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	01/13/2025

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on interview and record review, the facility failed to ensure residents and/or their representatives were offered the opportunity to participate in care conferences for 5 for 6 sampled residents (Resident 21, 156, 154, 40 & 25) reviewed for right to participate in planning care. This failure placed residents at risk of a diminished quality of life when not allowed to be involved in their long-term care needs. Findings included . 1) Resident 21 was admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS, an assessment tool), dated 12/09/2024, documented Resident 21 was cognitively intact. On 01/07/2025 at 2:45 PM, Resident 21 said they had not had a care conference or any meeting to discuss their care while at the facility. The Electronic Health Record (EHR) documented Resident 21 had no care conference since being admitted . On 01/13/2025 at 10:01 AM, Staff A, Administrator, said no formal care conference was completed with Resident 21. Staff A said a care conference should have been completed. 42960 2) Resident 156 was admitted to the facility on [DATE]. The MDS 5-day scheduled assessment dated [DATE], documented Resident 156 was moderately cognitively impaired. On 01/07/2025 at 12:53 PM, Resident 156's representative said they had reached out to social services because they knew what they wanted for discharge and wanted to begin the process. A record review of the EHR showed Resident 156 had no care conferences since admission. On 01/10/2025 at 8:22 AM, Staff Y, Social Services Coordinator, said Resident 156's representative said they had reached out to her regarding discharge. A care conference was scheduled but Staff Y said she canceled it. On 01/13/2025 at 10:42 AM, Staff A, Administrator, said Resident 156 did not receive a care conference and her expectation would be for staff to document the rationale for why it was canceled. (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: 505484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER: Northwoods Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE: 2321 Schold Place Northwest Silverdale, WA 98383	

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) Resident 154 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 154 was cognitively intact. On 01/07/2025 at 12:10 PM, Resident 154 said they had not been contacted by staff to set up a care conference to discuss care planning or schedule a care conference. A record review of the EHR showed a progress note on 01/09/2025 by Staff Y, Social Services Coordinator, documented patient was wondering about her discharge status, and Staff Y said she would update them today after a meeting where staff reviewed care planning. On 01/13/2025 at 10:42 AM, Staff A, Administrator, said Resident 154 did not have a care conference and this did not meet her expectations because Resident 154 initiated a meeting with social services to discuss discharge planning. 4) Resident 40 was admitted to the facility on [DATE]. The 5-day MDS, dated [DATE], documented Resident 40 was moderately cognitively impaired. On 01/07/2025 at 2:18 PM Resident 40 said that they had not had a care conference and staff had not talked to them about scheduling one. A record review of Resident 40's EHR showed a progress note on 01/09/2025 by Staff Y, Social Services Coordinator, said Resident 40 asked her to call their representative to set up a care conference. On 01/10/2025 at 8:22 AM, Staff Y, Social Services Coordinator, said Resident 40 asked me to set up a care conference after I talked to them yesterday. On 01/13/2025 at 10:42 AM, Staff A said Resident 40 has not had a care conference and this does not meet her expectation because Resident 40 initiated the process of setting up a care conference. Staff A said in the future they plan to offer to set up a care conference when they provide residents their base line care plan and document it in the EHR. 5) Resident 25 was admitted to the facility on [DATE]. The Admission MDS, dated [DATE], documented Resident 25 was severely cognitively impaired. On 01/07/2025 at 10:28 AM, Resident 25's representative said they had not had a care conference, and they had to talk to the case worker to find out what the plan for discharge was after being admitted to the facility for 12 days. A Review of Resident 25's EHR showed Resident 25 had not had a care conference since admission. On 01/09/2025 at 3:10 PM, Staff G, Resident Care Manager said Resident 25 did not have a care conference. Reference WAC 388-97-1020(2)(f)

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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** 46793 Based on interview and record review, the facility failed to ensure resident choices regarding bathing type were honored for 1 of 4 sampled residents (Resident 103) reviewed for choices. The facility's failure to accommodate resident preferences related to type of bathing placed residents at risk for feelings of un-cleanliness, powerlessness, diminished self-worth, and a decreased quality of life. Findings included . Resident 103 was admitted to the facility on [DATE]. The Entry Minimum Data Set, an assessment tool, dated 01/05/2025, documented Resident 103 was cognitively intact, and required assistance with bathing and transfer. On 01/08/2025 at 9:25 AM, Resident 103 said they were told they could not have a shower and were told they could only receive a bed bath. Resident 103 stated, I want a shower. On 01/10/2025 at 6:23 AM, Resident 103 said they received a bed bath yesterday and was told they could not have a shower due to mobility. The Electronic Health Record documented Resident 103 was scheduled to receive showers on Tuesdays, Thursdays and Saturdays on evening shift. Resident 103 had received a bed bath on 01/07/2025 and 01/09/2025. On 01/10/2025 at 12:59 PM, when asked what would prevent a resident from receiving a bed bath instead of a shower, Staff D, Resident Care Manager, said if the resident needed a Hoyer lift, due to the Hoyer lift not fitting in the shower room, the resident would not receive a shower, but a bed bath instead. Staff D said physical therapy would assess a resident's ability to transfer and if the resident was not able to transfer, then they would receive a bed bath. On 01/13/2025 at 10:01 AM, Staff A, Administrator, said the only reason a resident would not receive a shower versus a bed bath would be resident preference or transfer status, meaning the resident was bed bound. Staff A said if the resident could be transferred to the shower chair, the resident should receive a shower per their preference. When asked if Resident 103 should have received a shower, Staff A said the expectation was the resident received a shower. Reference WAC 338-97-0900(1)-(4)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on interview and record review, the facility failed to provide a written transfer/discharge notice to the resident and/or their representative for 2 of 2 sampled residents (Residents 30 & 40), reviewed for hospitalization . This failure placed the resident and/or their representative at risk for not having an opportunity to make informed decisions about transfers/discharges. Findings included . 1) Resident 30 was admitted to the facility on [DATE]. The 5-Day Minimum Data Set (MDS, an assessment tool), dated 11/19/2024, documented Resident 30 was cognitively intact. Resident 30's Electronic Health Record (EHR) showed Resident 30 was transferred to the hospital on 11/12/2024 and returned to the facility on [DATE]. Resident 30's EHR did not show documentation that Resident 30 was offered and/or provided a transfer/discharge notice. On 01/10/2025 at 1:29 PM, Staff E, Admissions Coordinator, said the transfer notice should have been sent with the resident at the time of transfer to the hospital. Staff E said she was unable to determine if Resident 30 had a transfer notice sent with them to the hospital. On 01/13/2025 at 10:01 AM, Staff A, Administrator, said transfer notices should be completed in Point Click Care (PCC, Electronic Health Record system) and sent with the resident at the time of transfer. Staff A said if the transfer notice was not in PCC, then it was not completed. Staff A said a transfer notice should have been completed. 42960 2) Resident 40 was admitted to the facility on [DATE]. The 5-day MDS, dated [DATE], documented Resident 40 was moderately cognitively impaired. A review of the EHR showed Resident 40 was transferred to the hospital on 12/21/2024 and returned to the facility on [DATE]. Resident 40's EHR did not show documentation that Resident 40 was offered and/or provided a transfer/discharge notice. On 01/09/2025 at 3:40 PM, Staff G, Resident Care Manager, said she was not sure if the transfer notice was reviewed with Resident 40 and or their representative when they were sent to the hospital. Staff G said the transfer paperwork was sent with Resident 40 to the hospital and she did not have a copy or proof that it was provided. On 01/09/2025 at 3:58 PM Staff E, Admission Coordinator, said she did not have a transfer notice for Resident 40. On 01/13/2025 at 10:42 AM, Staff A, Administrator said she did not find a transfer notice for Resident 40 and said there was no documentation that it was completed. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-0140 (1)(a)(b)(c)(i-iii)

