review of the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual (a guide directing staff on how to accurately assess the status of residents), Version 1.19.1, dated October 2024, showed that the nursing home is required to complete an SCSA when the resident comes off hospice (a service that provides quality of life care for chronic conditions) benefit (revokes). The Assessment Reference Date (ARD) must be within 14 days from the effective date of the hospice election revocation. The RAI manual further showed that the assessment should be completed no later than 14 days after the determination was made (determination date plus 14 calendar days). Review of a face sheet printed on 06/02/2024 showed Resident 76 was readmitted to the facility on [DATE] with diagnoses to include worsening renal (related to kidneys, including their function responsible for filtering blood, regulating fluid balance and waste management through urine production) failure. Review of Resident 76's nursing progress notes dated 06/12/2024 showed that resident was admitted to hospice on 06/12/2024. Review of the hospice provider note dated 05/02/2025 showed Resident 76 was discharged from hospice services on 05/02/2025. Review of the SCSA MDS dated [DATE] showed that the MDS was completed on 05/29/2025 (13 days late). A joint record review and interview on 06/03/2025 at 3:16 PM with Staff CC, Registered Nurse, showed that Resident 76 was discharged from hospice on 05/02/2025. Staff CC stated that the MDS coordinator was responsible for updating the SCSA MDS after a significant change of condition. In an interview and joint record review on 06/05/2025 at 1:27 PM, Staff Q, MDS Coordinator, stated that they followed the RAI manual for completion of MDS assessments. A joint record review of the hospice provider note dated 05/02/2025, showed Resident 76 was discharged from hospice on 05/02/2025. Staff Q stated that the SCSA MDS was late. In an interview and joint record review on 06/06/2025 at 11:36 AM, Staff B, Director of Nursing, stated it was their expectation that MDS assessments were completed timely and, in this case, Resident 76's SCSA MDS was completed late. Reference: (WAC) 388-97-1000(3)(b)(5)(e)(ii) .

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	505416	A. Building B. Wing	06/06/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately assess 3 of 20 residents (Residents 1, 97 & 90), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessments for oral/dental status, medications, and hospice care (support for end-of-life care) placed the residents at risk for unidentified and/or unmet care needs, and a diminished quality of life. According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.19.1, dated October 2024, showed, .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. It further showed, .Hospice Services is a program for terminally ill persons [people] where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare [government-run health insurance] program as a hospice provider. The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS and ends at 11:59 PM on the day of the Assessment Reference Date (ARD or assessment period). RESIDENT 1 Review of a quarterly MDS dated [DATE] showed Resident 1 readmitted to the facility on [DATE]. Further review of the MDS showed, Section N (Medications) was marked as they were taking an antidepressant (medications to treat depression [a mood disorder that causes a persistent feeling of sadness and loss of interest]). Review of the April 2025 Medication Administration Record (MAR) showed Resident 1's order for an antidepressant medication was discontinued on 04/15/2025. It further showed that Resident 1 last received an antidepressant medication on 04/15/2025. In an interview and joint record review on 06/05/2025 at 11:09 AM, Staff Q, MDS Registered Nurse (RN), stated that they followed the RAI manual and when they completed Section N, they would review physician orders, and the MAR. Staff Q stated that the look back period for Section N was seven days. A joint record review of Resident 1's quarterly MDS dated [DATE], showed that it was coded for antidepressant use. A joint record review of Resident 1's April 2025 MAR showed they last received an antidepressant medication on 04/15/2025. Staff Q stated that Section N was not coded accurately and should have been. RESIDENT 97 (continued on next page)

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	505416	A. Building B. Wing	06/06/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the admission MDS dated [DATE] showed Resident 97 admitted to the facility on [DATE]. It further showed that Section L (Oral/Dental Status) was marked none of the above were present and that they were not marked for No natural teeth or tooth fragment(s) (edentulous [toothless]). Review of the Nutritional at Risk Assessment dated 03/13/2025 showed Resident 97 was edentulous. An observation and interview on 05/29/2025 at 12:23 PM, showed Resident 97 was edentulous. Resident 97 stated that they had all their teeth pulled out. In an interview and joint record review on 06/05/2025 at 11:16 AM, Staff Q stated that when they completed Section L, they would try to examine the resident's mouth if allowed, spoke with staff and reviewed documentation. Staff Q stated that Section L had a seven-day look back period. A joint record review of Resident 97's admission MDS dated [DATE], showed it was not marked for No natural teeth or tooth fragment(s) (edentulous). A joint record review of the nutrition assessment dated [DATE], showed Resident 97 was edentulous. Staff Q stated that based on the documentation reviewed, Section L should have been coded accurately for edentulous. In an interview on 06/05/2025 at 1:53 PM, Staff B, Director of Nursing, stated that they expected MDS assessments to be completed accurately. Review of a face sheet printed 06/05/2025, showed Resident 90 was admitted to the facility on [DATE]. Review of Resident 90's quarterly MDS dated [DATE] showed that hospice care was marked in Section O0110 (Special Treatments, Procedures and Programs), which indicated that Resident 90 received hospice services while a resident at the facility. Review of Resident 90's physician's orders, printed on 06/03/2025, did not show orders for hospice services. In an interview on 06/06/2025 at 8:46 AM, Staff G, RN, stated that Resident 90 was not under a hospice program and that Resident 90 had services for just comfort care. A joint record review and interview on 06/06/2025 at 11:27 AM with Staff R, MDS RN, showed that hospice care was marked in Section O0110 of Resident 90's quarterly MDS dated [DATE]. Staff R stated that there was no supporting documentation of Resident 90 having received hospice services in their electronic health record. Staff R further stated that hospice care should not have been marked and that they expected MDS would be completed accurately. In an interview on 06/06/2025 at 11:44 AM, Staff B stated that the facility followed the RAI Manual for coding accuracy and that they expected MDS assessments would be completed accurately. Reference: (WAC) 388-97-1000(1)(b) .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** RESIDENT 101 Review of a face sheet printed on 06/02/2025, showed Resident 101 admitted to the facility on [DATE]. Review of Resident 1's Level I PASARR dated 02/12/2025 showed that Section IV (Service Needs and Assessor Data) was marked No level II evaluation indicated at this time due to exempted hospital discharge. Level II must be completed if discharge does not occur. Review of the census tab in the EHR printed on 06/02/2025, showed Resident 101's status was active. In an interview and joint record review on 06/02/2025 at 2:21 PM, Staff F, Social Worker, stated that if a resident was marked for hospital exempted discharge on their Level I PASARR that was completed prior to their admission, they would have to complete a new Level I PASARR if the resident was in the facility for more than 30 days. A joint record review of Resident 101's Level I PASSAR dated 02/12/2025, showed it was marked for No level II evaluation indicated at this time due to exempted hospital discharge. Level II must be completed if discharge does not occur. Staff F stated that they did not see a new Level 1 PASARR completed in Resident 101's EHR after their 30 days stay and that a new Level I PASARR should have been completed. In an interview on 06/04/2025 at 3:50 PM, Staff A stated that they expected staff to follow their policy and that a new Level I PASARR for Resident 101 should have been completed after their 30 days stay. Reference: (WAC) 388-97-1975 (1)(3)(5) Based on interview and record review, the facility failed to ensure Preadmission Screening and Resident Review (PASARR-an assessment used to identify people referred to nursing facilities with Serious Mental Illness [SMI], Intellectual Disabilities [ID]; or Related Conditions [RC] are not inappropriately placed in nursing homes for long-term care) Level II PASARR referral was made for 1 of 5 residents (Resident 102), reviewed for PASARR screening. In addition, the facility failed to complete Level I PASARR screening form for an exempted hospital discharge resident who remained in the facility for more than 30 days for 1 of 5 residents (Resident 101). These failures placed the residents at risk of not receiving the care and services appropriate for their needs. Findings included . Review of the facility's policy titled, admission Criteria, dated 10/01/2021, showed that all new admissions and readmissions are screened for mental disorders, intellectual disabilities or related disorders per the Medicaid PASARR process. The policy further showed, If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD [Related Disorders], he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. RESIDENT 102 (continued on next page)

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	505416	A. Building B. Wing	06/06/2025

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a face sheet printed on 06/04/2025 showed Resident 102 admitted to the facility on [DATE]. Review of Resident 102's Level I PASARR dated 03/11/2025 showed that a diagnosis of mood disorders (a mental health condition that affects a person's emotional state, causing persistent feelings of sadness, irritability, or extreme mood swings) was marked. Further review of the Level I PASARR showed, resident recently had a decline with mood, adjustment disorder [a mental health condition that occurs when a person struggles to cope with a stressful life event, leading to emotional or behavioral symptoms]). In an interview and joint record review on 06/04/2025 at 10:19 AM, Staff O, Social Worker, stated that Resident 102 was admitted to the facility with a negative Level I PASARR. Staff O stated that the new Level I PASARR was completed on 03/11/2025 due to Resident 102's decline with their mood. Staff O stated that Resident 102's Level II PASARR referral was made. A joint record review of Resident 102's Electronic Health Record (EHR) showed that there was no documentation that a referral was made. Staff O stated, I believe I faxed the referral, but I do not have the fax cover sheet or the documentation to confirm. In an interview on 06/05/2025 at 2:02 PM, Staff A, Administrator, stated that when a residents' Level I PASARR screening indicated they met the criteria, they should be referred for a Level II PASARR evaluation. Staff A further stated that Resident 102's Level II PASARR referral should have been made and there should have been documentation for it.

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	505416	A. Building B. Wing	06/06/2025

