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	07/29/2025

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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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review, the facility failed to log and investigate grievances for 1 of 1 resident (Resident 22) reviewed for grievances and for 3 of 8 Resident Council monthly meeting minutes (Months: March 2025, May 2025, & June 2025) reviewed for grievances. This failure placed residents at risk of abuse and neglect, grievances to not be responded to timely or at all, and a diminished quality of life. Findings included . Review of the facility's policy titled “Grievance,” dated 03/2025, showed the purpose of grievances was “to assure the concerns are quickly and thoroughly evaluated and acted upon in order to resolve issues which affect the quality of life and care for residents in our facility.” <Resident 22> Resident 22 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set Assessment, dated 04/06/2025, showed they were cognitively intact and required substantial to maximal assistance with toileting hygiene. During an interview on 07/16/2025 at 1:28 PM, Resident 22 reported they had recently filed a grievance related to a recent brief change by a Certified Nursing Assistant on the night of 07/14/2025. Review of the facility's grievance log on 07/21/2025, showed no grievance was logged for Resident 22. During an interview on 07/23/2025 at 12:02 PM, Resident 22 located and identified Staff H, Medication Technician, as the staff who filled out the grievance. Staff H joined the interview and said the incident occurred several days prior, and they had written the grievance and confirmed with Resident 22 before they turned it in. During an interview on 07/23/2025 at 12:40 PM, Staff B, Director of Nursing Services (DNS), was asked how long the facility had to log a grievance, and said the grievance should be logged soon after it was received that shift. Staff B went to the social services department to review the grievance log for July 2025, with Staff F, Social Services Director. No grievances were found for Resident 22 for July 2025. When told of the incident for Resident 22, both Staff B and Staff F said they were unaware of the incident. Staff F said it should have been brought to either themself or Staff B, discussed in stand up, and then Staff B and Staff F would have investigated it. When asked if it should have been logged, Staff F said yes. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident Council> The previous 6 months of Resident Council Meeting Minutes (official notes from Resident Council meetings) were requested, and the facility provided the following months for review: 09/2024, 10/2024, 12/2024, 03/2025 (handwritten notes provided), 04/2025, 05/2025, 06/2025, 07/2025. No Resident Council meetings were held for 01/2025 and 02/2025, and although a meeting occurred, no 11/2024 meeting minutes were provided. The facility's grievance log was reviewed from 02/25/2025 through 06/30/2025. 1) Review of the March 2025 Resident Council meeting minutes, dated 03/17/2025, showed a resident (resident identified by room number) sent four items of clothes to laundry and they never came back (not logged on grievance log). A resident (resident identified by first name only, no last name) said call lights were not being answered in a timely manner around shift change (not logged on grievance log). An unidentified person reported the nurse on B hall did not seem to know how to do her job (no names associated with grievance, no description of issue, not logged on grievance log). On 07/24/2025 at 3:30 PM, when asked about the missing clothing, Staff A, Administrator, said missing laundry would go on a missing property form. When asked if a missing property form had been filled out, Staff A said, no, it should have been. In response to the call lights, Staff A said she would expect a grievance to have been filled out. In response to the nurse on B hall's competency concern, Staff A said, I expected that a grievance would have been filed, so that the facility could have investigated and offered training. 2) Review of the May 2025 Resident Council meeting minutes, dated 05/08/2025, showed residents on B hall had some reservations about a nurse that was recently working night shift and the DNS was documented as being responsible for following up with the nurse. The meeting minutes did not identify which residents had the concern, or what the specific concerns were with this staff member. A resident (identified by room) was concerned about call lights being answered in a timely manner after lunch (not logged on the grievance log). On 07/24/2025 at 3:30 PM, when asked if the Resident Council meeting minutes documentation, of the reservations by residents with the night shift nurse, met expectations, Staff A said no, because we would not know who to talk to. In response to the call lights concern, Staff A said she would have expected it to have been a grievance. 3) Review of the June 2025 Resident Council meeting minutes, dated 06/10/2025, showed a resident (identified by a room number) reported an issue (did not specify issue), and nursing staff confirmed they would file a grievance and follow up. There was no grievance for the resident identified by room number, until 06/30/2025. A report was made of a resident's missing plant (did not identify which resident), with action taken listed as the grievance would be filed and followed up on (was not logged on the grievance log). On 07/24/2025 at 3:30 PM, in response to the unspecified issue, Staff A said a grievance should have been done. In response to the missing plant, Staff A said a grievance should have been done. On 7/22/2025 at 1:07 PM Staff CC, Activities Director, when asked how he was keeping a record of the Resident Council meeting minutes and tracking grievances, said if it is in the meeting minutes, I would follow up the next month with the results of the grievance. Staff CC said they did not usually (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	put grievances in the meeting minutes unless it was something that was experienced by a wider variety of residents. Staff CC said they wrote down everything from Resident Council meetings into handwritten notes, but for the grievances, they did not usually transcribe them to the typed official minutes. When asked why he was not including grievances in the official meeting minutes, Staff CC said it was because if one person had a grievance, they would not include that in the official minutes. When asked how he was making sure grievances were followed up on, Staff CC said they talk to them afterwards. In response to a request for the handwritten minutes for the last six months, Staff CC said that once they type them into the computer, they did not know what happened to them. Staff CC said they provided handwritten meeting minutes for 03/2025 and another month, and that was all they had. Review of the provided documentation of handwritten notes, showed the second month Staff CC had, was for November (no year). The document was labeled “Resident Council-November” with bullet points of “policy/procedure,” “create name badges for residents,” “Committee members,” “QAPI-resident council notes/grievances,” “actives critical element pathway-reviewed survey books,” “resident council meeting notes-document,” “July 23rd 2:30 pm, and “accounts payable”. No other information was provided. On 07/24/2025 at 3:40 PM, when informed Staff CC was not putting individual grievances that come up in Resident Council meetings into the official meeting minutes and that Staff CC was unable to provide all handwritten minutes for the last 6 months, Staff A said it did not meet her expectations. Staff A said the facility should be able to provide copies, should be documenting minutes with resident names, and should have been writing up grievances for anything that was grievance worthy. Reference WAC 388-97-0460 .

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review, the facility failed to ensure psychotropic medications (any drug affecting mental processes, emotions, and behavior) were adequately monitored, documented non-pharmacological interventions (NPIs, non-medication interventions to decrease behavior episodes), and/or had consent obtained for 5 of 7 residents (Residents 61, 22, 1, 2 & 3) reviewed for unnecessary medication or behaviors. This failure placed residents at risk of unnecessary medications, medication complications, and a diminished quality of life.Findings included.1) Resident 61 was admitted to the facility on [DATE] with diagnoses of anxiety, depression, and unspecified disorder of adult personality and behavior (a diagnosis when a resident does not fit criteria for any specific personality disorder but still has significant impairment in social, occupational, or other important areas of functioning). The Quarterly Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 61 was moderately cognitively impaired. Resident 61 was taking one scheduled antidepressant and one scheduled antianxiety medication. Review of Resident 61's orders showed a depression target mood monitor, for isolation, crying, feeling easily frustrated or restless, even over small things. Licensed Nurses (LNs) were to record on the Treatment Administration Record (TAR) how many behaviors occurred, and if they did any NPI interventions such as offer to talk with resident, offer to take to activities, and/or get social services. Resident 61 had an antidepressant side effect monitor that listed impaired memory, concentration, and increased confusion in elderly. Resident 61 also had an anxiety target mood monitor, for crying, verbal aggression, panic attacks, and restlessness. LNs were to record on the TAR how many behaviors occurred, and if they did any NPI interventions such as talk with resident, redirect resident, and/or get social services. Resident 61 had an antianxiety medication side effect monitor which included confusion. Review of the electronic health record (EHR), showed Resident 61 on [DATE] had reported to staff that medications were causing memory loss. The [DATE] TAR was reviewed with no adverse side effects noted in the documentation. Review of the past 30 days of behaviors noted by the Certified Nursing Assistants (CNAs), reviewed on [DATE], showed Resident 61 had behaviors on: [DATE]-repeats movement [DATE]- yelling/screaming [DATE]- abusive language, threatening behavior [DATE]- yelling, screaming [DATE]-rejection of care [DATE]- yelling, screaming, abusive language, threatening behavior, and rejection of care Review of Resident 61's July TAR, on [DATE], showed no behaviors or side effects were (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented, and no NPI were documented as being attempted. During an interview on [DATE] at 2:26 PM, Staff J, Unit Manager, said Resident 61 could have inappropriate behaviors including being aggressive, verbally abusive, resistive to assistance and care, and was forgetful and confused. When asked if they would expect behaviors such as easily frustrated or restless, verbal aggression, or increased confusion, to show up on Resident 61's TAR, Staff J said yes. For the CNA documentation of verbal aggression on [DATE], Staff J was unable to find any documentation of this on the TAR or of NPIs being given. When asked how the facility was assessing for the necessity of medication if the behaviors were not logged on the TAR, Staff J said without it logged on the TAR, they could not. During an interview on [DATE] at 12:45 PM, Staff B, Director of Nursing Services (DNS), said Resident 61 had a target behavior with NPIs listed for talking to the resident, redirecting, and getting social services involved. When explained that the behaviors were not being documented on the TAR, Staff B reviewed the TAR and acknowledged staff were not documenting the behaviors or NPIs. 2) Resident 22 was admitted to the facility on [DATE], with diagnoses including depression, anxiety, and bipolar disorder (mental health condition with extreme mood swings). The Quarterly MDS, dated [DATE], showed they were cognitively intact. Review of Resident 22's medications showed they were taking a medication called divalproex, an anticonvulsant/mood stabilizer, for bipolar disorder. Review of Resident 22's orders showed no adverse side effect monitors or behavior monitors for divalproex. During an interview on [DATE] at 2:26 PM, Staff J, Unit Manager, confirmed Resident 22 did not have behavior monitors or adverse side effect monitors in place. During an interview on [DATE] at 12:45 PM, Staff B, DNS, said Resident 22 should have had adverse side effect and behavior monitors for divalproex. 3) Resident 1 was admitted to the facility on [DATE]. According to the 5-day MDS, dated [DATE], Resident 1 was severely cognitively impaired. Resident 1's diagnoses included unspecified dementia (thinking that interferes with daily functioning) with unspecified severity with other behavioral disturbance. A review of Resident 1's physician orders showed he was on two psychotropic medications as follows: Physicians order, dated [DATE], for Namenda (medication used to treat Alzheimer's/dementia), in the morning for dementia- memory. Physicians order, dated [DATE], for levetiracetam (a seizure medication), two times a day related to unspecified dementia, unspecified severity, with other behavioral disturbance. Review of the EHR showed no consents were located and no side effect monitoring were in place for the Namenda or levetiracetam. On [DATE] at 9:45 AM, Staff B, DNS, said consent should be obtained on the day of admission, when a resident comes in with psychiatric medications. Staff B said, regarding Resident 1, Namenda was a (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dementia medication, and she did not believe the facility had obtained consent. When asked about the levetiracetam consent, Staff B looked in the EHR and said she did not see one. Staff B acknowledged there was no side effect monitoring in place for either medication and said there should have been. On [DATE] at 7:24 AM, Staff B, DNS, said she had talked with the pharmacist consultant about levetiracetam and the indication for the levetiracetam had probably been entered incorrectly, as Resident 1 had been on this medication previously for seizure disorder. When asked if the pharmacy should have caught this in review, Staff B said yes, whoever had entered the order probably did not correct it with the provider. 4) Resident 2 was admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed Resident 2 was cognitively intact. Resident 2 was prescribed a psychotropic medication as follows: the order, dated [DATE], was for Seroquel (antipsychotic), at bedtime for bipolar disorder. Review of the EHR for Resident 2 showed there was no behavior monitoring, target behaviors, side effect monitoring, or NPIs in place for Seroquel. On [DATE] at 9:45 AM, Staff B, DNS, when asked what should be in place for psychotropic medications, said it should have consent, behavior monitors, side effect monitors, and be care planned. Regarding Resident 2's Seroquel, Staff B said behavior monitoring, target behaviors, and side effect monitoring were not in place and should have been. Regarding NPIs, Staff B said Resident 2 did not have them in place. 5) Resident 3 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact, had no psychiatric diagnosis, had a physical health questionare-9 (PHQ-9, a tool used to assess the severity of depression, a score of 0-4= none to minimal depression) score of 0, but received antidepressant medication on seven of seven days during the assessment period. Review of the EHR showed a Mood & Behavior Note,” dated [DATE], documented Resident is showing signs of suicidal ideation (SI). CNA on floor came to me with concerns that this resident stated that he wanted to die, etc. I went to talk to the resident and told him that we are here for him and asked if he had a plan. Resident stated he just wants to go to his apartment. Resident has been put on q [every] 15-minute checks. RCM [unit manager] notified. Social services notified. A [DATE] nurses' note documented that Resident 3 was started on sertraline (an antidepressant) daily for depression, was referred for a psychiatric consultation, and continued with q15 minute checks. A [DATE] social service note, documented that Resident 3 did not want to hurt himself and did not have a plan. An antidepressant medication care plan, revised [DATE], identified the target behaviors (TBs) for the use of sertraline as crying, isolation and negative talk. Review of the [DATE] TAR showed the TBs that were identified on the behavior monitor for the use of sertraline were feeling sad, irritable, empty or hopeless. These TBs differed from the TBs identified on Resident 3's care plan. Additionally, neither the care plan nor the behavior monitors on the TAR identified SI as a TB for sertraline use. On [DATE] at 12:31 PM, Staff Z, Unit Manager, said the TBs identified on the care plan should match the TBs that were being monitored on the behavior monitor, but acknowledged they did not. When asked if SI should have been included in the TBs, Staff Z stated, Yes. A [DATE] provider note documented Resident 3 recently had episodes of expressing SI and has recently lost his son to overdose and is asked to be seen to follow up. The provider also documented He is currently denying suicidal thoughts (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and has been without self-harming behaviors. A [DATE] pharmacy consultation report documented Resident 3 had received sertraline since [DATE] and was due for a GDR (Gradual Dose Reduction - an attempt to get residents on the lowest effective dose of a medication) review. The consult recommended reducing Resident 3's sertraline from 50 milligrams (mg) daily to 25 mg daily or to document a clinical rationale why a GDR for this resident was contraindicated. On [DATE] the provider declined the recommendation for a GDR, and documented Resident 3 had frequent SI, was grieving the loss of his son, and had stabilized on sertraline. Review of the EHR showed the only documentation present related to SI was the initial [DATE] mood and behavior note that documented a CNA reported the resident said he wanted to die. No documentation was present in the EHR that the resident ever said he wanted to kill himself or planned to do so. All subsequent notes related to SI from [DATE] - [DATE] documented Resident 3 did not want to harm himself and had no plan to do so. Review of the Quarterly MDS, dated [DATE], and the Significant Change MDS, dated [DATE], showed Resident 3 scored 0 on both PHQ-9 s, indicating the resident had none to minimal signs/symptoms of depression. On [DATE] at 12:31 PM, when asked if they could find any documentation that supported Resident 3 had demonstrated/verbalized SI since the initial report from the CNA who reported Resident 3 said they wanted to die, Staff Z, after reviewing Resident 3's EHR, stated, No. When asked what the justification was for the continued use of sertraline and/or declining the pharmacist's recommendation for a GDR, in the absence of SI or signs and symptoms of depression Staff Z stated, There's not [a justification] In an interview on [DATE] at 10:16 AM, Staff F, Social Services Director, said they were unaware of Resident 3 having any SI after their son died. Staff F reported that Resident 3 and the son were estranged. When asked if they knew why provider(s) believed Resident 3 had frequent SI or episodes of SI Staff F stated, No. Reference WAC 388-97-1060 (3)(k)(i) .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review, the facility failed to report allegations of abuse, neglect, misappropriation (taking money or assets) and accidents to the State Agency within 24 hours, to log the allegation and/or accident in the facility's reporting log as required for 6 of 8 residents (Residents 61, 33, 58, 60, 20 and 63) when reviewed for abuse/neglect. This failure placed residents at risk for unaddressed abuse, neglect, misappropriation, psychosocial harm, decreased quality of life and other negative outcomes. Review of the facility's policy titled, “Abuse, Neglect, Exploitation and Misappropriation Prevention Program“, revised September 2024, showed the facility was to identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. The facility was to investigate and report any allegations within time frames required by federal requirements. <Resident 61> Resident 61 admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 05/09/2025, showed Resident 61 was moderately cognitively impaired. The facility's grievance log (a log of general concerns reported by staff, residents, or family) was reviewed from 02/25/2025 through 06/30/2025. Resident 61 had an entry on 05/22/2025, for giving another resident their debit card and that $800.00 dollars went missing from their account. A review of the facility provided Accident and Incident Log (a formal record used by facilities to document all accidents and incidents involving residents, staff, or visitors, including all reportable incidents or allegations) from 01/14/2025 through 07/15/2025, showed no record of the incident for Resident 61. On 07/25/2025 at 12:51 PM, Staff A, Administrator, when asked if the incident with Resident 61 should have been logged in the Accident and Incident log, thoroughly investigated, and reported to the State Agency and law enforcement, Staff A said, yes, none of that was done. <Resident 33> Resident 33 admitted to the facility on [DATE]. Review of the Significant Change MDS, dated [DATE], documented Resident 33 was severely cognitively impaired. The facility's grievance log showed an entry on 05/15/2025, that Resident 33 had told a Life Skills Coach that a blonde-haired girl was mean to her and grabbed her arm. A review of the facility provided Accident and Incident Log from 01/14/2025 through 07/15/2025, showed no record of the incident for Resident 33. On 07/24/2025 at 3:30 PM, Staff A, when asked if the incident for Resident 33 was reported to the state, said no, it should have been. <Resident 58> (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 58 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed Resident 58 was cognitively intact. During a Resident Council meeting on 07/18/2025 at 2:06 PM, Resident 58 said three to four months previously they had fallen out of bed with their call light. Resident 58 said they had hit their head and their ear was bleeding, and they laid on the floor for half an hour before Staff X, Certified Nursing Assistant (CNA) came on shift and responded to the call light. Resident 58 said he told Staff X he was on the floor for half an hour. Review of the Accident and Incident log showed an entry of a fall on 01/22/2025 for Resident 58. On 07/25/2025 at 9:48 AM, Staff X, CNA said she recalled the fall incident for Resident 58, she had just started her shift and noted from the call light system that the call light had been on for 35 minutes. Staff X said she answered the light and found Resident 58 on the floor with blood on their ear, saying “it was quite a bit of blood.” When asked if she told anyone about the long call light time, Staff X said she told the nurse and filled out a fall report mentioning the long call wait time. Staff X said she did not fill out a grievance form for the long call light wait time, but had included it in her fall report. The facility provided a report of accidents and incidents that were reported to the State Agency from 01/03/2025 through 07/15/2025, Resident 58's fall with long wait time was not reported. On 07/25/2025 at 12:50 PM, Staff A said with regards to Resident 58's fall, a resident interview had not been conducted, a grievance form had not been done, a call light wait time investigation had not been done, she could not provide a copy of Staff X's fall report, and indicated it was not reported to the State Agency. When asked if this met her expectations, Staff A said, no, it did not. <Resident 60> Resident 60 admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed Resident 60 was cognitively intact. On 07/18/2025 at 9:48 AM, Resident 60 reported that two weeks previously staff told him to have a bowel movement (BM) in the bed, although they had told staff they could stand and needed help to the bathroom. When asked who told them to have a BM in bed, Resident 60 said Staff W was the CNA who told them to have a BM in bed. Resident 60 said he had told everybody, they said they were working on it. Resident 60 said he had told Staff B, Director of Nursing Services (DNS), and she had said she would handle it. On 07/18/2025 at 10:37 AM, Staff A was informed of the above allegations and asked what her expectations of staff were, Staff A said, to report it, especially the DNS, report it and notify me (the administrator) and start the investigation process. On 07/24/2025 at 2:17 PM, Staff B, DNS when asked if Resident 60 ever reported to her that he was told to have a BM in bed, said she recalled Resident 60 say a staff member kind of brushed Resident 60 off and told them to go in their brief. Staff B said she told Resident 60 he should be treated with dignity and respect , and she would look into it. Staff B said Resident 60 could not tell her who or a date/a time, and she personally did not remember. When asked if this was something that should have been reported to the State Agency, Staff B said, we should do a grievance form and look into it, I (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would have to route to my administrator to see if it should be reported. On 07/24/2025 at 4:01 PM, Staff A said she did speak with Staff B, and Staff B did not report the allegation to the State Agency. Staff A said her expectation was that it would be reported. <Resident 20> Resident 20 admitted to the facility on [DATE]. Review of the Annual MDS, dated [DATE], documented Resident 20 was cognitively intact. On 07/23/2025 at 7:50 AM, Resident 20 said they had a fall and slipped on the floor in the shower room, and could not reach the call light cord. Resident 20 said the door had not been shut all of the way and they were able to push their wheelchair out the door. At 9:11 AM, Resident 20 added that when they had fallen earlier this year, they had dislocated their right shoulder, and they were sent to the hospital. Review of a progress note, dated 02/24/2025, documented that Resident 20 had a fall in the shower room, had “resistance” to their right arm, was in severe pain, and Emergency Medical Services were called to take Resident 20 to the hospital. Review of the facility's Accident and Incident Log from 01/14/2025 through 07/15/2025, showed no entry for Resident 20. The facility provided reports of accidents and incidents that were reported to the State Agency from 01/03/2025 through 07/15/2025, showed Resident 20's fall had not been reported. On 07/28/2025 at 10:27 AM, Staff A, Administrator, regarding Resident 20's fall with injury and hospitalization, said it should have been logged on the Accident and Incident log, and it should have been reported to the State Agency. <Resident 63> Resident 63 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact. Review of the electronic health record (EHR) showed Resident 63 was transferred to acute care on 07/07/2025 and re-admitted to the facility on [DATE]. On 07/25/2025 at 1:25 PM, Resident 63 explained that prior to hospitalization she received a $666 check from her father's estate. Resident 63 said they had $375 left which they stored in the top locking drawer of their bedside dresser. When they accessed the top drawer on 07/17/2025, the $375 was missing. Resident 63 said on 07/17/2025 they notified Staff Q, Revenue Cycle Manager, of the missing money because she was aware of the check they had received from their father's estate, and notified Staff R, Social Service Assistant. Resident 63 indicated since reporting the missing money eight days prior, no one had followed up with them. On 07/25/2025 at 2:13 PM, Staff Q, Revenue Cycle Manager, acknowledged they were notified of the missing money by Resident 63 on 07/17/2025. Staff Q said they were aware Resident 63 was expecting a check from her father's estate, but did not know it had been received and cashed. Staff Q (continued on next page)

