

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Bremerton Trails Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2701 Clare Avenue Bremerton, WA 98310	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46068</p> <p>Based on observation, interview and record review, the facility failed to administer medications per physician orders and guidelines for 4 of 5 residents (Resident 1, 2, 3 and 4) reviewed for medications. This failure placed residents at risk of clinical complications, unintended medication side effects, and infection.</p> <p>Findings included .</p> <p>Review of the facility's undated policy titled, Flexible Medication Pass Policy, showed AM medications to be administered between 6 AM and 10 AM, Midday medications to be administered between 10 AM and 2 PM and PM medications to be administered between 4 PM and 8 PM. The policy said that medications ordered TID [three times a day] shall be given every AM, Midday, and PM unless otherwise indicated by the nature of the medications.</p> <p><RESIDENT 1></p> <p>Resident 1 was admitted to the facility on [DATE] with diagnosis of medically complex conditions. The Minimum Data Set Assessment (MDS), an assessment tool, dated 01/23/2025, showed the resident was cognitively intact and required assistance with activities of daily living.</p> <p>On 04/24/2025 at 11:19 AM, Resident 1 said they were concerned the facility was not administering their eye medication correctly and said their eye really hurt and was not getting better.</p> <p>Resident 1's Ophthalmologist (physician specializing in the eye) office visit note, dated 03/20/2025, showed the resident still had bacterial conjunctivitis (eye infection) and was to start Maxitrol (an eye medication to treat infection) twice per day in both eyes and schedule a follow up appointment in two weeks.</p> <p>Resident 1's Medication Administration Record (MAR), dated 03/01/2025 through 03/31/2025, and 04/01/2025 through 04/30/2025, showed no documentation the Maxitrol was administered.</p> <p>Resident 1's physician orders, dated 04/02/2025, showed the resident was to be administered Polytrim (medication to treat eye infection) eye drops in left eye until the follow-up ophthalmology appointment on 04/10/2025.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 1's progress notes, dated 04/10/2025, showed the resident's ophthalmologist office cancelled the follow up appointment on 04/10/2025 due to technical difficulties and the appointment would be rescheduled.</p> <p>Resident 1's Ophthalmologist office visit note, dated 04/17/2025, showed the resident had ongoing conjunctivitis and was to be administered Polytrim eye drops QID [four times per day].</p> <p>Resident 1's MAR, dated 04/01/2025-04/30/2025, showed no documentation Polytrim was administered after 04/10/2025.</p> <p>On 05/01/2025 at 10:41 AM, Staff B, Licensed Practical Nurse and Resident Care Manager, said they had reviewed Resident 1's medical record and said the nurse transcribed the Maxitrol order incorrectly and therefore it didn't show up correctly for the nurses to administer it. Staff B said the resident did not receive the medication as ordered. Staff B said the Polytrim was stopped per the physician's order on 04/10/2025 in preparation for the Ophthalmologist appointment and when the appointment was cancelled there was no documentation they had reached out to the provider to clarify. Staff B said the Polytrim was not restarted following the 04/17/2025 appointment and it should have been administered per the physician orders.</p> <p><RESIDENT 2></p> <p>Resident 2 was admitted to the facility on [DATE], with diagnoses to include stroke and medically complex conditions. The MDS, dated [DATE], showed the resident was cognitively intact.</p> <p>On 04/23/2025 at 11:25 AM, Resident 2 said they were not getting their medications at the right times. Resident 2 said they took gabapentin (medication for nerve pain) three times per day, and they needed to receive the meds at regular intervals and the nurses were not always bringing them at the right time and they had been fighting to get it right.</p> <p>Resident 2's physician orders, dated 04/03/2025, showed an order for gabapentin 300 MG [milligrams] three times a day.</p> <p>Resident 2's medication audit report, showed gabapentin was administered at the following dates and intervals:</p> <p>04/04/2025: 9:33 AM, 11:57 AM and 3:40 PM</p> <p>04/05/2025: 10:11 AM, 1:07 PM and 2:31 PM</p> <p>04/07/2025: 8:17 AM, 10:15 AM, and 3:27 PM</p> <p>04/08/2025: 8:23 AM, 10:40 AM and 5:35 PM</p> <p>04/15/2025: 8:00 AM, 10:20 AM, and 5:19 PM</p> <p>04/16/2025: 8: 34 AM, 11:29 AM and 2:50 PM</p> <p>04/17/2025: 9:36 AM, 12:44 PM and 5:15 PM</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>04/18/2025: 7:52 AM, 11:17 AM, and 2:26 PM</p> <p>04/19/2025: 9:29 AM, 12:32 PM and 2:45 PM</p> <p>04/21/2025: 9:11 AM, 1:17 PM and 5:40 PM</p> <p>04/23/2025: 8:22 AM, 12:15 PM and 2:35 PM</p> <p>On 05/01/2025 at 2:16 PM, Staff C, Assistant Director of Nursing (ADON), said the facility's medication policy directed the medications ordered TID to be given AM, Midday and PM but the schedule could be changed if the medication needed different intervals between medication administration times. Staff C said they contacted the facility's pharmacist, and the pharmacist said gabapentin should be given at least six hours apart when used for nerve pain. Staff C said the licensed nurses should have adjusted the medication schedule for the gabapentin to ensure there was six hours between each dose.</p> <p><RESIDENT 3></p> <p>Resident 3 was admitted to the facility on [DATE] with diabetes diagnosis. The MDS, dated [DATE], showed the resident was cognitively intact.</p> <p>Resident 3's physician orders, dated 04/14/2025, showed Lispro insulin (medication to treat diabetes), inject 6 units before meals.</p> <p>On 04/24/2025 at 12:17 PM, Resident 3 was observed eating their lunch. The resident had eaten the entire portion of chicken and half of their beans. Staff A, Registered Nurse (RN), entered the room and completed a blood glucose test (test that checks the level of glucose in the blood) and administered an injection of Lispro insulin. When asked why they did not administer the Lispro insulin before the meal, Staff A said they did not have time, and they were just getting to it.