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on interview and record review, the facility failed to provide written bed hold notices at the time of transfer to the hospital for 2 of 2 sampled residents (40 and 30) reviewed for hospitalization . This failure placed the residents at risk for lack of knowledge regarding their right to hold their bed while in the hospital. Findings included . 1) Resident 40 was admitted to the facility on [DATE]. The 5-day Minimum Data Set (MDS, an assessment tool) dated 12/16/2024, documented Resident 40 was moderately cognitively impaired. A review of the Electronic Health Record (EHR) showed Resident 40 was transferred to the hospital on 12/21/2024 and returned to the facility on [DATE]. Resident 40's EHR did not show documentation that Resident 40 was offered and/or provided a bed hold notice at the time of transfer. On 01/09/2025 at 3:40 PM, Staff G, Resident Care Manager, said the bed hold policy was addressed when a resident was admitted to the facility and not when they are transferred to the hospital. On 01/09/2025 at 3:58 PM, Staff E, Admission Coordinator, said she did not have a bed hold notice for Resident 40. On 01/13/2025 at 10:42 AM, Staff A, Administrator, said she did not see a bed hold notice for Resident 40 and acknowledged it should have been done when Resident 40 was transferred to the hospital. 46793 2) Resident 30 was admitted to the facility on [DATE]. The 5 Day MDS, dated [DATE], documented Resident 30 was cognitively intact. Resident 30's EHR showed Resident 30 was transferred to the hospital on 11/12/2024 and returned to the facility on [DATE]. Resident 30's EHR did not show documentation that Resident 30 was offered and/or provided a bed hold notice at the time of transfer. On 01/10/2025 at 1:29 PM, Staff E, Admissions Coordinator, said the bed hold should have been sent with the resident at the time of transfer to the hospital. Staff E said they did not find a bed hold notice for Resident 30 and their should have been a bed hold notice. On 01/13/2025 at 10:01 AM, Staff A, Administrator, said the bed hold notices should be offered to the resident, when transferring to the hospital. Staff A said if the bed hold was not the EHR, then it was not completed. Staff A said a bed hold should have been offered. Reference WAC 388-97-0120 (4)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to develop and implement a baseline care plan, within 48 hours of admission, that included instruction needed to properly care for 1 of 11 residents (Resident 105) reviewed for new admission. This failure placed residents at risk for unidentified and unmet needs, and other negative health outcomes. Findings included . Resident 105 admitted to the facility on [DATE] with orders for oral suctioning, which is an aerosol generating procedure (AGP/a procedure that creates respiratory particles that are small and light enough to remain suspended in air for long periods of time and that can travel past six feet from source and through surgical masks). Review of the baseline care plan showed it was not identified the resident required suctioning or AGP precautions. On 01/13/2025 at 11:01 AM, Staff D Resident Care Manager (RCM), said Resident 105's need for suctioning and AGP precautions should have been addressed on the baseline care plan. Resident 105 admitted with an order for NPO (nothing by mouth). Review of the baseline care plan showed the resident's NPO status was not identified. On 01/13/2025 at 11:01 AM, Staff D, RCM, said Resident 105's NPO status should have been on the baseline care plan. Review of Resident 105's baseline care plan showed no instruction was provided to staff on how to provide oral care to the resident given their NPO status (e.g. brush teeth with toothpaste, used moistened toothettes etc.), or who was to provide it (licensed staff, nurses' aides etc.). On 01/13/2025 at 11:01 AM, Staff D, RCM, said direction on how to provide oral care to resident 105 should have been on their baseline care plan. Reference WAC 388-97-1020(3)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50488 Based on observation, interview, and record review, the facility failed to develop and implement person-centered comprehensive care plans that identified resident specific care needs and interventions for 1 of 4 residents (Resident 13) reviewed for activities of daily living. The failure to identify residents' self-care deficits, and develop and implement interventions to meet their needs, placed residents at risk for feelings of helplessness, frustration, decreased intake/weight loss and a diminished quality of life. Findings included . Resident 13 admitted to the facility on [DATE]. The Admission MDS, dated [DATE], showed Resident 13 had decreased function to the upper extremities (includes the arms, wrists, and hands), needed limited to moderate assistance with ADLs, and was moderately cognitively impaired. On 01/08/2025 at 9:36 AM, Resident 13 was observed with a breakfast tray that had an unopened protein drink and a packet of cocoa. When asked about how breakfast was, Resident 13 said they couldn't finish because of the inability to open the drink and packet. Resident 13 held up their left hand and demonstrated how difficult it was to open the fourth and fifth fingers due to pain and tremors. At 1:09 PM, Resident 13 was observed in a wheelchair to the left side of the bed with an uncut chicken breast on the tray and an unopened protein drink. The call light was wrapped around the rail on the right side of the bed and was not in reach. Resident 13 said the aide had set down the tray and had not offered to assist with anything. Resident 13 said they had attempted to cut the chicken but was unable. The call light was pushed and was answered at 1:28 PM, at which point the resident did not want the food as it was cold. On 01/08/2025 at 1:39 PM, Staff V, CNA, stated, I gave Resident 13 her tray and opened her straw. I did not offer to cut up the chicken. When asked how the aides know how much assistance to give a resident, she said it was on the task list which was driven by the care plan. Review of the care plan, dated 12/17/2024, showed Resident 13 had self-care deficits that required assistance from staff. It showed a potential nutritional risk due to demands for healing. It did not give guidance to staff on how much assistance to provide for meals. On 01/09/2025 at 9:20 AM, Staff C said Resident 13 had a history of cubital tunnel syndrome (a compression or irritation of the ulnar nerve causing numbness, tingling, and shooting pain in the hand or ring and little finger) which was found in the discharge hospital notes. When asked if that diagnosis and related interventions should have been addressed on the care plan, she said it should have been. Reference WAC 388-97-1020(1), (2)(a)(b)

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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** 50488 Based on observation, interview, and record review, the facility failed to re-assess and revise the care plan for 1 of 7 residents (Resident 23) reviewed for care planning. This failure placed residents at risk for skin impairment related to immobility, for delay in care services, and for a diminished quality of life. Findings included . Resident 23 admitted to the facility on [DATE] with diagnoses of fractures of the left shoulder and hip and type 2 diabetes with neuropathy (nerve damage, usually to the legs and feet). The Admission Minimum Data Set, an assessment tool, dated 12/09/2024, showed Resident 23 was moderately cognitively impaired and needed extensive assistance with activities of daily living. <Skin impairment risk and Mobility> Review of the care plan, dated 12/04/2024, showed Resident 23 had risk for skin impairment related to surgical incision, left shoulder sling, and immobility. Interventions included: Float bilateral heels when in bed. Arm sling to support left proximal humerus (shoulder), check skin integrity with ON/OFF schedule every shift for appliance application and monitoring of left arm sling. There were no directions for what the ON/Off schedule was. There were no assistive devices on the care plan. Review of the January 2025 Treatment Administration Record showed nurses were signing off each shift that heels were being floated, that foam boots were on while in bed, and that the arm sling was being placed and removed. The foam boots were not on the care plan. On 01/07/2025 at 4:05 PM, Resident 23 was observed on their back in bed with both feet pressed against the footboard. Their heels were on a pillow but were not floated and no foam boots were in place. There was a trapeze above the bed and a transfer pole (both assistive devices) on the right side of the bed. On 01/08/2025 at 10:15 AM and 3:03 PM, Resident 23 was observed on their back in bed with heels not floated and foam boots on the couch in the room. When asked if staff ever floated the heels, Resident 23 stated, Some know how to do it right and some don't. When asked if staff ever put on the foam boots, Resident 23 said they had tried, but the boots caused more pressure and discomfort. <Infection> Review of the care plan, dated 12/04/2024, showed Resident 23 had a urinary tract infection and was on antibiotics. Interventions were to monitor, document, and report side effects and response to treatment, including worsening of condition. Review of the January 2025 Medication Administration Record showed no antibiotic was being given. <Showering> (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/07/2025 at 3:52 PM, Resident 23 stated, I would like to shower but they only give me bed baths. Review of the care plan, dated 12/04/2024, showed Resident 23 was to receive bathing services with assistance from one-two staff on Tuesday, Thursday, and Saturday evenings. Weight bearing status was as tolerated. On 01/09/2025 at 11:26 AM, Staff AA, Certified Nursing Assistant, said the aides work with therapy to determine if a resident can be showered. On 01/09/25 at 12:23 PM, Staff Z, Rehabilitation Director, said typically residents who need a Hoyer (mechanical lift) for transfer receive bed baths. When asked if therapy would need to clear Resident 23 for showers due to the arm sling, she said, No. When asked how an aide would know what type of bathing a resident can have, she said it would be on the care plan which would transfer to the task list. She said nursing staff could give a shower without the rehabilitation department doing an assessment. Reference WAC 388-97-1020(2)(c)(d)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of practice for 4 of 35 sampled residents (Residents 105, 33, 304 & 49) reviewed. The failure of nursing staff to follow and/or clarify incomplete physicians' orders, to accurately document the medication dose that was administered, and to notify the provider of trendable medication refusals, placed residents at risk for medication errors, adverse side effects, unmet care needs and other potential negative outcomes. Findings included . 1) Resident 105 admitted to the facility on [DATE]. Review of the 12/26/2024 hospital transfer paperwork showed the residents transfer diagnoses were identified as: severe hypoglycemia (low blood sugar); fecal impaction (severe constipation at the end of gastrointestinal tract) with overflow diarrhea and clostridium difficile (a bacterium that causes an infection of the colon) carrier. On 12/31/2024, an order was obtained to give polyethylene glycol (a laxative) twice daily via percutaneous endoscopic gastrostomy tube (a PEG tube is an endoscopic medical procedure in which a tube is passed into a patient's stomach through the abdominal wall) for fecal impaction. Review of the January 2025 Medication Administration Record (MAR) showed the polyethylene glycol was refused by Resident 105 on the following dates: a) 01/01/2025- refused the AM and PM dose. b) 01/02/2025- refused the PM dose. c) 01/04/2025- refused the PM dose. d) 01/06/2025- refused the AM and PM dose. e) 01/07/2025- refused the AM and PM dose. f) 01/08/2025- refused the AM dose g) 01/09/2025- refused the PM dose h) 01/10/2025- refused the AM dose i) 01/11/2025- refused the PM dose j) 01/12/2025- refused the PM dose Review of the electronic health record (EHR) showed no documentation indicating the provider was notified of Resident 105's pattern of refusing the polyethylene glycol. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/13/2025 at 1:43 PM, Staff D, Resident Care Manager (RCM), said the physician should have been notified when a medication was refused or held. When asked if there was any documentation to show the physician was notified Resident 105 refused thirteen doses of polyethylene glycol in twelve days, Staff D, RCM, stated, No. 2) Resident 304 had a 01/07/2025 order for morphine sulfate extended release (MS ER/a strong pain killer) 15 miligrams (mg) every eight hours as needed (PRN) for pain 6-10 on a scale to 10. On 01/10/2025 at 8:43 AM, Resident 304 requested their PRN MS ER for lower back/leg pain which they rated as a 3 on a scale to 10. Staff X, Registered Nurse (RN), prepared MS ER 15 mg and administered it to the resident. On 01/10/2025 at 9:14 AM, when asked what pain level Resident 304's PRN MS ER could be administered for, Staff X, RN, said for pain levels of 6-10 out of 10, and confirmed they administered the medication outside of the ordered parameters. Review of the January MAR showed in the seven days since the PRN MS ER order was obtained, facility nurses administered it six times for a pain level less than six, as follows: 01/07/2025 at 8:17 PM- 5/10 01/09/2025 at 10:08 AM- 3/10 01/11/2025 at 12:08 AM- 0/10 01/12/2025 at 9:38 PM- 4/10 01/13/2025 at 12:11 PM- 4/10 On 01/13/2025 at 1:47 PM, Staff D, RCM, said nurses should administer medications in accordance with the physician ordered parameters, but acknowledged on the above referenced occasions they failed to do so. 3) Resident 33 admitted to the facility on [DATE]. Record review showed the resident received intravenous (IV) ertapenem (an antibiotic) via a midline (a type of IV catheter that is placed into a vein in the arm. It is longer than a standard IV and can stay in place for up to 29 days) for 28 days from 12/13/2024 - 01/08/2025. Review of the midline maintenance and monitoring orders showed there was no orders for or documentation to show the facility: a) Measured and documented the midline external length upon insertion, or with the weekly dressing changes. c) Measured and documented the upper arm circumference upon insertion, or with the weekly dressing changes. d) Changed the needleless injection caps with the weekly dressing changes. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Northwoods Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 2321 Schold Place Northwest Silverdale, WA 98383	

