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	03/16/2026

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

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify the resident/resident's representative and Ombudsman in writing of the reason for the transfer/discharge to the hospital, convey the required information to the hospital and provide written bed hold notice at the time of transfer to the hospital for 4 of 4 sampled residents (Residents 34, 68, 18 and 66) when reviewed for hospitalization. These failures placed the residents at risk for lacking knowledge regarding their transfer, discharge rights and the right to hold their bed while in the hospital and diminished quality of life.Findings included .Resident 34 Review of the electronic health record (EHR) showed Resident 26 admitted to the facility on [DATE] with diagnoses that included left calf ulcer, heart failure and muscle weakness. Resident 34 was able to make needs known. Review of Resident 34's EHR showed hospitalization on 02/09/2026 and readmission to the facility on [DATE]. There was no documentation showing a bed hold was offered, a completed transfer discharge form or the required information was provided to the hospital at the time of transfer. Resident 68 Review of the EHR showed Resident 68 admitted to the facility on [DATE] with diagnoses that included diabetes (too much sugar in the blood) and chronic obstructive pulmonary disease (a lung disease that effects ability to breathe). Resident 68 was able to make needs known. Review of Resident 68's EHR showed a resident-initiated, against medical advice, discharge on [DATE]. The facility made contact with Resident 68 and they were able to verify their current address. The transfer discharge form was incomplete and not provided to the resident nor was the Ombudsman notified. During an interview on 03/13/2026 at 3:02 PM, Staff C, Patient Care Manager, stated the licensed nurse on duty at the time of transfer offered verbal bed holds but did not provide the resident/representative with a written copy. Staff C stated the facility did not complete the transfer/discharge form and notify the ombudsman for residents who left against medical advice. During an interview on 03/16/2026 at 8:10 AM, Staff B, Director of Nursing Services (DNS), stated they were unaware the transfer/discharge form was to be completed for all discharged residents to include those who left against medical advice. Staff B stated the facility only communicated bed holds verbally and did not provide residents with documentation explaining the bed hold. Staff B stated the lack of documentation showing if the hospital was provided with the required information (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at the time of transfer did not meet their expectations. Resident 18 Resident 18 was admitted to the facility on [DATE]. Review of the 02/01/2026 discharge MDS, showed the resident was transferred to acute care on 02/01/2026, return anticipated Review of Resident 18's EHR showed no documentation was present to show staff:a- Provided written notification to Resident 18 and/or their representative regarding the 02/01/2026 discharge.b- Sent required documents, called report, or otherwise conveyed the minimum required information to the receiving provider.c- Provided written notification to the Ombudsman. On 03/16/2026 at 9:53 AM, when asked if there was documentation to show the Ombudsman was notified of Resident 18's 02/01/2026 discharge, Staff H, Receptionist, said No. During an interview on 03/16/2026 at 12:42 PM, when asked if there was documentation to show staff provided written notification to Resident 18 and/or their representative or that staff sent required documents, called report, or otherwise conveyed required information to the receiving provider, Staff A, Administrator, indicated facility staff sent information with the resident in a packet at the time of discharge but acknowledged the resident's record had no documentation of what information, if any, had been sent. Staff A also confirmed there was no documentation that staff notified the resident or their representative in writing regarding the discharge. Resident 66 Resident 66 was admitted to the facility on [DATE]. Review of the 01/08/2026 Discharge MDS, showed the resident was transferred to acute care on 01/08/2026, return anticipatedReview of Resident 66s EHR showed no documentation was present to show staff:a- Provided written notification to Resident 66 and/or their representative regarding the 01/30/2026 discharge.b- Sent required documents, called report, or otherwise conveyed the minimum required information to the receiving provider.c- Provided written notification to the Ombudsman. On 03/16/2026 at 9:53 AM, when asked if there was documentation to show the ombudsman was notified of Resident 66's 01/08/2026 discharge, Staff H, Receptionist, said No. During an interview on 03/16/2026 at 12:42 PM Staff A, Administrator, said they could not find documentation that a written notice was provided to Resident 66 or their representative, or that indicated what documents and/or information was communicated to the receiving provider. Reference WAC 388-97-0120 (4)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents and/or resident representatives were provided education about COVID-19 vaccination, including risks, benefits and potential side effects for 4 of 5 sampled residents (Resident 2, 27, 54 and 16) reviewed for COVID-19 immunizations. Additionally, for facility staff the facility failed to annually screen and offer the COVID-19 vaccination (or provide information on where the vaccine could be obtained) and document if the vaccine was accepted/declined. These failures denied the residents and/or their representative and staff the right to make informed decisions.Findings included.Review of the facility policy, titled Coronavirus Disease (COVID-19) - Vaccination of Residents, revised June 2022, documented before the vaccine was offered, the resident was to be provided with education regarding the benefits, risks, and potential side effects associated with the vaccine. Under the section titled Documentation and Reporting, the policy documented the resident's medical record would include documentation that indicated the resident or resident representative was provided education regarding benefits and potential risks associated with the COVID-19 vaccine, to include samples of the educational materials used, the date the education took place and the name of the individual who received the education. Review of the facility policy, titled Coronavirus Disease (COVID-19) - Vaccination of Staff, revised June 2022, documented the COVID-19 vaccine education, documentation and reporting would be overseen by the facilities infection preventionist and coordinated by his or her designee. The policy went on to document that the vaccine may be offered and provided by the facility or indirectly offered, such as through an arrangement with a pharmacy partner, local health department, or other appropriate health entity. The policy documented staff members would be screened for contraindications to the vaccine, medical precautions and prior vaccination before being offered the vaccine.Lack of Resident COVID-19 Vaccine Education Resident 16 was admitted to the facility on [DATE], review of Resident 16's medical record showed no documentation to support that risks and benefits and/or education were provided to the resident and/or the resident's representative.Resident 2 was re-admitted to the facility on [DATE], review of Resident 2's medical record showed no documentation to support that risks and benefits and/or education were provided to the resident and/or the resident's representative.Resident 27 was admitted to the facility on [DATE], review of Resident 27's medical record showed no documentation to support that risks and benefits and/or education were provided to the resident and/or the resident's representative.Resident 54 was admitted to the facility on [DATE], review of Resident 54's medical record showed no documentation to support that risks and benefits and/or education were provided to the resident and/or the resident's representative.On 03/13/2026 at 2:34 PM, Staff E, Assistant Director or Nursing (ADON), confirmed there was no documentation Resident's 2, 27, 54, and 16 and/or their representative's had been provided education on the COVID-19 vaccination. Staff E said it did not meet her expectations, and she could see there needed to be some changes made. On 03/16/2026 at 9:30 AM, Staff A, Administrator, said residents' admission packet had information on vaccines, the admission nurse would go over previous vaccinations, and Staff E would do education as well. Staff A said Staff E monitored all vaccines in the building. When asked about the lack of documentation of education for the COVID-19 vaccination for residents, Staff A looked in the electronic health record and confirmed education had not been documented. Staff A said all the tools were present to document education that had been provided, and her expectation was that education be provided and documented.FAILURE TO ANNUALLY SCREEN/EDUCATE/OFFER/KEEP RECORD OF ACCEPTANCE OR DECLINATOIN OF COVID-19 VACCINATION FOR STAFFOn 03/11/2026 at 10:52 AM, Staff E, ADON, was asked if she had documentation that Staff was screened, educated, offered the COVID-19 vaccination and a record of (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff's current COVID-19 vaccination status. Staff E said that was not something she did and she was not involved in the COVID-19 vaccination process.On 03/13/2026 at 2:05 PM, Staff A, Administrator, when asked who was responsible for ensuring staff were screened, educated and offered or provided information on where to obtain the COVID vaccination, Staff A said when staff were hired there was a page in the hiring packet on vaccinations and an area to document if they had received the COVID-19 vaccination or not. On 03/13/2026 at 2:20 PM, Staff A, when asked if staff were annually educated, screened and informed where they could receive the COVID-19 vaccine, Staff A said they had an All-Staff meeting in which COVID-19 vaccine was encouraged and education on the vaccine was reviewed. Staff would sign that they attended the meeting, Staff A said she had no documentation that staff signed annually that they were screened, educated, offered or informed where they could receive the vaccine and indicated no annual record was kept of staff acceptance or declination of the vaccine.On 03/16/2026 at 9:30 AM, Staff A, regarding the annual screening, educating, offering and documenting of the current COVID-19 vaccination status, Staff A said COVID-19 was discussed in the All-Staff meetings, but moving forward there should be a more formalized process.Reference WAC 388-97-1620(2)(b)(i)(ii)