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	505240	A. Building B. Wing	07/29/2025

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reported they informed Resident 63 that they would inform the Administrator about the missing money. When asked if then Administrator was notified Staff Q stated, “No.” On 07/25/2025 at 2:58 PM, Staff F, Social Services Director, said Staff R, Social Service Assistant, was not available for interview as they had the day off, but acknowledged Resident 63 had reported they were missing more than $300 from their top drawer. Staff F said both Staff Q and Staff R should have initiated a missing property report but failed to do so. Review of the facility's July 2025 Accident and Incident Log, showed Resident 63's alleged missing money was not logged. In an interview on 07/25/2025 at 3:03 PM, Staff B, DNS, said they were not informed that Resident 63 alleged $375 was missing from their top drawer. Staff B acknowledged that Staff Q and Staff R should have immediately reported the allegation. Staff B confirmed the alleged misappropriation should have been recorded on the incident log, the State Agency notified, and an investigation initiated. When asked if any of those things had occurred, Staff B said no. Reference WAC 388-97-0640(5)(a), (6)(a)(c)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review the facility failed to conduct a thorough investigation for 6 of 7 sampled residents (Resident 45, 2, 58, 60, 61 & 63) reviewed for incident investigations. Failure to conduct a thorough investigation, to identify the root cause(s) and all contributing factors related to incidents and investigations placed residents at risk for unidentified abuse or neglect, risk for injury, unmet care needs and a diminished quality of life.Findings included . Review of the facility's policy titled, “Abuse, Neglect, Exploitation and Misappropriation Prevention Program”, Revised September 2024, showed regarding abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation (taking money or assets) the facility was to thoroughly investigate all allegations and the administrator initiates investigations. “The individual conducting the investigation at a minimum: a. reviews the documentation and evidence b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; c. observes the alleged victim, including his or her interactions with staff and other resident's; d. interview the person reporting the incident e. interview any witnesses to the incident f. interviews the resident (as medically appropriate) or the resident's representative g. interview the resident's attending physician as needed to determine the resident's condition h. interviews staff members (on all shifts) who have had a contact with the resident during the period of the alleged incident; i. interviews the resident's roommate, family members, and visitors; j. interviews other resident's to whom the accused employee provides care or services; k. reviews all events leading up to the alleged incident; and l. documents the investigation completely and thoroughly” Upon conclusion of the investigation, the investigator records the findings of the investigation on approved documentation forms and provides the completed documentation to the administrator. <Resident 45> Resident 45 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 05/01/2025, documented Resident 45 was cognitively intact. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/16/2025 at 11:08 AM, Resident 45 said they had an incident with Staff F, Social Services Director, Staff Z, Unit Manager (UM)/ Registered Nurse (RN), and an unidentified Certified Nursing Assistant (CNA, the CNA was later identified as Staff AA). Resident 45 said all three staff members had taken them to the shower room for a shower. While in the shower room, Staff F had taken the hose with the spray nozzle and had sprayed them down with the hard force of the nozzle head, and told the CNA, “This is how you shower a resident. Resident 45 said after the shower, they told Staff N, Certified Occupational Therapy Assistant, about the incident. Staff N told Resident 45 that Staff F should not have been in the shower with the resident. Resident 45 said they asked Staff N not to say anything because they did not want to be retaliated against. On 07/23/2025 at 10:30 AM, when asked about the incident on June 14, if they had given permission for Staff F to be in the shower room, Resident 45 stated, “no, I didn't want her there.” Review of the Accident and Incident Log for June 2025, showed no documentation the incident was logged or reported to the appropriate authorities. On 07/16/2025 at 2:10 PM, Staff A, Administrator, was informed of the allegations. On 07/21/2025 at 3:38 PM, Staff A emailed the completed abuse investigation for Resident 45. The facility investigation included the following documents: -Grievance form completed on 07/16/2025 by Staff E, Regional Registered Nurse (RN) and signed by Staff B, Director of Nursing Services (DNS), -Abuse, Neglect Exploitation and Misappropriation Prevention Program policy, -Online Incident Report, -Resident 45's Care Plan (current)-Refusing ADL's, care, cleaning and Behavioral problem, -Progress notes dated 06/14/2025, -Progress notes dated 05/10/2025, -Written statement from Staff F, SSD, -Written statement from Staff Z, UM/RN, -Written statement completed by Staff E, Regional RN, via phone conversation with Staff AA, CNA, -Written statement from Staff N, Certified Occupational Therapy Assistant, -Restorative Program Initiation or Quarterly Evaluation v1-v2, -Progress Note dated 06/09/2025, -Training Log/Sign In Sheet dated 07/17/2025: training objectives: Abuse, Neglect, Misap.; How to communicate w/ residents and Residents rights and Dignity, with signature pages. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/24/2025 at 2:02 PM, Staff B, DNS, said when completing an investigation for allegations of abuse or neglect, the facility would suspend the staff member immediately, notify the Administrator and provider, complete a head-to-toe assessment of resident, if allegations of physical abuse, and start the investigation. An investigation would include interviewing the resident in detail, interviewing other residents, possible witnesses, interviewing staff members involved and other staff. Staff B said the Interdisciplinary Team (IDT) will meet and discuss allegations, make recommendations. Staff B said the facility had 5 days to complete the investigation and submit the findings to the State agency. Staff B said the facility would also do re-education/in-services with all staff regarding allegations. Staff B said if required the Ombudsman, Adult Protective Services and law enforcement would be notified. When asked how the facility determined the root cause or ruled out abuse and neglect, Staff B said they look at the mental status of the resident, look over all the information as a team to make a determination if it was abuse or neglect. Staff B said after the investigation was completed the facility would notify the State agency, State registry, if needed, re-educate staff and update the resident's care plans. When asked about Resident 45's investigation, Staff B said they did not know the details of the allegations, only that it was something about Resident 45 and the shower. Staff B confirmed they filled out the grievance form for the investigation. Staff B said Staff F, SSD and Staff Z, UM/RN, were suspended and returned 1-2 days later. When asked about Resident 45's care plan, Staff B confirmed the care plan was not updated, and should have been. When asked how the facility was ensuring this was not happening to other residents, Staff B said they re-educated staff and their recommendation to the IDT would have been care in pairs for this resident. When asked about other resident interviews, Staff B said they had discussed interviewing other residents in the IDT meeting. Staff B said they should have completed interviews with other residents. When questioned if Staff F, SSD should have been in the shower room with Resident 45 while they were showering, Staff B was unsure of the question. The question was clarified that the SSD presence in the shower room was outside their normal scope of practice, Staff F was not a CNA, Licensed Practical Nurse, or Registered Nurse. Staff B said Staff F should have only been in the shower room if Resident 45 allowed it. It was explained Resident 45 did not want Staff F in the shower room, while they were showering. Staff B said Staff F should not have been in the shower room. On 07/24/2025 at 3:09 PM, when asked if the investigation reports provided were full and complete investigations/records, Staff A, Administrator, said yes, they had given everything in the record. Staff A said when an allegation of abuse had been reported the facility would report it to the State, start the investigation, suspend the staff involved and investigate if this had happened to other residents too. Staff A said they would report to law enforcement, the parties responsible, the company, Social Services, Ombudsman and the Medical Director. Staff A said they would obtain statements from residents, witnesses, roommates, other residents, staff involved and other staff. Staff A said the IDT would meet, to make sure all pertinent staff were aware, and all information was shared, the care plan would be updated, new interventions could be implemented, and all staff would be re-educated. When asked about ruling out abuse and neglect or determine root cause, Staff A said making sure it had not happened before, the resident's mental status would be assessed, making sure it happened here and not somewhere else and ensuring no other residents were harmed. Staff A was asked about Resident 45's investigation. Staff A said as soon as they were made aware of the allegation, they reported it to the State Agency, interviewed the two staff members involved, then suspended the two staff members and started the investigation. Staff A said the resident was interviewed. Staff E, Regional RN, completed a phone interview with Staff AA, CNA. When asked about the specific event that took place, Staff A said Resident 45 was refusing to take a shower due to agency staff, staff informed Staff F, SSD and Staff Z, UM/RN, both staff spoke with the resident. Resident 45 agreed to take a shower. Staff A said Staff Z and Staff AA took Resident 45 into the shower room. Staff F, SSD, was not in the shower room with Resident 45, so there was no need to suspect abuse. Staff A was (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stopped and informed Staff F had been interviewed and self-reported that they were in fact in the shower room when Resident 45 was showering. Staff A acknowledged Staff F was in the room at the time of showering. Staff A said Staff F should have only been in the room if Resident 45 allowed it. It was explained Resident 45 did not want Staff F in the shower room, while they were showering. Staff A said Staff F should not have been in the shower room. When asked if Resident 45's care plan had been updated, Staff A said they thought it had been. When informed there were no updates to the care plan, Staff A said it was the expectation that the care plan be updated immediately. When asked how the facility would prevent this from happening to other residents, Staff A said they definitely needed to talk with staff about “staying in their lane. When asked about investigations lacking interviews with other residents and other staff, Staff A said yes, the expectation was that other staff members and residents would be interviewed as part of a thorough investigation. <Resident 63> Resident 63 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact. On 07/25/2025 at 1:25 PM, Resident 63 explained that prior to hospitalization she received a $666 check from her father's estate. Resident 63 said they had $375 left which was stored in the top locking drawer of their bedside dresser. On 07/17/2025 the resident said they accessed their top drawer and found their $375 was missing. Resident 63 said that same day (07/17/2025) they notified Staff Q, Revenue Cycle Manager, and Staff R, Social Service Assistant, of the missing money. Resident 63 said in the eight days since reporting the missing money, there had been no follow up from facility staff. On 07/25/2025 at 2:13 PM Staff Q, Revenue Cycle Manager, acknowledged Resident 63 notified them that more than $300 was missing from their top drawer. Staff Q said they told Resident 63 they would report it to the Administrator. When asked if they had notified the Administrator, Staff Q stated, “No.” On 07/25/2025 at 2:58 PM, Staff F, SSD, said Staff R, Social Service Assistant, was not available for interview as they had the day off, but acknowledged Resident 63 had reported to Staff R that they were missing more than $300 from their top drawer. Staff F said both Staff Q and Staff R should have initiated a missing property report but failed to do so. Review of the facility's July 2025 incident log on 07/25/2025, eight days after Resident 63's reported more than $300 was missing from their drawer, showed the alleged misappropriation was not logged. In an interview on 07/25/2025 at 3:03 PM, when asked if Resident 63's allegation that more than $300 was missing from their top drawer had been investigated Staff B, DNS, said no and indicated they were unaware of the allegation. <Resident 61> Resident 61 admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed Resident 61 was moderately cognitively impaired. A review of the facility's Grievance Log (a log of concerns reported by staff, residents, or family) from 02/25/2025 through 06/30/2025, showed an entry on 05/22/2025 for Resident 61. The (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Grievance Log entry documented that Resident 61 reported they gave another resident their debit card and that $800.00 dollars was missing from their account. The log additionally documented that the Social Services Director informed Resident 61 there was nothing social services could do because it was against the facility's policy to give another resident money or a debit card. A review of the facility provided Accident and Incident Log (a formal record used by facilities to document all accidents and incidents involving residents, staff, or visitors) from 01/14/2025 through 07/15/2025, showed no record of the incident for Resident 61. On 07/25/2025 at 12:51 PM, Staff A, Administrator, when asked if the incident for Resident 61 should have been logged, thoroughly investigated, reported to the State Agency and law enforcement said, yes, none of that was done. <Resident 58> Resident 58 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed Resident 58 was cognitively intact. During a Resident Council meeting on 07/18/2025 at 2:06 PM, Resident 58 said 3-4 months previously they had fallen out of bed with their call light. Resident 58 said they hit their head and their ear was bleeding, and they laid on the floor for a half hour before Staff X, CNA, came on shift and responded to the call light. Resident 58 said he told Staff X he had been on the floor for half an hour. On 07/25/2025 at 9:48 AM, Staff X, CNA said she recalled the fall incident for Resident 58, she had just started her shift and noted from the call light system that the call light had been on for 35 minutes. Staff X said she answered the light and found Resident 58 on the floor with blood on their ear, saying “it was quite a bit of blood.” When asked if she told anyone about the long call light time, Staff X said she told the nurse and filled out a fall report mentioning the long call wait time. Staff X said she did not fill out a grievance form for the long call light wait time, but it was in her fall report. On 07/25/2025 at 12:50 PM, Staff A, Administrator, said with regards to Resident 58's fall, a resident interview had not been conducted, a grievance form had not been done, a call light wait time investigation had not been done, she could not provide a copy of Staff X's fall report, and indicated it was not reported to the State Agency. When asked if this met her expectations, Staff A said, no, it did not. <Resident 2> Resident 2 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 2 was cognitively intact. On 07/16/2025 at 10:56 AM, Resident 2 said an unnamed CNA had come to change their brief and brought Staff Y, CNA with her. Resident 2 said that the unnamed CNA was being rough with her when pushing her over. Resident 2 reported she had said “stop it, don't touch me,” and that the unnamed CNA did not stop. Resident 2 said she did not recall the CNA's name, but she had complained about it and had not seen the CNA since then, saying the facility had dealt with it, and she had reported it. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/18/2025 at 8:48 AM, Staff A, Administrator, was informed of the above allegations. A progress note, dated 07/18/2025, documented that when Social Services Director followed up with Resident 2 about her concerns pertaining to the care practices of unknown CNA, Resident 2 stated she told nurses U, RN, and V, Licensed Practical Nurse and had noticed the CNA had not been back. On 07/24/2025 at 3:35 PM, Staff A, Administrator, was told that according to the Social Services Director progress note Resident 2 reported she had told Staff U and V about her allegations. When asked if the facility interviewed Staff U and Staff V, Staff A said, Staff U was out of the country, and no they had not interviewed Staff V. When asked if Staff Y had been interviewed since she had reportedly been there for the alleged rough handling, Staff A, said, no. When asked if the facility had interviewed other staff members, Staff A said, no. When asked if the facility had interviewed other residents, Staff A said, yes, I will get them to you. No further documentation was provided regarding other resident interviews. When asked if this met her expectations of a thorough investigation, Staff A said, without interviewing Staff Y and Staff V, no, it was not a thorough complete investigation. <Resident 60> Resident 60 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], documented Resident 60 was cognitively intact. On 07/18/2025 at 9:48 AM, Resident 60 reported that about two weeks ago, staff told them to have a bowel movement (BM) in the bed, although Resident 60 had told staff they could stand and just needed help to the bathroom. When asked who told them to have a BM in bed, Resident 60 said Staff W, CNA, told them to have a BM in bed. Resident 60 said he had told everybody, and they had said they were working on it. Resident 60 said they had told Staff B, DNS and she had said she would handle it. On 07/18/2025 at 10:37 AM, Staff A, Administrator, was informed of the above allegations. On 07/24/2025 at 2:17 PM, Staff B, DNS when asked if Resident 60 ever reported to her that he was told to have a BM in bed, said she recalled Resident 60 said a staff member kind of brushed Resident 60 off and told them to go in their brief, Staff B said she had told Resident 60 they should be treated with dignity and respect and she would look into it. Staff B said Resident 60 could not tell her who had said this, a date or a time and she didn't remember. When asked if this was something that should be reported to the State Agency, Staff B said, we should do a grievance form and look into it. Staff B said she would have to route to the administrator to see if it should be reported. Review of a Social Services Progress Note, dated 07/18/2025, documented SSD followed up with the resident about their concerns pertaining to staff behavior, care practices, customer service, and resident dignity at the facility. There was no mention in the progress note that Staff F, SSD, asked Resident 60 about being told to have a BM in his brief. On 07/24/2025 at 4:01 PM, Staff A, Administrator, when asked about Resident 60's investigation and if other residents had been interviewed (this was not included in investigation paperwork that was provided), Staff A said, yes, I will email those to you. When asked if other staff members were interviewed other than the alleged perpetrator, Staff A said, no, that she had interviewed those mentioned, but no others. When asked if she interviewed Staff B, DNS, since the resident stated he had reported an allegation to her, Staff A said she did speak with Staff B, and Staff B didn't report it (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to the State Agency, and her expectation was that it would have been reported. When asked about the documented follow up conversation Staff F had with Resident 60 in which Staff F documented she had interviewed the resident about “staff behavior, care practices, customer service, and resident dignity, but did not document that she asked about the specific allegations Resident 60 had made, Staff A said, Staff F should have talked with Resident 60 about the specific allegations. When asked if Staff A would expect the concerns to be documented in the progress note, Staff A said, yes, it should be narrowed down to what the problem was. No additional documentation of resident interviews was provided. Reference WAC 388-97-0640(6)(a)(b) .

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review, the facility failed to provide written notice of transfer at the time of transfer to the hospital for 3 of 3 sampled residents (Residents 10, 63 and 68) reviewed for hospitalization. This failure placed the residents at risk for lack of knowledge related to discharge and transfer status.Findings included .1) Review of the electronic health record (EHR) showed Resident 10 admitted to the facility on [DATE]. Review of Resident 10's Minimum Data Set (MDS, an assessment tool) showed hospitalizations on 06/10/2025 with readmission to the facility on [DATE] and 06/19/2025 with readmission to the facility on [DATE]. There was no documentation showing a written notice detailing the transfer was provided to the resident.2) Review of the EHR showed Resident 63 admitted to the facility on [DATE]. Review of Resident 63's discharge MDS showed hospitalization with Return Anticipated on 07/07/2025 and readmission to the facility on [DATE]. There was no documentation showing a written notice detailing the transfer was provided to the resident.3) Review of the EHR showed Resident 68 admitted to the facility on [DATE]. Review of Resident 68's discharge MDS showed Discharge Return Anticipated on 05/30/2025. There was no documentation showing a written notice detailing the transfer was provided to the resident.During an interview on 07/17/2025 at 2:55 PM, Staff F, Social Services Director, said a form titled WA Nursing Home Transfer or Discharge Notice/Notice of Voluntary Transfer (Bed Hold) was completed electronically; however, residents were not provided a copy of the transfer notice.During an interview on 07/17/2025 at 3:02 PM, Staff A, Administrator, said the expectation was that residents were provided a written copy of the transfer and bed hold in a language they understood at the time of the transfer or within 24 hours.Reference WAC 388-97-0120 (4).

