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	03/04/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 investigate an allegation of misappropriation of a phone for 1 of 3 (Resident 1) residents reviewed. This failure placed residents at risk of loss of property, lack of communication with the community and a decreased quality of life.Findings included.Resident 1 was admitted on [DATE] with diagnoses including depression, and anxiety. The Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 1 had moderate cognitive impairment, required substantial/maximal assistance from staff for bed mobility and moderate assistance to transfer to a chair. Resident 1's progress notes, dated 02/13/2026, showed Resident 1 reported their family member had removed their personal phone and would not return it. The notes showed the SSA [Social Service Assistant] staff completed a report to the state agency for concern for possible exploitation/control of resident communication device by family members.On 03/04/2026 at 9:17 AM, Staff A, Social Service Assistant, said Resident 1 alleged their family member had taken their cell phone from them. Staff A said they reported it to the state agency. Staff A said they had not completed an investigation and/or attempted to locate the phone. Staff A said their only action related to the allegation was reporting it to the state agency and leaving a voice mail on the family member's phone. Staff A said they had not heard back from the family member and/or taken any further action.On 03/04/2026 at 10:40 AM, Resident 1, said their family member had taken their cell phone and they wanted it back, it's the only way I have to communicate to the outside world.On 03/04/2026, Staff B, Administrator, said they were unaware of Resident 1's allegation of their cell phone being taken by their family member. Staff B said the staff should have initiated a grievance about a missing item when they were made aware of the missing phone and initiated an investigation. Staff B said if the phone was not located, an incident report would be initiated with the ongoing investigation and a report to the state agency. Staff B said staff did not follow the facility's policy for an allegation of misappropriation.Reference WAC 388-97-0640(6)(a)(b)

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assist residents with positioning in bed, eating and toileting for 2 of 3 (Resident 1 and 2) residents reviewed for care. This failure placed residents at risk of malnutrition, dehydration, poor hygiene, pain and loss of dignity.Findings included.Review of the facility's policy titled, Activities of Daily Living (ADLs), revised March 2018, showed appropriate care and services would be provided for residents who were unable to carry out ADLs independently, including support and assistance with hygiene, mobility, toileting, and dining. The policy showed if residents with cognitive impairment or dementia resisted care, staff would attempt to identify the underlying cause of the problem and not just assume the resident was refusing or declining care and would approach the resident in a different way or at a different time or have another staff member speak with the resident.RESIDENT 1Resident 1 was admitted to the facility on [DATE] with diagnoses including depression, anorexia, stroke and hemiparesis (loss of movement on one side). The Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 1 had moderate cognitive impairment, was at risk of malnutrition, had experienced a weight loss, required substantial/maximal assistance from staff for bed mobility, personal hygiene, dressing and required set-up assistance for eating. The MDS showed Resident 1 was dependent on staff for toileting and frequently incontinent of bladder and bowel.Resident 1's Kardex (Nursing Assistant's care instructions), as of 03/02/2026, showed Resident 1's call light and needed items, water was to be in reach. The Kardex showed Resident 1 was independent with eating but required supervision and needed encouragement to get up, and to offer alternative meals/snacks if low intake occurred. The Kardex showed staff were to report to the nurse when Resident 1 refused to eat or drink and required extensive assistance with check and change for toileting and bed mobility.On 02/27/2026 at 10:16 AM, Collateral Contact 1 (CC1), said when they visited Resident 1 the resident complained of sitting in urine and feces, not receiving assistance with getting out of bed, eating, and was unable to turn himself. CC1 said Resident 1 was completely dependent on staff for care and the resident smelled, the call light was behind the bed and out of reach, the floor was sticky and the resident