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	11/18/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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

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F 0584 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 and interview the facility failed to ensure painted ceiling surfaces was maintained in a homelike environment for 1 of 22 sampled residents (Resident 1) reviewed for homelike environment and sound levels were homelike in 1 of 1 hallway (room [ROOM NUMBER]- 77 Hallway) reviewed for exit door. These failures placed residents at risk for an environment that was not homelike and a decreased quality of life. Findings included.CEILING SURFACE:Resident 1 admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 09/12/2025, indicated Resident 1 was cognitively intact. On 09/22/2025 at 1:51 PM, Resident 1 pointed to an area on their ceiling that was missing paint. Observation of the area showed approximately 4 inches by 1.5 inches that was missing paint, and another adjacent area also missing paint. Resident 1 also pointed to two other areas that had plaster protruding from the ceiling, each the size of a 50-cent piece. Resident 1 said this was not the kind of thing they wanted to see, the way their room looked made a difference to them. On 09/29/2025 at 8:35 AM, Staff J, Charge Nurse (sometimes called Unit Manager in this facility, often called Resident Care Manager in other facilities), Licensed Practical Nurse, went to Resident 1's room and observed the areas missing paint and plaster protruding out. Staff J said it looked like a curtain rail had been moved leading to the plaster protruding, and she was not sure what was going on with the paint missing. Staff J said this did not meet her expectations for a homelike environment. HALLWAY:Review of Resident Council Meeting Minutes, dated 04/17/2025, documented Resident 85 told the group that the door across the hall slammed so hard it was scary and they would like something put on the door to help prevent the loud slamming. Review of the April Grievance log showed this was not listed. During an interview and observation on 09/22/2025 at 12:40 PM, the alarm to the exterior door went off and was heard very loudly in Resident 67's room. Resident 67 said that it was the exit for residents that smoked or for staff when garbage needed to be taken out. During an interview on 09/23/2025 at 10:12 AM, Resident 12 said the backdoor slammed all night long and they had told everyone about the door slamming. During an observation period on 09/25/2025 from 6:40 PM to 7:50 PM, the hallway and room [ROOM NUMBER] were observed, and the exit next to the exterior exit (next to rooms [ROOM NUMBERS]) was heard to make loud noises. At 6:40 PM, the door was slammed shut. At 7:00 PM, the exit door alarm was heard blaring from inside room [ROOM NUMBER]. Resident 12 said they hear this all night. In the hallway, a staff member was witnessed leaving room [ROOM NUMBER], to allow a resident outside through the exterior door. The alarm turned off, then turned back on, turned off again. At 7:01 PM, The alarm went off again, staff had to come turn it off. Resident 87 came out of their room and stated, Press the code and it won't go off, the staff responded, I did. Resident 87 said it had been going off all day, and stated, Unf***ing believable, these people have worked here longer than me. At 7:25 PM, a resident exited the door and a slam was heard behind them. From the hallway, Resident 12 was heard from their room yelling, Quit slamming that door please! At 7:46 PM, a resident returned from outside and the door slammed behind them. At 7:50 PM, the door slammed, and a resident yelled from their room about it. During an interview on 09/30/2025 at 3:46 PM, Staff E, Maintenance Director, was asked what the facility had been doing to alleviate the noise from the exterior door near the 70's rooms. Staff E said they tried weather stripping to muffle, but it had already come off. When asked what the facility did when this concern was brought up in April 2025 at the Resident Council meeting, Staff E said that was when they put the weather stripping on, that has now peeled off. Staff E said that they had talked to staff about using other entrances, but it is what it is. During an interview on 10/01/2025 at 8:44 AM, Staff D, Charge Nurse/Registered Nurse, was asked if they get frequent complaints about the exit door. Staff D said maintenance was aware and the complaint was only for a few people, due to the alarm going off if they did not do the alarm fast enough. When told of the observation of the door slamming multiple times and the alarm going off, with three different residents heard upset about it from their rooms, Staff D acknowledged this was not homelike. During an interview on 10/01/2025 at 10:02 AM, Staff A, Administrator, was asked how the facility had attempted to make the environment more homelike due to the exit door slamming at night. Staff A said it was an emergency fire door, they should not be going out the door in the first place. Staff A said they could put more sealant around the side and will now update the residents to not use that door since it is an emergency door. Reference F585Reference WAC 388-97-0880.