STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

BROADVIEW DEVELOPMENT ASSOCIATES II
IDA CULVER HOUSE BROADVIEW
12505 GREENWOOD AVE N
SEATTLE, WA 98133

RE: IDA CULVER HOUSE BROADVIEW License # 945

Dear Administrator:

This letter addresses Compliance Determination(s) 68951 (Completion Date 12/02/2025) and 64763 (Completion Date 09/22/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/02/2025 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2140-2, WAC 388-78A-2140-2-a, WAC 388-78A-2140-2-b, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2600-1-b, WAC 388-78A-2410-9, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2-a, WAC 388-78A-2320-1-a, WAC 388-78A-2320-1-b, WAC 388-78A-2320-1, WAC 388-78A-2320-2-b, WAC 388-78A-2320-2-c, WAC 388-78A-2320-2-d, WAC 388-78A-2320-2-e, WAC 388-78A-2320-3-b, WAC 388-78A-2320-3-d, WAC 388-78A-2320-3-e, WAC 388-78A-2350-1

The Department staff who did the on-site verification:
Keiko Kitano, Licensor
Alma Duran, Licensor

If you have any questions, please contact me at (253)312-1446.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J

Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for the unannounced on-site full inspection on 08/21/2025 and 08/26/2025 of:

IDA CULVER HOUSE BROADVIEW
12505 GREENWOOD AVE N
SEATTLE, WA 98133

The following sample was selected for review during the unannounced on-site visit: 10 of 96 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Alma Duran, Licensor
Keiko Kitano, Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

Statement of Deficiencies	License #: 945	Compliance Determination # 64783
Plan of Correction	IDA CULVER HOUSE BROADVIEW	Completion Date
Page 2 of 16	Licensee: BROADVIEW DEVELOPMENT ASSOCIATES II	09/22/2025

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Jeanie Singer
Residential Care Services

9/23/2055
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Kim Mulvaney
Administrator (or Representative)

9/24/25
Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

(b) Based on standard policies and procedures in the assisted living facility provided that they are consistent with the reasonable accommodation requirements of state and federal law.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that a Negotiated Service Agreement (NSA) included an alternate plan for bath aide services provided by a hospice (care provided to the terminally ill) agency for 1 of 1

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Jamie Singer
Residential Care Services

9/23/2055
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative)

Date

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(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

(b) Based on standard policies and procedures in the assisted living facility provided that they are consistent with the reasonable accommodation requirements of state and federal law.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that a Negotiated Service Agreement (NSA) included an alternate plan for bath aide services provided by a hospice (care provided to the terminally ill) agency for 1 of 1

sampled resident (Resident 4) and failed to ensure the NSA was updated to reflect the current health status and care and service needs for 2 of 5 sampled residents (Residents 6 and 7). This placed Resident 4 at risk for not receiving care and services when the Hospice bath aide would not be able to provide bathing services and placed Residents 6 and 7 at risk of having their health adversely affected by not receiving needed care and services.

Findings included...

RESIDENT 4
Record review showed that the ALF admitted Resident 4 on [redacted]/2015 with multiple diagnoses, and that Resident 4 was admitted into hospice care on 07/17/2025.

In an interview, on 08/25/2025 at 2:40 PM, Staff T (Community Health Nurse) stated Resident 4 had been receiving hospice bath aide services.

Review of a Functional Evaluation (FE, equivalent to a Full Assessment), dated 07/17/2025, showed that Resident 4 required one-person hands-on assistance with bathing and showering. The FE showed the ALF staff would provide showers for Resident 4 on an as needed basis due to their incontinent condition, and Resident 4 would receive showers through hospice services.

Review of the Service Plan Report (SPR, equivalent to NSA), under the section of Bathing and Showering, dated 03/09/2025, showed no plan indicating that Resident 4 would be receiving hospice bath aide services, and there was no alternate plan included if the hospice bath aide was not available to provide the bathing care.

In an interview, on 08/26/2025 at 1:54 PM, Staff S (Personal Services Manager) acknowledged that there was no alternate plan for bathing documented in Resident 4's SPR.