appeared to not have received care. CC1 said they were concerned for the resident.Durning a continuous observation in Resident 1's room on 03/02/2026 from 11:47 AM until 1:33 PM the following observations were made:On 03/02/2026 at 11:47 AM, Resident 1 was observed lying in bed. Resident 1's room had a strong odor of urine present. Resident 1's bedside table was out of reach of the resident and a meal tray with breakfast food and drinks were on the table and they appeared untouched and/or opened. Resident 1's call light was observed pinned to the mattress at the head of the bed on the resident's right side. Resident 1's left arm was in a splint, and the resident said their right arm hurt and they could not use it. Resident 1 said I need water. Staff E, Resident Care Manager (RCM), was at the nursing station and agreed to assist Resident 1. Staff E brought a pitcher of water to Resident 1. Resident 1 said they had not had water in two days. Staff E assisted Resident 1 with the water, and the resident drank the entire pitcher and requested more water. Staff E obtained another pitcher of water and Resident 1 continued to drink the water. Resident 1 said they wanted food. Staff E checked the tray on the bedside table and said they would find an aide to assist the resident. Staff E said they could smell the urine in the room, Staff E checked Resident 1's brief and said it was a little bit wet. Staff E said they would have housekeeping come to the room and an aide to assist Resident 1. Staff E placed the water pitcher onto the bedside table out of reach of the resident and exited the room.On 03/02/2026 at 12:05 PM, Resident 1 asked for assistance with the call light. Resident 1 said they could not see the call light and did not know where it was. Resident 1 was observed attempting to reach the call light but was unable to. Resident 1 said their arm hurt and they couldn't raise it.On 03/02/2026 at 12:10 PM, Staff F, Certified Nursing Assistant (CNA), was observed entering Resident 1's room. Resident 1 said they wanted help with food and water. Staff F (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said they were assisting Resident 1's roommate and told Resident 1 to wait a minute. Staff F exited the room.On 03/02/2026 at 12:16 PM, Staff G, CNA, entered the room. Resident 1 said they wanted water and food and had not eaten in three days. Staff G told Resident 1 it was almost lunch time. Staff G said they were assigned to Resident 1 and had been on shift since 6:00 AM. Staff G said they had checked Resident 1's brief at 8:00 AM, it did not need to be changed, and they took Resident 1's blood pressure. Staff G said Resident 1 did not want breakfast at that time and wanted to sleep. Staff G said they had been checking on Resident 1 and they had been sleeping. Staff G said they were not sure if Resident 1 needed assistance with eating. Staff G acknowledged that Resident 1 was awake, and said they were wondering if they should wait until lunch was served. Resident 1 said, I want food, I haven't eaten in two days. Resident 1 asked Staff G to assist them to turn on their call light. Staff G exited the room and said they would bring food.On 03/02/2026 at 12:24 PM, Staff G was sitting at the nursing station.On 03/02/2026 at 12:27 PM, Staff E, RCM, entered Resident 1's room with a lunch tray. Resident 1 said they needed an ambulance for their arm and they wanted water, Staff E said they would go and check their chart. Staff E assisted Resident 1 with water and said they would get someone to assist Resident 1 with eating.On 03/02/2024 at 12:29 PM, Staff H, Licensed Practical Nurse (LPN), entered Resident 1's room. Staff H said they had Resident 1's medication. Resident 1 said they did not want their medications, but they needed an ambulance because their arm was twisted and wanted the police called because the roommate had stolen their wife and twisted their arm. Staff H assisted Resident 1 with water, and the resident finished the pitcher of water. Staff H offered the juice on the lunch tray and Resident 1 drank the entire carton of juice. Staff H brought the table over and positioned it across the bed within Resident 1's reach and opened the food containers. Resident 1 told Staff H they could not move their arm. Staff H assessed the resident's arm and said they had good strength, Resident 1 reiterated they were still unable to move their arms and told Staff H they needed someone to assist them to eat. Staff H left the room and said they needed to discuss the concerns with their supervisor.On 03/02/2026 at 12:37 PM, Staff G, CNA, was observed in the hallway with the coffee cart.On 03/02/2026 at 12:39 PM, Staff H, LPN, entered the room with