

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/23/2026
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, during a COVID-19 (contagious viral respiratory illness) outbreak, the facility failed to evaluate residents and staff for their COVID-19 vaccination status, to have a system in place to evaluate residents for being removed off of isolation precautions that was consistent with local health jurisdiction recommendations, to provide/order COVID-19 vaccinations, to update resident representatives about the outbreak, and/or to follow personal protective equipment (PPE) recommendations which included: having current N-95 fit tests (yearly or as needed testing to ensure proper fit of the available N-95 mask) for staff entering aerosol precaution (requires the use of gown, gloves, N-95 face mask, and eye protection) rooms, male staff wearing N-95 masks had clean shaven faces (no stubble or beard), and all PPE removed upon exiting the aerosol precaution rooms for 1 of 1 outbreak reviewed. This failure placed residents and staff at risk for spread of infectious diseases, contracting COVID-19, and a diminished quality of life. Findings included. COVID OUTBREAK INFECTION CONTROL SURVEILLANCE Review of the document titled, Bremerton Trails PA - COVID Timeline, showed the facility had 46 residents and 20 staff that contracted COVID-19. Review of the facility's correspondence with their local health jurisdiction, dated 06/11/2026 at 10:52 AM, showed they were given guidance on resident isolation that stated, Resident Isolation Isolation ends for patients who are not severely immunocompromised when: At least 10 days have passed since symptoms first appeared, AND At least 24 hours have passed since last fever without fever reducing medications, AND Symptoms have improved. Review of the document titled Resident Demographics, undated, a COVID-19 surveillance form (how the facility was keeping track of infections), showed 11 residents were listed as exposed and 24 residents were listed as asymptomatic (no symptoms). All these residents tested positive for COVID-19. The 11 exposed residents did not have symptoms listed to show if they were asymptomatic or had symptoms that needed to be followed. This form had a column for vaccination status (if up to date, if needing vaccination, etc.) to be reviewed, it was blank for all 46 residents. Review of the document titled Staff Demographics, undated, a staff COVID-19 surveillance form, showed the 20 staff all had a blank column for vaccination status. For the column of the staff's last day worked, 11 staff had blanks. The last date of a positive staff test, was on 06/12/2026. Review of Resident 2's electronic health record, showed Resident 2 on 06/12/2026 tested positive for COVID-19 and a provider had seen them and assessed them to have nasal congestion, generalized weakness, and loss of appetite. On 06/14/2026, a progress note had documented Resident 2 had cough and runny nose observed. During an interview on 06/23/2026 at 9:40 AM, Resident 2 said they had not been tested since their initial positive COVID-19 test result, they had just gotten released from isolation that day. When asked if they were having any symptoms, Resident 2 said they were having a scratchy throat, but they were unsure what it was from. During an interview on 06/23/2026 at 1:06 PM, Staff A, Assistant Director of Nursing/Licensed Practical Nurse/Infection Preventionist, regarding the Resident Demographics form, said they should have written asymptomatic and exposed, the residents were all exposed, and they should have put they were asymptomatic. Regarding Resident 2 being listed as asymptomatic, Staff A said the log was not updated to reflect symptoms after the initial testing. When asked how the facility was tracking that (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	symptoms had resolved to take residents off isolation precautions, Staff A stated, Good question, I don't have an answer for that. Regarding the form Staff Demographics, Staff A acknowledged the blanks and said they still had some work to do with this outbreak. Staff A said they had not reviewed COVID-19 vaccinations for staff or residents, they did not have time for it, and they absolutely should have reviewed them. RESIDENT REPRESENTATIVE NOTIFICATION AND COVID VACCINATIONReview of Resident 1's electronic health record, showed no record Collateral Contact 1 (CC1), Resident 1's durable power of attorney (POA, decision maker when unable), had been notified of the outbreak.During an interview on 06/22/2026 at 7:33 PM, CC1, said they had not received notification there was any kind of outbreak. CC1 said Resident 1 called them and told them they were in lockdown due to a COVID-19 exposure. During an interview on 06/23/2026 at 9:46 AM, Resident 1 said they wanted CC1 to have been notified at the start of the outbreak. Resident 1 said they were lucky and had not gotten COVID-19, they had not been vaccinated for COVID-19 yet and CC1 had been trying to get them the vaccine, and they would take the vaccine today if offered. During an interview on 06/23/2026 at 1:06 PM, Staff