RESIDENT 6
NOTE: The American Heart Association (AHA) guidelines issued in 2017 state that the goal BP for all adults is less than 120/80 mm Hg. Hypotension occurs when blood pressure (BP) is less than 90/60 millimeters of mercury (mm Hg). Low blood pressure is usually not harmful unless there are other symptoms that concern a health care professional such as confusion, dizziness, nausea, fainting, fatigue, etc.

Record review showed the ALF admitted Resident 6 on [redacted]/2025 with multiple disabling diagnoses including [redacted]. Review of the Service Plan Report (SPR – equivalent to NSA), dated 04/16/2025, showed Resident 6 required staff assistance with medication management.

Review of the July electronic Medication Administration Record (eMAR), dated 07/06/2025, showed Resident 6 was prescribed midodrine tablets (used to treat low blood pressure that causes dizziness of fainting) three times a day. Review of the eMAR, showed Resident 6 received midodrine from 07/09/2025 through 07/28/2025 three times a day. The eMAR showed Resident 6's systolic BP (the top number in a blood pressure reading during contraction of the heart muscle) readings ranged from 96 to 107, and diastolic (the bottom number in a BP reading when heart is at rest between beats) ranged from 59 to 68.

Review of Resident 6's SPR, dated 04/16/2025, showed no information for caregivers on how to monitor, observe signs and symptoms, or interventions related to high and low BP results.

RESIDENT 7
Record review showed the ALF admitted Resident 7 on [redacted]/2024 with multiple disabling diagnoses including [redacted] and [redacted].

Review of Resident 7's SPR, dated 07/18/2025, did not include information to monitor for and who to report if there were signs and symptoms high and low BS. The SPR showed Home Health (HH) changed Resident 7's IFC. The SPR did not include a backup plan for when HH was unable to provide their service, how to monitor and what to observe and what to report.

In an interview, on 08/22/2025 at 12:05 PM, Staff R (Community Health Nurse) verified that Resident 7's SPR needed to be updated to address signs and symptoms of high and low BS, and IFC care.

Statement of Deficiencies	License #: 945	Compliance Determination # 64763
Plan of Correction	IDA CULVER HOUSE BROADVIEW	Completion Date
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Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, IDA CULVER HOUSE BROADVIEW is or will be in compliance with this law and / or regulation on (Date) 11/6/25. 11/6/2025

KK confirmed amended POC date with Provider on 10/2/2025.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Kris Mulvaney

Administrator (or Representative) Date 9/22/25

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(b) Provide the necessary care and services for residents, including those with special needs;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to implement its policy for proper and safe installation of a side bed rail (SBR) for 1 of 1 sampled resident (Resident 3). This failure placed Resident 3 at risk for serious bodily harm, including death from entrapment from a bed mobility device.

Findings included...

Review of the United States Food and Drug Administration (FDA) website, on 08/26/2025, showed the FDA developed a document regarding SBR use in health care facilities titled, "A Guide to Bed Safety." The document outlined the importance of frequent assessment to monitor a resident's physical and mental status, monitoring high risk residents, and ensuring safe installation of SBRs. The document outlined risks of using side rails including strangulation, suffocation, bodily injury, or death when a person could get caught, an increased fall risk if not used properly, and feelings of isolation and unnecessary restriction and being prevented from completing activities of daily living.

Review of the FDA website, on 08/26/2025, showed specific measurements for SBR safety in a posting titled, "Overview of the U.S. food and drug administration's potential zones of bed entrapment." The overview specified the following information:

ZONE 1: Within the Rail - any open space between the perimeters of the rail can present

Plan/Attestation Statement

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In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(b) Provide the necessary care and services for residents, including those with special needs;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to implement its policy for proper and safe installation of a side bed rail (SBR) for 1 of 1 sampled resident (Resident 3). This failure placed Resident 3 at risk for serious bodily harm, including death from entrapment from a bed mobility device.

Findings included...

Review of the United States Food and Drug Administration (FDA) website, on 08/26/2025, showed the FDA developed a document regarding SBR use in health care facilities titled, "A Guide to Bed Safety." The document outlined the importance of frequent assessment to monitor a resident's physical and mental status, monitoring high risk residents, and ensuring safe installation of SBRs. The document outlined risks of using side rails including strangulation, suffocation, bodily injury, or death when a person could get caught, an increased fall risk if not used properly, and feelings of isolation and unnecessary restriction and being prevented from completing activities of daily living.