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the State PASARR (Pre-admission Screening and Resident Review-an assessment used to identify people [resident] referred to nursing facilities with Serious Mental Illness [SMI], intellectual disabilities [ID], or related conditions are not inappropriately placed in nursing facility for long term care) Coordinator after a significant change in condition for 3 of 8 residents (Residents 76, 1 & 10), reviewed for PASARR. This failure placed the residents at risk for unmet mental health services necessary to obtain the resident's highest level of psychosocial well-being and diminished quality of life. Finding included . Review of an online document title, Preadmission Screening and Resident Review, dated 02/14/2020, showed that According to Medicaid, as part of the PASARR process, the facility is required to notify the appropriate state mental health authority or state intellectual disability authority when a resident with a mental disorder (MD/SMI) or ID has a significant change in their physical or mental condition. Referral to the State Mental Health (SMH) or ID authority should be made as soon as the criteria indicative of a significant change are evident. RESIDENT 76 Review of a face sheet printed on 06/05/2025 showed Resident 76 readmitted to the facility on [DATE] with diagnoses that included Major Depressive Disorder (MDD- a mental health condition characterized by persistent feelings of sadness, low mood, and loss of interest in activities that were once pleasurable), and Post-Traumatic Stress Disorder (PTSD-a mental health condition that can develop after experiencing or witnessing a traumatic event). Review of a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS-an assessment tool) dated 05/26/2025 showed Resident 76 had diagnoses of MDD, anxiety (excessive and persistent worry, fear, and nervousness that can interfere with daily life) and PTSD. Review of the hospice provider note dated 05/02/2025 showed Resident 76 was discharged from hospice services on 05/02/2025. A joint record review and interview on 06/03/2025 at 3:16 PM with Staff CC, Registered Nurse, showed hospice provider note included Resident 76 discharged from hospice care on 05/02/2025. Staff CC stated that Resident 76 needed an SCSA to be completed. In an interview on 06/06/2025 at 10:40 AM, Staff F, Social Worker, stated that if a significant change of condition was identified for a resident with MD or ID, then the resident needed to be referred for PASARR Level II for evaluation. Staff F stated a referral completed on 06/05/2025, and it was late. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/06/2025 at 11:36 AM, Staff B, Director of Nursing, stated that it was their expectation that staff would notify the mental health authority or the State PASARR Coordinator after a resident had a significant change in condition. RESIDENT 1 Review of a face sheet printed on 06/05/2025, showed Resident 1 readmitted to the facility on [DATE] with diagnoses that included anxiety disorder, and MDD. Review of Resident 1's Level I PASARR dated 04/04/2024, showed Section IV (Service Needs and Assessor Data) was marked for Level II evaluation referral required for significant change. Review of Resident 1's Electronic Health Record (EHR) did not show documentation for a completed Level II PASARR evaluation. A joint record review and interview on 06/03/2025 at 3:03 PM with Staff F, showed Resident 1's Level I PASARR dated 04/04/2024 was marked for Level II evaluation referral required for significant change. Staff F stated that they were not able to see that a Level II evaluation was completed and that there's nothing after that date. Staff F further stated that they would double check with the PASARR Coordinator. When asked how often they followed up with the PASARR Coordinator, Staff F stated, quarterly. In a follow up interview on 06/04/2025 at 3:39 PM, Staff F stated that they had followed up with the PASARR Coordinator and that they were told that they did not have Resident 1's referral. Staff F further stated that they did not see documentation that a follow up was made to the PASARR Coordinator. In an interview on 06/04/2025 at 3:45 PM, Staff A, Administrator, stated that they expected staff to follow up on Level II PASARR evaluation referrals. RESIDENT 10 Review of a face sheet printed on 06/02/2025 showed Resident 10 was admitted to the facility on [DATE] with a diagnosis that included bipolar disorder (a mental illness characterized by intense mood swings). Review of the MDS look up tab showed Resident 10 had an SCSA MDS dated [DATE]. Review of the EHR showed Resident 10 had a Level I PASARR dated 03/12/2018. Further review of the EHR did not show Resident 10 had a new and/or updated PASARR. An additional review of the EHR did not show documentation that the State mental health authority or PASARR Coordinator had been informed of Resident 10's significant change in condition. A joint record review and interview on 06/03/2025 at 2:14 PM with Staff F, showed Resident 10 had a Level I PASARR dated 03/12/2018. A joint record review of the EHR did not show a new or updated PASARR completed for Resident 10. Staff F stated, there was no new PASARR or referral for a Level II completed for [Resident 10]. There should have been one completed and the PASARR Coordinator was not notified [about Resident 10's significant change in status]. (continued on next page)

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	505416	A. Building B. Wing	06/06/2025