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review and interview, the facility failed to provide a written bed hold notice, at the time of transfer to the hospital, for 3 of 3 sampled residents (Residents 10, 63 and 68) reviewed for hospitalization. This failure placed the residents at risk for not knowing their right to hold their bed while in the hospital and a diminished quality of life.Findings included . 1) Review of the electronic health record (EHR) showed Resident 10 admitted to the facility on [DATE].Review of Resident 10's Minimum Data Set (MDS, an assessment tool) showed hospitalizations on 06/10/2025 with readmission to the facility on [DATE] and 06/19/2025 with readmission to the facility on [DATE]. There was no documentation showing a bed hold notice was provided to the resident.2) Review of the EHR showed Resident 63 admitted to the facility on [DATE]. Review of Resident 63's discharge MDS showed hospitalization with Return Anticipated on 07/07/2025 and readmission to the facility on [DATE]. There was no documentation showing a bed hold notice was provided to the resident.3) Review of the EHR showed Resident 68 admitted to the facility on [DATE]. Review of Resident 68's discharge MDS showed Discharge Return Anticipated on 05/30/2025. There was no documentation showing a bed hold notice was provided to the resident.During an interview on 07/17/2025 at 2:55 PM, Staff F, Social Services Director, said a form titled WA Nursing Home Transfer or Discharge Notice/Notice of Voluntary Transfer (Bed Hold) was completed electronically however, residents were not provided a copy of the bed hold. During an interview on 07/17/2025 at 3:02 PM, Staff A, Administrator, said the expectation was that residents were provided a written copy of the transfer and bed hold in a language they understood at the time of the transfer or within 24 hours.Reference WAC 388-91-0120(4).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review, the facility failed to accurately assess 4 of 18 residents (Residents 47, 3, 31, & 28) whose Minimum Data Sets (MDS, an assessment tool) were reviewed. Failure to ensure accurate assessments regarding active diagnoses (Residents 3 and 31), restorative services (Resident 47), and mobility status (Resident 28), and placed residents at risk for unidentified and/or unmet care needs. Findings included . Review of the Resident Assessment Instrument [a manual that directs nurses how to accurately code a MDS) showed that in order to code a restorative nursing program the following must be met:a) A measurable and objective goal must be documented in the care plan and medical record.b) Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record. 1) Resident 47 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident received a restorative walking program on seven of seven days, and a restorative active range of motion program on four of seven days during the assessment period. Review of the Quarterly MDS, dated [DATE], showed Resident 47 received a restorative walking program on three of seven days, and a restorative active range of motion program on seven of seven days during the assessment period. Review of the electronic health record (EHR) showed Resident 47s restorative programs were not periodically evaluated as was required. The most recent restorative evaluation was performed on 11/04/2024. On 07/24/2025 at 12:44 PM, Staff EE, MDS Director, said restorative programs were evaluated quarterly. When asked if Resident 47's restorative programs had been evaluated in the past two quarters, Staff EE said no and acknowledged the programs should not have been coded on the above referenced MDS assessments. 2) Resident 3 was admitted to the facility on [DATE]. Review of the EHR showed the resident was started on sertraline (an antidepressant) on 10/17/2024, for a diagnosis of depression. A 10/17/2024 psychotropic medication (medication that affects brain functioning, processing, and mental state) consent for sertraline identified the reason medication was prescribed as depression. Review of the Quarterly MDS, dated [DATE], the Significant Change MDS, dated [DATE], and the Quarterly MDS, dated [DATE], showed the resident had no psychiatric diagnoses (including depression), but received antidepressant medication during the assessment period. On 07/24/2025 at 1:01 PM, Staff EE, MDS Director, acknowledged depression should have been coded as an active diagnosis on the above three referenced MDSs, but was not. 3) Resident 31 was admitted to the facility on [DATE]. Review of the Quarterly MDSs, dated 10/16/2024, 01/16/2025 and 04/16/2025, showed Resident 31 had a diagnosis of obstructive uropathy and required use of an indwelling urinary catheter. A 09/17/2024 urology consultation documented Resident 31 had a history of prostate cancer and was status post prostatectomy (a surgical procedure for the partial or full removal of the prostate gland) and radiation, which was complicated by a bulbar urethral stricture (a condition where the urethra, in the area beneath the scrotum, becomes narrowed due to scar tissue) and bladder neck contracture (a condition where scar tissue narrows the opening between the urethra and the bladder). Resident 31 then underwent a Direct Visual Internal Urethrotomy (DVIU, surgery to widen a stricture, narrow area, in the urethra) on 01/21/2021. The urologist documented, [Resident 31] has requested to keep the foley catheter in place at the present time. PLAN Inguinal and scrotal wounds appear to be healing very well. Scrotal ulcer is almost completely gone, patient is having troubles with his catheter clogging but he does prefer catheter management, so he is not having wetness around his inguinal and scrotal wounds which I think is reasonable. On 07/24/2025 at 12:44 PM, Staff EE, confirmed Resident 31 did not have an active diagnosis of obstructive uropathy, and said the above three referenced MDSs needed to be corrected. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) Resident 28 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], showed Resident 28 was assessed to need maximum assistance with sit to stand. During an interview on 07/21/2025 at 2:54 PM, Resident 28 was asked about being able to stand and pivot and said they had not stood in almost two years. During an interview on 07/21/2025 at 3:22 PM, Staff K, Licensed Practical Nurse, when asked when the last time Resident 28 got out of bed and into a wheelchair, said they had worked at the facility for a year and a half and had not seen Resident 28 get out of bed and into a chair. Staff K said she had not seen Resident 28 get out of bed. During an interview on 07/23/2025 at 10:11 AM, Staff J, Unit Manager, when asked if Resident 28 ever gets out of bed, said no. Staff J said every time they offer, Resident 28 refused. During an interview on 07/24/2025 at 1:46 PM, Staff EE said for section GG of the MDS, on mobility, it was based on nurse charting, aides charting, and input from therapy. When asked how this was assessed for Resident 28, as they were not getting out of bed, Staff EE said if Resident 28 did not get out of bed, then it was not accurate. Staff EE was unable to provide documentation the other MDS nurses used to fill out the assessment. Reference WAC 388-97-1000 (1)(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review, the facility failed to ensure Level 1 Pre-admission Screening and Resident Review (PASRR, document that screens resident for needing further mental health evaluations) were accurate and complete for 4 of 7 residents (Residents 3, 22, 53 & 61) reviewed for PASRR. This failure placed residents at risk of unidentified and unmet care needs related to mental health, and a diminished quality of life.Findings included.1) Resident 3 was admitted to the facility on [DATE], and had a diagnosis of depression. Resident 3 had sertraline, an antidepressant, prescribed since 10/17/2024. Review of Resident 3's Level 1 PASRR, dated 02/21/2024, showed no serious mental illness boxes were selected. Review of the electronic health record (EHR), showed no other Level 1 PASRRs were completed.During an interview on 07/21/2025 at 11:31 AM, Staff F, Social Services Director, reviewed Resident 3's Level 1 PASRR and said there were no serious mental illnesses selected on the form, and no Level 2 PASRR was required. Staff F reviewed Resident 3's sertraline orders and said the order was for depression. Staff F said they should have updated Resident 3's Level 1 PASRR, as they would need a Level 2 for the sertraline medication and the depression diagnosis.2) Resident 22 was admitted to the facility on [DATE], with diagnoses including depression, anxiety, and bipolar disorder (mental health condition with extreme mood swings). Review of Resident 22's Level 1 PASRR, dated 09/22/2024, showed an exemption (this allows residents to be admitted to the nursing home directly from the hospital, anticipated to need fewer than 30 days of care, to receive services temporarily without undergoing a full PASRR evaluation). The box selected showed, No Level II evaluation indicated at this time due to exempted hospital discharge: Level II must be completed if scheduled discharge does not occur. Review of the EHR showed no other Level 1 PASRR was done. During an interview on 07/21/2025 at 11:31 AM, Staff F, when asked if Resident 22 had a new Level 1 PASRR completed after staying past the initial 30 days, said they had only sent the exemption PASRR. When asked about Resident 22 being at the facility for almost one year, Staff F said they would redo the Level 1 PASRR. 3) Resident 53 was admitted to the facility on [DATE], with a diagnosis of major depressive disorder.Review of Resident 53's Level 1 PASRR, dated 03/18/2025, showed it was an exemption. Review of the EHR showed no other Level 1 PASRR was done.During an interview on 07/21/2025 at 11:31 AM, when asked if Resident 53 had a new Level 1 PASRR completed after staying past the initial 30 days, Staff F acknowledged they had not known a new Level 1 PASRR was required after the initial 30 days, and now needed to review every resident with a Level 1 PASRR exemption. 4) Resident 61 was admitted to the facility on [DATE] with diagnoses of anxiety, depression, and unspecified disorder of adult personality and behavior (a diagnosis when a resident does not fit criteria for any specific personality disorder but still has significant impairment in social, occupational, or other important areas of functioning).Review of Resident 61's Level 1 PASSRs from 07/24/2024 and 07/30/2024, showed for serious mental illness that Mood Disorders-Depressive or Bipolar was selected, Anxiety Disorders was selected, but Personality Disorders was not selected. During an interview on 07/22/2025 at 9:04 AM, when told the diagnosis of unspecified disorder of adult personality and behavior was added to Resident 61's chart on 07/30/2024, Staff F acknowledged the Level 1 PASSR should have been redone to include all of Resident 61's diagnoses.Reference WAC 388-97-1915 (1)(2)(a-c).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation, interview and record review, the facility failed to ensure resident care plans (CPs) were reviewed, revised, and accurately reflected residents' care needs for 7 of 18 sample residents (Residents 3, 63, 61, 31, 1, 42 & 47) whose care plans were reviewed. These failures placed residents at risk for unmet care needs and diminished quality of life.Findings included . 1) Review of Resident 3's pressure ulcer care plan, revised 06/19/2025, showed Resident 3 had an unstageable left heel pressure ulcer, which was treated with a wound vac (device used to promote wound healing by applying negative pressure to the wound bed), that was to be changed three times a week. Review of the electronic health record (EHR) showed the wound vac had been discontinued on 06/17/2025. A 06/24/2025 wound consult note documented Resident 3's left heel wound bed was now visible and that the wound had progressed from unstageable to a full thickness stage 3 pressure ulcer. On 07/28/2025 at 12:21 PM, Staff J, Unit Manager, said the care plan was inaccurate and needed to be updated to reflect Resident 3's current treatment and that the wound progressed from unstageable to a stage 3 pressure ulcer. Review of the 04/19/2025 admission/re-admission nursing assessment, dated 04/19/2025, showed the resident was edentulous (had no teeth) and admitted with full upper dentures and no lower dentures. On 07/25/2025 at 8:53 AM, Resident 3 said he only had his top dentures when he admitted to the facility because his bottom dentures were accidentally left in storage. Review of Resident 3's activities of daily living (ADLs) care plan, initiated 03/04/2025, did not identify if the resident had natural teeth or dentures. For oral care the care plan read Is able to (SPECIFY: rinse and spit, brush teeth, clean dentures). Although staff were directed “specify” what care the resident required and could perform, they failed to do so. The care plan also failed to identify the resident as edentulous or that they had their top dentures only On 12/28/2025 at 12:21 PM, Staff J, UM, said the care plan needed to be updated/revised to reflect the resident was edentulous, with only a top denture and was able to clean his dentures with set up. Review of Resident 3's antidepressant medication for sadness, depression, and suicidal ideation (SI) care plan, identified the target behaviors (TBs) for the use of the antidepressant medication sertraline, were crying, isolation, and negative talk. Review of the July 2025 Treatment Administration Record (TAR) showed the TBs for the use of sertraline were feeling sad, irritable, empty or hopeless. On 07/22/2025 at 12:44 PM, when asked if the TBs identified on the care plan for the use of sertraline should match the TBs being monitored on the TAR, Staff J, UM, said yes, but acknowledged they did (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not. 2) Resident 63's dental consult, dated 05/08/2025, showed they had a four centimeter by two and a half centimeter irregular white patch to the upper left throat. The dentist recommended 1 week follow-up for white patch, may need biopsy. A night guard (mouthpiece) was also recommended due to Resident 63 grinding their teeth. Review of Resident 63's dental care plan, revised 06/06/2025, showed there was no documentation/information about irregular white patch on the resident's throat, or the pending biopsy. Nor was there anything documented about the resident's teeth grinding or the recommendation that the resident wear a night guard at night. On 07/25/2025 at 9:26 AM, when asked about Resident 63's irregular white patch that was pending a biopsy, propensity to teeth grind their teeth, and need to wear a night guard should have been care planned, Staff F, Social Services Director (SSD), stated, Yes. When asked if they had been care planned, Staff F stated, No. 3) Resident 61's limited physical mobility care plan, revised 05/27/2025, identified a goal of participating in restorative nursing programs (RNPs) six days per week (6x/wk). The residents upper and lower extremities Range of Motion (ROM) programs via Omnicycle, also documented they would be provided 6x/wk. Review of Resident 61's activities of daily living self-care deficit care plan, revised 07/11/2025, identified a goal of participating in RNPs 3x/week. On 07/28/2025 at 12:36 PM, Staff J, UM, confirmed that the care plans provided conflicting goals for the frequency of Resident 61's participation and needed to be revised, Staff J indicated they would need to speak with the Restorative Nurse to determine which goals and directions were accurate. 4) Review of Resident 31's Quarterly Minimum Data Set (MDS, an assessment tool), dated 04/16/2025, showed the resident had a diagnosis of obstructive uropathy and required the use of an indwelling urinary catheter. Review of Resident 31's alteration in urinary elimination related to indwelling catheter care plan, revised 04/17/2025, showed no supporting diagnoses or clinical justification for use was documented/included in the care plan (including obstructive uropathy). On 07/22/2025 at 12:49 PM, when asked if the supporting diagnoses/ justification for Resident 31's urinary catheter use should have been care planned, Staff Z, UM, said yes, it should be there. When asked if it was Staff Z stated, No. Review of Resident 31's comprehensive care plan showed no documentation or indication Resident 31 was to wear pressure offloading boots when in bed. Resident 31 had an order, dated 11/11/2024, to wear pressure offloading boots whenever in bed for pressure reduction. On 07/22/2025 at 12:58 PM Staff Z, UM, confirmed Resident 31's pressure offloading boots were not care planned. When asked if they should have been, Staff Z, stated, Yes. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 31's nutrition care plan, revised 04/17/2025, showed the resident was on a 1500 milliliter (ml) fluid restriction per day and there should be No water pitcher in room. On 07/22/2025 at 12:46 PM, Staff Z, UM, confirmed Resident 31 had a water pitcher on their bedside table. When asked if staff implemented the nutrition plan of care, Staff Z stated, No. 5) Resident 1 was admitted to the facility on [DATE]. According to the 5-day MDS, dated [DATE], Resident 1 was severely cognitively impaired. Resident 1's diagnosis included unspecified dementia (thinking that interferes with daily functioning) with unspecified severity with other behavioral disturbance. Review of Resident 1's care plan showed they had impaired cognitive function/dementia or impaired thought processes related to dementia. The care plan also documented that Resident 1 was their own health care decision maker and would continue to make choices related to all end-of-life concerns or advanced directive topics. On 07/21/2025 at 9:56 AM, Staff B, Director of Nursing Services (DNS), when asked about the care plan that indicated Resident 1 was his own health care decision maker, said the care plan had been created by the social worker, Resident 1 was not cognitive, and the care plan should have been revised. On 07/21/2025 at 10:17 AM, Staff F, Social Services Director, when asked about the care plan accuracy for Resident 1, said if a resident did not have an advanced directive she would always enter they were their own decision maker. When asked if Resident 1's care plan was person centered and specific for them, Staff F said no, it should not have been in the care plan that they had the ability to make their own decisions. 6) Resident 42 admitted to the facility on [DATE]. The admission MDS, dated [DATE], showed Resident 42 was cognitively intact. On 07/16/2025 at 3:32 PM, observation showed Resident 42 had mobility bars on both sides of their bed. Review of Resident 42's orders showed an order, dated 06/26/2025 for mobility bars. Review of Resident 42's care plan showed that the mobility bars were not care planned. On 07/23/2025 at 8:39 AM, Staff B, DNS, when asked what should be in place for residents having mobility bars, said assessment, evaluation, consent and care plan. When asked if Resident 42's care plan included mobility bars, Staff B looked in the EHR and said she did not see mobility bars on the care plan and it should have been there. 7) Resident 47 was admitted to the facility on [DATE], with a diagnosis of chronic pain. Review of Resident 47's EHR, showed a banner at the top of the electronic page that said “Record ACCURATE pain scale. 0/10 is not accurate for this resident.” Review of Resident 47's pain care plan showed it did not include this information. During an interview on 07/23/2025 at 10:28 AM, Staff J, UM, when asked if the banner related to pain (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was added to the care plan, looked at the care plan and said it did not look like it. During an interview on 07/24/2025 at 12:45 PM, Staff B, DNS, when asked about the pain banner not being on the care plan, said everything should be care planned. Staff B reviewed his most recent pain evaluation on 7/15 and said they were in pain due to a pressure sore and pain on their hip. Reference F697 Reference WAC 388-97-1020(2)(c)(d) .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of practice for 7 of 18 sampled residents (Residents 45, 41, 3, 31, 63, 47 & 22) reviewed. The failure to obtain vital signs when required, follow medication hold parameters, notify providers when medications were held, administer oxygen at the ordered rate, clarify incomplete or conflicting orders, and only sign for tasks that were completed, placed residents at risk for medication errors and associated complications, unmet care needs and a diminished quality of life.Findings included. Review of the facility's policy titled, “Vital Signs Monitoring Policy”, dated 06/01/2025, defines vital signs as temperature, pulse, respirations, blood pressure, oxygen saturation, and pain level. Vitals were to be obtained and documented on admission, as ordered by the physician, when there was a change in condition, before and after administration of medications that affect vital signs, before and after procedures, and as part of routine monitoring (at minimum per shift or per facility protocol). <Respiratory Care> 1) Resident 45 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 05/01/2025, documented Resident 45 was cognitively intact and received oxygen (O2) therapy. On 07/16/2025 at 11:36 AM, Resident 45 was observed wearing a nasal cannula (NC, a device that delivers oxygen to your nostrils). Resident 45's O2 tubing was dated 05/25/2025 and the O2 concentrator was set at 1 liter per minute (lpm). On 07/21/2025 at 10:10 AM, Resident 45 was observed wearing a NC. Resident 45's O2 tubing was dated 05/25/2025 and the O2 concentrator was set at 1 liter per minute (lpm). The electronic health record (EHR) documented Resident 45 had an order for O2 tubing to be changed, labeled and dated every Sunday night. Resident 45's O2 concentrator was to be set at 2 lpm per NC as needed for shortness of breath and exertion. The Oxygen Treatment Administration Record (TAR) from July 2025, documented Resident 45's O2 tubing was changed 07/06/2025, 07/13/2025 and 07/20/2025. On 07/21/2025 at 12:38 PM, Staff GG, Licensed Practical Nurse (LPN), said there was a designated scheduling person who was responsible for filling over the counter medications and changing O2 tubing, but they did not know who that person was. Staff GG said O2 tubing should be changed every week. Staff GG was accompanied to Resident 45's room and when asked what the date written on the O2 tubing was, said, 05/25/2025. When asked if the O2 tubing should have been changed, Staff GG did not answer the question but instead turned to Resident 45 and asked if they wanted the O2 tubing changed. Resident 45 said yes, that it had only been changed once since they got there. When asked again if the O2 tubing should have been changed, Staff GG said to speak to the person responsible for changing the tubing. On 07/24/2025 at 10:26 AM, Staff B, Director of Nursing Services (DNS), said O2 tubing should be changed every Sunday night by staff, but anyone could change the O2 tubing as needed. Observations on 07/16/2025 and 07/21/2025 were explained. Staff B was asked to review the O2 TAR for July (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2025. When shown that nursing staff were signing that the O2 tubing had been changed, Staff B said nursing staff should not have signed for things they did not complete. When it was explained that Resident 45 was wearing the NC and it had been running at 1lpm, Staff B said staff should have checked the O2 concentrator to make sure it was operating at the correct settings. <Hold Parameters> 2) Resident 41 was admitted to the facility on [DATE]. The Annual MDS, dated [DATE], documented Resident 41 was cognitively intact. Resident 41 had an order for metoprolol (blood pressure medication) with parameters: hold for Systolic Blood Pressure (SBP, top number) less than 120 and Heart Rate less than 50 beats per minute (BPM). The Medication Administration Record (MAR) for July 2025, documented Resident 41 had SBP less than 120 on the following days and was given metoprolol: 07/03/2025 112/6507/04/2025 110/8007/06/2025 119/8507/08/2025 117/7407/09/2025 118/7307/10/2025 118/7307/11/2025 118/7307/16/2025 115/6007/18/2025 113/85 On 07/24/2025 at 10:26 AM, Staff B, DNS, said all staff should be verifying medication orders and parameters before giving any medications. Staff B reviewed Resident 41's metoprolol order. When shown the dates the mediation was given outside the order parameters, Staff B said the medication should not have been given to the resident outside the parameter orders. <Non-pharmacological Interventions> Resident 41 was prescribed scheduled morphine (opioid) and oxycodone (opioid) for pain. Resident 41 had an order documenting non-pharmacological interventions (NPIs) including “1-Repositioning 2- Relaxation 3-Diversional Activities 4-Redirection” were to be used and effectiveness documented every shift. The TAR for July 2025 showed no NPIs had been documented. On 07/24/2025 at 10:26 AM, Staff B, DNS, said NPIs should have been attempted prior to administering any pain medication and confirmed no NPIs were attempted prior to pain medication administration. <Respiratory Care> 3) Resident 3 had a 09/25/2024 order for continuous O2 at 2 lpm via NC. On 07/17/2025 at 12:00 PM, 07/18/2025 at 2:33 PM, and 07/19/2025 at 12:58 PM, Resident 3 was lying in bed receiving O2 at 3 lpm via NC. On 07/24/2025 at 9:16 AM, Staff J, Unit Manager (UM), was asked to verify how much oxygen (liters/minute) Resident 3 was being administered. Staff J looked at the O2 concentrator and stated, “3.5 liters.” Staff J confirmed Resident 3's O2 order was for 2 lpm and acknowledged facility nurses had been administering O2 at a rate that exceeded the physician's order. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the July 2025 TAR showed on 07/17/2025, 07/18/2025, 07/19/2025 and 07/24/2025 facility nurses had documented they had administered Resident 3's O2 at 2 lpm as ordered. On 07/28/2025 at 12:31 PM, Staff J, UM, when asked if facility nurses were expected to document the rate of O2 delivered on their shift, Staff K said, “Yes.” Staff J then acknowledged that facility nurses erroneously documented they administered O2 at 2 lpm as ordered. <Air Mattress> Resident 3 had a 03/03/2025 order for a low air loss mattress for pressure redistribution. On 07/17/2025 at 12:00 PM, 07/18/2025 at 2:33 PM, 07/19/2025 at 12:58 PM, and 07/24/2025 at 8:41 AM, Resident 3 was observed lying in bed on a standard pressure reduction mattress in place. No air mattress had been placed as ordered. On 07/24/2025 at 9:16 AM, when asked if Resident 3 was on a low air loss mattress as ordered Staff J, UM, stated, No. Staff J said the resident was on one in their prior room and indicated the air mattress must not have been transferred with the resident when they changed rooms. Review of the July 2025 TAR showed the day shift nurses on 07/17/2025, 07/18/2025, 07/19/2025 and 07/24/2025 signed that they checked the placement and function of Resident 3's low air loss mattress. On 07/28/2025 at 2:06 PM, Staff J, UM, said facility nurses erroneously signed they checked the placement and function of the air mattress and acknowledged from at least 07/17/2025 - 07/24/2025, Resident 3 did not have a low air loss mattress. <Catheter Care> 4) Resident 31 had a 09/10/2024 order for catheter care every shift, and to ensure the catheter was securely anchored to prevent catheter related trauma. On 07/22/2025 at 12:36 AM, Resident 31 said their catheter was not secured with a catheter strap and pulled the leg of his shorts up, which revealed there was no securement device present. Review of the July 2025 TAR showed the day shift nurse on 07/22/2025, had signed Resident 31's catheter strap was in place. On 07/22/2025 at 1:21 PM, Staff Z, UM, after speaking with the resident and observing their catheter, confirmed Resident 31 did not have a catheter strap in place and indicated the nurse erroneously signed that one was present. <Edema> Review of the EHR showed Resident 31 had a 10/28/2024 order to apply compression stockings every morning for edema, and a 11/11/2024 order for pressure offloading boots to both feet when in bed. On 07/18/2022 at 2:16 PM and 07/22/2025 at 12:26 AM, Resident 31 was observed sitting or lying in (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	their bed without offloading boots in place. The resident's boots were observed sitting on top of a bookshelf across from the foot of the bed. Resident 31 reported that they seldom wore offloading boots. On 7/17/2025 at 3:12 PM, 07/18/2022 at 2:16 PM, and 07/23/2025 at 3:27 PM, Resident 31's compression stockings were not applied. Resident 31 stated, I told you the other day . I am lucky if I get them once or twice a week. Review of the July 2025 TAR showed on the above referenced dates; facility nurses signed that Resident 31's offloading boots were in place when in bed and that they applied the resident's compression stockings as ordered. During an interview on 07/23/2025 at 3:35 PM, Staff Z confirmed Resident 31's compression stockings were not applied and said the facility nurses signed that the tasks were completed in error. <Hold Parameters> 5) Resident 63 had a 09/26/2024 order for carvedilol (a blood pressure medication) twice a day, with instruction to hold the medication if the resident's SBP was less than 110, diastolic blood pressure (DBP) was less than 65 or their pulse (P) was less than 50. Review of the May and June 2025 MARs showed on the following dates/times nurses administered Resident 63's carvedilol outside of the physician ordered parameters. 05/18 5PM DBP = 64; administered. 05/26 8AM DBP = 64; administered. 05/26 5PM DBP = 61; administered. 05/28 5PM DBP = 60; administered. 05/29 5PM DBP = 60; administered. 05/30 5PM DBP = 54; administered. 05/31 5PM DBP = 63; administered. 06/03 5PM-DBP = 61; administered. 06/06 8AM-DBP = 49; administered. 06/06 5PM-DBP = 49; administered. 06/09 5PM-DBP = 48; administered. 06/10 5PM-DBP = 59; administered. 06/16 5PM-DBP = 64; administered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	06/17 5PM-DBP = 47; administered. Resident 63 had a 10/17/2024 order for amlodipine (blood pressure medication) once a day, with directions to hold the medication if the resident's SBP was less than 100 or their DBP was less than 60. Review of the June 2025 MAR showed on the following dates/times nurses administered Resident 63's amlodipine outside of the physician ordered parameters. 06/06 7PM-DBP = 48; administered. 06/09 7PM-DBP = 48; administered. 06/10 7PM-DBP = 59; administered. 06/17 7PM-DBP = 47; administered. On 07/22/2025 at 1:16 PM, Staff J, UM, confirmed on the above referenced dates, facility nurses administered Resident 63's amlodipine and carvedilol when they should have been held as ordered. <Medication Documentation without Administration> 6) Review of the EHR showed Resident 47 admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD, a disease that causes obstructed airflow from the lungs). Resident 47 was able to make needs known. During an interview on 07/17/2025 at 9:42 AM, Resident 47 said the facility was billing their insurance for medications they had not received. Resident 47 said they had not received Flonase (a nasal spray for allergies) however it was on their medication list. During an interview and observation on 07/17/2025 at 10:10 AM, Staff E, Licensed Vocational Nurse (LVN) checked the medication cart and said there was no Flonase for Resident 47. Staff E reviewed the EHR and verified a provider's order written on 07/15/2025 for Flonase. When asked about the initials on the MAR, Staff E verified they were their initials for administration of the Flonase on 07/16/2025 and 07/17/2025. Staff E stated, I must have just accidently checked the box that the Flonase was administered but it was not. During an interview on 07/17/2025 at 10:12 AM, Staff B, DNS, said the expectation was that staff signed for medications that have been administered to Resident 47. <Medication Order without Location> <Lack of Vitals> 7) Resident 22 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], showed they were cognitively intact. Review of Resident 22's orders showed they had a scheduled topical lidocaine patch, without a location listed for it to be applied to. Resident 22's orders showed they were taking scheduled oxycodone every 8 hours, with hold parameters for SBP less than 110, heart rate less than 60, or a respiratory rate less than 8. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 22's blood pressures showed only two values, taken 09/28/2024 and 03/20/2025. Review of Resident 22's heart rates and respirations showed their last values were taken on 05/18/2025. During an interview on 07/21/2025 at 2:42 PM, Resident 22 was asked about the frequency of their vitals. Resident 22 said staff rarely got vitals and this was not due to their personal preference. When asked if they wanted more vitals obtained, said yes that would be a good idea. During an interview on 07/22/2025 at 2:26 PM, Staff J, UM, said they expected vitals to be obtained with pain medication, and a typical resident should have daily vitals taken. For Resident 22, Staff J said their expectation was for vitals to be taken before staff gave oxycodone. Staff J reviewed Resident 22's blood pressures and said they only had two readings, which did not meet expectations. Staff J counted 25 heart rate readings in total, and said it should have been a lot better than that, as it should have been done with every medication with hold parameters. Staff J said Resident 22's lidocaine patch order should have a location listed and only said apply to skin. During an interview on 07/24/2025 at 12:45 PM, Staff B, DNS, when asked their expectation for staff when an order for lidocaine did not have a location in the order, said that it states the area affected or where it should be applied, for the nurse to know where to put it. Reference F686, F690 Reference WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i) .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review, the facility failed to ensure residents received the care they were assessed to require regarding cognitive services, laboratory testing, bowel management, podiatry services, dialysis services, and peripherally inserted central catheter (PICC) management for 8 of 18 sample residents (Resident 61, 22, 63, 3, 31, 4, 44 & 42) reviewed. These failures placed residents at risk for unidentified and unmet care needs, and a decreased quality of life.Findings included. <Cognitive Services> >Resident 61< Resident 61 was admitted to the facility on [DATE] with diagnoses of anxiety, depression, and unspecified disorder of adult personality and behavior (a diagnosis when a resident does not fit criteria for any specific personality disorder but still has significant impairment in social, occupational, or other important areas of functioning). The Quarterly Minimum Data Set (MDS, an assessment tool), dated 05/09/2025, showed Resident 61 was moderately cognitively impaired. Resident 61 was taking one scheduled antidepressant and one scheduled antianxiety medication. Review of Resident 61's provider note from 11/07/2024, showed the provider had a diagnostic statement that included vascular dementia, mild, with mood disturbance and dementia, mild or unspecified. The plan wrote, “Mild vascular dementia in the setting of heavy alcohol use and longtime nicotine dependence with Depression and Anxiety Plan: Encourage participation in social activities and games outside of room. Encourage increase in physical activity. Will continue to provide a safe environment for patient. Gradual cognitive decline to be anticipated. Monitor for sx [symptoms] of increased agitation, behavior disturbances.” Review of Resident 61's progress notes showed in April the psychiatry provider had listed on 04/10/2025 that Resident 61 was having worsening confusion and difficulty answering orienting questions, and became more irritable regarding perception that the facility was not showing a sufficient level of respect. The provider said their impression was that Resident 61 had an unspecified cognitive disorder, and believed Resident 61's cognitive function was significantly progressing. The provider recommended that a Saint [NAME] University Mental Status Examination (SLUMS, a screening test for Alzheimer's disease or other kinds of dementia) score be obtained to better approximate current cognition. Review of a progress note from the same psychiatry provider, on 04/24/2025, said Resident 61 did not recall who they (the provider) were from two weeks prior, remained confused with limited insight and frustration, and did not have insight into risks of smoking in the facility. The provider listed under their impression that Resident 61 had unspecified cognitive disorder, and recommended SLUMS. Review of Resident 61's care plans showed a care plan for “At risk for injury when smoking r/t [related to] Cognitive deficit,” added 11/08/2024, and an “impaired cognitive function/dementia or impaired thought process r/t neurogenic communication deficit [inability to communicate effectively due to damage or disease affecting the brain],” initiated on 07/20/2024. Review of Resident 61's diagnoses in the electronic health system being used by the facility, showed no diagnosis for a cognitive disorder. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 61's behavior monitors showed none for a cognitive disorder. During an interview on 07/22/2025 at 9:04 AM, Staff F, Social Services Director (SSD) was asked about Resident 61's diagnosis of unspecified disorder of adult personality and behavior and if they could explain anything about this diagnosis. Staff F stated, “no I can't” and explained this was not a diagnosis that they saw often. Staff F said Resident 61 could sometimes be nice, sometimes was not, could go from nice to irate, and could be verbally abusive to staff. Staff F said Resident 61 was followed by the inhouse psychiatric provider, and sometimes by the Alta Vista provider (an outside mental health provider) but they did not have records for those outside provider visits currently. When asked if Resident 61's care plan mentioned this diagnosis, Staff F said it was not separated and was tied into cognitive function and neurogenetic deficit. When asked if staff would know how to care for Resident 61 for this diagnosis, from the information in the care plan, Staff F said the care plan says to document behaviors. During an interview on 07/22/2025 at 2:26 PM, Staff J, Unit Manager (UM), said Resident 61 had inappropriate behaviors, could be aggressive, verbally abusive, resistive to assistance and care, and was forgetful and confused. When asked about the provider note from 11/07/2024 saying Resident 61 had vascular dementia and why the facility did not add this to his electronic record for diagnoses or pursued further as a diagnosis, Staff J said they were not at the facility at the time. When asked if it was an active diagnosis, Staff J said no. When asked about the psychiatric provider in April documenting Resident 61 had unspecified cognitive disorder twice, if the facility was implementing anything with this, Staff J said not that they were aware of. During an interview on 07/23/2025 at 12:40 PM, Staff B, Director of Nursing Services (DNS), reviewed Resident 61's active diagnoses in their electronic health system and said they did not see anything for a cognitive disorder. Staff B reviewed the behavior monitors and confirmed there were none for a cognitive disorder, only for anxiety and depression. When asked if staff should have followed up with the April psychiatry notes listing unspecified cognitive disorder or the November provider note listing vascular dementia, Staff B said absolutely. Staff B reported the most recent MDS showed Resident 61 had moderate cognitive impairment. <Laboratory Services> >Resident 22< Resident 22 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], showed they were cognitively intact and required substantial to maximal assistance with toileting hygiene. During an interview on 07/16/2025 at 10:26 AM, Resident 22 said they needed a blood test for their liver functions due to medications they were taking. Resident 22 said the tests had been ordered, the laboratory personal had come twice but were unsuccessful, and they usually needed ultrasound to get laboratory tests completed. Resident 22 said it had been a two month process of self-advocating for laboratory tests, which had not been completed. Review of Resident 22's orders showed laboratory tests were ordered on 05/21/2025 and 05/29/2025. Review of Resident 22's laboratory test results showed no completed laboratory test values for those dates. During an interview on 07/22/2025 at 2:26 PM, Staff J, UM, said the laboratory personal usually come (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/22/2025 at 2:26 PM, Staff J, UM, confirmed Resident 22 went from 07/03/2025 to 07/10/2025 and 07/12/2025 to 07/15/2025 without a bowel movement. When asked if Resident 22 had any progress notes or any as needed medications given for bowel stimulation, Staff J said not that they saw. Staff J looked at the scheduled docusate that was held on 07/15/2025 and said it documented the medication was not available. When asked if there were any progress notes about the bowel protocol for the dates reviewed, Staff J said no. During an interview on 07/24/2025 at 12:45 PM, Staff B, DNS, said their expectation for staff regarding the bowel protocol was for there to be standing orders, as needed medication to be given, what was done to help, and documentation of what was given and if it was effective. The dates listed above with no bowel movement were reviewed, Staff B said they were unsure of what had happened for Resident 22 related to the bowel protocol and they would have expected documentation. >Resident 63< Resident 63 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact. Review of the electronic health record (EHR) showed the resident had the following bowel care orders:a) MOM as needed, if no BM on third day. b) Dulcolax Suppository, administer one suppository rectally as needed, if no results from MOM after 12 hours. Review of the bowel record showed Resident 63 had no BM from 06/13/2025 - 06/19/2025 (7 days). Review of the June 2025 MAR showed Resident 63 did not receive any as needed bowel medication during the month. On 07/23/2025 at 3:50 PM, when asked if Resident 63 was provided MOM on the third day of no BM as ordered Staff J, UM, said, It does not appear so. >Resident 3< Resident 3 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact. Review of the EHR showed the resident had the following bowel care orders:a) MOM as needed if no BM on third day.b) Dulcolax Suppository, administer one suppository rectally as needed, if no results from MOM after 12 hours.c) Fleet Enema one application rectally as needed for constipation if no results from Dulcolax in 4-6 hours. If noresults from enema, notify provider. Review of the bowel record showed Resident 3 had no BM for the following periods:a) 06/24/2025 - 06/27/2025 (4 days).b) 06/18/2025 - 06/20/2025 (3 days). Review of the June 2025 MAR showed Resident 3 was not administered as needed bowel medication after three days without a BM, as ordered. On 07/23/2025 at 3:37 PM, Staff J, UM, said facility nurses should have administered MOM on 06/27/2025 and 06/21/2025 day shift, but did not. <Fluid Restriction> >Resident 31< Resident 31 was admitted to the facility on [DATE]. Review of the EHR showed a 09/26/2024 order for a 1500 milliliter (ml) per day (1500 ml/day) fluid restriction. Nursing would provide: 300 ml on day and evening shift and 180 ml on night shift for a total of 780 ml/ day. Dietary would provide 240 ml with each meal for a total of 720ml/day. A nutrition care plan, revised 04/17/2025, showed no water pitcher was to be in Resident 31's room. Review of the June 2025 MAR showed nurses recorded the amount of fluid they provided each shift, but there was no instruction, or place provided, for nursing to reconcile the fluids provided by nursing with the fluids provided with meals, to calculate Resident 31's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	total fluid intake/day. When the fluids provided by nursing was reconciled with the fluids provided at meals for the seven-day period of 06/24/2025 - 06/30/2025, revealed the following daily fluid intake totals:6/24 Nursing= 660; meals= 1720; Total= 2380- exceeded restriction.6/25 Nursing= 780; meals= 1309; Total = 2089- exceeded restriction.6/26 Nursing= 660; meals= 2240; Total= 2900- exceeded restriction.6/27 Nursing= 600; meals= 960; Total= 1560- exceeded restriction.6/28 Nursing= 780; meals= 660 , dinner not charted; Total= 1440; incomplete documentation.6/29 Nursing= 660; meals= 720, dinner not charted; Total= 1380; incomplete documentation.6/30 Nursing= 900; meals= 1460; Total= 2360- exceeded restriction.Of the seven days that were reconciled, Resident 31 exceeded the fluid restriction on five days and the other two had incomplete documentation. On 07/22/2025 at 12:50 PM, when asked how nursing determined if a resident was adherent with a fluid restriction, Staff Z, UM, said, nursing calculates the resident's total fluid intake per day. When asked if that occurred for Resident 31, Staff J stated, No. Staff J reviewed the seven days that were reconciled and confirmed Resident 31 exceeded the fluid restriction on five of seven days. Staff J acknowledged the failure to reconcile fluids provided by nursing, with the fluids provided at meals, precluded staff from determining if Resident 31 was adherent with the restriction and identifying that the restriction was frequently exceeded. <Positioning> <Resident 4< Resident 4 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 4 was cognitively intact. On 07/17/2025 at 10:32 AM, Resident 4 said they were not able to reposition themselves without assistance. Resident 4 said staff only turn them when they change their brief. On 07/22/2025 at 6:50 AM, Resident 4 said they needed help sitting up in bed, they felt “scrunched up” and it hurt being in this position. Resident 4 was leaning in the center of the bed with their feet about 1 foot from bottom of bed and had a rolled up blanket on top of pillow under their neck. Resident 4 said they had pressed the call light 10 minutes prior, Staff X, Certified Nursing Assistant (CNA) had responded and told them they needed to find another staff to assist and left the room. On 07/22/2025 at 7:42 AM, (52 minutes after the start of the observation, 1 hour and 2 minutes after Resident 4 said they pressed the call light button) Staff X, CNA and Staff KK, CNA, came into Resident 4's room and repositioned Resident 4. On 07/24/2025 at 10:26 AM, Staff B, said residents who required assistance with repositioning, should be repositioned at least every two hours. Staff B said it was expected that staff respond to call lights/repositioning in a timely manner, “as soon as possible.” When told about the observation on 07/22/2025 and residents reporting staff would come into the room, turn off the call lights and not return for 30 minutes to 2 hours, Staff B said that it was not acceptable. On 07/28/2025 at 2:10 PM, Staff A, Administrator, said call lights should be answered as soon as possible. When the observation on 07/22/2025 was explained, Staff A said that was not acceptable. When asked if it was acceptable for staff to turn off a resident's call light and not return for an hour or more, Staff A said no, it was not acceptable. (continued on next page)

