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	11/10/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review, the facility failed to assess and monitor identified wound(s), perform ordered treatment(s), identify risk factors for skin breakdown, develop and implement interventions, and ensure routine skin check were conducted for 1 of 2 residents (Resident 8) reviewed for non-pressure skin conditions. Resident 8 experienced harm when their abdominal wound increased in size/worsened. These failures placed other residents that required would care at risk for altered wound healing, avoidable wound decline, delayed identification and treatment of newly developed wounds, pain, infection and a diminished quality of life. Findings included. Resident 8 was admitted to the facility on [DATE]. Review of the admission Minimum Data Set showed the resident was cognitively intact, had diagnoses of peripheral vascular disease (PVD, a slow and progressive disorder of the circulatory system, characterized by narrowing, blockage, or spasms in blood vessels or arteries, which can lead to reduced blood flow to the limbs causing pain and/or ulceration) and diabetes, was free of pressure, diabetic, arterial or venous stasis ulcers, and had a surgical wound.Review of a hospital wound note, dated 08/29/2025, documented Resident 8 had a dehisced surgical wound (separation of wound edges along the suture line resulting in the wound re-opening) to the midline abdomen, that measured 9.8 centimeter (cm) x 2.8 cm x 0.5 cm, with a red granulated wound bed, serosanguinous drainage (a mixture of thin yellow serous fluid and blood, often appears pink in color) and a wound area of 27.44 cm2.Resident 8's admission nursing assessment, dated 08/30/2025, showed they admitted with an abdominal wound and amputated toes of the right foot. The assessment did not include wound measurements or wound characteristics (e.g. wound bed tissue type, type/amount of drainage etc.) No other skin issues were identified. An admission Summary nurses' note, dated 08/30/2025 at 4:27 PM, documented the resident had a wound vac (negative pressure wound therapy, uses negative pressure or suction to increase blood flow, oxygen delivery and nutrient supply to the wound area and removes drainage and debris, to decrease risk of infection and promote faster wound healing) in place to the midline abdomen, and noted all toes on the right foot were amputated.The hospital transfer orders/paperwork, dated 08/30/2025, showed a wound vac at 125 mm/Hg (millimeters of mercury) continuous suction, was placed by hospital staff prior to transfer. Dressing changes were to be completed twice a week and as needed.Review of the comprehensive care plan, dated 08/30/2025, did not show development of goals and interventions that directed care of the abdominal wound, use of the wound vac , or frequency of skin assessments. No interventions were identified that would minimize the risk for further breakdown or wound decline. Review of the August and September 2025 Treatment Administration Records (TARs) showed there was no documentation from 8/30/2025 until 09/12/2025 related to wound care for Resident 8.Resident 8's electronic medical record (EMR) showed no documentation the wound care and wound vac orders had been transcribed. There was no documentation that the abdominal wound had been assessed, measured and monitored or that any skin checks or wound assessment were performed from admission until 9/12/2025 for Resident 8's right calf wound or until 09/23/2025 for Resident 8's abdominal wound.Review of a nurses' note, dated 09/12/2025 at 1:37 AM, documented Resident 8 had a new 3 centimeter (cm) x 3 cm x 0.5 cm ulcer to the right posterior calf. The wound bed was 75percent slough (non-viable tissue consisting of dead yells, proteins and debris), with serosanguinous drainage. The resident reported the area was painful to touch. Staff notified the provider, obtained a treatment order and the resident was referred to the wound clinic for evaluation.Review of the September TAR, after it was initiated 09/12/2025, showed an order to treat Resident 8's right lateral LE wound (not present on admission). The TAR did not document the resident's abdominal wound, use of the wound vac and the need for twice weekly dressing changes. still failed to identify the residents' abdominal wound, use of a wound vac and need for twice weekly dressing changes. A wound consult note, dated 09/16/2025, showed the resident had a 5.5-centimeter (cm) x 2.4 cm x 0.2 cm, non-pressure wound to the right lateral LE. The wound required mechanical debridement. The provider documented devitalized (dead) tissue was removed to the level of healthy bleeding tissue which included biofilm (a thin, slimy film of bacteria that can adhere to the surface of a wound). The debridement extended down to the level of subcutaneous tissue (bottom layer of skin containing fat tissue, blood vessels, nerves and other components.) Resident 8's abdominal wound, use of wound vac, was not assessed or addressed in the wound care.A wound consult note, dated 09/23/2025 (24 days after admission to the facility), showed Resident 8's midline abdominal wound was assessed to be 9.02 cm x 4.09 cm x 0.3 cm, and had a wound