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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** .Based on interview and record review, the facility failed to develop and implement comprehensive person-centered care plans for 5 of 17 sample residents (Resident 16, 69, 74, 72 & 2) whose care plans were reviewed. Failure to develop and implement care plans that were individualized, and accurately reflected resident care needs related to constipation, target behaviors for psychotropic (drugs that affect behavior, mood, thoughts, or perception) medication use, activities, and weights monitoring, placed residents at risk for unidentified and/or unmet care needs and potential negative health outcomes.Findings included . Resident 16Resident 16 was admitted to the facility on [DATE]. Review of the 09/06/2025 admission MDS, showed the resident received an anticoagulant (medication that prevent or reduce blood clot formation) during the assessment period. Record review showed a 09/02/2025 order for Eliquis (an anticoagulant) twice daily for atrial fibrillation (a sustained heart rhythm disorder.) An anticoagulant therapy with Eliquis care plan, initiated 02/18/2026, documented the antidote to Eliquis was Vitamin K, and directed staff to have it on hand for emergencies. Review of Eliquis' manufacturer's insert showed the only recognized antidote was Andexxa (a recombinant protein used as an antidote to rapidly reverse the anticoagulation effects of apixaban) . On 03/16/2026 at 1:10 PM, Staff A, Administrator, confirmed Vitamin K was not an antidote to Eliquis and said the care plan was inaccurate Resident 69Resident 69 was admitted to the facility on [DATE]. Review of the 03/06/2026 admission Minimum Data Set (MDS, an assessment tool), showed the resident was cognitively impaired and had an active diagnosis of constipation. Review of the Daily Skilled Nursing Note Summaries from 03/01/2026 - 03/10/2026 showed they documented Resident 69 would have Daily assessment and monitoring of gastrointestinal (GI) function including bowel sounds, abdominal distension, and stool characteristics Review of the altered elimination due to bowel and bladder incontinence care plan, initiated 03/09/2026, showed the resident's active diagnosis of constipation was not addressed. Nor did the care plan interventions instruct staff to perform daily assessment and monitoring of Resident 69's GI function including bowel sounds, abdominal distension, and stool characteristics as documented in the resident's daily skilled nursing notes. On 03/16/2026 at 12:46 PM, Staff A, Administrator, said Resident 69's active diagnosis of constipation, and identified intervention(s) of daily GI function assessment and monitoring should have been addressed/incorporated into the residents bowel and bladder care plan. Resident 74Resident 74 was admitted to the facility on [DATE]. Review of the 02/16/2026 admission MDS, showed the resident was cognitively intact, had a diagnosis of heart failure and received diuretic medication (medications that help kidneys remove excess sodium and water from the body) during the assessment period. Record review showed a 02/11/2026 order for torsemide (a diuretic) daily for chronic heart failure, and a 02/12/2026 order to for daily weights. A heart failure care plan, initiated 02/11/2026, directed staff to obtain daily weights and report to the provider weight gains greater than 3 lbs. lbs. in 24-hours, or greater than 5 lbs. in a week. A renal insufficiency care plan, initiated 02/11/2026, directed staff to report to the provider a weight gain of greater than 2 lbs. in 24 hours. On 03/16/2026 at 12:34 PM, Staff A, Administrator, acknowledged the two care plans provided conflicting instruction to staff related to the amount of weight the resident could gain in 24 hours before provider notification (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was required. Staff A indicated the heart failure care plan was accurate and the renal insufficiency care plan needed to be revised. On 03/10/2026 at 11:59 AM, Resident 74 indicated they were not consistently provided bathing as scheduled. A skilled services care plan, initiated 02/11/2026, documented Resident 74 was to be showered three times a week on Monday, Wednesday and Friday, on evening shift. Review of Resident 74's bathing record showed for the two-week period of 02/25/2026 - 03/10/2026, staff offered/provided a shower on one of the resident's six scheduled shower days. On 03/16/2028 at 12:38 PM, when asked if Resident 74's plan of care for bathing type/frequency was implemented, Staff A, Administrator, said, No. Resident 72Resident 72 was admitted to the facility on [DATE]. On 03/10/2026 at 11:18 AM, Resident 72 said their showers were not always provided. A skilled services care plan, initiated 03/03/2026, showed Resident 72 was to be showered three times a week, on Monday, Wednesday and Friday on evening shift. Review of Resident 72's bathing record showed in the two-week period of 02/28/2026 - 03/13/2026, staff offered/provided a shower on two of the resident's six scheduled shower days. On 03/16/2028 at 12:39 PM, Staff A, Administrator, confirmed Resident 72's plan of care for bathing type/frequency was not consistently implemented. Resident 2Resident 2 re-admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 2 was cognitively intact. On 03/09/2026 at 12:25 PM, Resident 