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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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Dialysis Communication> >Resident 44< Resident 44 was admitted to the facility on [DATE]. The 5-Day MDS, dated [DATE], documented Resident 44 was moderately cognitively impaired. Resident 44 went to a dialysis (process of removing waste products and excess fluid from the blood) clinic three times a week. A provider's order, dated 04/29/2025, ordered staff to send the resident to the dialysis center with vital signs, the MAR, and to document the time of the last meal consumed. Record review of the Dialysis Communication Records from 07/01/2025 through 07/22/2025 showed no documentation that the vital signs, MAR, and time of last meal consumed had been sent with Resident 44. On 07/23/2025 at 1:25 PM, Staff V, Licensed Practical Nurse, when asked what information was sent with Resident 44 to dialysis said, we fill out our own vital signs here before dialysis but do not send that information to the clinic, we do not send the MAR. On 07/28/2025 at 10:21 AM, Staff B, DNS, when asked about vital signs, the MAR and time of last meal consumed being sent to dialysis with Resident 44, Staff B said staff had not been sending the MAR, and if an order was there staff should be following it or have the order changed. <Failed to provide podiatry services> >Resident 44< On 07/16/2025 at 1:36 PM, Resident 44 showed an area on the bottom of their right foot and said it hurt, and they had the area shaved off in the past. Resident 44 said they were waiting for the facility to set up a podiatry appointment and it had been a while now. Resident 44 said the area on their foot had grown back, it was like a hard corn, it hurt and made it hard to walk. Resident 44 said when they had first arrived at the facility they had told staff they needed the corn taken care of. Resident 44 said they had started going to the recreational room for a month and a half working out but they were not walking because it hurt, so they had to take the wheelchair everywhere they went and could probably walk if they did not have the corn. Review of Resident 44's orders showed the following order dated 06/22/2025, referral to podiatry to treat and evaluate painful hard lesion/callus to sole of foot. A second order, dated 07/02/2025, showed the resident was referred to podiatry for evaluation and treatment of corn on plantar surface of right foot. On 07/22/2025 at 12:24 PM, Staff F, Social Services Director, provided a list of residents who she had requested to be seen on 06/26/2025 and 06/27/2025 by the visiting podiatrist. Resident 44 was not on the list. Staff F said she had added some names to the list later but was unable to find that documentation. When told Resident 44 reported she has not been seen yet and still had an observable area on the bottom of their foot, Staff F said that it was not acceptable for an order to be put in on 06/22/2025, and Resident 44 not to have been seen yet. Staff F said if the podiatrist had not been able to see her at the facility, Resident 44 could have been sent out to see a podiatrist. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<PICC LINE> >Resident 42< Resident 42 admitted to the facility on [DATE]. The admission MDS, dated [DATE], showed Resident 42 was cognitively intact. Resident 42 had a PICC line in place. Review of physician's orders for Resident 42 showed they had an order, dated 06/24/2025, for PICC dressing change every 7 days and staff were to measure the upper arm circumference and external catheter length with each dressing change. Review of the Treatment Administration Record (TAR) from 07/01/2025 through 07/17/2025, showed the last PICC dressing change was on 07/09/2025, according to the orders a dressing change would have been due on 07/16/2025. Review of Resident 42's EHR showed that Resident 42 did not have arm circumference or external catheter length measurement documentation and did not have their PICC dressing change done on 07/16/2025. On 07/23/2025 at 8:27 AM, Staff B, DNS, when asked what interventions/orders are put in place for a PICC line said, flush before and after medication administration, the dressing needs to be changed weekly and as needed, and monitoring the site on a routine basis. When asked if arm circumference and external catheter length should be measured and documented with PICC dressing change, Staff B said, yes. When asked when Resident 42's last PICC dressing change was, Staff B confirmed it was on 07/09/2025. When asked about the arm circumference and external catheter length measurements, Staff B acknowledged there was an order for this, and it wasn't being documented. On 07/25/2025 at 8:15 AM, Staff B said Resident 42's PICC dressing should have been changed on the “16th or 17th” and it had not been done. Reference WAC 388-97-1060 (1)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure services were provided to increase range of motion (ROM) and/or to prevent further decrease in range of motion for 4 of 4 sampled residents (Resident 61, 47, 2 & 53) reviewed for limited range of motion. These failures placed residents at risk for a decline in functional abilities, discomfort and a diminished quality of life.Findings included… <Resident 61> Resident 61 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, as assessment tool), dated 05/09/2025, documented Resident 61 was moderately cognitively impaired and required extensive assistant with most cares. During interview and observation on 07/16/2025 at 12:28 PM, Resident 61 said their right-hand fingers had become more contracted since being at the facility, and they had repeatedly asked for an appointment with the Medial Director. Resident 61 said they had been told “no” when they asked to see the Medial Director and that they could soak the hand in hot water. Observation of Resident 61's right hand showed three of five fingers with a visible curve. Review of Resident 61's Occupational Therapy (OT) Evaluation and Plan of Treatment, dated 07/30/2024 - 08/28/2024, documented “initial hospitalization due to BLE [biliteral lower extremities] cellulitis and R [Right] index finger osteomyelitis [infection to bone] s/p amputation [after amputation].” Prior level of function for self-care was determined as independent. Reason for therapy documented “due to the documented impairments and associated functional deficit, without skilled therapeutic interventions, the patient is at risk for: falls, further decline in functional and increased dependency of caregivers. Resident 61 was ordered OT services for 30 days at a frequency of five days a week. Review of Resident 61's Occupation Therapy Discharge summary, dated [DATE], showed a discharge reason of “maximum potential achieved, referred to RNP [Restorative Nursing Program].” Review of provider note for Resident 61, dated 11/05/2024, documented “Contracture, right hand. Shows stiffness and contracture of right middle finger. Encourage right hand stretching and exercises to prevent worsening contractures of fingers. Will refer to PT/OT for evaluation.” Review of provider note, dated 11/21/2024, documented Resident 61 requested to be seen for pain to the joints in both hands and the resident described his finger was locking and the pain interfered with his sleep. A referral to OT to evaluate and treat hand weakness and locking as seen with 'trigger fingers. Review of a Nursing to Therapy Communication progress note, dated 11/24/2024, documented “Resident is showing a possible change in condition in the following areas: Other changes: Bilat hand weakness/locking.” Review of a nursing progress notes, dated 11/25/2024, documented “Writer spoke with resident, resident voiced concern regarding Right middle finger being stiff and flexed. [Provider] (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	communication form filled out regarding concern.” Review of provider note, dated 11/29/2024, documented Resident 61 had normal range of motion and was complaining of pain to both hands that was worse on the right hand joints with mild edema/swelling and without redness. Review of a provider note, dated 12/12/2024, documented Resident 61 was seen for 30 day follow up visit, complaining of pain and with contracted finger to right hand with the 3rd digit [middle finger] binding at the tip/contracted with stiffness Orders for a xray of the right hand was ordered and noted the referral made for OT at the provider's last visit. (11/05/2025) Review of a nursing progress note dated 12/14/2024, documented resident had xray completed to their right hand. Review of a nursing progress note, dated 12/15/2024, documented results of the right hand xray as, CONCLUSION: No acute fracture. Persistent third DIP [Dupuytren contracture is a genetic disorder that makes the tissue under the skin of your palms and fingers thicken and tighten] joint flexion may be due to ligamentous injury; trigger finger or contracture and results were placed in providers box with providers communication form for Medical Doctor or Nurse Practitioner follow up. Review of a Nursing to Therapy Communication progress note, dated 12/16/2024, documented “Resident is showing a possible change in condition in the following areas: Other changes: Right hand contracture.” Review of a nursing progress note, dated 12/17/2024, documented “Writer alerted to resident requesting to see a doctor regarding his right hand. Writer explained what was happening regarding his right hand. Physical Therapy (PT) referral, xray completed 12/14/2024, and referral to an outside clinic for Botox injections. Resident frustrated regarding his right hand. Provider notified of resident request to see external doctor regarding fingers. Review of provider note, dated 12/23/2024, documented “being seen today for contracture of right hand . had an amputation of his index finger and is fearful of needing to have another amputation if he does not get his hand fixed.” Patient reports he is waiting to begin therapy for his hand. Occupational Therapist, [Staff P], was present during today's visit and informed patient that she was performing his intake and that he will start therapy soon.” Review of Resident 61's Occupational Therapy Evaluation and Plan of Treatment, dated 12/23/2024,-,01/21/2025, documented Resident 61 had long standing history of contracture versus frozen joint with now increased limitation in PIP [proximal interphalangeal] and was referred to skilled OT services for splinting and treatment. The evaluation went on to document resident had contracture with functional limitations and decreased long finger extension. Resident 61's goals on the evaluation were documented as quoting the resident, saying, ‘No one has done anything for this hand, I just don't want to have an amputation again.' Clinical impressions documented, “patient presents with impairments in dexterity and strength resulting in limitations and/or participation restrictions in the areas of self-care which requires skilled OT services to assess safety and independence with self-care and functional tasks of choice, assess the need for adaptions/assistive devices, decrease painful condition of upper extremity, develop and instruct in exercise program, design and implement Restorative Nursing Programs and provision modalities and strengthening in order to decrease pain in upper extremities to allow for ADL [activities of daily (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	living] participation.” Review of provider orders, showed Resident 61 was ordered OT services for 30 days at a frequency of three days a week that started on 12/23/2024. Review of Resident 61's Electronic Health Record (EHR) showed Resident 61 participated in OT services on 12/23/2024, 12/24/2024, 12/26/2024, 01/02/2025, 01/03/2025, 01/04/2025, 01/07/2025, 01/08/2025, 01/10/2025, 01/14/2025, 01/16/2025, 01/18/2025, 01/21/2025, 01/24/2025, 01/25/2025 & 01/28/2025. Review of Resident 61's Electronic Health Record (EHR) showed Resident 61 did not have any formal therapies or RNP from 01/29/2025 to 06/10/2025 Review of Resident 61's Occupation Therapy Discharge summary, dated [DATE], documented discharge reason was, “highest practical level achieved” and documented resident was capable of putting on and taking off the PIP extension splint for continued use after discharge. Discharge recommendation was for 24-hour care and no RNP. Review of 61's Mobility Care Plan, initiated 07/30/2024, last updated 05/27/2025, documented RNP for ROM which included Omnicycle (hand bike) for bilateral upper extremities for 15 minutes, six days a week and for lower extremities level 2, 15 minutes, six days a week. There was no documentation in the mobility care plan to support or address contracture to right hand or the splint. In an interview, on 07/24/2025 at 9:30 AM, Staff L, Restorative Nursing Aide, said Resident 61 was currently in ROM services for strengthening, elbow flexion and transfer training. When asked about Resident 61's hand contracture, Staff L said they knew nothing about concerns with the resident's hand. In an interview, on 07/24/2025 at 9:53 AM, when asked about Resident 61's involvement in OT services, Staff M, Physical Therapy Assistant (PTA), said Resident 61 was in OT services earlier in the year. Staff M said Resident 61 was assessed and demonstrated appropriate taking on and off of their splint but eventually lost the splint. Staff M stated no other OT services for Resident 61's hand were provided after the 01/28/2025 discharge. In an interview on 07/25/2025 at 12:44 PM, Staff O, Director of Rehabilitation Services, when asked if Resident 61 was assessed to be at high risk for continued contracture formation during the OT eval and treatment that ended 09/09/2024, Staff O stated, “Yes and the 3rd digit was impaired, and the 4th within normal limits.” When asked about the delay between Resident 61 voicing their concerns on 11/05/2024 until 12/23/2024 (48 days) when services were started. Staff O indicated this was too long of a delay and said they would have expected to be notified as soon as a referral was made or a resident verbalized complaints. Staff O said that a ROM program for someone at high risk for contracture should have been six to seven days a week, not the three times a week that had been started in September of 2024. Staff O showed the Omnicycle as Resident 61's current ROM equipment but acknowledged the Omicycle would not range the fingers. Staff O confirmed the lost splint was never replaced. <Resident 47> Resident 47 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed the resident was cognitively intact, and participated in restorative nursing active ROM and walking programs during the assessment period A limited physical mobility care plan, initiated 03/20/2024, showed Resident 47 was to be provided with RNPs for upper and lower extremity ROM and an ambulation program six to seven days per week. Review of an initial restorative evaluation, dated 05/19/2025, showed the resident was assessed to require the following RNPs/frequencies: a) Ambulation – Ambulate 60 feet with a front wheeled walker and stand by assistance in the parallel bars six day per week. b) Upper extremity passive/active assisted ROM to bilateral shoulders, arms, wrist, fingers to all planes six to seven days per week. c) Lower extremity passive/active assisted ROM on NuStep (exercise machine that combines upper and lower body movement) six days per week. Review of the June 2025 restorative record showed Resident 47's ambulation program was offered 12 times, and their ROM programs were offered 19 times, rather than the minimum of 24 times they were assessed to require. Review of the July 2025 restorative record from 07/01/2025 – 07/21/2025, showed Resident 47's ambulation program was offered seven of 18 times, and their ROM programs 13 of 18 times. <Resident 2> Resident 2 was admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed the resident was cognitively intact, had impaired functional ROM to one upper extremity, and did not receive restorative nursing services during the assessment period. Review of an initial restorative evaluation, dated 05/19/2025, documented “Resident discharged from skilled therapies. Restorative program initiated by PT to maintain functional mobility. Includes active ROM program, to be performed up to 6 days weekly x15 minutes or to resident tolerance. Will review quarterly and as needed.” The June 2025 restorative record from 06/09/2025 – 06/30/2025 (23 days) showed Resident 2's ROM program was offered 10 of 18 times. Review of the July 2025 restorative record from 07/01/2025 – 07/21/2025, showed Resident 2 was offered their ROM program seven of 18 times. <Resident 53> Resident 53 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact, had no limitation in functional ROM of motion, and no restorative nursing services during the assessment period. Review of an initial restorative evaluation, dated 05/19/2025, documented that RNPs for ambulation (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and ROM were initiated by PT therapy following discharge from skilled services. A limited physical mobility care plan, initiated 03/28/2025, showed the resident would be provided a restorative ambulation program up to six times a week, and a lower extremity ROM program via omni cycle for 15 minutes, up to six times a week. Review of the June 2025 restorative record showed Resident 53 was offered their ambulation program and ROM program 17 of 24 times. Review of the July 2025 restorative record from 07/01/2025 – 07/21/2025, showed Resident 53's ambulation program was offered 9 of 18 times and their ROM program 11 of 18 times. Review of the restorative binder showed residents on RNPs were divided into two groups. Group One's RNPs were scheduled to be provided on Mondays, Wednesdays and Fridays (three times per week). Group Two's RNPs were scheduled for Tuesdays, Thursdays and Saturdays (three times per week). A note was added to all the RNPs that said at least three times a week, up to six times per week, regarding the frequency at which programs would be provided. On 07/23/2025 at 1:41 PM, when asked what determined if a resident would be offered/provided their RNPs three, four, five or six times a week (e.g. staff convenience and availability versus patient tolerance) Staff S, Restorative Aide, said it depended on patient tolerance. Staff S said that programs written for three to six times a week needed to be offered six times a week, and if the resident chose not to participate, a refusal should be documented. When asked why restorative staff were not offering residents their RNPs six times a week Staff S stated, “Not enough time.” On 07/23/2025 at 2:29 PM, Staff L, Restorative Aide, explained that Residents' RNPs were divided up into two groups, with one groups RNPs scheduled for Mondays, Wednesdays and Fridays and the other groups RNPs scheduled for Tuesdays, Thursdays and Saturdays (three times a week) to ensure residents received their programs at least three times a week. When asked why they didn't provide them all six times a week as they were assessed to require Staff L said they (restorative aides) have dining room duty for breakfast and lunch daily along with other extra duties, so they do not have time to complete the RNPs six times per week. When asked what determined if a resident would be offered/provided their RNPs three, four, five or six times per week, Staff L stated, “Staff convenience and availability.” On 07/25/2025 at 12:44 PM, when asked if a RNP for ROM provided three times a week would be effective in maintaining ROM and preventing contracture formation in residents who were identified to be at risk Staff O, Director of Rehabilitation Services, stated, “No, we do not write or recommend RNPs for three times a week. It is either six or seven days a week.” Reference WAC388-97-1060 (3)(d)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 residents were assessed and potential accident hazards/falls were thoroughly investigated for 3 of 3 residents (Resident 61, 58 & 20) reviewed for fall investigations. This failure placed residents at risk of falls, injury, and a diminished quality of life.Findings included.Review of the facility's policy titled Smoking Policy-Residents, revised 08/2022, showed the facility was to fill out Safe Smoking Evaluation forms on admission, quarterly, upon significant change, and as determined by staff. 1) Resident 61 was admitted to the facility on [DATE] with a diagnosis of weakness. The Quarterly Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 61 was moderately cognitively impaired. Resident 61 smoked cigarettes. Review of progress notes before the 01/14/2025 fall, showed on 12/17/2024 Resident 61 had requested to see a doctor regarding the fingers on their right hand.Review of a psychiatry visit note on 01/09/2025, showed Resident 61 expressed their primary concern was due to their right hand contracture that led to amputation.Review of the progress note on 01/14/2025, written by Staff K, Licensed Practical Nurse, showed that Resident 61 had an unwitnessed fall.Review of the facility's Accident and Incident Log (a log where facilities are required to record accidents and incidents, such as a fall with injury) showed this fall was not listed as unwitnessed. Review of Resident 61's fall packet for 01/14/2025, showed Resident 61 had a fall in the smoking area, where they reported, I dropped my cigarettes and was trying to pick them up. A box was selected that said Others present (staff, visitors, residents etc.), but it was reported as an unwitnessed fall in the progress note. The two witness/staff statements were from Resident 61 and Staff K, with Staff K having been in the conference room at the time of the fall. Under immediate measures put in place, written in was N/A [not applicable]. Under the section Why do you think the fall happened? Ask until you cannot ask why anymore, Staff K wrote, Slid out of chair. There was no further information provided on why Resident 61 slid out of the chair. The section for the scene to be drawn was empty. The resident was noted to be on a blood thinner, without any information on what the provider response was and if the resident was to be sent to the emergency room. Under resident factors (possibly contributing to fall), cognition and behavior problems were both blank. The 5 Whys Worksheet was blank, no identified root cause was filled out. Nowhere in the packet was information on if Resident 61's hands were reviewed as possible contributing factors, nor was the most recent Smoking Evaluation Form mentioned.Review of Resident 61's care plans showed on 11/08/2024, a care plan was initiated for at risk of injury when smoking related to cognitive deficit. Review of the Smoking Evaluation forms, showed Resident 61's most recent form, before the 01/14/2025 fall, was done on 11/07/2024. The evaluation said Resident 61 was not taking psychotropic medications (medications that affect the brain's function, processing, or mood) and had intact memory, which was not consistent with the record. The evaluation said Resident 61 was assessed to smoke independently. The evaluation done prior, on 10/30/2024, said Resident 61 had problems with short-term and long-term memory, was inconsistent and/or problematic with decision-making ability, and Resident 61's cognition did impact their ability to smoke independently. After the 01/14/2025 fall, the next Smoking Evaluation was not completed until 02/27/2025.Review of Resident 61's current Smoking Evaluation form, dated 05/25/2025, showed Resident 61 was not allowed to smoke. The evaluation stated, Resident previously had holes in belongings r/t [related to] smoking. Resident's cognition fluctuates, resident collects cigarette butts. Caught smoking in room on more than 1 occasion.During an observation on 07/22/2025 at 10:55 AM, Resident 61 was observed smoking outside with staff supervision. Review of Resident 61's 02/21/2025 Fall Packet, showed under Why do you think the fall happened? Ask until you cannot ask why anymore no staff or witnesses answered this. The licensed nurse (LN), was listed as being in the hallway during the fall. Under immediate investigation, which instructed staff to document using their (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(staff or witness) own words, the resident under what happened had documented tried transferring with assistance attempted to use dresser to steady but fell and for the licensed nurse in the hallway, under what happened, had written, Resident was trying to transfer using dresser. Fell. Under Certified Nursing Assistant (CNA), there is a date and location (room) of staff during the fall, but no name of the staff and no information included under what happened. The Post Fall Analysis Tool was blank, with no contributing factors filled in. During an interview on 07/22/2025 at 2:58 PM, when asked what they expect in an investigation for falls for a resident, Staff J, Unit Manager, said how they fell, why they fell, such as wrong footwear, witnesses, if they were trying to mobilize themselves, if they had low blood pressure or blood sugar. After reviewing Resident 61's fall investigations from 01/14/2025 and 02/21/2025, Staff J acknowledged the investigations were not thorough. Regarding the 01/14/2025 fall, when asked if they would have expected immediate measures to have been put in place to be included in the investigation, said yes. Staff J said there was no root cause for the fall. When asked if an updated smoking evaluation should have been completed after the fall, Staff J said yes. Staff J reviewed the 11/07/2024 Smoking Evaluation and confirmed it was not accurate. Staff J reviewed the 05/25/2025 Smoking Evaluation and acknowledged it said Resident 61 was not able to smoke and needed a new smoking evaluation. During an interview on 07/24/2025 at 12:45 PM, Staff B, Director of Nursing Services (DNS), was asked to review the fall investigations. For 01/14/2025, Staff B said it did not look like it was filled out completely, that staff were to draw the scene and did not, and they were unable to verify if staff informed the doctor that Resident 61 was on a blood thinner based on the Fall Packet. Staff B reviewed the progress notes for a root cause, and said they were unable to find an interdisciplinary team note with this information. When asked about if the fall related to smoking should have had an updated Smoking Evaluation done, Staff B stated, yes, right away. When told about Resident 61 being observed smoking outside with supervision, and the most recent Smoking Evaluation showing Resident 61 was not allowed to smoke, Staff B said Resident 61 should have an updated Smoking Evaluation done. 2) Resident 58 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed Resident 58 was cognitively intact.During a Resident Council meeting on 07/18/2025 at 2:06 PM, Resident 58 said three to four months previously they had fallen out of bed with their call light. Resident 58 said they had hit their head and their ear was bleeding, and they laid on the floor for half an hour until staff responded to the call light. Review of the Accident and Incident Log showed an entry of a fall on 01/22/2025 for Resident 58.On 07/25/2025 at 9:48 AM, Staff X, CNA said she recalled the fall incident for Resident 58, she had just started her shift and noted from the call light system that the call light had been on for 35 minutes. Staff X said she answered the light and found Resident 58 on the floor with blood on their ear, saying it was quite a bit of blood. When asked if she told anyone about the long call light time, Staff X said she told the nurse and filled out a fall report mentioning the long call wait time.Review of Resident 58's Fall Packet for the 01/22/2025 fall, showed nothing was listed under immediate measures put in place to protect the resident and ensure safety. For immediate investigation, there were no names listed for the LN or CNA that found the resident. Under what happened, the LN and CNA answers for what happened were identical, Found resident sitted on floor. Under why do you think the fall happened, it was blank for the resident, LN, and CNA. The draw the scene section was blank. Under was the resident on blood thinner, yes was selected with no further documentation on if provider was notified of the blood thinner and questioned on if the resident should have been sent to the Emergency Room. The 5 Whys Worksheet was blank, with no root cause listed. There was no fall report in the investigation, by Staff X. On 07/25/2025 at 12:50 PM, Staff A, Administer, said with regards to Resident 58's fall, a resident interview had not been conducted, and she could not provide a copy of Staff X's fall report. 3) Resident 20 admitted to the facility on [DATE]. Review of the Annual MDS, dated [DATE], documented Resident 20 was cognitively intact.On 07/23/2025 at 7:50 AM, Resident 20 said they had a fall and slipped on the floor in the shower room, and could not reach the call light cord. Resident 20 said the door had not been shut all (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the way and they were able to push their wheelchair out the door. At 9:11 AM, Resident 20 added that when they had fallen earlier in the year, they had dislocated their right shoulder, and they were sent to the hospital. Review of the facility's Accident and Incident Log, from 01/14/2025 through 07/15/2025, showed no entry for Resident 20.Review of Resident 20's Fall Packet from 02/24/2025, showed under immediate investigation that only an LN assisted the resident during the fall, who heard the resident yelling for help from the shower room. Under why do you think the fall happened, this was blank for both the resident and the LN. The packet did not have a 5 Whys Worksheet which reviews root cause, no additional paperwork was provided to show the fall was investigated for root cause. During an interview on 07/24/2025 at 2:17 PM, Staff B, DNS, when asked about components involved in the facility's fall investigations, said incident reporting, a fall huddle packet with investigative components, and the interdisciplinary team should meet to determine root cause and go over components of fall, determine new interventions, and update the care plan. When asked if an interview with the resident should be part of the fall investigation, Staff B said if they were cognitively intact, then absolutely. When asked about Resident 20's fall on 02/24/2025, Staff B reviewed the care plans and electronic health record, and said they did not see that specific fall care planned with new interventions, a solid interdisciplinary team note saying it was discussed with who was present and what interventions were going to be. Staff B said the care plan should have been updated to reflect what the new plan was going to be. Staff B was unable to find documentation that Resident 20 was interviewed regarding their fall. On 07/28/2025 at 10:27 AM, Staff A, regarding Resident 20's fall with injury and hospitalization, said it should have been logged on the Accident and Incident Log. When asked about Resident 20 reporting they were unable to reach the call light in the shower room due to the cords being too short, and having to push their wheelchair to open the door (not fully closed) to get assistance, and this not being found as their interview in the fall packet, Staff B said yes, that Resident 20 should have been interviewed as part of a complete investigation.Reference WAC 388-97-1060 (3)(g).