</p> <p><RESIDENT 4></p> <p>Resident 4 was admitted to the facility on [DATE] with diabetes diagnosis. The MDS, dated [DATE], showed the resident was cognitively intact.</p> <p>Resident 4's physician orders, dated 04/17/2025, showed Lispro insulin inject 16 units before meals.</p> <p>On 04/24/2025 at 12:54 PM, Resident 4 was observed with their empty lunch plate on their table. Resident 4 said they did not like the chicken, but they ate it. Staff A, RN, entered the room and completed a blood glucose test and administered an injection of Lispro insulin. When asked why they did not administer the Lispro insulin before the meal, Staff A said they did not have time.</p> <p>On 04/24/2025 at 1:59 PM, Staff C, ADON, said medication should be given per the physician's orders.</p> <p>Reference WAC 388-97-1060(3)(k)(iii)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46068</p> <p>Based on interview, observation and record review, the facility failed to ensure staff maintained infection control practices by cleaning blood glucose monitors (a device that measures the amount of glucose in your blood) between residents, performing hand hygiene before and after resident care, and maintaining separation between clean and dirty tasks for 1 of 3 (Staff A) staff observed. This failure placed residents at risk of contagious disease, infection and clinical complications.</p> <p>Findings included .</p> <p>Review of the Center for Disease Control and Prevention (CDC) web page titled, Considerations for Blood Glucose Monitoring and Insulin Administration, dated 08/07/2024, showed if blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per the manufacturer's instructions, to prevent the spread of blood and infectious agents.</p> <p>Review of the CDC web page titled, Clinical Safety Hand Hygiene for Healthcare Workers, dated 02/27/2024, showed health care workers should clean their hands immediately before touching a patient, after touching a patient or patient's surrounding, and immediately after glove removal.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/24/2025 at 12:17 PM, Staff A, Registered Nurse, donned gloves and placed a blood glucose monitor in a plastic container with alcohol pads, a bottle of glucose strips (test strip blood is placed on and inserted into the glucose monitor) and a lancet (device used to pierce the finger to obtain blood). Staff A entered Resident 1's room and completed the blood glucose check, wiped the resident's finger before and after utilizing an alcohol pad and then placed the glucose monitor and the used alcohol wipes back into the plastic container. Staff A wiped the resident's skin with an alcohol wipe and then administered insulin (medication used to treat diabetes) to the resident. Staff A placed the used alcohol wipe and insulin pen (device used to administer insulin) into the plastic container and exited the room. Staff A removed their gloves and without washing their hands removed the dirty alcohol pads and glucose strip from the container and placed them in the garbage. Staff A placed the insulin pen into the medication cart and disposed of the lancet into the hazardous waste container. Staff A did not clean and/or disinfect the plastic container. Staff A left the blood glucose monitor on top of the medication cart and proceeded down the hall to the dining room to administer medication to Resident 2. Resident 2 was sitting in their wheelchair at a table in the dining room with another resident seated beside them. Staff A donned gloves without using hand hygiene, gathered the same glucose monitor, without cleaning and/or disinfecting it and placed a glucose testing strip into the monitor and prepared to lance Resident 2's finger to test their glucose. The procedure was interrupted and when Staff A was asked if they needed to clean the glucose monitor between residents, Staff A said they had forgotten and went back to the cart to clean the monitor. Staff A said they had been taught by their preceptor to use alcohol wipes to clean the monitor. Staff B, Resident Care Manager, approached Staff A and clarified the monitor was to be cleaned and disinfected with the purple top disinfecting wipes (disinfecting wipes in a container with a purple top that contain disinfectant that kills infectious diseases) and described the procedure. Staff A cleaned the monitor and then returned to the dining room with the glucose monitor, alcohol wipes and insulin pen in the same plastic container that had been used with Resident 1. Staff A used the alcohol wipes to clean Resident 2's finger, completed the glucose testing and administered insulin into Resident 2's upper arm at the dining table. Staff A placed the dirty alcohol wipes, glucose monitor and insulin pen into the plastic container and returned to the medication cart. Staff A removed the supplies from the plastic container. Staff A removed their gloves. Staff A did not clean and/or disinfect the plastic container and/or perform hand hygiene. Staff A proceeded to another resident's room to administer medications, donned gloves without performing hand hygiene and utilized the same plastic container to hold their supplies without cleaning and/or disinfecting it.</p> <p>On 04/24/2025 at 1:59 PM, Staff C, Infection Preventionist, said the facility's glucose monitor must be cleaned utilizing the disinfecting wipes from the container with the purple top per the manufacturer instructions. Staff C said alcohol wipes were insufficient to disinfect the glucose monitors. Staff C said the glucose monitors should be wiped down and left to air dry for 2-5 minutes before using them on another resident. Staff C said hand hygiene should be performed before and after all resident care and tasks including medication administration and glucose testing. Staff C said the plastic container must be cleaned after the dirty supplies are removed. Staff C said glucose testing and insulin administration should not be completed in the dining room. Staff C said the staff did not follow their infection control procedures.</p> <p>Reference WAC 388-97-1320 (1)(a)(c)</p>		