a water pitcher. Resident 1 said they could not hold it; Staff H assisted the resident to drink. Staff H asked the resident why they had not eaten their lunch. Resident 1 said they could not reach it and they were hungry. Staff H cut up the food and gave Resident 1 a couple of bites. Staff H left the room. Staff E, RCM entered the room with Staff C, Physician (MD) and Staff I, Social Service Director (SSD). Resident 1 said they feared their roommate and they hurt on the right side of their body. Staff C, MD, assessed Resident 1. Resident 1 said they were hungry and needed help because they could not move their arms. Staff C, MD asked Staff E, RCM to have someone assist Resident 1 with eating.On 03/02/2026 at 12:56 PM, Staff C, MD, told Staff G, CNA that Resident 1 needed assistance with eating and to be repositioned. Staff G acknowledged the request and exited the room with Staff C.On 03/02/2026 at 12:57 PM, Staff I, SSD, told Resident 1 they would find the resident a new room so they felt safe and they would find someone to assist the resident with eating because Staff I heard Resident 1 was hungry. Resident 1 said they needed assistance to eat their lunch. Staff I said they were unable to assist the resident, but they would stay with them until someone came.On 03/02/2026 at 1:07 PM, Staff C, MD, entered the room and told Resident 1 they were ordering tests to determine the cause of the resident's arm pain. Resident 1 said with a loud voice, I want to eat. Staff C told Staff I that they needed a staff person to assist Resident 1 with their lunch tray.On 03/02/2026 at 1:18 PM, Resident 1 asked Staff I to assist them to put on the call light. Staff F, CNA entered the room and Staff I asked them if they could assist Resident 1 with their lunch.On 03/02/2026 at 1:33 PM, Staff F, CNA, assisted Resident 1 with their lunch (1 hour since the tray was brought to Resident 1). Resident 1 said the mashed potatoes tasted bad and were cold. During the continuous observation Resident 1 was not provided with incontinent care. On 03/04/2026 at 12:33 PM, Staff D, Director of Nursing, said they expected staff to assist residents at mealtimes. Staff D said the licensed nurses should have made rounds and when a resident has not eaten their meal there was to be a change (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	communicated to the Resident Care Manager. Staff D said Resident 1's immediate need was for food, water and incontinent care. Staff D said Resident 1 should have been changed and repositioned. Staff D said that should have been the focus for the staff and acted on. Staff D said when the nursing assistants began their shift, they should ensure the residents had fresh water in reach and was available to them. Staff D said it was Staff G's first day in the facility and was they were not familiar with Resident 1.RESIDENT 2Resident 2 was admitted on [DATE], with diagnoses to include rib and pelvic fractures. The Minimum Data Set Assessment, dated 02/08/2026, showed Resident 2 had severe cognitive impairment and required extensive assistance from staff for bed mobility and transfers.Resident 2's ADL Care Plan, dated 12/24/2025, showed Resident 2 was totally dependent on staff for bed mobility and transfers.Resident 2's Pain Care Plan, dated 12/25/2025, showed Resident 2's pain was related to multiple fractures. The care plan showed staff were to observe for and report to nurse any s/sx [signs or symptoms] of non-verbal pain: mood/behavior (restless, squirmy, constant motion), eyes (wide open/narrow slits/shut, glazed, tearing, no focus), face (sad, crying, worried, scared, clenched teeth, grimacing) body (tense, rigid, rocking, curled up, thrashing).On 02/05/2026 at 11:17 AM, Resident 2 was observed lying in their bed, the head of the bed was upright at 90 degrees and Resident 2 had slid down the bed and their back was unsupported by the mattress due to the position of the bed. Resident 2's legs were moving up and down, their facial expression was a grimace and they were whining softly. Resident 2 was dressed in a gown with their brief exposed. Resident 2 was visible from the hallway in this position.On 02/05/2026 at 11:35 AM, 11:46 AM, 11:49 AM, 12:04 PM, and 12:05 PM, Resident 2 was observed lying in their bed, the head of the bed was upright at 90 degrees and Resident 2 had slid down the bed and their back was unsupported by the mattress due to the position of the bed. Resident 2 was dressed in a gown with their brief exposed. Resident 2 was visible from the hallway in this position. During these observations facility staff were observed to walk by Resident 2's room and glance into the room but did not enter the room and/or assist