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	11/18/2025

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 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 observations, interviews and record review, the facility failed to evaluate the effectiveness of current pressure offloading treatment plan, document weekly wound assessment and measurements, consistently re-position the resident as care planned every two to three hours and follow physician wound treatment interventions as ordered to prevent development or worsening of pressure ulcers (PU) for 1 of 1 sampled resident (Resident 2) reviewed for PU. Resident 2 experienced harm when their previously healed chronic PU re-developed and worsened from Stage II (a shallow, open sore that has broken through the top two layers of skin, the epidermis and dermis) to Stage III (a deep wound that has gone through the top two layers of skin and into the fatty tissue underneath), and caused an increase in pain level during wound care that required stronger pain medication management.Findings included .Findings included .Resident 2 was admitted to the facility on [DATE]. The Significant Change Minimum Data Set (MDS, an assessment tool) dated 07/13/2025, documented Resident was severely cognitively impaired and required maximum assistance with cares. The MDS documented Resident 2 had no current PU but was at risk for PU. Interventions listed on the MDS included pressure reducing device for bed, turning and repositioning, pressure ulcer care and applications of ointments and medications.A contacted wound consultant progress note, dated 07/08/2025, documented As of today, the wound has completely closed with no evidence of erythema [redness or discoloration of the skin], edema [swelling caused by excess fluid trapped in the body's tissues], or tenderness to palpation. All wound care caregivers have been notified about preventive measures which include turning and repositioning, offloading and nutritional supplements. Stage II, Status closed. A contacted wound consultant progress note, dated 08/05/2025, documented The wound has been present for approximately 30 days and has increased in size. Previous treatments included offloading. The patient's underlying comorbidities are being managed by the agency's [facility] primary care physician. The goal is to facilitate complete closure of the patents chronic wound. Because of numerous comorbidities, the aim is to also prevent the progression of the wound, prevent infection, as well as prevent hospitalization. Stage II. Status increased in size. The patient education was shared with facility staff as patient is forgetful.Resident 2's PU care plan, initiated 09/02/2023, revised 08/12/2025, documented the following: Has pressure ulcer center midline coccyx: r/t [related to] dermal frailty [frail skin], disease process, history of ulcers, decreased mobility, incontinence-Assess/record/monitor wound healing weekly and PRN. Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvement and declines to the MD.-Avoid positioning on resident's buttocks. Reposition every 2-3 hours for off-loading, use pillows.- Educate resident/family/caregivers as to cause of skin breakdown: including: transfer/positioning requirements; importance of taking care during ambulating/mobility; good nutrition; and frequent repositioning.- Apply topical skin protectant to protect from fecal and/or urinary incontinence.A nursing progress note, dated 08/17/2025, documented, Resident c/o [complaining of] increasing pain during coccyx [tailbone] wound dressing changed. Dressing changed x2 [two times] this shift secondary to soiling. Note to MD [Medical Director]. Resident states Tylenol not helpful.A nursing progress note, dated 08/19/2025, (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	documented, Resident seen by provider, new order for oxycodone [pain medication] PRN [as needed] during treatments.A contacted wound consultant progress note, dated 08/19/2025, documented The wound has been present for approximately 30 days and is deteriorating. Previous treatments included off-loading, wound debridement [process of removing dead, damaged, or infected tissue and debris from a wound to promote healing], daily dressing changes and advanced wound care dressings. The patient's underlying comorbidities are being managed by the agency's [facility's] primary care physician. The goal is to facilitate complete closure of the patient's chronic wound. Because of numerous comorbidities, the aim is also to prevent the progression of the wound, prevent infection, as well as prevent hospitalization. Stage III. Status deteriorating. Wound Stage progressed from Stage II to Stage III. The reason is changed wound stage to Stage 3, slough has developed.A physician's order, dated 09/04/2025, stated, WOUND CARE: center midline coccyx: Clean the wound with saline [salt water], pat dry with gauze sponge. Apply Santyl [ointment with enzymes that breaks down dead tissue], nickel thick, to the wound bed. Top with impregnated gauze (oil emulsion) to the wound bed, followed by calcium alginate [high absorbent dressing]. Apply skin prep [a liquid barrier film to protect the skin around a wound from moisture, friction, and adhesives] to peri [around] wound. Cover with 6x6 (centimeter - cm] foam with silicone bordered dressing and secure with tape daily and PRN soilage or dislodgement every dayshift for skin impairment and as needed for skin impairment soiled and dislodgement. On 09/22/2025 at 11:00 AM, Resident 2 was observed lying in bed on their back, with blankets pulled over their body. Resident 2's eyes were shut, and mouth was open. On 09/22/2025 at 3:08 PM, Resident 2 was observed sitting at a 45-degree angle, in bed, with blankets pulled over their body. Resident 2's eyes were shut, and mouth was open.On 09/23/2025 at 8:39 AM, Resident 2 was observed lying in bed on their back, with blankets pulled over their body. Resident 2's eyes were shut, and mouth was open. On 09/24/2025 at 8:51 AM, Resident 2 was observed lying in bed on their back, with blankets pulled over their body. Resident 2's eyes were shut, and mouth was open.On 09/24/2025 at 11:15 AM, Resident 2 was observed lying in bed on their back, with blankets pulled over their body. Resident 2's eyes were shut, and mouth was open.On 09/24/2025 at 9:58 AM, observation of Resident 2's wound cleaning was completed with Staff L, Licensed Practical Nurse (LPN). Staff L prepared all wound treatment supplies on top of cart with barrier. At 10:09 AM, Staff L performed hand hygiene, donned (to put on) Personal Protective Equipment (PPE), obtained wound treatment supplies and entered Resident 2's room. Staff L, applied wound cleanser to gauze, cleaned the wound and then threw the gauze away. Staff L said they used that wound cleanser because it was nothing more than saline. Staff Removed his gloves, preformed hand hygiene and donned a new pair of gloves. Staff L took the backing off of dressing bandage, picked up the dressing with alginate, santyl, oil emulsion gauze and applied to wound. Staff L said the dressing change was completed and doffed (to take off) gloves. On 09/24/2025 at 10:18 AM, when asked why they used wound cleanser, versus saline (as ordered), Staff L stated, because we got this. I don't know what the ingredient is besides normal saline, I know there is something in there. Staff L said they were used to using wound cleanser. Staff L wrapped up barrier supplies and placed them in the garbage and took wound cleanser bottle out of the room. Staff L doffed gown but did not complete hand hygiene. When asked why they did not apply skin prep as ordered, Staff L stated, That particular bandage works so well it doesn't need skin prep, I don't like skin prep, it gets the skin outside the bandaged area sticky. That foam dressing is really nice and gentle on the skin.In an observation and interview on 09/24/2025 at 12:41 PM, Resident 2 was sitting up in bed (at a 45-degree angle). When asked about pain level, Resident 2 said their pain level was currently about a 7 (on scale from 0-10, 0 being no pain, 1- being extreme pain). When asked about repositioning, Resident 2 said staff would sometimes offer repositioning, but not often and would not offer any other non-pharmacological inventions for pain relief. This was the first time Resident 2 was observed awake.On 09/25/2025 at 8:32 AM, Resident 2 was observed sitting at a 45-degree angle, in bed, with blankets pulled over their body. Resident 2's eyes were shut, and mouth was open.On 09/29/2025 at 12:58 PM, Resident 2 was observed sitting at (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	a 45-degree angle, in bed, with blankets pulled over their body.In an observation and interview on 09/29/2025 at 12:58 PM, Resident 2 was sitting up in bed, (at a 45-degree angle). When asked about pain, Resident 2 said their pain was at a 7, but they were given an oxycodone earlier and it is helping with the pain. Resident 2 said they had a wound treatment today, they checked on my bottom, it hurt like hell, because they scrubbed it. Resident 2 said they told the doctor and nurse that they wanted to get out of bed after the wound treatment but was told they could not do that because they had never gotten the resident out of bed before. When asked about the PU, Resident 2 said they believe the PU was getting worse and it hurts. Resident 2 said he had been repositioned that morning, because they did wound care.On 09/29/2025 at 2:32 PM, Resident 2 was sitting at a 45-degree angle, in bed, with blankets pulled over their body. Resident 2's eyes were shut, and mouth was open.On 09/29/2025 at 3:52 PM, Resident 2 was sitting at a 45-degree angle, in bed, with blankets pulled over their body. Resident 2's eyes were shut and mouth was open.On 09/30/2025 at 12:51 PM, Staff PP, Certified Nursing Assistant (CNA) said residents were required to be repositioned every two hours and the resident's repositioning care plan/schedule was located in the Kardex (CNA's documentation record) or resident's chart. When asked what staff should do when the resident was asleep and needed to be repositioned, Staff PP said they would double check to see if it was ok to wake the resident and then reposition them.On 09/30/2025 at 1:17 