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	05/29/2026

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 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 pain medications for 2 of 3 residents (Resident 1 and 2) reviewed for medication administration. This failure placed residents at risk of increased pain, clinical complications, frustration and a decreased quality of life.Findings included.RESIDENT 1Resident 1 admitted on [DATE] with diagnoses of metastatic (cancer that has spread) cancer and femur (thigh bone) fracture. The Minimum Data Set Assessment (MDS), an assessment tool, dated 05/04/2026, showed Resident 1 received scheduled and as needed pain medication. The MDS showed Resident 1 had frequent pain that made it hard to sleep and limited their day-to-day activities. On 05/12/2026 at 1:37 PM, Collateral Contact 1 (CC1), said Resident 1 was living with an inoperable (not a candidate for surgery) femur fracture and advanced metastatic cancer that caused Resident 1 extreme pain. CC1 said Resident 1 was receiving routine pain medication at the hospital prior to transferring to the facility. CC1 said approximately an hour after Resident 1 transferred to the facility they were left in excruciating pain. CC1 said Resident 1 was left for greater than eight hours without narcotic (a potent pain medication used to relieve moderate to severe pain) pain medication and was only given Tylenol (medication for mild pain). CC1 said the facility staff told them they were unable to obtain the narcotic pain medication any faster. CC1 said Resident 1 endured unnecessary suffering.Resident 1's physician order, dated 04/28/2026, showed an order for Oxycodone (narcotic pain medication) 5 milligrams every eight hours as needed for pain.Resident 1's physician order, dated 04/28/2026, showed an order for Acetaminophen (generic name for Tylenol) as needed for mild pain (1-3 on pain scale).Resident 1's Medication Administration Record (MAR), dated 04/01/2026 through 04/30/2026, showed Resident 1 was assessed for pain on 04/28/2026 at 11:00 PM with pain score of 8 (pain monitoring scale: 0=no pain, 1-3 mild pain, 4-5 moderate pain, 6-10 severe pain).Resident 1's Administration History Record, dated 04/28/2026 through 04/29/2026, showed Resident 1 received acetaminophen on 04/28/2026 at 11:58 PM and Resident 1's first dose of Oxycodone was administered on 04/29/2026 at 7:40 AM.On 05/29/2026 at 1:45 PM, Staff A, Assistant Director of Nursing (ADON), said the facility was unable to order medications for residents until the resident was physically in the facility. Staff A said Resident 1 was not admitted until after 6:00 PM on 04/28/2026. Staff A said the medications would not arrive until after midnight. Staff A said the facility had an emergency medication dispensing cabinet that licensed staff could obtain medications from. Staff A said the licensed staff notified the pharmacy they needed to obtain the medications from the emergency cabinet and the pharmacy would supply an access code. Staff A said they were aware that Resident 1 did not receive their narcotic pain medications timely when they were experiencing severe pain on admission but did not know why the licensed nurse did not follow the facility process for accessing medications from the emergency dispensing cabinet. Staff A said the expectation was for licensed staff to contact another licensed nurse, management and/or the resident's physician if they were unable to access medications per the physician's orders. Staff A said there was no reason Resident 1 should not have had their narcotic pain medication available to them. RESIDENT 2Resident 2 was admitted on [DATE] with a diagnosis of fibromyalgia (chronic disorder causing widespread (continued on next page)

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	05/29/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	body pain). The MDS, dated [DATE], showed Resident 2 was cognitively intact.On 05/15/2026 at 12:49 PM, Resident 2 said their narcotic pain medication was never available on time, the medication did not get reordered on time and they had to go without the medication. Resident 2 said when that happened, they would go through withdrawals and that made them not want to be touched, they did not want to do anything and they were in a lot of pain, it is horrible.Resident 2's physician orders, dated 04/27/2026, showed to give Oxycodone every four hours for pain.Resident 2's MAR, dated 05/01/2026 through 05/31/2026, showed Resident 2's Oxycodone was not administered on 05/06/2026 at 8:00 PM and 05/26/2026 at 4:00 PM and 8:00 PM.Resident 2's progress notes, dated 05/06/2026, showed Oxycodone was not administered because on call from pharmacy and not able to get pull code at that time.Resident 2's progress notes, dated 05/26/2026, showed Resident 2's Oxycodone was not administered because staff contacted the pharmacy and the pharmacist stated they required a new script.On 05/29/2026 at 3:48 PM, Staff A, ADON, said they reviewed Resident 2's medical chart and said they did not know why Resident 2 missed their dose on 05/06/2026 and/or why the staff could not obtain a code to access the emergency medication dispensing cabinet if the resident did not have their medication available. Staff A said there was a new script for the Oxycodone signed on 05/26/2026. Staff A said the licensed nurse should have pulled the Oxycodone from the emergency medication dispensing cabinet. Staff A said they did not know why licensed staff did not follow the facility process and/or contact management or the resident's physician if they did not have access to the physician's prescribed medication.Reference WAC 388-97-1300(1)(a)(4)(e).