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. .Based on observation, interview, and record review, the facility failed to ensure sufficient qualified nursing staff were available to provide care and services as evidenced by information provided in Resident/Surveyor interviews for 10 sampled residents (Resident 45, 22, 47, 63, 4, 53, 31, 41, 66 & 58) interviewed, and 8 staff (Staff MM, NN, LL, GG, X, S, L & T) interviewed. The facility had insufficient staff to ensure residents received assistance with activities of daily living, restorative services and staff documentation. These failures placed residents at risk for unmet care needs and a diminished quality of life.Findings included .<Resident Interviews> On 07/16/2025 at 10:59 AM, Resident 45 said there were not enough staff, especially on night shifts. The Certified Nursing Assistants (CNAs) will sometimes respond in a timely manner, but the nurses take a long time. Resident 45 said they have waited for nurses to respond anywhere between 30 minutes to 3 hours. On 07/16/2025 at 1:12 PM, Resident 22 said the facility was always understaffed and the wait times for call lights were long. Resident 22 said they had to sit in their own feces for up to an hour and a half waiting for staff to come and change them. Resident 22 said staff will often come into the room, turn off the call light, tell them they will be back and do not return for hours. When asked how long they knew it had been an hour, Resident 22 pointed to the clock on the wall. On 07/16/2025 at 2:46 PM, Resident 47 said call light times were long, they have waited on the toilet for more than 30 minutes for staff to respond multiple times. On 07/17/2025 at 9:17 AM, Resident 63 said there were not enough staff, and they often have to wait over and hour to get staff to respond to the call lights. Resident 63 said many times staff will come in, turn off the call light, leave and not return. Resident 63 said they will push the call light button again. On 07/17/2025 at 10:11 AM, Resident 4 said there was not enough staff to address all the residents care needs, the staff were often rushed to get through the tasks and will often forget things like bringing in water. Resident 4 said it takes a long time for call lights to be responded to; mornings and afternoon were the busiest times. On 07/17/2025 at 10:36 AM, Resident 53 said they were supposed to get their medication at 8PM, most of the time they do not get their medications until after 12 AM. Resident 53 said they have to wait a long time for staff to respond to the call lights. Resident 53 said they had to sit in their own feces, waiting for staff to come and change them. Resident 53 said they believed they were starting to get sores, from not being changed in a timely manner. On 07/17/2025 12:37 PM, Resident 31 said the evening shift often has the longest wait times for staff to respond. Resident 31 said they had to sit on the toilet for up to two hours waiting for staff. On 07/17/2025 at 1:02 PM, Resident 41 said call light response times vary from instant response to waiting for 3 hours for staff to arrive. Resident 41 said the night shift was the worst about wait times. On 07/18/2025 at 2:31 PM, Resident 66 said some of the CNAs would come by, say this was not their room, “I am not your CNA,” they may say they will find you CNA and then leave, but then you can wait 30 to 45 minutes, they should at least check on what you need. During the same (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview, Resident 58 said just last week they were being escorted to the shower, he asked the CNA (name unknown) if they could set up things for the shower. The unidentified CNA told Resident 58 “I am working this hall, but you are not my resident.” On 07/21/2025 at 2:42 PM, Resident 22 said they were not able to get up and go to the dining room today, because there were not enough staff to help them get out of bed. When asked how this made them feel, Resident 22 said not important. <Staff Interviews>On 07/23/2025 at 9:33 AM, when asked about Resident 47 having been left on the toilet for over 30 minutes, Staff MM, CNA, said sometimes it happens when staff were not on the floor. On 07/23/2025 at 12:23 PM, when asked about Resident 22 not being able to get out of bed, Staff NN, CNA, said yes, it happens when the staff were busy, like today. On 07/24/2025 at 8:50 AM Staff LL, CNA, said they were able to get through most of their daily tasks, the hardest tasks to complete was getting all the residents their showers. 07/24/2025 at 8:58 AM, Staff GG, Licensed Practical Nurse said they were not able to complete all their daily assignments every day, the hardest task to complete was wound treatments. On 07/25/2025 at 9:48 AM, when asked about a specific fall with a resident, Staff X, CNA, said when they started their shift, they noticed the residents call light was on for 35 minutes and they found him lying on the floor with blood on right side on his ear and it was quite a bit of blood. When asked how long they knew the call light had been on, Staff X said we have a call light system, it tells how long someone has been waiting for. Staff X said it happens a lot more often when we get here in the mornings, staff stop answering and wait for morning people to arrive, it happens quite often. <Resident Council>Review of the March 2025 Resident Council meeting minutes, dated 03/17/2025, showed a resident (resident identified by first name only, no last name) said call lights were not being answered in a timely manner around shift change. Review of the May 2025 Resident Council meeting minutes, dated 05/08/2025, showed a resident (identified by room) was concerned about call lights being answered in a timely manner after lunch. <Infection Control>On 07/17/2025 at 12:52 PM, when told their name was provided (after two other names) as the current IP, Staff B, Director of Nursing Services (DNS), asked, “Who told you that?”. Staff B said they would clarify that they were the DNS and had infection control training. When asked if there was an IP at this time, Staff B said there was one that traveled to all the facilities, but since the change over in ownership, all the nurses had been pitching in to help with infection control. On 07/17/2025 at 1:18 PM, Staff E, Regional Registered Nurse, said Staff B was the designated IP due to having the certification. Staff E said the facility transferred ownership about 6 weeks ago and lost the IP that was shared between facilities, and the facility was attempting to recruit. <Restorative Services>On 07/23/2025 at 1:41 PM, when asked why restorative staff did not offer/provide residents' restorative nursing programs (RNPs) six times a week, Staff S, Restorative Aide (RA), said there was “Not enough time.” Staff S explained that on top of their (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	restorative duties, each RA had dining room duty for the breakfast and lunch meals, which on average took one hour per meal, so two hours per shift. Staff S said RAs were scheduled for an eight-hour shift, minus their 30-minute lunch and two hours for dining room duty leaves them with 5.5 hours to provide restorative services. Staff S said the RAs also had the following extra duties although they were not necessarily performed daily:a) clean wheelchair cushions and covers as needed.b) Check nurses' station refrigerators.c) Check Roho cushions for proper inflation.d) Perform weekly weights on all residents, which Staff L said Staff T did for 5.5 hours every Mondays and Staff L finished (for 2-3 hours) on Wednesdays. On 07/23/2025 at 2:29 PM, when asked why restorative staff did not offer/provide residents' RNP six times a week, Staff L, RA, explained that currently they only scheduled one RA on Sundays and Tuesdays, and on Wednesday half their shift was spent finishing resident weights. Staff L indicated on Mondays, Staff T, RA, spent their entire shift getting residents' weekly weights. Staff L indicated the restorative staff could offer/provide Residents' their RNPs six times a week if their work hours were spent on restorative services each day. Staff L said currently they could not offer/provide RNPs six times a week due to the amount of time their extra duties take them away from restorative services. On 07/28/2025 at 9:43 AM, Staff T, RA, agreed with Staff L and Staff S's assertions that the biggest barrier to providing residents' their RNP six times a week, was time. Staff T agreed that extra duties assigned to RAs took 2-3 hours per shift away from the provision of restorative services. <Administration Interviews>On 07/24/2025 at 10:26 AM, Staff B, Director of Nursing Services, said it was expected that staff respond to call lights/repositioning in a timely manner, “as soon as possible. When told about the observation on 07/22/2025 and residents reporting that staff would come into the room, turn off the call lights and not return for 30 minutes to 2 hours, Staff B said that it was not acceptable. On 07/28/2025 at 2:10 PM, Staff A, Administrator, said call lights should be answered as soon as possible. When the observation on 07/22/2025 was explained, Staff A said that was not acceptable. Staff A said they were alerted through the call light system if a call light has been on for more than 30 minutes. When asked if it was acceptable for staff to turn off a resident's call light and not return for an hour or more, Staff A said no, it was not acceptable. When asked if staff respond to the call light and do not provide care to the residents was acceptable, Staff A said no. Reference F585, F610, F688 & F882Reference WAC 388-97 -1080 (1), 1090 (1).