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 an allegation of abuse within the required timeframe(s) for 2 of 5 residents (Residents 3 & 12) reviewed for abuse/neglect investigations. This failure placed residents at risk of abuse, fear and a decreased quality of life. Findings included .Findings included . Review of the facility policy titled, Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property, undated, documented the facility was to report all alleged violations immediately but no later than two hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in seriously bodily injury. If the events that caused the allegation were not involving abuse, or if the reported events did not result in serious bodily injury, this could be reported in twenty-four hours to the Executive Director and to others. Resident 3 Resident 3 was admitted on [DATE] with diagnoses of anxiety and post-traumatic stress disorders. Resident 3's Minimum Data Set (MDS) Assessment, dated 08/05/2025, showed Resident 3 was cognitively intact. Resident 3's progress notes, dated 11/09/2025, showed CNA [certified nursing assistant] reported to LN [licensed nurse] that the resident told her that he took a staff's photo using his phone inside the room, and was told by that staff that he shouldn't take a photo, then he responded that it's okay because some of the staff has sent him nude photos, and that half of the staff here in this facility he had a romantic relationship with and already slept with. On 11/10/2025 at 12:51 PM, Staff B, Director of Nursing, Registered Nurse, said they were unaware Resident 3 had alleged they had nude photos of staff and had sexual relations with staff members. Staff B said they were not notified of the allegation by Resident 3. Staff B said they had read the allegation that morning in Resident 3's progress notes. Staff B said it was an allegation of sexual abuse, and the staff member should have reported the allegation immediately to the state agency and management. Staff B said after discovering the allegation in the progress notes they were in the process of initiating an investigation and making a report to the state agency. On 11/10/2025 at 2:52 PM, Staff A, Administrator, said they were not aware of Resident 3's allegation that staff had sent them nude photos and they had romantic relationships with staff. When asked if the staff should have reported the allegations, Staff A said an allegation of sexual abuse should be reported to management and the state agency immediately. Resident 12 Resident 12 was admitted to the facility on [DATE] with diagnoses of depression, anxiety, and muscle weakness. Review of Resident 12's Quarterly MDS, dated [DATE], showed they were cognitively intact and dependent on staff for cares. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 12's electronic health record, showed on 09/22/2025, Resident 12 had asked to speak to Staff R, Activities Aide, while staff was handing out daily papers (Resident 12 was not at the facility that morning after 10 AM due to dialysis treatment (filtering of the blood) outside of the facility). The progress note by Staff R, on 09/22/2025, documented Resident 12 had an issue with a nursing aide, and both the Administrator (Staff A) and Assistant Director of Nursing (Staff F) were notified about the situation. During an interview on 09/23/2025 at 10:12 AM, Resident 12 alleged physical abuse by Staff AA, Certified Nursing Assistant (CNA), and neglect by Staff BB, CNA. On 09/23/2025 at 11:19 AM (over 24 hours since the initial progress note regarding allegation), Staff A, Administrator, was informed by this writer of the allegations by Resident 12 about Staff AA, regarding physical abuse, and Staff BB, regarding neglect. During an interview on 09/29/2025 at 9:43 AM, Staff R clarified they were informed by Resident 12 about the physical abuse allegation at about 9:30 AM on 09/22/2025. Review of the facility's investigation for Resident 12, showed the physical abuse allegation investigation was started on 09/22/2025. The investigation included the time the allegations were submitted to the online mandatory reporting line, on 09/23/2025 at 2:05 PM. During an interview on 09/30/2025 at 12:01 PM, Staff F, Assistant Director of Nursing/ Infection Preventionist/ Licensed Practical Nurse, when asked if they had reported the allegation to the state when the investigation started, said they had not. When asked why not, Staff F said that from the statements received from Resident 12, it did not look like it was abuse or neglect. Staff F also acknowledged they were unable to interview Resident 12 until 09/23/2025. During an interview on 09/30/2025 at 12:45 PM, Staff B, Director of Nursing Services, said the facility had 24 hours to report an allegation of abuse that did not result in injury. When asked if it met expectations that the facility was made aware by Resident 12 of an allegation of abuse at 9:30 AM on 09/22/2025, but the facility did not report until 09/23/2025 in the afternoon, Staff B said it was reported the next day so they felt that was within the appropriate timeframe. Reference F610Reference WAC 388-97 -0640(5)(a).