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	05/07/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to prevent an altercation between 2 out of 3 residents (Resident 2 and Resident 3) reviewed for freedom from abuse. This failure placed residents at risk for injury, psychosocial harm, and a diminished quality of life. Finding included .Resident 2 admitted to the facility on [DATE] with diagnoses of anxiety, major depression, Schizophrenia (severe brain disorder that causes individuals to interpret reality abnormally, often resulting in delusions, hallucinations, and severely disorganized thinking and nicotine dependence). The quarterly Minimum Data Set, (MDS, and assessment tool) showed Resident 2 was cognitively intact. Resident 2 had a history of verbally and physically attacking other residents as documented in behavior notes dated 11/13/2025 and 02/11/2026, and 03/21/2026. After the 11/13/2026 incident, Resident 2 was assigned a staff member who would provide 1:1 supervision while Resident 2 was awake. Resident 3 was admitted to the facility on [DATE] with a diagnosis of nicotine dependence. The quarterly MDS showed Resident 3 was cognitively intact. A Behavior note, dated 04/18/2026, documented Resident 2 and Resident 3 had a verbal confrontation at the smoke shack. Resident 2 was cussing at Resident 3. An Incident Report, dated 04/19/2026, documented that on that day at 10:30 AM, Resident 3 was in the smoking shack. Resident 2 went outside and into the smoking shack without their assigned staff member. Resident 2 parked their wheelchair in front of Resident 3 and began speaking confrontationally. Resident 2 pushed Resident 3's wheelchair to which Resident 2 responded by waving a lit cigarette in Resident 3's face and grabbing their hand. The altercation caused both residents to fall out of their wheelchairs. No injuries were sustained. On 04/07/2026 at 1:45 PM, Staff B, Social Services Director, said they were responsible for the staffing and supervision of the smoking area. Staff B said there was a smoking attendant that was supposed to be outside during the set smoking hours. Staff B said there was not a smoking attendant outside at 10:30 PM on 04/19/2026.On 04/07/2026 at 3:45 PM, Staff A, Director of Nursing Services, said Resident 2 should not have been outside without their assigned staff member. Staff A said there had been some confusion about staffing responsibilities on 04/19/2026. Staff A said the assigned staff member had taken a lunch break at the time they were supposed to be with Resident 2. Reference WAC 388-97-0640(1)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505240	A. Building B. Wing	05/07/2026

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

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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 0689 Level of Harm - 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 interview and record review, the facility failed to ensure staff were adequately trained on newly implemented wander guard/elopement alarm system resulting in staff failing to recognize and respond timely to resident elopement alarms for resident assessed as at risk for wandering/elopement for 1 of 3 residents (Resident 1) reviewed for elopement. Resident 1 experienced harm when the resident exited the facility unsupervised in their wheelchair and then rolled down a hill, fell, and required emergency transport to the hospital where they were diagnosed with multiple facial fractures. This failure placed residents at risk of elopement, injury and a diminished quality of life. Findings included.Resident 1 was admitted to the facility on [DATE]. The quarterly Minimum Data Set, an assessment tool, dated 01/26/2026, showed Resident 1 was cognitively intact. Resident 1 had a history of a large left sided stroke (brain injury) that affected their safety awareness.Resident 1's elopement care plan, with interventions revised 05/21/2025, documented, all staff will continue to remind [Resident 1] that he may use the courtyard for safe wandering. All staff will continue to remind [Resident 1] that he must remain within eye contact so staff can see him.Resident 1's risk for falls care plan, with interventions revised 06/02/2025, documented, resident is not allowed in patio or parking without staff lot areas due to demonstrated severe fall risk. May go into courtyard.Wanderguard to wheelchair to notify staff when resident is trying to enter the front patio due to severe fall risk from steep driveway.Review of an incident report, dated 04/18/2026, showed Resident 1 wheeled through the front doors at approximately 6:10 PM. An alarm sounded at the nurse's station but was turned off by Staff C, Licensed Practical Nurse (LPN). The facility's video surveillance showed Resident 1 left the patio area and proceeded towards a bus stop that was located in front of the facility. The bus stop was situated at the top of a significant hill. Resident 1 rolled down the hill in their wheelchair and fell onto the street. Staff were notified by a person passing by and the community member called 911 and Resident 1 was sent to the hospital at 6:35 PM after a brief assessment at the roadside by facility staff.Hospital records, dated 04/19/2026, documented Resident 1 had multiple sinus fractures and a fracture under the left eye with bruising.On 05/07/2026 at 1:45 PM, Staff B, Social Services Director, said the WanderGuard system that had been in place would cause the front doors of the facility to close automatically when a resident wearing the bracelet would pass by the sensor located a few feet from the doors. Staff B was aware a new system had been installed recently but was not aware of how it functioned.On 05/07/2026 at 1:50 PM, Staff A, Director of Nursing, said a new system had been installed on 04/09/2026 and Resident 1 had received a new bracelet. Staff A said staff had not been educated about how the new system worked.On 05/07/2026 at 2:19 PM, Staff C said a beeping alarm had sounded several times during their day shift on 04/18/2026. Staff C said they had not known what the alarm was for. Staff C said another staff member told them to just hit reset at the nurse's station and at the front doors. When asked if they had looked outside when resetting the alarm at the door, Staff C said they had not. Staff C said they had worked for the facility for two years and was not aware Resident 1 had a WanderGuard bracelet.On 05/07/2026 at 3:10 PM, Staff A, DNS, said staff should have been in-serviced on the new system when it was installed. Staff A said a WanderGuard alarm should be responded to immediately to avoid potential and avoidable accidents.Reference WAC 388-97-1060(3)(g)