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e) Assessed the midline insertion site during dressing changes, and at least once per shift when not in use. f) Or flushed the midline. On 01/13/2025 at 12:55 PM, Staff C, Resident Care Manager/Registered Nurse, said facility nurses should have identified Resident 33's midline orders were incomplete and clarified them. 50945 4) Resident 49 was admitted to the facility on [DATE]. Review of Resident 49's orders showed they had an order for albuterol nebulization (breathing treatment) to be given as needed for a cough. During observation on 01/08/2025 at 2:34 PM, Staff F, Licensed Practical Nurse (LPN), started the albuterol treatment for Resident 49 and was unable to complete the full dose. Staff F explained Resident 49 had requested the treatment be stopped after about ten minutes, and that they would document in the resident's medical record that the resident declined to finish the rest of the dose and only received a partial dose. Review of the Electronic Health Record (EHR) on 01/09/2025 at 10:13 AM, showed no documentation of the partial dose given; however, the full dose was charted. During an interview on 01/09/2025 at 10:29 AM, Staff F, LPN, said they should have fixed their charting, and they did not believe they had. During an interview on 01/13/2025 at 2:52 PM, Staff A, Administrator/ Director of Nursing Services, said their expectation when a partial dose of medication was given, was for staff to have documented it and notified the provider. Staff A said it did not meet expectations that the nurse forgot to document the partial dose. Reference WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i)

