STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505431	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bothell Health Care	707 - 228th Southwest Bothell, WA 98021

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to provide supervision of two staff assistance and use of a mechanical lift (Hoyer) device to prevent an avoidable accident during a transfer for 1 of 3 residents (Resident 1), reviewed for accident hazards. Resident 1 experienced harm when they had an assisted fall while being transferred by one staff person without the use of the care planned Hoyer lift device, sustained a broken distal fibula (calf bone), and required transfer to the emergency room. This failure placed residents that require mechanical lift transfer or two staff extensive assistance at risk for injury, adverse outcomes, functional decline, and diminished quality of life. Findings included.Review of the facility's policy titled, Accidents and Supervision, revised in December 2025, showed Each resident will receive adequate supervision and assistive devices to prevent accidents.Review of the facility's policy titled, Comprehensive Care Plans, revised in December 2025, showed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.Review of the facility's undated investigation report showed that Resident 1 had a witnessed assisted fall in the shower room on 04/16/2026. Further review showed that the physician was notified of the radiology results and that they gave an order to transfer [Resident 1] to the emergency room for further evaluation and treatment.Review of the facility's radiology report dated 04/16/2026, showed that Resident 1 had an acute fracture involving right distal fibula [calf bone].Review of hospital records, showed a radiology report dated 04/16/2026, which revealed that Resident 1 had a displaced fracture of the distal fibular shaft [calf bone]. Further review of a hospital progress note dated 04/17/2026, showed that Resident 1 was placed in a three-way splint [a method for immobilizing ankle injuries while allowing for swelling].Review of Resident 1's admission Minimum Data Set (an assessment tool), dated 04/01/2026, showed that Resident 1 had a fall in the last month prior to admission.Review of Resident 1's Activities of Daily Living (ADL) care plan, printed on 04/30/2026, showed that it was revised on 04/17/2026 and that Resident 1 required a Hoyer (a mechanical lift for mobility support) transfer with two-person assistance due to a right ankle fracture. Review of the ADL care plan history, initiated on 03/26/2026, showed Resident 1's ADL care plan, revealed that Resident 1 required a Hoyer lift for transfers.Review of the therapy care guide, dated 03/27/2026, showed that Resident 1 required a mechanical lift and two-person extensive assistance for transfers.Observation and interview on 04/30/2026 at 10:49 AM, showed Resident 1 in bed. Resident 1 stated that they could not get out of bed because they had a broken ankle after a fall in the shower room. Resident 1 stated, I was almost ready to go home, now I have to stay here longer. Resident 1 stated that they had been in the shower room with an aide and at the end of the shower she [Staff C, Certified Nursing Assistant (CNA)] was going to start drying me off while standing up. I told her I was going down, I screamed for help. Resident 1 further stated that there was only one person helping transfer them from the wheelchair to standing in the shower room.In an interview and joint record review on 04/30/2025 at 1:01 PM, Staff (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 0689 Level of Harm - Actual harm Residents Affected - Few	F, Physical Therapist Assistant (PTA), stated that they were aware of Resident 1's fall. When asked what Resident 1's transfer status was prior to the fall, Staff F stated that it fluctuated during therapy, between one to two person assistance and nothing was changed and that it was still a Hoyer [lift] transfer. Staff F further stated that the plan of care for Resident 1 would not change until it's consistent.In a phone interview on 04/30/2026 at 2:27 PM, Staff C stated they would look at the care plan, talk to their [a resident's] aide to find out what a resident's transfer status was when bringing a resident to the shower room. Staff C stated that on the day of the fall [04/16/2026], they had asked Resident 1's aide how to transfer them and the aide told me extensive and didn't [did not] say if they were one or two-person [transfer]. Staff C stated that I asked [Resident 1] about her transfer and she said she could do with one person assistance. Staff C stated that they brought Resident 1 to the shower room and when they finished the shower, Resident 1 had to stand up to put on the brief, she said she could stand, I thought she was okay and when she stood up again to put on clothes Resident 1 stated that it feels like I'm sliding, I'm not stable. Staff C stated that there was a bench behind her but she said she couldn't [could not] do it or get back to the wheelchair. Staff C stated that Resident 1 had a gait belt on and they helped Resident 1 get to the floor. Staff C stated that Resident 1 said that their feet were hurting and they took off Resident 1's shoes. When asked what Resident 1's care plan said for transfers, Staff C stated that they were two-person extensive assistance and later I saw she was Hoyer transfer. Staff