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/05/2025 at 1:57 PM, Staff A stated that they expected a new Level I PASARR should have been completed and the PASARR Coordinator notified when Resident 10 had a significant change in their status. Reference: (WAC) 388-97-1975 (7) .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** NAIL CARE RESIDENT 76 Review of a quarterly MDS dated [DATE], showed Resident 76 needed substantial/maximal assistance (helper does more than half the effort) for personal hygiene. Observation on 06/02/2025 at 11:55 AM, showed Resident 76's right thumb fingernail was long and had brown matter underneath them. The left great toenail had black discoloration, and the right great toenail had brown discoloration. Both great toenails were thick and had brown matter underneath them. Resident 76 stated they could not clip or clean their nails and had requested staff assistance and were told, We will get to it when we have [a] chance. A joint observation and interview on 06/06/2025 at 10:37 AM, Staff T, License Practical Nurse, showed Resident 76's right thumb fingernail was long and had brown matter underneath them. The left great toenail had black discoloration, and the right great toenail had brown discoloration. Both great toenails were thick and had brown matter underneath them. Staff T stated that staff were responsible for residents' nail care and/or refer them to the podiatrist (foot doctor) [as needed], who visited weekly. Review of a comprehensive care plan printed on 06/05/2025 showed Resident 76 had no care plan for nail care. Review of Resident 76's nursing progress note dated 12/16/2024 showed a podiatrist referral. Further review of Resident 76's EHR did not show documentation that Resident 76 was seen or scheduled for a visit with the podiatrist. A joint record review and interview on 06/06/2025 at 11:14 AM with Staff B, showed Resident 76's EHR did not include documentation that nail care was provided, a podiatrist visit was scheduled or had occurred, and a care plan for nail care developed or implemented. Staff B stated it was the staff's responsibility to provide nail care or refer residents to the podiatrist. Staff B further stated that during ADL care, staff should clip the residents' nails, identify who require podiatry services, and then put them on the list to be seen. Reference: (WAC) 388-97-1020(1), (2)(a)(b) TOILETING HYGIENE RESIDENT 27 Review of a face sheet printed on 06/02/2025 showed Resident 27 readmitted to the facility on [DATE] with diagnoses that included unspecified dementia (memory loss severe enough to impair daily life and independent function). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly MDS dated [DATE] showed Resident 27 was dependent on staff with toileting hygiene and was always incontinent with bladder and bowel. In an interview on 05/30/2025 at 9:11 AM, Resident 27 stated that they would not get toileting assistance on night shift and that the aides tell them they did not have time. Resident 27 stated that they had told staff that they did not mind being woken up to be changed because they have sensitive skin and needed to be changed. Review of the Activities of Daily Living Self Care Performance Deficit care plan, revised on 08/24/2017, showed, TOILET USE: [Resident 27] has been declining to use [the] toilet or BSC [beside commode]. She is incontinent B/B [bladder and bowel]. Offer to assist res [Resident 27] to [the] toilet upon rising in AM [morning], at HS [hour of sleep], and prn [as needed]. Requires assist with toilet transfer, hygiene, and clothing management. If res [Resident 27] declines toileting then check and change her q [every] 2-3 hrs [two to three hours]. Review of Resident 27's urinary incontinence care plan intervention, revised on 01/07/2025, showed, INCONTINENT: Offer/assist with toileting/incontinent care every 2-3 hours and prn (resident stated she wants to be WOKEN UP) per her request. Review of Resident 27's toileting hygiene task from 05/07/2025 through 06/05/2025, showed no documentation that toileting hygiene assistance was provided on night shift on 05/07/2025, 05/11/2025, 05/13/2025, 05/14/2025, 05/19/2025, 05/20/2025, 05/22/2025, 05/26/2025, 05/27/2025, 05/30/2025, 06/01/2025, and on 06/04/2025. Review of Resident 27's Documentation Survey Report, dated March 2025 through May 2025 showed, Toileting Hygiene, showed the following: -March 2025- 25 days out of 31 days with no documentation that toileting hygiene assistance was provided. -April 2025- 17 days out of 30 days with no documentation that toileting hygiene assistance was provided. -May 2025- eight days out of 31 days with no documentation that toileting hygiene assistance was provided. Review of Resident 27's nursing progress note from March 2025 through June 2025, did not show that they refused assistance with toileting hygiene. In an interview on 06/05/2025 at 5:54 AM, Staff P, Certified Nursing Assistant (CNA), stated that they provided toileting assistance at night and that if they provided the care, they would document it in their charting system. Staff P further stated that they assisted Resident 27 during the night and that Resident 27 never refuses care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 06/05/2025 at 8:25 AM, Staff E stated that they expected CNAs to provide toileting care every two to three hours on night shift and document it under task in their charting system. A joint record review of the toileting hygiene task from 05/07/2025 through 06/05/2025, showed 12 days of missing documentation for night shift. Staff E stated, technically if it's not charted, it's not done. Staff E further stated that staff should have provided toileting care at night unless Resident 27 refused. In an interview on 06/05/2025 at 1:57 PM, Staff B stated that they expected staff to provide toileting care per the residents' Kardex (care guide for CNAs), at least two to three hours or as needed. Staff B further stated that they expected staff to document the care provided every shift and if the resident refused, staff should document it. BED POSITIONING RESIDENT 93 Review of a face sheet printed on 06/02/2025 showed Resident 93 was admitted to the facility on [DATE] with a diagnosis of left lower leg fracture (break in the bone). Review of a quarterly Minimum Data Set (MDS-an assessment tool) dated 04/03/2025 showed Resident 93 had severe cognitive impairment. Further review of the MDS showed Resident 93 was unable to walk and had limited range of motion in their lower legs. Review of Resident 93's comprehensive care plan printed on 05/30/2025 did not include Resident 93's bed placement against the wall including its risks and benefits. An observation on 05/30/2025 at 8:56 AM showed Resident 93 was lying in bed and their bed was positioned against the wall. In an interview and joint record review on 06/04/2025 at 1:29 PM, Staff J, RN, stated that Resident 93's bed was positioned against the wall. A joint record review of the comprehensive care plan revised on 05/30/2025 did not include Resident 93's bed against the wall including its risks and benefits. Staff J stated that the unit manager was responsible for the care planning. In an interview and joint record review on 06/04/2025 at 2:11 PM, Staff E stated that they were aware that Resident 93's bed was positioned against the wall. A joint record review of the EHR did not show Resident 93 was assessed, evaluated and informed about the risks/benefits of having their bed against the wall. Staff E stated that Resident 93 did not have a care plan regarding placement of their bed against the wall and that it should have been. In an interview on 06/05/2025 at 2:51 PM, Staff B stated that they expected staff to have care planned Resident 93's bed placement against the wall including its risks and benefits. ACTIVITIES PROGRAM RESIDENT 95 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Activities Programs, dated 10/01/2021, showed that the activities program was provided to support the well-being of residents and to encourage both independence and community interaction. The policy showed that activities were available daily and residents were given an opportunity to contribute to the planning, preparation, conducting, cleanup, and critique of the programs. The policy further showed that the resident's participation in activities was documented in the resident's medical record. Review of a face sheet printed on 06/04/2025 showed that Resident 95 admitted to the facility on [DATE]. Review of the admission MDS dated [DATE], showed Resident 95 was cognitively intact. The MDS further showed that it was very important for Resident 95 to listen to the music they like, keep up with the news, do their favorite activities and going outside to get fresh air when the weather was good. Review of Resident 95's care plan dated 04/22/2025, showed that the facility would encourage, support and assist [Resident 95] with family phone/virtual/in-person visits and invite, encourage and assist Resident 95 to attend group activities. The care plan further showed that [Resident 95] would be provided one on one visit as needed for emotional support and provide assistance and access to leisure activity supplies in room (magazines, newspaper, mystery books, TV (News, Sports [hockey, soccer, football baseball], channel 4/5, Price is Right game show, movies, country music, puzzles (fill in the blank) .). In an interview on 05/29/2025 at 1:01 PM, Resident 95 stated that they liked to do activities such as going out. When asked if they were doing activities in the facility, Resident 95 stated, No, I am supposed to have activities, but I have never seen any. Resident 95 further stated that they liked going out, and they went out once when their collateral contact visited them. Multiple observations on 05/29/2025 at 1:01 PM, on 06/02/2025 at 9:33 AM, and on 06/03/2025 at 8:45 AM, showed that Resident 95 was awake, lying in bed and did not have any leisure activity supplies in their room such as magazines, newspaper and mystery books. In an interview and joint record review on 06/03/2025 at 9:24 AM, Staff V, Activities Director, stated they expected the residents to participate in activities and that after they participated or refused, it should be documented. Staff V stated that they did not believe Resident 95 was coming to group activities, That is probably because [Resident 95] does not want to come. Staff V stated that Resident 95 was definitely doing activities independently, but for group activities, I do not see it on the chart. Staff V further stated, I do not think [Resident 95] had one on one. We should have let [Resident 95] participated in activities as planned in their care plan. I do not think everything listed on [Resident 95's] care plan was being implemented. A joint record review of activities progress notes from 04/21/2025 through 06/03/2025 did not show that Resident 95 had documentation for their activity participation. Staff V further stated that Resident 95's activity care plan should have been implemented. In an interview on 06/05/2025 at 2:02 PM, Staff A, Administrator, stated that their expectation was for residents to be offered activities that enhance their well-being and social engagement within the facility. Staff A further stated that Resident 95's activity care plan should have been implemented. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to develop and/or consistently implement care plans for 6 of 20 residents (Residents 36, 6, 93, 95, 27 & 76), reviewed for comprehensive care plans. The failures to implement care plans for nutrition, dental care, pain management, bed positioning, activities program, toileting hygiene, and nail care, 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 that The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified throughout the comprehensive Resident Assessment Instrument (RAI) [A manual used to guide resident assessments] process . All reasonable efforts will be made to incorporate the resident's personal and cultural preferences in developing goals of care. It further showed that each resident's comprehensive care plan would describe services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. NUTRITION CARE PLAN RESIDENT 36 Review of a face sheet printed on 06/05/2025, showed that Resident 36 admitted to the facility on [DATE] with diagnosis that included gastroparesis (a condition where the stomach [part of the body where food goes after it is eaten] muscles don't work properly to move food through the stomach, which can lead to vomiting and trouble digesting food). Review of Resident 36's care plan, printed on 06/04/2025 showed, Special instruction: INFO [information]: Give smaller meals more frequently: 4-5 [four to five] small meals a day versus 3 [three] large meals. Small particle diet for Gastroparesis. Observations on 05/30/2025 at 8:54 AM, on 06/03/2025 at 9:13 AM and on 06/05/2025 at 8:39 AM showed Resident 36's main entrée portions were fully covering the surface of their plate [served with regular portions]. A joint record review and interview on 06/04/2025 at 1:35 PM with Staff G, Registered Nurse (RN), showed Resident 36's Electronic Health Record (EHR) profile had instructions for smaller meals more frequently: 4-5 small meals a day versus 3 large meals. Small particle diet for Gastroparesis. Staff G stated that Resident 36 did not receive small meal portions and that, They look regular to me. A joint record review and interview on 06/05/2025 at 4:09 PM with Staff B, Director of Nursing, showed Resident 36's care plan had instructions for smaller meals more frequently: 4-5 small meals a day versus 3 large meals. Small particle diet for Gastroparesis. Staff B stated that they expected Resident 36's special instructions should be implemented. DENTAL CARE PLAN (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a nursing progress note dated 05/10/2025 showed it was labeled as a late entry, and that Resident 36's representative had notified staff in-person regarding Resident 36's broken tooth. It did not show that Resident 36 was referred to dental services regarding their broken tooth. Review of Resident 36's care plan, printed on 06/04/2025, showed that, Refer to dentist [doctor who takes care of teeth and gums] as indicated. In an interview on 06/05/2025 at 10:42 AM, Staff G stated that they were aware of Resident 36's broken tooth. In an interview and joint record review on 06/05/2025 at 11:53 AM, Staff D, RN Unit Manager (RNUM), stated that Resident 36 had not been referred to dental services for their broken tooth and that they should have been referred. A joint record review of Resident's 36's dental care plan showed, Refer to dentist as indicated. Staff D stated that Resident 36's dental care plan was not implemented. In an interview on 06/05/2025 at 4:06 PM, Staff B stated that they expected Resident 36's dental care plan would have been implemented. PAIN MANAGEMENT CARE PLAN RESIDENT 6 Review of a face sheet printed on 06/05/2025, showed that Resident 6 readmitted to the facility on [DATE] with diagnosis that included polyosteoarthritis (swelling and stiffness that affects multiple joints at the same time) and dorsalgia (back pain). Review of Resident 6's physician's orders, printed on 06/05/2025, showed orders for an analgesic (medication used to relieve pain) that was administered routinely and as needed for pain. Review of a care plan, printed on 06/06/2025, did not show a care plan was developed for pain management related to Resident 6's diagnosis of polyosteoarthritis and dorsalgia. A joint record review and interview on 06/06/2025 at 9:25 AM with Staff E, RNUM, showed Resident 6 had a diagnosis of polyosteoarthritis listed in their EHR. Further joint record review of Resident 6's EHR did not show that a pain management care plan was developed. Staff E stated that I don't [do not] see any care plan addressing pain or pain management, and that they expected a care plan to address Resident 6's pain management would have been developed. A joint record review and interview on 06/06/2025 at 11:55 AM with Staff B showed Resident 6 had a diagnosis of polyosteoarthritis and dorsalgia listed in their EHR. Further joint record review did not show that a pain management care plan was developed. Staff B stated, I don't [do not] see anything, and that they expected pain management would have been developed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care plans were revised timely and accurately to reflect changes in care related to discontinuation of hospice (a service that provides quality of life care for chronic conditions) services, initiation of comfort care or end-of-life care, and/or discontinuation of medication for 3 of 7 residents (Residents 76, 90 & 1), reviewed for care planning. These failures placed residents at risk for unidentified and unmet care needs, and a diminished quality of life. RESIDENT 76 Review of a face sheet printed on 06/02/2025 showed Resident 76 was readmitted to the facility on [DATE]. Review of a nursing progress note dated 06/12/2025 showed Resident 76 was admitted to hospice services on 06/12/2024. Review of Resident's 76's comprehensive care plan initiated on 06/12/2024 showed Resident 76 was on hospice for end-of-life/comfort care. Review of a hospice provider note dated 05/02/2025 showed Resident 76 was discharged from hospice services on 05/02/2025. In an interview and joint record review on 06/03/2025 at 3:16 PM, Staff CC, Registered Nurse (RN), stated that Resident 76 was discharged from hospice on 05/02/2025. Further review of the care plan showed it was not revised to reflect that Resident 76 was discharged from hospice care. Staff CC stated that the care plan should have been revised in a timely manner to reflect discharge from hospice care services. In an interview on 06/06/2025 at 11:42 AM, Staff B, Director of Nursing, stated that it was their expectation that once a resident was discharged from hospice, the care plan should have been reviewed and updated promptly to reflect the resident's change in status. Staff B further stated Resident 76's care plan should have been revised in a timely manner. RESIDENT 1 Review of a face sheet printed on 06/05/2025, showed Resident 1 readmitted to the facility on [DATE] with diagnoses that included major depressive disorder (persistent feelings of sadness and loss of interest, significantly impacting daily life). Review of the physician's order printed on 06/02/2025, showed Resident 1 did not have an order for an antidepressant (medication for depression or depressive disorder). Review of the April 2025 Medication Administration Record showed Resident 1's antidepressant medication was discontinued on 04/15/2025. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's mood care plan revised on 02/21/2023, showed, He takes a low dose of [an] anti-depressant medication routinely. In an interview and joint record review on 06/05/2025 at 8:08 AM, Staff J, RN, stated that they did not think Resident 1 was on an antidepressant medication. A joint record review of Resident 1's physician orders did not show an order for antidepressant medication. Staff J stated that if a residents' antidepressant medication was discontinued, it should have been reflected on their care plan. In an interview and joint record review on 06/05/2025 at 8:15 AM, Staff E stated that care plans were reviewed quarterly and as needed and if there were any changes to their plan of care. Staff E stated if residents were no longer on an antidepressant medication, and if they were informed about it, they would remove it from their care plan. A joint record review of Resident 1's physician orders showed that they did not have an order for antidepressant medication. Staff E stated, Resident 1 used to be [on antidepressant] but not anymore. A joint record review of Resident 1's mood care plan showed, He takes a low dose of an anti-depressant medication routinely. Staff E stated that Resident 1's care plan should have been updated. In an interview on 06/05/2025 at 1:55 PM, Staff B stated that they expected resident care plans to have been revised on admission, quarterly, and when there was a change in their care. Staff B further stated that they expected Resident 1's care plan to have been revised. Reference: (WAC) 388-97-1020 (2)(a)(5)(b) RESIDENT 90 Review of a face sheet printed on 06/05/2025, showed Resident 90 was admitted to the facility on [DATE]. Review of a progress note dated 08/23/2024 showed Staff F, Social Worker, wrote, [Resident 90] has had a decline in condition this assessment period r/t [related to] start of [Collateral Contact 2's] end-of-life comfort care program (similar to hospice). In an interview on 06/06/2025 at 8:46 AM, Staff G, RN, stated that Resident 90 received comfort care. Review of Resident 90's care plan, printed on 06/06/2025, did not show that their care plan was revised to include their transition to end-of-life comfort care program. A joint record review and interview on 06/06/2025 at 11:11 AM with Staff E, RN Unit Manager, did not show that Resident 90's care plan was revised to include end-of-life comfort care. Staff E stated that there was no care plan addressing end of life goals or treatments, and that they would expect the care plan to have been revised. In an interview on 06/06/2025 at 11:46 AM, Staff B stated they expected Resident 90's care plan to have been revised to include the focus of comfort care/end-of-life comfort care.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure there was an ongoing activity program to meet the needs of 1 of 1 resident (Resident 95), reviewed for activities. This failure placed the residents at risk for unmet activity pursuit, social isolation, and a diminished quality of life. Findings included . Review of the facility's policy titled, Activities Programs, dated 10/01/2021, showed that the activities program was provided to support the well-being of residents and to encourage both independence and community interaction. The policy showed that activities were available daily and residents were given an opportunity to contribute to the planning, preparation, conducting, cleanup, and critique of the programs. The policy further showed that the resident's participation in activities was documented in the resident's medical record. Review of a face sheet printed on 06/04/2025 showed Resident 95 admitted to the facility on [DATE]. Review of the admission Minimum Date Set (MDS-an assessment tool) dated 04/25/2025, showed that Resident 95 was cognitively intact. The MDS assessment further showed that it was very important for Resident 95 to listen to the music they like, keep up with the news, do their favorite activities and go outside to get fresh air when the weather is good. Review of Resident 95's care plan dated 04/22/2025, showed that the facility would encourage, support and assist Resident 95 with family phone/virtual/in-person visits and invite, encourage and assist Resident 95 to attend group activities. The care plan further showed that Resident 95 would be provided one on one visit as needed for emotional support and provide assistance and access to leisure activity supplies in room (magazines, newspaper, mystery books, TV [Television] News, Sports (hockey, soccer, football baseball), channel 4/5, Price is Right game show, movies, country music, puzzles .). In an interview on 05/29/2025 at 1:01 PM, Resident 95 stated that they like to do activities such as going out. When asked if they were doing activities in the facility, Resident 95 stated No, I am supposed to have activities, but I have never seen any. Resident 95 further stated that they liked going out, and they only went out once when their collateral contact visited them. Multiple observations on 05/29/2025 at 1:01 PM, on 06/02/2025 at 9:33 AM, and on 06/03/2025 at 8:45 AM, showed that Resident 95 was awake, lying in bed and did not have any leisure activity supplies in their room such as magazines, newspaper and mystery books. (continued on next page)

