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	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martha and Mary Health Service	19160 Front Street Northeast Poulsbo, WA 98370

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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 - Some	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 initiate the bowel protocol and accurately document bowel protocol interventions for 4 of 6 sampled residents (Resident 12, 8, 58 & 63) reviewed for bowel care. The failure to initiate and document bowel care, placed residents at risk for pain/discomfort, unmet care needs and other potentially negative health outcomes.Findings included . Review of facility policy titled, Bowel Management, dated January 2024, documented, If no BM [bowel movement] for 3 days or more, offer Bowel meds of resident choice listed below, along with non-pharmacological Interventions . MiraLAX 17gm [grams] in 4 – 8oz [ounce] of fluid, applesauce or pudding, PO [by mouth] QD [everyday] / PRN [as needed] no BM x 2 days. May be repeated two consecutive days Bisacodyl 5mg PO, 1 tablet PO Q 24 hours, PRN no BM x 2 days, if client does not prefer MiraLAX. May be repeated two consecutive days. Bisacodyl, 10mg PR, every 24 hrs., PRN for constipation. Fleets Enema (Mineral Oil) once daily PRN for failure of PO meds, and suppository, or per client request for constipation. Document Provider notification and orders in PCC notes. Resident 58 Resident 58 admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 11/14/2025, showed the resident was cognitively intact, and was not constipated during the assessment period. On 02/10/2025 at 11:57 AM, Resident 58 reported they had been struggling with constipation for a while. Record review showed Resident 58 had the following 11/28/2025 bowel care orders: a) Miralax every 24 hours as needed, administer if no bowel movement (BM) for two days.b) Bisacodyl 5 mg every 24 hours, as needed, if no BM times two days. May be repeated for two consecutive days.c) Bisacodyl Suppository insert rectally every 24-hours as needed for constipation.d) Fleet Oil Enema insert rectally every 24-hours as needed, if no results from suppository. Review of Resident 58s December 2025 bowel record showed they went the following periods without a BM:12/15/2025 - 12/19/2025 (5 days no BM)12/25/2025 - 12/29/2025 (5 days no BM) Review of the December 2025 Medication Administration Record (MAR) showed facility nurses failed to administer as needed bowel medications as ordered and in accordance with the facility bowel protocol. On 02/13/2026 at 12:50 AM, Staff B, Director of Nursing Services (DNS), acknowledged on the two above referenced occasions facility nurses failed to administer as needed bowel medication as ordered and as directed by the facility's bowel protocol. Resident 63 Resident 63 admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact, and was not constipated during the assessment period. Review of Resident 63's February 2026 bowel record showed they went the following periods without a BM or with only a small BM:-02/07/2026 - 02/11/2026 (5 days with one small BM) On 02/13/2026 at 12:50 AM, when asked if facility nurses administered Resident 63 as needed bowel medication on the above referenced occasion in accordance with the physician's orders and the facility bowel protocol Staff B, DNS, stated, No. Resident 8Resident 8 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 8 had short and long term memory problems and needed substantial to dependent assistance with activities of daily living (ADLs). A review of Resident 8's January 2026 MAR showed Resident 8 had orders for: - Bisacodyl tablet to be given orally every 24 hours as needed for constipation if no BM (Bowel Movement) after 2 days. May be repeated two (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consecutive days. Non-Pharmacological Interventions (evidence-based, non-invasive, and drug-free treatments designed to prevent, manage, or treat health conditions) done prior to administering this medication: 1. Offered prune juice. 2. Encouraged to drink more fluids. 3. Increase fiber intake. 4. Exercise. Dated 12/05/2023. - Bisacodyl suppository given rectally every 24 hours as needed for constipation, if Bisacodyl tablet and Miralax were ineffective. Non-Pharmacological Interventions done prior to administering this medication: 1. Offered prune juice. 2. Encouraged to drink more fluids. 3. Increase fiber intake. 4. Exercise. Dated 02/12/2025. - Fleet Oil Enema given rectally every 24 hours as needed for constipation. 1 time for failure of oral bowel medications and suppository, or per if the patient requests for constipation. Dated 12/05/2023. - MiraLax Powder given orally every 24 hours as needed for no BM after 2 days. Non-Pharmacological Interventions done prior to administering Miralax: 1. Offered prune juice. 2. Encouraged to drink more fluids. 3. Increase fiber intake. 