2 said they watched television for activities, and that they were not sure what activities were offered at the facility. When asked if staff from the activities department had come to see if they would like to participate in activities, Resident 2 said no, they had never talked with anyone about activities and they would probably participate if they were offered activities. Resident 2 had an Activities & Enrichment Evaluation assessment completed on 02/06/2026, which indicated their activity interests. Review of Resident 2's activities care plan on 03/10/2026, showed the care plan had been entered that day, five weeks after admission to the facility. On 03/11/2026 at 2:32 PM, Staff L, Activity Professional Certified, said she would normally enter the activities care plan when she did the assessment. When asked about the activities care plan for Resident 2 being entered five weeks after admission, Staff L said this did not meet her expectations. On 03/11/2026 at 3:31 PM, Staff B, Director of Nursing Services, was asked if Resident 2's activities care plan should have been put in prior to five weeks after admission, said yes. Reference WAC 388-97-1020(1)(2)(a)(b)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to consistently offer/provide showers and provide timely meal assistance to 3 of 3 Residents (Resident 72, 74 and 21) reviewed for activities of daily living (ADL). These failures placed dependent residents at risk for unmet care needs, poor hygiene and diminished quality of life.Findings included .Resident 72 Resident 72 was admitted to the facility on [DATE]. Review of the 03/05/2026 admission Minimum Data Set (MDS, an assessment tool), showed the resident was moderately cognitively impaired and decisions about bathing were Very Important. A skilled services care plan, initiated 03/03/2026, documented Resident 72 preferred showers three times a week on Monday, Wednesday and Friday, on evening shift. On 03/10/2026 at 11:18 AM, Resident 72 said they were not always provided their showers. Review of Resident 72's bathing record showed they received a shower on 03/04/2026 but were not offered/provided bathing again until 03/13/2026, nine days later. During an interview on 03/16/2026 at 12:35 PM, Staff A, Administrator, confirmed there was no documentation that Resident 72 was offered/provided bathing for nine days between 03/04/2026 - 03/13/2026, and that staff failed to offer/provide bathing in accordance with the resident's plan of care. Resident 74 Resident 74 was admitted to the facility on [DATE]. Review of the 02/16/2026 admission MDS, showed the resident was cognitively intact and decisions about bathing were Very Important. A skilled services care plan, initiated 02/11/2026, documented Resident 74 preferred showers three times a week on Monday, Wednesday and Friday, on evening shift. On 03/10/2026 at 11:59 AM, Resident 74 said when they changed rooms staff failed to provide bathing for over a week. Review of Resident 74's bathing record showed they received a shower on 02/24/2026 but was not offered/provided bathing again until 03/10/2026, 14 days later. During an interview on 03/16/2026 at 12:35 PM, Staff A, Administrator, confirmed there was no documentation of Resident 74 being offered/provided bathing for 14 days between 02/24/2026 - 03/10/2026, and that staff failed to offer/provide bathing in accordance with the resident's plan of care. Resident 21 Review of the electronic health record (EHR) showed Resident 21 admitted to the facility on [DATE] with diagnoses that included severe protein malnutrition, right side paralysis due to a stroke and dysphagia (swallowing difficulty). Resident 21 was dependent on staff assistance for all activities of daily living. Review of Resident 21's Care Plan, dated 02/21/2026, showed the following intervention Staff will provide assistance with meal consumption: Alternate small bites and sips. Use a teaspoon for eating. Do not use straws. Observation on 03/12/2026 at 8:20 AM, showed breakfast trays being passed out to resident rooms. Observation on 03/12/2026 at 9:21 AM, showed breakfast trays being picked up from resident rooms and the food cart taken back to the kitchen (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 03/12/2026 at 9:44 AM, Resident 21 was lying in bed in their gown and stated they did not receive breakfast. During an interview on 03/12/2026 at 9:44 AM, Staff J, Certified Nursing Assistant, stated they were assigned to Resident 21 but was unaware the resident did not receive breakfast and required feeding assistance. Staff J stated there was no meal tray on the cart for Resident 21. An observation on 03/12/2026 at 10:14 AM showed Resident 21 received a breakfast tray, two hours after initial tray pass. During an interview on 03/16/2026 at 8:38 AM, Staff B, Director of Nursing Services (DNS), stated the expectation was that staff were to be familiar with their assigned resident's plan of care and that residents' received that care timely. Reference WAC 388-97-1060 (2)(c)