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	06/06/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 06/03/2025 at 9:24 AM, Staff V, Activities Director, stated they expected the residents to participate in activities and that after they participated or refused, it should be documented. Staff V stated that they did not believe Resident 95 was coming to group activities, That is probably because [Resident 95] does not want to come. Staff V stated that Resident 95 was definitely doing activities independently, but for group activities, I do not see it on the chart. Staff V further stated, I do not think [Resident 95] had one on one. We should have let [Resident 95] participate in activities as planned in their care plan. I do not think everything listed on [Resident 95's] care plan was being implemented. A joint record review of activities progress notes from 04/21/2025 to 06/03/2025 did not show Resident 95 had documentation for their activity participation. Staff V stated that there should have been documentation indicating Resident 95 was participating in activities of their choice. In an interview on 06/05/2025 at 2:02 PM, Staff A, Administrator, stated that it was their expectation that residents should be offered activities to enhance their well-being and social engagement in the facility. Staff A further stated that Resident 95 should have been offered activities of their choice and that each instance of participation or refusal should have been documented to ensure proper tracking. Reference: (WAC) 388-97-0940(1)(2) .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to perform skin evaluations, implement appropriate monitoring and treatment after sustaining a skin injury, and/or failed to monitor and obtain daily weights for a resident on diuretic (water pill) therapy in accordance with professional standard of practice for 2 of 7 residents (Residents 21 & 98), reviewed for quality of care. These failures placed the residents at risk for unmet care needs and diminished quality of life. Findings Included . SKIN INJURY RESIDENT 21 During an observation and interview on 06/02/2025 at 10:43 AM, Resident 21 had two scabs (a dry protective) on their left knee and another two scabs on their right shin. Resident 21 stated that their skin injuries occurred due to a fall and that they were not receiving treatment. Review of the weekly skin assessment dated [DATE] showed that Resident 21 skin was intact. A joint observation and interview on 06/05/2025 at 10:34 AM with Staff KK, Registered Nurse (RN), showed Resident 21 had had two scabs on their left knee and another two scabs on their right shin. Staff KK was palpitating around the edges of the scabs/wounds, Resident 21 stated, it hurts. When asked about Resident 21's skin injury, Staff KK stated they were not aware of it. In an interview and joint record review on 06/05/2025 at 10:38 AM, Staff KK stated that for any skin injury, nursing staff were expected to provide first aid, notify the physician, family, document the injury in the skin assessment, and follow the provider's treatment recommendations. A joint record review of Resident 21's weekly skin assessments showed that the two scabs on their left knee and another two scabs on their right shin were not previously assessed. Staff KK stated that the scabs on Resident 21's left knee and right shin were not previously documented. In an interview on 06/06/2025 at 11:18 AM, Staff B, Director of Nursing, stated that skin assessments were completed weekly and during shower or sponge baths. Staff B further stated it was their expectation that all skin injuries to be documented, reported to the provider and family, and treated according to the physician's order. WEIGHT MONITORING RESIDENT 98 Review of a face sheet printed on 06/05/2025 showed Resident 98 was readmitted to the facility on [DATE]. Review of the May 2025 Medication Administration Record printed on 06/04/2025 showed Resident 98 received two diuretic medications. (continued on next page)

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	505416	A. Building B. Wing	06/06/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a daily weight documentation printed on 06/05/2025 showed that Resident 98's daily weights were not recorded for the following dates: 04/30/2025, 05/01/2025, 05/02/2025, 05/03/2025, 05/04/2025 and 05/05/2025. In an interview on 06/05/2025 at 3:55 PM, Staff II, Admissions RN, stated that residents' weights should be obtained at admission or readmission and that daily weights should have been recorded if the resident was on diuretic therapy. In an interview and joint record review on 06/06/2025 at 11:14 AM, Staff B, Director of Nursing, stated that resident weights were required on admission and weekly thereafter. A joint record of Resident 98's daily weights showed no documentation from 04/30/2025 to 05/05/20225. Staff B stated that residents receiving diuretics should be weighed daily. Staff B further stated that Resident 98's weights should have been recorded daily. Reference: (WAC) 388-97-1060 (1)(3)(b)(4) .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow a prescribed therapeutic diet of small, portioned meals for 1 of 3 residents (Resident 36), reviewed for nutrition/hydration. This failure placed the resident at risk for unintended weight loss, medical complications, and a diminished quality of life. Findings included . A review of the facility's policy titled, Therapeutic Diets, dated 10/01/2021, showed that, Therapeutic Diet, meant a diet ordered by a physician or delegated registered/licensed dietician as part of treatment for a clinical condition. It further showed that therapeutic diets were prescribed to support the resident's treatment and plan of care in accordance with his or her goals and preferences. Review of a face sheet printed on 06/05/2025, showed that Resident 36 admitted to the facility on [DATE] with diagnoses that included gastroparesis (a condition where the stomach muscles do not work properly to move food through the stomach, which can lead to vomiting and trouble digesting food) and Type I diabetes mellitus (a chronic condition that affects blood sugar levels). Review of Resident 36's care plan, printed on 06/04/2025 showed, Special instruction: INFO [information]: Give smaller meals more frequently: 4-5 small meals a day versus 3 large meals. Small particle diet for Gastroparesis. Observations on 05/30/2025 at 8:54 AM, on 06/03/2025 at 9:13 AM and on 06/05/2025 at 8:39 AM showed Resident 36's main entrée portions were fully covering the surface of their plate [served with regular portions]. Observation and interview on 06/04/2025 at 12:41 PM, showed Resident 36 was eating their lunch. Resident 36's lunch entrée consisted of uncoated strips of white meat, unpeeled potato slices and a serving of mixed corn kernels, peas, carrots, and lima beans. It further showed that Resident 36 was slowly chewing their food in between bites. Resident 36 stated that they asked staff to turn off their wall-mounted fan, because it takes so long to chew that my food gets cold .then it's just tasteless. In an interview on 06/04/2025 at 1:19 PM, Staff M, Certified Nursing Assistant, stated that Resident 36 received three regular meals delivered from the kitchen. Staff M further stated that Resident 36 received regular portions, not smaller portions. A joint record review and interview on 06/04/2025 at 1:35 PM with Staff G, Registered Nurse, showed Resident 36's EHR had instructions to receive smaller meals. Staff G stated that Resident 36 did not receive small meal portions and that, They look regular to me. Review of Resident 36's EHR weight records printed on 06/05/2025, showed that Resident 36 weighed 184. 0 pounds (lbs. -unit of measurement) on 04/29/2025 and weighed 173.0 lbs. on 05/29/2025. It showed that Resident 36 had a significant weight loss in 30 days (more than five percent loss of body weight in one month). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/05/2025 at 1:05 PM, Staff N, Registered Dietician, stated that Resident 36 was supposed to have small frequent meals and that it was related to Resident 36's diagnosis of gastroparesis. Staff N further stated that Resident 36 has had a significant weight loss from 04/29/2025 through 05/29/2025 and that they would, have to see how [Resident 36] is eating. A joint of observation and interview on 06/05/2025 at 1:12 PM with Staff N, showed Resident 36's lunch tray had regular sized portions. Staff N stated, It looks like regular portions, and that the kitchen should have provided entrée portions using a smaller scoop. Staff N further stated that Resident 36 should have been receiving three small-portioned meals along with snacks in between meals. A joint record review and interview on 06/05/2025 at 1:27 PM with Staff H, Dietary Manager, did not show that Resident 36's meal slip, dated 06/05/2025, indicated small-portioned meals. Staff H stated that Resident 36 received regular serving portions. A joint record review and interview on 06/05/2025 at 4:09 PM with Staff B, Director of Nursing, showed Resident 36's nutritional care plan had instructions to receive smaller meals more frequently: 4-5 small meals a day versus 3 large meals. Small particle diet for Gastroparesis. Staff B stated that they expected nursing staff would follow those orders. In an interview on 06/06/2025 at 8:16 AM, Staff A, Administrator, stated that they considered Resident 36's diet of small-portioned meals to be a therapeutic diet and that they expected staff would follow the diet. Reference: (WAC): 388-97-1100(1) .

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	505416	A. Building B. Wing	06/06/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper storage and labeling of respiratory equipment, and document oxygen (O2) saturation (the amount of O2 in the blood) for 1 of 3 residents (Resident 98), reviewed for respiratory care. These failures placed the resident at risk for respiratory infection, related complications, and a diminished quality of life. Findings Included . Review of the facility's undated policy titled, Oxygen Administration, showed that during O2 setup or adjustment, staff were instructed to check the mask, tank, humidifying (that increase humidity/moisture in the air) jar [container], to ensure they were in good working order and securely fastened. The policy further instructed staff to document the date and time the setup was performed. Review of a face sheet printed on 06/05/2025 showed Resident 98 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a progressive lung disease that makes it difficult to breathe) and acute hypoxic respiratory failure (a condition characterized by low levels of O2 in the blood). Review of Resident 98's May 2025 Medication Administration Record (MAR), printed on 06/03/2025 showed an order for two liters (unit of measurement) of O2 continuously at night, off during the day, and use of Bilevel Positive Airway Pressure (BIPAP- a device that helps people with breathing difficulties) at night. Review of Resident 98's physician order dated 01/02/2025, showed instructions for staff to check Resident 98's O2 saturation each shift and to notify the provider [medical team] if the saturation fell to 90 percent or lower. Review of the May 2025 MAR printed on 06/05/2025 did not show documentation of Resident 98's O2 saturation during night shift on the following dates: 04/03/2025, 05/02/2025, 05/19/2025, 05/20/2025, 05/24/2025, 05/25/2025 and 05/29/2025. Observations of Resident 98's O2 equipment on the following dates showed: - On 05/29/2025 at 10:37 AM, the O2 humidifier bottle was not dated. The BiPAP tubing nose piece was observed laying on the nightstand table and was not properly stored. - On 05/30/2025 at 9:22 AM, the O2 humidifier bottle was not dated. - On 05/30/2025 at 2:31 PM, the humidifier bottle was not dated and the BiPAP tubing nose piece was not properly stored. - On 06/02/2025 at 10:59 AM, the O2 nasal cannula (a flexible tubing that delivers O2 through the nose) was observed laying on the floor, not properly stored. The humidifier bottle was unlabeled. (continued on next page)

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	505416	A. Building B. Wing	06/06/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A joint observation and interview on 06/02/2025 at 11:12 AM with Staff DD, Licensed Practical Nurse, showed Resident 98's nasal cannula tubing was not properly stored, it was laying on the floor. Staff DD stated that the tubing should not be laying on the floor and that it should be stored in a bag. Staff DD were observed picking it up and placed it on top of the O2 concentrator without properly cleaning and/or storing it. Staff DD was asked whether the O2 humidifier bottle was labeled, Staff DD stated, No, it should be [labelled]. A joint observation and interview on 06/04/2025 at 8:56 AM with Staff D, Register Nurse Unit Manager, showed that the nasal cannula was not properly stored, it was laying on the floor. Staff D stated, It's [it is] not supposed to be laying on the floor. In an interview on 06/06/2025 at 11:22 AM, Staff B, Director of Nursing, stated that it was their expectation that all O2 tubing and humidifier bottles should have been dated and initialed, and that O2 saturation have been documented per the physician's order. Staff B further stated that nasal cannula should be stored in a clear plastic bag when not in use. Reference: (WAC) 388-97-1060 (3)(j)(vi) .

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	505416	A. Building B. Wing	06/06/2025

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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 and posted with actual hours worked after the start of each shift for 7 of 7 days (05/29/2025, 05/30/2025, 06/02/2025, 06/03/2025, 06/04/2025, 06/05/2025 & 06/06/2025), reviewed for sufficient and competent staffing. This failure placed the residents and their representatives at risk of not being fully informed of current staffing levels, potentially affecting their understanding of staff availability and care delivery. Findings Included . Review of the facility's policy titled, Posting Nursing Staffing Policy, dated 10/06/2022, showed the facility was required to post the daily nurse staffing information in a prominent location accessible to residents and visitors. The policy further showed the posting must include the facility name, current date, resident census, total number and actual hours worked by staff, and reflect staff absences due to callouts and illness for each shift. Observation on 05/29/2025 at 2:42 PM, showed a posted staffing form outside the elevator on the wall of the 400 hallways. The form showed shift times as follows: - Day shift: 6:00 AM to 2:30 PM - Evening shift: 2:00 PM to 10:30 PM - Night shift: 10:00 PM to 6:30 AM Multiple observations of the posted daily staffing form showed the planned actual hours, and it did not show the actual hours worked on the following dates and times: - On 05/29/2025 at 2:42 PM - On 05/30/2025 at 1:28 PM - On 06/02/2025 at 3:02 PM - On 06/03/2025 at 11:13 AM - On 06/04/2025 at 2:06 PM - On 06/05/2025 at 1:02 PM - On 06/06/2025 at 8:23 AM (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 06/06/2025 at 9:54 AM, Staff EE, Staffing Coordinator, stated that total actual hours were updated in real time by the front desk secretary as staff clocked in. A joint record review of the posted daily staffing forms dated 05/29/2025, 05/30/2025, 06/02/2025, 06/03/2025, 06/04/2025, 06/05/2025 & 06/06/2025 did not show the actual hours worked. Staff EE stated that planned hours, callouts, and illness were documented in the schedule book and were not shown on the posted staffing form. In an interview and joint record review on 06/06/2025 at 11:02 AM, Staff B, Director of Nursing, stated that it was their expectation that the total number and actual hours worked by licensed and unlicensed nursing staff would be posted for each shift A joint record review of the posted daily staffing forms dated 05/29/2025, 05/30/2025, 06/02/2025, 06/03/2025, 06/04/2025, 06/05/2025 & 06/06/2025 did not show the actual hours worked. Staff B stated the posted daily nurse staffing form was missing a column showing actual hours worked and that it should have been included. In an interview on 06/06/2025 at 1:34 PM, Staff A, Administrator, stated that the posted daily nurse staffing form should have included both the total number and the actual hours worked per shift. Staff A further stated this information was not shown on the daily nurse staffing. No associated WAC .