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. .Based on interview and record review, the facility failed to complete annual performance evaluation reviews for 3 of 3 sampled certified nursing assistants (CNAs) (Staff W, HH & JJ) reviewed for nurse aide performance reviews. This failure placed residents at risk for receiving care from unskilled staff and a diminished quality of life.Finding included .Staff W, CNA was hired 09/26/2016. Staff W's performance review was completed on 04/17/2024.Staff HH, CNA, was hired on 03/28/2023. Staff HH's last performance review was completed on 04/17/2024Staff JJ, CNA, was hired on 08/20/2021. Staff JJ's last performance review was completed on 04/17/2024On 07/28/2025 at 12:26 PM, Staff A, Administrator, said all staff records provided were full and complete records. Staff A said staff were reviewed annually. When shown the last annual review for the staff listed above, Staff A said all staff should have had their yearly performance reviews completed and documented. Reference WAC 388-97 -1680 (1), (2)(a-c).

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review, the facility failed to ensure monthly pharmacists recommendations for medication gradual dose reductions (GDRs) were responded to with accurate resident information and/or with completed resident-specific rationales for 3 of 4 (Residents 22, 61, & 41) reviewed for GDRs. This failure placed residents at risk of unnecessary medications and a diminished quality of life. Findings included.<Resident 22> Resident 22 was admitted to the facility on [DATE], with diagnoses including depression, anxiety, and bipolar disorder (mental health condition with extreme mood swings). The Quarterly Minimum Data Set Assessment (MDS), dated [DATE], showed they were cognitively intact. Resident 22 was taking scheduled psychotropic medications that included: one anticonvulsant/mood stabilizer, one antipsychotic, two antidepressants, and one antianxiety medication. Review of Resident 22's GDR review on 04/15/2025, showed the provider had declined the recommendations above because a GDR was clinically contraindicated for the resident. Under patient-specific rationale for why a GDR would likely impair function or cause psychiatric instability, the provider wrote, “Weekly panic attacks. Difficulty adjusting to facility with repeated desire to return home. Review of the electronic health record (EHR) showed no documentation to support weekly panic attacks. No behavior monitors were in place for psychotropic medications to suggest any of the medications were in place to reduce panic attacks. During an interview on 07/21/2025 at 2:42 PM, Resident 22 was asked about the panic attacks. Resident 22 said they occasionally occur once or twice a year, but since being at this facility has occurred one to two times every four months. When asked what helped with the panic attacks, Resident 22 reported breathing and calming down, that they dealt with it themselves by getting away from everyone. During an interview on 07/22/2025 at 2:26 PM, Staff J, Unit Manager, said they did not know about Resident 22's panic attacks and they were not in the care plan. During an interview on 07/24/2025 at 12:45 PM, Staff B, Director of Nursing Services (DNS), when asked about Resident 22's GDR documentation having mentioned weekly panic attacks and this not being supported in the resident's record, said there should have been a psychotropic medication (medications that affect the brain's functioning) meeting with the practitioner, DNS, pharmacist, psychiatrist, social services director, unit managers, and the resident. Staff B said they should have discussed with the resident which medication would be most appropriate to treat and monitor the panic attacks. Staff B said the panic attacks should have been investigated further to close the loop. When asked if the panic attacks should have been added to Resident 22's behavior monitors, if any of the psychotropic medications were treating this, said yes. <Resident 61> Resident 61 was admitted to the facility on [DATE] with diagnoses of anxiety, depression, and unspecified disorder of adult personality and behavior (a diagnosis when a resident does not fit (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	criteria for any specific personality disorder but still has significant impairment in social, occupational, or other important areas of functioning). The Quarterly MDS, dated [DATE], showed Resident 61 was moderately cognitively impaired. Resident 61 was taking one scheduled antidepressant and one scheduled antianxiety medication. Review of Resident 61's GDR form, dated 05/15/2025, showed the provider had declined a GDR and the section that said “Please provide CMS [Centers for Medicare & Medicaid Services, a federal agency] REQUIRED patient-specific rationale describing why a GDR attempt is likely to impair function or cause psychiatric instability in this individual” was left blank. During an interview on 07/22/2025 at 2:58 PM, Staff J, Unit Manager, reviewed the 05/15/2025 GDR for Resident 61 and confirmed there was no patient-specific documentation for the declination. During an interview on 07/24/2025 at 12:45 PM, when asked their expectation for patient-specific documentation, Staff B, DNS, said that it should have been put on the GDR form or in a separate progress note. Staff B reviewed Resident 61's GDR form and the EHR and said they could not tell why the GDR was not done. <Resident 41> Resident 41 was admitted to the facility on [DATE]. The Annual MDS, dated [DATE], documented Resident 41 was cognitively intact. Resident 41 was prescribed buspirone (antianxiety) and clonazepam (antianxiety) for anxiety, duloxetine (antidepressant) for neuropathy (often described as stabbing, burning, or tingling sensations, that can occur due to nerve damage or malfunctioning of the nervous system, affecting peripheral nerves, spinal cord, or brain) and quetiapine (antipsychotic) for bipolar disorder. The EHR documented Resident 41 was recommended on 02/18/2025, for a GDR of clonazepam or for the provider to indicate if the GDR was contraindicated. Staff FF, Advanced Registered Nurse Practitioner, declined the GDR on 02/25/2025, checking it was clinically contraindicated for Resident 41. Staff FF provided no patient specific rationale documentation as to why the GDR was contraindicated. The EHR documented Resident 41 was recommended on 05/13/2025 for a GDR of either clonazepam, buspirone, duloxetine or quetiapine, or for the provider to indicate if the GDR was contraindicated. Staff FF declined the GDR on 05/22/2025, checking it was clinically contraindicated for Resident 41. Staff FF provided no patient specific rationale documentation as to why the GDR was contraindicated. On 07/24/2025 at 10:26 AM, Staff B, DNS, was asked to review Resident's 02/18/2025 and 05/13/2025 pharmacy GDR recommendations. Staff B confirmed Staff FF failed to provide a patient specific rationale contraindication for Residents 41's recommended GDR. When asked what should happen when the provider failed to provide documentation for a clinically contraindicated GDR, Staff B said the provider should have entered a progress note, and the no patient-specific rationale should have been caught and addressed by staff. Reference WAC 388-97 -1300 (4)(c).