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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** 50488 Based on interview and record review, the facility failed to ensure that pharmacological and non-pharmacological interventions were implemented for 2 of 7 residents (Residents 45 and 8) reviewed for bowel managment. This failure placed the residents at risk for discomfort, constipation, and a decreased quality of life. Findings included . The Bowel Disorders-Clinical Protocol policy, revised September 2017, stated, the physician will identify and order pertinent cause-specific and symptomatic interventions 1) Resident 45 admitted to the facility on [DATE] with a diagnosis of wedge compression fracture (occurs when the front of a bone in the spine collapses, giving it a wedge shape) requiring pain medication. The Admission Minimum Data Set (MDS), an assessment tool, dated 12/19/2024, showed Resident 45 was cognitively intact and needed limited to moderate assistance with activities of daily living. On 01/08/2025 at 10:35 AM, Resident 45 said they had a pain contract for chronic (long term) pain management. Resident 45 said constipation had been an issue before admitting to the facility due to long term opiod use. When asked if there had been issues with constipation since admitting, Resident 45 said there was. A review of the bowel elimation record for December 2024 and January 2025 showed Resident 45 did not have bowel movements (BM) on the following days: 12/15/2024-12/18/2024, 12/21/2024, 12/22/2024, 12/29/2024, 01/02/2025, 01/06/2025, and 01/07/2025. A review of the orders, dated 12/15/2024, showed: docusate sodium (stool softener) 250 miligrams (mg) daily, do not give on day of senna (bowel stimulant), and senna 8.6mg, daily as needed. Do not give senna and docusate sodium on the same day. On 01/02/2025 both docusate sodium and senna were given. As needed (PRN) medications including: bisacodyl suppository, Fleet enema, milk of magnesia, mineral oil enema, and Miralax (medications used to stimulate bowel movements) were not ordered until 01/01/2025. The Medication Administration Record (MAR) for December 2024 and January 2025, showed no PRN medications were given other than on 01/02/2025. No non-pharmacological interventions were implemented. A review of the care plan, dated 12/15/2024, did not show chronic pain medication and related chronic constipation were addressed. No non-pharmacological interventions were listed on the care plan. On 01/10/2025 at 1:03 PM, Staff C, Case Manager (CM), said Resident 45 should have received both pharmocological and non-pharmacological interventions for days when there was no BM. Staff C said chronic constipation should have been addressed and interventions implemented on the care plan when the resident admitted . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50945 2) Resident 8 was admitted to the facility on [DATE]. The Admission MDS, dated [DATE], showed Resident 8 was cognitively intact and able to make their needs know. Review of Resident 8's orders showed three medications for bowel management: 1. MiraLax Packet PRN for constipation daily, if no bowel movement for one day 2. bisacodyl suppository PRN for constipation daily, if Miralax was ineffective 3. mineral oil enema PRN for constipation daily, if bisacodyl was ineffective Review of Resident 8's bowel record, showed they did not have a bowel movement on the following dates: 12/21/2024, 12/22/2024, and 12/23/2024 (3 days) 12/26/2024, 12/27/2024, and 12/28/2024 (3 days) Review of Resident 8's MAR, showed no PRN bowel management medications were given on the dates listed above. During an interview on 01/13/2025 at 10:14 AM, Staff G, CM, confirmed Resident 8 had no bowel movements from 12/21/2024 to 12/23/2024 and 12/26/2024 to 12/28/2024, that no Miralax was given those dates, and they were unable to provide documentation that non-pharmacological interventions were done. During an interview at 11:57 AM, Staff A, Administrator, said their expectations for Resident 8's bowel management was for medication to be given when residents met parameters as indicated, and that non-pharmacological interventions would be documented. Reference WAC 388-97-1060 (1)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50488 Based on observation, interview, and record review, the facility failed to consistently implement measures to prevent development of avoidable pressure ulcers and to thoroughly assess, monitor and obtain timely treatment orders for pressure ulcers for 1 of 4 sampled residents (Resident 38) reviewed for pressure ulcers. Resident 38 experienced harm when they developed two avoidable pressure ulcers which required hospitalization for surgical intervention and intravenous (in the vein) antibiotics. Findings included . Resident 38 admitted to the facility on [DATE] with diagnoses of blastocystitis (an infection of the intestines caused by a parasite, may cause diarrhea), weakness, and polyneuropathy (damage to multiple nerves). The Admission Minimum Data Set (MDS), an assessment tool, dated 12/13/2024, showed Resident 38 was severely cognitively impaired and needed extensive assistance for positioning and transfers. Review of the facility's policy titled, Pressure Ulcers/Skin Breakdown-Clinical Protocol, revised April 2018, showed, nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; b. Pain assessment; c. Resident's mobility status; d. Current treatments, including support surfaces. Review of the Admit Skin Evaluation form, dated 12/11/2024, showed Resident 38 had redness to their buttocks but no opened areas. The assessment did not document whether or not the redness was blanchable. The Braden Scale (a tool used to assess risk of pressure injury) documented on the same evaluation, showed a score of 9, indicating very high risk. The interventions on the form were: encouraged or assisted with repositioning and barrier cream. There were no identified skin impairment risks on the care plan or interventions. Review of nursing progress notes for Resident 38, dated 12/12/2024 and 12/13/2024, showed Resident 38 had red bottom and open area to the gluteal fold (crease in buttocks). Review of nursing progress notes, dated 12/14/2024 through 12/17/2024, documented no skin related concerns. Review of nursing progress notes, dated 12/19/2024, showed there was an open area on Resident 38's buttocks. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the weekly interdisciplinary team meeting note, dated 12/19/2024, showed, patient continues to have pain related to wound, but did not specify what wound. Review of the nursing progress notes, dated 12/19/2024 and 12/20/2024, showed no skin related concerns. Review of a nursing note, dated 12/21/2024, showed there was an open area to the coccyx (tailbone area) and left buttock. Review of the Weekly Skin Evaluation, dated 12/22/2024 at 9:09 PM, showed a Braden score of 12 which indicated high risk. The evaluation showed there was an open area to the coccyx, perineum (sensitive skin between the anus and the genitals) and left buttock. Interventions included: encouraged or assisted with repositioning, wheelchair cushion, nutritional interventions, barrier cream, physician and patient representative notified. Review of Electronic Health Record (EHR) from 12/11/2024 to 12/23/2024 did not show interventions or treatment for wound care or detailed descriptions, staging, or measurements of Resident 38's wounds. Review of a nursing progress note, dated 12/23/2024 at 2:30 PM, showed Staff C, Registered Nurse and Case Manager (CM), looked at wound, believes that the wound status needs a higher acuity, provider agreed. Resident 38 was transferred to the hospital later that same day. Hospital records for date of admission of 12/23/2024 showed the following: 12/23/2024 - Certified Wound Nurse evaluated and treated Resident 38 for three full-thickness wounds to the perianal area, coccyx and sacrum (area where lower spine and pelvis meet), of which the coccyx and sacral wounds appeared to be pressure injuries (unstageable). Measurements for the sacral wound were documented as, 4.7 cm [centimeter] length (larger of 2) by 1.3 cm by 0.8 cm. Photograph of wounds showed coccyx and sacral wounds somewhat conjoined. 12/24/2024 - Hospital Physician documented, pressure sacral decubitus [bedsore] stage III [full thickness loss of skin with fatty tissue visible] with acute infection. 12/27/2024 - Operative notes documented Resident 38 underwent surgical wound debridement [removal of dead tissue and deep cleaning] of sacral decubitus ulcer. Resident 38's EHR showed resident was readmitted to the facility on [DATE] with a new placement of a retention catheter (tube placed into the bladder for urine to drain) and antibiotic therapy. The care plan, dated 12/29/2024, showed to encourage off-loading or frequent shifting of position while in bed or chair. The Re-Admission MDS, dated [DATE], showed Resident 38 had a Stage 3 pressure ulcer. The section for skin and ulcer treatments were marked no for pressure reducing device in chair or a bed and turning and repositioning program. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 01/07/2025 at 10:35 AM, Resident 38 was observed lying on an air mattress. It had not been care planned and was not being monitored for correct settings. On 01/08/2025 at 11:11 AM, Staff C, CM, said prior to hospitalization , the wound(s) Resident 38 had were not pressure related. After reviewing the hospital notes, Staff C said it was a pressure ulcer. On 01/13/2024 at 10:33 AM, wound care was observed. Resident 38 had a large wound to the coccyx, a smaller wound to the left buttock, and another smaller wound to the right upper buttock. Resident 38 expressed pain and irritation with wound care. On 01/13/2025 at 2:41 PM, Staff A, Administrator, said the CM's were trained in wound management and would be the ones who assessed and documented on wounds. Reference WAC 388-97-1060(3)(b)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview and record review, the facility failed to ensure safety precautions were followed prior to administering enteral (tube feeding) nutrition for 1 of 1 resident (Resident 105) reviewed for enteral nutrition. The failure to validate enteral tube placement and to check gastric residuals (food, liquid, or material from a previous feeding left in the stomach at the start of the next feeding) placed residents at risk for increased abdominal distention, reflux (stomach acid coming up from the stomach into the esophagus), aspiration, respiratory compromise and other potential adverse outcomes. Findings included . Review of the facility's Enteral Feedings - Safety Precautions policy, revised May 2014, showed licensed staff were directed to: check enteral tube placement prior to each feeding and administration of medication; check gastric residual every 6-8 hours after a resident's target feeding volume and rate have been established; and document all assessments, findings, and interventions in the medical record. Resident 105 admitted to the facility on [DATE]. Review of the 12/30/2024 Admission Minimum Data Set (MDS, an assessment tool), showed the resident was cognitively intact, had a diagnosis of Inclusion Body Myositis (IBM, is an inflammatory muscle disease characterized by progressive muscle weakness and wasting), dysphagia (difficulty swallowing) and required enteral feeding to meet their nutritional needs. A clinical meeting note, dated 12/31/2024 at 2:42 PM, documented Patient not medically stable, chest x-ray ordered r/t [related to] coughing at night. Remains NPO [nothing by mouth], bolus [larger amount given over a shorter duration] tube feeding continues. Abdominal x-ray next week r/t continued diarrhea. A provider note, dated 01/03/2025, documented Resident 105's chest x-ray was negative, but they continued to require frequent suctioning. Due to the time it took for the nurse to come when they needed to be suctioned and their inability to turn the suction machine on/off independently, the resident kept the suction machine on all night resulting in it overheating. A friend stayed the night with Resident 105 to assist with management of the suction machine. Resident 105 was then provided an extended control for the suction machine that allowed them to turn it on/off independently and self-suction as needed. On 01/08/2024 at 9:15 AM, Resident 105 reported they had experienced increased GI upset/bloating and reflux since admission. Per the resident, facility nurses were not consistently checking their enteral tube placement or gastric residual prior to the provision of bolus feedings. Resident 105 believed this contributed to the increased reflux and need for self-suctioning. Review of Resident 105's enteral orders showed the following: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a) Administer Jevity 1.5 (a high-calorie, high-fiber, and balanced nutrition formula for tube feeding) 237 milliliters (ml)) bolus via enteral tube twice daily at 08:00 AM and 2:00 PM. b) Administer Osmolyte (a liquid formula that provides complete, balanced nutrition without fiber for patients with increased calorie and protein needs, or for those with limited volume tolerance) 1.5 (237 ml) bolus via enteral tube at 11:00 AM and 5:00 PM. c) Check residual prior to enteral feeding and administration of medications. Notify physician if greater than 100 ml. d) Check enteral tube placement prior to enteral feeding and administration of medications. On 01/10/2025 at 2:06 PM, Resident 105's 2:00 PM bolus feeding was observed. Staff X, Registered Nurse (RN), performed hand hygiene, gloved, drew up 60 ml of water into a piston syringe, and slowly flushed the enteral tube utilizing the syringe plunger (not to gravity). Staff X then removed the plunger from the 60 ml syringe and administered 237 ml of Jevity 1.5 to gravity. The enteral tube was again flushed with 60 ml of water utilizing the syringe plunger. Staff X, RN, did not check the enteral tube placement or the resident's gastric residual prior to administering the bolus feed or flushes as ordered. On 01/13/2025 at 11:01 AM, Staff D, Resident Care Manager, said Resident 105's tube placement and gastric residual should have been checked prior to administering the bolus feed. Reference WAC 388-97-1060 (3)(f)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview and record review, the facility failed to ensure intravenous (IV) access devices were assessed, maintained and monitored in accordance with professional standards of practice for 2 of 2 residents (Residents 33 & 103) reviewed for IV therapy. The failure to ensure IV orders included routine monitoring of IV insertion sites, flush orders, weekly changes of IV dressings and needleless injection caps, and initial and then weekly measurements of IV catheters external length and the residents arm circumferences, placed them at risk for loss of vascular access, infection, and other potential negative health outcomes. Findings included . <Facility Policy> Review of the facility's undated Central Venous Access Device (CVAD) Dressing Change policy showed for residents with Peripherally Inserted Central Catheters (PICCs), nurses would: a) Perform weekly PICC dressing changes and as needed if the dressing is soiled, wet or dislodged. b) Measure and document the PICC external length upon admission, weekly with dressing changes, and as needed. c) Measure and document upper arm circumference (10 cm above antecubital fossa) upon admit, with weekly dressing changes and as needed. d) Change needleless injection caps with weekly dressing changes, after blood draws and as needed. e) Assess vascular access insertion site upon admit, during dressing changes, at least every two hours during continuous therapy, and at least once per shift when not in use. The policy and procedure for midline (a type of IV catheter that is placed into a vein in the arm. It is longer than a standard IV and can stay in place for up to 29 days) maintenance and monitoring was requested but not provided. On 01/13/2025 at 12:37, Staff D, Resident Care Manager/Registered Nurse, said the policy and procedure was the same as the above CVAD policy. 1) Resident 33 admitted to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS, an assessment tool), dated 12/16/2024, showed the resident was cognitively intact, had diagnoses of urinary tract infection, sepsis (a potentially life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs) and perinephric abscess (a collection of pus around one or both kidneys. It is caused by an infection that spreads from a urinary tract) and required IV medication during the assessment period. A 12/15/2024 nurses' note documented Resident 33 had a midline placed to their left upper arm. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review showed Resident 33 received IV ertepenem (an antibiotic) from 12/13/2024 - 01/08/2025. Review of Resident 33's midline maintenance and monitoring orders showed a 12/26/2024 order for weeky midline dressing changes. There were no orders for or documentation to show the facility did the following during the resident's 27 days of IV antibiotic therapy: a) Measured and documented the midline external length upon inseriton, or with the weekly dressing changes. b) Measured and documented the upper arm circumference upon insertion, or with the weekly dressing changes. c) Changed the needleless injection caps weekly with the dressing changes. d) Assessed the midline insertion site during dressing changes, and at least once per shift when not in use. On 01/13/2025 at 12:55 PM, when asked if there was documentation to show the facility did the above required maintenance and monitoring of Resident 33's midline between 12/13/2024 - 01/08/2025 Staff C, Resident Care Manager/Registered Nurse, stated, No. 2) Resident 103 admitted to the facility on [DATE] with orders for IV cefepime every 12 hours for an infection related to cholelithiasis (gallstones). The 01/05/2025 hospital transfer orders showed Resident 103 had a PICC to the left upper arm. Review of the electronic health record (EHR) showed a 01/06/2025 order that directed staff to change the PICC dressing, measure arm circumference and external catheter length weekly. No documentation was found to show what the resident's arm circumference and external catheter length was upon admission. Review of January 2025 Medication Administration Record showed on 01/10/2025 staff signed they changed the PICC dressing, measured the arm circumference and external catheter length. However, no place was provided to record the resident's arm circumference or the external catheter length. Further review showed the nurse did not document the arm circumference or external catheter length in the EHR. On 01/13/2025 at 12:37 PM, when asked if there was any documentation to show the facility had measured Resident 103's arm circumference or external catheter length upon admission or anytime thereafter, Staff D stated, No, not that I see. Reference WAC 388-97-1060 (3)(j)(ii)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on observation, interview, and record review, the facility failed to obtain physician orders for continuous positive airway pressure (CPAP) machine settings and oxygen orders for use including label/date, oxygen tubing/supplies and nasal cannula (NC, flexible tubing that sits inside the nose and delivers oxygen) for 2 of 5 sampled residents (Resident 21 & 40) reviewed for respiratory care. This failure placed the residents at risk for unmet care needs, respiratory infections, and a diminished quality of life. Findings included . 1) Resident 21 was admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS, an assessment tool), dated 12/09/2024, documented Resident 21 was cognitively intact. On 01/08/2025 at 9:34 AM, Resident 103 was observed wearing a NC. The oxygen concentrator was set at 2. 5 liters per minute. The oxygen tubing had no date or labeling. Review of the Electronic Health Record (EHR) provided no physician's order for the use of oxygen, no setting and no cleaning instructions. On 01/10/2025 at 12:59 PM, Staff D, Resident Care Manager, said to administer oxygen there must be an order provided by the physician. Staff D reviewed the EHR and said there was no order for oxygen to be provided to Resident 103 and there should have been a physician's order. On 01/13/2025 at 10:01 AM, Staff A, Administrator, said an order was required prior to the administration of oxygen. Staff A said Resident 103 should have had an order for oxygen. 42960 2) Resident 40 was admitted to the facility on [DATE] and had a diagnosis of Obstructive Sleep Apnea (a condition that causes abnormal breathing during sleep and it is caused by the throat muscles relaxing and narrowing the airway, which can reduce oxygen levels in the blood.) The Admission MDS dated [DATE], documented Resident 40 was moderately cognitively impaired. On 01/08/2025 observations were made of a CPAP machine at the bedside of Resident 40. An order, dated 12/29/2024, stated, C-PAP on at night and when napping with auto home settings. Assist with placement as needed, every shift. On 01/09/2025 at 2:59 PM, Staff G, Care Manager, indicated she did not know the settings for Resident 40's CPAP because it was rented and the settings were preset. On 01/10/2025 at 10:32 AM, Staff A, Administrator, said an order for Resident 40's CPAP settings were recently placed and her expectation was for the settings order to be placed on admit. WAC 388-97-1060 (3)(j)(vi)