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	505416	A. Building B. Wing	06/06/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure physician orders were followed and/or clarified in accordance with professional standards of practice for 3 of 9 residents (Residents 16, 321 & 219), reviewed for medication administration. This failure placed the residents at risk for receiving incorrect medication dosage and formulation, adverse side effects, and a diminished quality of life. Findings included . Review of the facility's undated policy titled, [Company name] Medication Administration Policy, showed, This policy establishes the guidelines for the safe and effective administration of medications . The policy further showed that the .right medication, right dose . must be confirmed . during medication administration. In addition, the policy showed, This policy ensures that medications are administered safely and effectively . maintaining compliance with regulatory standards and best practices. RESIDENT 16 Review of Resident 16's June 2025 physician orders showed, Calcium 600+D3 [cholecalciferol-type of Vitamin D-a supplement] Oral [by mouth] Tablet 600-10 MG [milligram-unit of measurement]-MCG [microgram-unit of measurement] (Calcium Carbonate [type of calcium]-Cholecalciferol-a supplement) one time a day, started on 03/03/2025. Observation on 06/05/2025 at 8:33 AM, showed Staff Z, Registered Nurse (RN), administered a Citracal + D Calcium citrate [brand name, type of calcium supplement] - Vitamin D3 315 MG-250 IU [international unit-unit of measurement] Tablet to Resident 16 instead of the prescribed order above. In an interview and joint record review on 06/05/2025 at 8:44 AM, Staff Z stated that they administered a tablet of Citracal + D Calcium citrate - Vitamin D3 315 MG-250 IU to Resident 16. Staff Z stated that the prescribed medication was the same as the medication they administered to Resident 16. A joint record review of Resident 16's physician order showed, Calcium 600+D3 Oral Tablet 600-10 MG-MCG (Calcium Carbonate-Cholecalciferol). A joint record review of the medication administered to Resident 16 showed, Citracal + D Calcium citrate - Vitamin D3 315 MG-250 IU Tablet. Further joint record review of the physician order and the medication administered showed the medications were two different types of calcium (carbonate and citrate). Staff Z stated that Resident 16 had received different dosages of calcium and Vitamin D3. Staff Z further stated that the order should have been clarified with the pharmacist (a person who is professionally qualified to prepare and dispense medicinal drugs). (continued on next page)

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	505416	A. Building B. Wing	06/06/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 06/05/2025 at 12:15 PM, Staff E, RN Unit Manager, stated that they expected staff to administer medications as prescribed by the physician. A joint record review of Resident 16's physician order showed Calcium 600+D3 Oral Tablet 600-10 MG-MCG (Calcium Carbonate-Cholecalciferol). Staff E was shown an empty packet of the medication administered to Resident 16. A joint record review of the medication administered to Resident 16 showed Citracal + D Calcium citrate - Vitamin D3 315 MG-250 IU Tablet. Further joint record review of the physician order and the medication administered showed the medications were two different types/dosages of calcium (carbonate and citrate) and Vitamin D. RESIDENT 321 Review of Resident 321's June 2025 physician order showed, Calcium Carbonate-Vitamin D Oral Tablet 600-5 MG-MCG (Calcium Carbonate-Vitamin D) one tablet by mouth two times a day for bone health, started on 05/19/2025. A joint record review and interview on 06/05/2025 at 9:39 AM with Staff AA, Licensed Practical Nurse, showed Resident 321's June 2025 electronic Medication Administration Record (e-MAR) had orders for Calcium Carbonate-Vitamin D Oral Tablet 600-5 MG-MCG (Calcium Carbonate-Vitamin D). Staff AA stated that they had administered Resident 321 with the above prescribed order in the morning. When asked to show a sample of the medication administered to Resident 321, Staff AA pulled out a Caltrate [brand name] + D Calcium Carbonate-Vitamin D3 600 MG (1,500 MG)-400 IU from Resident 321's medication bin, and stated, this is what [they] received. A joint record review of Resident 321's physician order and the medication they had indicated they were not the same dosage. Staff AA stated that they should have clarified the order with the physician and the pharmacist. RESIDENT 219 Review of Resident 219's June 2025 physician order showed, Calcium Carbonate-Vitamin D Oral Tablet 600-5 MG-MCG (Calcium Carbonate-Vitamin D) two tablets by mouth two times a day for bone health, started on 05/13/2025. A joint record review and interview on 06/05/2025 at 9:39 AM with Staff AA, showed Resident 219's June 2025 e-MAR had orders for Calcium Carbonate-Vitamin D Oral Tablet 600-5 MG-MCG (Calcium Carbonate-Vitamin D). Staff AA stated that they had administered Resident 219 with the above prescribed order in the morning. When asked to show a sample of the medication administered to Resident 219, Staff AA pulled out a Caltrate + D Calcium Carbonate-Vitamin D3 600 MG (1,500 MG)-400 IU from Resident 219's medication bin, and stated, this is what I gave [them]. A joint record review of Resident 219's physician order and the medication they had were not the same dosage. Staff AA stated that they should have clarified the order with the physician and the pharmacist. A joint record review and interview on 06/05/2025 at 12:35 PM with Staff E, showed Resident 321 and Resident 219's had physician order of Calcium Carbonate-Vitamin D Oral Tablet 600-5 MG-MCG. A joint record review with Staff AA and Staff E showed the sample of the medication administered to Resident 321 and Resident 219 had different dosages of Vitamin D than what was prescribed by the physician. Staff E stated that they expected staff to have clarified the residents' medications with the physician and the pharmacist. (continued on next page)

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	06/06/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint records review on 06/05/2025 at 12:59 PM, Staff X, Consultant Pharmacist, stated that their pharmacy was in-house and they packaged and dispensed medications prescribed by the physician. Staff X was shown the medications administered to Resident 16, Resident 321 and Resident 219. Staff X stated that the medications were dispensed by their pharmacy. A joint record review of the physician orders and the medications dispensed by the pharmacy showed Resident 16, Resident 321 and Resident 219 received medications with different dosages of calcium and Vitamin D3 than what was prescribed by their physician. Staff X stated that the medication orders should have been clarified with the physician prior to dispensing. In an interview on 06/05/2025 at 1:30 PM, Staff B, Director of Nursing, stated that they expected staff to have clarified Resident 16, Resident 321 and Resident 219's medications with their physician. Staff B further stated that they expected the pharmacist to have dispensed medications as prescribed by their physician. Reference: (WAC) 388-97-1300(1)(b)(ii) .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** RESIDENT 1 Review of a face sheet printed on 06/05/2025, showed Resident 1 readmitted to the facility on [DATE]. Review of Resident 1's facility provided document titled, Note to Attending Physician/Prescriber, dated 03/05/2025, showed a copy of the recommendation to Please consider ordering a new BMP [Basic Metabolic Panel- a blood test that measures the levels of different substances in your blood]. Most BUN [Blood Urea Nitrogen-a blood test to measure kidneys [organs responsible for filtering blood, regulating fluid balance and waste management through urine production function] lab [laboratory] shows it abnormally high . It further showed that the Physician/Prescriber Response was not completed. In an interview and joint record review on 06/06/2025 at 1:11 PM, Staff B stated that the Registered Nurse Unit Managers (RNUM) managed the medication regimen review recommendations provided by the pharmacist consultant. Staff B stated that when they received the recommendation from the pharmacist, they would be given to the RNUM to review and those requiring to be reviewed/completed by the physician would be provided to them. When the physician was done reviewing/completing the recommendation, they would be given back to the RNUM to follow up on. Staff B stated that it would then be given to medical records to be scanned into the residents' EHR. A joint record review of Resident 1's Note to Attending Physician/Prescriber dated 03/05/2025, showed that it was not completed by the physician. Staff B stated that they expected that the physician would complete the pharmacist consultant recommendation form and that the form would be given to medical records to get scanned into the resident's EHR. Reference: (WAC) 388-98-1300 (4)(c) Based on interview and record review, the facility failed to ensure Medication Regimen Reviews (MRR) were consistently completed for 3 of 5 residents (Resident 6, 90 & 1), reviewed for unnecessary medications. This failure placed the residents at risk of receiving unnecessary medications and a diminished quality of life. Findings included . Review of the facility policy titled, Medication Regimen Review [MRR-a comprehensive assessment of a patient's medications, performed by a pharmacist to identify and address potential problems], revised on 06/06/2025, showed that the Consultant Pharmacist [a person who is professionally qualified to provide expert advice on medication management, safety, and regulatory compliance to various healthcare settings] will perform an MRR for every resident in the facility. It further showed that routine reviews will be done monthly. RESIDENT 6 Review of a face sheet printed on 06/05/2025, showed that Resident 6 readmitted to the facility on [DATE]. (continued on next page)

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	505416	A. Building B. Wing	06/06/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of physician orders, printed on 06/05/2025, showed that Resident 6 had prescribed medications. Review of the facility's MRR binder for the year 2025 did not show documentation of Resident 6's MRR for the months of March and April of 2025. Review of Resident 6's Electronic Health Record (EHR) did not show documentation of completed MRRs for the months of March and April 2025. On 06/03/2025 at 8:19 AM and on 06/04/2025 at 9:44 AM written requests were submitted to Staff A, Administrator, for additional documentation of completed MRRs, including MRRs for Resident 6. Review of additional requested MRRs on 06/04/2025 at 2:04 PM, did not show documentation of completed MRRs for Resident 6 for the months of March and April 2025. RESIDENT 90 Review of a face sheet printed on 06/05/2025, showed that Resident 90 was admitted to the facility on [DATE]. Review of physician orders, printed on 06/03/2025, showed that Resident 90 had prescribed medications. Review of the facility's MRR binder for year 2025 did not show documentation of Resident 90s MRR for the months of March and April of 2025. Review of Resident 90's EHR did not show documentation of completed MRRs for the months of March and April 2025. On 06/03/2025 at 8:19 AM and on 06/04/2025 at 9:44 AM written requests were submitted to Staff A for additional documentation of completed MRRs, including MRRs for Resident 90. In an interview on 06/06/2025 at 8:12 AM, Staff A stated that they had provided all MRRs available as was requested. Staff A further stated that they expected MRRs would be completed monthly as per the facility's policy. In an interview on 06/06/2025 at 11:55 AM, Staff B, Director of Nursing, stated that they expected MRRs would be completed monthly, and that documentation would be available in the residents' EHR.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 300 UNIT MEDICATION STORAGE ROOM A joint observation and interview on 06/05/2025 at 9:09 AM with Staff D, RNUM, showed the following expired medical supplies: -Four unopened safety scalpels with an expiration date of 09/30/2023. -Two unopened disposable dermal (skin) curette (medical instrument used to scrape or remove unwanted tissue/skin) with an expiration date of 03/01/2023. -One unopened Bard-[NAME] (brand) scalpel with an expiration date of 07/31/2022. Staff D stated that they were expired and that they should have been discarded. Staff D stated that the Unit Managers checked the medication storage rooms and that the staff that used the medical supplies should have checked the five rights, which included to check for expiration date. In an interview on 06/06/2025 at 1:18 PM, Staff B stated that they expected expired medical supplies to be disposed of. Staff B further stated that they expected the medication room to be checked at least once a month and to dispose/discard expired medications/medical supplies. 500 UNIT MEDICATION ROOM REFRIGERATOR TEMPERATURE LOG A joint record review and interview on 06/05/2025 at 8:39 AM with Staff E, showed that the 500-unit medication room Quarterly Daily Refrigerator Temperature Record, dated May 2025 showed three days of missing entries and the June 2025 Refrigerator Temperature Record had two days of missing entries. Staff E stated that staff should have been checking the temperature of the medication room refrigerator daily. In an interview on 06/06/2025 at 1:18 PM, Staff B stated that staff should have checked the temperature of the 500-unit medication room refrigerator daily. Reference: (WAC) 388-97-1300(2) Based on observation, interview, and record review, the facility failed to appropriately label medication and ensure expired medications, laboratory/medical supplies and biologicals (diverse group of medicines made from natural sources) were disposed of timely in accordance with current accepted professional standards for 3 of 4 medication carts (200 unit, 600 unit & 400 unit) and for 1 of 3 medication rooms (300 unit), and failed to ensure refrigerator temperatures were monitored for 1 of 3 medication room refrigerators (500 unit), reviewed for medication storage and labeling. These failures placed the residents at risk for receiving compromised and ineffective medications and medical supplies, possible infections, and adverse consequences. Findings included . (continued on next page)