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 by ensuring residents were provided scheduled medication, were updated promptly of medication unavailability, and/or were observed during medication administration, for 2 of 22 sampled residents (Residents 3 & 8) reviewed for professional standards, and to appropriately label multiuse medications for 1 of 3 medication carts (Olympic 2 cart) reviewed for medication storage observation. This failure placed residents at risk for medication complications, for receiving expired medication, and a diminished quality of life. Findings included.1) Resident 3 was admitted to the facility on [DATE], with diagnoses of hypertension (a condition where the force of blood against the artery walls is consistently too high) and heart failure (a condition where the heart cannot pump blood effectively enough to meet the body's demands). The Quarterly Minimum Data Set (MDS, an assessment tool), dated [DATE], documented Resident 3 was cognitively intact. Resident 3's electronic health record (EHR) showed an order, dated [DATE], for eplerenone, to treat congestive heart failure and hypertension, scheduled once a day.A review of Resident 3's July Medication Administration Record (MAR), showed eplerenone had a blank box, no documentation, on [DATE] and [DATE]. A review of Resident 3's [DATE] MAR, showed eplerenone had an x documented, in the box, on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. A review of Resident 3's EHR, showed a progress note by the provider, dated [DATE], documenting Resident 3's medication eplerenone was on hold due to pharmacy availability. A progress note dated [DATE], documented eplerenone was on hold. A progress note dated [DATE], documented Resident 3 reported a concern about not receiving eplerenone, and the pharmacy, provider and resident were notified.On [DATE] at 12:21 PM, Resident 3 said they were not getting their blood pressure pill, eplerenone, every morning and the staff never told them why. Resident 3 said they should have told me what was going on.On [DATE] at 2:03 PM, Staff D, Charge Nurse (also called Unit Manager at this facility, often called Resident Care Manager in other facilities) / Registered Nurse (RN), reviewed Resident 3's [DATE] MAR with blanks and acknowledged it. Staff D said her expectation was for the staff to write a progress note on [DATE]th and 20th and there were no progress notes. Staff D said Resident 3's [DATE] MAR had an x on the 4th and 8th - 18th and this meant the medication was not given. Staff D said the medication was not available from the pharmacy and there were no progress notes documenting this until the 16th. Staff D said the nurse should have charted the provider was notified, the blood pressure was stable and they were waiting on medication from pharmacy. Staff D said there were no progress notes documenting why it was not given until, [DATE], [DATE], and [DATE]. Staff D said the resident should have been notified by the staff that the medication was not available. Staff D said she did not see a progress note that documented the resident was notified. On [DATE] at 2:27 PM, Staff B, Director of Nursing Services (DNS), said while looking at Resident 3's [DATE] MAR, he did not see anything in the notes and it looked like Resident 3 missed this medication. Staff B said while looking at the [DATE] MAR, there should have been a note from the nurse documenting the medication was not available and documented the provider and pharmacy were contacted. Staff B said the nursing staff could have notified the provider and received a new order or put the medication on hold. Staff B said there was a hold order for the medication on the 17th and 18th and there were progress notes by the nursing staff charting the medication was not given on the 16th-18th. Staff B said he did not see documentation Resident 3 was notified the medication was not available.2) Resident 8 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], showed Resident 8 was cognitively intact. During an observation and interview on [DATE] at 3:18 PM, Resident 8 opened their top drawer of their dresser and three white pills were seen in a medicine cup. At 3:34 PM, Staff Q, Licensed Practical Nurse (LPN), came into the room and Resident 8 said the three pills were melatonin. Review of Resident 8's [DATE] MAR, showed Resident 8 had melatonin ordered on [DATE] for once a night at bedtime. From the MAR, Resident 8 had 6 documented nights of receiving melatonin, [DATE] to [DATE], before they were found with 3 of the pills (3 out of 6 nights were not taken).During an interview on [DATE] at 10:04 AM, Staff D, Charge Nurse/RN, said their expectation for nurses regarding watching residents take their medication, was that nurses would stay in the room with the resident until all their medications had been correctly administered. During an interview on [DATE] at 3:19 PM, Staff B, DNS, said the nurse should make sure residents have taken their medication, fully swallowed, before they leave the room. MEDICATION WITHOUT OPEN DATE:On [DATE]

