STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2024
NAME OF PROVIDER OR SUPPLIER: Northwoods Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE: 2321 Schold Place Northwest Silverdale, WA 98383	

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 - 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** 45203 Based on interview, observation and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice when a change of condition was not addressed timely for 1 of 3 residents (Resident 1) and when neurological (neuro) assessments were not consistently performed following unwitnessed falls for 3 of 3 residents (Resident 1, 2, and 3) reviewed for quality of care. Resident 1 experienced harm when they had to be emergently transferred to the hospital when they had a significant change in their baseline cognition and status following an unwitnessed fall. These failures placed residents at risk for medical complications, poor clinical outcomes, unmet care needs, pain, and a diminished quality of life. Findings included . Review of the facility policy, titled, Change in Resident's Condition or Status, revised May 2017, documented the nurse would notify the physician or physician on call when there was a change in the residents' physical, emotional, or mental condition. Review of the facility policy, titled Falls-Clinical Protocol, revised March 2018, documented residents would be assessed for fall risks. Nursing staff would assess, document and report changes in cognition or level of consciousness, neurological status, and pain. Review of the facility document, titled, Incident Report Licensed Nurse Checklist, undated, documented nurses were to initiate neuro checks for all residents that hit their head or any unwitnessed falls for patients that were not cognitively intact. The document included a page titled, [facility name] Neurological Record. The bottom of that document showed neuro checks were to be performed every 15 minutes times four, then every hour times four, then every shift for 72 hours. <Resident 1> Resident 1 was readmitted to the facility on [DATE] with diagnoses and problems including a lumbar compression fracture with recent surgical intervention, frequent falls and a baseline cognitive disorder. The Medicare 5-day Minimum Data Set (MDS), an assessment tool, dated 09/15/2022, documented Resident 1 was cognitively impaired. The care plan, initiated 09/08/2022, documented Resident 1 was alert and oriented to person, place, time, and situation. Per the care plan, Resident 1 had hearing and visual impairment and was at risk for falls. (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 - Actual harm Residents Affected - Few	Review of a provider note, dated 09/19/2022 and untimed, documented Resident 1 was in no acute distress, their pain appeared well controlled, and the resident appeared comfortable. The resident had a urinalysis that showed signs of a urinary tract infection and an antibiotic was started. The resident also showed increased wheezing and coughing and a chest x-ray was ordered. Chest x-ray results were not found in the medical record or provided by the facility. Review of a daily skilled summary note, dated 9/19/2022 at 11:01 PM, documented, Resident 1 was more alert and less confused, oriented to person, no cognitive or behavior changes were noted, no changes to speech noted, cough and weakness were noted, Resident 1 reported severe pain, and the pain medication increased their ability to rest. Review of a daily skilled nursing note, dated 09/20/2022 at 8:15 PM by Staff D Licensed Practical Nurse (LPN), documented Resident 1 had increased confusion, was fearful, unaware of surroundings and situation, and staff were unable to reorient Resident 1. Resident 1 displayed jumbled speech and decreased oral intake of less than 50% of their food and fluids were offered. Documentation of provider notification of these assessed findings was not found in the medical record or provided by the facility. Review of a facility investigation report, dated 09/21/2022 at 4:06 PM, documented Resident 1 was found on the floor and reported he fell while using his walker, unassisted. The report documented when the resident was asked what happened, they said, I was just moving and felt like it. Resident 1 was assessed for injury, with no injuries noted and neurological assessments were initiated. Review of Resident 1's medical record showed neurological assessments were performed at 4:06 PM, 4:21 PM, 4:36 PM, 4:51 PM, 5:51 PM. Review of a daily skilled summary note, documented by Staff D, dated 09/21/2022 at 8:10 PM, showed Resident 1 called out loudly, repeatedly, was confused, disoriented and restless. Resident 1's speech was jumbled and unintelligible. Resident 1 was unable to tolerate repositioning without extreme pain even with two-person assist, and decreased oral intake of food and fluids eating less than 25% of food and fluids offered, rattled breathing and shortness of breath [SOB] noted at rest, worsened with lying