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	06/09/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were free of physical abuse from other residents for 2 of 4 residents (Resident 1 and 2) reviewed for abuse. This failure placed residents at risk of physical injury, fear and a decreased quality of life.Findings included.Review of the facility's policy titled, Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property, undated, showed that each resident had the right to be free from abuse, the definition of abuse was willful infliction of injury, intimidation resulting in physical harm, pain or mental anguish and instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish.RESIDENT 1Resident 1 was admitted on [DATE] with diagnoses including a stroke with hemiparesis (brain injury with weakness or inability to move one side of body) and dementia. The quarterly Minimum Data Set Assessment (MDS), an assessment tool, dated 04/28/2026, showed Resident 1 had severe cognitive impairment and required substantial assistance to self-propel and turn in the wheelchair.On 06/08/2026 at 1:26 PM, Resident 3 said Resident 1 entered their room in a wheelchair and stopped at the sink. Resident 3 said Resident 1 was touching Resident 3's belongings at the sink and they asked Resident 1 three times to get out of their room. Resident 3 said staff members were sitting at the nursing station directly outside of their room and could hear them ask Resident 1 to leave the room. Resident 3 said the staff did nothing to assist them so Resident 3 approached Resident 1 to get them out of the room and Resident 3 said Resident 1 drew back their arm to position it to strike Resident 3. Resident 3 said they fired on Resident 1 and cracked them in the jaw. Resident 3 said they told Resident 1, you raised your hand to me and take that. Resident 3 demonstrated the motion of punching with a closed fist. Resident 3 said it was not the first time Resident 1 had entered their room but in the past Resident 3 said Resident 1 left when they were asked.On 06/08/2026 at 2:04 PM, Staff A, Licensed Practical Nurse (LPN), said they witnessed the altercation between Resident 1 and Resident 3. Staff A said they were in the nursing station completing tasks during change of shift. Staff A said they witnessed Resident 1 passing the nursing station and veered into Resident 3's room. Staff A said they told Resident 3 to hold on but before they could assist Resident 1, Resident 3 punched Resident 1 in the face with a closed fist and kicked Resident 1's wheelchair. Staff A said Resident 1 was in the doorway when it happened and Resident 1 was attempting to leave the room but due to their physical limitations struggled to turn the wheelchair around. Staff A said Resident 3 was very reactive and became verbally aggressive with noise and anyone that had cognitive impairment. Staff A said Resident 3 did not like other residents to pass by their room. Staff A said staff tried to redirect any residents that got close to Resident 3's doorway but they did not always see them in time and there was not always someone available to watch Resident 3's room.Review of the facility's incident report, dated 06/05/2026, showed Resident 3 was observed to strike Resident 1 in the face and kicked the wheelchair as Resident 1 passed by Resident 3's room.Resident 3's risk of verbal and physical aggression care plan, initiated on 04/08/2025 and revised on 06/06/2026, showed Resident 3's behavior history: 07/01/2024 verbal resident-to-resident (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	altercation, 03/29/2025 verbal resident-to-resident altercation, 05/23/2025 verbal aggression, 11/18/2025 verbal aggression with another resident, 11/24/2025 verbal aggression toward staff, 01/02/2026 aggressive behavior, 03/04/2026 verbal aggression during care conference.Resident 3's Psychiatry (medical provider specializing in mental, emotional, and behavior disorders) provider notes, dated 04/29/2026, showed Resident 3 was seen due to concerns of increased behaviors. The notes showed there was little documentation to suggest what the behaviors were that were of concern. The notes showed Resident 3 acknowledged that they got angry at times and used the example when a peer might be outside of their room yelling at the nursing station and how it was disruptive to them. The notes showed the concern of worsening behavior appeared likely to be rooted in Resident 3's expectations, their personality and communication breakdown between them and the staff. The notes showed Resident 3 would likely benefit from a behavior plan and clear communication about expectations as well as the opportunity to clearly articulate their care needs.RESIDENT 2Resident 2 was admitted [DATE] with diagnosis of dementia. The annual MDS, dated [DATE], showed Resident 2 had severe cognitive impairment, required supervision to ambulate with a walker (medical equipment that provides stability with walking) and had verbal behavioral symptoms directed at others.On 06/08/2026 at 1:45 PM, Resident 3 said Resident 2 hollered at staff when they needed something, and the staff knew that Resident 3 would come out of their room. Resident 3 said they had came out of their room and were talking to Resident 2 when Resident 2 started cussing at them and Resident 2 spit on Resident 3. Resident 3 said they grabbed Resident 2's arm and said, you aren't going to spit at me. Resident 3 said they told the staff to keep troubled residents away from their door because it took away their peace and quiet.On 06/08/2026 at 3:34 PM, Staff B, LPN, said they were at the nursing station when Resident 2 came out of their room making noise and wanted pain medication. Staff B said Resident 3 came out of their room and went towards Resident 2. Staff B said they tried to intercept Resident 3 but Resident 3 was too strong and pushed them away and grabbed Resident 2's arm. Staff B said Resident 3 was aggressive with any noise and had hatred towards Resident 2 when they made screaming noises. Staff B said when Resident 2 made noise it triggered Resident 3's behavior.Review of the facility's incident report, dated 05/28/2026, showed Resident 2 was observed coming from their room to the nursing station and while in the hallway was attacked by Resident 3 and in the process Resident 3 grabbed Resident 2's hand.FINAL INTERVIEWSOn 06/09/2026 at 1:51 PM, Staff C, Social Service Director, said Resident 3 did not like to be around people with dementia, it made Resident 3 easily irritated. Staff C said they did not think Resident 3 was triggered by noise. Staff C said Resident 2 talked but they had never heard that Resident 2 made loud noises and/or yelled. Staff C said Resident 3 was seen by the psychiatric provider, but they only managed medications and did not provide behavioral interventions and/or recommendations. When asked if they had reviewed the 04/29/2026 Psychiatry provider notes and implemented any of the recommendations, Staff C said, I don't think so.On 06/09/2026 at 2:20 PM, Staff D, Assistant Director of Nursing, said Resident 3 had a history of aggression, yelling and cursing but now they were hitting. Staff D said they did not review the 04/29/2026 psychiatric provider notes and/or implement any of the recommendations. Staff D said hitting was physical abuse. Staff D said they thought Resident 3 did not mean to grab Resident 2 but acknowledged that would be physical abuse if Resident 3 grabbed a resident aggressively. Staff D said after the incident between Resident 3 and Resident 1 they had placed Resident 3 on one-on-one staffing because Resident 3 said they would do it again if any resident came in his area.Reference WAC 388-97-0640(1)