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 01/13/2025
NAME OF PROVIDER OR SUPPLIER Northwoods Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 2321 Schold Place Northwest Silverdale, WA 98383	

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on observation, interview and record review, the facility failed to ensure residents were appropriate for the use of mobility bars, for 1 or 3 residents (Resident 103) reviewed for physical restraint, and to ensure prior to use of mobility bars that residents were evaluated for risk of entrapment and informed consent was obtained for 3 of 3 residents (Residents 103, 8 & 33) reviewed for physical restraint. This failure placed residents at risk for not knowing risks of mobility bars, accidents/harm/entrapment related to mobility bars, and a diminished quality of life. Findings included . Review of the document titled, Proper Use of Side Rails, dated December 2016, showed the facility was to assess for risk of entrapment, to add the assistive device to the resident's care plan, and was to obtain consent. The document also specified that side rails were only allowed if they were used to treat a medical symptom and assist with mobility or transfer of the resident. 1) Resident 103 was admitted to the facility on [DATE]. The Entry Minimum Data Set, as assessment tool, dated 01/05/2025, documented Resident 103 was cognitively intact. On 01/08/2025 at 10:20 AM, Resident 103 was observed laying in bed with bed mobility bars attached to the bed. When asked if the bed rails helped with mobility, Resident 103 demonstrated by attempting to turn and reach for the bedrails, but was unable to grab the bedrails, due to limited motion and the ability to grab the bed rails with their hands. On 01/09/2025, review of the Electronic Health Record (EHR), provided no documentation for bed mobility bars, including consent, orders, risk and benefits, assessments or care plan information. On 01/13/2025 at 11:40 AM, when shown the consent form and the order for the bed mobility bars, dated 01/10/2025 and asked if the consent and order should have been completed at the time the bedrails were installed, Staff Z, Rehabilitation Director, said yes. Staff Z said the process for assessing residents using bed rails as bed mobility bars could be completed by nursing or rehabilitation staff Staff Z said the process included determining what type of mobility bar would be used and what the resident's cognition was and if mobility bars would be appropriate. Staff Z said if the resident wanted bed mobility bars, they would have the resident sign a consent form. When asked how the facility was physically assessing if the bed rails would be considered a physical restraint, Staff Z stated, we're not. Staff Z said depending on the residents' cognition, the bed rails could be a restraint. When it was explained Resident 103 had limited repositioning capabilities and had difficulty reaching the bed rails behind them, Staff Z said staff would ask the resident to press the call light for assistance. When asked if the bed rails really assisted Resident 103, Staff Z did not answer the question directly, but instead said Resident 103 was assessed to be able to move independently and the bedrails would help with mobility. No assessment was provided documenting Resident 103 could use the bedrails. 50945 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Resident 8 was admitted to the facility on [DATE]. During an observation and interview on 01/07/2025 at 10:38 AM, Resident 8 was seen with mobility bars on the upper sides of their bed. Resident 8 said they used their mobility bars for moving in bed. Review of the EHR on 01/09/2025, showed Resident 8 did not have an order, care plan, assessment, nor consent for the mobility bars. During an interview on 01/09/2025 at 12:29 PM, Staff C, Case Manager (CM), said after reviewing the EHR, said they could not find an order or care plan for Resident 8 and that there should have been. Staff C said they would need to track down the assessment done by the therapy department. Facility staff provided a document on 01/10/2025 titled, Assistive Device Consent for Resident 8. No signature by the resident was found and the date listed on the form was 01/10/2025. During an interview on 01/13/2025 at 12:00 PM, Staff A, Administrator, said an assessment and consent were needed to ensure mobility bars were not acting as a restraint. Staff A said the Assistive Device Consent did not have a risk of entrapment assessment and their expectation was for it to be completed, and the patient would have signed the form. 3) Resident 33 was admitted to the facility on [DATE]. During an observation and interview on 01/07/2025 at 2:21 PM, Resident 33 was seen with mobility bars on the upper sides of their bed. Resident 33 said they used the mobility bars for moving in bed, and the mobility bars did not prevent them from getting out of bed. Review of the EHR on 01/09/2025, showed Resident 33 did not have an order, care plan, assessment, nor consent for the mobility bars. During an interview on 01/09/2025 at 12:36 PM, Staff C, CM, after reviewing the EHR, said they could not find an order or care plan for mobility bars and there should have been. Documentation was requested for an assessment for the mobility bars. During a follow-up interview on 01/13/2025 at 10:35 AM, Staff C, CM, said Resident 33 did not have an assessment for mobility bars completed by therapy. During an interview on 01/13/2025 at 12:00 PM, Staff A, Administrator, when asked if it met expectations that Resident 33 had no care plan, no order, no assessment, and no consent, said this did not meet their expectations. Reference WAC 388-97-1060 (3)(g) -0230

