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	03/31/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident's guardian of clinical changes for 1 of 3 residents (Resident 1) reviewed. This failure placed residents at risk of lack of advocacy, support and assistance with medical decision making.Findings included.Review of the facility's policy titled, Resident Representative, revised 02/2021, showed that the facility treats the decisions of the resident representative as the decisions of the resident to the extent delegated by the resident or the extent required by the court, the term resident representative is defined as the court-appointed guardian or conservator of a resident.Resident 1 was admitted on [DATE] with diagnosis of cerebral palsy (neurological disorder affecting body movement due to abnormal brain development or injury).Review of Resident 1's Superior Court of [NAME], Guardianship Letter, dated 02/07/2025, showed Resident 1 had a court appointed guardian of person and conservator of the estate with full authority. The letter showed Collateral Contact 1 (CC1), was appointed as Resident 1's guardian.On 03/25/2026 at 3:54 PM, CC1 said when Resident 1 stopped eating no one contacted them. CC1 said the facility did not respect their guardianship and did not contact them when Resident 1 started to have stomach issues. CC1 said it was frustrating because Resident 1 did not fully understand their medical issues and that is why they had a guardian. CC1 said they finally had a care meeting, but it took too long for the facility to involve them.Resident 1's progress notes, dated 02/02/2026, showed Resident 1 had one episode of nausea and vomiting reported. There was no documentation that Resident 1's representative was notified.Resident 1's medical provider notes, dated 02/05/2026, showed Resident 1 was seen by the medical provider for complaints of frequent loose stools, abdominal discomfort and bloating of 24 hours duration and complaints of worsening fatigue and generalized weakness. The note showed medical care planning was reviewed and discussed with the resident and the plan was close monitoring for deterioration and to send stool to the lab. There was no documentation that Resident 1's representative was notified.Resident 1's progress notes, dated 02/13/2026, showed Resident 1 refused to eat breakfast and lunch and did not want to have anything because it made them feel upset and refused anti-nausea medications. There was no documentation that Resident 1's representative was notified.Resident 1's medical provider notes, dated 02/17/2026, showed that Resident 1 was being seen after a report that they had refused to take any meal and/or medications for last 24 hours. The notes showed Resident 1 had no energy/interest to talk and felt exhausted. The notes showed Resident 1 appeared frailer and more fatigued than usual. The notes showed the plan was to rehydrate the resident with intravenous fluid (administration of fluid through a vein) and to call family members/POA [power of attorney] for a discussion. There was no documentation that Resident 1's representative was notified.Resident 1's progress notes dated 02/19/2026, showed intravenous fluids were initiated. There was no documentation that Resident 1's representative was notified.Resident 1's provider notes, dated 02/24/2026, showed CC1 and Resident 1 had a care meeting with the provider and facility staff to discuss current over all conditions.On 03/31/2026 at 3:03 PM, Staff B, Director of Nursing, said that resident's guardians should be notified of any change in a resident's condition and/or plan of care. Staff B reviewed Resident 1's medical (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: 505123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record and said there were many opportunities to notify the guardian when Resident 1's condition changed from their baseline and there was no evidence the staff notified them. Reference WAC 388-97-0320(1)(a)-(d)(2)(a)(b).

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 03/31/2026
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)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate and provide resolution for a grievance for 1 of 3 residents (Resident 2) reviewed. This failure placed residents at risk of inadequate care, disrespect and a diminished quality of life.Findings included.Review of the facility's undated policy titled, Grievances: Resident/Resident Representative, showed the facility provided residents and resident representatives with an uninhibited grievance procedure and encouraged the resident/resident representative to discuss any and all grievances so issues may be resolved, communicate with the resident/resident representative and attempt to resolve the issue within five days, and follow up with the resident/resident representative about the grievance to ascertain satisfaction with the resolution of the reported concern.Resident 2 was admitted on [DATE] with diagnoses of depression and anxiety. The Quarterly Minimum Data Set Assessment, dated 02/08/2026, showed the resident had moderate cognitive impairment, occasionally incontinence of urine and required moderate assistance with toileting.Resident 2's care plan, revised 06/02/2025, showed the staff were to check the resident every two hours, ask if they needed to use the restroom and check to make sure the resident was clean and dry.On 02/27/2026 at 10:27 AM, Collateral Contact 2 (CC2), said they had gone to visit Resident 2 on 02/19/2026 and found them soaking wet and agitated. CC2 said Resident 2 usually giggled when they saw CC2 