STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505531	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heron's Key	4340 Borgen Blvd NW Gig Harbor, WA 98332

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to accurately assess dental status for 1 of 2 sampled residents (Resident 8) when reviewed for dental care. This failure placed the Resident at risk of pain, weight loss, and diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 8 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation (irregular heart rhythm), heart failure, chronic kidney disease (loss of kidney functions), and weakness. Resident 8 was able to communicate their needs. Observation and interview on 02/10/2026 at 11:02 AM showed Resident 8 sat in their chair and pointed to their mouth and stated, My teeth have fallen out, and No dentist comes here. Observation showed Resident 8 had missing teeth. Review of the EHR showed Resident 8 had a quarterly minimum data set (MDS, a required assessment), dated 11/16/2025, marked with no dental issues. Review of the care plan, dated 11/24/2025, showed Resident 8 had no dental focus area. During an interview on 02/11/2026 at 2:15 PM, Staff E, Registered Nurse (RN)/MDS, stated the MDS should have been marked accurately, and the care plan should reflect the status of teeth. During an interview on 02/13/2026 at 9:31 AM, Staff B, Director of Nursing Services, stated the expectation was for the MDS to correctively reflect residents' dental status, and Resident 8's MDS need to be corrected. Reference WAC 399-97-1000(1)(a)(b)(4)(a)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide quality care related to monitoring of resident skin injuries (bruises), bowel management, and orthostatic blood pressure (blood pressure taken while a person is laying, sitting and standing to monitor for sudden drop in pressure) for 2 of 9 sampled residents (Residents 8 and 11) when reviewed for quality of care. This failure placed residents at risk of injuries, untreated constipation, discomfort, and a diminished quality of life. Findings included.Resident 8Review of the electronic health record (EHR) showed Resident 8 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation (irregular heart rhythm), heart failure, chronic kidney disease (loss of kidney functions), and weakness. Resident 8 was able to communicate their needs. Observation and interview on 02/10/2026 at 11:08 AM, showed Resident 8 sat in the chair in their room and pointing towards two reddish colored bruises on their left forearm. During a follow up interview on 02/12/2026 at 11:50 AM, Resident 8 stated they did not know how the bruises were happening. Review of the EHR, showed Resident 8 had multiple progress notes related to bruises on different areas of their hands/arms. There was alert monitoring of the bruises, but it was not clear the size, color, or actual location. Progress notes on 01/17/2026 described a large bruise on the top of right hand. Progress notes on 01/31/2026 described a bruise to the left upper extremity (LUE, left upper portion of the arm) near the elbow sized 3x3 centimeters and almost fading. Progress notes on 02/01/2026 recorded a bruise on right hand and left upper arm. On 02/05/2026, progress notes described new bruising to the inner right forearm. Review of the weekly skin evaluation forms from January and February2026 showed Resident 8 had no new issues on a weekly basis. During an interview on 02/12/2026 at 1:27 PM, Staff D, Licensed Practical Nurse (LPN), stated the process for new bruises was to notify providers, obtain orders to monitor, initiate an investigation, and place the resident on alert status. During an interview on 02/13/2026 at 9:33 AM, Staff B, Director of Nursing Services (DNS), stated the nurses were expected to conduct weekly skin evaluations and have measurements and descriptions of the bruises. Staff B stated the records for Resident 8 did not meet expectations. Resident 11Review of the EHR showed Resident 11 was admitted to the facility on [DATE] with diagnoses to include delusions (false beliefs), hypertension (high blood pressure), diabetes (high blood sugar), and dementia (impaired memory, thinking and reasoning that interfere with daily life). Resident 11 could not communicate their needs. Review of EHR showed Resident 11 had a provider's order for monthly orthostatic blood pressure for 02/01/2026 that was not complete. Review of the documentation for bowel monitoring showed Resident 11 did not have bowel movements documented for four consecutive days in February 2026 (02/05/2026, 02/06/2026, 02/07/2026, and 02/08/2026). Review of the providers' orders showed Resident 11 had an order for milk of magnesia to be given for constipation, if there was not a bowel movement in three days. Review of the February 2026 medication administration record showed no milk of magnesia given to Resident 11. During an interview on 02/13/2026 at 9:52 AM, Staff B, DNS, stated the expectation was for license nurses to follow provider's orders and the bowel protocol. Staff B stated the records for Resident 11 did not meet expectations. Reference WAC 399-97-1060(1)-(3)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide routine dental care for 1 of 2 sampled residents (Resident 3) when reviewed for dental needs. This failure placed the resident at risk for difficulty eating, dental pain, unintended weight loss, and diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 3 was admitted to the facility on [DATE] with diagnoses to include chronic kidney disease (loss of kidney functions), atrial fibrillation (irregular heart rhythm), and heart failure. Resident 3 was able to communicate their needs. During an interview on 02/10/2026 at 9:28 AM, Resident 3 stated they lost a tooth and needed to see a dentist, but their dentist did not see patients in wheelchairs. Review of the EHR showed no dental consultations. Review of the care plan, dated 07/07/2025, showed no dental needs addressed for Resident 3. During an interview on 02/12/2026 at 11:54 AM, Staff E, Registered Nurse/Minimum Data Set (RN/MDS), stated the facility did not automatically assign dentists for the residents, Resident 3 needed to be referred for dental services, and the care plan should accurately address dental needs. During a follow up interview on 02/13/2026 at 10:33 AM, Resident 3 stated they had five missing teeth, and a gold filling that fell out. During an interview on 02/13/2026 at 9:40 AM, Staff B, Director of Nursing Services, stated the facility would be working on the dental needs for Resident 3 and the records did not meet expectations. Reference WAC 399-97-1060(3)(j)(vii)