

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505240	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/02/2025
NAME OF PROVIDER OR SUPPLIER  Port Washington Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure scheduled care and services for 2 of 3 residents (Resident 1 and Resident 2) reviewed for quality of care. This failure placed the residents at risk for decline in hygiene, unidentified weight changes, and diminished feelings of well-being. Findings included. Resident 6 Resident 6 admitted to the facility on [DATE] with diagnoses to include a fractured femur (leg bone) and legal blindness. The 5-day Minimum Data Set (MDS), an assessment tool, dated 9/02/2025, showed Resident 6 was moderately cognitively impaired. Resident 6 needed extensive assistance for Activities of Daily Living (ADLs). Review of Resident 6's orders, dated 8/30/2025, showed weights were to be obtained weekly for four weeks. No weight was recorded until 9/12/2025 and was documented as 172 pounds. One more weight was recorded on 10/03/2025 and was documented as 162 pounds, a loss of 10 pounds. Resident 6's care plan, dated 10/01/2025, two days before they discharged, did not address any care needs. There were no directions for staff in regard to bathing, obtaining weights, or what to do about refusals of care. The care plan showed Resident 6 had a nutritional risk due to co-morbidities (presence of two or more diseases or medical conditions). On 11/24/2025 at 4:30PM, documents were requested from Staff A, Administrator, for showers/bathing received by Resident 6 during their stay at the facility. No documents were provided. Resident 7 Resident 7 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], showed Resident 7 was cognitively intact. Resident 7 needed extensive assistance with ADLs. Resident 7's care plan, dated 10/23/2025, showed they were to receive a bath twice weekly and as needed. A sponge bath was to be given when a full bath or shower could not be tolerated. The care plan did not have directions for staff about refusals. Review of the Bathing Task form, a tool used by Certified Nursing Assistants (CNAs) to document, showed the following: On 11/23/2025 and 11/06/2025, not applicable was marked. On 11/10/2025, 11/13/2025, and 11/20/2025, refused was marked. On 11/23/2025 a shower was given. Review of Resident 7's orders, dated 10/24/2025, showed weights were to be obtained weekly for four weeks. A weight of 129 pounds (lbs) was obtained on 10/23/2025, 126.6 lbs obtained on 11/05/2025, and 126.5 lbs obtained on 11/07/2025. No other weights were documented. On 11/21/2025 at 4:10PM, Staff B, Licensed Practical Nurse, Unit Manager, was asked what the expectation was for obtaining weights after admission. They said weights should be obtained on the date of admission and weekly times four weeks. When asked if the wheelchair scale on B hall was functioning, Staff B said they didn't know. Staff B said they had heard it wasn't working a while ago but that would be a question for maintenance. Maintenance staff were not available for questioning. On 11/24/2025 at 4:30PM, Staff A, Administrator, said weights should be obtained weekly as ordered. Staff A said they didn't know the wheelchair scale was not functioning. Staff A said showers/baths should be offered at least twice per week and as the resident requests. Staff A said they did not know why not applicable would ever be marked for showers/baths. Staff A said care plans should reflect personalized care needs, including interventions for refusal of care. Reference WAC 388-97-1060(1)-(3)</p>

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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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>(continued on next page)</p>

