STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505484	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northwoods Lodge	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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40914 Based on interview and record review, the facility failed to thoroughly investigate allegations of abuse, neglect, and accident hazards for 4 of 5 residents (1, 2, 3, & 4) reviewed for abuse, neglect and accidents. The failure to thoroughly investigate an allegation of staff to resident mistreatment, identify the alleged perpetrator (AP), and implement interventions to ensure the alleged victims (AV) and other residents' safety, placed residents at risk for continued abuse/neglect, psychosocial harm, accident risk, and decreased quality of life. Findings included . <Resident 1> Resident 1 was admitted to the facility on [DATE] with diagnoses of major depressive disorder, bipolar disorder (mental illness that can cause unusual shifts in mood, energy, activity levels, and concentration), and heart failure. The quarterly Minimum Data Set (MDS), dated [DATE], documented Resident 1 has severe cognitive impairment. Resident 1 required partial to moderate assistance from staff with activities of daily living (ADLs). The care plan, dated 06/28/2024, documented Resident 1 was at risk for falls due to a decline in the resident's function, decreased independence and having had ten falls. Interventions included that staff would ensure the resident's needs were met, furniture was locked, was not moved, and a clear pathway was maintained. A sensor alarm would be used in the resident's wheelchair and while in bed to alert staff of a potential fall. Resident 1 would have one-to-one supervision while up and in their wheelchair due to poor safety awareness and elopement risk. Progress notes, dated 07/01/2024, documented one-to-one continued for the shift. Progress notes, dated 07/05/2024, documented Resident 1 was on a one-to-one for safety. Progress notes, dated 07/06/2024, documented Resident 1 had sustained a fall at 1 AM and the nurse who responded documented her assessment which matched the fall investigation. When the resident was questioned as to why she was trying to get up, the resident said she was trying to see what everyone was doing outside and verbalized that her room was different, and it didn't feel like her home. The note showed the resident had been moved that same day to be in a room with another resident that required a one-to-one. The nurse documented Resident 1 had only been scheduled to have a one-to-one during the day and evening shifts but not on the night shift. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility fall investigation, dated 07/06/2024, documented Resident 1 was found on the floor of their room at approximately 1 AM, was assessed for injuries and assisted back to bed. The investigation showed the nurse who responded to the fall noted the resident was on the floor, bare foot, the floor was wet, and the resident's sensor alarm was not on. The last documented visual check was at 12:45 AM. The Nursing Assistant was educated about the sensor alarm not being on, ensuring proper footwear, an x-ray was ordered of the resident's hip, and they were transferred to the emergency room for right hip fracture, notifications were made. Contributing factors to the fall were notes as; the floor was wet, the resident recently changed rooms, and was ambulating without assistance. The facility did not have findings of abuse or neglect. The investigation did not include a thorough evaluation of all factors contributing to Resident 1's fall. The facility did not consider the absence of the one-to-one sitter, the wet floor or the recent change in room or develop additional interventions regarding these issues. The facility did not obtain statements from all potential witnesses. The facility did not provide a statement from Staff E to further understand the missing bed alarm one-to-one observation. On 09/27/2024 at 4:00 PM, Staff B, Registered Nurse (RN) and Director of Nursing (DNS), said they did not complete a thorough investigation of Resident 1's falls. <Resident 2> Resident 2 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD) and ischemic cardiomyopathy (the heart muscle cannot pump effectively due to lack of blood supply). The admission MDS, dated [DATE], documented Resident 2 had moderate cognitive impairment. Resident 2 required supervision with ADLs. Progress notes, dated 06/22/2024, documented staff had found the resident in the facility parking lot. Resident 2 said they wanted to leave and get out of here. A nurse from another unit brought the resident back to the nurses' station in a wheelchair and reported they had been found in the parking lot of the facility. Resident 2 had been seen ten minutes prior. Notifications were made and the resident was placed on a one-to-one. The facility investigation was requested but no written documentation to show the incident was thoroughly investigated was provided. On 09/27/2024 at 4:00 PM, Staff B, said she could not provide documentation of the investigation. Staff B said they were aware of issues with investigations and were working on addressing concerns. <Resident 3> Resident 3 was admitted to the facility on [DATE] with diagnoses of pancreatic cancer and sepsis (a life-threatening emergency that happens when your body's response to an infection damage vital organs). The quarterly MDS, dated [DATE], documented Resident 3 had no cognitive impairment. Resident 3 required partial to moderate assistance from staff with ADLs. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility investigation, dated 06/30/2024, showed Resident 3 reported two [descriptor] male CNAs responded to the call light and started going through Resident 3's drawers and cabinets. The resident said one NA walked out of the room while the other began to provide incontinence care. Resident 3 had to tell the NA How to do his job and he was rough when turning the resident. Resident 3 said this was not ok. The resident did not want to be cared for by male agency staff anymore. A key was given to the resident for a locked drawer to keep her belongings. The investigation did not address the concerns with rough treatment by the NAs. The investigation did not include identification of the staff or interviews with staff. The facility did not update the resident's care plan to address the request of no male agency staff. On 09/27/2024 at 4:00 PM, Staff B, said they did not address all concerns reported by Resident 3 and the care plan should have been updated. The facility did not complete a thorough investigation. <Resident 4> Resident 4 was admitted to the facility on [DATE] with diagnoses of kidney failure and diabetes mellitus. The quarterly MDS, dated [DATE], documented Resident 4 has moderate cognitive impairment. Resident 4 requires supervision with ADLs. Progress notes, dated 08/04/2024, documented Resident 4 reported pain in their lower back and hips. The resident reported they had fallen in the bathroom on 08/02/2024. Resident 4 said they bounced around like a ping-pong ball hitting their right hip and head on the sink. They fell to the floor and got stuck underneath the sink. A neurological check was completed with no concerns identified. Bruising was found to the resident's right hip and lower back. The decision was made to send the resident to emergency room . Fall investigation, dated 08/02/2024, documented no finding of abuse or neglect. The investigation did not show evidence of interviews or a summary to determine the root cause of the fall. On 09/27/2024 at 4:00 PM, Staff B, said they did not complete a thorough investigation of Resident 4's fall See F689 Reference WAC 388-97-0640 (6)(a)(b)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40914 Based on observation, interview and record review, the facility failed to provide the assessed level of supervision required to ensure residents were free from avoidable accidents for 1 of 3 residents (Resident 1) reviewed for accident hazards. Additionally, the facility failed to document supervision for 2 of 2 residents (Residents 1 & 2) reviewed for accident hazards. Resident 1 experienced harm when they fell from bed and sustained a hip fracture, pain, and hospitalization . This failure placed residents at risk for injury and a diminished quality of life. Findings included . Resident 1 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, bipolar disorder (mental illness that can cause unusual shifts in mood, energy, activity levels, and concentration), and heart failure. The quarterly Minimum Data Set (MDS), dated [DATE], documented Resident 1 had severe cognitive impairment and required partial to moderate assistance from staff with activities of daily living (ADLs). The 06/28/2024 MDS documented Resident 1 had two falls with no injury during the assessment period. The MDS, dated [DATE], documented Resident 1 had two falls with no injury during the assessment period. The care plan, dated 06/28/2024, documented Resident 1 was at risk for falls due to a decline in the resident's function, decreased independence and having had ten falls. Interventions included that staff would ensure the resident's needs were met, furniture was locked, was not moved, and a clear pathway was maintained. A sensor alarm would be used in the resident's wheelchair and while in bed to alert staff of a potential fall. Resident 1 would have one-to-one supervision while up and in their wheelchair due to poor safety awareness and elopement risk. Resident 1's medical record showed Resident 1 had unexpected falls on 05/19/2024, 05/30/2024, 06/01/2024, twice on 06/02/2024, 06/03/2024, 06/08/2024, 06/12/2024, 07/05/2024, and 07/06/2024 (fall with major injury). The facility did not consistently identify the root cause of the falls, complete an assessment to identify a pattern in Resident 1's falls, or ensure interventions were implemented to prevent an unexpected fall. On 06/08/2024, Resident 1 was found sitting on the floor in her room. The sensor alarm was not attached to the resident. The NA (nursing assistant) was educated on the use of the sensor alarm and one-to-one supervision was implemented on 06/10/2024. Physician orders, dated 06/10/2024, showed orders for one-to-one supervision for Resident 1. Physician orders, dated 06/25/2024, showed updated orders for one-to-one supervision while the resident was up in their wheelchair due to poor safety awareness and elopement risk during all shifts. Progress notes, dated 07/01/2024, documented one-to-one continued for the shift. Progress notes, dated 07/05/2024, documented Resident 1 was on a one-to-one for safety. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Progress notes, dated 07/06/2024, documented Resident 1 had sustained a fall at 1 AM and the nurse who responded documented her assessment which matched the fall investigation. When the resident was questioned as to why she was trying to get up, the resident said she was trying to see what everyone was doing outside and verbalized that her room was different, and it didn't feel like her home. The note showed the resident had been moved that same day to be in a room with another resident that required a one-to-one. The nurse documented Resident 1 had only been scheduled to have a one-to-one during the day and evening shifts but not on the night shift. Facility fall investigation, dated 07/06/2024, documented Resident 1 was found on the floor of their room at approximately 1:00 AM, was assessed for injuries and assisted back to bed. The investigation showed the nurse who responded to the fall noted the resident was on the floor, bare foot, the floor was wet, and the resident's sensor alarm was not on. An x-ray was ordered of the resident's hip, and they were transferred to the emergency room for right hip fracture. Contributing factors to the fall were noted as; the floor was wet, the resident recently changed rooms and was ambulating without assistance. The hospital History and Physical, dated 07/07/2024, documented Resident 1 had sustained a right hip fracture because of a fall. The resident's hip fracture did not require surgical intervention. On 09/05/2024 at 8:02 AM, Staff E, NA, said they were an agency NA. Staff E was Resident 1's primary care giver on the night the resident fell . Staff E said someone had called in shortly before the shift started and the shift was not covered, causing the staff to have to pick up additional residents. Staff E was assigned to Resident 1 and their roommate, who both required one-to-one supervision, and about ten other residents. A nurse told Staff E everything would be fine, and they would help them watch residents. Staff E said they were aware Resident 1 required a sensor alarm and knew it was on the resident at one point. Staff E did not have time to check to make sure the sensor alarm was still in place. Staff R was helping other resident's when Staff F, NA, found Resident 1 on the floor. Staff E said they were not asked to give a statement regarding contributing factors to Resident 1's fall. Staff E said they felt they were blamed for Resident 1 falling and Staff E was asked not to return to the facility. On 09/26/2024 at 11:45 AM, Staff G, NA, said they were an agency NA who worked the night of Resident 1's fall. Staff G said they remembered Resident 1 required one-to-one supervision due to a fall risk. Resident 1 had been recently moved from a room next to a nurses' station to another room at the end of the hall. Resident 1 was moved into a room with another resident who required one-to-one supervision. Staff G said, in all their experience, they had never seen a resident at risk for falls moved further from staffs' view. Staff G said it was too far to see in the room. Staff G said they were not involved in Resident 1's care the night of the fall, but did recall that staff called in and were not replaced and this increased everyone's workload. The staff caring for Resident 1 had two residents requiring one-to-one supervision and other residents to provide care. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 09/27/2024 at 10:01 AM, Staff F said they were an agency NA who worked the night of Resident 1's fall. Staff F said a staff member called in shortly before the shift started and no one was called in to cover the shift. Staff F said Staff E had two residents who required one-to-one supervision as well as other residents to assist. Staff F said normally the facility provided enough staff to cover the shift, but this was a unique night. Staff F said the number of staff were not enough to cover the one-to-one supervision needed for Resident 1 and their roommate. During the shift, Staff E was called out of Resident 1's room. Staff F heard someone yelling and found Resident 1 on the floor in their room. Staff F called the nurse, and they assisted the resident back into bed. Staff F said they were not asked to give statements regarding contributing factors to Resident 1's fall. Facility NAC (Nursing Assistant - Certified) Daily Sheet, dated 07/05/2025, documented one one-to-one for Staff