STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505474	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martha and Mary Health Service	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess, monitor and document a controlled fall timely for 1 of 3 (Resident 1) residents reviewed for quality of care. This failure placed residents at risk of delayed medical intervention and pain.Findings included.Resident 1 was admitted on [DATE] with diagnoses of heart disease and arthritis. The annual Minimum Data Set Assessment, dated 02/25/2026, showed Resident 1 had moderate cognitive impairment.Resident 1's fall risk care plan, dated 02/24/2025, showed Resident 1 was at high risk of falls and had limited physical mobility.On 05/07/2026 at 1:01 PM, Collateral Contact 1 (CC1), said they had visited Resident 1 on Monday, 04/27/2026. CC1 said during the visit Resident 1 complained that their wrist hurt and they had sore foot. CC1 said Resident 1's roommate said Resident 1 had fallen. CC1 said the staff had not contacted them and they had to bring it to the attention of the nurse. CC1 said they were very concerned they were not contacted about the fall and the delay in care. CC1 said Resident 1 did not have xrays taken until Tuesday evening 04/28/2026 and was sent to the hospital late Tuesday night. Review of the facility incident report, dated 04/27/2026, showed Resident 1 was found to have significant bruises and swelling on their right ankle and wrist on Tuesday morning 04/28/2026, during an assessment before their shower. The report showed Resident 1 stated they had fallen the other night in the bathroom. The report showed a witness statement by Staff A, Certified Nursing Assistant (CNA), that indicated they were transferring Resident 1 from the toilet to the wheelchair on Monday 04/27/2026 at 4:45 AM, Resident 1 suddenly lost energy and had to be caught and helped the rest of the way to the wheelchair. The statement showed Resident 1 said they could not complete the transfer and started to sit as they were going to the floor. The statement showed Staff A caught Resident 1 and hoisted them the rest of the way to the wheelchair. The statement showed Staff A told the nurse on the unit about the event since it was unusual for Resident 1. The incident report showed Staff B, Registered Nurse (RN) was contacted on 04/29/2026 for a statement and Staff B said Staff A had reported the event to them, but they did not further assess the resident afterwards and/or place Resident 1 on alert charting. The incident report showed the root cause was Resident 1 had sustained an acute right distal metaphyseal (wrist) fracture and a fractured right ankle from an event that occurred on NOC (night) shift on 04/26/2026.On 05/13/2026 at 1:40 PM, Staff C, Unit Manager, said on Tuesday 04/28/2026, the shower aide notified Staff C that Resident 1 was unable to transfer to the wheelchair, and their right ankle was very swollen and black and blue in color. Staff C said they went and assessed Resident 1 and Resident 1's roommate told Staff C that Resident 1 had fallen. Staff C said they were unaware that an incident occurred and started an investigation. Staff C said it revealed on Monday 04/27/2026, Staff D, Licensed Practical Nurse (LPN) had placed an order request in the medical provider's binder that indicated Resident 1 had a swollen and painful wrist and a bruise on their shin. Staff C said no further assessment and/or documentation was completed from the time of the incident on 04/27/2026 at 4:45 AM until Staff C initiated an investigation and clinical intervention on 04/28/2026 in afternoon. Staff C said Staff D left the order request in the medical provider's binder but did not call and/or contact the provider. Staff C said the medical provider was not aware of the injury until Tuesday 04/28/2026 when they came to the facility and reviewed the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documents in the binder. Staff C said Staff B, RN, told them they were aware of the incident but did not assess Resident 1, put them on alert and did not complete an incident report because Staff B thought it wasn't a fall if the resident did not hit the ground. Staff C said Staff B should have assessed Resident 1 when Staff A, CNA, notified Staff B that Resident 1 had an incident in the bathroom while transferring and was not acting like themselves. Staff C said if a Resident had a controlled fall an incident report should be initiated. Staff C said that when Staff D found Resident 1 with a swollen and painful wrist and a bruise, they should have placed Resident 1 on alert charting and contacted the medical provider.Resident 1's order request, dated 04/27/2026, showed Resident 1 had stated they had pain in the right wrist, wrist appeared swollen and they did not want their blood pressure taken on that side and bruising on the left shin was noted.On 05/13/2026 at 2:18 PM, Staff D, LPN, said they were assigned to resident 1 on day shift 04/27/2026. Staff D said Resident 1 had swelling on their right wrist and bruise on the shin. Staff D said they could not remember if CC1 had made them aware of the swelling and pain. Staff D said they completed an order request and placed it in the medical provider's binder. Staff D said they did not contact the medical provider. Staff D said they thought they had placed Resident 1 on alert and notified the oncoming nurse.On 05/13/2026 at 2:23 PM, Staff E, RN, said they were the evening shift nurse on 04/27/2026 and had taken over the care of Resident 1 from the day shift nurse Staff D on 04/27/2026. Staff E said they had no knowledge of any incident and/or injuries with Resident 1. Staff E said if they would have been aware they would have monitored the wrist and leg for further swelling, pain and/or discoloration. Staff E said Resident 1 was not on alert charting.Review of Resident 1's electronic medical record on 05/13/2026 showed no alert charting and/or monitoring of Resident 1's right wrist and/or bruising to their leg on day, evening and/or night shift on 04/27/2026.On 05/13/2026 at 3:47 PM, staff F, Director of Nursing, said they thought Resident 1 was placed on monitoring for their right wrist on 04/27/2026.WAC Reference 388-97-1060(1)-(3).