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> .Based on observation, interview and record review, the facility failed to identify, address, and adjust care needs for 5 of 5 residents (Resident's 1, 2, 3, 4 and 5) who experienced dementia-related behaviors, and/or the negative impacts of those behaviors. This failure placed residents at risk of not achieving or maintaining their highest practicable level of mental and psychosocial well-being. Findings included. Resident 1 Resident 1 admitted to the facility on [DATE] and had a history of Neurocognitive Disorder with Lewy Bodies (brain disease with dementia like symptoms, including disorganized thinking, memory loss, vivid hallucinations, and mood swings.) The admit Minimum Data Set (MDS), dated [DATE], showed Resident 1 was severely cognitively impaired. Resident 1 had a walker and was able to ambulate around the facility. A review of November 2025's Certified Nurse Aide (CNA) Behavior Monitoring form documented the following: Yelling/Screaming - 11/10/2025, 11/12/2025, 11/14/2025 Wandering - 11/10/2025, 11/12/2025, 11/13/2025, 11/18/2025 Sexually inappropriate - 11/14/2025, 11/19/2025 No interventions were added or recorded on the Behavior Monitoring form. Resident 1's care plan, dated 8/15/2025, did not have wandering, sexually inappropriate, or yelling/screaming listed as behaviors. It did not have any interventions listed. The Kardex (a tool used by certified nursing assistants) did not provide guidance or interventions for staff to use for behaviors. Resident 2 Resident 2 was admitted to the facility on [DATE]. The admit MDS, dated [DATE], showed Resident 2 was cognitively intact and needed limited assistance for Activities of Daily Living (ADLs). On 11/27/2025 at 3:17PM, Resident 2 said Resident 1 came into their room uninvited on several occasions, especially at night. Resident 2 said about three weeks prior, Resident 1 had come into their room and urinated on their bed while they were in it. Resident 2 said Staff C, Assistant Director of Nursing Services (ADNS), knew about this incident. Resident 3 was admitted to the facility on [DATE]. The 5-day MDS, dated [DATE], showed Resident 3 was cognitively intact and needed limited assistance for ADLs. On 11/27/2025 at 3:20PM, Resident 2's roommate, Resident 3 spoke up and said on one of those occasions, about three weeks prior, Resident 1 took off all their clothes, climbed into the bed, and attempted to initiate sexual contact. When asked what they would do when these visits occurred, Resident 2 and Resident 3 said they would yell at Resident 1 and call for staff to help. Both residents expressed anger, frustration, and feelings of helplessness about these visits from Resident 1. On 11/27/2025 at 3:42PM, Staff C, ADNS, said they knew that Resident 1 was wandering into rooms and that sometimes things went missing. Staff C denied any knowledge of Resident 2 being urinated on or Resident 3 being sexually assaulted. When asked how care staff would know what interventions to employ with Resident 1, Staff C said by following the Kardex which was created by the care plan. On 11/27/2025 at 4:00PM, Staff C, Social Services Director, was asked if there were any investigations completed for either Resident 2 or Resident 3's accusations. Staff C said they were not aware these incidents had occurred. When asked if Resident 1 had wandering or sexually inappropriate behaviors, Staff C said they had wandering behaviors. When asked to review the documentation on November 2025's Behavior Monitoring form, Staff C said they were surprised Yelling/Screaming and Sexually inappropriate behaviors were noted. Staff C said there were no interventions in place for Resident 1's behaviors. Resident 4 Resident 4 admitted to the facility on [DATE] with a diagnosis of dementia with behavioral disturbances. The admission MDS, dated [DATE], documented Resident 4 was moderately cognitively impaired. Resident 4 needed extensive assistance for most activities of daily living. An admission Progress note, dated 9/17/2025, documented yelling out behaviors. A facility Psychiatry note, dated 9/18/2025, documented Resident 4 was heard yelling from the hall, but when approached, was confused, agitated, and distressed. On the following dates and times, Resident 4 was heard yelling and screaming and their door was closed for each observation. 11/13/2025 at 1:15PM and 3:10PM. 11/21/2025 at 2:00PM and 4:15PM. 11/24/2025 at 1:30PM and 4:15PM. Resident 5 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], showed Resident 5 was cognitively intact and needed moderate assistance for ADLs. On 11/24/2025, Resident 5, whose room was two doors down from Resident 4's, said they heard screaming and yelling about 18 hours a day. Resident 5 said they had migraines from the yelling and had to wear ear plugs to bed every night. Resident 5 said the screaming affected their ability to sleep, rehabilitate, and to enjoy any quality of life. When asked how the staff responded to the yelling, Resident 5 said they didn't seem to know what to do. On 11/24/2025 at 1:56PM, Staff D, Certified Nursing Assistant, said they document behaviors on the Behavioral Monitoring form but there wasn't any place to document interventions. When asked how they</p>		

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide consistent specialized services for 1 of 3 residents (Resident 1) reviewed for rehabilitation therapies. This failure placed residents at risk for delayed maximum function and a diminished quality of life. Findings included. Resident 6 was admitted to the facility on [DATE] with diagnoses to include a fractured femur (leg bone) and legal blindness. The 5-day Minimum Data Set (MDS), an assessment tool, dated 9/02/2025, showed Resident 6 was moderately cognitively impaired. Resident 6 needed extensive assistance for Activities of Daily Living (ADLs). Review of the Occupational Therapy (OT) and Physical Therapy (PT) care plans and orders showed Resident 6 was to receive services five times per week for four weeks for each therapy. The services start date was 9/1/2025 and ended on 9/29/2025, the certification period. Review of the OT progress notes showed Resident 6 received a total of nine visits from OT during the certification period, 11 visits short according to the care plan. Review of the PT progress notes showed Resident 6 received a total of 14 visits during the certification period, six visits short according to the care plan. Resident 6 was served a notice that insurance would no longer be covered on 9/18/2025 and was discharged on 9/20/2025. On 11/25/2025, Staff A, Administrator, said all residents should receive specialized services according to their care plan. Reference WAC 388-97-1280(1)(a)(b)(4)</p>		