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Port Washington Post Acute	140 South Marion Avenue Bremerton, WA 98312

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. .Based on observation, interview and record review, the facility failed to ensure medications were dated when opened when required, and expired medications were discarded in accordance with professional standards of practice for 1 of 1 medication room, and 1 of 2 medication carts (B Hall Cart) reviewed. Additionally, facility staff failed to ensure treatment carts were closed and locked when left unattended and unsecure medications were not left at bedside. These failures resulted in residents having unsupervised access to medications and biologicals not intended for their use, and for receiving expired/outdated medications. Findings included .<Medication Room> Observation of the Medication Room on 07/28/2025 at 1:45 PM, with Staff H, Medication Technician, revealed the following:1) A multiuse vial of Tuberculin Purified Protein Derivative (PPD) with an open date of 06/23/2025. 2) A multiuse vial of Tuberculin PPD with an open date of 06/25/2025.3) A multiuse vial of Tuberculin PPD that was opened and undated.Review of the Tuberculin PPD package insert, showed vials were to be dated when opened and discarded after 30 days. Staff H, Medication Technician, confirmed the PPD vials with open dates of 06/23/2025 and 06/25/2025 were expired, the third vial was not dated when opened, and confirmed all three vials needed to be discarded. <B Hall Medication Cart> Observation of the B Hall Cart on 07/24/2025 at 9:34 AM, with Staff Z, Unit Manager, showed the following:1) Resident 3- Spiriva Respimat inhaler was opened and undated. The package insert showed the inhaler was to be dated when opened and discarded 90 days after opening.2) Resident 47- A lispro insulin pen was opened and undated. The package insert showed the lispro pen was to be dated when opened and discarded 28 days after opening.Staff Z, Unit Manager, confirmed the two above-mentioned medications were opened and undated, and needed to be discarded. <Unsecured Treatment Cart> On 07/18/2025 at 10:48 AM, the A Hall treatment cart was observed unlocked and unattended with the bottom drawer pulled out. Observation of the contents of the bottom drawer showed a large container of bio freeze cream, a purple top container of Sani-Cloth germicidal wipes, anti-fungal powder and saline enemas. The contents of the four unsecure drawers above the bottom drawer, were unknown. Staff DD, Certified Nursing Assistant, approached the cart on 07/18/2025 at 10:51 AM, and closed and locked the cart. On 07/21/2025 at 11:54 AM, Staff Z, Unit Manager, said nurses were expected to secure/lock their medication/treatment carts prior to leaving them unattended. <Medication at Bedside> On 07/21/2025 at 11:54 AM, 2 bottles of Nystatin powder, a prescription anti-fungal medication, were observed on the bedside table of a resident. At 07/21/2025 at 12:12 PM, Staff V, Licensed Practical Nurse, entered the resident's room, confirmed the 2 bottles were Nystatin medication, and said they should not be stored in the room. On 07/23/2025 at 8:23 AM, Staff B, Director of Nursing Services, when asked if medication should be left at the bedside, stated, “absolutely not”. When told of the observation of the 2 bottles of Nystatin medication observed at bedside, Staff B said this did not meet her expectations and the medication bottles should have been locked and secured. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference WAC 388-97-1300 (2) .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. .Based on observation, interview, and record review, the facility failed to prepare and serve palatable food under sanitary conditions when reviewed for kitchen. These failures placed residents at risk of foodborne illness, meal displeasure and a diminished quality of life.Findings included .<Brief Initial Tour>Observation on 07/16/2025 at 9:37 AM, showed 10 loaves of undated opened and unopened bread.Observation on 07/16/2025 at 9:38 AM, showed a shop fan with visible debris blowing in the direction of freshly baked uncovered rolls.<Follow Up Visit>Observation on 07/18/2025 at 9:45 AM, showed Non-Staff Member RR, sitting in the kitchen on their cellphone without a hair restraint.Observation on 07/18/2025 at 9:47 AM, showed Staff C, Dietary Manager assisting in the kitchen without a hair restraint.Observation on 07/18/2925 at 9:49 AM, showed Staff PP, Dietary Aide, in the kitchen assisting with dishes with a long unrestrained beard.Observation on 07/18/2025 at 10:43 AM, showed Staff SS, Dietary Assistant Director, put multiple slices of pork in a Black and Decker blender and turned it on. At 10:53 AM, Staff SS was observed filling a pitcher of hot water from the coffee machine and pouring unmeasured amounts of water into the chopped pork blender.Observation at 07/18/2025 at 10:57 AM, showed Staff SS added 1 scoopful of powder to the blended pork followed by an additional amount of unmeasured water. Staff SS blended the mixture again, checked the consistency with a spatula and then placed it in the warmer.During an interview on 07/18/2025 at 11:00 AM, Staff SS said the powder added was a thickener. Staff SS said the facility provided a recipe to follow when preparing puree for meals. Staff SS said they used 3 oz of pork, 1/4 teaspoon of thickener and 1 cup of water. Staff SS noted the facility industrial blender broke over a week prior, so they used a small Black and Decker blender which made prepping puree challenging.Review of production recipe on 07/18/2025 at 11:30 AM, showed the recipe called for 3 oz of meat, 3/4 teaspoon of food thickener and 2 tablespoons of water or stock.During an interview on 07/18/2025 at 2:49 PM, Staff C, Dietary Manager, said anyone who entered the kitchen should wear a hair restraint for sanitation purposes. Staff C said the food items including bread should have been dated and all foods should have been covered after preparation. Staff C said dietary staff were to follow recipes when preparing meals including puree and that it did not meet expectations.During an interview on 07/16/2025 at 2:57 PM, Staff A, Administrator, said the uncovered prepared food and undated food items did not meet their expectations.Reference WAC 388-97-1100 (3), -2980.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review, the facility failed to ensure their antibiotic stewardship program tracked and monitored infections by completing monthly antibiotic line lists (a system to track all the infectious organisms in the building, to make sure they met criteria for antibiotic usage) with complete lists of symptoms, reevaluating residents for continued antibiotic use, and/or ensuring antibiotic stewardship by following up with staff with education regarding proper containers for urine cultures for 3 of 3 months (Months: April 2025, May 2025, and June 2025) reviewed. This failure placed residents at risk of unnecessary medication, the development of multidrug resistant organisms (MDROs), and a diminished quality of life.Findings included.During an interview on 07/17/2025 at 1:18 PM, Staff B, Director of Nursing Services, said the facility used McGeer's criteria for screening residents for antibiotic usage. Review of the April 2025 Antibiotic Line List, showed Resident 49 did not meet criteria for continued antibiotic usage according to the Revised McGeer's criteria. Resident 49 was listed with the symptom of dysuria (pain or burning with urination) starting on 03/30/2025 and their urinalysis (UA, urine test for urinary tract infection(UTI)) was negative. Review of Resident 49's progress notes from 03/23/2025 to 04/06/2025, showed Resident 49 had painful urination that was only mentioned on 03/30/2025; on 04/04/2025 they refused all medications and on 04/06/2025 they refused their antibiotic because they felt fine. Review of the April 2025 Antibiotic Line List, showed Resident 49 started antibiotics on 04/02/2025.Review of Resident 49's Infection Screening Evaluation, on 04/02/2025, showed the only symptom Resident 49 had was acute dysuria. The form showed the facility had used two conflicting screening forms for antibiotic initiation, Loeb's criteria and McGeer's criteria, to determine if Resident 49 met criteria for antibiotic usage. At this time, the UA had not resulted and McGeer's criteria could not have been evaluated without the sample, and there was no progress note on if the facility had attempted to follow up on the UA results.Review of Resident 49's UA results showed it resulted to the facility on [DATE] at 11:26 AM, after being received by the laboratory on 03/31/2025. The electronic health record, showed no record of Resident 49 being reevaluated on 04/05/2025 due to the negative urine culture. Review of Resident 49's symptoms and UA results with the Revised McGeer Criteria Checklist, showed that a UTI must complete both categories 1 and 2 to meet criteria. For 1, it was met by dysuria. For 2, it was not met at this time as there were no bacteria in the UA sample. Review of Resident 49's antibiotic stewardship progress note, dated 04/07/2025, documented, UA was collected and noted to have negative nitrates, negative for bacteria, slightly elevated WBC (white blood cell count). Culture not completed at this time. Provider ordered ABO [antibiotic] to be given. Resident received the dose of Ceftriaxone IM [intramuscularly] and 4 doses of Augmentin [oral antibiotic] but has been refusing x 2 days. Resident states he is no longer having issues and does not want the ABO. Resident has been educated on the importance of completing the course of ABO. Criteria was met for ABO use.During an interview on 07/24/2025 at 9:30 AM, when asked how many days Resident 49 had painful urination, Staff B said the antibiotic line listing was missing this. When asked if there were any other symptoms, Staff B said they were not aware of any other symptoms. After reviewing the antibiotic stewardship progress note from 04/07/2025, Staff B said that there should have been a discussion with the provider to discontinue the antibiotic due to the resolution of symptoms, and about the antibiotic usage not meeting McGeer's criteria. When asked how the facility tracked which residents did or did not meet criteria for antibiotic usage, as the April 2025 Antibiotic Line List did not have a column for this, Staff B acknowledged there was not a column and said there needed to be a better line listing. When asked how education could be provided to staff if this was not being tracked, Staff B said it needed to be tracked, reviewed in meetings, and reviewed for McGeer's criteria.Review of the April 2025 Antibiotic Line List, showed Resident 4 had a positive UA test showing a UTI, but no urine culture (test to determine organism(s) present to allow providers to select the most effective (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	antibiotic and prevent prescription of antibiotics that will be ineffective) was completed.Review of Resident 4's UA test results, resulted on 03/30/2025, showed the urine culture was not performed due to improper specimen submittal.Review of the April 2025 Antibiotic Line List, showed Resident 4 started oral antibiotics, ciprofloxacin, on 04/02/2025. No other antibiotics were listed. The line list showed Resident 4 had painful urination and abdominal pain, with an onset date of 03/26/2025.Resident 4's progress notes were reviewed from 03/25/2025 to 04/01/2025. On 03/25/2025, nursing had noted Resident 4 had just been treated for a yeast infection and was having symptoms of burning and irritation to the vaginal area. During these dates reviewed, no other progress notes noted any symptoms. On 04/01/2025, an alert note showed res[ident 4] is on day 2/7 IM [intramuscular] ABT [antibiotic treatment] Ceftriaxone for complicated UTI. Res is afebrile and has no s/s [signs/symptoms] of adverse reactions.Review of Resident 4's antibiotic stewardship progress note from 04/02/2025, showed Resident with c/o [complaint of] dysuria, pelvic pain and fatigue to provider.During an interview on 07/24/2025 at 9:30 AM, when asked how the facility knew a resident was on the right antibiotic without a culture completed, Staff B stated Exactly. For Resident 4, Staff B said the specimen quality was inadequate and not performed, and someone should have followed up on this with the provider. When asked what kind of education or follow up was done with staff to prevent a similar situation of a resident having a UA but no culture performed due to incorrect specimen container, Staff B said staff should have had more education/reeducation. For if the antibiotic line listing for Resident 4 should have included burning and irritation to the vaginal area, Staff B said yes. Documentation was requested for May and June 2025 antibiotic line lists, none were provided. During an interview on 07/24/2025 at 9:30 AM, Staff B said antibiotic line lists were important because they allowed the facility to know what residents' symptoms were, track them, and to see what was going on overall. Staff B confirmed there were no antibiotic line list for May or June 2025. No Associated WAC.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. .Based on interview and record review, the facility failed to ensure they had a designated infection preventionist (IP) for the facility, to ensure the program monitored, tracked, and trended antibiotics and infections throughout the entire facility for 2 of 3 months reviewed (May 2025 and June 2025). This failure placed residents at risk of infection, unidentified care needs, and a diminished quality of life.Findings included.During the Entrance Conference on 07/16/2025, Staff A, Administrator, provided a staff name for the IP role. After the Entrance Conference, at 11:37 AM, Staff A sent an email with another staff name listed as IP. During an interview on 07/17/2025 at 12:39 PM, when asked who they reported an antibiotic resistant organism or contagious disease to, Staff K, Licensed Practical Nurse, said infection control, which was now being handled by the unit managers. During an interview on 07/17/2025 at 12:52 PM, when told their name was provided (after two other names) as the current IP, Staff B, Director of Nursing Services (DNS), said they would clarify that they were the DNS and had infection control training. When asked if there was an IP at this time, Staff B said there was one that traveled to all the facilities, but since the change in ownership, all the nurses had been pitching in to help with infection control.On 07/17/2025 at 1:18 PM, Staff E, Regional Registered Nurse, said Staff B was the designated IP due to having the certification. Staff E said the facility transferred ownership about six weeks prior and lost the IP that was shared between facilities, and the facility was attempting to recruit.Review of infection control surveillance documentation was provided on 07/18/2025 for January, February, March, and April 2025. Staff A emailed and said the facility had transitioned to a new management group and was now using an infection control surveillance process that was integrated into their electronic health system. During an email on 07/21/2025 at 12:20 PM, Staff A, when asked for May and June 2025 antibiotic line listing records, wrote, The records provided were from January until April and demonstrating the detailed work of the facility's traveling IP nurse prior to our transition. No additional facility wide antibiotic line listing or infection surveillance reports were provided. During an interview on 07/24/2025 at 9:30 AM, Staff B was asked the purpose of infection surveillance. Staff B said it was to identify outbreaks, to mitigate and not have things spread, it defined who had what and in what room, and involved isolation depending on what was going on to prevent the spread to others. When asked how the facility was providing ongoing analysis of surveillance data and documentation of follow-up activity in response, Staff B said the facility was inputting the information into the electronic health system and could get a report, it would be printed and analyzed, and the facility could do a map (using facility floor plan to show rooms where certain organisms were present) to designate rooms. When asked to confirm that a map of organisms was provided for April 2025 but none for May or June 2025, Staff B confirmed this. When asked to confirm that an infection control summary was done for April 2025, but none for May or June 2025, Staff B confirmed this. When asked their expectations for the facility, related to monthly documentation of the infection control summary which discusses trends, analysis, and a plan, Staff B said they should have it done, it should be addressed in monthly quality meetings, and anything identified should have been followed up on. Staff B was asked about not knowing the IP role was part of their role and the administrator giving two other names, if they were given any designated time to work in the role of IP before 07/16/2025. Staff B said they were not told and had no official amount of time for performing IP duties. Reference F881, F887No Associated WAC.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review, the facility failed to ensure residents received COVID-19 vaccinations for 3 of 6 residents (Residents 4, 22, & 39) reviewed for vaccinations. This failure placed residents at increased risk of complications from contracting COVID-19 and diminished quality of life.Findings included.Review of the facility's infection surveillance documentation, from a COVID-19 outbreak in February 2025, showed 38 residents tested positive for COVID-19. For vaccination status listed, only 1 resident of the 38 was listed as up to date.1) Resident 4 was admitted to the facility on [DATE].Review of Resident 4's electronic health record (EHR), showed they tested positive for COVID-19 on 02/08/2025.Review of Resident 4's documents from admission, showed they had a COVID-19 vaccine on 02/02/2021. Review of Resident 4's COVID-19 vaccination record, showed they had not had the vaccine while at the facility. Review of Resident 4's progress notes from 07/01/2025, showed they were requesting the COVID-19 vaccine. During an interview on 07/22/2025 at 7:11 AM, Staff B, Director of Nursing Services (DNS), said the purpose of giving COVID-19 vaccinations was for anyone who would get COVID-19, that they could have lesser symptoms. When asked how often vaccines should be reviewed or offered, Staff B said they should be offered on admission and in the early fall for COVID-19. When asked about documentation on admission, Staff B said their expectation was for it to be offered and residents could consent or decline, based on what they previously had, and it should have been in the resident's chart. When asked for expectation for timeliness of vaccination, Staff B said as soon as was possible. When asked about Resident 4 having an admission order saying they could have the COVID-19 vaccine and if there was a reason for them to have not received one at that time, Staff B said this was an order for everyone on admission, and they did not see any record of Resident 4 having been given a COVID-19 vaccine on admission. When asked if they could confirm Resident 4 had not had any COVID-19 vaccines during this whole admission, Staff B said they had not. On 07/22/2025 at 12:48 PM, Staff B provided documentation for Resident 4's historical COVID-19 vaccine, for 05/28/2024, obtained from the Washington State Immunization Information System on 07/22/2025. The document had a recommended date for the next COVID-19 vaccine as 08/22/2024 with an overdue date of 09/18/2024, with a status of Past Due.During a follow up interview on 07/22/2025 at 1:24 PM, Staff B, when asked if there was no record of the 05/28/2024 COVID-19 vaccine by the facility until today, said yes. When asked if from the document provided, if it gave a recommendation for another dose, Staff B said usually they are given in the fall, offered annually. 2) Resident 22 was admitted to the facility on [DATE].Review of Resident 22's EHR, showed they tested positive for COVID-19 on 02/04/2025.Review of Resident 22's COVID-19 vaccination record, showed they had only been administered the vaccine once while at the facility, on 03/13/2025. During an interview on 07/22/2025 at 7:11 AM, when asked if there was a reason Resident 22 had not received the COVID-19 vaccine on admission, Staff B said that was early [NAME] when they offer it and based on the EHR could say Resident 22 did not get one at that time. When asked about the COVID-19 outbreak in February of 2025, Staff B confirmed Resident 22 was only vaccinated after testing positive for COVID-19. The COVID-19 outbreak documentation was reviewed, and Staff B said it appeared quiet a few residents had not gotten the COVID-19 vaccine at that time.3) Resident 39 was admitted to the facility on [DATE]. Review of Resident 39's COVID-19 vaccine records showed they had been given one on 08/16/2024. Review of Resident 39's EHR showed a consent for the COVID-19 vaccine from 04/29/2025. A progress note on 07/01/2025 also showed Resident 39 was eligible and consented to the COVID-19 vaccine. On 07/18/2025, a progress note showed Resident 39 tested positive for covid. During an interview on 07/22/2025 at 7:11 AM, Staff B acknowledged Resident 39 had not gotten the COVID-19 vaccine since consented for in April (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2025. When asked if it met expectations that they were not given the consented for vaccination, Staff B said it did not meet expectations. No Associated WAC.

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. .Based on observation and interview, the facility failed to ensure kitchen equipment was maintained in a safe, functional, and working condition for 1 of 1 sampled freezer when reviewed for kitchen. This failure placed residents at risk of inadequate meal quality and a diminished quality of life.Findings included .Observation during the brief initial tour on 07/16/2025 at 9:34 AM, showed no thermometer in the freezer.Review of the freezer temperature log on 07/16/2025, showed the log was completed for the dates 07/16/2025 and 07/17/2025 with documented temperatures of zero degrees.During an interview on 07/16/2025 9:45 AM, Staff C, Dietary Manager, said they could not locate a thermometer for the freezer and had no knowledge of which staff member had documented the temperatures for 07/16/2025 and 07/17/2025. Staff C said the expectation was for staff to take the freezer temperatures every morning and afternoon, and document them accurately.During an interview on 07/16/2025 at 2:15 PM, Staff G, Corporate Maintenance, said the walk-in freezer temperature was between 15-17 degrees. Staff G said they cleaned the coils and planned to wait 30 minutes to see if the freezer temperature would drop to the appropriate temperature.Observation on 07/17/2025 at 8:45 AM, showed the freezer was empty of all contents.During an interview on 07/17/2025 at 9:00 AM, Staff A, Administrator, said the freezer was inoperable and they were waiting for an outside vendor to repair the freezer. Staff A said the expectation was for staff to take the freezer temperature and document as directed. Staff A said staff were expected to immediately report issues/concerns with facility equipment.Reference WAC 388-97-1100(2).