PM, Staff OO, CNA, said residents should be repositioned every two hours or as needed or requested. Staff OO said all information for repositioning was located in the Kardex. Staff OO said if residents were asleep during the repositioning time frame, they would ask staff if it was ok to wake the resident during sleep, if not then they would let the resident sleep without repositioning themOn 09/30/2025 at 1:42 PM, Staff B, Director of Nursing Services, said staff should be repositioning residents every two hours, during rounds and as needed. Staff B said if the resident was sleeping, staff could wake the resident if they knew the resident would be ok with being woken up. When asked about identifying, documenting and reporting skin changes/conditions, Staff B said all skin conditions should be documented on the shower sheet, given to the charge nurse, unit managers and contracted wound consultants. When asked about Resident 2's PU, Staff B reviewed the electronic health record (EHR). Staff B said Resident 2 was admitted to a Stage II PU, measurements were taken, and contracted wound consultants provided treatment. Staff B was asked to review the July 2025 contracted wound consultants note. Staff B confirmed that Resident 2's PU was documented as resolved. Staff B was asked to review what current inventions were in place to minimize the return of the PU. Staff B confirmed there had been a repositioning intervention that had been discontinued on 07/11/2025 and had never been reinstated. Staff B said the expectation of offloading pressure should have been implemented as far as the resident could tolerate. Staff B was asked to confirm what stage the PU was in currently and said it was Stage III, from resolved. Staff B said the expectation was that further interventions should have been implemented for Resident 2. When observations were explained about staff providing wound care, not using saline or skin prep, Staff B said they would have to check into the difference between the wound cleanser and saline, but yes, staff should have followed the physician's orders. Additional follow-up was not provided. On 09/30/2025 at 1:07 PM, Resident 2 was observed lying in bed on their back, with blankets pulled over their body. Resident 2's eye were shut and mouth was open.On 09/30/2025 at 3:44 PM, Resident 2 was observed lying in bed on their back, with blankets pulled over their body. Resident 2's eyes were shut, and mouth was open.On 09/30/2025 at 3:55 PM, Staff BB, CNA, with Staff B, DNS present, said Resident 2 had a wound on his lower back, staff have attempted to have Resident 2 turn on their side and use the wedges, however Resident 2 does not like to sleep on their side and will often refuse to use the wedges/pillows.On 10/01/2025 at 8:59 AM, Resident 2 was observed sitting at a 45-degree angle, in bed, with blankets pulled over their body. Resident 2's eyes were shut, and mouth was open.On 10/01/2025 at 11:10AM, Resident 2 was observed sitting at a 45-degree angle, in bed, with blankets pulled over their body. Resident 2's eyes were shut, and mouth was open.Reference F684.Reference F757.Reference WAC 388-97-1060 (3)(b)

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation, interview and record review, the facility failed to ensure care and services were provided in a dignified manner which maintained and enhanced quality of life for 3 of 5 sampled residents (Resident 65, 8 & 12) reviewed for dignity. This failure placed residents at risk for feelings of embarrassment, unmet care needs, decreased self-worth and a diminished quality of life. Findings included 1) Resident 65 was admitted to the facility on [DATE]. The Annual Minimum Data Set (MDS, an assessment tool), dated 06/06/2025, documented Resident 65 was severely cognitively impaired and required maximal assistance with cares. On 09/24/2025 at 12:04 PM, Resident 65 was yelling from their room Hello, I need to be cleaned up. Staff L, Licensed Practical Nurse (LPN), was standing at the medication cart parked outside Resident 65's door. Staff L walked away from the cart, down the hallway away from Resident 65's room and returned to the medication cart two minutes later. At 12:07 PM, Staff L, entered Resident 65's room and stated, You need some attention. [Staff P, Certified Nursing Assistant, (CNA)], will be here in a little bit. The odor of feces could be smelled from across the hall. Resident 65 was sitting on their bed, wearing only a brief and a shirt. A liquid brown substance was observed coming out from under their brief and was trailing down the left side of the resident's outer thigh and bed. Staff L pulled the privacy curtain shut, turned on call light, exited Resident 65's room and returned to the medication cart. On 09/24/2025 at 12:09 PM, Staff M, CNA, walked past Resident 65's room, observed the call light on and asked Staff L, LPN, if Resident 65 needed assistance. Staff L said Resident 65 could wait for their CNA to return to the floor. On 09/24/2025 at 12:11 PM, Staff N, CNA, entered Resident 65's room, spoke briefly with Resident 65, turned off the call light and exited the room without assisting Resident 65 with personal hygiene care. At 12:14 PM, Staff M, CNA, returned to Resident 65's room and asked, Oh no, has anyone checked on you yet? At 12:15 PM, Staff M exited the room, found a second CNA on the hall and returned to the room at 12:16 PM to provide care to Resident 65. Resident 65's assigned CNA, Staff P, did not return to the hallway until 12:21 PM. On 09/29/2025 at 1:14 PM, Staff J, Charge Nurse (also called Unit Manager at this facility, often called Resident Care Manager in other facilities)/LPN, said they expected staff to show dignity to residents by introducing themselves, pulling the curtain shut while providing care, asking the residents what their concerns were, and providing care in a gentle and timely manner. Staff J said residents should receive care at the time the staff were in the room. When told of the observation of staff telling Resident 65 they would have to wait for care, Staff J said staff should not have left the resident in that condition, it was not acceptable to leave a resident and the resident should have been changed. Staff J said this was not their expectation and the inaction was not okay. On 09/30/2025 at 1:42 PM, Staff B, Director of Nursing Services (DNS), said staff should provide privacy, have supplies ready and speak with the resident when providing care. When told of the observation of the staff telling Resident 65 they would have to wait for personal hygiene care, Staff B said it was not their expectation nor was it acceptable to tell a resident to wait or to leave a resident in a soiled brief. 2) Resident 8 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], showed Resident 8 was cognitively intact, and was independent with toileting. On 09/26/2025 at 6:05 AM, Resident 8, in the hallway, said they wanted to report a nurse for not being kind. Resident 8 said the nurse had given them Tylenol, which was unnecessary. At 6:08 AM, Staff S, LPN, entered the conversation and said that Resident 8 had requested eye drops but they had been busy on the floor and with training new staff. Staff S said when they remembered to give the eye drops, Resident 8 asked for their thyroid medication and Tylenol. Staff S said when they went to give the Tylenol, Resident 8 refused and it was not given. Staff S, in front of Resident 8, then said Resident 8 had memory issues, and was rude to her. At 6:08 AM, Resident 8 responded by pointing at Staff S and saying they needed a new job. Staff S continued to say that they had written the request (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for Tylenol down. Review of Resident 8's Medication Administration Record on 09/26/2025 at 6:53 AM, showed no Tylenol was given that morning or overnight. During an interview on 09/26/2025 at 7:12 AM, Staff B, DNS, when asked if it met expectations if a nurse had called a resident rude in front of them, Staff B said no, this was their home, and that was bad customer service. Staff B said Staff S should have redirected Resident 8 in a calm and gentle way; and with Resident 8 being confused, should have veered away from an argument while in the hallway. During an observation on 09/26/2025 at 10:45 AM, Resident 8 was seen telling Staff Q, LPN, that at about 10:00 PM the night before, a young staff member had checked Resident 8's underwear to see if they needed to be changed, despite the fact they could independently use the bathroom. Resident 8 said this was no longer a safe place. Staff Q said the staff member must have gotten a bad report. Resident 8 said that it was when they were sleeping, and this was unsettling. Staff Q said they understood the concern and recognized that Resident 8 was continent. Resident 8 thanked Staff Q for understanding, then told them their nurse overnight (Staff S) was not nice, should stop and be kinder to people, and should not work in this kind of job. 3) Resident 12 was admitted to the facility on [DATE], with diagnoses of depression and anxiety. The Quarterly MDS, dated [DATE], showed Resident 12 was cognitively intact and dependent on staff for cares. During an observation on 09/26/2025 at 6:01 AM, Staff S opened the door to Resident 12's room and was heard telling the staff caring for Resident 12 to pull the curtain for privacy. Resident 12's roommate was in the room at the time. During an interview on 09/26/2025 at 1:41 PM, Resident 12's roommate, Resident 67, said the curtain was not pulled this morning, Resident 12 was exposed several times that morning when staff went to change Resident 12, and they personally had to close the curtain one of the times. During an interview on 09/30/2025 at 8:20 AM, Resident 12 said they did not like the curtain being open, and regarding the curtain being left open on 09/26/2025 stated, I am laying here naked and the curtain is open. During an interview on 10/01/2025 at 8:44 AM, Staff D, Charge Nurse/RN, when told of Resident 12's curtain not being pulled while staff provided care with their roommate being in the room and asked their expectation for staff in maintaining resident privacy and dignity, said their expectation was that staff would pull the curtain. Reference WAC 388-97-0180(1-4).