4. Exercise. Dated 12/05/2023. A review of Resident 8's bowel movement record documented the resident did not have a bowel movement on 01/16/2026, 01/17/2026, 01/18/2026 and 01/19/2026, a span of 4 days. A review of Resident 8's January 2026 MAR documented no bowel medications ordered were given in January. On 02/12/2026 at 10:39 AM, Staff H, Licensed Practical Nurse (LPN)/Unit Manager (UM), said Resident 8 should have been administered bowel medications on January 18th. On 02/13/2026 at 12:55 PM, Staff B, DNS, said his expectation was for the bowel protocol to have been started, for staff to document if a resident refused and to notify the provider. Resident 12Resident 12 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 12 was rarely/never understood or able to understand others. Review of the January 2026 and February 2026 Bowel Elimination record documented Resident 12 had no BM's from 01/12/2026-01/14/2026 (3 days) (with a small BM on 01/15/2026), 01/16/2026-01/19/2026 (4 days), and 01/29/2026-02/02/2026 (5 days). Review of the January 2026 and February 2026 Documentation Survey Report Bowel Elimination record documented Resident 12 had no BM's from 01/10/2026-01/14/2026 (with a medium BM on 01/15/2026), 01/16/2026-01/19/2026 (4 days), and 01/29/2026-02/02/2026 (5 days). A nursing progress note dated 01/14/2026 at 7:00 PM, documented Bisacodyl was administered. with a follow up progress note, dated 01/15/2026 at 4:17 PM, that documented the Bisacodyl was ineffective. Bisacodyl was administered again on 01/15/2026 at 7:02 PM. A progress note, dated 01/16/2026 at 5:40 AM, documented the Bisacodyl was ineffective. No further progress notes were found related to the current no BM episode. No progress notes were found showing the bowel protocol had been initiated for the 01/16/2026-01/19/2026 (4 days) no BM episode. No progress notes were found showing the bowel protocol had been initiated for the 01/29/2026-02/02/2026 (5 days) no BM episode. On 02/12/2026 at 9:40 AM, Staff C, Unit Manager/Licensed Practical Nurse (LPN), said the bowel protocol included 6 shifts with no BM, after that the day shift would complete non-pharmacological interventions, like prune juice or exercise, then evening shift with administer Miralax or Bisacodyl, resident preference. Staff would repeat this the following day. When shown the inconsistent documentation (Bowel Elimination record with small BM, Survey Report with medium BM and progress notes documenting no BM), Staff C said the documentation needed to be consistent, because they would not be able to tell if the resident had a BM or not. Staff C was shown the 01/16/2026 and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/29/2026 no BM episodes and said the bowel protocol should have been initiated, and the documentation should have reflected that. On 02/12/2026 at 10:13 AM, Staff B, DNS, was shown the inconsistent documentation for the 01/10/2026 BM episodes. Staff B said the documentation should have been consistent but stated the resident may have used the bathroom without staff knowledge. When shown the 01/16/2026 and 01/29/2026 no BM episodes, Staff B said the bowel protocol should have been initiated and documented. Reference WAC 388-97-1060 (1)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure fluid intake was accurately monitored, documented, and assessed for 2 of 2 residents (Residents 16 & 4) reviewed with a fluid restriction. The failure to accurately record fluid intake and to calculate the 24-hour fluid intake total, precluded staff from determining if residents was adherent with or were exceeding the fluid restriction. This placed residents at risk for fluid volume overload, fluid and electrolyte imbalances, unidentified education needs and other medical complications. Findings included .Review of the facility's Fluid Restriction policy, revised 01/2025, showed a fluid restriction order would include the total amount of the fluid restriction per day, and identify how the fluid would be distributed between dietary department and nursing. If a resident was non-adherent or refused the fluid restriction, staff would identify and document why, educate the resident on the risks and benefits of non-adherence and notify the physician.Resident 16Resident 16 was admitted to the facility on [DATE]. Record review showed the resident had a 07/18/2025 order for a 1500 milliliter (ml) fluid restriction. The order showed that day shift was allotted 800 ml; evening shift 500 ml; and night shift 200 ml. The order did not allot any fluids to the dietary department as directed in the facility's fluid restriction policy.An activity of daily living care plan, revised 08/01/2025, listed Resident 16's 1500 ml fluid restriction as an intervention. The comprehensive care plan did not include the reason for the fluid restriction (hyponatremia, low sodium) or identify what the goals of the fluid restriction were. Review of the electronic health record (EHR) showed Resident 16's fluid intake with meals was recorded under Nutrition-Fluids in point of care (POC), and the fluids provided by nursing were documented on the Medication Administration Record (MAR.) Review of the February 2025 MAR showed nurses recorded the amount of fluid they provided each shift. The MAR did not include any instruction to staff to reconcile the fluids recorded on the MAR with the fluid intake at meals recorded in POC. Nor was there a space provided for nurses to record the resident's total 24-hour fluid intake.When the fluid intake recorded on the MARs was reconciled with the fluid intake recorded with meals, for the seven-day period of 02/04/2026 -02/10/2026, it showed the following:02/04/2026 total fluid intake = 2240 ml; exceeded restriction.02/05/2026 total fluid intake = 2330 ml; exceeded restriction.02/06/2026 total fluid intake = 2060 ml; exceeded restriction.02/07/2026 total fluid intake = 2080 ml; exceeded restriction.02/08/2026 total fluid intake = 2080 ml; exceeded restriction.02/09/2026 total fluid intake = 2950 ml; exceeded restriction.02/10/2026 total fluid intake = 2440 ml; exceeded restriction.Additionally, during the seven-day period Resident 16's fluid intake for 5 of the 21 meals was left blank. Review of the EHR showed there was no documentation present to show Resident 16's 24-hour fluid intake totals had been calculated or that staff had identified the resident routinely exceeded the restriction. Resident 4Resident 4 was admitted to the facility on [DATE]. Record review showed the resident had a 07/31/2025 order for a 1500 ml fluid restriction. The order showed that day shift was allotted 800 ml; evening shift 500 ml; and night shift 200 ml. The order did not allot any fluids to the dietary department as directed in the facility's fluid restriction policy.A nutrition care plan, revised 02/09/2026, listed Resident 4's 1500 ml fluid restriction as an intervention. The comprehensive care plan did not include the reason for the fluid restriction (hyponatremia, low sodium) or identify what the goals of the fluid restriction were. Review of the EHR showed Resident 4's fluid intake with meals was recorded under Nutrition-Fluids in POC, and the fluids provided by nursing were documented on the MAR. Review of the February 2025 MAR showed nurses initialed off on Resident 4's fluid restriction but did not record the amount of fluid they provided the resident on their shift. The failure of facility nurses to record the amount of fluid they provided Resident 4 precluded staff from being able to calculate the resident's 24-hour fluid intake totalDuring an interview on 02/13/2026 at 12:11 PM, Staff B, Director of Nursing Services, said Resident 16's and Resident 4's fluid restriction orders should have identified how much of the 1500 ml (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	per day was allotted to dietary and how much to nursing, nursing should have recorded the amount of fluid they provided, and the person or shift responsible for reconciling the resident's fluid intake and calculating the 24-hour fluid intake total, should have been identified and a place to document the total provided. Reference WAC 388-97-1060 (3)(i)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on interview and record review, the facility failed to provide documentation of records and evidence of real time analysis of their infection control program for 2 of 6 months (December 2025 and January 2026) reviewed for monthly line listings, monthly maps and/or monthly summaries for the facility's surveillance program. These failures could prevent the facility from identifying trends and implementing interventions that would prevent residents from acquiring facility related infections.Findings included.The facility's policy titled Infection Surveillance. dated 11/2025, documented Monthly time periods will be used for capturing and reporting data. Line charts will be used to show data comparisons over time and will be monitored for trends. On 02/12/2026 at 1:15 PM, Staff I, Infection Preventionists (IP)/Registered Nurse (RN), when asked if she had a line listing for December 2025, said no. Staff I said, she had been behind in December and decided to keep up with January and February because they were currently happening.On 02/13/2026 at 8:45 AM, Staff I, IP/RN, said she had been working on the line listing for December 2025 and she would be able to provide it within an hour. When asked if she had performed the antibiotic stewardship in real time in December, Staff I said there had been quite a few infections in the month of December that had not met criteria for antibiotics and she was working on it currently. Staff I said she had not had time to complete the line listing in December because she had been doing two jobs at that time.On 02/13/2026 at 9:25 AM, Staff I, IP/RN, said she was currently working on the December 2025 line listing. Staff I said she did