

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

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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 07/15/2026
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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide enter post hospital discharge wound care orders and provide consistent wound care treatments for pressure ulcers for 1 of 3 residents (Resident 1) reviewed for wounds. Resident 1 experienced harm when the sacral pressure ulcer (injury to the skin and underlying tissue over the tailbone), present on hospital discharge and readmission to the facility, worsened became infected and required surgical incision and drainage of the wound. The facility's failure placed residents at risk of worsening wounds, clinical complications and pain. Findings included. Resident 1 was readmitted to the facility on [DATE] with diagnoses of diabetes and kidney disease. Resident 1's discharge Minimum Data Set Assessment, an assessment tool, dated 06/11/2026, showed Resident 1's memory was ok and they had three unstageable pressure ulcers (locations not identified - full thickness pressure injuries in which the base of the wound is covered with dead tissue). Review of Resident 1's alteration in bowel elimination/continence care plan and bladder incontinence care plan, dated 03/31/2026, showed resident frequent had both bowel and urinary incontinence. Review of Resident 1's skin care plan, dated 05/24/2026 and revised 07/13/2026, showed resident 'Has/potential for a pressure ulcer of the sacrum r/t [related to] history of ulcers, decreased mobility with an intervention, dated 06/23/2026 (the day after resident's return to the hospital), to ensure resident had an air mattress to promote wound healing. Additional interventions included staff were to assess/record/monitor wound healing weekly and as needed, measure length, width, and depth where possible, assess and document status of wound perimeter, wound bed healing progress and report improvement and declines to the MD. Review of resident 1's Hospital Provider Orders-Nursing Home Transfer, dated 06/16/2026, showed wound care ordered per facility protocol and/or attached wound care notes. Review of Resident 1's hospital wound care notes, dated 06/12/2026 and uploaded to Resident 1's electronic medical record on 06/17/2026, showed a sacrum (large bone at the base of the spine) unstageable pressure ulcer (wound where dead tissue covers the wound bed so completely a clinician cannot see how deep the damage goes) that had serosanguineous drainage (normal type of wound fluid), no odor, and a full thickness stage 3 pressure ulcer (pressure ulcer with full thickness loss of skin exposing subcutaneous tissue) on the left gluteal fold (skin crease below the buttocks separating them from the upper thigh). The notes showed recommendations for wound care; cleanse wounds with wound cleaner, allowing cleaner to soak for five-10 minutes, pat dry, apply SilvaSorb (antimicrobial [kills microorganisms or stops them from growing] wound dressing) to wound bed and cover with gauze and a foam dressing and change every two days. Review of Resident 1's Skin Issues evaluation, dated 06/17/2026, showed an unstageable pressure ulcer on the rear left thigh that measured 3.5 Centimeters (CM) x 2.5 CM x 0.0 CM with a wound area of 6.34 CM² (squared) and an unstageable pressure ulcer on the coccyx (bone at base of the spine directly below the sacrum) that measured 6.69 CM x 7.64 CM x 0.0 CM with a wound area of (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 0686 Level of Harm - Actual harm Residents Affected - Few	41.05 CM2. The Skin Issues evaluation showed sections for interventions and clinical suggestions to be documented, the sections were blank. Review of Resident 1's medical provider notes, dated 06/18/2026, showed Resident 1 had multiple non stageable pressure wounds to the sacrum, and left ischium (bone forming the lower and back part of the hip located underneath the buttock) and the plan was to continue wound care per wound care team recommendation. Review of Resident 1's medical record on 07/15/2026, showed no documentation the facility implemented and/or provided wound care for Resident 1's left gluteal fold and sacral pressure ulcers from readmission on [DATE] through 06/22/2026. Review of Resident 1's Wound Consultant Assessment, dated 06/22/2026, showed Resident 1 had a left ischium pressure ulcer that was a stage 2 and measured 3.0 CM x 3.5 CM x 0.2 CM with a wound area of 10.5 CM2. The Assessment showed Resident 1 had a full thickness sacrum pressure ulcer vs [versus] terminal skin failure (the irreversible death of skin and underlying tissue caused by the body's natural shutdown process) with a strong wound odor, 8.5 CM x 6.0 CM x 0.3 CM with a wound area of 51.0 covered in slough (layer of dead tissue) with moderate purulent exudate (commonly known as pus, a thick, milky fluid that indicates an underlying infection). The Assessment showed that given Resident 1's history and how quickly the wound developed that they were considering terminal wound failure but if it improved over the next week would consider adjusting the dx [diagnosis] to pressure injury. The assessment recommended a wound culture and to speak with the medical provider regarding starting Resident 1 on antibiotics. Review of Resident 1's wound culture of their sacral wound [though documentation identified it incorrectly as the buttocks as explained in interview below], collected 06/23/2026, showed heavy growth of bacteria. Review of Resident 1's progress notes, dated 06/25/2026, showed Resident 1 was discharged to the hospital due to their dialysis port being blocked. Review of Resident 1's hospital wound notes, dated 07/01/2026, showed Resident 1's sacral wound was an unstageable pressure ulcer, with purulent drainage and moderate odor. Review of Resident 1's hospital progress notes, dated 07/03/2026, showed Resident 1 had an infected sacral decubitus ulcer that was scheduled for debridement and I & D [incision and drainage] by general surgery. On 07/04/2026 at 1:14 PM, hospital staff, Collateral Contact 1, reported that Resident 1 said the wound on their bottom was not being cleaned consistently and they were unaware it was severe enough to require surgery. Review of Resident 1's hospital wound care notes, dated 07/06/2026, showed Resident 1's sacral wound was treated with sharp debridement and incision and drainage of an abscess (localized pocket of pus from an infection) on 07/03/2026. During an interview on 07/15/2026 at 12:22 PM, Staff A, Assistant Director of Nursing, said Resident 1 had pressure ulcers on their sacrum, identified additionally as the coccyx and the left rear thigh, identified additionally as the ischium and gluteal fold. Staff A said these wounds had been treated by the facility during Resident 1's prior stay at the facility before they were readmitted on [DATE] from the hospital. Staff A said nursing staff did not notify them that Resident 1 was missing wound treatment orders in the electronic medical record and no wound care orders were entered on admission on [DATE]. Staff A reviewed Resident 1's electronic medical record and said there was no documentation and/or evidence that the facility had provided wound care for Resident 1's pressure ulcers on their sacrum and left ischium from readmission on [DATE] until the wound consultant's assessment on 06/22/2026. Staff A said it was unacceptable and the nursing staff should have notified the medical provider and followed the wound care orders per the hospital transfer orders on 06/16/2026. Reference WAC 388-97-1060(3)(b)		