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. .Based on interview and record review, the facility failed to ensure residents with personal funds/resident trust accounts had ready access to their accounts during evenings and weekends for 38 of 38 residents reviewed for person funds accounts. This failure placed residents at risk of not having access to their accounts during non-banking hours, a decreased sense of autonomy and a diminished quality of life. Findings included On 09/24/2025 at 11:53 AM, Staff T, Revenue Cycle Manager, said the residents did not have access to their personal fund accounts after hours. Residents only have access when the front desk was staffed from 8:30 AM until 6:00PM.On 09/24/2025 at 4:25 PM, Staff A, Administrator, said the residents did not have access to their funds on the weekends and after hours. Staff A said he was going to change that today by having a nurse cart with funds available if a resident requests money after hours.Reference WAC 388-97-0340 .

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review, the facility failed to ensure quarterly personal fund statements were provided to residents with personal fund accounts for 38 of 38 residents reviewed for personal fund accounts. This failure placed residents at risk of not having an accurate accounting of their personal funds held in trust by the facility.Findings included Resident 60 was re-admitted to the facility on [DATE]. The Quarterly Minimum Data Set (an assessment tool), dated 08/01/2025, documented the resident was moderately cognitively impaired.On 09/23/2025 at 9:44 AM, Resident 60 said I don't get statements. On 09/24/2025 at 11:53 AM, Staff T, Revenue Cycle Manager, said I am trying to give the residents statements every 6 months. The last time I gave out statements was April 2025 and before that was October 2024. On 09/24/2025 at 4:25 PM, Staff A, Administrator, said the residents have not received quarterly statements and are not receiving them every month like he would prefer. Staff A said that was going to change.Reference WAC 388-97-0340.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. .Based on interview and record review, the facility failed to ensure the transfer of funds, from a resident personal fund account, was completed within 30 days following their discharge for 1 of 5 residents (Resident 111) reviewed for personal funds. This failure placed the residents and/or their representatives at risk for loss of funds and the interest accumulated.Findings included .A review of the list of personal fund accounts, listed Resident 111 with a balance of $2072.98On 09/24/2025 at 11:53 AM, Staff T, Revenue Cycle Manager, said Resident 111 had not been at the facility for over a year and Resident 111 still had money in their personal fund account. Staff T said he did not have access to Resident 111's account anymore and the previous company had not withdrawn the money.On 09/24/2025 at 4:25 PM, Staff A, Administrator, said Resident 111's account was not closed within 30 days of transfer and Staff A said he would call the previous company and have them take care of this now.Reference WAC 388-97-0340.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation and interview the facility failed to ensure painted ceiling surfaces was maintained in a homelike environment for 1 of 22 sampled residents (Resident 1) reviewed for homelike environment and sound levels were homelike in 1 of 1 hallway (room [ROOM NUMBER]- 77 Hallway) reviewed for exit door. These failures placed residents at risk for an environment that was not homelike and a decreased quality of life. Findings included.CEILING SURFACE:Resident 1 admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 09/12/2025, indicated Resident 1 was cognitively intact. On 09/22/2025 at 1:51 PM, Resident 1 pointed to an area on their ceiling that was missing paint. Observation of the area showed approximately 4 inches by 1.5 inches that was missing paint, and another adjacent area also missing paint. Resident 1 also pointed to two other areas that had plaster protruding from the ceiling, each the size of a 50-cent piece. Resident 1 said this was not the kind of thing they wanted to see, the way their room looked made a difference to them. On 09/29/2025 at 8:35 AM, Staff J, Charge Nurse (sometimes called Unit Manager in this facility, often called Resident Care Manager in other facilities), Licensed Practical Nurse, went to Resident 1's room and observed the areas missing paint and plaster protruding out. Staff J said it looked like a curtain rail had been moved leading to the plaster protruding, and she was not sure what was going on with the paint missing. Staff J said this did not meet her expectations for a homelike environment. HALLWAY:Review of Resident Council Meeting Minutes, dated 04/17/2025, documented Resident 85 told the group that the door across the hall slammed so hard it was scary and they would like something put on the door to help prevent the loud slamming. Review of the April Grievance log showed this was not listed.During an interview and observation on 09/22/2025 at 12:40 PM, the alarm to the exterior door went off and was heard very loudly in Resident 67's room. Resident 67 said that it was the exit for residents that smoked or for staff when garbage needed to be taken out. During an interview on 09/23/2025 at 10:12 AM, Resident 12 said the backdoor slammed all night long and they had told everyone about the door slamming. During an observation period on 09/25/2025 from 6:40 PM to 7:50 PM, the hallway and room [ROOM NUMBER] were observed, and the exit next to the exterior exit (next to rooms [ROOM NUMBERS]) was heard to make loud noises. At 6:40 PM, the door was slammed shut. At 7:00 PM, the exit door alarm was heard blaring from inside room [ROOM NUMBER]. Resident 12 said they hear this all night. In the hallway, a staff member was witnessed leaving room [ROOM NUMBER], to allow a resident outside through the exterior door. The alarm turned off, then turned back on, turned off again. At 7:01 PM, The alarm went off again, staff had to come turn it off. Resident 87 came out of their room and stated, Press the code and it won't go off, the staff responded, I did. Resident 87 said it had been going off all day, and stated, Unf***ing believable, these people have worked here longer than me. At 7:25 PM, a resident exited the door and a slam was heard behind them. From the hallway, Resident 12 was heard from their room yelling, Quit slamming that door please! At 7:46 PM, a resident returned from outside and the door slammed behind them. At 7:50 PM, the door slammed, and a resident yelled from their room about it. During an interview on 09/30/2025 at 3:46 PM, Staff E, Maintenance Director, was asked what the facility had been doing to alleviate the noise from the exterior door near the 70's rooms. Staff E said they tried weather stripping to muffle, but it had already come off. When asked what the facility did when this concern was brought up in April 2025 at the Resident Council meeting, Staff E said that was when they put the weather stripping on, that has now peeled off. Staff E said that they had talked to staff about using other entrances, but it is what it is. During an interview on 10/01/2025 at 8:44 AM, Staff D, Charge Nurse/Registered Nurse, was asked if they get frequent complaints about the exit door. Staff D said maintenance was aware and the complaint was only for a few people, due to the alarm going off if they did not do the alarm fast enough. When told of the observation of the door slamming multiple (continued on next page)

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	505123	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bremerton Trails Post Acute	2701 Clare Avenue Bremerton, WA 98310

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	times and the alarm going off, with three different residents heard upset about it from their rooms, Staff D acknowledged this was not homelike. During an interview on 10/01/2025 at 10:02 AM, Staff A, Administrator, was asked how the facility had attempted to make the environment more homelike due to the exit door slamming at night. Staff A said it was an emergency fire door, they should not be going out the door in the first place. Staff A said they could put more sealant around the side and will now update the residents to not use that door since it is an emergency door. Reference F585Reference WAC 388-97-0880.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 have a system in place that ensured grievances were initiated, logged, addressed, and resolved in a timely manner to residents' complaints verbalized during Resident Council meeting for 3 of 3 months (July 2025, August 205 and September 2025) and for 3 of 3 sampled residents (Resident 33, 8 & 12) reviewed for grievances. The failure to initiate, log, investigate verbalized concerns, inform residents of their findings and actions taken, if any, prevented the facility from identifying care trends and determining if actions taken were effective in resolving the reported issues. These failures resulted in residents verbalizing the same complaints for multiple months without resolution, and placed residents at risk of feeling frustrated, unimportant, unheard, and a decreased quality of life.Findings included Review of the facility policy titled Grievances: Resident/Resident Representative no date, documented Responsibilities of Grievance Officer include: Overseeing the grievance process; designating the process for receiving and tracking grievances through to their conclusion; leading any necessary investigations by the center; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations. [.]4. Initiate the Resident Grievance Report for any and all concerns.