STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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) 76353 (Completion Date 04/23/2026) and 72746 (Completion Date 02/25/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/23/2026 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-2160

The Department staff who did the on-site verification:
Michelle Mcglon, Nursing Consultant Institutional

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

Residential Care Services
Investigation Summary Report

Provider/Facility: IDA CULVER HOUSE BROADVIEW
License/Cert.#: 945
Compliance Determination #: 72746
Investigator: Michelle Mcglon
Investigation Date(s): 02/10/2026 through 02/25/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 210730
Region/Unit #: RCS Region 2 / Unit J

Allegation(s):

1. The Named Staff (NS) was instructed to clock out at their scheduled time, after the Named Resident (NR) had a fall, leaving multiple residents unattended.
2. The NR refused assistance with incontinence care, resulting in being soiled for an unknown amount of time at the Assisted Living Facility (ALF).
3. The NR should be a two person assist with care due to aggressive behaviors.
4. The NS remained with the ALF residents, resulting in missed break and written disciplinary action.

Investigation Methods:

Sample:	Total residents: 97 Resident sample size: 3 Closed records sample size:
Observations:	Residents Activities Dining Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Activity Staff Executive Director
Record Reviews:	State reporting log Resident Records

Investigation Summary:

1. Interview and record review showed the ALF had adequate staff per floor for each shift allowing staff to safely clock out at their scheduled time. The ALF staff reported a care staff was in the common area to supervise the residents at all times. The fall was not a result of the NS clocking out. Record review of a working schedule showed the ALF had adequate staffing. No failed practice identified.
2. Interview and record review showed that the NR had refused staff assistance with care. The ALF staff reported the NR had aggressive behaviors and would refuse.

Record review showed the ALF had interventions in place, including reapproaching the NR. No failed practice identified.
3. Interview and record review showed the ALF failed to provide have two caregivers when providing care and transfers. This failure may have contributed to the NR falling at the ALF. Failed practice identified. See Statement of Deficiency 388-78A-2160.
4. Interview and record review showed the ALF had adequate staffing. The ALF staff reported having adequate staff to take breaks as scheduled. Record review showed adequate staffing to accommodate breaks. Sampled resident representatives reported care staff always being available. Unable to substantiate. No failed practice identified.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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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 an unannounced on-site complaint investigation on 02/10/2026 of:

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

This document references the following complaint number(s): 210730

The following sample was selected for review during the unannounced on-site visit: 3 of 97 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Michelle Mcglon, Nursing Consultant Institutional

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

Statement of Deficiencies	License #: 945	Compliance Determination # 72746
Plan of Correction	IDA CULVER HOUSE BROADVIEW	Completion Date
Page 2 of 3	Licensee: BROADVIEW DEVELOPMENT ASSOCIATES II	02/25/2026

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 Siegen
Residential Care Services

2/26/2026
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)

3/4/26
Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed implement the Negotiated Service Agreement (NSA) for 1 of 1 sampled residents (Resident 1). This failure may have contributed to a fall when Resident 1 was assisted by one caregiver instead of two.

Findings included...

Record review of a Service Plan Report (SPR- equivalent to a NSA), revised on 11/13/2025, showed that the ALF admitted Resident on [redacted]/2021. The SPR showed Resident 1 was a high fall risk. The SPR showed Resident 1 required two-person hands-on assistance with all transfers.

Record review of an Incident Report (IR), dated 01/22/2026, showed Staff B (Registered Nurse) documented while being assisted to transfer in the bathroom with only one caregiver, Resident 1 had a fall. The IR stated Resident 1's fall may have been a result of not implementing the SPR that required two person assist with transfers and toileting due to the resident's unsteady gait and impulsive behavior.

In an interview, on 02/23/2026 at 12:31 PM, Staff A (Community Health Director) stated

Statement of Deficiencies	License #: 945	Compliance Determination # 72746
Plan of Correction	IDA CULVER HOUSE BROADVIEW	Completion Date
Page 3 of 3	Licensee: BROADVIEW DEVELOPMENT ASSOCIATES II	02/25/2026

that the caregiver was not implementing the SPR when Resident 1 fell.

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) 4/11/26.

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

Tim Mulvaney
Administrator (or Representative)

3/4/26
Date