not have monthly summaries for December 2025 and January 2026 and did not have a surveillance map for December 2025. Staff I said the purpose of the monthly summaries and surveillance maps was to document patterns of infections to see if there were concerns about transmission from resident to resident. Staff I said, I could not see what I was doing in December and what was going on as far as trends but the other months, yes I had a map, and I could see the trends. On 02/13/2026 at 12:55 PM, Staff B, Director of Nursing Services (DNS) said, the infection control program should contain monthly documentation that included a line listing, surveillance map, and a monthly summary. Staff B said the documentation was important for reporting, tracking, following where a source of infection was started, how long residents were to be on isolation, and when staff could come back to work. Staff B said going forward the line listing and map should be kept up to date.On 02/13/2026 at 11:44 AM, Staff I, IP/RN, provided a surveillance map and line listing for December 2025. On 02/13/2026 at 1:09 PM, Staff B, DNS, said the monthly summaries should be kept up to date and his expectation was for it all to be completed in real time.On 02/15/2026 at 1:35 PM, Staff A, Administrator, provided monthly summaries for November 2025, December 2025, and January 2026.Reference WAC 388-97-1320 (1)(a),1320 (2)(a)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promote and facilitate resident choice related to frequency and type of bathing and access to fluids of choice for 3 of 3 residents (Residents 4, 38 & 6) reviewed for choices. The failure to promote and facilitate resident self-determination by offering and honoring residents' choices related to bathing type and frequency and access to beverages of choice, placed residents at risk for poor hygiene, dehydration, feelings of powerlessness, and diminished quality of life.Findings included .Review of the facility's Promoting Resident Self Determination policy, revised 11/2024, showed it was the facility's practice to protect and promote resident rights by promoting and facilitating resident self-determination through support of resident choice. The facility would ensure that each resident had the opportunity to exercise autonomy regarding those things that were important in their life such as preferences. Each resident had the right to choose aspects of their daily routine (including sleeping, eating, bathing and waking times), consistent with their interests, assessments, and plans of care. In the event a resident refused care or treatment, the refusal would be documented and the care/treatment reoffered. Resident 4Resident 4 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 12/15/2025, showed the resident was cognitively intact, bathing/showering was not attempted, and choices related to bathing were Very Important. On 02/09/2026 at 3:12 PM, when asked if they could choose their frequency of bathing Resident 4 stated, No, I would prefer two showers a week, but you only get one. Resident 4 went on to explain each room had an assigned shower day and whatever day was assigned was when you would be showered. A self-care deficit care plan, revised 02/09/2026, showed Resident 4 required one-to-two-person assistance with bathing. Staff were directed to provide bathing with a goal of once a week, if they were unable to perform a shower, staff were to offer a bed bath. Another intervention on the same care plan directed staff to provide Bi-Weekly shower/bath/bed bath, shampoo and nail care. On 09/12/2026 at 10:23 AM, Resident 4 said being bathed bi-weekly or even once a week did not represent their goal for bathing which they indicated would be at least two times a week. Review of Resident 4's bathing record for the 30-day period of 01/14/2026 - 02/09/2026 showed the following.01/16/2026- Bed bath given01/23/2026- Bed bath given01/30/2026- refused02/06/2026- Bed bath given Review of the electronic medical record showed no documentation related to why the resident refused bathing on 01/30/2026 or documentation that staff offered the resident bathing the next day. Resident 38Resident 38 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact, dependent on staff for bathing, and choices related to bathing were Very Important. On 02/10/2026 at 10:16 AM, when asked if they could choose their frequency of bathing Resident 38 stated, No, when I came in, I would get two [showers] a week, but now I only get one and that is just terrible. Resident 38 said staff would tell you what your assigned shower day was, they did not ask for resident input. An activity of daily living (ADLs) care plan, revised 01/05/2026, documented Resident 38 required one person assistance with bathing, with a goal of providing bathing once weekly or as needed. If unable to perform a shower staff were directed to offer a bed bath. The care plan did not specify what unable to perform a shower meant (e.g. resident refusal or staff convenience). Further review showed Resident 38 was previously care planned to receive one to two showers a week, but the care plan was revised to one shower a week on 12/04/2023. On 09/12/2026 at 10:23 AM, when asked if they were included in establishing a goal (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of being bathed once a week as documented on their care plan, Resident 38 stated, No, that's not enough. Review of Resident 38's bathing record for the 30-day period of 01/14/2026 - 02/09/2026 showed the following.01/14/2026- Bed bath given01/21/2026- Bed bath given01/28/2026- Bed bath given02/04/2026- Bed bath given On 02/11/2026 at 11:44 AM, the facility was requested to provide information on who identified/obtained resident preferences, when and where they were documented. The facility provided their Promoting Resident Self Determination policy but it did not include who, how or when resident care preferences were identified or where they were documented. During an interview on 01/13/2026 at 12:40 PM, when asked how it was determined that Resident 4's and 38's goal for provision of bathing/showers was once a week when both resident's indicated that was not their goal Staff B, Director of Nursing Services, explained that the default was once a week, but the facility would provide bathing more frequently if requested. When asked if the facility staff asked the residents if one shower a week was an acceptable before care planning it as the goal Staff B indicated they would check into what the process was. No further information was provided. Resident 6 Resident 6 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 6 was cognitively intact and needed staff set up or clean up assistance for eating and activities of daily living (ADLs) except Resident 6 was dependent on staff for bathing. On 02/09/2026 at 11:23 AM, no water or fluids were observed at Resident 6's bedside and they said, I don't have water and I would like to get it. Resident 6 was asked, have you asked for water? And they said, No I just go without. On 02/10/2026 at 10:23 AM, no water or fluids were observed at Resident 6's bedside. Resident 6 was asked, do you have water? And they said, no. On 02/11/2026 at 8:12 AM, Resident 6 said they did not have water, and they were waiting on their breakfast tray. On 02/11/2026 at 8:26 AM, Resident 6 was sitting up in bed, eating their breakfast. A carton of milk and a cup of water were observed on Resident 6's tray. On 02/11/2026 at 11:26 AM, No water or fluids were observed at Resident 6's bedside, Resident 6 was asked if they wanted water and Resident 6 said yes. On 02/11/2026 at 11:27 AM, Staff K, Licensed Practical Nurse (LPN) went into Resident 6's room and said he did not see water at Resident 6's bedside. Resident 6 said they would like water with ice and Staff K said he would bring Resident 6 some water with ice. Staff K said he brings Resident 6 a cup of water to take with their medications, but Resident 6 will ask him to pour it out after they have taken their medications. Staff K said Resident 6 was not on a fluid striction and Resident 6 could have water at bedside, including a pitcher of water. On 02/11/2026 at 12:26 PM Staff H, Licensed Practical Nurse/Unit Manager said it was the responsibility of the hospitality aides to be offering water to residents, but there was not a hospitality aide today. Staff H said we should be offering water to residents if they were not on a fluid restriction or if we were not monitoring their fluids. The Certified Nursing Assistants should have been offering water throughout the day when there was not a hospitality aide. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/11/2026 at 1:20 PM, Staff B, Director of Nursing Services, said it was the hospitality aide's responsibility to offer water to the residents and water would be offered by the staff. Reference WAC 388-97-0900(1)-(4)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a clean, comfortable and homelike environment on 1 of 2 shower rooms ([NAME] Unit). The failure to ensure the floor was clean and in good repair and the vinyl wall panels were free of damage (cracks, missing pieces etc) placed resident at risk for a diminished quality of life and resulted in a less than homelike environment. Findings included . On 02/10/2026 at 10:16 AM, Resident 38 wanted to discuss the The state of the shower room. They stated, there are cracks in the floor that are filled with caulking, the walls are damaged, tiles are cracked and/or missing. It needs to be fixed. It is a mess. I suggested they stop using the shower room because it needs work badly. On 02/10/2026 2:19 PM, observation of the shower room outside the double doors to the [NAME] Unit revealed the following:The shower room flooring consisted of a seamless resinous (epoxy) surface. The flooring demonstrated extensive discoloration, surface wear, and areas of patching. The finish