[.]6. Read the Resident Grievance Report immediately when it is received from the employee and/or resident/resident representative.a. If the Grievance is an allegation of resident abuse, neglect, misappropriation of resident property, and exploitation, or an injury of unknown source, please take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated and refer to Preventing and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source and Misappropriation of Resident Property Procedure located in Section ___ of the , or State specific Abuse and Neglect Guidance. [.]8. Communicate with the resident/resident representative and attempt to resolve the issue within five (5) days. [.]12. Maintain the Resident Grievance Log (Copy Form). [.]15. Receive the original Resident Grievance Report from the Department assigned to the Grievance and file the completed original Resident Grievance Report in an Administrative file in the Social Services Department.16. Retain the results of all Grievances for a period of no less than four (4) years from the issuance of the Grievance decision.Resident Council Review of Resident Council Meeting Minutes for July 2025, dated 07/24/2025, documented Resident 1 reported concerns with call lights is still an issue, still having issues with getting starches, and major shortage is staff especially on weekends. Resident 53 was supposed to see a dentist, but has not seen it, and almost choked on yesterday's beef stew. Resident 26 had documented concerns with the menu, menu has been all over the place not staying to what it says and yesterday's stew was unchewable. None of the following grievances were located on the July 2025 Grievance Log. Review of Resident Council Meeting Minutes for August 2025, dated 08/21/2025, documented Resident 13 had concerns about staff shortages on the Saturdays and they had not received a shower last Saturday. Resident 85 was concerned about their messages not getting to the doctor, they had never heard back from the doctor regarding their diet and supplements. The note stated, she understands we are understaffed but it is affecting her health. Resident 4 said nursing aides were slow to respond and left them in the bathroom for over 20 minutes. Resident 1 said staff are busy chatting and joking and not answering calls (20 minutes or more). Resident 53 said they wanted a pitcher of water in their room, so they would not have to wait for staff to bring water. None of the listed concerns were documented on the August 2025 Grievance Log.Review of Resident Council Meeting Minutes for September 2025, dated 09/18/2025, Resident 1 said their bathroom needed to be cleaned better by housekeeping and staff were using too much bleach. Resident 72 agreed with Resident 1 and said housekeeping was not (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	emptying the trash and it was filling up with briefs. None of the listed concerns were documented on the September 2025 Grievance Log.On 10/01/2025 at 10:03 AM, Staff H, Activities Director, said they took notes at the Resident Council Meetings. Staff H, regarding Resident Council Meeting Minutes, explained they wrote who attended the meeting, both staff and residents, then the residents' concerns were brought up and they would write the name of the staff member who responded to that resident's concern. Staff H said the G at the end of the residents' concern, meant a grievance form was completed for that specific concern. Staff H said once the grievance form was filled out, it was given to the Grievance Officer, who was Staff A, Administrator, and Staff A would respond to the concern(s). When shown the July, August and September 2025 Resident Council Meeting Minutes, Staff H said the grievance forms were completed and provided to the Grievance officer. Staff H was then shown the Grievance log, Staff H said they provided the grievances to Staff A, but confirmed the grievances were not on the log and should have been.On 09/30/2025 at 2:25 PM, an email was sent to Staff A requesting all grievance forms that had been completed in August and September 2025. As of 11/18/2025 the actual grievance forms had not been provided. Residents1) Resident 33 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS, an assessment tool), dated 09/05/2025, documented Resident 33 was cognitively intact. A review of a questionnaire, dated 09/19/2025, showed Resident 33 was asked by Staff G, Social Services Assistant, Do you feel staff respond in a timely manner? and Resident 33 responded no.On 09/25/2025 at 11:12 AM, Staff B, Director of Nursing [NAME] (DNS), said if he received this information from a resident during an investigation, he would ask the patient to do a grievance and if they cannot do a grievance then they would do a grievance for them. Staff B said he did not have a grievance for Resident 33.On 09/25/2025 at 12:58 PM, a review of the facility grievance log did not list Resident 33 after the questionnaire dated 09/19/2025.On 09/29/2025 at 12:57 PM, Staff B said he did not have a grievance for Resident 33 and he would educate his social workers on this. Staff B said there was follow-up with Resident 33 but he did not have documentation of it.2) Resident 8 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], showed Resident 8 was cognitively intact, and was independent with toileting. On 09/26/2025 at 6:05 AM, Resident 8 in the hallway said they wanted to report a nurse for not being kind. Resident 8 said the nurse had given them Tylenol, which was unnecessary. During an interview on 09/26/2025 at 7:12 AM, Staff B, DNS, was informed of Resident 8 wanting to report a nurse for not being kind, and the following interaction between Resident 8 and Staff S, Licensed Practical Nurse (LPN), in the hallway. During an observation on 09/26/2025 at 10:45 AM, Resident 8 was seen telling Staff Q, LPN, that at about 10:00 PM the night before, a young staff member had checked Resident 8's underwear to see if they were needing to be changed, despite the fact they could independently use the bathroom. Resident 8 said this was no longer a safe place. Staff Q said the staff member must have gotten a bad report. Resident 8 said that it was when they were sleeping, and this was unsettling. Staff Q said they understood the concern and recognized that Resident 8 was could independently use the bathroom. Resident 8 thanked Staff Q for understanding, then told them their nurse overnight (Staff S) was not nice, should stop and be kinder to people, and should not work in this kind of job. During an interview on 09/29/2025 at 11:16 AM, Staff Q said they had told their unit manager about both staff Resident 8 had reported to them, but had not filed a grievance. When asked who usually was responsible for filing a grievance, if it was the nurse or manager, Staff Q said the manager usually files the grievance. During an interview on 09/29/2025 at 12:51 PM, Staff D, Charge Nurse (also called Unit Manager at this facility, often called Resident Care Manager in other facilities)/Registered Nurse, confirmed they had been told about both staff regarding Resident 8. Staff D said they did not file a grievance, as they were the last one to find out. Review of the September Grievances, updated and provided on 09/30/2025, did not include Resident 8 and the two staff. During an interview on 10/01/2025 at 11:08 AM, Staff B confirmed they did not have any grievances for Resident 8 regarding the two staff, and said yes, for any concern there should be a grievance. 3) Resident 12 was admitted to the facility on [DATE], with a diagnosis of depression. The (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review, the facility failed to ensure psychotropic medications (any drug that affects the brain activities associated with mental processes and behavior) were regularly monitored for side effects and target behaviors for 5 of 7 residents (Resident 105, 48, 1, 7, & 9) reviewed for unnecessary medication or behavioral/emotional. This failure placed residents at risk of unnecessary medication usage, increase in side effects without interventions, and a diminished quality of life.Findings included Review of the facility's policy entitled, Psychotropic Medication Use, revised July 2022, documented: Residents receiving psychotropic medications are monitored for adverse consequences, including:1. anticholinergics effects - flushing, blurred vision, dry mouth, altered mental status, difficulty urinating, falls, excessive sedation and constipation;2. cardiovascular effects - irregular heart rate or pulse, palpitations, lightheadedness, shortness of breath, diaphoresis, chest/arm pain, increased blood pressure, orthostatic hypotension;3. metabolic effects - increased cholesterol and triglycerides, poorly controlled or unstable blood sugar, weight gain;4. neurologic effects - agitation, distress, extrapyramidal symptoms, neuroleptic malignant syndrome, Parkinsonism, tardive dyskinesia, cerebrovascular events; and5. psychosocial effects - inability to perform ADLs or interact with others, withdrawal or decline from usual social patterns, decreased engagement in activities, diminished ability to think or concentrate.1) Resident 105 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS, an assessment tool), dated 09/21/2025, documented Resident 105 was moderately cognitively impaired. Review of Resident 105's electronic health record (EHR) showed they were prescribed aripiprazole (antipsychotic medication) for depression (a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), sertraline (antidepressant) for depression and trazadone (antidepressant) for depression. Review of the Medication Administration Record (MAR) September 2025 and Treatment Administration Record (TAR) September 2025 showed no side effect monitoring or target behavior monitoring for any of the listed psychotropic medications. On 09/29/2025 at 10:05 AM, Staff K, Charge Nurse (also called Unit Manager at this facility, often called Resident Care Manager in other facilities) /Licensed Practical Nurse (LPN), confirmed Resident 105 did not have side effect monitoring or target behavior monitoring related to psychotropic drug use and should have. On 09/30/2025 at 1:42 PM, Staff B, Director of Nursing Services (DNS), said Resident 105 should have had side effect monitoring and target behavior monitoring for all psychotropic medications. 