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	06/08/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent physical abuse for 1 of 3 residents (Resident 1), reviewed for abuse investigations. Resident 2 entered Resident 1's room and hit them on the right side of their face with a closed fist. This failure placed residents at increased risk of injury, emotional distress, and a diminished quality of life. Findings included . Review of the facility's policy titled, Elopements and Wandering Residents revised on 12/2025, showed, this facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person centered plan of care addressing the unique factors contributing to wandering or elopement risk. The policy further showed the following definitions: Wandering is random or repetitive locomotion that may be goal-directed (e.g., the person appears to be searching for something such as an exit) or non-goal directed or aimless. Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. RESIDENT 1Review of the quarterly Minimum Data Set (MDS - a required assessment tool) dated 04/24/2026, showed Resident 1 was admitted to the facility on [DATE] with diagnosis that included muscle weakness. The MDS also showed the resident had mild to moderate impaired thinking/memory. RESIDENT 2Review of the admission MDS dated [DATE], showed Resident 2 was admitted to the facility on [DATE] with diagnosis that included unspecified dementia with agitation (significant cognitive [thinking] decline and behavioral agitation [severe restlessness, irritability, with purposeless physical movements]). The MDS also showed the resident had severely impaired thinking/memory. Review of the admission wander risk assessment form dated 05/22/2026 showed Resident 2 was at a high risk to wander. Review of the Resident Visual Check Flow forms dated 05/23/2026 through 05/28/2026 showed staff were scheduled to visually check Resident 2's location every fifteen minutes, and initial when done. Review of the facility event summary report dated 05/28/2026, showed the facility staff received a phone call from law enforcement agency and was informed that Resident 1 had called them and reported that a person had come into their room and hit them in the face. The event summary report further showed the facility staff interviewed Resident 1 who confirmed that they did call the law enforcement agency after a person rummaged through their room, and when asked what they were doing and told them to leave, the person hit them on their chin and left the room. Resident 1 stated after the person [Resident 2] left their room, they turned on their call light and called the law enforcement agency. Resident 1 provided a description of the person seen in the room, was assessed for pain/injuries and none were identified. The facility event summary report showed Resident 1 had a follow-up interview with the provider on 05/29/2026 and Resident 1 reported to the provider that the person that came into their room and hit them in the face was [Resident 2] and that they found a book that belonged to Resident 2 in their bathroom. Further review of the facility event summary report showed staff were interviewed about the event, confirmed Resident 2 wandered in the facility at times and confirmed the book that was found in Resident 1's bathroom belonged to Resident 2. In an interview on 06/03/2026 at 2:16 PM, Resident 1 stated, I was (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asleep in bed, and I woke up because I heard someone trolling around in my room and my bathroom, I asked them what they wanted, what were they looking for and they would not answer me, so I asked them to leave. Then they came over to me while I was still in bed and hit me two times in the face, on my chin with their fist. And then they left my room, I turned on my call light and then I used my phone to call 911 [law enforcement agency]. I later found out that it was another resident here, they left their book in my bathroom and took a roll of my paper towels with them when they left my room. In an interview on 06/04/2026 at 1:16 PM, Staff C, Nursing Assistant Certified, stated Resident 2 was a wanderer and did wander into other residents' rooms. Staff C stated staff were assigned to check on Resident 2 every fifteen minutes to see where they were and what they were doing. Staff C stated the staff that were assigned to check on Resident 2 every fifteen minutes were also assigned to provide care for other residents, which made checking on Resident 2 every fifteen minutes difficult at times. Staff C further stated that if a resident went into another resident's room and hit them in the face, that would be physical abuse.In an interview on 06/08/2026 at 12:55 PM, Staff D, Licensed Practical Nurse, stated Resident 2 wandered in the facility and was at high risk for elopement. Staff D stated staff were assigned to visually check on Resident 2 every fifteen minutes and confirm Resident 2's whereabouts in the facility and what they were doing. Staff D further stated the staff that were assigned to visually check Resident 2 every fifteen minutes were also assigned to provide care for other residents. Staff D further stated that if a resident went into another resident's room and hit them in the face, that would be physical abuse.In an interview on 06/08/2026 at 2:13 PM, Staff B, Director of Nursing Services, stated Resident 2 was at risk of wandering in the facility. Staff B stated the fifteen-minute visual checks on Resident 2 should have been completed by the staff that was assigned to care for Resident 2, and the staff that was assigned to care for Resident 2 was also assigned to care for other residents. Staff B stated the book that was found in Resident 1's bathroom belonged to Resident 2 and during staff interviews, staff stated they had seen Resident 2 walking with a roll of paper towels. Staff B further stated that it was physical abuse when Resident 2 entered Resident 1's room and hit them in the face. Reference: (WAC) 388-97-0640(1) .