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on observation, interview and record review, the facility failed to ensure that 1 of 3 sampled residents (Resident 30) received foods that accommodated the residents' preferences and allergies. This failure placed residents at risk for meal dissatisfaction, allergic reaction, and a diminished quality of life. Findings included . Resident 30 was admitted to the facility on [DATE]. The 5-Day Minimum Data Set (MDS, dated [DATE]) documented Resident 30 was cognitively intact. On 01/07/2025 at 10:35 AM, Resident 30 said the food did not taste good and there was no taste to the food. Resident 30 said the dietitian would visit them, take their food preferences and then nothing would happen. Resident 30 said the dietitian had visited them at least three times since their admission and they were still getting items on the meal tray they should not have. Resident 30 said they did not like beef and had requested a substitution, but they continued to receive beef with meals. Resident 30 said she was diabetic and would often get sweet desserts too. On 01/07/2025 the lunch meal was beef stew with mashed potatoes. At 2:13 PM, Resident 30 confirmed they received beef stew for lunch. On 01/09/2025, the lunch meal was Swedish meatballs with parsley noodles and broccoli. Observation on 01/09/2025 at 12:53 PM, showed resident had a blue tray (meaning alternative diet or diet type). Dietary staff plated Resident 30's plate with meatballs, cut into smaller bites with noodles and broccoli. On 01/09/25 at 1:26 PM, Staff U, Dietary Manager, said the meatballs were made of chicken and beef. On 01/13/2025 at 10:54 AM, Staff T, Dietitian, said the process for obtaining resident preferences, started with them meeting with the new admit within two days. Staff T said they had a list of questions they would ask about, including allergies and preferences for both food and drinks, and then the slip would be provided to the kitchen to be updated in the residents chart. Staff T said they would check in with residents as needed to make sure the resident was receiving the correct dietary menu. When asked specifically about Resident 30's preferences, Staff T said Resident 30 had complained about the food before and had a preference of no beef. It was explained Resident 30 had beef items twice during the past week and Staff T said Resident 30 should not have had beef. At 11:02 AM, Staff U, Dietary Manager, said allergies and preferences would be sent by the Dietitian and they would update the residents food card. Staff U provided six dietary change slips for Resident 30. A dietary change slip, dated 12/05/2024, documented Resident 30 requested all beef products be replaced with fish. It was explained Resident 30 received beef items twice during the past week. When asked if Resident 30 should have had the beef replaced with fish, Staff U said yes. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-1120 (3)(a) .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on observation, interview and record review the facility failed to store, prepare and serve food to residents in accordance with professional standards for 1 of 1 kitchen and 2 of 2 unit refrigerators/freezers reviewed for food service safety. The failure to maintain documented refrigerator, freezer and dishwasher temperatures, prevent contamination of uncovered foods during transportation, to throw out expired foods and maintain sanitary conditions placed residents at risk of foodborne illness (caused by the ingestion of contaminated food or beverages), unsanitary conditions, and diminished quality of life. Findings included . <Food storage temperature logs> Review of the food storage temperature logs documented the following missing entry dates: Walk in refrigerator: [DATE] AM shift [DATE] PM shift Walk in Freezer: [DATE] AM shift [DATE] PM shift Kitchen refrigerator: [DATE] AM shift [DATE] PM shift Kitchen Freezer: [DATE] AM shift [DATE] PM shift Pantry Refrigerator/Freezer: [DATE] [DATE] (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dining Room Refrigerator/Freezer: [DATE] [DATE] Review of the Dishwasher temperature logs documented the following missing entry dates: [DATE] Evening shift [DATE] Evening shift [DATE] Evening shift [DATE] Evening shift [DATE] Evening shift [DATE] Day Shift [DATE] Evening shift [DATE] Evening shift [DATE] Evening shift [DATE] Evening shift [DATE] Evening shift [DATE] Evening shift [DATE] Evening shift [DATE] Evening shift [DATE] Evening shift [DATE] Morning, Day & Evening shift [DATE] Evening shift [DATE] Day & Evening shift [DATE] Evening shift [DATE] Evening shift (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] Evening shift [DATE] Evening shift [DATE] Evening shift [DATE] Evening shift [DATE] Evening shift [DATE] Evening shift On [DATE] at 3:39 PM, when asked about the missing entries for the food storage temperature logs and dishwasher temperature logs, Staff U, Dietary Manager, said the dates should have been filled in. <Expired foods> On [DATE] at 11:11 AM, observation of the kitchen cart next to oven showed: Lea & [NAME] Worcestershire Sauce 1 gallon-best if used by [DATE] [NAME] [NAME] Style Cooking Wine 1 gallon-best if used by [DATE]. 80%/20% Vegetable Olive Oil blend 1 gallon, had no use by date given. At 11:17AM, Staff U, Dietary Manager, said the staff check all foods everyday for expirations dates. When shown the multiple gallon containers of expired food, Staff U said those containers should have been removed from rotation. <Moldy container> On [DATE] at 11:30 AM, observation of the Walk in Refrigerator showed: Tartar sauce 1 gallon with no expiration date. Date on label documented Tartar sauce was received [DATE]. Observation of mold growing on the outside of container, 6 spots each about the size of a pencil eraser. At 11:35 AM, Staff U said the yellow label on the container was the date it was received from the distributor. Mold growing on the outside of the container was shown to Staff U. When asked if mold growing on the container was acceptable, Staff U said no. <Under covered foods during transportation> Observations of uncovered food being delivered to resident's rooms and/or dining room: On [DATE] at 1:04 PM, room [ROOM NUMBER], uncovered pudding. At 1:09 PM, room [ROOM NUMBER], uncovered lemon bar. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 1:14 PM, Dining room, uncovered salad and dessert. On [DATE] at 1:31 PM, Dining room, Jello/fruit on tray was uncovered. At 1:36 PM, meal tray being carried down dining room hallway included uncovered Jello/fruit. At 1:38 PM, another meal tray being carried down dining room hallway included uncovered Jello/fruit. On [DATE] at 12:53 PM, observation of uncovered foods that were placed on resident trays included pudding cup, diced peaches, vegetable salads and fruit salad. At 2:46 PM, Staff U, Dietary Manager, said they had never covered items like pudding cup, diced peaches, vegetable salads and fruit salad since they had been working there. When asked how they were preventing contamination of foods from the cart to the residents room/dining rooms with the uncovered foods, Staff U stated I can't guarantee non-contamination in the hallways. <Unsanitary conditions> On [DATE] at 11:54 AM, Staff W, Dietary Aide, dropped a pen on floor, then picked up pen and put it in their pants pocket. Staff W completed hand hygiene, but did not sanitize the pen. At 12:03 PM, Staff W pulled the same pen from their pocket, wrote on cup lids and then returned the pen back to their pocket. When asked about the non-sanitized pen that was retrieved from Staff W's pocket, Staff W said they did not clean the pen before using it again and should have. At 2:46 PM, the observation of the dropped pen without sanitizing it by Staff W was explained, Staff U said Staff W should have sanitized the pen before using it again or gotten a new pen. Reference WAC ,d+[DATE] -1100 (3), 2980

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on observation, interview and record review, the facility failed to ensure transmission based precautions (TBPs, extra precautions to prevent spread of infection) were implemented consistently and as indicated for 3 of 3 sampled residents (Residents 105, 40,33) reviewed for aerosol generating procedures (AGPs, procedures that generate aerosols that could be infectious), 2 of 3 sampled residents (Residents 17 &33) reviewed for enhanced barrier precautions (EBPs, infection control precaution of wearing gown and gloves during high contact activities during resident care) and 1 of 2 sampled residents (Resident 38) reviewed for contact precautions (infection control precaution of wearing gown and gloves before room entry and while in room) observation. Additionally, the facility failed to ensure the Legionella Water Management Programs (LWMP) was updated to current industry standards, and that sharps containers were replaced when full. These failures placed residents at risk of cross-contamination, infection, complications, and a diminished quality of life. Findings included . <Aerosol Generating Procedures> Review of the facility policy titled Coronavirus Disease (COVID-19)-Aerosol Generating Procedures, dated December 2021, showed procedures considered to be AGPs were open suctioning of airways, sputum induction, and continuous positive airway pressure (CPAP, device that assists with breathing) machines. All employees that went into residents' rooms while on AGP precautions were to wear respirators (N-95 masks, protection against breathing in infectious particles), gloves, isolation gown or protective clothing, and eye protection. 1) Resident 105 was admitted to the facility on [DATE] and was on continuous AGP for suctioning. Review of Resident 105's progress notes showed a provider note on 12/31/2024 that stated, leave suction at bedside for oral secretion management, and a nursing note on 01/02/2025 stated patient has had the suction machine on 24 hours so that she can use it at will. During an observation on 01/08/2025 at 1:10 PM, there was no writing on the AGP sign outside of Resident 105's room to say when AGP was started, completed, ended, or that it was continuous. During an observation at 2:13 PM, Staff H, Certified Occupational Therapist Assistant, entered Resident 105's room without eye protection or a mask. At 2:27 PM, the resident's visitor entered the room and requested a mask. Staff H told the visitor the resident did not have anything respiratory related. During an observation at 2:32 PM, Staff I, Rehabilitation Technician, put on a surgical mask (no N-95), did not wear eye protection, and entered the room. During an interview at 2:55 PM, Staff D, Resident Care Manager (RCM), said they probably should have written continuously on the AGP sign. Staff D confirmed AGP precautions were not implemented until 01/07/2025, after the survey had started. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/13/2025 at 9:18 AM, Staff A, Administrator/Director of Nursing Services (DNS)/ Infection Preventionist (IP), said it did not meet expectations staff entered Resident 105's room unaware of the AGP continuous precautions, and there was no AGP signage until 01/07/2025. 2) Resident 40 was admitted to the facility on [DATE] and was on AGP precautions for CPAP usage at night. During an observation on 01/10/2025 at 6:26 AM, the AGP sign outside of Resident 40's room showed no writing to say when it was started, completed, or ended. At 8:23 AM, Staff J, Certified Nursing Assistant (CNA), entered Resident 40's room without a gown, N-95 mask, or gloves. During an interview at 8:28 AM, Staff J, said Resident 40 took off their CPAP before Staff J had gotten on duty, and staff did not need to wear additional protection. During an interview at 8:33 AM, Staff K, Registered Nurse, said they did not know what time Resident 40's CPAP came off. During an interview at 8:36 AM, Resident 40 said they did not know when they last used their CPAP machine, but that the CPAP was not used the previous night. During an interview at 8:39 AM, Staff J, CNA, said that the AGP sign outside of the resident's room should have been marked. During an interview at 8:43 AM, Staff L, CNA, said AGP is for when the CPAP is running and for 2 hours afterwards. Staff L explained that the nurse or the aid would be the only ones who would know when the CPAP machine was taken off. During an interview on 01/13/2025 at 9:18 AM, Staff A, Administrator/DNS/IP, said their expectation was for there to be clear communication between dayshift and nightshift staff, with signage filled out as applicable. 3) Resident 33 was admitted to the facility on [DATE] and had a CPAP machine for overnight. During observations on 01/07/2025 at 2:25 PM, 01/09/2025 at 9:32 AM, and 01/10/2025 at 8:50 AM, no AGP signage was found outside of Resident 33's room. During an interview on 01/10/2025 at 8:50 AM, Resident 33 said they used their CPAP every night, and had taken it off that morning after wearing it overnight. During an interview at 8:54 AM, Staff M, CNA, said Resident 33 was not on AGP precautions and they did not know when the resident took off their CPAP machine. During an interview at 9:00 AM, Staff N, Licensed Practical Nurse (LPN), said they were not told what time Resident 33's CPAP machine was taken off. <Enhanced Barrier Precautions> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled Enhanced Barrier Precautions, dated August 2022, showed EBPs were indicated for residents that had wounds and/or indwelling medical devices (devices left inside the body for a period of time), and that EBPs were to remain for the duration of the resident's stay (or until resolution of wound and/or discontinuation of all indwelling devices). 1) Resident 17 was admitted to the facility on [DATE] and had a leg wound. During an observation on 01/08/2025 at 2:57 PM, Staff C examined Resident 17's exposed wound and asked them to go back into their room for a dressing change. There was no signage outside of Resident 17's room indicating they were on EBP. Observation on 01/08/2025 at 3:01 PM, showed Staff C, RCM, and Staff F, LPN, performed wound care, neither were wearing gowns. After wound care was performed and a new bandage was applied, Staff C, was observed to remove their gloves (did not perform hand hygiene), took a pen and marked the bandage with the date, then dropped the pen on the ground, picked up the pen and put the pen on the side table (did not perform hand hygiene). Staff C then touched the dressing while talking to Resident 17 and their visitor, touched the mobility bar, touched the bandage, touched Resident 17's leg, touched the bandage again, touched their own hair, touched the mobility bar again, touched their face with their left hand, touched their face with their right hand, touched their bangs and handed a green folder to Resident 17 and their visitor. Staff C then touched their own face again, touched the resident's right hand, touched their own face, touched Resident 17's right shoulder, touched their glasses, removed belongings from under Resident 17, cleaned up the room, and touched their own hair. During an interview on 01/08/2025 at 3:31 PM, Staff C, RCM, when asked why the EBP signage was removed before Resident 17 was discharged , said Resident 17 had no infection and the wound was surgical. When asked about what isolation precaution items were needed for wound care, Staff C said if it was a regular wound, then only gloves and hand washing. If wound was infected, then gown, gloves, and mask. When asked if hand hygiene should occur if you touched your face, Staff C said yes. During an interview on 01/09/2025 at 10:58 AM, Staff F, LPN, said gown and gloves should be worn for wound care, and it did not meet expectations they did not wear gowns during Resident 17's wound care. Staff F said it did not meet expectations that the signage was taken down before Resident 17 was discharged . During an interview on 01/13/2025, Staff A, Administrator/DNS/IP, said the observations of staff not wearing gowns during wound care for Resident 17 and the lack of hand hygiene observed after wound care, did not meet expectations. Staff A said the signage for EBP not being displayed did not meet expectations. 2) Resident 33 was admitted to the facility on [DATE]. During an observation on 01/07/2025, Resident 33 had a urinary catheter, intravenous device (IV), and a drain (indwelling medical device used to drain fluids from the body). During an observation and interview on 01/09/2025 at 9:28 AM, Resident 33 was observed to still have their IV and drain, but no longer had a catheter. Resident 33 said they were going home that day. During an observation at 9:32 AM, no signage was seen outside of Resident 33's door. (continued on next page)