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure they informed and provided written information to residents on their right to formulate an advance directive (AD, written instruction for the provision of health care when the individual is incapacitated, such as a living will or durable power of attorney (POA) for health care) for 2 of 4 residents (Resident 4 & 1) reviewed for advance directives. This failure placed residents at risk for not having their choice of who to care for them when incapacitated, not having their health care wishes honored, and a diminished quality of life. Findings included . <Resident 4> Resident 4 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool) dated 04/11/2024, documented Resident 4 was cognitively intact. Resident 4's AD care plan documented the resident did not have an AD and declined to formulate an AD. The electronic health record (EHR) showed no documentation Resident 4 was offered and had accepted or declined to formulate an AD. On 07/22/2025 at 12:03 PM, Staff F, Social Services Director, said the facility offers the AD at care conferences. When asked to locate Resident 4's AD, Staff F was unable to locate documentation supporting if Resident 4 was offered and had accepted or declined to formulate an AD. Staff F said Resident 4 did not have an AD. <Resident 1> Resident 1 was admitted to the facility on [DATE]. The 5-Day MDS, dated [DATE], documented Resident 1 was severely cognitively impaired. Resident 1's AD care plan documented the resident did not have an AD formulated, was his own health care decision maker, and instructed if warranted due to MD (Medical Doctor) evaluation activate resident's POA (power of attorney) document. Review of the EHR showed no documentation of a POA document for Resident 1. On 07/21/2025 at 10:17 AM, Staff F, SSD, when asked if Resident 1 had an AD, said no, that in Resident 1's care conference it had been discussed and Resident 1's son and wife did not want to formulate an AD at the time. When asked about the care plan that documented Resident 1 had a POA, Staff F said that was documented in error and that Resident 1 did not have an active POA and that the documentation showing Resident 1's family had been offered education regarding formulating an AD could not be located. Reference WAC 388-97-0280(3)(c)(i-ii) .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation, interview and record review, the facility failed to provide personal privacy during personal care for 1 of 1 sampled resident (Resident 45) reviewed for privacy. This failure placed residents at risk of loss of privacy during personal care, embarrassment and a decreased quality of life.Findings included .Resident 45 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (an assessment tool), dated 05/01/2025, documented Resident 45 was cognitively intact.On 07/16/2025 at 11:08 AM, Resident 45 said they had an incident with Staff F, Social Services Director (SSD), Staff Z, Unit Manager (UM) and an unidentified Certified Nursing Assistant (the CNA was later identified as Staff AA). Resident 45 said all three staff members had taken them to the shower room for a shower. While in the shower room, Staff F had taken the hose with the spray nozzle and was spraying them down with the hard force of the water from the nozzle head, telling the CNA, This is how you shower a resident. Resident said after the shower, they told Staff N, Certified Occupational Therapy Assistant, about the incident. Staff N told Resident 45 that Staff F should not have been in the shower with the resident. Resident 45 said they asked Staff N not to say anything because they did not want to be retaliated against.On 07/23/2025 at 10:30 AM, when asked about the incident on June 14, if she had given permission for Staff F to be in the shower room, Resident 45 stated, no, I didn't want her there.On 07/23/2025 at 10:04 AM, when asked what license(s) or credentials the staff held, Staff F, SSD, said they were a Certified Behavioral Health Tech. Staff F confirmed they do not hold a Certified Nursing Assistant (CNA) license, a Licensed Practical Nurse (LPN) or Registered Nurse (RN). Staff F was asked to explain the events that took place with Resident 45, in regard to the concerns with the shower and the role they played in the events. Staff F said Resident 45 had been making complaints about the staff all week and did not want them to shower her. Staff F said they and Staff Z, UM/RN had gone to Resident 45's room and spoke to her about taking a shower. Resident 45 finally agreed to take a shower. Staff AA, CNA and Staff BB, CNA, assisted Resident 45 to the shower room. Staff F said after Resident 45 was assisted to the shower chair, Staff BB left the room and Staff F, Staff Z and Staff AA remained in the room with Resident 45. Staff F said Resident 45 gave her permission to stay in the shower room. Staff F said Resident 45 was provided with a clean washcloth and soap, Resident 45 cleaned under one arm pit, then threw the washcloth on the ground. Resident 45 received a new washcloth and repeated that same action under the other armpit. Resident 45 received a new washcloth and cleaned under one breast and threw it on the ground. Resident 45 received a new washcloth and repeated that same action under the other breast. Resident 45 received another washcloth and cleaned her private area. When asked where everyone was standing in the room, Staff F attempted to explain and eventually said let me show you and went to the A Hall shower room. Staff F showed where all staff were standing in the shower room and acknowledged they, Staff Z and Staff AA were present in the shower room when Resident 45 received the shower. On 07/24/2025 at 2:02 PM, when questioned if Staff F, SSD should have been in the shower room with Resident 45 while they were showering, Staff B was unsure of the question. The question was clarified that the SSD presence in the shower room was outside their normal scope of practice, Staff F was not a CNA, Licensed Practical Nurse, or Registered Nurse. Staff B said Staff F should have only been in the shower room if Resident 45 allowed it. It was explained Resident 45 did not want Staff F in the shower room, while they were showering. Staff B said Staff F should not have been in the shower room.On 07/24/2025 at 3:09 PM, when asked about the specific event that took place with Resident 45's shower, Staff A, Administrator, said Staff F, SSD, was not in the shower room with Resident 45, so there was no need to suspect abuse. Staff A was stopped and informed Staff F had been interviewed and self-reported that they were in fact in the shower room when Resident 45 was showering. Staff A then acknowledged Staff F was in the room at the time of the shower. Staff A said Staff F should have only been in the room if Resident 45 allowed it. It was (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	explained Resident 45 did not want Staff F, in the shower room, while they were showering. Staff A said Staff F should not have been in the shower room. When asked how the facility would prevent this from happening to other residents, Staff A said they definitely needed to talk with staff about staying in their lane.Reference WAC 388-97 -0360, 0500(1).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation, interview and record review, the facility failed to ensure pressure injuries (PIs) were consistently assessed, and ordered pressure redistribution measures and equipment were in place and functional for 1 of 2 residents (Resident 3) reviewed for PIs. The failure to ensure an ordered low air loss mattress was in place and functional and to routinely assess identified PIs, detracted from the ability to determine if current treatments and interventions were effective and appropriate. This failure placed residents at risk for prolonged wound healing, unidentified decline, development of avoidable PIs, pain and decreased quality of life. Findings included . The National Pressure Injury Advisory Panel (NPUIP) provided the following PI stage descriptions:- PI- localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device, because of intense and/or prolonged pressure or pressure in combination with shear.- Stage 1 Pressure Injury: Non-blanchable erythema (redness) of intact skin.- Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis.- Stage 3 Pressure Injury: Full-thickness skin loss in which adipose (fat) is visible in the ulcer.- Stage 4 Pressure Injury: Full-thickness skin and tissue loss with exposed or directly palpable fascia (connective tissue), muscle, tendon, ligament, cartilage or bone in the ulcer.- Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar (tissue death). Resident 3 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), showed the resident was cognitively intact, was at risk for development of PIs, and had one unstageable PI that was not present on admission.Review of the electronic health record (EHR) showed Resident 3 had the following PI treatment orders:a) Clean left heel PI with wound cleanser, pat dry with gauze sponge. Apply medical grade honey to necrotic tissue, followed by Hydrofera Blue (wound treatment) to the wound bed. Cover with 6x6 silicone bordered foam dressing and secure with roll gauze and tape three times a week and as needed if dislodged or soiled.b) A 07/10/2025 order for a heel protector to the left foot with direction to check placement each shift.c) A 06/17/2025 order for Mupirocin External Ointment 2 % (Mupirocin) apply to left heel topically every other day and cover with a bordered gauze dressing. d) A 03/03/2025 order for low air loss mattress for pressure redistribution. On 07/17/2025 at 12:00 PM, 07/18/2025 at 2:33 PM, 07/19/2025 at 12:58 PM, and 07/24/2025 at 8:41 AM, Resident 3 was observed in bed lying on a standard pressure reduction mattress. There was not a low air loss mattress on the resident's bed as ordered.On 07/24/2025 at 9:16 AM, Staff J, Unit Manager, confirmed Resident 3 did not have a low air loss mattress in place.Review of an unstageable PI to the left heel care plan, revised 06/19/2025, showed staff were to assess/record/monitor wound healing weekly and as needed. This included measuring the wound length, width, and depth where possible, and assessing and documenting wound bed tissue type, amount and character of drainage, wound edges, peri wound appearance and healing progress/response to treatment. Staff were directed to report improvement or decline to the physician. The care plan also documented Resident 3 had a wound vacuum in place, that was to be changed three times a week. Review of the electronic health record (EHR) showed the wound vac was discontinued on 06/17/2025, and a wound consult, dated 06/24/2025, documented Resident 3's left heel PI had progressed from unstageable to a stage III. Review of the weekly wound assessments/evaluations for Resident 3's left heel, showed a 05/27/2025 wound consultation that assessed Resident 3's left heel PI as unstageable due to slough/eschar (devitalized tissue) to the wound base. The consultation recommended continuing negative pressure therapy with the wound vac.Review of the EHR showed no wound assessments, measurements or monitoring of Resident 3's left heel PI were documented for the next five weeks (06/03/2025, 06/10/2025, 06/17/2025, 06/24/2025 or 07/01/2025). On 07/28/2025 at 01:31 PM, Staff J, UM, acknowledged it was the expectation that PIs would be assessed weekly and include a (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound description and measurements. When asked if there was documentation that Resident 3's left heel PI was assessed/measured during the five-week period between 05/27/2025 and 07/08/2025, Staff J stated, No. Reference WAC 388-97-1060(3)(b).

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation, interview, and record review the facility failed to ensure 1 of 1 residents (Resident 31) reviewed for indwelling urinary catheters (a flexible tube used to empty the bladder and collect urine in a drainage bag) had a valid medical justification for urinary catheterization, was assessed for removal of the catheter timely, and received catheter care in accordance with professional standards of practice. These failures placed residents at risk for loss of bladder tone and normal bladder function, urethral trauma and tearing and other negative health outcomes.Findings included .Review of the facility's policy titled, Catheter Care, Urinary, revised August 2022, staff would:a) Ensure that the catheter remained secured with a securement device to reduce friction and movement at the insertion site.b) Review and document the clinical indication(s) for catheter use.c) Nursing and the interdisciplinary team would assess and document ongoing need for a catheter that was in place.d) Remove the catheter as soon as it was no longer needed. Resident 31 was admitted to the facility on [DATE]. Review of the 04/16/2025 Quarterly Minimum Data Set (MDS, an assessment tool), showed the resident was cognitively intact, had a diagnosis of obstructive uropathy (urinary tract disorder that occurs when urine flow is obstructed) and required use of an indwelling urinary catheter. Review of the alteration in urinary elimination related indwelling catheter care plan, revised 04/17/2025, showed no supporting diagnosis or clinical justification documented for Resident 31's indwelling urinary catheter use. On 07/17/2025 at 12:42 PM, when asked why they had a urinary catheter, Resident 31 stated, I have the catheter, so I don't sit in wet diapers. I did have a wound they were debriding, but it healed. On 07/22/2025 at 12:36 PM, a when asked if the catheter was secured with a leg strap Resident 31 stated, No. On 07/24/2025 the resident pulled the leg of his shorts up, which revealed there was no securement device in place. On 07/22/2025 at 1:21 PM, when asked if Resident 31 had a catheter strap in place Staff EE, Unit Manager, asked the resident and followed the catheter to the insertion site and stated, No. When asked if a securement device should be in place, Staff EE stated, Yes. A 09/17/2024 urology consultation documented Resident 31 had a history of prostate cancer and was status post prostatectomy (a surgical procedure for the partial or full removal of the prostate gland) and radiation, which was complicated by a bulbar urethral stricture (a narrowing of the urethra) and bladder neck contracture (a condition where the bladder opening narrows due to scar tissue formation). Resident 31 then underwent a Direct Visual Internal Urethrotomy (DVIU, surgery to widen a stricture, narrow area, in your urethra.) on 01/21/2021. The urologist documented, [Resident 31] has requested to keep the foley catheter in place at the present time. PLAN Inguinal and scrotal wounds appear to be healing very well. The scrotal ulcer is almost completely gone. The patient is having troubles with his catheter clogging but he does prefer catheter management, so he is not having wetness around his inguinal and scrotal wounds which I think is reasonable. On 07/22/2025 at 12:49 PM, when asked if Resident 31 had a diagnosis of obstructive uropathy or still had inguinal/scrotal wounds Staff EE, stated, No. When asked what the clinical justification for the use of the catheter Staff EE was stated, There isn't one. Reference WAC 388-97-1060 (3)(c).

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review, the facility failed to ensure pain was appropriately addressed, monitored, and recorded, or to ensure side effect monitors were in place and non-pharmacological interventions (NPI's, non-medication interventions for pain) were documented for pain medications for 2 of 6 residents (Residents 47 & 2) reviewed for unnecessary medications or pain management. This failure placed residents at risk for an increase in pain, inability to perform therapy services, medication complications, and a diminished quality of life. Findings included.<Resident 47> Resident 47 was admitted to the facility on [DATE], with a diagnosis of chronic pain. The Quarterly Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 47 was cognitively intact, and was receiving restorative nursing programs that included seven days of active range of motion and three days of walking. Review of Resident 47's Medication Administration Record (MAR), showed they were receiving scheduled acetaminophen (non-opioid pain medication) three times a day and scheduled oxycodone (opioid pain medication) every six hours. For pain scores connected to acetaminophen administration, Resident 47 had documented pain scores of 0/10 (no pain) on 07/02/2025, 07/07/2025, 07/11/2025, 07/15/2025, 07/21/2025, and 07/22/2025. For pain scores connected to oxycodone administration, Resident 47 had documented pain scores of 0/10 on 07/16/2025 and 07/22/2025. Review of Resident 47's electronic health record (EHR), showed a banner at the top of the record that said “Record ACCURATE pain scale. 0/10 is not accurate for this resident.” Review of Resident 47's pain care plan showed it did not include this information. Review of the facility's Restorative Nursing Monthly Log for July 2025, showed Resident 47 had refused restorative nursing services on 07/15/2025, 07/17/2025, 07/19/2025, 07/20/2025, 07/21/2025 and 07/22/2025. A note under the most recent refusals said “c/o [complaint of] pain”. Review of the EHR showed, on 07/15/2025, an outside wound consulting and treatment company did an initial evaluation for a stage 3 pressure ulcer (full thickness tissue loss, fat may be visible but bone, tendon, or muscles are not exposed) to the coccyx (near the tailbone). Review of Resident 47's Pain Evaluation, dated 07/15/2025, showed they had pain to their right hip that was chronic stabbing, aching pain that was constant, and pain to a sacral (near the tailbone) pressure ulcer that had stinging pain when touched and ached when sitting on it for a long time. Their current pain level during the assessment was a 7/10, their pain at its least was reported to be a 5/10, and their pain at the worst was reported to be a 10/10. During an interview on 07/16/2025 at 2:37 PM, Resident 47 reported they had plenty of pain. Resident 47 said in the morning it starts as a 9/10 pain, drops down to a 6/10, then down to a 5/10, where it usually stays. Resident 47 said they did not feel like the facility was doing enough to address the pain. During an interview on 07/23/2025 at 8:28 AM, Resident 47 was asked when the last time their pain (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was 0/10 and said, not since they were hospitalized in December. During an interview on 07/23/2025 at 8:36 AM, Staff K, Licensed Practical Nurse, said Resident 47 had chronic pain all the time, and that the lowest Resident 47's pain gets down to was probably a 4 or 5/10, adding they did not think Resident 47 was ever pain free. On 07/23/2025 at 9:17 AM, Resident 47 was asked about their recent refusal for restorative therapy. Resident 47 said they had been dealing with more pain in areas that were more sensitive, and they hurt too much. On 07/23/2025 at 9:30 AM, Staff K said they were working their third shift in a row. When asked if they were informed Resident 47 had been refusing restorative therapy, said they did not know, but would guess it was due to pain. When asked if they ever were informed when a resident refuses restorative services, Staff K said no. During an interview on 07/23/2025 at 10:28 AM, Staff J, Unit Manager, said they were not aware of Resident 47 refusing restorative services due to pain. When asked their expectation for staff regarding refusals from restorative services, Staff J said they would like to be notified. When asked if there had been a conversation with the provider on how to help manage Resident 47's pain better for restorative services, Staff J said no because they were unaware of the refusals due to pain. When asked if they had ever been informed of a resident refusing restorative services, said they personally had not been. During an interview on 07/23/2025 at 10:52 AM, Staff L, Restorative Aide, when asked why Resident 47 had refused five days of restorative in the previous six days, said it was from pain. Staff L was unable to provide any names of nurses notified of the refusals. During an interview on 07/24/2025 at 12:45 PM, when asked what their expectations were regarding Resident 47 missing recent restorative sessions due to pain, Staff B, Director of Nursing Services (DNS), said that Resident 47 would be pain free enough to participate. Staff B said refusals had not been reported to them. When told of the recent dates Resident 47 had refused restorative and their pain score having been recorded as zero on 07/21/2025 and 07/22/2025, Staff B said staff needed to document what Resident 47 said their pain was and should have completed a change of condition form with provider notification (related to the pain). <Resident 2> Resident 2 was admitted to the facility on [DATE]. According to the admission MDS, dated [DATE], Resident 2 was cognitively intact. Review of Resident 2's orders showed an order, dated 05/14/2025, for hydromorphone (a potent pain medication that can have various side effects ranging from mild to serious) to be given five times a day for severe pain. A second order, dated 05/10/2025, documented staff were to provide NPIs to reduce pain and document effectiveness as needed. Review Resident 2's EHR, showed no side effect monitoring was ordered and no NPIs were documented for the ordered hydromorphone. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/23/2025 at 8:07 AM, Staff B, DNS, looked in Resident 2's EHR and stated, “I don't see we are monitoring for side effects for pain medication, I would expect them to.” Staff B acknowledged there was an order in place to attempt NPIs and said it was PRN (as needed), so she did not think staff were doing them. Staff B looked at the documentation and confirmed staff were not documenting NPIs. Staff B said staff should be trying NPIs, documenting them, and the order should have been a standard order, not as needed. Reference WAC 388-97-1060 (1) .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation and interview, the facility failed to provide food in accordance with preferences for 1 of 11 sampled residents (Resident 20) reviewed for dining. This failure placed residents at risk for potential dissatisfaction with meals and a diminished quality of life.Findings included .Review of the electronic health record (EHR) showed Resident 20 admitted to the facility on [DATE]. Resident 20 was able to make needs known. Observation of the lunch meal on 07/16/2025 at 12:30 PM, showed Resident 20's tray card had allergies/dislikes of cheese, dairy, pork and processed meats. Resident 20 was served salad, a baked potato to include sour cream, cheese and green onions, chocolate pudding with whipped topping and beef.During an interview on 07/16/2025 at 12:45 PM, Resident 20 stated, I don't make it a big deal anymore they've given me things I've told them I don't like over and over.During an interview on 07/16/2025 at 1:02 PM, Staff D, Dietetic Technician, said the sour cream, cheese and pudding with a whipped topping were not appropriate for resident based on the allergies/preference.During an interview on 07/16/2025 at 2:47 PM, Staff C, Dietary Manager, said the resident's preferences should have been honored.During an interview on 07/16/2025 at 2:59 PM, Staff A, Administrator, said the expectation was that staff followed resident preferences and allergiesReference: WAC 388-97-1140(6).

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	07/29/2025

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation, interview, and record review, the facility failed to ensure residents received therapeutic diets as ordered by the physician for 2 of 10 residents (Residents 1 and 47) reviewed for dining. This failure placed the residents at risk for medical complication or nutritional deficits.Findings included .Observation of the lunch meal service on 07/18/2025 showed the primary lunch meal consisted of bratwurst, oven browned potatoes, sauerkraut, lemon chiffon pie and a dinner roll. According to the menu for Consistent Carbohydrate Diet (CCHO, a diet that aids in controlling blood sugar) residents would receive wheat bread in place of the dinner roll. Staff OO, Cook, was plating the food and was assisted by Staff C, Dietary Manager. Tray line was observed from 12:06 PM-1:30 PM and showed the following:<Resident 1>Resident 1 was admitted to the facility on [DATE] with diagnoses to include diabetes (too much sugar in the blood). The 5-Day Minimum Data Set (MDS, an assessment tool), dated 06/30/2025, documented Resident 1 was severely cognitively impaired.Observation of the lunch meal service on 07/18/2025 at 12:06 PM, showed Staff OO prepared Resident 1's meal tray, the resident was provided the primary lunch. Resident 1's tray card showed the resident was on a CCHO diet and should have received wheat bread.<Resident 47>Review of the electronic health record (EHR) showed Resident 47 admitted to the facility on [DATE] with diagnoses that included diabetes.Observation of the lunch meal service on 07/18/2025 at 12:10 PM, showed Staff OO prepared Resident 47's meal tray, the resident was provided the primary lunch. Review of Resident 47's tray card showed the resident was on a CCHO diet and should have received wheat breadDuring an interview on 07/18/2025 at 12:20 PM, Staff C, Dietary Manager, confirmed staff should have provided residents on the CCHO diet with wheat bread and it did not meet expectations that no wheat bread was prepped for the lunch meal.Reference WAC 388-97-1200(1).