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	505416	A. Building B. Wing	06/06/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's undated policy titled, Medication Storage, showed, The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The policy further showed, The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. 200 UNIT MEDICATION CART During a joint observation and interview on 06/05/2025 at 9:48 AM, with Staff AA, Licensed Practical Nurse (LPN), showed the following items: -One undated opened Neomycin (brand name-antibiotic [medication to treat infection]) eye ointment, -One bottle of Milk of Magnesia (brand name-laxative [medication to soften stools]) with an expiration date of 03/2025 (March 2025), -One container of Hemoccult Sensa Developer (brand name- rapid test to check for blood in the stool) with an expiration date of 2023-06 (June 2023), -Five individually packed Sani-cloth (brand name) bleach germicidal (substance that kills germs or inhibit their growth) disposable wipes with expiration dates of 2021/05 (May 2021), - Four Bisacodyl (brand name-laxative) rectal (anus) suppositories (medication administered through the anus) with expiration dates of 01/2025 (January 2025), and -One tube of silver collagen wound gel (for wound healing) with an expiration date of 04/2025 (April 2025). Staff AA stated that they were expected to discard expired medications and medical supplies and that they should have done so. 600 UNIT MEDICATION CART During a joint observation and interview on 06/05/2025 at 10:48 AM, with Staff L, LPN, showed one unopened bottle of Nitroglycerin (brand name-drugs to treat chest pain) tablet with an expiration date of 03/2025 (March 2025). Staff L stated, it [Nitroglycerin bottle] should have been discarded or returned to the pharmacy. 400 UNIT MEDICATION CART During a joint observation and interview on 06/05/2025 at 11:46 AM, with Staff J, Registered Nurse (RN), showed three Bisacodyl rectal suppositories with expiration dates of 01/2025 (January 2025). Staff J stated that they should have discarded the expired suppositories. In an interview on 06/05/2025 at 12:04 PM, Staff E, RN Unit Manager (RNUM), stated that staff were expected to label and date when they first opened a medication. Staff E stated that medication and/or medical supplies with expired dates were either returned to the pharmacy or discarded. Staff E stated that they expected staff to have labeled/dated medication when they first opened it and that expired medications and/or medical supplies had been discarded or returned to the pharmacy. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/05/2025 at 1:41 PM, Staff B, Director of Nursing, stated that they expected staff to label/date opened medication and discard expired medications and/or medical supplies.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure dental services were offered and/or provided for 1 of 1 resident (Resident 36), reviewed for dental services. This failure placed the resident at risk for unmet dental care needs and a diminished quality of life. Findings included . Review of the facility's policy titled, Dental Services, dated 10/01/2021, showed that Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. It further showed that routine dental services were provided through a referral to community dentists (tooth doctor), to the resident's personal dentist, referral to community dentists and/or referral to other health care organizations that provide dental services. Review of a face sheet printed on 06/05/2025, showed that Resident 36 admitted to the facility on [DATE]. In a phone interview on 05/29/2025 at 2:30 PM, Resident 36's representative stated that Resident 36 had a broken a tooth, and that they notified facility staff of it. Resident 36's representative further stated that they had not received an update regarding Resident 36 receiving dental services. An observation and interview on 06/04/2025 at 12:41 PM, showed Resident 36 was lying in bed and eating their meal. Resident 36's lunch entrée consisted of uncoated strips of white meat, unpeeled potato slices and a serving of mixed corn kernels, peas, carrots, and lima beans. It further showed Resident 36 was slowly chewing in between bites of their meal. Resident 36 stated that they asked staff to turn off their wall-mounted fan, because it takes so long to chew that my food gets cold .then it's just tasteless. In an interview on 06/05/2025 at 8:49 AM, Staff F, Social Services, stated that, I was not informed of the broken tooth in the [nursing] progress note on 05/10/2025. When asked if Resident 36 had been referred to dental services, Staff F stated that they would confirm and refer to the list of residents who were referred to the in-house dental hygienist (a health professional who specializes in preventative dental care). Review of a nursing progress note dated 05/10/2025 showed it was labeled as a late entry, and that Resident 36's representative had notified staff in-person regarding Resident 36's broken tooth. It did not show that Resident 36 was referred to dental services regarding the broken tooth. In an interview on 06/05/2025 at 10:42 AM with Staff G, Registered Nurse (RN) and Staff D, RN Unit Manager, Staff G stated that they were aware of Resident 36's broken tooth. Both Staff G and Staff D stated that Resident 36 had not been referred to dental services and that, because it's [it is] not bothering [Resident 36]. Both Staff G and Staff D stated, Yes, when asked if residents would be referred to dental services for preventative dental care. Both Staff G and Staff D further stated that they considered an assessment for a broken tooth as preventative care. (continued on next page)

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	505416	A. Building B. Wing	06/06/2025

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a follow up interview on 06/05/2025 at 11:53 AM, Staff D stated that Resident 36 had not been referred to dental services for their broken tooth and that Resident 36 should have been referred. In a follow up interview on 06/05/2025 at 12:01 PM, Staff F stated that they were unable to locate documentation indicating that Resident 36 had been referred to dental services related to the broken tooth. In an interview on 06/05/2025 at 4:06 PM, Staff B, Director of Nursing, stated that they expected a resident with a known broken tooth, would be referred to dental services and that Resident 36 should have been referred. Reference (WAC): 388-97-1060 (3)(vii) .

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	505416	A. Building B. Wing	06/06/2025

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure meal preferences were provided for 2 of 7 residents (Residents 35 & 10), reviewed for food preferences. This failure placed the residents at risk of not having their food choices honored, dissatisfaction with food served, and a diminished quality of life. Findings included . RESIDENT 35 Review of the annual Minimum Data Set (MDS-an assessment tool) dated 05/07/2025 showed Resident 35 had an intact cognition. In an interview on 05/29/2025 at 10:39 AM, Resident 35 stated that they were provided with a menu selection for their breakfast, lunch and dinner. Resident 35 stated that they would cross out the food items they did not want and circled or wrote down the ones they preferred to have. Resident 35 stated, I don't [do not] like the menu selection. Resident 35 further stated that the kitchen staff don't [do not] pay attention to what you like. Review of the lunch menu for 06/03/2025 at 10:32 AM, showed, Marinated [seasoned] chicken or glazed [coated with sweet ingredients and spices] ham, mashed potatoes, carrots, angel food cake [sponge cake with cream]. An observation and interview on 06/03/2025 at 12:05 PM, Resident 35's lunch meal tray showed a marinated chicken thigh, mashed potatoes, carrots, angel food cake, two cups of ice cream and two cups of hot chocolate. Resident 35 stated, Look, they gave me what I have crossed out [marinated chicken or the glazed ham, mashed potatoes and carrots]. They did not follow the menu and that they were annoyed. Resident 35 further stated that they did not like the marinated chicken or the glazed ham, mashed potatoes, and carrots. A joint record review and interview on 06/03/2025 at 12:11 PM, with Staff K, Certified Nursing Assistant, showed Resident 35's lunch menu selection ticket had crossed out the following: marinated chicken or glazed ham, mashed potatoes and carrots. Staff K stated that they were aware that Resident 35 had crossed out the food items on their lunch menu selection ticket. Staff K stated that they delivered Resident 35's lunch meal tray, which the kitchen staff had prepared and included the food items Resident 35 had crossed out. Staff K further stated that Resident 35's menu choices or preferences were not followed and that they should have done so. A joint record review and interview on 06/03/2025 at 12:15 PM, with Staff L, Licensed Practical Nurse, showed Resident 35's lunch menu selection ticket had crossed out the following: marinated chicken or glazed ham, mashed potatoes and carrots. Staff L stated that they expected staff to have followed Resident 35's meal choices and/or preferences before they provided Resident 35's meal tray. In an interview on 06/03/2025 at 12:18 PM, Staff D, Registered Nurse [RN] Unit Manager (RNUM), stated that they expected staff to have followed Resident 35's meal choices and/or preferences. (continued on next page)

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	505416	A. Building B. Wing	06/06/2025