appeared degraded with heavy uneven discoloration throughout the room, particularly around the floor drain and high-traffic areas. A crack in the flooring greater than six feet long was filled with white one-inch-wide caulking. The fiberglass reinforced plastic (FRP) wall panel was damaged in multiple areas. One area at the lower right corner of the shower room was observed to be cracked and partially detached, exposing the underlying substrate material, which was not smooth, intact or cleanable. On 02/13/2026 at 12:58 PM, Staff B, Director of Nursing Services, observed the shower room and confirmed the degraded and heavily discolored flooring and damaged FRP panels. Staff B said the facility had plans to redo the shower room but had not gotten to it yet. Reference WAC 388-97-0880

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	505474	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martha and Mary Health Service	19160 Front Street Northeast Poulsbo, WA 98370

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure resident care plans (CPs) were reviewed, revised, and accurately reflected residents' care needs for 3 of 24 residents (Residents 4, 16 & 38) whose care plans were reviewed. These failures placed residents at risk for unidentified and/or unmet care needs and diminished quality of life.Findings included .Resident 4Resident 4 was admitted to the facility on [DATE]. Record review showed an order, dated 07/31/2025, for a 1500 milliliter (ml) per day fluid restriction secondary to hyponatremia (low sodium). A nutrition CP, revised 02/09/2026, documented the resident was on a 1500 ml per day fluid restriction. The care plan did not identify the goal of the fluid restriction, identify how the fluid would be allotted between the dietary department and nursing; instruct staff what action, if any, should be taken if the resident was non-adherent with the restriction (e.g., patient education, risk versus benefits, Physician notification etc.), or indicate whether the resident should have a water pitcher at bedside. On 02/13/2026 at 12:17 PM, Staff B, Director of Nursing Services, said a fluid restriction CP should have been developed that identified the goals of the fluid restriction and that included direction to staff related to what to assess and monitor, whether a water pitcher should be at bedside, and what action , if any, should be taken if the resident was non-adherent with the restriction. Resident 16, COVID-19 Care PlanResident 16 was admitted to the facility on [DATE]. Record review showed a 02/01/2026 nurses note that documented Resident 16 had a COVID rapid test performed which was positive for COVID-19. The resident was placed on isolation with aerosol precautions. Review of the COVID-19 CP, initiated 01/31/2026, directed staff to follow contact/droplet precautions when providing care, monitor the resident for psychosocial symptoms/risks related to being on isolation, educate family members on transmission-based precautions, provide alternate methods of communication and to provide or modify activities of choice within guidelines and limitations of isolation precautions. The CP did not include direction to staff to assess/monitor the residents for respiratory signs and symptoms and/or complications. On 02/13/2026 at 12:17 PM, Staff B, DNS, said Resident 16's COVID CP should have included direction to assess/monitor their respiratory status and to notify the provider of any changes or complications. Fluid RestrictionReview of Resident 16's electronic health record showed they had an order, dated 07/18/2025, for a 1500 ml per day fluid restriction secondary to hyponatremia. An activity of daily living self-care deficit CP, revised 08/01/2025, had an intervention of Fluid restriction: 0600-1400 [day shift] = 800mL, 1400-2200 [evening shift] = 500mL, 2000-0600 [Night shift] = 200mL. The CP did not identify what the 24-hour fluid restriction was (e.g. 1500 ml/day); identify how the fluid would be allotted between the dietary department and nursing; direct staff what action, if any, staff should take if the resident was non-adherent with the restriction; identify what the goal of the fluid restriction was (e.g. fluid volume overload, hyponatremia etc.); indicate whether the resident should have a water pitcher at bedside. During an interview on 02/13/2026 at 12:17 PM, Staff B, DNS, said a fluid restriction CP should have been developed that identified the goals of the fluid restriction and that included direction to staff related to what to assess and monitor, whether a water pitcher should be at bedside, and what action , if any, should be taken if the resident was non-adherent with the restriction. Resident 38, PASRRResident 38 was admitted to the facility on [DATE]. Review of a level I Preadmission Screening and Resident Review (PASRR) showed the resident had diagnoses of mood disorder; anxiety disorder, delusional disorder (a type of serious mental illness (psychotic disorder) characterized by the presence of one or more, often non-bizarre, false beliefs (delusions) lasting at least one month, while the person otherwise functions relatively normally) and personality disorder (a type of mental health condition characterized by long-term, inflexible, and unhealthy patterns of thinking, functioning, and behaving). Review of the Level II PASRR treatment plan, dated 02/25/2020, showed facility staff were directed to speak with the (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 38's family members to determine what the resident's delusions presented as in the past and to clarify that delusions were present in the absence of metabolic encephalopathy and infection. Review of the comprehensive CP, initiated 07/11/2019, showed the resident's diagnoses of delusional disorder and personality disorder were not identified as problems/Focus, no goals of treatment or interventions were developed or implemented. The only mention of delusions was on a behavior monitor CP, initiated 07/11/2019, that directed staff to monitor for delusions or hallucinations. Nor did the comprehensive CP identify what Resident 38's delusions were. During an interview on 02/13/2026 at 1:05 PM, when asked if Resident 38's diagnoses of delusional disorder and personality disorder were addressed in the comprehensive CP Staff N, Social Service Director/ Case Manager, stated, No. Fluid RestrictionReview of the comprehensive CP, initiated 01/16/2020, showed under Special Instructions it was documented that Resident 38 was on a 1700 ml per day fluid restriction. Review of Resident 38's electronic health record showed the resident had an order, dated 09/22/2023, for a 1700 ml per day fluid restriction but it was discontinued on 10/23/2023. During an interview on 02/13/2026 at 1:05 PM, Staff N, Social Services Director/ Case Manager, said the CP needed to be updated.Reference WAC 388-97-1020(2)(c)(d)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure bathing services were provided as scheduled, or reoffered if refused, for 1 of 1 resident (Resident 14) reviewed for Activities of Daily Living (ADL) care. This failure placed residents at risk for poor hygiene, skin breakdown, reduced dignity and a diminished quality of life. Findings included.Review of the facility's Promoting Resident Self Determination policy, revised 11/2025, documented Each resident has the right to choose aspects of their daily routine (including sleeping, eating, bathing and waking times), consistent with their interests, assessments, and plans of care. In the event a resident refuses care or treatment, the refusal is to be documented and the care/treatment reoffered.Resident 14 was admitted to the facility on [DATE] with diagnosis of dementia. The Annual Minimum Data Set, (an assessment tool), dated 12/29/2025, documented Resident 14 was moderately cognitively impaired and had no rejections of care. On 02/10/2026 at 9:44 AM, Resident 14 was observed to have shiny oily looking hair, which was slicked down to their head. Resident 14's hair looked unkempt and messy, and observation showed a brown substance under their fingernails. When asked when their last shower was, Resident 14 was unsure. On 02/11/2026 at 8:25 AM, Resident 14 was observed to have hair plastered to their head, appearing to have oil in it, it appeared unkempt and the hair was going in different directions. When asked if they were offered showers regularly, Resident 14 said they did not remember.Review of Resident 14's care plan, reviewed on 02/10/2026, documented Resident 14 had an ADL self-care performance deficit related to increased weakness and decreased mobility secondary to dementia. The care plan documented for Bathing/Showering that Resident 14 required 1-2-person assistance with showers with a goal of once weekly or as needed. On 02/11/2026 at 1:06 PM, Staff D, Certified Nursing Assistant/Lead Shower Aide, said that Resident 14's shower day was Fridays. Staff D said Resident 14 sometimes refused showers. On 02/11/2026 at 1:12 PM, Staff C, Unit Manager/Licensed Practical Nurse, looked in the electronic health record at the last 30 days of showers for Resident 14, and reported Resident 14 last had a shower on 01/23/2026, 19 days previous. When asked for records of refusals and reapproaches since 01/23/2026, Staff C said she would check with the shower aide and find the information.On 02/11/2026 at 1:41 PM, Staff C said Resident 14 should have had two showers since their last one on 01/23/2026, but she could not find any documentation of refusals or reapproaches since that time. Staff C said there should have been documentation of refusals and reapproaches, it was not unusual for Resident 14 to refuse showers, but Resident 14 should have been showered since that time.On 02/13/2026 at 8:44 AM, Staff B, Director of Nursing Services, was informed of the observations of Resident 14's hair being oily and unkempt. Staff B was