Review of the FDA website, on 08/26/2025, showed specific measurements for SBR safety in a posting titled, "Overview of the U.S. food and drug administration's potential zones of bed entrapment." The overview specified the following information:

ZONE 1: Within the Rail - any open space between the perimeters of the rail can present

a risk of head entrapment. FDA recommended space: less than 4 34 inches (“).

Review of the ALF’ policy titled Bed Mobility Enablers (BME), dated 06/01/2007, under the sections of Procedure 2) and 7), showed that an evaluation of the resident’s needs would be noted in the Negotiated Service Agreement (NSA), and the Community Health Director or designee would place in the NSA the additional routine observations that would be made to ensure that the BME was always correctly in place and covered to reduce entrapment potential. This would include weekly checks by employees for proper placement. Under the section of Procedure 5), showed that the type of BME would be evaluated according to federal standards. Horizontal measurement would be less than 4 ¾” and openings within the BME would be less than 4 ¾” or greater than 12 ½”.

Record review showed that the ALF admitted Resident 3 on [redacted]/2025 with multiple diagnoses. Review of Resident 3’s Bed Mobility Assessment, dated 04/14/2025, showed that Resident 3 had been using a SBR, and they kept it on the foot of the bed for bed mobility.

Observation, on 08/26/2025 at 08:10 AM, showed a SBR on the foot of the bed in Resident 3’s apartment. Observation showed an open space/gap within the SBR measured 11” in length and 17” high. There was no protection from the gap in the SBR.

Review of Resident 3’s Service Plan Report (SPR, equivalent to NSA), dated 04/16/2025, showed no plan indicating Resident 3’s needs for the SBR for bed mobility. The SPR did not have routine observations, or weekly checks per the ALF’s policy, to ensure the SBR would be placed correctly and covered to reduce entrapment potential.

In an interview, on 08/26/2025 at 1:54 PM, Staff S (Personal Services Manager) acknowledged there was no plan developed in Resident 3’s SPR for SBR safety per the ALF’s BME policy.

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I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, IDA CULVER HOUSE BROADVIEW is or will be in compliance with this law and / or regulation on (Date) 11/6/2025

KK confirmed amended POC date with Provider on 10/2/2025.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Kim Mulvaney
Administrator (or Representative)

9/24/25
Date

WAC 388-78A-2410 Content of resident records. The assisted living facility must organize and maintain resident records in a format that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

(9) Documentation consistent with WAC 388-78A-2120 Monitoring resident well-being.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to document monitoring of skin conditions for 2 of 2 residents (Residents 1 and 5). This placed Residents 1 and 5 at risk for not receiving appropriate wound care and deteriorate health conditions.

Findings included...

RESIDENT 1
Record review showed that the ALF admitted Resident 1 on [redacted]/2024, with multiple diagnoses.

Review of a Progress Note (PN), dated 06/20/2025, showed that Resident 1 had fallen and sustained three skin tears with minimal bleeding on their left arm. Review of the June 2025 electronic Treatment Records (eTARs) showed that beginning 06/21/2025, the ALF would provide wound care to the skin tears every day and notify a physician about any signs and symptoms (S/S) of infection. Review of the eTARs showed no documentation indicating that the ALF provided wound care or monitored the skin condition from 06/25/2025 to 08/27/2025.

Review of a PN, dated 08/02/2025, showed that Resident 1 had fallen and sustained a skin tear on the left forearm. Review of the August 2025 eTARs showed that the ALF would provide wound care to the skin tear on the left arm every Monday, Wednesday,

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_____ _____

Administrator (or Representative) Date

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This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to document monitoring of skin conditions for 2 of 2 residents (Residents 1 and 5). This placed Residents 1 and 5 at risk for not receiving appropriate wound care and deteriorate health conditions.

Findings included...

RESIDENT 1
Record review showed that the ALF admitted Resident 1 on [redacted]/2024, with multiple diagnoses.

Review of a Progress Note (PN), dated 06/20/2025, showed that Resident 1 had fallen and sustained three skin tears with minimal bleeding on their left arm. Review of the June 2025 electronic Treatment Records (eTARs) showed that beginning 06/21/2025, the ALF would provide wound care to the skin tears every day and notify a physician about any signs and symptoms (S/S) of infection. Review of the eTARs showed no documentation indicating that the ALF provided wound care or monitored the skin condition from 06/25/2025 to 06/27/2025.

