STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505240	A. Building B. Wing	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Port Washington Post Acute	140 South Marion Avenue Bremerton, WA 98312

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 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation, interview, and record review, the facility failed to ensure comprehensive skin assessments were completed for 3 of 3 residents (Resident 1, Resident 2, and Resident 3) sampled for services meeting professional standards. This failure placed the residents at risk for unidentified skin impairments, worsening skin impairments, and rehospitalization.Findings included .<Resident 1>Resident 1 was admitted to the facility on [DATE] with several chronic wounds to the lower extremities. The quarterly Minimum Data Set (MDS, an assessment tool), dated 03/04/2025, showed Resident 1 was cognitively intact and needed substantial assistance for most Activities of Daily Living (ADL's). Resident 1 discharged to the hospital on [DATE] for surgical intervention for the wounds.An admission note, dated 11/26/2025, showed Resident 1 admitted to the facility with wounds to the right lower leg, left lower leg, left heel, left large and 5th toes. Measurements were provided. Contracted wound management company did not admit Resident 1 to their service until 02/24/2025. There were no measurements or characteristics documentation of Resident 1's wounds after 11/26/2025 on the weekly Skin Evaluations.On 12/19/2024, Resident 1 was sent to the hospital for cellulitis (skin infection) to their legs. On 04/02/2025, Resident 1 was sent to the hospital with, two huge skin tears to left forearm. No Skin Evaluations were completed with identifying documentation for either of these incidents.On 06/17/2025 at 4:15 PM, Staff E, Charge Nurse, and Staff F, Charge Nurse, were asked who completes the weekly Skin Evaluations and what were the expectations. They said nurses completed them and should be documenting location, measurements, characteristics (such as odor and/or drainage), healing progression, and notification of provider if worsening or if treatment was not effective. They said a referral to their contracted wound management was made if there was an open area to the skin<Resident 2>Resident 2 was admitted to the facility on [DATE]. The quarterly MDS showed Resident 2 was cognitively intact and needed substantial assistance for most ADL's.On 06/17/2025 at 2:15PM, Resident 2 said they had very uncomfortable skin conditions to the folds of their abdomen, groin, and under the breasts. The Treatment Administration Record (TAR) showed Resident 2 was supposed to have the areas cleansed, dried, and have an antifungal powder placed twice per day. Resident 2 said the treatment was only happening once per day and that they had complained to the nurse manager. A separate treatment was started on 06/03/2025 and was completed on 07/09/2025 for a coccyx (tailbone) wound. Weekly Skin Evaluations spoke to redness in the folds, but there was no documentation about a coccyx wound. There were no characteristics documented about the skin conditions to the folds.On 7/10/2025 at 3:20PM, Staff B, Director of Nursing (DNS), said they were unaware of Resident 2 having a coccyx wound. When asked if nurses were signing off on treatments that hadn't been completed, Staff B said, possibly, but that Resident 2 sometimes refused care. When asked if nurses would then document the refusal and notify the provider, Staff B said they should.<Resident 3>Resident 3 was admitted to the facility on [DATE]. The annual MDS showed Resident 3 was cognitively intact and needed substantial assistance with most ADL's.Review of the TAR for February showed an order for wound care starting 02/26/2025. A Skin Evaluation, dated 02/25/2025, noted redness to abdominal folds and under breasts but did not say anything about a wound. No documentation was found that identified or defined the wound.A Skin Evaluation form, dated 06/16/2025, showed Resident 3 had a new skin tear to the back of the right knee. No measurements or characteristics documentation was completed. Contracted wound management company admitted Resident 3 to their service on 06/24/2025 and measured the wound at 0.55 centimeters (cm) long, 1.78cm wide, and 0.15cm deep. The wound required debridement (medical procedure to remove dead tissue) and advanced wound care dressings and treatment.On 07/15/2025 at 3:00PM, Staff C, Licensed Practical Nurse, said the nurses completed a full head to toe weekly Skin Evaluation. Staff C said they documented the location of skin conditions but had not been documenting measurements or characteristics. When asked how the nurses would know when skin conditions were worsening, or if treatments were not effective without that information, Staff C said they wouldn't. Staff C said that information gets lost along the way.On 07/15/2025 at 3:30PM, Staff B, DNS, said Skin Evaluation forms should be completed for any skin impairment and should include location, measurements, and characteristics. Staff acknowledged there was confusion about how to effectively utilize the forms.Reference WAC 388-97-1620 (20)(b)(i)(ii),(6)(b)(i)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review, the facility failed to ensure 1 of 3 residents (Resident 4) were free of significant medication errors. This failure placed residents at risk for receiving medications not ordered by a provider, overdosing, and possible medical complications. Resident 4 was admitted to the facility on [DATE] with diagnoses to include an old myocardial infarction (heart attack) and heart disease. An assessment by social services on 07/04/2025 showed Resident 4 was mildly cognitively impaired. Resident 4 was sent to the emergency department at 12:30AM on 07/05/2025 for angina (chest pain). Review of the nursing progress note, dated 07/04/2025, showed Resident 4 began complaining of angina and 911 was called at 11:40PM. Staff G, Agency Licensed Practical Nurse (LPN), administered 81mg of chewable aspirin every five minutes for a total of 324mg. Review of the Medication Administration Report showed Resident 4 had an order for 81mg of chewable aspirin daily in the morning for heart health. Resident 4 received that dose at 6AM on 07/04/2025. There were no orders for any additional doses of aspirin. On 07/10/2025 at 5:00PM, Staff G, LPN, said they simultaneously called 911 and began administering the aspirin. When asked if they had received a doctor's order for that administration, Staff G said they had not. They said they had been trained by their agency to begin the aspirin protocol for anyone having chest pain. Staff G said they called the doctor after the resident was sent out to inform them 324mg of aspirin was given. On 7/10/2025 at 5:10PM, Staff A, Administrator, and Staff B, Director of Nursing Services, were asked if the facility had a protocol in place for administering 81mg of chewable aspirin every five minutes for a maximum of 325mg for chest pain. They both said no. When asked if the doctor should have been called before beginning any medication administration, they both said yes. Reference WAC 388-97-1060 (3)(K)(iii)