and when they walked in that time they knew something was wrong. CC2 said a staff member was reassigned and they assisted the resident with being changed. CC2 said they wrote a grievance, but they had not heard from the facility and did not know what action the facility had taken.Resident 2's grievance, dated 02/19/2026, showed CC2 documented when they arrived at the facility Resident 2's IPAD (computer tablet) was off and they seemed upset. The grievance showed CC2 asked Resident 2 if they wanted the IPAD on and Resident 2 said they had to wait five minutes to be changed and they were told they would change their nasty *ss in five minutes. The grievance showed CC2 said it was evident through Resident 2's upset behavior and what they were telling CC2 they had been given a consequence of no IPAD and sitting in wet clothes. The grievance showed CC2 felt this was abuse/neglect of a resident and they wanted immediate removal of the staff responsible and a report filed.Resident 2's incident report, dated 2/23/2026, showed the facility had received the grievance from CC2 regarding Resident 2 being upset and had to wait to be changed before using their IPAD. The incident report showed they reported the incident to the state agency. The incident report showed Staff C, Unit Manager, had interviewed CC2 and Resident 2 and Resident 2 had confusion and denied they were soaking wet. The incident report showed Staff C assigned a different nursing assistant to assist with the brief change and CC2 was present. Staff C indicated Resident 2 was not soaking but the brief was still changed and they followed up with the nursing assistant and reminded them to check on all residents in a timely manner when they needed to be changed/cleaned. Staff C said Resident 2 and CC2 were satisfied when they left the room.On 03/24/2026 at 12:39 PM, Staff D, Certified Nursing Assistant, said they cared for Resident 2 often and were familiar with their care. Staff D said on 02/19/2026 they were not assigned to Resident 2, but the nurse had asked them to change the resident. Staff D said CC2 was present in the room when they arrived. Staff D said Resident 2 was sitting in their wheelchair and was not acting like themselves. Staff D said Resident 2 appeared timid and kept saying I have to sit here for five minutes. Staff D said Resident 2 was acting timid when entering the bathroom, which was not typical behavior for them. Staff D said Resident 2's brief was soaked through their pants onto the wheelchair, and their socks were soaked too. Staff D said they had never seen Resident act like this and/or this wet. Staff D said CC2 was the only one present when they changed Resident 2. Staff D said they had not been interviewed and/or asked about the grievance or Resident 2's condition.On 03/26/2026 at 3:34 PM, Staff B, Director of Nursing, said they had not (continued on next page)

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	03/31/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interviewed Staff D about Resident 2's condition. Staff B said they did not investigate the behavior of Resident 2 and why they were upset.On 03/31/2026 at 4:51 PM, Staff C, Unit Manager, said they had responded to Resident 2's room when they were told of CC2's concerns on 02/19/2026. Staff C said they ensured an aide assisted Resident 2 with care and left the room to give them privacy. Staff C said they returned later to the room and Resident 2 looked great. Staff C said they did not remember if CC2 was present. Staff C said they did not believe they followed up with CC2 regarding the grievance.On 03/31/2026 at 5:45 PM, Staff A, Administrator, said they were the Grievance Official, and the facility should have thoroughly investigated the grievance and discussed their findings and the resolution with CC2.Reference WAC 388-97-0460.

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 03/31/2026
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)
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 interview and record review, the facility failed to obtain emergency medical services timely for 1 of 3 residents (Resident 3) reviewed for quality of care. This failure placed residents at risk of medical complications, physical distress and a decline in condition.Findings included.Resident 3 was admitted on [DATE] with diagnoses of dementia, respiratory failure and heart failure. The admission Minimum Data Set Assessment, dated 10/30/2025, showed Resident 3 had severe cognitive impairment and required substantial assistance with activities of daily living.On 03/25/2026 at 3:46 PM, Collateral Contact 3 (CC3), said they visited Resident 3 daily at the facility. CC3 said the day Resident 3 was sent to the hospital they were at the facility visiting and Resident 3 was having difficulty breathing and not able to get enough air. CC3 said they told the staff to contact the doctor. CC3 said Resident 3 appeared to be sleeping and/or unconscious. CC3 said they went home and were later contacted in the middle of the night by hospital staff and told Resident 3 was admitted to the hospital. CC3 said it should not have taken that long to get Resident 3 to the hospital.Resident 3's SBAR Communication Form, dated 12/19/2025, showed Resident 3 was experiencing shortness of breath and the symptom had not occurred before. The SBAR showed Resident 3's oxygen saturation (measures the percentage of oxygen-carrying red blood cells in the blood with normal ranges typically between 95% and 100%) was 90%. The SBAR showed the physician was notified on 12/19/2026 at 6:45 PM and ordered Resident 3 to be sent to the