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review, the facility failed to develop and implement pharmacy procedures that ensured medications were timely and accurately received, dispensed and administered to meet the needs of 7 of 7 residents (Residents 1, 2, 3, 4, 5, 6 & 7) reviewed for admission medication reconciliation. These failures placed residents at risk for ineffective or subtherapeutic treatment of underlying medical conditions due to omissions of time-sensitive and high-risk medications. Findings included. Review of the facility's undated and untitled pharmacy order timelines and procedures quick reference form showed the facility had two scheduled pharmacy deliveries per day Monday - Friday. Medications ordered prior to 10:00 AM would be delivered between 7:00 PM - 9:00 PM, and medications ordered after 10:00 AM but prior to 7:30 PM would be delivered between 2:00 AM - 4:00 AM. Medications ordered after the 7:30 PM, the cutoff time, would be delivered on the next scheduled delivery (7:00 PM - 9:00 PM) the following day. If medication was needed prior to the next scheduled delivery but the cutoff time was missed, the order should be entered/sent via the electronic medical record (EMR) system as usual. The nurse should then call to request the medication(s) be delivered via STAT [as soon as possible] delivery. Medication orders for controlled substances, complex compounds, IV medications, or with directions greater than 140 characters must be faxed. Resident 1Resident 1 was admitted to the facility on [DATE]. Review of the hospital transfer orders, dated 08/28/2025, showed the transfer diagnoses included left lower extremity (LE) cellulitis (bacterial infection of skin), possible intravascular thrombus (blood clot) in the abdominal aorta, a recent acute right internal jugular blood clot (attributed to prior facial trauma) and a history of a left ventricle blood clot secondary to intravenous drug use.Review of the hospital Medication Administration Record (MAR), printed on 08/28/2025 at 5:16 PM, showed Resident 1 received therapeutic anticoagulation therapy twice daily with rivaroxaban, for treatment of a left ventricular and a right intrajugular (large neck veins) blood clot. The MAR documentation showed Resident 1's 8:00 AM dose of rivaroxaban was administered at 9:33 AM, but the 5:00 PM dose was not administered. The Rivaroxaban Discharge Instructions that were included in the After Visit Summary [AVS], dated 08/28/2025, showed in the event of a missed dose, if the medication was being taken twice daily for the treatment of blood clots, the missed dose should be taken as soon as available. If the missed dose was not available until the time of the next scheduled dose, in this instance, both doses may be administered at the same time. Review of the August 2025 MAR showed Resident 1's rivaroxaban order was input into the EMR on 08/28/2025 at 4:24 PM and was scheduled to be administered twice a day at 7:30 AM and 5:30 PM. The MAR documentation showed facility staff failed to administer the 08/28/2025 5:30 PM and 08/29/2025 8:00 AM scheduled doses of rivaroxaban. On each occasion staff documented 6 [drug not available]. Review of the electronic medical record (EMR) showed there was no documentation present that showed facility staff called the pharmacy to request STAT procurement of the medication(s), attempted to get emergency/first dose access to the medication, notified the provider of the consecutive omitted doses, and/or to request an interim bridge order.Review of the (EMR) showed there was no documentation to show facility staff called the pharmacy for STAT procurement of the medication, made any attempt to get emergency/first dose access to the medication via the facility's Omnicell (an automated medication dispensing system used to provide first dose/emergency access to medications), or notified the provider to obtain an interim bridge order.Review of the Omnicell inventory on 08/28/2025 showed three tablets of 10 mg rivaroxaban were available, but none were pulled to administer to Resident 1.A progress note, dated 08/29/2025 at 3:03 PM, documented Resident 1's rivaroxaban was on order. The note did not address why Resident 1's rivaroxaban was not included with the facility's 2:00 AM - 4:00 AM delivery, given it was input/ordered via EMR on 08/28/2025 at 4:24 PM, more than three hours prior to the cutoff time of 7:30 PM. There was no documentation of the actions, if any, the nurse took to obtain the medication.Hospital medical records showed a computed tomography angiogram (a specialized imaging test that uses X-rays and contrast dye to visualize blood vessels and tissues in detail), dated 08/31/2025, that Resident 1 had a right lower lobe pulmonary embolus (blood clot gets stuck in an artery in the lung, blocking blood flow to part of the lung). Resident 2Resident 2 was admitted to the facility on [DATE] at 5:47 PM. Review of the hospital transfer orders showed the resident was to receive vancomycin (an antibiotic) four times a day, to treat Clostridium Difficile (C. diff, a highly contagious bacterium that causes diarrhea and inflammation of the colon. This condition is particularly dangerous for elderly patients who have a higher risk for severe outcomes including