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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** Based on interview and record review, the facility failed to provide the necessary care and services to maintain residents' highest practicable level of well-being for 1 of 6 sampled residents (Resident 69) reviewed for bowel management and for 1 of 2 sampled residents (Resident 74) reviewed for edema and/or weight monitoring. The failure to initiate bowel care in accordance with physician's orders and the facility's bowel protocol, and the failure to obtain and evaluate weights, and notify the provider of weight variances as ordered, placed residents at risk for delayed identification and treatment of fluid volume overload, and abdominal pain, nausea, and decreased appetite related to untreated constipation. Findings included .Bowel ManagementResidents 69Resident 69 was admitted to the facility on [DATE]. Review of the 03/06/2026 admission Minimum Data Set (MDS, an assessment tool), showed the resident was cognitively impaired and had an active diagnosis of constipation. On 03/10/2026 at 10:09 AM, Resident 69 reported they had a long history of constipation. Record review showed Resident 69 had the following 03/01/2026 as needed (PRN) bowel care orders:- Miralax 17 gram dissolved in four ounces of water every 24-hours PRN; Give first for bowel care.- Bisacodyl 5 milligrams one tablet every 24-hours PRN for constipation; Give second for bowel care if Miralax ineffective.- Bisacodyl 5 milligrams two tablets every 24-hours PRN for constipation; Give third for bowel care if Miralax and 5mg Bisacodyl ineffective.- Mineral Oil Enema rectally every 24-hours PRN for constipation; Give fourth for bowel care if Miralax and Bisacodyl 10mg ineffective.- Notify MD/NP if constipation persists for 4 days or more. Review of Resident 69's bowel record showed no documented bowel movement (BM) from 03/03/2026 - 03/06/2026 (4 days.) The March 2026 Medication and Treatment Administration Records (MAR/TAR) showed Resident 69 was not administered PRN bowel medication until 03/11/2026. Review of the Daily Skilled Nursing Note Summary from 03/01/2026 - 03/06/2026 showed they documented Management of Altered GI Function: Daily assessment and monitoring of GI function including bowel sounds, abdominal distension, and stool characteristics in each note, but there were no abdominal/bowel assessments documented. On 03/16/2026 at 12:32 PM, when asked if there was documentation to show staff performed an abdominal/bowel assessment and/or administered the resident PRN bowel medication when they went without a BM for four consecutive days from 03/03/2026 - 03/06/2026 Staff A, Administrator, said no. Edema Management/Weight Monitoring Resident 74Resident 74 was admitted to the facility on [DATE]. Review of the 02/16/2026 admission MDS, showed the resident was cognitively intact, had a diagnosis of heart failure and received diuretic medication (medications that help kidneys remove excess sodium and water from the body through increased urine) during the assessment period. Resident 74 had a 02/11/2026 order for torsemide (a diuretic) daily for chronic heart failure. A renal insufficiency care plan, initiated 02/11/2026, directed staff to monitor, document, and report to the provider: edema, weight gain of over two pounds (Lbs.) in a day.A heart failure care plan, initiated 02/11/2026, directed staff to obtain daily weights and report weight increases greater than three lbs. in a day or greater than five lbs. in a week. Record review showed a 02/12/2026 order to obtain daily weights related to heart failure.Review of the February 2026 TAR showed Resident 74 weighed the following:- 02/13/2026= 344.9 Lbs.- 02/14/2026= 352.2 (+7.3 Lbs. in 24 hours); Record review showed there was no documentation to show the provider was notified.- 02/18/2026 352.7 Lbs.- 02/19/2026= 339 Lbs. (-13.7 Lbs. in 24 hours), Record review showed there was no documentation to show the provider was notified.-02/22/2026= 320.8 Lbs.- 02/24/2026- 336.2 Lbs. (+ 15.4 Lbs. in 48-hours). Record review showed there was no documentation to show the provider was notified. On 03/16/2026 at 12:58 PM, when asked if there was documentation to show the provider was notified of Resident 74's weight variances of greater than two pounds in 24-hours Staff A, Administrator, stated, Not that I see. Reference WAC 388-97-1060 (1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a safe environment was maintained related to falls for 1 of 1 sampled resident (Resident 21) when reviewed for accident hazards. This failure placed the residents at risk for avoidable injuries and a diminished quality of life.Findings included.Review of the electronic health record (EHR) showed Resident 21 admitted to the facility on [DATE] with diagnoses that included severe protein malnutrition, right side paralysis due to a stroke and dysphagia (difficulty swallowing). Resident 21 was dependent on staff assistance for all activities of daily living.Review of the February 2026 incident log showed Resident 21 had an unwitnessed non-injury fall on 02/26/2026.Review of the facility incident report, dated 02/27/2026, showed the following interventions were in place at the time of the fall: fall mat, bed in lowest position and bed alarm. No new interventions or corrective measures were documented.Review of the March 2026 incident log showed Resident 21 had an unwitnessed non-injury fall on 03/03/2026.Review of the facility incident report, dated 03/03/2026, showed Resident 21 was found lying on the floor next to their bed. Documentation showed the bed alarm was not on and the bed was not in the lowest position at the time of the fall. Corrective measures taken were staff education and implementation of 15-minute checks.Observation on 03/12/2026, between 8:20 AM