C stated that I didn't [did not] do two-person extensive [transfer], I thought she [Resident 1] was okay, as [Resident 1] stated, ?I can do it.' Staff C stated, I was wrong and stated that they did not follow the care plan. Staff C further stated that later I found out she [Resident 1] needed a Hoyer, I went to the computer, went to her care plan, I missed it the first time.In a phone interview on 04/30/2026 at 2:19 PM, Staff D, Registered Nurse, stated on the day of [Resident 1's] fall, I was in the hall, she [Staff C] called for help. Staff D stated that when they went inside the shower room [Resident 1] was on the floor, her right leg was bent and touching the wall. Staff D stated that at the time of the fall, Resident 1 was a two-person transfer with Hoyer. Staff D further stated that when they got to the shower room, she [Staff C] was by herself with Resident 1.In an interview and joint record review on 05/01/2026 at 9:31 AM, Staff B, Resident Care Manager (RCM), stated that they expected staff to follow resident care plans. Staff B stated that if therapy changes things they [RCMs] will update care plans. Staff B stated that CNAs should check care plans every day and should look at care plans to know how a resident transfers. Staff B stated that if a resident tells staff that they could do a transfer with less assistance than what the care plan says, they can't [cannot] go against what the care plan says. Staff B stated that only therapy can make changes, doesn't [does not] matter what the resident says. Staff B stated that Resident 1 required a Hoyer for transfers at the time of their fall on 04/16/2026. A joint record review of Resident 1's ADL care plan, showed that it was revised on 04/17/2026 after the fall. Further review of the care plan history showed Resident 1's ADL care plan that was initiated on 03/26/2026 revealed Resident 1 required a Hoyer lift for transfers. Staff B stated that on 04/16/2026 Resident 1 was a Hoyer transfer. A joint record review of the therapy care guide, dated 03/27/2026, showed that Resident 1 required a mechanical lift and two-person extensive assistance for transfers. Staff B stated that I was there when she [Staff C] said ?I need help', [Resident 1] was on the floor and that Staff C was by themselves with Resident 1 and I did not see a Hoyer.In an interview and joint record review on 05/01/2026 at 10:54 AM, Staff G, PTA, stated that they made changes to a resident's transfer status when they could do it consistently with therapy, and then they train the charge nurse, then the aide in charge [of the resident] and then change the plan of care. Staff G stated that nurse staff should not change a resident's transfer status until the plan of care is changed in writing. Staff G stated that they had worked with Resident 1 prior to their fall on 04/16/2026 and stated that the plan of care hadn't [had not] been changed yet and was still a mechanical lift transfer because sometimes she was an easy transfer, sometimes hard. Staff G stated that they had started to train some aides to use a two-person with a walker transfer with Resident 1 but it [plan of care] hadn't [had not] been (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	changed.In an interview on 05/01/2026 at 11:05 AM, Staff E, Director of Rehabilitation, stated that the process to change a resident's transfer status was to train the charge nurses, aides, and then change the plan of care. Staff E stated that we insist they [aides] follow the pocket guides [care plan] until the RCM changes it [care plan].In an interview and joint interview on 05/01/2026 at 10:10 AM, Staff A, Director of Nursing, stated they expected staff to follow resident care plans. Staff A stated that staff would know a resident's transfer status by looking in their care plan or Kardex (a care guide for CNAs). Staff A stated that if there was a change in transfer status there would be a sheet [care guide] from therapy with changes and then the nurse manager will update the care plan. Staff A stated they expected staff to follow residents' transfer status. A joint record review of Resident 1's ADL care plan printed on 04/30/2026, showed it was revised on 04/17/2026 and that Resident 1 required a Hoyer transfer with two-person assist due to a right ankle fracture. Further review of the care plan history showed Resident 1's ADL care plan, was initiated on 03/26/2026, and that Resident 1 required a Hoyer lift for transfers. A joint record review of the therapy care guide, dated 03/27/2026, showed that Resident 1 required a mechanical lift and two-person extensive assistance for transfers. Staff A provided an additional therapy care guide, dated 04/16/2026, that showed Resident 1 was a two-person extensive assist with transfer (not a Hoyer transfer). Staff A stated that the aides had been trained for a two-person extensive assist with transfer with Resident 1. In a follow-up interview at 11:28 AM, Staff A stated that they expected staff to follow residents' care plans and that Resident 1's ADL care plan showed they were a Hoyer transfer at the time of the fall [04/16/2026]. Staff A stated that Staff C should not have taken the resident's word for it. Staff A further stated that Staff C did not follow Resident 1's transfer status, should have had a second person, and that Resident 1 sustained a fracture from the fall.Reference: (WAC) 388-97-1060 (3)(g).