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RESIDENT 10 Review of a quarterly MDS dated [DATE] showed Resident 10 had intact cognition. In an interview on 05/30/2025 at 10:37 AM, Resident 10 stated, I don't [do not] get my menu sometimes, and sometimes the food was not appetizing. In an interview on 06/03/2025 at 8:49 AM, Resident 10 stated they had pizza for dinner and that they did not like the way it was served. Observation and interview on 06/04/2025 at 12:22 PM showed Resident 10 had a sandwich wrapped in transparent plastic on a plate and a can of root beer on their bedside table. Resident 10 were not in their room. Another observation at 12:58 PM showed an uneaten tuna sandwich without dressing or condiments with half of its bread flap open on Resident 10's bedside table. Resident 10 were not in their room; they were observed on the phone at the unit nursing station. Staff J, RN, was observed outside of Resident 10's room. Staff J stated that Resident 10 had told the kitchen staff that they did not get the sandwich they had asked for and was upset about their tuna sandwich. Another observation and interview on 06/04/2025 at 1:09 PM, showed Resident 10 was teary-eyed. Resident 10 stated, I specifically asked them for tuna salad sandwich with celery and green onions chopped up with mayonnaise mixed with tuna on a good bread. Resident 10 further stated that they called the kitchen and spoke to a staff. A joint observation and interview on 06/04/2025 at 1:16 PM, Staff H, Dietary Manager, delivered Resident 10 a tuna salad sandwich on a plate covered with a transparent wrap. Resident 10 stated, It [tuna sandwich] should have been like this. Staff H stated that they prepared the tuna salad sandwich themselves. When Staff H was shown the tuna sandwich that was delivered earlier, Staff H stated, It should [not have] been prepared like that and that Resident 10's menu choice and/or preference should have been followed. Another interview on 06/04/2025 at 1:31 PM, Staff J stated that residents had the daily menu in the morning and they choose the menu for lunch and dinner. Staff J stated that Resident 10 did not get the meal they had chosen, and it was not the first time it had happened, and that Resident 10 had spoken about it during the food committee [meeting]. In an interview on 06/04/2025 at 2:27 PM, Staff E, RNUM, stated that they expected residents' meal choices and/or preferences to be honored and followed by the facility. Staff E stated that Resident 10's meal choices and preferences should have been followed by staff. In an interview on 06/04/2025 at 2:47 PM, Staff B, Director of Nursing, stated, I expected staff to honor or follow residents' choices and preferences about their meals. Reference: (WAC) 388-97-1120 (3)(a) .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure foods were handled appropriately in accordance with professional standards of food safety for 1 of 1 dry storage room (Kitchen Dry Storage Room), 3 of 4 refrigerators (Kitchen Cooler A Refrigerator, Kitchen Cooler H Refrigerator and Kitchen Cooler D Refrigerator), 1 of 1 seasoning shelf (Kitchen Seasoning Shelf) and 5 of 6 dining room refrigerators (500 unit, 300 unit, 100 unit, 600 unit & 700 unit), reviewed for food services. The failure to date and discard expired food items and/or before use by date, placed the residents at risk for food borne illness (caused by the ingestion of contaminated food or beverages), cross contamination, and a diminished quality of life. Findings included . Review of the facility's policy titled, Receiving and Storage of Food, dated 10/01/2021, showed, Foods shall be received and stored in a manner that complies with safe food handling practices. The policy showed, All foods stored in the refrigerator or freezer will be covered, labeled and dated. The policy further showed that food items and snacks kept in the nursing units must be labeled with the resident's name, the item and the use by date. Review of the facility's policy titled, Date Marking for Food Safety, dated on 03/09/2023, showed, The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. The policy further showed, Prepared foods that are delivered to the nursing units shall be discarded within two hours, if not consumed. These items shall not be refrigerated as the time/temperature controls cannot be verified. KITCHEN DRY STORAGE ROOM A joint observation and interview on 05/29/2025 at 8:10 AM with Staff H, Dietary Manager, showed that eight loaves of white bread, 12 loaves of raisin bread, 13 loaves of wheat bread, eight loaves of sourdough bread, and eight hamburger buns had no expiration or use by date. Staff H stated that the bread and/or loaves of bread were taken out of the freezer. Staff H stated that their process required bread removed from the freezer to be dated and then placed in the refrigerator. Staff H further stated that the bread/loaves of bread had been removed from the freezer a few days ago and should have been labeled to monitor their use-by date or discarding timeline. KITCHEN REFERIGATORS COOLER A A joint observation and interview on 05/29/2025 at 8:22 AM with Staff H, showed the following: -one opened Dijon Mustard with a use-by date of 05/13/2025 -one opened jar of cherry filling with a use-by date of 05/19/2025. (continued on next page)

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	06/06/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-one opened jar of chicken base with no use by/expiration date. Further observation showed an opened date of 5/24 [05/24/2025]. -one opened jar beef base with no use by/expiration date. Further observation showed an opened date of 5/13 [05/13/2025]. -one opened jar of chopped garlic with no use by/expiration date. Further observation showed an opened date of 5/26 [05/26/2025]. Staff H stated that the Dijon Mustard and cherry filling should have been discarded. Staff H further stated that the chicken base, beef base and chopped garlic should have had a use-by date. COOLER H A joint observation and interview on 05/29/2025 at 8:35 AM with Staff H, showed two containers of half and half were opened on 5/27 [05/27/2025] and one almond milk was opened on 5/28 [05/28/2025]. Further observation showed that the food items did not have use-by dates. Staff H stated that the half and half and the almond milk should have been labeled with a use-by date. COOLER D A joint observation and interview on 05/29/2025 at 8:41 AM with Staff H, showed a container of cooked ham with a preparation date of 5/23 [05/23/2025]. Further observation showed the cooked ham did not have a use-by date. Staff H stated that it should have had a use-by date. KITCHEN SEASONING SHELF A joint observation and interview on 06/05/2025 at 9:18 AM with Staff H, showed one opened container of cinnamon, one opened container of whole thyme leaves, one opened container of herbs de [NAME], and one opened container of old bay with no opened and use-by dates. Further observation showed an opened container of ground coriander with use by date of 2/4 [02/04/2025]. Staff H stated that the cinnamon, whole thyme leaves, herbs de [NAME], and old bay should have had open and use-by dates. Staff H stated that ground coriander was expired and should have been discarded. DINING ROOM REFRIGATORS 500 UNIT DINNING ROOM REFRIGATOR A joint observation and interview on 06/05/2025 at 10:39 AM with Staff H, showed two opened jugs of milk, one opened carton of orange juice, and one opened carton of half and half with no opened/use by date. Staff H stated that the milk, orange juice, and half and half should have had opened and use-by dates. 300 UNIT DINING ROOM REFRIGATOR (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A joint observation and interview on 06/05/2025 at 10:49 AM with Staff H, showed one opened carton of half and half, one opened carton of soy milk, one opened jug of milk with no opened/use-by date. Staff H stated that the half and half, soy milk, and milk should have had opened and use-by dates. 100 UNIT DINING ROOM REFRIGATOR A joint observation and interview on 06/05/2025 at 10:55 AM with Staff H, showed one cranberry juice, opened on 05/28/2025, with a use-by date of 06/04/2025. Staff H stated that the opened cranberry juice was expired and should have been discarded. 600 UNIT DINING ROOM REFRIGATOR A joint observation and interview on 06/05/2025 at 12:54 PM with Staff H showed one opened jug of milk and one opened carton of half and half with no opened and use-by date. Further observation showed one opened carton of thickened apple juice labeled with open date of 05/20/2025 and it did not show a use by date. Staff H stated that the milk and half and half should have had an open and use-by date. Staff H stated that the thickened apple juice was expired and should have been discarded. 700 UNIT DINNING ROOM REFRIGATOR A joint observation and interview on 06/05/2025 at 12:57 PM with Staff H, showed that one opened carton of thickened lemon-flavored water, and one opened half and half did not have an opened and use by date. Further observation showed a sandwich, prepared on 5/30 [05/30/2025]. Staff H stated that the thickened lemon-flavored water, and half and half should have had an opened and use-by date. Staff H stated that the sandwich expired and should have been discarded. In an interview on 06/05/2025 at 2:02 PM, Staff A, Administrator, stated that they expected kitchen staff to check the food items regularly, to date when first opened, and discarded when expired/passed the use by date. Staff A further stated the food items that were undated/passed the use by date should have been dated and/or discarded. Reference: (WAC) 388-97-1100 (3) .

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	06/06/2025

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F 0838 Level of Harm - Potential for minimal 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. 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) was updated to include a contingency plan (to handle potential challenges or disruptions based on the findings from the facility assessment) and plans to maximize direct care staff recruitment and retention. This failure placed the residents at risk for unmet care needs. Findings included . Review of the facility's document titled, [Facility Name] Facility Assessment, updated on 04/25/2025, did not show documentation of the facility's contingency plan and plans to maximize direct care staff recruitment and retention. In an interview on 06/06/2025 at 10:59 AM, Staff A, Administrator stated that the facility's contingency plan and plans to maximize direct care staff recruitment and retention were not referenced in the facility assessment, updated on 04/25/2025. Staff A further stated that they would include them in the facility assessment. No associated WAC .

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	505416	A. Building B. Wing	06/06/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure clinical or medical records were complete and accurate for 1 of 3 residents (Resident 118), reviewed for resident records. The failure to document resident health condition (assessment and evaluation) placed the resident at risk for incomplete and inaccurate medical records and unmet care needs. Findings included . Review of a face sheet printed on [DATE] showed Resident 118 was admitted to the facility on [DATE]. Review of Resident 118's Minimum Data Set (an assessment tool) look up page showed a completed Death in Facility assessment dated [DATE]. Review of the [DATE] nursing progress notes printed on [DATE] did not show documentation about Resident 118's clinical status or condition on [DATE]. Review of vital signs (measurable overall health status that included blood pressure (BP), heart rate (HR) and breathing rate) data for Resident 118, showed that their BP, HR and breathing rate were last documented on [DATE]. Review of the Electronic Health Record (EHR) did not show documentation of Resident 118's clinical status on [DATE]. In an interview and joint record review on [DATE] at 12:43 PM, Staff AA, Licensed Practical Nurse, stated they were working on day shift on [DATE], and that they were assigned to Resident 118. A joint record review of the vital signs did not show documentation of Resident 118's BP, HR and breathing rate on [DATE] and [DATE]. A joint record review of Resident 118's nursing progress note showed the last documentation was dated [DATE] and had no documentation about Resident 118's clinical status on [DATE]. Staff AA stated there was no information for Resident 118's BP, HR and breathing rate on [DATE] and [DATE] and that the last nursing note was dated [DATE]. Staff AA stated that they did not write a progress note about Resident 118's clinical status on [DATE]. In a telephone interview on [DATE] at 2:17 PM, Resident 118's Collateral Contact (CC2) stated that Resident 118 went to the hospital on [DATE] for a planned diagnostic (the process of identifying illness, condition or injury) procedure and had a cardiac arrest (sudden loss of heart function) during the procedure. Resident 118's CC2 stated, They tried to do CPR [Cardio-Pulmonary Resuscitation-emergency lifesaving procedure] but [Resident 118] did not make it. [Resident 118] expired [died] on [DATE]th [[DATE]] at around 11:30 [AM] in the morning. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on [DATE] at 2:52 PM, Staff B, Director of Nursing, stated that Resident 118 was known to them and that Resident 118 went out for a medical appointment/planned procedure on [DATE] and did not die here [in the facility]. A joint record review of Resident 118's EHR did not show documentation about their medical appointment or planned procedure or Resident 118's clinical status on [DATE]. Staff B stated that there was no documentation about Resident 118 leaving the facility for the planned procedure or medical appointment. Staff B stated that there was no documentation about Resident 118's clinical status and/or about their death in their medical record. Staff B further stated, I expected that there should have been forms of documentation about [Resident 118]'s clinical status or their death. Reference: (WAC) 388-97-1720 (1)(a)(i)(ii)(4)(b)(i)(ii)(iii) .