flat, and disoriented, and severe pain continues this shift, now unable to tolerate efforts to reposition. Documentation of provider notification of these assessed findings was not found in the medical record or provided by the facility. Review of a neuro check summary, dated 09/21/2022 at 9:10 PM, documented Resident 1 was restless, lethargic, drowsy, unable to follow commands, and words were unintelligible. Documentation of provider notification of these assessed findings was not found in the medical record or provided by the facility. There were no clinical notes or neuro check summary notes in Resident 1's medical record between 09/21/2022 at 9:10 PM to 09/22/2022 at 6:17 PM, when a late entry note was made regarding the resident's condition at 8:45 AM on 09/22/2022. No additional documentation was provided by the facility. Reivew of a nursing note, dated 09/22/2022 at 6:17 PM, documented at 8:45 AM that morning Resident 1 had been found moaning loudly, unable to swallow or drink fluids, unable to follow simple commands and was transported to the emergency room (ER) for evaluation. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of an ER Provider note, dated 09/22/2022 at 9:21 AM, documented the resident arrived at the ER for decreased mental ability/confusion. The resident was unable to voice any words and any movement caused them pain. The ER provider documented the emergency medical transport service staff received a limited report, as it was change of shift at the facility. Resident 1 was admitted to the intensive care unit based on the number of fractures and for severe sepsis. A hospital diagnostic imaging report, dated 09/22/2022 at 10:43 AM, documented Resident 1 was found to have multiple sternal (breastbone) fractures, multiple right upper rib fractures involving the first through fifth ribs, and new compression fracture deformities of C7, T1, T2, T3, T4 (Cervical and Thoracic vertebra) and a small, new right sided pleural effusion (excessive collection of fluid in the lungs). On 01/11/2024 at 3:40 PM, Staff C, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM), said when staff find a resident on the floor, staff were to get help, make sure the resident was safe and allow the nursing staff to start their assessments on the resident, including neurological checks. Staff C said neuros were supposed to be completed every 15 minutes for one hour, then once an hour for four hours and then every shift for 72 hours. Staff C said if there were any concerns regarding the resident, they were documented in the medical record. Staff C said staff were to notify the Care Manager, the provider, and the family. At 3:55 PM, when asked about Resident 1's condition, Staff B, Registered Nurse (RN), Administrator in Training (AIT) and Director of Nursing Services (DNS) (with Staff A, Administrator, present for interview), said Resident 1 was admitted to the facility with a lumbar fracture. Staff B said the Resident was in a lot of pain and hollering out. Staff B said a Certified Nursing Assistant found Resident 1 on the floor on 09/21/2022. Staff B said Staff D, LPN, had stayed with Resident 1 all that night. Staff B said Staff D had first kept the medication cart outside Resident 1's room to keep a visual on them and then after Staff D had completed their medication pass to their assigned residents, Staff D was reported to have been in Resident 1's room all night. Staff B said Resident 1 was found non-responsive at 8:45 AM on 09/22/2022. When asked about Resident 1's neuro checks, Staff B said neuro checks were completed at 4:06 PM, 4:21 PM, 5:50 PM, and 9:10 PM. On 01/12/2024 at 10:45 AM, Staff B, RN/AIT/DNS (with Staff A, Administrator, present for interview), when asked why only four neuro checks were documented, Staff B said the staff member was sitting in the room with Resident 1 all night. When asked about staff documentation including assessments, neuro checks and progress notes regarding Resident 1, Staff B stated, unfortunately she was not charting what she needed to chart. When asked if neuro checks should have been completed, Staff B said Staff D had not done neuro checks because Resident 1 had no abnormalities in his baseline. On 02/12/2024, Collateral Contact 1 (CC1) said they visited Resident 1 every day and CC1 said after they left on the day Resident 1 fell (09/21/2022), they were called by the facility and informed Resident 1 fell and was found in front of the bathroom floor, but everything was fine. The following morning (09/22/2022), CC1 said they received a call that Resident 1 was non-responsive, and they were sending the resident to the hospital. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 03/28/2024 at 2:11 PM Staff B, RN/AIT/previous DNS, said residents who had unwitnessed falls would be assessed for injury and neuro assessments would be completed. Staff A said the suggested/recommended times for completion of neuros were every 15 minutes for four times, then every hour for four times and then every shift for 72 hours. Staff B said the LNs would be reassessing for injury during the neuro assessments. Staff B said she would expect LN staff to notify the provider if changes from baseline were noted. When asked if a resident was documented to have increased pain, lethargy, and confusion, would she expect the provider to be notified, Staff B responded, Yes. At 5:09 PM, Staff D, LPN, said when a resident had an unwitnessed fall, they were assessed for injury neuro checks were initiated. Staff D said neuro checks were to be performed every 15 minutes times four, then every hour times four, and then every shift for 72 hours. Staff D said changes to a resident that would cause her concern included, increased pain and decrease in cognition or function. Staff D said she would report these to the provider and the oncoming shift. Staff D said she recalled Resident 1 by name, and could recall some details of his stay, she recalled he had a fall (prior to the fall on 9/21/2022) and went to the hospital and readmitted back to the facility. Staff D recalled Resident 1 had confusion, back pain, and would call out as a baseline. Staff D could not recall notifying the provider for any concerns but said she may have through the secured electronic record. Staff D said she believed she had completed the neuros on Resident 1 and that this might have been done on paper and not transcribed to the electronic record. The facility did not provide any additional documentation regarding communication to a provider and or completion of additional neuro checks for Resident 1. <Resident 2> Resident 2 was admitted to the facility on [DATE]. The Admission MDS, dated [DATE], documented the resident was medically complex and cognitively impaired. The care plan, initiated on 03/11/2024, documented Resident 2 was at risk for falls. Review of a nursing note, dated 03/26/2024 at 6:33 AM, documented Resident 2 reported he had an unwitnessed fall in the bathroom the night before but had not told anyone until that morning and then they started neuro checks. Review of Resident 2's medical record showed the first neuro check was documented on 03/26/2024 at 12:52 PM, over six hours after Resident 1 informed facility staff of the fall. The next neuro check was at 4:07 PM. The last documented neuro check was documented on 03/27/2024 at 6:06 PM. Neuros were not completed every 15 minutes times four or every four hours times four. On 03/28/2024 at 11:42 AM, Resident 2 was observed laying on his back in bed with blankets over the lower half of his body. When asked about the fall on 03/08/2024, Resident 2 said he had fallen in the middle of the night, while using the bathroom. Resident 2 said he did not use the call light, nor did he call out for help, he pulled himself back into his wheelchair and returned to bed. Resident 2 said the next morning, during a dressing change, it was noted he had a large cherry blossom (red bruise) on the back of his right thigh. At this point, Resident 2 pulled off the blankets and pointed to the back of his right thigh. Resident 2 said that is when he informed staff about the fall. Resident 2 said the only thing staff had done was tell him to start wearing non-skid socks. <Resident 3> (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Resident 3 was admitted to the facility on [DATE]. The Admission MDS, dated [DATE], documented the resident was medically complex and cognitively impaired. The care plan initiated on 03/03/2024 documented Resident 3 was at risk for falls. Review of a nursing note, dated 03/08/2024 at 9:00 PM, documented Resident 3 had an unwitnessed fall in the bathroom and neuros were initiated. Review of Resident 3's medical record showed neuros were initiated on 03/09/2024 at 11:25 AM, over 14 hours after the fall with checks on/at 03/10/2024 at 3:37 AM, 03/10/2024 at 3:41 PM, 03/11/2024 at 3:09 AM, and 03/12/2024 at 2:15 AM. Neuros were not completed every 15 minutes times four or every four hours times four. On 03/28/2024 at 1:34 PM, Staff E, Registered Nurse, said when a resident was found on the floor the nurse was to complete a head-to-toe assessment for injuries and ask what happened. Once the initial assessment was completed, staff were to help the Resident back to bed if applicable and start neuro checks. Staff E said neuro checks were to be completed every 15 minutes for the first hour, then once an hour for four hours and then once a shift for 72 hours. Staff E said the facility staff were to notify the provider and family of the incident. Staff E showed a blank copy of Incident Report Licensed Nurse Checklist, and said staff will fill out the paper copy of the neuro checklist packet and when it was completed it was given to the Resident Care Manager. Staff E said everything was entered into the electronic health record. On 03/28/2024 at 2:45 PM, Staff A and Staff B were given until close of business 03/29/2024 to provide any additional documentation. The facility did not provide any additional documentation. Reference WAC 388-97-1060 (1)