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 01/13/2025
NAME OF PROVIDER OR SUPPLIER: Northwoods Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE: 2321 Schold Place Northwest Silverdale, WA 98383	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview at 10:58 AM, Staff F, LPN, said they did not see any signage outside of Resident 33's room and the IV had now been removed, but there should have been an EBP sign for their drain. During an observation and interview at 11:49 AM, Staff R, CNA removed a Hoyer lift (device for moving residents) from Resident 33's room. Staff R said they did not wear a gown in the room because there was no signage up on the wall. During an interview on 01/10/2025 at 8:54 AM, Staff M, CNA, said Resident 33 was no longer on EBP. When asked if Resident 33 still had a drain, Staff M said yes. During an interview at 9:00 AM, Staff N, LPN, said there was no signage and Resident 33 should have been on EBP for their drain. During an interview on 01/13/2025 at 9:18 AM, Staff A, Administrator/DNS/IP, said it did not meet expectations Resident 33 did not have signage up and staff did not know about the precautions. <Contact Precaution Room> Review of the facility policy titled Isolation- Categories of Transmission-Based Precautions, revised September 2022, showed Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment 1) Resident 38 was admitted to the facility on [DATE]. During an observation and interview on 01/08/2025 at 1:43 PM, Staff M, CNA was observed to enter Resident 38's room with another CNA. The signage outside of the room said the resident was on contact precautions. The CNAs were observed to assist Resident 38 with moving from a wheelchair to the bed, using a Hoyer lift. During this observation, multiple items in the room were touched, including the resident, and then the Hoyer lift again. Staff M removed their gown and gloves, hand sanitized, and then touched the door to leave the room with the Hoyer lift. Staff M brought the Hoyer lift to the other end of the building, left the Hoyer lift (without wiping it with disinfectant), and then walked back to their assigned unit and said they were done. During this interview, Staff M said the signage outside of Resident 38's door said contact precautions, and Hoyer lifts were not included in items that needed to be wiped down after use in a contact room. During an interview on 01/08/2025 at 3:05 PM, Staff D, RCM, said the Hoyer lift should have been wiped down after being used in a contact room. During an interview on 01/13/2025 at 9:18 AM, Staff A, Administrator/DNS/IP, said the CNA was incorrect about not needing to wipe down the Hoyer lift after being in a contact room, and their expectation was for it to have been cleaned. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Legionella Water Management Program> According to the Centers for Disease Control and Prevention (CDC) document, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings, dated 06/24/2021, Legionella is a bacterial contaminate in water systems that can cause pneumonia. Legionnaires' disease has been on the rise in the United States, so Legionella Water Management Programs (LWMP) are now industry standard for large buildings. Key points from the guidelines set forth by the CDC are: 1. Facilities need to actively identify and manage hazardous conditions that support growth and spread of Legionella 2. Examples of where Legionella can grow: a. Hot and cold water storage tanks b. Water heaters c. Water filters d. Faucets and faucet flow restrictors e. Showerheads and hoses f. Pipes, valves, and fittings g. Infrequently used eyewash stations h. Ice machines i. Medical devices including CPAP machines 3. The program's elements should be reviewed annually, when changes occur in regulations or guidelines, or when a major maintenance or water service changes. 4. The LWMP should have a team that includes someone with expertise in infection prevention and diseases, understands accreditation standards/licensing requirements, and risk/quality management staff. 5. Legionella grows best from 77 to 113 degrees Fahrenheit (F) and can still grow outside of this range 6. Residents with healthcare-associated pneumonia (bacterial infection of the lungs with an onset of greater than or equal to 48 hours after admission) should be tested for Legionnaires disease Review of the facility document titled Water Management Program for Building Water Systems Site Management Plan, dated 11/02/2017 and 2019, showed members of the program were Staff O, Environmental Service Director and one other maintenance staff member. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the LWMP diagram provided on 01/09/2025, undated and untitled, did not show where water was received from (water from outside of building). The cold water was shown to have started from the mechanical room and went to resident rooms, laundry and kitchen with no mention of gym or other areas in facility with water. The hot water from the water heaters (not shown on diagram) was drawn with a line with the words: Hot to resident rooms, hot out to Laundry and hot out to kitchen. Two of the three water heater lines had temperatures listed, one did not. The diagram did not show water leaving the areas listed as waste. The diagram did not identify where potentially hazardous conditions could occur. During an interview on 01/09/2025 at 8:03 AM, Staff O, Environmental Service Director, said they were the staff member in charge of the program, that one other maintenance member was a part of the team, but that the infection preventionist/administrator was not directly involved. During this interview, Staff O said the facility checked water temperatures once a week to make sure the temperature in resident rooms were no lower than 100 degrees F and no higher than 120 degrees F. When asked if that prevented Legionella from growing, Staff O said it did not. Staff O said they did not have a process for monitoring how long a room was empty for and ensuring faucets were flushed. During this interview, Staff O was able to verbalize, but was unable to show in writing/diagram, what interventions the facility would implement if control measures (what the facility does to limit growth/spread of Legionella) were not met and what would occur for a contingency response (such as construction). Staff O verbally said remediation should occur in these situations, then looked through the LWMP binder, and said they could not find the remediation steps in the binder, and it should have been there. During this interview, Staff O said the LWMP was reviewed once a year by them by reviewing sampled water Legionella test results. Staff O said they did not participate in QAPI (facility's quality assurance and performance improvement) related to Legionella. When asked if they could show how the facility documented and communicated all activities of the LWMP, Staff O said the only thing available was the sampled water Legionella test results. During a follow up phone interview on 01/09/2025 at 2:38 PM, Staff O said the LWMP had not identified ice machines as an area of growth for Legionella. After reviewing the facility's LWMP policy on other at-risk water systems, that included ice machines, Staff O mentioned the ice machines were cleaned and descaled every six months (the receipts were not readily available in the LWMP binder). During an interview on 01/10/2025 at 11:29 AM, Staff A, Administrator/DNS/IP, when asked their role in the LWMP said they were a member of the team, they understood the process and how it related to infection control, but maintenance was in charge of the testing. When asked for an example of how the facility would screen a resident for Legionnaires, Staff A said they could not provide an example, they had not had to screen because they had not had a scenario of when it would be applicable. When asked if the facility diagram showed where water from the drinking fountain was from (observed outside of the gym), Staff A said it did not. (continued on next page)