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	505416	A. Building B. Wing	06/06/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Infection Prevention and Control Program (IPCP) policies and procedures were reviewed annually as required, failed to handle a urinary catheter (a semi-flexible tube inserted into the bladder to drain urine) drainage bag appropriately for 1 of 2 residents (Resident 1), and failed to disinfect/sanitize medical equipment between resident use for 1 of 2 staff (Staff I), reviewed for infection control. In addition, the facility failed to ensure 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 2 of 8 residents (Residents 77 & 219). These failures placed the residents, staff, and visitors at an increased risk of infection and related complications. Findings included . Review of the facility's policy titled, Infection Control Program, dated 10/24/2022, showed, Infection control policies, procedures, and protocols will be reviewed at least annually. Review of the facility's undated policy titled, Urinary Catheter Care, showed, Be sure the catheter tubing and drainage bag are kept off the floor. Review of the facility's policy titled, Enhanced Barrier Precautions (EBP) Policy, dated 03/28/2024, showed, The purpose of this policy is to outline the guidelines for implementing Enhanced Barrier Precautions (EBP) in order to reduce the transmission of multidrug-resistant organisms (MDROs) within our facility. EBP will be utilized in conjunction with standard precautions (infection prevention practices used to prevent the transmission of infectious disease) to provide targeted gown and glove use during high-contact resident care activities [use Personal Protective Equipment (PPE) when transferring, dressing, bathing/showering]. INFECTION CONTROL POLICY-ANNUAL REVIEW Review of the IPCP policies and procedures showed that they have not been reviewed at least annually. The following policies were last reviewed and/or dated below: -Infection Control Program-reviewed on 10/24/2022 In a telephone interview on 06/05/2025 at 2:40 PM, Staff W, Infection Preventionist, stated that they reviewed IPCP policies every six months to annually and that they talked about it in Quality Approvement and Performance Improvement (a data driven and proactive approach to quality improvement) meetings. Staff W was informed of the Infection Control Program policy dated 10/24/2022, Staff W stated that it should have been reviewed every six months to annually. In an interview and joint record review on 06/06/2025 at 1:26 PM, Staff B, Director of Nursing, stated that IPCP policies were reviewed quarterly and when there was a change. A joint record review of the Infection Control Program policy showed that it was dated 10/24/2022. When asked if the IPCP policies should be reviewed annually, Staff B stated, yes. (continued on next page)

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	505416	A. Building B. Wing	06/06/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 06/06/2025 at 2:20 PM, Staff A, Administrator, stated that they typically reviewed all IPCP policies annually. A joint record review of the Infection Control Program, policy showed that it was dated 10/24/2022 and it further showed, Infection control policies, procedures, and protocols will be reviewed at least annually. Staff A stated that they expected IPCP policies to be reviewed annually. URINARY CATHETER CARE RESIDENT 1 Review of the quarterly Minimum Data Set (an assessment tool) dated 04/29/2025 showed Resident 1 readmitted to the facility on [DATE] and had a diagnosis of obstructive uropathy (a condition where urine flow is blocked). It further showed that Resident 1 had an ostomy (surgery to create an opening from an area inside the body to the outside). Observation on 06/04/2025 at 12:33 PM, showed Resident 1 was lying in bed with their urinary catheter drainage bag touching the floor. At 12:42 PM, Staff Y, Certified Nursing Assistant (CNA), entered Resident 1's room, delivered their lunch tray and left the room. Resident 1's urinary catheter drainage bag remained touching the floor. In an interview and joint observation on 06/04/2025 at 1:00 PM, Staff Y stated that Resident 1's urinary catheter drainage bag should not have been on the floor and that sometimes I find it on the floor, and I have to hang it. Staff Y stated they did not know what happened. A joint observation showed Resident 1's urinary catheter drainage bag was touching the floor. Staff Y stated that it should not have been on the floor. In an interview on 06/06/2025 at 11:40 AM, Staff E, Registered Nurse [RN] Unit Manager (RNUM), stated that they expected staff to ensure urinary catheter drainage bags were not touching the floor and that It's [it is] an infection control issue. Staff E further stated that Resident 1's urinary catheter drainage bag should not have been on the floor. In an interview on 06/06/2025 at 1:07 PM, Staff B stated that they expected staff to ensure urinary catheter drainage bags were not touching the floor. Staff B further stated that Resident 1's urinary catheter drainage bag should not have been on the floor. DISINFECTING MEDICAL EQUIPMENT STAFF I Review of the facility's policy titled, Cleaning and Disinfecting Resident Care Items and Equipment, dated 10/01/2021, showed, Resident-care equipment, including reusable items and durable medical equipment [reusable medical devices] will be cleaned and disinfected according to current CDC [Centers for Disease Control] recommendations for disinfection . The policy further showed, Durable medical equipment (DME) must be cleaned and disinfected before reuse [reused] by another resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 06/04/2025 at 9:40 AM showed Staff I, CNA, took out the sit-to-stand lift (a medical device designed to assist individuals with limited mobility in transitioning from a seated position to a standing position) from Resident 67's room after Staff I assisted them in their wheelchair. Staff I did not clean or disinfect the sit-to-stand lift and moved it to Resident 9's room. Staff I then assisted Resident 9 to transfer them from bed to the toilet using the lift. At 10:13 AM, Staff I assisted Resident 9 to transfer to their wheelchair using the sit-to-stand lift. Staff I then moved the sit-to-stand lift and placed it alongside the unit hallway. Staff I proceeded to go outside unit and did not clean or disinfect the sit-to-stand lift. In an interview on 06/04/2025 at 10:25 AM, Staff I stated that they sanitized or disinfected the sit-to-stand lift after they used it. When asked if they had cleaned or disinfected the sit-to-stand lift between resident use, Staff I stated, Yes. I used the hand sanitizer and [the] paper towel. I also used the washcloth to sanitize it. Staff I showed a package labeled adult washcloth and stated, it [washcloth] has chemicals in there that can be used to clean, too. Staff I stated that they used the washcloth to wipe the handlebars of the sit-to-stand lift where [Resident 67 and Resident 9] placed their hands. When asked if they cleaned and disinfected the other parts of the lift equipment, Staff I stated, No, I only sanitized or wiped the handle. In an interview on 06/04/2025 at 11:43 AM, Staff J, RN, stated that staff were expected to clean and disinfect medical equipment after resident use. Staff J stated that they used the Microdot Minute [brand name] wipes (disinfectant wipes). Staff J further stated that this [microdot minute wipes] should have been used to clean and disinfect [the sit-to-stand lift]. USE OF PPE RESIDENT 77 An observation on 05/30/2025 at 10:56 AM, showed Staff FF, CNA, was in Resident 77's room (an EBP room) with Staff GG, Student Aide, they transferred Resident 77 to their wheelchair. Further observation showed Staff FF and Staff GG were not wearing gowns and gloves when assisting Resident 77 to their wheelchair. In an interview and joint record review on 05/30/2025 at 11:19 AM, Staff FF stated that Resident 77 was on EBP due to urinary catheter use. A joint record review of the EBP signage posted outside Resident 77's room showed, Wear gloves and a gown for the following high-contact Resident Care activities .transferring. When asked if they were wearing gloves and gown when transferring Resident 77 to their wheelchair, Staff FF stated, No. Staff FF further stated that they should have worn their gloves and gown when transferring Resident 77 to their wheelchair. In an interview on 06/02/2025 at 11:20 AM, Staff J stated that staff were expected to wear the required PPE when providing care with residents on EBP. Staff J stated that Staff FF should have worn their gloves and gown when they transferred Resident 77 to their wheelchair. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/04/2025 at 2:11 PM, Staff E stated that they expected staff to follow EBP and PPE guidelines and to clean and disinfect residents' equipment between residents' use. Staff E stated that they used Sani-cloth [brand name] disinfectant wipes and Microdot Minute wipes to sanitize or disinfect residents' equipment. Staff E stated that Staff FF should have worn proper PPE when transferring residents on EBP and that Staff I should have used the proper disinfectant for the sit-to-stand lift between resident use. In an interview on 06/04/2025 at 2:34 PM, Staff B stated that they expected staff to follow PPE guidelines for residents on EBP and to use proper disinfectants to clean, sanitize and disinfect residents' equipment between use. RESIDENT 219 Observations on 05/29/2025 at 8:53 AM and at 1:15 PM, showed that an EBP signage was posted outside Resident 219's Room (room [ROOM NUMBER]). Observation and interview on 05/29/2025 at 1:31 PM, showed Staff BB, CNA, transferred Resident 219 from their wheelchair to their bed without using gown and gloves. When Staff BB was done assisting Resident 219, they left the room without performing hand hygiene. Staff BB stated that they did not use PPE during the transfer and that they should have. Staff BB stated that they did not perform hand hygiene before and after they transferred the resident. Staff BB further stated that they forgot that Resident 219 was on EBP. In an interview on 06/04/2025 at 12:34 PM, Staff AA, Licensed Practical Nurse, stated that they expected staff to appropriately use PPE during resident care. Staff AA further stated that Staff BB should have followed the EBP procedure. In an interview on 06/04/2025 at 1:36 PM, Staff B stated that staff assisting residents in EBP rooms must follow the instructions displayed on the EBP signage. Staff B stated that Staff BB should have adhered to the EBP protocol and wore the required PPE. Staff B further stated that Staff BB should have performed hand hygiene. Reference: (WAC) 388-97-1320 (1)(a)(c) (5)(c) .

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	505416	A. Building B. Wing	06/06/2025

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the pneumococcal vaccine (used to prevent pneumonia [a lung infection]) and influenza vaccine (used to prevent influenza [an infection of the nose, throat, and lungs]) were offered for 1 of 5 residents (Resident 54), reviewed for immunizations and infection control. This failure placed the residents at risk of acquiring, transmitting, and/or experiencing potentially avoidable complications from pneumococcal and influenza disease. Findings included . Review of the facility's undated policy titled, Pneumococcal Vaccine, showed, Residents will be offered pneumococcal vaccine to aid in preventing pneumonia/pneumococcal infection. It further showed, Re-vaccinations of the pneumococcal vaccine will be administered to those residents who are deemed appropriate by the physician. Review of the facility's policy titled, Influenza Vaccine, dated 08/10/2023, showed, All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. It further showed, Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated or the resident or employee has already been immunized. Review of a face sheet printed on 06/05/2025 showed Resident 54 admitted to the facility on [DATE]. Review of Resident 54's immunization record printed on 06/06/2025 showed that they received an influenza vaccine on 11/14/2023 and Pneumovax [pneumococcal vaccine] Dose 2 on 04/08/2020. Further review did not show that Resident 54 received the annual influenza vaccine and the most current pneumococcal vaccine. Review of the Electronic Health Record (EHR) showed no documentation that Resident 54 was offered the annual influenza vaccine, pneumococcal vaccine or was informed about the risks and benefits. In a telephone interview on 06/05/2025 at 2:40 PM, Staff W, Infection Preventionist, stated that they had access to the state immunization database and would go there to check if residents' were up to date on their vaccinations. Staff W stated that on admission, they would offer the influenza and pneumococcal vaccine and if they refused, they would explain the risk and benefits and would document it. If the resident accepted the vaccination, they would give the consent form to the pharmacist (a person who is professionally qualified to prepare and dispense medicinal drugs) who would administer the vaccine. (continued on next page)

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	505416	A. Building B. Wing	06/06/2025

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 06/06/2025 at 11:17 AM, Staff E, Registered Nurse Unit Manager, stated that they offered the influenza vaccine annually. A joint record review of Resident 54's immunization record did not show documentation that they received the annual influenza vaccine and that they received the Pneumovax Dose 2 on 04/08/2020. Staff E stated there was no documentation that the vaccines were given unless he refused and that it would have been documented in their EHR or it wound be documented in the vaccination consent form. Staff E stated that they were not able to find documentation that Resident 54 received the first dose of the pneumococcal vaccine or documentation that they had refused it. Staff E further stated they would ask the pharmacy as they usually had residents' vaccination records. Review of Resident 54's WA IIS [Washington State Immunization Information System]-Patient Vaccination record dated 06/05/2025, showed that they were Past Due for pneumococcal and influenza vaccine. In an interview and joint record review on 06/06/2025 at 11:59 AM, Staff X, Consultant Pharmacist, stated nursing staff would provide them with the consent form for the vaccine and that they would administer it. If residents' refused, they would document it. Staff X stated that they did not have a record that they had administered the annual influenza vaccine to Resident 54 and that they may not have gotten a consent form to administer the vaccine. A joint record review of Resident 54's immunization record showed that Resident 54 received Pneumovax Dose 2 on 04/08/2020. Staff X stated that Resident 54 was eligible for the Prevnar 20 (a vaccine that protects against 20 strains of bacteria that cause pneumococcal disease) and based on the information they had, they would recommend that for Resident 54. In an interview on 06/06/2025 at 1:54 PM, Staff B, Director of Nursing, stated that they offered the influenza vaccine annually and that pneumococcal vaccines offered to residents' depended on what the pharmacy recommended and what vaccine they needed. Staff B stated that Staff W ensured residents' were up to date on their vaccines and if they were not, they would be offered the vaccine. Staff B stated that they did not see the annual influenza vaccine record for Resident 54 and that it should have been offered to them. Staff B further stated that Resident 54 should have been offered the recommended pneumococcal vaccine. Reference: (WAC) 388-97-1340 (1)(2) .