Review of a PN, dated 08/02/2025, showed that Resident 1 had fallen and sustained a skin tear on the left forearm. Review of the August 2025 eTARs showed that the ALF would provide wound care to the skin tear on the left arm every Monday, Wednesday,

and Friday, and notify the physician for any S/S of infection. The eTARs showed that on 08/08/2025, there was no documentation to indicate the ALF provided wound care and monitored for S/S of infection.

Review of Resident 1's active records, including PNs, showed, as of 08/22/2025, there was no documentation showing that the ALF provided the wound care or monitored Resident 1's skin condition from 06/25/2025 to 06/27/2025 and on 08/08/2025.

In an interview, Staff S (Personal Services Manager), on 08/26/2025 at 01:54 PM, stated that Licensed Nurses (LNs) were responsible for providing wound care and monitoring skin conditions to any residents. Staff S acknowledged that LNs had not documented that they had provided wound care or monitored for Resident 1 during the times in question.

In a follow-up telephone interview, on 09/12/2025 at 3:26 PM, Staff I (Community Health Nurse) stated that they had monitored Resident 1's skin conditions in accordance with the eTARs in June and August 2025 but simply forgot to document the condition in Resident 1's records after they had finished the wound care.

RESIDENT 5
Record review showed that the ALF admitted Resident 5 on [redacted]/2019 with multiple diagnoses.

Record review showed that on 07/12/2025, a physician ordered that during each day shift, the ALF should monitor the increase swelling of Resident 5's legs as well as any S/Ss of infection on two open skin areas on their left leg. Review of the July and August 2025 eTARs showed that on 07/20/2025, 08/08/2025, and 08/17/2025, there was no documentation indicating that the ALF monitored the condition of Resident 5's swollen legs or open skin areas.

Review of Resident 5's active records, including PNs, showed that, as of 08/22/2025, there were no documents indicating that the ALF had monitored Resident 5's leg condition or open skin areas on 07/20/2025, 08/08/2025, and 08/17/2025.

In an interview, on 08/26/2025 at 01:54 PM, Staff S acknowledged that LNs had not documented that they monitored Resident 5's swollen legs or the open skin areas on 07/20/2025, 08/08/2025, and 08/17/2025.

In a follow-up interview, on 09/11/2025 at 10:25 AM, Staff T (Community Health Nurse) stated that they monitored Resident 5's legs every day when they worked, but sometimes they were distracted by other things, and forgot to document in the eTARs or PNs about the condition of Resident 5's legs.

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KK confirmed amended POC date with Provider on 10/2/2025.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Kim Mulvaney
Administrator (or Representative)

9/22/25
Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to develop and implement systems that support and promote safe medication service for 1 of 5 sampled residents (Resident 10) who required staff assistance with medications. This resulted in Resident 10 not receiving their medications as prescribed potentially causing health complications.

Findings included...

Record review showed the ALF admitted Resident 10 on [redacted]/2023 with multiple diagnoses including [redacted]. Review of the Service Plan Report (SPR – equivalent to Negotiated Service Agreement), dated 07/23/2025, showed Resident 10 required staff assistance with medication management.

Review of a Progress Notes (PN), dated 06/28/2025, showed Resident 10 went to Urgent Care due to symptoms of a urinary tract infection (UTI - a common type of infection that can affect any part of the urinary system). The PN showed Resident 10 returned to the

Plan/Attestation Statement

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Administrator (or Representative) Date

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(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to develop and implement systems that support and promote safe medication service for 1 of 5 sampled residents (Resident 10) who required staff assistance with medications. This resulted in Resident 10 not receiving their medications as prescribed potentially causing health complications.

Findings included...

Record review showed the ALF admitted Resident 10 on [redacted]/2023 with multiple diagnoses including [redacted]. Review of the Service Plan Report (SPR – equivalent to Negotiated Service Agreement), dated 07/23/2025, showed Resident 10 required staff assistance with medication management.