the resident.On 02/25/2026 at 12:18 PM, Staff J, Occupational Therapist, entered Resident 2's room. Resident 2 was observed lying in their bed, the head of the bed was upright at 90 degrees and Resident 2 had slid down the bed and their back was unsupported by the mattress due to the position of the bed. Resident 2 was dressed in a gown with their brief exposed. Staff J said Resident 2 was not positioned correctly in the bed and appeared uncomfortable and in pain. Staff J said Resident 2 had pelvic fractures and it would be painful to be in that position in bed.On 02/25/2026 at 12:44 PM, Staff K, Certified Nursing Assistant, said they were assigned to care for Resident 2. Staff K said they had repositioned Resident 2 between 11:45 AM and 12:00 PM. When asked what care they had provided, Staff K said they had made sure Resident 2's legs were not hanging off the bed and were straight. Staff K said they did not need to adjust Resident 2 in the bed and Resident 2 had blankets covering them.On 02/25/2026 at 4:02 PM, Staff L, Assistant Director of Nursing, said they expected staff would position residents correctly in their bed and would expect all staff to assist when they observed a resident in an uncomfortable position.Reference WAC 388-97-1060(2)(c)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide physician ordered medications for 1 of 3 residents (Resident 3) reviewed for medication administration. This failure placed residents at risk of increased pain, frustration and a decreased quality of life.Findings included.Review of the facility's policy titled, Pharmacy Services Overview, revised April 2019, showed pharmaceutical services consisted of: pharmacy services were available to residents 24 hours a day, seven days a week, and residents had sufficient supply of their prescribed medications and received medications in a timely manner. Resident 3 was admitted on [DATE], with diagnoses including chronic pain and spinal stenosis (narrowing of the spinal canal, causing pressure on the spinal cord, typically resulting in pain and numbness). The Minimum Data Set Assessment, dated 11/26/2025, showed Resident 3 was cognitively intact.On 03/02/2026 at 2:10 PM, Resident 3 said the facility continually ran out of their oxycodone (pain medication). Resident 3 said they were on every four-hour cycle and when they missed a dose they were in a lot of pain. Resident 3 said the staff told them different reasons why they would run out; it wasn't ordered, agency nurse did not order, mix up between shift nurses, doctor did not sign prescription, insurance won't cover and other excuses. Resident 3 said they were tired of the delays.Resident 3's physician orders, dated 01/31/2026, showed Resident 3 was to receive oxycodone 10 MG [milligrams] six times per day and oxycodone 10 MG tablet every six hours as needed for pain management.Resident 3's Medication Administration Record (MAR), dated 02-02-2026 through 02-28-2026, showed the oxycodone was not administered on 02/07/2026 at 12:00 AM, 4:00 AM, 4:00 PM and 8:00 PM, on 02/20/2026 at 12:00 AM and 02/28/2026 at 4:00 AM, 12:00 PM, 4:00 PM and 8:00 PM.Resident 3's progress notes, dated 02/07/2026, showed oxycodone was not available and awaiting pharmacy delivery.Resident 3's progress notes, dated 02/19/2026 at 9:15 PM showed medication administration notes for oxycodone two tablets six times per day. The note showed only one tablet was available and the medication was on order.Resident 3's progress notes, dated 02/19/2026 at 11:56 PM, showed Oxycodone was on order.Resident 3's progress notes, dated 02/28/2026 at 4:30 AM, showed no access to Pixis (secure medication storage) and the resident was aware that the AM shift would come shortly.Resident 3's progress notes, dated 02/28/2026 at 9:34 AM, showed oxycodone tablets unavailable in Omnicell (medication storage unit) and the pharmacy was informed.Resident 3's progress notes, dated 02/28/2026 at 4:56 PM and 9:09 PM showed the oxycodone was pending pharmacy delivery.On 03/04/2026 at 10:09 AM, Staff C, Medical Provider, said they expected the license nurse to administer medication per their order.On 03/04/2026 at 12:33 PM, Staff D, Director of Nursing, said they investigated the reason for Resident 3 not receiving their oxycodone consistently and they discovered the pharmacy was not sending the amount of oxycodone the facility had requested to be refilled. Staff D said they spoke to the supervisor of the pharmacy, and they were unable to communicate a reason for not sending the requested amount of medication. Staff D said the facility would have to begin ordering refills twice per week to correct the situation.Reference WAC 388-97-1300(1)(a)(4)(e)