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	05/29/2026

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to have a functioning call light system on 1 of 3 Resident Care Units (Cove unit). This failure placed residents at risk of delayed response to emergencies, care needs and fear for their well-being.Findings included.On 05/14/2026 at 11:34 AM, Resident 3 said their call light was not working. Resident 3 said it had not been working since the day before. Resident 3 was observed pushing the call light. The call light above the resident's door did not illuminate, there was no audible sound and the room number on the call system panel across from the nursing station did not illuminate. Resident 3 said if they needed assistance they had to get into their wheelchair and wheel out into the hallway to flag someone down for assistance. Resident 3 said the staff were aware and they had not been given anything to alert the staff they needed assistance.On 05/14/2026 at 11:37 AM, Staff B, Certified Nursing Assistant (CNA), said the call light in Resident 3's room had stopped working the day before. Staff B said the system was still not working on the Cove unit and the staff had given some of the residents bells but they did not have enough for all the residents.On 05/14/2026 at 11:38 AM, Resident 4 said their call light was not functioning. Resident 4 said it had stopped working the previous day. Resident 4 said they had to yell when they needed assistance and they had to yell if their roommate needed assistance because their voice was not loud enough for anyone to hear. Resident 4 said it had taken longer to get help, and they were not given a bell to alert staff they needed assistance. Resident 4 was observed pushing the call light. The call light above the resident's door did not illuminate, there was no audible sound and the room number on the call system panel across from the nursing station did not illuminate.On 05/14/2026 at 12:17 PM, Resident 5 said they had not had a functioning call light since yesterday at about 5:00 PM. Resident 5 said the staff told them the call light system was down. Resident 5 said they were not given a bell and/or any other instructions for alerting staff when they needed assistance. Resident 5 said they would just wait until they happened to see staff or just bear it.On 05/14/2026 at 12:19 PM, Resident 6 said they had been pushing the button and no one was coming yesterday and the staff let them know the call light system was down. Resident 6 said they had not been given a bell to alert staff. Resident 6 said they just had to wait until staff made rounds, that made them very nervous because they had chronic shortness of breath and had no way of yelling loud enough.On 05/14/2026 at 12:37 PM, Resident 7 said the day before about 2:30 PM they had pushed the call light, and no one came. Resident 7 said an aide poked their head in the room about 3:30pm and told me the call light system was not working. Resident 7 said they used their cell phone to contact the front desk and asked to speak with a manager about the situation. Resident 7 said no one came and/or contacted them. Resident 7 said later that evening they expressed their concern to their aide, and the aide went and retrieved their supervisor. Resident 7 said the nurse listened to the concern and gave them a bell to alert staff. Resident 7 said the staff could not always hear the bell and they were dependent on staff for assistance and were incontinent. Resident 7 said the wait was longer. Resident 7 said they would yell but a lot of residents yelled in the unit, so it was not very effective. Resident 7 said they believed it was a very risky situation and although they had a phone to contact people, they knew a lot of the residents were helpless.On 05/14/2026 at 12:44 PM, Staff C, Licensed Practical Nurse, said they were the evening supervisor on 05/13/2026 and had talked to Resident 7 regarding the concern of the call light system not functioning. Staff C said Resident 7 had explained they were fearful that something could happen in the middle of the night. Staff C said they were aware there were bells in the nursing carts and they did not know why no one on the prior shift had not given Resident 7 one. Staff C said they obtained the bell and gave it to Resident 7. Staff C said they sent a message through the staff phone app for all employees and Staff E, scheduling coordinator, responded they already had a work order in.On 05/14/2026 at 12:54 PM, Staff A, Assistant Director of Nursing, said they had a stand down meeting on 05/13/2026 around 3:00 PM and it was discussed a few call lights (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	05/29/2026

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on the Cove were not working. Staff A said they were told the corporate Maintenance person had been notified and would be at the facility on 05/14/2026.On 05/14/2026 at 1:00 PM, observed Staff B, CNA's, message on the staff phone app that read; Cove lights not working, dated 05/13/2026 at 3:24 PM.On 05/14/2026 at 1:14 PM, Staff A, ADON said they saw the message on the phone app at 3:24 PM but did not investigate the amount of call lights not working on the Cove and/or ensure all residents had ways to alert staff or ensure staff knew how to proceed.On 05/14/2026 at 1:19 PM, Staff D, Plant Operations/Maintenance Director Consultant, said they were already scheduled to come to the facility on [DATE] for other repairs to the call light system. Staff D said they were contacted on 05/14/2026 at 10:47 AM and notified the call light system was down on the Cove unit. Staff D said that was their first notification that the system was down. Staff D said if they had been notified on 05/13/2026 that the call light system was not working they would have sent someone out and/or came themselves at that time. Staff D said it was an urgent matter because it related to resident safety and the expectation was the facility would notify them immediately when there was a resident safety issue.On 05/14/2026 at 1:46 PM, Staff E, Scheduling Coordinator, said they were notified around 4:00 PM on 05/13/2026 that some of the call lights on the Cove unit were not working. Staff E said between 6:00 PM and 6:30 PM they found out no call lights on the Cove unit were working. Staff E said all the staff knew at this point and Staff F, Maintenance Director, was notified and they reported that Staff D, Plant Operations/Maintenance Director Consultant, was coming on 05/14/2026 at around 11:00 AM.On 05/14/2026 at 3:17 PM, Staff G, Administrator, said they found out the call light system was not functioning by reading a grievance they retrieved from the grievance box that morning. Staff G said they were not aware the call light system had been down since 05/13/2026. Staff G said if they knew they would have contacted Staff D, Plant Operations/Maintenance Director Consultant, for immediate repair.Reference WAC 388-97-2280(1) (a-c).