Review of Progress Notes (PN) dated 06/28/2025, showed Resident 10 went to Urgent Care due to symptoms of a urinary tract infection (UTI - a common type of infection that can affect any part of the urinary system). The PN showed Resident 10 returned to the

Statement of Deficiencies	License #: 945	Compliance Determination # 84763
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ALF with a physician's order for cefadroxil 500 milligrams (MG) (an antibiotic used to treat UTI) twice a day for seven days.

Review of the June 2025 electronic Medication Administration Record (eMAR) showed Resident 10 received 13 doses instead of the physician's ordered 14 doses of cefadroxil.

Review of the eMAR, dated 07/29/2025, showed Resident 10 had a physician's order for cephalexin 500 MG (an antibiotic used to treat dysuria – pain or discomfort when urinating caused by bacterial infections of the urinary tract), three times a day for seven days.
Review of the June 2025 eMAR showed, Resident 10 received 18 doses instead of the physician's ordered 21 doses of cephalexin.

Director

In an interview, dated 08/28/2025 at 1:15 PM, Staff F (Community Health ~~Nurse~~) confirmed. Resident 10 did not receive their antibiotics as ordered by the physician.

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KK confirmed amended POC date with Provider on 10/2/2025.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Kim Mullamp — Administrator (or Representative)

9/26/25 — Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

(c) Initial and on-going assessments of the nursing needs of each resident;

(d) Development of, and necessary amendments to, the nursing component of the

ALF with a physician's order for cefadroxil 500 milligrams (MG) (an antibiotic used to treat UTI) twice a day for seven days.

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Review of the June 2025 eMAR showed, Resident 10 received 18 doses instead of the physician's ordered 21 doses of cephalexin.

In an interview, dated 08/26/2025 at 1:15 PM, Staff F (Community Health Nurse) confirmed. Resident 10 did not receive their antibiotics as ordered by the physician.

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(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

(c) Initial and on-going assessments of the nursing needs of each resident;

(d) Development of, and necessary amendments to, the nursing component of the

negotiated service agreement for each resident;

(e) Implementation of the nursing component of each resident's negotiated service agreement; and

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(b) Chapter 18.88A RCW, Nursing assistants;

(d) Chapter 246-841 WAC, Nursing assistants; and

(e) Chapter 246-888 WAC, Medication assistance.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure that nurse delegation (ND) was in place for 3 of 5 sampled residents (Residents 7, 8, and 10) who received prescribed medicated skin treatments and medication administration by unlicensed staff. This placed Residents 7, 8, and 10 at risk of health complications when unlicensed staff administered medications without receiving proper nurse delegation and nurse oversight.

Findings included...

NOTE: Washington Administrative Code (WAC) 246-840-930 Criteria for delegation, in community-based and in-home care settings, before delegating a nursing task, the registered nurse delegator shall decide if a task is appropriate to delegate based on the elements of the nursing process: ASSESS, PLAN, IMPLEMENT, EVALUATE. PLAN (10) If the registered nurse delegator determines delegation is appropriate, the nurse: (a) Discusses the delegation process with the patient or authorized representative, including the level of training of the nursing assistant or home care aide delivering care. (b) Obtains written consent. The patient, or authorized representative, must give written, consent to the delegation process under chapter 7.70 Revised Code of Washington (RCW). Documented verbal consent of patient or authorized representative may be acceptable if written consent is obtained within 30 days; electronic consent is an acceptable format. Written consent is only necessary at the initial use of the nurse delegation process for each patient and is not necessary for task additions or changes or if a different nurse, nursing assistant, or home care aide will be participating in the process. (12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes: (b) The delegated nursing task is specific to one patient and is not transferable to another patient; (c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide; IMPLEMENT (15) The registered nurse delegator is accountable and responsible for the delegated nursing task. The registered nurse delegator monitors the performance of the task(s) to assure compliance with established standards of practice, policies and procedures and appropriate documentation of the task(s). EVALUATE (16) The registered nurse delegator evaluates the patient's responses to the delegated nursing

care and to any modification of the nursing components of the patient's plan of care.(17) The registered nurse delegator supervises and evaluates the performance of the nursing assistant or home care aide, including direct observation or other method of verification of competency of the nursing assistant or home care aide. The registered nurse delegator reevaluates the patient's condition, the care provided to the patient, the capability of the nursing assistant or home care aide, the outcome of the task, and any problems.