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Northwoods Lodge	2321 Schold Place Northwest Silverdale, WA 98383

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During this same interview at 11:29 AM, Staff P, Regional [NAME] President, said areas of concern at the facility for Legionella included CPAP machines with a water reservoir. Staff P said the facility diagram did not show areas of concern, only the standard way water came into the building and was distributed, and that they could identify areas of concern on the diagram. Staff P said the contingency plan should have been added to the LWMP binder. <Sharps Containers> During observations on 01/08/2025 at 3:00 PM and 01/09/2025 at 9:20 AM, room [ROOM NUMBER]'s sharps container (container for discarding sharp items) was full, with the flap up saying full. During observations on 01/07/2025 at 11:49 AM, 01/08/2025 at 3:54 PM, 01/09/2025 at 9:20 AM, and 01/10/2025 at 8:53 AM, room [ROOM NUMBER]'s sharps container was full. During observations on 01/08/2025 at 3:53 PM and on 01/09/2025 at 9:38 AM, room [ROOM NUMBER]'s sharps container was full. During an interview and observation on 01/09/2025 at 10:32 AM, Staff F, LPN, went into rooms [ROOM NUMBER], and confirmed the sharps containers were full. During an observation on 01/09/2025 at 11:32 AM, room [ROOM NUMBER]'s sharps container was full. During an observation on 01/10/2025 at 6:23 AM, room [ROOM NUMBER]'s sharps container was full. During an interview on 01/13/2025 at 9:18 AM, Staff A, Administrator/DNS/IP, said they expected staff to immediately address sharps containers being full when they became aware of it, and it did not meet expectations a sharps container was observed to still have been full after staff had been notified. Reference WAC 399-97-1320 (1)(a)(c), (2)(a)(b) 37044

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F 0881

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Implement a program that monitors antibiotic use.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50945

Based on interview and record review, the facility failed to ensure the antibiotic stewardship program had an accurate and complete antibiotic line listing, with symptoms and McGeers Criteria (tool for infection surveillance and antibiotic stewardship, provided criteria to show if antibiotics were indicated) reviewed, and providers were updated on residents that did not meet criteria for antibiotic usage, for 3 of 3 residents (Resident 30, 354, & 355) reviewed for antibiotic line listing. This failure placed residents at risk of developing multi-drug resistant organisms, unidentified care needs, and a diminished quality of life.

Findings included .

During an interview on 01/08/2025 at 8:14 AM, Staff A, Administrator/Director of Nursing Services (DNS)/Infection Preventionist (IP), when asked to describe the antibiotic stewardship program, said they looked to see if the antibiotic use was appropriate/indicated, reviewed cultures as they resulted, and made sure the treatment/antibiotic was susceptible to the organism. Staff A said the facility was using McGeer Criteria.

1) Resident 30 was admitted to the facility on [DATE].

Review of Resident 30's Electronic Health Record (EHR), showed Resident 30 was prescribed Macrobid (an antibiotic) for a urinary tract infection (UTI) from 11/28/2024 to 12/07/2024.

Review of Resident 30's progress notes showed on 11/21/2024 that Resident 30 had symptoms of fatigue, general unwellness, and dizziness. The bladder scanner showed possible urinary retention, so an in and out urinary catheterization (tube that goes into bladder to remove urine) was done, with one liter of urine removed from the bladder. A note on 11/22/2024 showed laboratory values, including a urinary analysis with culture and sensitivity, were ordered for dizziness, bladder distention and retention of urine for three days. An indwelling (device left inside the body for a period of time) urinary catheter was placed.

Progress notes on 11/28/2024 showed Resident 30 had vaginal discharge with an odor, and later complained of pain in their vaginal area. One note said, I did a urine dip that resulted in positive leukocytes, protein, and blood. Called the on-call provider and was instructed to send a urine culture to test out for bacteria.

Review of the EHR showed the urine sample sent to the laboratory on 11/22/2024 had a urinary analysis that did not indicate culture. The urine sample sent to the laboratory on 11/28/2024 was ran as a urinary analysis which did not indicate culture. The progress note above stated that the provider on 11/28/2024 instructed for a urine culture to be obtained, not a urinary analysis (it was already completed in the form of a urinary dip test). No urinary culture was obtained in the record before the antibiotic was started.

Review of the November 2024 antibiotic line listing, showed Resident 30 had listed:

a. admitted [DATE]

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	505484	A. Building B. Wing	01/13/2025

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F 0881

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

b. Symptom onset date of 12/28/2024

c. Signs and symptoms- pain, urgency

d. Antibiotic start date/end date- 11/28/2024 to 12/02/2024

e. Date of culture 11/28/2024

f. Organism on culture- not indicated

g. Drug sensitivity- susceptible

The symptom of urgency was not found in the EHR. Resident 30 had a urinary catheter on 12/28/2024. There was no culture ran on 11/28/2024, and therefore there was no organism found in order to determine the organism was susceptible to the antibiotic.

Review of the December 2024 antibiotic line listing, showed Resident 30 had listed:

a. admitted [DATE]

b. Symptom onset date of 12/20/2024

c. Antibiotic start date/end date- 12/02/2024 to 12/07/2024

d. Signs and symptoms- urgency, frequency, burning

e. Date of culture 12/21/2024

f. Organism on culture- not indicated

g. Drug sensitivity- susceptible

The symptom onset date of 12/20/2024 and the date of culture of 12/21/2024, were after antibiotics had finished on 12/07/2024. There was no organism listed to be able to determine if it was susceptible to the antibiotic. The symptoms of urgency and frequency were not found in the EHR, as symptoms for antibiotics being reordered.

During an interview on 01/09/2025 at 9:40 AM, Resident 30, when asked when they have had a UTI while having a urinary catheter in place, if they develop increased urgency or the sensation of needing to urinate more, said no.

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	505484	A. Building B. Wing	01/13/2025

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/13/2025 at 2:33 PM, Staff A, Administrator/DNS/IP, when asked how they knew Macrobid was the appropriate antibiotic for Resident 30, said they did not. When asked if there was a urine culture on 11/28/2024, Staff A said that the urinary analysis came back as not indicated for a culture, and there was no culture and sensitivity done. Staff A said that for the 12/21/2024 culture listed on the antibiotic line list, that this was done in error since the antibiotic ended on 12/07/2024. When asked how symptoms were obtained from Resident 30 with a urinary catheter in place, Staff A looked at the symptoms on the line list and said they would not think Resident 30 would be able to say frequency or urgency with a urinary catheter in place. When asked if either the 11/28/2024 or 12/02/2024 doses met McGeers Criteria, Staff A said no. Staff A said when it did not meet McGeers Criteria, that the provider should have been notified and it should have been documented. 2) Resident 354 was admitted to the facility from 11/01/2024 to 11/04/2024. Review of the EHR, showed Resident 354 on 11/04/2024 had a sputum culture that was sent to the laboratory, which was described to be mostly blood. Review of the November 2024 antibiotic line listing, showed Resident 354 had two lines listed, both documented that Resident 354: a. admitted [DATE] b. symptom onset date of 11/05/2024 c. sign and symptoms- per hospital d. date of culture- per hospital e. organism on culture- na (not applicable) f. drug sensitivity- susceptible Further review of the line listing for Resident 354 showed one antibiotic was started on 11/01/2024 and the second antibiotic was started on 11/12/2024. During an interview on 01/13/2025 at 2:33 PM, Staff A, Administrator/DNS/IP, when asked if Resident 354 met McGeer Criteria, said no they did not think Resident 354 met criteria. When asked what their symptoms were, Staff A said it looked like the antibiotic line listing should have included symptoms for the pneumonia (lung infection). When asked about the onset date of symptoms being after the resident had left the facility, Staff A said the onset date looked incorrect. When asked about the culture that said per hospital, if one was done before the start of the antibiotics and what the result was, Staff A said this was missing information. 3) Resident 355 was admitted from 10/02/2024 to 10/10/2024. Review of the October 2024 antibiotic line listing, showed Resident 355 had two lines listed, both documented that Resident 354: a. admitted [DATE] (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. sign and symptoms- rosacea c. date of culture- N/A (not applicable) d. organism on culture- empty e. drug sensitivity- susceptible f. stop dates- N/A During an interview on 01/13/2025 at 2:33 PM, Staff A, Administrator/DNS/IP, when asked if Resident 355 met McGeer Criteria or if there was documentation of a conversation with the provider when criteria was not met, said no to both questions. When asked about how long Resident 355 was on antibiotics for, Staff A said Resident 355 was on antibiotics until discharge and it should have been updated on the antibiotic line list. During this interview, Staff A said without a culture they could not know if the organism was susceptible to the antibiotic, that the residents on the line listing that said, per hospital did not have any additional forms with symptoms listed and they should be listing the symptoms. Staff A said the examples listied during the interview did not meet expectations. No Associated WAC