2) Resident 48 was admitted to the facility on [DATE] with a diagnosis of anxiety (a mental health condition characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily life) and depression. The Quarterly MDS, dated [DATE], documented Resident 48 was moderately cognitively impaired. Resident 48's EHR showed orders for: - buspirone for anxiety - duloxetine for depressionOn 09/26/2025 at 10:22 AM, Staff D, Charge Nurse/Registered Nurse (RN), while looking at the chart she said they did not see where Resident 48 was being monitored for target behaviors. Staff D said we should be monitoring target behaviors for depression and anxiety. On 09/26/2025 at 10:37 AM, Staff B, DNS, said Resident 48 did not have orders for target behavior monitoring and all residents should have orders if they are on psychotropic medication. 3) Resident 1 admitted to the facility on [DATE], with diagnoses of anxiety disorder, depression, and post-traumatic stress disorder (PTSD, mental health condition that develops after a person experiences or witnesses a traumatic or life-threatening event). The Quarterly MDS, dated [DATE], indicated Resident 1 was cognitively intact. On 09/24/2025 at 8:31 AM, Resident 1 said a lot of their anxiety was late at night, their head would not shut up, and they still had to wait hours before their anxiety medication was available again. Resident 1 said they did not need the medication when they first woke up, it was usually later in the afternoon that they started getting shaky and (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nervous.Review of Resident 1's orders, showed they had a completed order, dated 08/13/2025, for hydroxyzine, every 6 hours as needed for anxiety, order for 30 days. Resident 1's active orders showed an order, dated 09/22/2025, for hydroxyzine, every 12 hours for anxiety. (It went from being available every 6 hours to every 12 hours.)Review of Resident 1's Medication Administration Record and TAR, from 09/01/2025 through 09/23/2025, showed Resident 1 had the as needed anxiety medication on the following dates: 09/05/2025, 09/06/2025, 09/08/2025 and 09/09/2025, but there was no target behavior monitoring in place for anxiety. On 10/01/2025 at 10:39 AM, Staff D, Charge Nurse/RN, when asked if a resident was prescribed a medication to treat anxiety what would they expect to be in place, Staff D said, target behaviors, side effects, and alert charting. Staff D said behavior monitoring should be in place for all psychotropic medications (drugs that affect the brain and alter mental processes and behavior) and should be specific to the resident. When asked if Resident 1 had target behaviors monitored for anxiety, Staff D said no target behaviors were in place and they should have been.4) Resident 7 readmitted to the facility on [DATE] with diagnoses that included bipolar disorder (extreme mood swings), depressive disorder, and generalized anxiety disorder. The Medicare 5-day MDS, dated [DATE], indicated Resident 7 was cognitively intact. Resident 7 had the following scheduled psychotropic medications ordered.1. quetiapine (antipsychotic medication) related to bipolar disorder, order dated 07/15/2025.2. trazadone (antidepressant medication) related to major depressive disorder, order dated 07/15/2025.3. buspirone (anti-anxiety medication) related to generalized anxiety disorder, order dated 07/15/2025. Review of Resident 7's MAR and TAR from 09/01/2025 through 09/23/2025, showed that no target behaviors were ordered or monitored for any of Resident 7's three psychotropic medications. On 10/01/2025 at 10:29 AM, Staff D, Charge Nurse/RN, when asked what needed to be in place when a resident was on a psychotropic medication said, behavior monitoring, side effect monitoring, consent, alert charting for 7 days, target behaviors and target moods. When asked if target behaviors should be defined and documented on, Staff D said yes, and they should have been specific to the resident. When asked if Resident 7 had target behaviors ordered for their three psychotropic medications, Staff D acknowledged they were not ordered and said this did not meet her expectations. 5) Resident 9 was admitted to the facility on [DATE] with a diagnosis to include delirium due to physiological condition. The Significant Change MDS, dated [DATE], documented Resident 9 was moderately cognitively impaired. Review of Resident 9's EHR, showed a physician's order, dated 09/19/2025, for an antipsychotic medication quetiapine for delirium. Review of Resident 9's MAR for September 2025, did not show documentation of monitoring of side effects related to antipsychotic medication use. In an interview and joint record review on 09/26/2025 at 09:50 AM, Staff D, Charge Nurse/ RN said any resident taking a psychotropic medication, was also monitored for side effects. Staff D was unable to find documentation that psychotropic side effects monitoring was taking place for Resident 9.In an interview on 09/26/2025 at 09:58 AM, Staff B, DNS/RN, said they expected residents who were prescribed psychotropic medications would have monitoring of side effects documented in the physician's orders and in the MAR. Staff B was unable to provide documentation of side effects monitoring for Resident 9.Reference WAC 388-97-1060 (3)(k)(i), 0620 (1)(a) .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interviews and record review, the facility failed to accurately code the Minimum Data Sets (MDS, an assessment tool) for 3 of 3 sampled residents (Resident 4, 3 & 2) reviewed for the communication restorative program. The failure to ensure all required components of a communication restorative program were met and were accurately coded placed residents at risk for unidentified and/or unmet care needs and a diminished quality of life.Findings included.Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) Version 3.0 User's Manual (a guide used by facilities for accurately recording resident's health status and information), dated 10/2024, documented one restorative program that could be recorded on the MDS, was a communication program. Instructions from the RAI showed facilities could code, under the MDS communication program, activities provided to residents that were aimed at improving or maintaining their self-performance with functional communication skills (ability to convey basic needs, wants, and thoughts) or that assisted the residents with using residual (remaining) communication skills and adaptive devices. For these activities to count on the MDS, they needed to be:1. Individualized to the resident's needs2. Planned3. Monitored4. Evaluated5. Documented1) Resident 4 was admitted to the facility on [DATE]. Resident 4's Quarterly MDS, dated [DATE], showed they were cognitively intact and had been in a restorative communication program that they were coded as having done 4 days during the assessment window. During an interview on 11/18/2025 at 8:56 AM, Resident 4 said they were independent while playing Yahtzee. Review of Resident 4's Restorative Program Quarterly Evaluation, dated 04/21/2025, documented Resident 4 was enjoying the communication program and socialization continued. Review of Resident 4's care plans showed they had a care plan on restorative nursing services related to (r/t) End stage renal disease, weakness, deconditioning, morbid obesity, initiated 06/25/2025. The goal was listed as, Restorative goal: to maintain socialization and the interventions/tasks were listed as, RESTORATIVE PROGRAM: Communication program- Resident to meet in dining room with other resident to participate in a board game or Yahtzee, up to 6x week for 15 minutes a day. Document in PCC [the electronic health record]. This restorative program was not able to show what the resident's current level of communication was, what communications goals they were working on that could be measured and how, and did not explain what kind of communication was expected of the resident during the Yahtzee games. During an interview on 11/18/2025 at 9:45 AM, Staff FF, Restorative Certified Nursing Assistant (CNA), said for the Yahtzee restorative program, residents played cards and were all independent. When asked what kind of notes were taken of residents during the Yahtzee games, Staff FF was only able to provide a score sheet (no notes were provided on how residents were doing with their communication goals during the games). For Resident 4's restorative program, Staff FF said their goal was to maintain communication and friendship. During a group interview on 11/18/2025 at 1:18 PM, Staff B, Director of Nursing Services (DNS), Staff LL, MDS Assistant/Licensed Practical Nurse (LPN) were present in person and Staff NN, MDS consultant/Registered Nurse (RN) was present via phone call. At 1:28 PM, Staff MM, MDS Director/ RN, joined the interview via phone call. When asked how Resident 4's restorative program met the requirements for being coded on the MDS, Staff MM said Resident 4's goal was to increase socialization since they were gone for hours a day at dialysis, this was a way for them to be more social with other residents. When asked if Resident 4's goal was measurable, Staff NN said if Resident 4 was showing up and participating, then they were meeting the goal. 2) Resident 3 was admitted to the facility on [DATE]. Review of their Quarterly MDS, dated [DATE], showed they were cognitively intact and had been in a restorative communication program that they were coded as having done 3 days during the assessment window. During an interview on11/18/2025 at 9:07 AM, Resident 3 said that while they had received the restorative program, staff read the bible to them. Review of Resident 3's Restorative Program Initiation Evaluation, dated 04/02/2025, documented, (continued on next page)