and 9:44 AM, showed one 15-minute check was completed.Observations on 03/09/2026 at 11:35 AM, 03/10/2026 at 9:35 AM, 03/11/2026 at 1:31 PM and 03/12/2026 at 8:20 AM showed two small thin mats on the floor at Resident 21's bed side.During an interview on 03/12/2026 at 12:52 PM, Staff O, Maintenance, stated that the two mats on the floor in Resident 21's room were concentrator floor mats used for oxygen tanks. Staff O stated that they would replace the floor mats with a fall mat if they could locate one in the facility.During an interview on 03/16/2026 at 8:20 AM, Staff B, Director of Nursing Services, stated that they did not have a fall mat in place because maintenance could not find one. The expectation was that central supply should have been notified to order the fall mat. Staff B stated that it did not meet their expectation that the fall interventions were not implemented. Reference WAC 388-97-1060 (3)(g)

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	505484	A. Building B. Wing	03/16/2026

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

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide non-pharmacological interventions (NPI) prior to the use of as needed pain medications for 4 of 6 residents (Residents 30, 74, 5 and 2) when reviewed for unnecessary medication. This failure placed the residents at risk of receiving unneeded medications and a diminished quality of life.Findings included . Resident 30Review of the electronic health record (EHR) showed Resident 30 admitted to the facility on [DATE] with diagnoses to include high blood pressure, depression (mood disorder) and anxiety. Resident 30 was able to make needs known. Review of Resident 30's medication list showed a provider's order dated 02/24/2026 for acetaminophen (a pain medication) every four hours as needed (PRN) for pain. Review of Resident 30's medication list showed a provider's order, dated 02/27/2026, to offer non-pharmaceutical intervention prior to PRN medication administration 1) redirect, 2) 1:1, 3) activity, 4) return to room, 5) toilet, 6) give food, 7) give fluids, 8) change position, 9) adjust room temperature, 10) backrub 11) imagery. Review of Resident 30's March 2026 medication administration record (MAR) showed acetaminophen administered on March 1st, 3rd, 4th ,5th ,6th and 12th. There was no documentation that NPI's were offered/provided prior to the administration of the medication. During an interview on 03/13/2026 at 2:45 PM, Staff C, Patient Care Manager, stated nursing staff should have offered ice and repositioning prior to administering the as needed pain medication. Staff C stated the expectation was to document Resident 30's pain level and the interventions attempted and make sure the appropriate PRN medication is given for the pain level. During an interview on 03/16/2026 at 8:27 AM, Staff B, Director of Nursing Services, stated the expectation was for staff to offer and document NPI's prior to administering PRN pain medication. Resident 74Resident 74 was admitted to the facility on [DATE]. Review of the 02/16/2026 admission Minimum Data Set (MDS, an assessment tool), showed the resident was cognitively intact, had a diagnosis of heart failure and hypertension and received diuretic medication (medications that help kidneys remove excess sodium and water from the body through increased urine) during the assessment period. Record review showed Resident 74 had the following 02/11/2026 orders:a) Eplerenone one time a day for heart failure, Hold medication for a systolic blood pressure (SBP - top or first number of blood pressure reading) less than 110.b) Torsemide one time a day for heart failure, Hold medication for a SBP less than 110, Review of the February and March 2026 Medication Administration Record (MAR) showed on the following dates the medication was administered outside of the ordered parameters:Eplerenone:02/20/2026- BP= 105/63; medication was administered.03/8/2026- BP= 109/64; medication was administered.03/14/2026- BP= 107/64; medication was administered. Torsemide02/20/2026- BP= 105/63; medication was administered. During an interview on 03/16/2026 at 12:58 PM, Staff A, Administrator, said on the above referenced occasions the medication(s) should have been held, and acknowledged facility nurses administered the medication(s) outside of the physician ordered parameters. Resident 5Resident 5 was admitted to the facility on [DATE]. Review of the 02/19/2026 admission (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS, showed the resident had a diagnosis of heart failure and hypertension and received diuretic medication during the assessment period. Record review showed Resident 5 had a 02/17/2026 order for Metoprolol twice a day for atrial fibrillation, and a 02/14/2026 order that identified cardiac medication hold parameters: Hold for SBP less than 110 or a pulse less than 60, if not otherwise specified. Review of the February 2026 MAR showed on the following dates staff administered Resident 5's Metoprolol outside of the ordered parameters: 02/20/26 8pm dose- BP= 105/55, medication was administered. 