ED [emergency department] for tx [treatment] and eval [evaluation]. The SBAR showed CC3 was contacted on 12/19/2026 at 6:48 PM.Resident 3's progress notes, dated 12/20/2026 at 3:53 AM, showed that approximately 0250 [2:50 AM] the resident was still not picked up by Olympic transportation and the dispatcher advised they were on the list with no ETA [estimated time of arrival]. The notes showed at 030 [3:30 AM] the dispatcher called the facility and stated that 911 needed to be called as they could not provide transportation after all, 911 was called and the resident was transported to the hospital for respiratory distress via ambulance.On 03/26/2026 at 12:02 PM, Staff E, Registered Nurse, said they were caring for Resident 3 on 12/19/2026. Staff E said they completed the SBAR for Resident 3 and contacted the physician and the family. Staff E said it was the end of their shift, and they gave report to the oncoming nurse. Staff E said they reported that Resident 3 needed to be sent to the emergency department for respiratory distress and to contact the paramedics. Staff E said they left the facility and assumed the oncoming nurse had contacted 911. Staff E said the facility only transports residents with Olympic Ambulance for non-emergent conditions. Staff E said for shortness of breath and breathing issues, 911 should always be contacted.On 03/26/2026 at 3:34 PM, Staff B, Director of Nursing, said staff are expected to contact 911 for emergency services to transport residents to the hospital for emergent conditions. Staff B said Olympic Ambulance is utilized for non-emergent transport. Staff B said nursing staff should contact emergency services for a resident experiencing shortness of breath and/or respiratory distress.Reference WAC 388-97-1060(1)-(3)

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 03/31/2026
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)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide social service advocacy following an abuse allegation and assistance with representation for 1 of 3 residents (Resident 4) reviewed. This failure placed residents at risk for abuse, lack of a healthcare advocate and emotional wellbeing.Finding included.Resident 4 was admitted on [DATE] with diagnoses of anoxic brain injury (brain damage caused by lack of oxygen), dysarthria (speech disorder caused by brain damage that results in difficult to understand speech). The Quarterly [NAME] Data Set Assessment, dated 03/12/2026, showed Resident 4 had moderate cognitive impairment and was dependent on staff for activities of daily living.Resident 4's hospital's Palliative Care Follow Up Note, dated 02/04/2026, showed Resident 4 did not have decisional capacity for medical decision making. The note showed there was no DPOA [durable power of attorney] (delegated legal authority for decisions), and the LNOK [legal next of kin] Collateral Contact 4 (CC4) did not want to be part of the care decisions. The note showed the care decisions were deferred to Collateral Contact 5 (CC5).Resident 4's admission summary, dated [DATE], showed Resident 4 was admitted and accompanied by CC5. The summary showed CC5 signed all admission forms.Resident 4's medical record profile showed CC5's contact information listed first in the priority of contacts.Review of a report made to the state agency on 02/16/2026, showed that during communication therapy, Staff F, Speech Therapist, reported on 02/16/2026, Resident 4 said that CC5 had done something to them and pounded their hands on their chest, they remembered someone had hit them in the back of the head but didn't know who it was and they were sometimes afraid of CC5.Resident 4's progress notes dated, 02/17/2026 and 02/18/2026, showed CC5 was at Resident 4's bedside.Resident 4's progress notes dated 02/22/2026, showed CC5 was at Resident 4's bedside and the room smelled like foreign substances and CC5 was seen waking Resident 4 and then asked nurse to administer pain medications.Resident 4's medical provider notes dated 03/09/2026, showed Resident 4 was disoriented to time and place with a new onset of paranoia and continued delirium with agitation throughout. The note showed Resident 4 had fast waxing and waning consciousness with brief span of mentation.Resident 4's social service notes dated 03/09/2026, showed the DON [Director of Nursing] educated CC5 that they could visit if they agreed to follow rules by not spending the night and bringing substances into the facility.Resident 4's psychiatry note dated 03/11/2026, showed there had been concern about CC5 provided Resident 4 with elicit substances and Resident 4 appeared to be able to make wishes known at that time and it would be prudent for Resident 4 to identify a POA [power of attorney].Resident 4's progress notes dated 03/14/2026, showed Resident 4 was found unresponsive and was transported to the hospital.Resident 4's medical provider notes dated 03/19/2026, showed Resident 4 was readmitted to the facility from the hospital on [DATE] after altered mental status and overdose. The note showed CC5 posed a significant danger to Resident 4 and was banned from visiting Resident 4. The note showed Resident 4 tried to express themselves, but it was hard to understand what they were trying to say due to severe dysarthria, it seemed Resident 4 was able to comprehend what was said to them and attempted to respond verbally.Resident 4's progress notes dated 03/19/2026, showed Resident 4 was readmitted to the facility, experiencing severe anxiety and staff contacted CC4 for consent to treat Resident 4 but the person at the phone number indicated they were not CC4.On 03/24/2026 at 1:10 PM, Resident 4 was observed lying on their bed. Resident 4 was speaking unintelligibly and motioning with hands. Resident 4 was unable to make clear sounds and/or follow yes/no answers. Resident 4 appeared in distress and an aide was summoned.On 03/26/2026 at 12:39 PM, Staff G, Social Service Director, said the social service department reported Resident 4's allegation of abuse on 02/16/2026. Staff G said they reported the allegation but did not put any other interventions in place and/or take other actions following the report. Staff G said they continued to utilize CC5 as (continued on next page)