A, Assistant Director of Nursing/Licensed Practical Nurse/Infection Preventionist, said Resident 1 would have been the person notified of the outbreak. Staff A after reviewing 1's POA paperwork, said they were unaware of Resident 1's POA and they would need to send the notification email to the appropriate people (CC1). Staff A said yes, that Resident 1's POA should have been notified when they went into isolation. Staff A said Resident 1 was due for the COVID-19 vaccination and had consented, they had not ordered the vaccine yet. AEROSOL PRECAUTIONS AND PERSONAL PROTECTIVE EQUIPEMENTDuring an observation on 06/22/2026 at 9:42 AM, Staff B, Certified Nursing Assistant, was observed leaving room [ROOM NUMBER], an aerosol precaution room, without removing their face shield or N-95 mask. At 9:43 AM, they were observed returning to room [ROOM NUMBER] with a beverage. After leaving room [ROOM NUMBER], they were then observed wearing the same N-95 mask and face shield as they went into room [ROOM NUMBER], an aerosol precaution room. Staff B left room [ROOM NUMBER] still wearing the same N-95 mask and face shield, and continued on down the hallway carrying a pitcher from that room. During an observation on 06/22/2026 at 10:44 AM, Staff C responded to a call light for room [ROOM NUMBER], an aerosol precaution room. After leaving the room, they took off their gloves, face shield and gown, threw their gown in the trash bin, put their face shield on a medium glove container on the PPE cart, then lifted the face shield and walked down the hallway with their shield and the same N-95 on, to alert nursing to room [ROOM NUMBER]'s need, then walked to their office.During an observation on 06/22/2026 at 12:22 PM, Staff B was observed standing at the meal cart, in the hallway near room [ROOM NUMBER], already wearing a face shield. At 12:30 PM, Staff B was observed coming out of room [ROOM NUMBER], they were still wearing their N-95 mask and face shield and proceeded on down the hallway. During an observation on 06/23/2026 at 10:07 AM, review of a sign outside of room [ROOM NUMBER], showed how staff were supposed to put on and take off PPE for aerosol contact precautions. Staff were to take off PPE and dispose of the PPE in this order: 1. gloves2. gown3. wash or gel hands4. respiratory and eye cover (face shield): remove from earpiece or ties to discard- do not grab from front of respirator. 5. wash or gel hands (even if gloves used). During an interview on 06/23/2026 at 10:25 AM, Staff D, Housekeeper, was visualized wearing a N-95 mask over a beard. Staff D said they were taught to wear a N-95 mask if the room was labeled as an aerosol precaution, they would wear a face shield, N-95, and gown. When asked when they change their N-95 mask, Staff D said once an hour because of the sweat and beard. Staff D said they were not fit tested for it, and they did go into aerosol precaution rooms. Staff D said they had tested positive for COVID-19 on 06/12/2026. During an interview on 06/23/2026 at 10:29 AM, Staff B, Certified Nursing Assistant, said for taking off PPE after being in an aerosol precaution room, they would remove their gown in trashcan in room and gloves, hand hygiene, then out of the room they should remove mask and face shield. During an interview on 06/23/2026 at 11:45 AM, Staff C, Staffing Coordinator, when asked about the observation of them the previous day, said they had gone (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to their office to wipe down their face shield and change their mask (was not done directly outside of room [ROOM NUMBER]). During an interview on 06/23/2026 at 1:00 PM, Staff E, Certified Nursing Assistant, said they were fit tested for an N-95 mask a couple years ago. When asked about their visible facial hair and if there were any precautions related to that with wearing an N-95 mask, Staff E said they normally do wear one, it did not affect them. Staff E said they shaved once a week, and they had not received education on shaving more frequently during this outbreak. During an interview on 06/23/2026 at 1:06 PM, Staff A, Assistant Director of Nursing/Licensed Practical Nurse/Infection Preventionist, acknowledged that general staff were not up to date on fit testing. Regarding Staff D, Staff A said this staff had just started working and had not been fit tested yet. Regarding Staff E, Staff A said they believed they were agency. Staff A said they had forgotten to tell the male staff to shave. Regarding removing PPE after entering an aerosol precautions room, Staff A said staff should complete care, then take off their gloves and gown in room, then outside of room hand hygiene, then remove their face shield and mask and then hand hygiene again. Staff A said Staff C and Staff B should have removed their face shields and masks after leaving the room, but before leaving the area outside of the room and acknowledged this was not done in these observations. Staff A said the face shield should not have been put on a box of gloves, and any item the face shield was on should have been thrown away. Reference WAC 388-97 -1320 (2)(a)(b)		