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	505123	A. Building B. Wing	11/18/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	New restorative communication program. Resident is requesting the bible reading.Review of Resident 3's care plans showed they had an alteration in sensory/communication r/t speech disturbance care plan, initiated 07/08/2025. The goal was listed as Will maintain communication abilities by review date and the interventions/tasks were listed as, RESTORATIVE: communication program: RESTORATIVE: communication program: Bible reading with staff up to 6x week for 15 minutes, Document in PCC. This restorative program was not able to show what the resident's current level of communication was, what communications goals they were working on that could be measured, and did not explain the resident was not involved in reading the bible, but instead was being read to by staff. During an interview on 11/18/2025 at 9:45 AM, Staff FF, Restorative CNA, said for Resident 3's restorative program of bible reading, it involved staff reading the bible to Resident 3. During a group interview on 11/18/2025 at 1:28 PM, Staff MM, MDS Director/ RN, with Staff B, Staff LL, and Staff NN present, was asked how Resident 3's program met requirements for being coded on the MDS. Staff MM said Resident 3's program was communication for bible reading, started on 04/02/2025, and was to maintain communication and socialization. 3) Resident 2 was admitted to the facility on [DATE]. The Significant Change MDS, dated [DATE], documented Resident 2 was severely cognitively impaired and required maximum assistance with cares. The MDS documented Resident 2 participated in the communication restorative program, via bible study. Resident 2's Restorative care plan, dated 06/25/2025, documented Resident 2's participation in the communication restorative program was related to difficult hearing and included Restorative goal: to maintain communication ability. Staff will do bible study/question per resident choice. 15 minutes a day up to 6x week. The restorative care plan did not document the residents' communication/cognition level, resident specific interventions or goals, how the goals would be measured, communication expectations or monitoring related to the resident's progress in the communication restorative program. Review of the August 2025 Restorative Nursing Monthly Log documented Resident 2 participated in 15 of 26 communication bible study opportunities. Review of the September 2025 Restorative Nursing Monthly Log documented Resident 2 participated in 19 of 23 communication bible study opportunities.On 11/18/2025 at 9:45 AM, when asked about communication restorative program care plans, Staff FF, Restorative CNA, said residents were care planned for 15 minutes on the Omni bike and or communication skills. When asked what the communication restorative program included, Staff FF said they (staff) would read books, magazines or the bible to the residents and would play Yahtzee. Staff FF said the goal of the communication restorative program was to build confidence and skills for the residents. Staff FF said staff would complete assessments to see if the residents are doing well and pass the information on to Physical Therapy or Staff MM, MDS Director/RN, who would complete the evaluations. When asked if residents received assistance during the readings or board games, Staff FF said no, the residents were independent, and staff would only read to the residents or play the games with them. When asked if there were any notes that documented the residents' participation and/or progress/decline in such areas, Staff FF said they do not take notes, they only document if the resident has attended the activity and was only able to provide scoring sheets for the Yahtzee game, that had no names or dates. No notes were provided about interactions during bible reading sessions. When asked about Resident 2's communication restorative program goals, Staff FF said Resident 2's goal was to increase communication by being read the bible.On 11/18/2025 at 1:18 PM, Staff B, DNS, Staff LL, MDS Assistant/LPN, were present in person and Staff NN, MDS consultant/Registered Nurse (RN) was present via phone call. At 1:28 PM, Staff MM, MDS Director/RN, joined the interview via phone call. Staff LL confirmed Resident 2 was in the communication restorative program. Staff MM said Resident 2 qualified for the program because they did not get out of bed and very seldom had visitors, therefore their goal for the communication restorative program was socialization and to maintain communication. None of the staff were able to provide specific resident interventions, goals, resident's involvement or monitoring/documentation for the bible reading communication restorative program. On 11/18/2025 at 2:01 PM, Staff B with Staff LL present, were explained the RAI Manuel's (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	requirements for a communication restorative program, that included resident specific goals, measurable interventions, the resident's involvement, monitoring, completed evaluations and/or documentation. When asked how the communication restorative program meet this criteria, Staff B, stated, I finally understand, it doesn't, this is an activity, not a communication restorative program.Reference WAC 388-97 -1000 (1)(b).

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review, the facility failed to ensure baseline care plans were developed, implemented and given to the resident within 48 hours of admission for 3 of 3 sampled residents (Resident 107, 105 & 78) reviewed for new admission. This failure placed residents at risk for unidentified and/or unmet care needs, and other negative health outcomesFindings included .1) Resident 107 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS, an assessment tool) documented still in progress. The electronic health record (EHR) showed no baseline care plan had been created or was given to the resident. On 09/24/2025 at 2:48 PM, Resident 107 said they never received a baseline care plan 48 hours after admission. 2) Resident 105 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident was moderately cognitively impaired. The EHR showed the baseline care plan was initiated 09/22/2025, 8 days after Resident 105 was admitted . On 09/24/2025 at 3:28 PM, Resident 105 said he did not remember receiving a baseline care plan. On 09/29/2025 at 10:05 AM, Staff K, Charge Nurse (also called Unit Manager at this facility, often called Resident Care Manager in other facilities) /Licensed Practical Nurse (LPN), said residents were to receive their baseline care plan within 48 hours of admission. Staff K confirmed Resident 107 and Resident 105 did not receive their baseline care plan and should have. 3) Resident 78 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident was severely cognitively impaired. The EHR showed the baseline care plan was initiated 09/11/2025, 4 days after Resident 105 was admitted , but was not given to the resident.On 09/30/2025 at 10:40 AM, Staff K, Charge Nurse/LPN, said Resident 78's baseline care plan was incomplete due to a Durable Power of Attorney (DPOA) issue, and it was not provided to the resident or the DPOA.On 09/30/2025 at 1:42 PM, Staff B, Director of Nursing Services, said all residents should receive a baseline care plan within 48 hours of admission. Staff B confirmed Resident 107, Resident 105 and Resident 78 did not receive their baseline care plans within 48 hours of admission and said they should have. Reference WAC 388-97 -1020 (3).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation, interview and record review, the facility failed to ensure care conferences (meetings with the interdisciplinary team and the resident and/or their representative to review and/or revise the care plan after each Minimum Data Set (MDS) assessments) occurred for 3 of 3 residents (Residents 4, 6, & 58) reviewed for care conferences, or to update resident care plans for 3 of 22 sampled residents (Residents 8, 12, & 1). This failure placed residents at risk of unidentified and unmet care needs, and a diminished quality of life. Findings included.Care Conferences: 1) Resident 4 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 06/23/2025, showed Resident 4 was cognitively intact. During an interview on 09/23/2025 at 7:47 AM, Resident 4, when asked if they have been included in quarterly care conferences where the facility reviewed their medication, therapy services, and general care, said they did not think the facility was doing them and they could not recall the last time they had a care conference. Review of Resident 4's electronic health record (EHR), showed Resident 4 had three completed MDS assessments within the past year, with one in progress. Documentation was only found for one of the care conferences following the MDS assessments, for 07/07/2025. During an interview on 09/26/2025 at 11:05 AM, Staff G, Social Services Assistant, said the interdisciplinary team collaborated as a team for care conferences and they would review plan of care with the residents on admission, discharge, and quarterly. When asked when care plans were reviewed with the resident, Staff G said the residents were provided with a baseline care plan on admission, then the full care plans were reviewed at the initial care conference, and reviewed at every other care conference. Staff G confirmed they were only able to find a documented care conference for Resident 4 for 07/07/2025, during the past year. 2) Resident 6 was admitted to the facility on [DATE]. The Modification of Quarterly MDS, dated [DATE], showed Resident 6 was cognitively moderately impaired. Resident 6 had a power of attorney. During an interview on 09/23/2025 at 10:05 AM, Resident 6 said they were not receiving care conferences. Review of Resident 6's EHR, showed they had four MDS assessments completed in the past year, with no documentation found of any care conferences. During an interview on 09/26/2025 at 11:05 AM, Staff G, Social Services Assistant, was unable to find any care conferences for