02/25/26 8pm dose- BP= 97/63; Medication was administered.02/26/26 8pm dose- BP= 108/60; Medication was administered.02/27/26 8pm dose- BP= 101/63; Medication was administered. During an interview on 03/16/2026 at 12:58 PM, Staff A, Administrator, acknowledged on the above referenced occasions Resident 5's metoprolol should have been held, but confirmed facility nurse administered the medication outside of the physician ordered parameters. Resident 2 Resident 2 re-admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 2 was cognitively intact. Resident 2 had a provider order, dated 02/11/2026, for acetaminophen to be given every 6 hours as needed for pain. Resident 2 had another provider order, dated 02/11/2026, for oxycodone (medication to relieve pain) to be given every 8 hours as needed for a pain level of 6-10/10 (pain scale based on 1-10, with 1 indicating no pain and 10 the highest level of pain). Review of Resident 2's MAR from 03/01/2026- 03/13/2026, showed they had an order for staff to document non-pharmacological interventions (NPI) for pain to 1. Lower back or 2. Bilateral legs. The NPIs were to include 1: repositioning, 2: removing lights and loud noises, or 3: pillows. Staff were to document the location of the pain and the interventions attempted. Review of the documentation showed no NPIs had been attempted. Resident 2's MAR from 03/01/2026- 03/13/2026, documented acetaminophen had been administered 13 times and oxycodone had been administered 15 times, with documentation that NPIs had been attempted. Further review of the MAR showed Resident 2 received oxycodone two times on 03/09/2026, with a pain level reported as 5/10, outside of the ordered parameters of 6-10/10. On 03/16/2026 at 11:23 AM, Staff B, DNS, confirmed that Resident 2 had ordered NPIs. When asked if NPIs had been attempted prior to administration of the acetaminophen and oxycodone, Staff B said NPIs were not connected to the orders for the pain medications and no NPIs had been attempted that she could see. Staff B confirmed the oxycodone had been given two times outside of the ordered parameters on 03/09/2026 and said this did not meet her expectations. Reference WAC 388-97-1060(3)(k)(i)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents' records were complete and accurate for 2 of 2 residents (Residents 54 and 2) reviewed for accurate and complete records. Failure to maintain complete and accurate records placed residents at risk for unmet care needs and for a diminished quality of life. Findings included.Resident 54Review of the facility policy, titled Requesting, Refusing, and/or Discontinuing Care or Treatment, documented that if a resident refused care or treatment, the licensed nurse, Director of Nursing or designee would meet with the resident to determine why the resident was refusing care or treatment, try and address the residents' concerns and discuss alternative options; and discuss potential outcomes or consequences (positive and negative) of the resident's decision. Resident 54 was admitted to the facility on [DATE] with a diagnosis of dementia (loss of intellectual functioning). Review of the admission Medicare 5 Day Minimum Data Set, (MDS, an assessment tool) documented Resident 54 was moderately cognitively impaired and was dependent on others for showering/bathing. On 03/10/2026 at 11:46 AM, Resident 54 was observed in bed, with disheveled hair going in different directions.On 03/12/2026 at 12:16 PM, Resident 54's hair was observed to be oily in appearance and was sticking out on the sides. Resident 54 had a provider order, dated 02/23/2026, for showers scheduled on Monday, Wednesday and Friday on evening shift. The order instructed staff to document whether a shower was given and if not given staff were instructed to write a progress note on why the shower was not done and complete the Shower Refusal form. Staff were to document plus or minus sign to indicate if a shower was received, and write a progress note if not received every night shift on Monday, Wednesday and Friday. Review of Resident 54's shower record documented under type of bath received showed 10 different categories for staff to choose from as follows:a. Occupational Therapy provided the patient with a bath or shower todayb. Bed Bathc. Sponge bathd. Regular bathe. Showerf. Offered, but patient refusedg. Activity Did not Occurh. Resident Not Availablei. Resident Refusedj. Not applicableReview of Resident 54's shower record from 02/22/2026 through 03/11/2026 documented they had not had a shower since 02/25/2026, and the record did not indicate Resident 54 was offered and refused the missed showers, but that the Activity Did not Occur for six scheduled showers.02/22/2026- Not Applicable02/23/2026- Bed Bath02/25/2026- Shower02/27/2026- Activity Did not Occur03/02/2026- Activity Did not Occur03/04/2026- Activity Did not Occur03/06/2026- Activity Did not Occur03/09/2026- Activity Did not Occur03/11/2026- Activity Did not OccurOn 03/12/2026 at 12:43 PM, Staff M, Certified Nursing Assistant (CNA), said if a resident refused to shower or bathe, they would ask the resident again later and if resident was still not wanting to take a shower, he would alert his supervisor and fill out a refused shower form.On 03/12/2026 at 12:46 PM, Staff N, CNA, said if a resident refused a shower or bath, she would write a refusal form and write on the form what specifically the resident refused and ask the resident what the reason for refusal was and see if there was anything that could be done and then she and the nurse would sign the form. Staff N showed the refusal form binder. Review of the binder showed one refusal form, dated 02/27/2026, regarding shower/full bed bath refusal for Resident 54. On 03/12/2026 at 2:44 PM, Staff