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 03/31/2026
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)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 4's representative following the 02/16/2026 allegation. Staff G said CC5 was not allowed to visit Resident 4 at the facility for a little while around 03/09/2026, because staff had concerns about CC5 bringing substances in the facility and spending the night. Staff G said Staff B, Director of Nursing, talked with CC5 and they agreed not to bring any substances into the facility and CC5 continued to visit Resident 4. Staff G said they had not spoken to Resident 4 since readmission on [DATE]. Staff G said they did not believe Resident 4 could make complex medical decisions, but they were not sure because they were not good with medical stuff and did not really understand why Resident 4 was at the facility. Staff G said they called CC4 on 03/26/2026 and CC4 said it would be ok if the staff contacted them about Resident 4. Staff G said CC4 had not been in contact with Resident 4 prior to Resident 4's facility admission. When asked who the staff had been talking to about medical issues since Resident 4 was readmitted , Staff G said they thought they had been trying to contact CC4, but CC4 had not agreed to act as a contact until 03/26/2026. Staff G said they changed Resident 4's medical record profile on 03/26/2026, listing CC4 as the primary contact because Staff B, Director of Nursing, had asked them to change it. Staff G said they had not thought about updating it before 03/26/2026. When asked if Staff G had explored legal authority for decision making for Resident 4 since the allegation of physical abuse on 02/16/2026 and/or the concern of CC5 bringing in substances on 03/09/2026 to Resident 4, Staff G said they did not think so.On 03/26/2026 at 2:41 PM, Staff F, Speech Therapist, said they could not fully assess Resident 4's cognitive status because of Resident 4's dysarthria and physical condition. Staff F said they did not have a test that would definitively determine if Resident 4 was cognitively aware to make informed medical decisions.On 03/31/2026 at 11:56 AM, Staff H, Social Service Assistant, said they made the report to the state agency on 02/16/2026 because Resident 4 made an allegation of physical abuse. Staff H said they did not complete a facility incident report or make any care plan changes/interventions and/or take any further action. Staff H said CC5 continued to be Resident 4's representative. Staff H said on 03/25/2026, they reached out to a Guardian service to inquire if they would represent Resident 4 because CC5 was no longer allowed to visit Resident 4 since readmission to the facility on [DATE]. Staff H said they had not attempted to speak with Resident 4 about the hospital stay and/or CC5 and they did not know if anyone else had either.On 03/31/2026 at 3:04 PM, Staff I, Unit Manager, said they were unaware of Resident 4's 02/16/2026 allegation of physical abuse. Staff I said CC5 was considered Resident 4's representative. Staff I said approximately around 03/06/2026 they thought CC5 was acting weird, they had contacted CC4 and made them aware. Staff I said CC4 was aware of Resident 4's and CC5's substance abuse issues. Staff I said they called CC4 because they suspected CC5 of bringing Resident 4 elicit substances. Staff I said Staff B, Director of Nursing, met with CC5 on 03/09/2026 and after that meeting CC5 was allowed to visit Resident 4 and Resident 4 indicated they wanted CC5 to visit. Staff I said between 03/09/2026 and 03/18/2026 when Resident 4 was readmitted from the hospital, CC5 was Resident 4's representative and the staff were notifying CC5 of any medical changes. Staff I said the staff began contacting CC4 after Resident 4 returned from the hospital. Staff I said Resident 4's medical record was not updated to indicate CC4 was the primary contact, but the nursing staff knew. Staff I said CC4 would sometimes answer the phone when they contacted them but acted like they did not care.On 03/31/2026 at 3:10 PM, Staff B, Director of Nursing, said they did not put any interventions in place and/or update the care plan after meeting with CC5 regarding bringing in substances to the facility because they had no proof. Staff B said they were unaware of the physical abuse allegation on 02/16/2026 and they were only monitoring for substance abuse. Staff B said they believed they did not make it clear to the nursing staff who was Resident 4's representative. Staff B said they thought the managers were aware, but it did not trickle down to the floor staff. On 03/31/2026, Staff A, Administrator, said they were the abuse coordinator at the facility, and they were unaware of Resident 4's allegation of abuse on 02/16/2026. Staff A said an investigation should have been initiated by the facility process and Staff G and Staff H should have investigated a representative for Resident 4 at a minimum.Reference WAC 388-97-0960(1)