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	05/19/2026

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 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 observation, interview, and record reviews, the facility failed to identify, and to provide for needs and services in a timely manner for 2 of 3 residents (Resident 1 and Resident 2) reviewed for quality of care. This failure placed residents at risk for unmet needs and a diminished quality of life.Findings included.Resident 1Resident 1 admitted to the facility on [DATE] at 5:00 PM with a new Percutaneous Endoscopic Gastrostomy tube (PEG, a flexible feeding tube placed directly into the stomach through the abdominal wall). Resident 1 had a history of esophageal obstruction (blockage of the tube connecting the throat to the stomach) and difficulty swallowing. A nurse's note, dated 05/03/2026, documented Resident 1 was cognitively intact.On 05/18/2026 at 3:08 PM, Resident 1 said they only stayed at the facility for 1 night due to not receiving all of their medications and not receiving them via the PEG tube. Resident 1 said they only received 1 feeding at 8PM on 05/03/2026, that it was not done correctly, and that the pole it was attached to was dirty and not stable.Review of the hospital discharge orders, dated 05/03/2026, showed Resident 1 was to receive a 330 millimeters (mls) bolus of Jevity 1.2 (a type of formula) via the PEG tube every 6 hours, at 8AM, 12PM, 4PM, and 8PM.Review of the May Medication Administration Record showed the residual volume was to be checked prior to the bolus feeding utilizing a syringe. If the volume was greater than 100mls, the feeding was to be held for an hour. If the volume was still greater than 100mls after an hour, the doctor was to be notified. The residual volume was not tested before administration of the 8PM bolus.Review of the May Medication Administration Record showed Resident 1 did not receive 16 medications that were due between 4:30PM on 05/03/2026 and 12:00PM on 05/04/2026. The missed medications included ones for pain and for gastroesophageal reflux disease (a chronic digestive condition where stomach acid or bile repeatedly flows back into the esophagus).On 05/19/2026 at 3:50PM, Staff E, Registered Nurse, said Resident 1's medications were not delivered on 05/03/2026. Staff E said they could only administer the one medication that could be pulled from the Omnicell (an onsite medication storage unit) during their night shift. Staff E said they could not test the residual volume and could not administer the medication via the PEG tube because the facility did not have any syringes.An incident report, dated 05/19/2026, showed the anticipated delivery of Resident 1's medications wasn't going to be until 1PM on 05/04/2026.Resident 2Resident 2 admitted to the facility on [DATE] with a diagnosis of obstructive sleep apnea (condition where the throat muscles repeatedly relax and block the airway during sleep). The admission 5-day Minimum Data Set, an assessment tool, dated 05/12/2026, showed Resident 2 was cognitively intact.On 05/19/2026 at 12:30PM, Resident 2 said they were told by the hospital that the facility would have a Continuous Positive Airway Pressure (CPAP, delivers a steady stream of air to keep the throat open) machine and accessories when they arrived. Resident 2 said without it, they would wake up gasping for air and crying. Resident 2 said they had talked to Staff B, Social Services Assistant, Staff C, Assistant Director of Nursing, and Staff D, Charge Nurse, about the need for the machine but nothing was done. Resident 2 said a relative had finally brought the one from home 2 days prior, but it still had not been set up.On 05/19/2026 at 12:32PM, a CPAP machine was observed on the right bed side stand. It was not plugged in. There were no accessories, such as a mask and or tubing, attached to or by the (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	machine.On 05/19/2026 at 1:12PM, Staff C, Assistant Director of Nursing, said they were not aware that Resident 2 needed a CPAP. Staff C said they did not know there was a CPAP in the room.On 05/19/2026 at 2:55PM, Staff B, Social Services Assistant, said they had spoken to Resident 2 about the CPAP when they went to welcome Resident 2 on 05/05/2026. Staff B said they brought it to the attention of Staff C, Assistant Director of Nursing, that same day.On 05/19/2026 at 3:35PM, Staff D, Charge Nurse, said they were aware Resident 2 had requested a CPAP. Staff D said they had meant to call the hospital and request the documentation from Resident 2's last sleep study but had not. Staff D said they did not have orders for the CPAP that was at the bedside.On 05/19/2026 at 4:00PM, Staff A, Director of Nursing Services, said residents should have needed medications and equipment provided in a timely manner. Staff A said equipment should be clean and in good working order.Reference WAC 388-97-1060(1)-(3)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a safe, functional, and sanitary environment and equipment in Storage room [ROOM NUMBER] located diagonally across from the nurses' station. This failure placed residents and staff at risk for cross contamination, substandard infection control, injury, and a diminished quality of life.Findings included.On 05/19/2026 at 12:00 PM, Storage room [ROOM NUMBER] was entered to inspect feeding and intravenous (IV) poles. The door was not locked and, when opened, knocked into 3 IV poles. The poles were rusted, dirty, and very unstable when tested for stability. Equipment including portable bedside commodes, feeding pumps, and nebulizers (inhaled medication delivery systems) were seen scattered and piled around the small room. Some were visibly soiled but there was no way to tell if others were clean or dirty. Biohazard boxes for the disposal of sharps containers were stacked on top of each other. A full sharps container was observed setting on the edge of one of the boxes, not closed or locked.On 05/19/2026 at 12:15 PM, Staff A, Director of Nursing Services, viewed Storage room [ROOM NUMBER]. Staff A said they knew the room needed to be completely cleaned out and reorganized. Staff A said clean and dirty equipment should not be stored in the same room. Staff A said sharps containers needed to be closed and locked for safety. Staff A said they had ordered new IV poles and that the old ones needed to be thrown away. Staff A said all storage rooms needed to be locked to prevent residents from entering them.Reference WAC 388-97-3220 (1)