I, NA. No staff call-ins were noted. No rooms were noted to be assigned to each NAs. Staff E did not have a resident with one-to-one supervision assigned to them. On 09/27/2024 at 2:30 PM, an observation was made of Resident 1's original room which was directly across from the nurses' station and would provide for visual checks of the resident. The room was surrounded by the community area, busy with staff and visitors. Observations of the room Resident 1 had been moved to the same day as the fall with injury. The room was near the end of a long hall. The room was separated from the community area and away from activity of the facility. At 2:58 PM, Staff H, NA, said residents at risk for falls were kept in a highly supervised area. Staff H said residents who were high fall risk required frequent visual checks. Staff H said sometimes residents required a sensor alarm to alert staff if they were attempting to self-transfer. At 3:04 PM, Staff D, Registered Nurse (RN), said normally they would keep a resident near the nurses' station if they were at risk for falls. They need to make frequent visual checks of these residents. They often use sensor alarms if someone was a fall risk to alert staff if the resident attempted to get up. Staff D said they were unsure why Resident 1 was moved to a room down the hall because the prior room was next to the nurses' station. Staff D said there was no standard form or means of documenting the assessment of a resident once they fall. They used a post-fall form which addressed only the current fall, but they were not evaluating the overall history and patterns of resident's falls. At 3:24 PM Staff C, RN, said they had no standard falls assessment form to use when they needed to re-assess a resident for fall risk. Staff C said they would use nursing judgement to complete an assessment. At 4:00 PM, Staff B, RN and Director of Nursing (DNS), said they did not comprehensively assess Resident 1's fall. Staff B said they did not implement interventions consistently. Staff B was unaware a staff called off on the night of Resident 1's fall. Staff B said the NAC Daily Sheet should reflect the assignments and any updates due to call-ins. Staff B said Resident 1 was moved to be in the same room as another resident who required a one-to-one. Staff B admitted there were times a staff member would not be able to watch both residents. Staff B said there was no regular form used for fall risk assessment after admission. <1:1 supervision> <Resident 1> (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Resident 1 was admitted to the facility on [DATE] with diagnoses of major depressive disorder, bipolar disorder, and heart failure. The quarterly MDS, dated [DATE], documented Resident 1 has severe cognitive impairment. Resident 1 required partial to moderate assistance from staff with activities of daily living (ADLs). The care plan, dated 06/28/2024, documented Resident 1 is at risk for falls due to a history of decline in function and independence and repeated falls. Interventions showed Resident 1 would have one-to-one supervision while up in their wheelchair due to poor safety awareness and elopement risk. Physician orders, dated 06/10/2024, showed orders for one-to-one supervision for Resident 1. Physician orders, dated 06/16/2024, showed orders for one-to-one supervision for fall prevention. The resident has poor safety awareness. Invite resident into community area for visual supervision. Staff to meet need of resident (toileting, comfort, etc.). Physician orders, dated 06/25/2024, showed updated orders for one-to-one supervision while the resident was up in their wheelchair due to poor safety awareness and elopement risk during all shifts. Progress notes, dated 07/01/2024, documented one-to-one continued for the shift. Progress notes, dated 07/05/2024, documented Resident 1 was on a one-to-one for safety. A review of the medical record showed no documentation of one-to-one supervision for Resident 1. <Resident 2> Resident 2 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD) and ischemic cardiomyopathy (the heart muscle cannot pump effectively due to lack of blood supply). The admission MDS, dated [DATE], documented Resident 2 had moderate cognitive impairment. Resident 2 required supervision with ADLs. Progress notes, dated 06/22/2024, documented staff had found the resident in the facility parking lot. Resident 2 said they wanted to leave and get out of here. A nurse from another unit brought the resident back to the nurses' station in a wheelchair and reported they had been found in the parking lot of the facility. Resident 2 had been seen ten minutes prior. Notifications were made and the resident was placed on a one-to-one. A review of the medical record showed no documentation of one-to-one supervision for Resident 2. On 09/27/2024 at 4:00 PM, Staff B said they did not document one-to-one supervision. Staff B said they could not show the one-to-one supervision intervention had been implemented for Resident 1 or Resident 2. Reference WAC 388-97-1060(3)(g)