Resident 6 for the past year. 3) Resident 58 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], showed Resident 58 was cognitively intact. During an interview on 09/22/2025 at 11:23 AM, Resident 58 said they were unsure if they had any care conferences. Review of Resident 58's EHR, showed they had two completed MDS assessments, with one in progress. Documentation was found for one care conference, on 07/29/2025. During an interview on 09/26/2025 at 11:05 AM, Staff G, Social Services Assistant, was only able to find documentation of the one care conference for Resident 58, on 07/29/2025. During an interview on 09/29/2025 at 12:08 PM, Staff C, Social Services Director, said their expectations for care conferences was for the interdisciplinary team to discuss resident care, that everyone in that team would be there for a meeting to give their input, and each department would document under their section of the review. When asked if it met expectations there was no supporting documentation that Resident 4, 6, and 58 received all of their quarterly care conferences, Staff C said no. Care Plans: 1) Resident 8 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], showed Resident 8 was cognitively intact. During an observation and interview on 09/22/2025 at 3:18 PM, Resident 8 opened their top drawer of their dresser and three white pills were seen in a medicine cup. At 3:34 PM, Staff Q, Licensed Practical Nurse, came into the room and Resident 8 said the three pills were melatonin. Review of Resident 8's care plan on 09/27/2025 at 12:16 PM, showed it had not been updated with information after the three pills were found in their dresser. During an interview on 09/29/2025 at 3:19 PM, Staff B, Director of Nursing Services (DNS), said Resident 8's care plan was (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not updated after the pills were found in their room and it should have been. 2) Resident 12 was admitted to the facility on [DATE], with a diagnosis of depression. The Quarterly MDS, dated [DATE], showed Resident 12 was cognitively intact. Review of Resident 12's EHR, showed they were hospitalized from [DATE] to 08/28/2025 after being found unresponsive and for new seizure activities. After hospitalization, they were prescribed seizure medications, and a diagnosis of seizures was added to their chart on 08/28/2025. Review of Resident 12's care plans on 09/23/2025 at 4:06 PM, showed their care plan was not updated after hospitalization with the new diagnosis of seizures to include interventions and goals. During an interview on 09/29/2025 at 10:03 AM, Staff D, Charge Nurse (also called Unit Manager at this facility, often called Resident Care Manager in other facilities)/ Registered Nurse (RN), reviewed Resident 12's care plans, and said the care plan should have been updated and they would update it now. Review of Resident 12's EHR, showed they had a gradual dose reduction (GDR) of their most recent antidepressant medication, sertraline 50 mg, which was decreased on 07/24/2025 to 25mg, and decreased again on 07/31/2025 to none. Review of Resident 12's care plans on 09/23/2025 at 4:06 PM, showed their care plan had listed they were taking an antidepressant. It was not updated with the GDR attempts, that Resident 12 was currently not taking any antidepressant, or any information for staff on monitoring for recurrent depression symptoms. During an interview on 10/01/2025 at 8:44 AM, Staff D said Resident 12's care plan was not updated after being taken off their antidepressant medication. During an interview on 10/01/2025 at 11:08 AM, Staff B, DNS, when asked if care plans should be updated after hospitalizations or after an antidepressant was discontinued, said yes. 3) Resident 1 was admitted to the facility on [DATE], with diagnoses of anxiety disorder, depression and post-traumatic stress disorder (PTSD, mental health condition that develops after a person experiences or witnesses a traumatic or life-threatening event). The Quarterly MDS, dated [DATE], indicated Resident 1 was cognitively intact. On 09/22/2025 at 1:19 PM, Resident 1 said they had anxiety and PTSD. Resident 1 said the PTSD was due to past sexual abuse issues and for that reason they did not feel comfortable having a male shower aid. Review of Resident 1's care plan showed no care plan specific to PTSD that outlined Resident 1's triggers (specific stressors that would cause a PTSD response). Additionally, there was no mention in the care plan that Resident 1 preferred no male shower aids. Review of the 09/18/2025 Resident Council Meeting Minutes, showed documentation that Resident 1 said a male nursing aide was the only one available on some of their shower days and they did not want a male nursing aide, which they said was known by the facility and documented. On 09/26/2025 at 11:25 AM, Staff D, Charge Nurse/RN, said if a resident had a diagnosis of PTSD there should be a specific care plan for that. When asked if Resident 1 had a care plan for PTSD, that identified triggers and interventions, Staff D said there was a care plan for paranoia related to PTSD, but there should be a specific care plan for PTSD.On 09/26/2025 at 11:33 AM, Staff G, Social Services Assistant, when asked if a resident had a diagnosis of PTSD if there should be a care plan specific to that, said yes and the Social Services department was responsible for putting that care plan in. When asked what the care plan would include for someone with PTSD, Staff G said it should include triggers and things that would help. After reviewing Resident 1's care plan, Staff G acknowledged there was not a care plan specific to PTSD with triggers listed, and said it should have been there and been customized for Resident 1.On 10/01/2025 at 10:25 AM, Staff D, Charge Nurse/RN, said if a resident had said they did not want male caregivers, it should be on their care plan. When asked if Resident 1 had no male caregivers on their care plan, Staff D said no, it should have been there.Reference F742Reference WAC 388-97-1020(2)(c)(d)(f), (4)(b), (5)(b).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 initiate bowel protocol interventions for 4 of 8 residents (Resident 10, 78, 100 & 8) reviewed for constipation, to ensure blood glucose levels were appropriately monitored and intervened upon for 1 of 2 resident (Resident 67) reviewed for insulin, to provide documentation of events leading to hospitalization for 1 of 3 residents (Resident 12) reviewed for hospitalization, and to provide overall quality care for 1 of 22 sampled residents (Resident 2). These failures placed residents at risk of unmet care needs, constipation, hospitalizations and a diminished quality of life. Findings included .Bowel Protocol: Record review of the facility policy titled, Constipation, no date, defined constipation as three or more days of no bowel movement (BM). The policy documented the following interventions were to be implemented: Standard bowel care to relieve constipation (in the absence of a bowel obstruction) with a provider order may include the following:- Milk of Magnesia [laxative] 30 ml PO [by mouth] HS [hour of sleep] after eight shifts of no BM - Bisacodyl Suppository rectally if no results from the Milk of Magnesia- Fleets Enema rectally if no results from the Bisacodyl Suppository1) Resident 10 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 07/23/2025, documented the resident was alert and oriented.Review of Resident 10's BM task sheet, showed documentation of Resident 10's BM activity on 09/18/2025 at 5:20 PM. Resident 10's next BM was documented on 09/23/2025 at 5:18 PM, approximately 5 days since the last BM.Review of Resident 10's Medication Administration Record (MAR) from 09/18/2025 to 09/23/2025, did not show documentation of medication intervention for no BM after 3 days.2) Resident 78 was admitted to the facility on [DATE]. The Admission/ 5-Day MDS, dated [DATE], documented the resident was severely cognitively impaired.Review of Resident 78's BM task sheet, showed documentation of Resident 78's BM activity on 09/11/2025 at 6:07 AM. Resident 78's next BM was documented on 09/16/2025 at 3:02 PM, approximately 5 days since the last BM.Review of Resident 78's MAR, dated September 2025, showed Resident 78 was administered Milk of Magnesia on 9/15/2025 at 9:07 AM, approximately 1 day after the 3 day window outlined in the policy.3) Resident 100 was admitted to the facility on [DATE]. The Admission/Medicare 5 Day MDS, dated [DATE], documented the resident was severely cognitively impaired.Review of Resident 100's BM task sheet, showed no documentation of Resident 10's BM activity from 09/15/2025 until 09/20/2025 at 4:34 PM, five days after admitting. Review of Resident 100's MAR from 09/15/2025 to 09/23/2025, showed no documentation of BM medication intervention.In an interview on 09/26/2025 at 9:20 AM, Staff V, Licensed Practical Nurse (LPN), stated, If a person doesn't go in 72 hours [3 days], we give them Milk of Magnesia. Staff V said it was the expectation for staff to document bowel interventions on the MAR. Staff V was unable to provide documentation of timely administration of BM interventions for Residents 10, 78, and 100. In an interview on 09/26/2025 at 9:52 AM, Staff B, Director of Nursing Services (DNS), said it was his expectation for staff to review the daily BM list, and initiate interventions per policy. Staff B stated, I don't let it go more than 48 hours. Staff B was unable to provide documentation of bowel interventions initiated for Residents 10, 78, and 100.4) Resident 8 was admitted the facility on 02/16/2023. The Quarterly MDS, dated [DATE], showed Resident 8 was cognitively intact, and was independent with toileting. During an interview on 09/22/2025 at 3:30 PM, Resident 8 said they did have constipation. Review of Resident 8's bowel record, showed they had a period of no bowel movement recorded from 09/10/2025 to 09/14/2025 (5 days). Review of Resident 8's MAR from 09/10/2025 to 09/14/2025, showed Resident 8 did not have