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide Occupational Therapy (treatment that evaluates and treats people who have injuries, illnesses, or disabilities to help them live as self-sufficiently as possible by developing, recovering, or maintaining skills needed for everyday activities of life) for 2 of 3 (Resident 112 and 69) residents reviewed for therapy services. This failure placed residents at risk of decreased physical function, delay in returning home, and decreased quality of life.Findings included .RESIDENT 112Resident 112 was admitted on [DATE] with fractures from a motor vehicle accident. Resident 112's physician order, dated 08/26/2025, showed an order for OT [occupational therapy] evaluation and treat. Resident 112's medical provider admit visit, dated 08/27/2025, showed the assessment/plan was for OT eval and treat.On 11/05/2025 at 2:20 PM, Staff QQ, Occupational Therapist, said they had completed Resident 112's evaluation on 09/18/2025. When asked why Resident 112's occupational therapy evaluation was not completed upon admission, Staff QQ said there were no occupational therapists available.Resident 112's occupational therapy evaluation, dated 09/18/2025, showed Resident 112's start of care was 09/18/2025.On 11/05/2025 at 3:19 PM, Staff RR, Director of Rehabilitation (DOR), said Resident 112 had an order for occupational therapy on admission but the facility did not have an occupational therapist available. Staff RR said Resident 112 did not receive occupational therapy until 09/18/2025. Staff RR said they did not know if the medical provider was notified.RESIDENT 69Resident 69 was admitted on [DATE] with back fractures. Resident 69's physician orders, dated 08/29/2025, showed an order for OT [occupational therapy] evaluation and treatment.Resident 69's medical provider notes, dated 09/05/2025 and 09/09/2025, showed the assessment and plan was to continue OT.Resident 69's occupational therapy evaluation, dated 09/16/2025, showed the start of care was 09/16/2025.On 11/10/2025 at 11:46 AM, Staff RR, DOR, said they were unable to initiate occupational therapy for Resident 69 on admission because they did not have an occupational therapist available. Staff RR said they initiated occupational therapy for Resident 69 on 09/16/2025. Staff RR said they were unaware if the medical provider was informed of the delay in initiating occupational therapy for Resident 69.FINAL INTERVIEWOn 11/10/2025 at 2:52 PM, Staff A, Administrator, said they expected when a resident had a physician order for therapy it would be provided. Staff A said they had the resources to obtain occupational therapy services. Staff A said they were unaware the facility did not have an Occupational Therapist available for Resident 112 and Resident 69.Reference WAC 388-97-1280(1)(a)(b)(4).

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. .Based on interview and record review, the facility failed to provide accurate and complete access to all resident records for 1 of 1 annual recertification survey. These failures had the potential risk of causing a delay in the survey process, not addressing resident concerns and a diminished quality of life. Findings included .On 09/22/2025 at 9:50 AM, the survey team entered Bremerton Trails Post Acute. The survey teams' business cards were provided to Staff B, Director of Nursing Services, for access to Point Click Care (PCC, the electronic health care (EHR) system used for record maintenance). On 09/22/2025 at 10:09 AM, during the Entrance Conference with Staff A, Administrator, and Staff B, Director of Nursing Services (DNS), they were reminded that surveyors needed access to all medical records within required timeframe. The Grievance log was also requested at this time. On 09/22/2025 at 11:33 AM, the Grievance log was provided with the last date of entry documented as 09/08/2025. On 09/22/2025 at 2:17 PM, PCC access was provided to surveyors.On 09/23/2025 at 8:37 AM, Staff A and Staff B were informed that the PCC access provided did not have access to all medical records, including Medication Administration Records (MAR), Treatment Administration Records (TAR), various assessments, care plans, nutritional reports and laboratory results. Staff A and Staff B said they did not know why and would address the problem immediately.On 09/24/2025 at 8:49 AM, Staff A and Staff B were again informed that surveyors still did not have access to all medical records, including various assessments, nutritional reports and laboratory results.On 09/24/2025 at 3:57 PM, Staff A was updated about continued lack of access to the complete medical record Staff A said they did not know what the problem was and did not know what to do. Staff A said it was out of their hands. On 09/26/2025 at 9:28 AM, Staff B was informed of continued lack of access to complete medical record. Staff B said that they were told by their corporate office that the ownership company was hesitant to give access to all medical records. On 09/26/2025 at 11:04 AM, a second log in was provided to allow visualization of laboratory results. On 09/29/2025 at 8:20 AM, Staff A was emailed, requesting an updated Grievance log and Accident and Incident Log, including all entries up to date (09/28/2025). On 09/29/2025 at 9:05 AM, the exact same Grievance log received on 09/22/2025 was provided.On 09/30/2025 at 2:12 PM an updated Grievance log (through 09/30/2025) was provided but was still missing reported Grievances.Reference F585. Reference WAC 388-97-1720