

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2025
NAME OF PROVIDER OR SUPPLIER Martha and Mary Health Service		STREET ADDRESS, CITY, STATE, ZIP CODE 19160 Front Street Northeast Poulsbo, WA 98370	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46068</p> <p>Based on interview and record review, the facility failed to provide assistance with toileting and bed mobility for 1 of 3 residents (Resident 1) reviewed for quality of care. This failure placed residents at risk for skin breakdown, poor hygiene and pain.</p> <p>Findings included .</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses of cancer and pressure ulcers (injury to skin and underlying tissue resulting from prolonged pressure).</p> <p>Resident 1's admission screening and history evaluation, dated 04/03/2025, showed the resident was cognitively intact, needed assistance from staff with bed mobility, totally dependent for toileting and had acute and chronic pain.</p> <p>Resident 1's care plan, dated 04/03/2025, showed the resident was a 1 PA [person assist] with bed mobility and a 1-2 PA with maximum assist using bed pan for bowel movements. The care plan showed the resident had impairments to the skin integrity in the perineal area (sensitive skin between the anus and the genitals), lower extremities, coccyx (tailbone) and heels.</p> <p>Review of the facility's incident report, dated 04/09/2025, showed Resident 1 was placed on the bedpan at approximately 9:15 PM on 04/08/2025 by the evening shift staff. The report showed the evening staff failed to report to the night shift staff the resident was using the bedpan. The report showed the night shift staff had provided the resident with medication and assessment. The report showed the night shift staff were unaware the resident was lying on the bedpan and there was no evidence the staff had repositioned the resident during their shift. The report showed on 04/09/2025, at approximately 7:15 AM, Staff A, Licensed Practical Nurse (LPN), and the wound care team rolled the resident onto their side to assess the resident's wounds and discovered the bedpan. The report showed the resident remembered asking to be placed on the bedpan the night before but said they must have fallen asleep with the bedpan under them and never asked for it to be removed. The report showed the resident sustained a possible deep tissue injury (a type of pressure injury where the soft tissue is damaged by prolonged pressure) measuring approximately 1.0 centimeters (cm) x 2.0 cm on their left gluteal fold (crease between the buttocks and the upper thigh).</p> <p>(continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/14/2025 at 2:32 PM, Staff A, LPN, said Resident 1 had pressure ulcers on their coccyx and heels that were present on admission. Staff A said residents with pressure ulcers and/or at risk for pressure ulcers should be repositioned at least every two hours. Staff A said if a resident refused to be repositioned, they would expect the licensed nurse to provide education to the resident of the risks of not changing positions. Staff A said Resident 1 required assistance from staff to turn on their side due to pain and weakness.</p> <p>On 04/14/2025 at 3:09 PM, Staff B, Director of Nursing, said they expected the nursing staff to turn and reposition Resident 1 every two hours during their shift. Staff B said the night shift aides were unaware the bedpan was under Resident 1, and they assumed the staff had not turned the resident due to their pain. Staff B said the resident was lying on the bedpan from approximately 9:15 PM on 04/08/2025 until 04/09/2025 at 7:15 AM.</p> <p>Reference WAC 388-97-1060 (2)(c)</p>