C, Patient Care Manager, said the expectation for documentation if a resident was refusing shower/bathing was for the CNA to reapproach and if resident still refused then let floor nurse know and then reapproach as a team, if after that the resident said no to both CNA and Nurse, then the nurse was to write a progress note and the CNA should do a refusal form and put it in the refusal binder. Staff C said the CNA was expected to also document in the electronic health record (shower record) the refusal as well. Regarding Resident 54's apparent lack of shower since 02/25/2026, Staff C said Resident 54 refused everything. Regarding the CNA documenting activity did not occur, Staff C confirmed this indicated the shower did not happen and said staff should have documented refusals. When asked if the lack of (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refusal forms for showers met her expectations, Staff C said no, she would see if she could locate additional refusal forms.On 03/16/2026, Staff A, Administrator, provided one additional refusal form relating to showers, dated 03/06/2026, for Resident 54, with no refusal forms provided for 03/02/2026, 03/04/2026, 03/09/2026, 03/11/2026. On 03/16/2026 at 11:01 AM, Staff B, Registered Nurse (RN)/ Director of Nursing Services (DNS), when asked what her expectations of staff were when a resident was refusing showers said, reapproach and ask resident if it was an issue with time preference or male vs female aide. Staff B said if the resident was still refusing to shower the CNA and nurse would reapproach the resident to determine if there was something else they could do to accommodate the resident. Regarding Resident 54 not having a documented shower for two weeks, Staff B said Resident 54 had been refusing care. Regarding CNA documenting activity did not occur, on 02/27, 03/02, 03/04, 03/06, 03/09 and 03/11/2026, Staff B said staff was documenting activity did not occur as opposed to refused, it looked like it had not been offered, and she thought it was incorrect documentation. When reviewing the order for staff to fill out a refusal form for refused showers, Staff B was told there were only two provided that pertained to showers, leaving four missing. Staff B said the forms were used for tracking if there were consistent refusals. When asked if staff should have filled out the refusal forms, Staff B said it was a way to communicate with the nurse so the CNA would not forget to let them know the resident had refused, to track refusals, and identify patterns. Staff B was asked how the facility was identifying the barriers to showering for Resident 54 who had not had a shower for over two weeks according to CNA documentation, Staff B said Resident 54 had behaviors and dementia. When asked if she had met with Resident 54 to determine why they were refusing showers, Staff B said she had not met with them on why they were refusing showers. When asked if the lack of correct/and or present documentation met her expectations, Staff B said no, not to the accuracy she would like. Resident 2Resident 2 re-admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 2 was cognitively intact. On 03/09/2026 at 12:25 PM, Resident 2 said they watched television for activities, and that they were not sure what other activities were offered at the facility. When asked if staff from the activities department had come to see if they would like to participate in any of the activities offered, Resident 2 said no, they had never talked with anyone about activities and they would probably participate if they had been offered them. On 03/11/2026 at 2:32 PM, Staff L, Activity Professional Certified, said that all activities were done in the dining room and she offered arts and crafts, bingo, storytelling, painting, Sitter Cise (exercise), balloon toss, and a popcorn social on Tuesdays and Thursdays. Staff L said she posted an activity program calendar in Resident's rooms on the cork board and let them know the activities of the month and would tell them the times of activities were on the calendar, and she would also go into the room and let them know what was going on that day. When asked when attempts were made to include a resident or when contact was made with the resident regarding activities did, she document this, Staff L said yes, she would document it in a progress note. When asked if Resident 2 participated in activities offered at the facility, Staff L said she would go to Resident 2's room almost every day and Resident 2 would say no, they were ok. Staff L said she would offer one-to-one times with Resident 2 if they did not want to participate in group activities and sometimes, they would accept. When asked if there was any documentation of interactions with Resident 2 since their admission five weeks previous, Staff L looked in the electronic health record at progress notes and said she was unable to find any documentation of interactions with Resident 2.On 03/11/2026 at 3:31 PM, Staff B, Registered Nurse, RN/DNS, when told Resident 2 reported no one had talked with them about activities and they would probably participate if offered activities, and that Staff L was unable to provide any documentation that she had interacted with Resident 2 since admission, Staff B said she would think in over a month's time there would have been documentation that Staff L had interacted with Resident 2. Reference WAC 388-97-0940(1)(2)