informed Staff C had provided documentation and confirmed Resident 14 had not been showered since 01/23/2026 and was unable to provide documentation of refusals or reapproaches since that time. When asked if this met his expectations, Staff B said staff should attempt showers and reapproach if a resident was refusing and there should have been documentation of this. Reference WAC 388-97-1060(2)(c)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure medications were administered within ordered parameters for 1 of 5 residents (Resident 3) reviewed for unnecessary medications. This failure placed residents at risk of receiving medications outside of ordered parameters and a decreased quality of life.Findings included.Resident 3 was admitted to the facility on [DATE]. According to the Quarterly Minimum Data Set (an assessment), dated 12/23/2025, Resident 3's skills for daily decision making were moderately impaired.Resident 3 had an order, dated 02/17/2025, for Hydrocodone-Acetaminophen (pain medication) to be given every four hours as needed for moderate to severe pain with a pain score of 6-10 (the numbers were based on a numeric rating scale for pain assessment, where 0 represent no pain and 10 represents the worst pain imaginable)Review of Resident 3's Medication Administration Record (MAR) from 01/01/2026 through 01/31/2026, documented the Hydrocodone-Acetaminophen had been administered 38 times outside of the ordered parameters, with numeric pain scores documented under level 6. Review of Resident 3's MAR from 02/01/2026 through 02/10/2026, documented the Hydrocodone- Acetaminophen had been administered four times outside of the ordered parameters, with numeric pain scores documented under level 6.On 02/12/2026 at 3:16 PM, Staff C, Unit Manager/Licensed Practical Nurse, reviewed the January and February 2026 MARs and acknowledged the pain medication had been given outside of ordered parameters and said it should not have been given outside of parameters.On 02/13/2026 at 8:47 AM, Staff B, Director of Nursing Services, regarding Resident 3's pain medication given outside of parameters in January and February 2026, said this did not meet his expectations. Staff B said staff should try nonpharmacological interventions (non-medication interventions) first, then other pain medications if available next, and if pain was not relieved then staff should check with the provider to see if they were able to give the medication outside of parameters. Reference WAC 388-97-1060(3)(k)(i)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review and interview, the facility failed to maintain a medication error rate of less than 5%, by having an error rate of 8%, with 2 of 25 medication administration errors for observed opportunities. This failure placed residents at risk of medication complications, misuse of medications, and a diminished quality of life. Findings included.MEDICATION NOT GIVEN AS ORDEREDOn 02/11/2026 at 9:37 AM, Staff E, Registered Nurse, said that Resident 13 had just finished their breakfast and she would be giving ferrous sulfate, a medication ordered to be taken with breakfast.On 02/11/2026 at 9:51 AM, Resident 13 was observed to be given the ferrous sulfate, along with pantoprazole.Review of the order for Pantoprazole, dated 11/18/2025, included to take the medication with an empty stomach approximately 30 minutes to 1 hour before meal. On 02/12/2026 at 11:13 AM, Staff E, said the pantoprazole should have been give on an empty stomach, not after breakfast. On 02/12/2026 at 11:35 AM, Staff B, Director of Nursing Services (DNS), when asked about Staff E giving ferrous sulfate and pantoprazole when Resident 13 had just had breakfast, said it did not meet their expectations. MEDICATION LEFT AT BEDSIDEOn 02/11/2026 at 8:56 AM, Staff F, Licensed Practical Nurse, was observed giving medications to Resident 36. Staff F gave Resident 36 a plastic cup with approximately 8 ounces of liquid with medication polyethylene glycol (bowel medication) dissolved in the liquid. Staff F told Resident 36 to keep the medication and sip on it, then left the room leaving the medication with the resident.On 02/11/2026 at 9:01 AM, Staff F was asked if it was acceptable to leave medication with the resident, Staff F said she probably should have stayed with Resident 36, but they would not have drank the medication right away. On 02/12/2026 at 10:39 AM, Staff B, DNS, regarding the observation of polyethylene glycol being left with Resident 36 to finish, said a resident should have a self-assessment prior to having medication left at bedside. Staff B said they believed Resident 36 had a self-administration of medication assessment done.Review of the electronic health record showed there was a self-administration of medication document for Resident 36, dated 02/11/2026 at 10:01 AM, over an hour after the observation of the medication being left at Resident 36's bedside.Reference WAC 388-97-1060(3)(k)(ii)