Review of ALF's undated Disclosure of Services (DOS), showed the ALF allowed nursing assistants to administer oral, topical medications, and eye, ear, and nose drops under the delegation of a registered nurse.

In an interview, on 08/21/2025 at 9:30 AM, Staff H (Executive Director) stated that the ALF had not been providing ND in the Memory Care Unit (MCU) because Licensed Nurses (LN) were available 24 hours a day, seven days a week.

RESIDENT 7
Record review showed that the ALF admitted Resident 7 to the MCU on [redacted]/2024 with multiple medical diagnoses. Review of the Service Plan Report (SPR - equivalent to Negotiated Service Agreement), dated 06/24/2025, showed Resident 7 required staff assistance with medication management.

Review of an Order Summary Report, showed Resident 7's physician prescribed clobetasol ointment (a potent topical ointment used to treat various skin conditions) to be applied to a penile ulcer twice a day, and nystatin cream with gentamycin (a topical antifungal medication used to treat skin infection) daily.

Review of Resident 7's June, July, and August 2025 electronic Medication Administration Records (eMAR) showed Staff B (Medication Technician ((MT)), Staff J (MT), Staff K (MT), Staff L (MT), Staff M (MT), Staff N (MT), Staff O (MT), Staff P (MT), and Staff Q (MT) initialed the eMARs, indicating they administered the medicated creams to Resident 7 on multiple occasions.

In an interview, on 08/25/2025 at 9:25 AM, Staff J stated that they administered eye drops and medicated creams to residents.

Record review showed Resident 7 had no ND in place.

RESIDENT 8
Record review showed the ALF admitted Resident 8 on [redacted]/2024 with multiple disabling diagnoses including [redacted]. Review of the SPR, dated 04/07/2025, showed that Resident 8 was unable to self-direct medication and treatments, requiring staff assistance with medication management.

Review of the June, July, and August 2025 eMARs, showed that Resident 8 was prescribed Refresh Tears (used to relieve dry and irritated eyes) instill two drops in each eye twice daily.

Review of the eMARs showed the Refresh Tears were initialed as being administered to Resident 8 by Staff B, J, K, L, M, N, O, and Q.

In an interview, on 08/25/2025 at 10:25 AM, Staff J stated that they administered eye drops and medicated creams to residents.

Record review showed Resident 8 had no ND in place.

RESIDENT 10
Record review showed the ALF admitted Resident 10 on [redacted]/2023 with multiple diagnoses including [redacted] and [redacted]. Review of the SPR, dated 04/16/2025, showed Resident 10 required assistance with medication and treatments.

Review of an Order Summary Report, dated 07/08/2025, showed Resident 10 was prescribed metronidazole (a topical medication used to treat rosacea) to apply to face twice daily.

Review of the July eMAR showed Staff B, Staff J, Staff K, Staff L, Staff M, Staff N, and Staff O initialed the eMAR, indicating they administered the medicated cream to Resident 10 on multiple occasions.

Record review showed Resident 10 had no ND in place.

In an interview, on 08/25/2025 at 9: 25 AM, Staff J stated that they administered eye drops and medicated creams to residents.

In an interview, on 08/26/2025 at 1:15 PM, Staff H (Administrator/Executive Director) acknowledged that LNs should be administering medications and treatments in the Memory Care Unit.

Statement of Deficiencies	License #: 945	Compliance Determination # 64783
Plan of Correction	IDA CULVER HOUSE BROADVIEW	Completion Date
Page 14 of 16	Licensee: BROADVIEW DEVELOPMENT ASSOCIATES II	09/22/2025

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, IDA CULVER HOUSE BROADVIEW is or will be in compliance with this law and / or regulation on (Date) 11/6/2025

KK confirmed amended POC date with Provider on 10/2/2025.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Administrator (or Representative) 9/20/25 Date

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed notify the primary care physician (PCP) for 2 of 2 residents (Residents 7 and 9) when medications were not given as ordered. This failure resulted in Resident 7 and 9 receiving medications on dates in which they were not ordered and placed them at risk of compromised health status.

Findings included...

