STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505123	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bremerton Trails Post Acute	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)
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. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505123	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bremerton Trails Post Acute	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)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record reviews, the facility failed to provide competent and sufficient staff to complete resident showers and personal care according to their plan of care for 5 of 11 residents (Resident 1, 2, 3, 4 and 5) reviewed for sufficient staffing. This failure placed residents at risk of poor hygiene, loss of dignity, frustration and a decreased quality of life Findings included.RESIDENT 1Resident 1 was admitted on [DATE]. The Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 1 was cognitively intact. Resident 1's Activity of Daily Living Care Plan (ADL), dated 03/24/2025, showed Resident 1 required assistance with dressing, personal hygiene, transfers and required extensive assistance with bed mobility. The care plan showed Resident 1 was incontinent of bowel and bladder and staff were to check the resident every two hours and assist with toileting as needed.On 08/24/2025 at 10:46 AM, Resident 1's call light was observed on.On 08/24/2025 at 10:47 AM, Staff A, Certified Nursing Assistant (CNA), was observed entering Resident 1's room and immediately exited the room and the call light was observed to be off.On 08/24/2025 at 10:47 AM, Resident 1 said they had been waiting since 5:30 AM to get up for the day and have their brief changed. Resident 1 said the staff kept coming in, shutting off the call light and stating they would find someone to assist. Resident 1 said they had been given four popsicles that day due to the heat but no morning care. Resident 1 said staff never offered to get them ready for their day, they had to tell staff they needed assistance, and the delays happened frequently. Resident 1 said they had not been changed and/or cleaned up since approximately 2:00 AM.On 08/24/2025 at 11:04 AM, Staff B, CNA, said they were a fill in staff member and had been assigned Resident 1 since 8:00 AM. Staff B said they had looked at Resident 1's brief to determine if it was wet at approximately 8:00 AM. Staff B said there was a line on the brief that indicated if the brief was wet. Staff B said the line did not indicate Resident 1 needed to be changed. Staff B said they had not provided any other care to Resident 1 except to deliver the breakfast tray and ice water. RESIDENT 2Resident 2 was admitted on [DATE]. The MDS, dated [DATE], showed Resident 2 was cognitively impaired.Resident 2's ADL care plan, dated 04/03/2025, showed Resident 2 required assistance with dressing, oral care, personal hygiene, incontinent care and transfers. Resident 2's care plan showed Resident 2 needed set up assistance for eating and to uncover foods and cut up as needed.Resident 2's Resistive to Care plan of care, revised 06/19/2025, showed staff were to negotiate a time for ADLs to allow participation in the decision making and if the resident resisted ADLs, staff were to leave and return 5-10 minutes later and try again.On 08/24/2025 at 10:33 AM, 11:15 AM and 11:45 AM, Resident 2 was observed lying on their right side in bed. The resident's eyes were closed. Resident 2's breakfast tray was on the overbed table with eggs and toast on the plate. Resident 2 had on a shirt and briefs. The bed linens partially covered Resident 2. Resident 2's call light was on the floor and the room had a strong urine smell. Resident 2's bathroom was observed with urine on the toilet seat, a brown substance on the floor and a strong smell of urine. The garbage can under the sink outside of the bathroom was observed with a wet brief in it.On 08/24/2025 at 11:45 AM, Staff B, CNA, said they were assigned Resident 2. Staff B said they started caring for Resident 2 at 8:00 AM and they checked and changed Resident 2 and gave them breakfast but had not done any other care. Staff B said they asked the resident, and Resident 2 had said no so they had not done anything else.On 08/26/2025 at 7:47 PM, Resident 2 was observed lying at the end of their bed with a brief and shirt on. Resident 2's call light was observed on the floor, the room smelled of urine and other odors and their meal tray was on the table next to the bed.On 08/26/2025 at 8:06 PM, Resident 2 was observed lying at the end of their bed yelling for help.On 08/26/2025 at 9:30 PM, Resident 2 was observed in a shirt and brief, a strong smell of urine and other odors in the room, the call light on the floor and the meal tray was on the table next to the bed.On 08/26/2025 at 9:45 PM, Staff C, CNA, was observed with a cart that contained snacks going from room to room. Staff C was observed entering Resident 2's room and offered them a snack. Staff C was observed serving Resident 2 a snack and exiting the room. When asked if Staff C could smell urine in the room, Staff C said they did not know but they could check the resident. Staff C proceeded to check Resident 2's brief and discovered the Resident was incontinent of bowel. On 08/26/2025 at 9:48 PM, Staff D, CNA, said they were assigned to care for Resident 2. When asked if they had provided care to Resident 2, Staff D said they had not had time to provide care to Resident 2 since their shift started at 6:30 PM because they had been busy with call lights, taking vital signs and helping other residents.Resident 2's POC (CNA documentation of care) response history for behavior, dated 08/24/2025 and 08/26/2025, showed