RESIDENT 7
Record review showed the ALF admitted Resident 7 on [redacted]/2024 with multiple disabling diagnoses including [redacted]. Review of Resident 7's Service Plan Report (SPR – equivalent to Negotiated Service Plan), dated 07/18/2025, showed Resident 7 required staff assistance with medication management including a weekly injection to treat high blood sugar levels.

Review of the August 2025 electronic Medication Administration Record (eMAR) showed a physician's order for weekly Ozempic to be given every seven days on a Saturday. The eMAR showed Resident 7 did not receive their Ozempic injection on 08/02/2025 as it was unavailable in the ALF.

In an interview, on 08/22/2025 at 12:05 PM, Staff R (Community Health Nurse) stated that there was no Ozempic injection available on 08/02/2025. Staff R stated that they contacted their pharmacy for delivery. Staff R stated the Ozempic was delivered to the

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, IDA CULVER HOUSE BROADVIEW is or will be in compliance with this law and / or regulation on (Date)_____ .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

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Based on interview and record review, the Assisted Living Facility (ALF) failed notify the primary care physician (PCP) for 2 of 2 residents (Residents 7 and 9) when medications were not given as ordered. This failure resulted in Resident 7 and 9 receiving medications on dates in which they were not ordered and placed them at risk of compromised health status.

Findings included...

RESIDENT 7
Record review showed the ALF admitted Resident 7 on [redacted]/2024 with multiple disabling diagnoses including [redacted]. Review of Resident 7's Service Plan Report (SPR – equivalent to Negotiated Service Plan), dated 07/18/2025, showed Resident 7 required staff assistance with medication management including a weekly injection to treat high blood sugar levels.

Review of the August 2025 electronic Medication Administration Record (eMAR) showed a physician's order for weekly Ozempic to be given every seven days on a Saturday. The eMAR showed Resident 7 did not receive their Ozempic injection on 08/02/2025 as it was unavailable in the ALF.

In an interview, on 08/22/2025 at 12.05 PM, Staff R (Community Health Nurse) stated that there was no Ozempic injection available on 08/02/2025. Staff R stated that they contacted their pharmacy for delivery. Staff R stated the Ozempic was delivered to the

ALF on 08/04/2025.

Review of Resident 7's records showed no documentation that the PCP was notified the Ozempic was given late, no request to change the days of the weekly injection to ensure it was continued on a "weekly" basis.

RESIDENT 9
Record review showed the ALF admitted Resident 9 on [redacted]/2025 multiple diagnoses including [redacted] and [redacted]. Review of the SPR dated 06/26/2025 showed Resident 9 required staff assistance with medication management.

Review of a physician's order, dated 07/02/2025, showed Resident 9 was prescribed 1 gram of sodium chloride (NaCl - used to help maintain bodily functions, such as fluid balance and nerve transmission, and prevent dehydration) to be given three times a week specific to Mondays, Wednesdays and Saturdays.

Review of Resident 9's July and August eMARs, showed Resident 9 received NaCl on Mondays, Wednesdays and Fridays, instead of Mondays, Wednesdays and Saturdays as ordered.

Record review showed no documentation that Resident 9's PCP was notified the medication was not given as ordered, or to request it be given on Fridays instead of Saturdays.

In an interview, on 08/25/2025 at 11:24 AM, Staff I (Community Health Nurse) confirmed sodium chloride had been routinely given to Resident 9 on Fridays instead of Saturdays since July 2025.

In an interview, on 08/26/2025 at 1:15 PM, Staff F (Community Health Director) confirmed the lack of notification to PCP when Residents 7 and 9 did not receive medications as prescribed.

Statement of Deficiencies	License #: 945	Compliance Determination # 64763
Plan of Correction	IDA CULVER HOUSE BROADVIEW	Completion Date
Page 16 of 16	Licensee: BROADVIEW DEVELOPMENT ASSOCIATES II	09/22/2025

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, IDA CULVER HOUSE BROADVIEW is or will be in compliance with this law and / or regulation on (Date) 11/6/2025.

KK confirmed amended POC date with Provider on 10/2/2025.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Kim Mulvany
Administrator (or Representative)

9/24/25
Date

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, IDA CULVER HOUSE BROADVIEW is or will be in compliance with this law and / or regulation on (Date)_____ .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

_____ _____

Administrator (or Representative) Date