any PRN (as needed) bowel medications given. Review of Resident 8's progress notes from 09/10/2025 to 09/14/2025, showed none related to the bowel protocol during this time frame. Review of Resident 8's care plans, showed an alteration in bowel elimination constipation care plan, initiated on 12/01/2023, with a goal to have a normal bowel movement at least every third day. During an interview on 09/26/2025 at 10:08 AM, Staff D, Charge Nurse (also called (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Unit Manager at this facility, often called Resident Care Manager in other facilities) /Registered Nurse (RN), said the bowel protocol was to be implemented on day three. Staff D confirmed Resident 8 had no bowel movement documented for the above 5 days, said it did not look like the bowel protocol was followed, and confirmed there were no alert charting during those dates. Staff D said staff should have asked Resident 8 about their bowel movements, an alert should have popped up since they were marked as having no bowel movement, and the bowel protocol should have been followed. Blood Glucose Levels:Resident 67 was admitted to the facility on [DATE] with a diagnosis of Type 2 Diabetes Mellitus (trouble with regulating blood sugars). The Quarterly MDS, dated [DATE], showed Resident 67 was cognitively intact. During an interview on 09/22/2025 at 1:41 PM, Resident 67 said their blood sugar was not supposed to go under 80, but had been since admission. Resident 67 said they have been symptomatic, with feeling shaky and falling asleep. Review of Resident 67's electronic health record (EHR), showed on 09/23/2025 a blood glucose reading of 40 was recorded at 11:29 PM. No progress notes were found, no interventions were found. Review of Resident 67's orders, showed an order dated 12/06/2024, for if blood glucose was under 70, the staff was to administer juice, skim milk, glucose tablets, sugar cubes, hard candy, or glucose gel. Blood glucose was to be rechecked every 15 minutes after giving one of the interventions, until glucose levels were 90 or higher. The provider was to have been notified, and a protein snack would be given afterwards. During an interview on 09/30/2025 at 8:25 AM, Resident 67 said they did not see their blood glucose numbers this week, but their blood glucose will drop right after their diabetic medications, and they had not been eating as much this week. During an interview on 10/01/2025 at 8:44 AM, Staff D, Charge Nurse/RN, when asked if they knew about Resident 67's low blood sugar reading of 40, said no, they had not been alerted about it by anyone. Staff D was unable to find any progress notes or interventions given related to the blood glucose level. Staff D said the blood glucose level was retaken the next day, about 6 hours later. Staff D said their expectation was for staff to have given Resident 67 their glucose order by mouth if Resident 67 was alert and oriented, or by injection if not alert and oriented. During an interview on 10/01/2025 at 11:08 AM, Staff B, DNS, when asked their expectations of staff when Resident 67 had a blood glucose reading of 40, said the hypoglycemic (low blood sugar) protocol should have been adhered to. Hospitalization Documentation:Resident 12 was admitted to the facility on [DATE], with diagnoses of End Stage Renal Disease (final stage of chronic kidney disease, where kidneys can no longer function adequately) requiring dialysis (machine that filters the blood), chronic respiratory failure, and chronic heart failure. The Quarterly MDS, dated [DATE], showed Resident 12 was cognitively intact. During an interview on 09/23/2025 at 10:12 PM, Resident 12 reported they had a seizure causing them to be hospitalized , and they woke up in the intensive care unit. Resident 12's roommate, Resident 67 said Resident 12 had been sleeping all night, and did not wake up for the visiting cat or to eat/drink at dinner. Resident 67 said they had stayed up all night watching Resident 12, and in the morning Resident 67 had unusual movement with their hands, looking like they were trying to write in the air. Review of Resident 12's EHR, showed they were hospitalized from [DATE] to 08/28/2025 after being found unresponsive and for new seizure activities. Review of Resident 12's progress notes, showed there was no progress note to document the care provided to the resident before hospitalization or provide any details of what occurred overnight. Review of Resident 12's hospitalization records, showed the hospital had written, According to her roommate, she was found unresponsive in the morning after not following her usual bedtime routine. Upon arrive to the ED [Emergency Department], she was minimally responsive to painful stimulation and exhibited left-sided shaking [.]During an interview on 09/29/2025 at 10:03 AM, Staff D, Charge Nurse/RN, said they expected documentation/progress notes of the events leading up to a hospitalization. Staff D looked at Resident 12's chart and said there was a transfer form that said altered mental status and included vitals. When asked what events led to the hospitalization, Staff D said they were unable to find anything and this did not meet expectations. During an interview on 10/01/2025 at 11:08 AM, Staff B, DNS, said their expectation for staff in (continued on next page)

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	505123	A. Building B. Wing	11/18/2025

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Bremerton Trails Post Acute	2701 Clare Avenue Bremerton, WA 98310

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	regards to documentation for Resident 12's hospitalization, was for there to have been a completed change of condition form. Reference F657Reference F757Reference WAC 388-97-1060 (1).

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation, interview and record review, the facility failed to maintain acceptable parameters for weight loss by ensuring proper implementation of interventions for 1 of 4 sampled residents (Resident 55) reviewed for nutrition. Additionally, the facility failed to maintain and ensure adequate fluid hydration and fluid restrictions were implemented for 4 of 4 sampled residents (Residents 107, 17, 12 and 4) reviewed for hydration. These failures placed residents at risk for continued weight loss, dehydration, fluid overload and a diminished quality of life.Findings included. MEALS MISSING DIETARY INTERVENTIONS1) Resident 55 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia and nutritional deficiency. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 08/29/2025, documented Resident 55 was severely cognitively impaired.On 09/24/2025 at 1:16 PM, Review of Resident 55's lunch ticket showed they were to have an enhanced diet (whole milk, extra butter, sauce, gravy, dessert instead of fruit), ice cream or magic cup, cereal with all meals, double fruit or dessert, extra butter, gravy, sauce, whole milk. Review of Resident 55's delivered meal showed no cereal was provided. Staff FF, Certified Nursing Assistant (CNA), when asked if Resident 55 had gotten cereal with their lunch stated, I guess not.On 09/25/2025 at 5:52 PM, Staff O, CNA, was sitting next to Resident 55 on a chair as the resident ate. Staff O confirmed Resident 55 had only one cookie provided with her meal and had already eaten it. Review of Resident 55's dinner ticket showed enhanced diet, ice cream or magic cup, cereal with all meals, double fruit or dessert, extra butter, gravy, sauce, whole milk. Review of Resident 55's meal showed it was missing ice cream or magic cup, one additional cookie, and cereal. On 09/25/2025 at 6:41 PM, Staff II, Registered Dietician and Staff JJ, Dietary Technician, when told of observation of missing dietary interventions, Staff II said they needed to do an in service with staff to discuss accuracy of plating, following a system, and when something was not available to offer substitutes. Staff JJ said the facility was out of ice cream/magic cup at the time. When asked if this met expectations, Staff II said they had some in servicing and auditing to do. On 09/29/2025 at 12:38 PM, review of Resident 55's lunch ticket showed enhanced diet, ice cream or magic cup, cereal with all meals, double fruit or dessert, extra butter, gravy, sauce, whole milk. On 09/29/2025 at 12:56 PM, Staff JJ, Dietary Technician, acknowledged that Resident 55's lunch meal was missing cereal and had no extra gravy, and said cereal should have been part of Resident 55's meal. STAFF KNOWLEDGE OF CUT UP ASSISTANCEReview of resident 55's provider orders showed their diet order, dated 03/20/2025, included cut-up assistance.On 09/30/2025 at 12:58 PM, during an observation of Resident 55 eating lunch they were observed without their food cut up and were not eating it. Staff KK, CNA, was present and assisting another resident. When asked if Resident 55 required cut-up assistance for their meal, Staff KK said, they did not believe so, it should have said on their ticket if they did and it did not say it there. Staff KK said if Resident 55's food needed to be cut up it would have come precut.On 10/01/2025 at 12:14 PM Staff B, DNS, said that Resident 55's order for cut up assistance should have been noted on the meal ticket and the Kardex (directions for CNAs) and acknowledged it was not. HYDRATION1) On 09/24/2025 at 2:58 PM, Resident 107 said they had gone to the dinner room for lunch today but was not given anything to drink with their lunch meal. 2) On 09/25/2025 at 1:21 PM, Staff F, Assistant Director of Nursing/Infection Preventionist, delivered room [ROOM NUMBER], bed 1's lunch meal and Staff X, Housekeeping Supervisor, delivered room [ROOM NUMBER], bed 2's lunch meal trays. Neither meal tray was delivered with a beverage and neither staff asked the residents if they would like something to drink with their meals. When asked about beverages with their meals, Resident 107 and Resident 17 confirmed neither staff asked the residents about beverages with their meals. On 09/30/2025 at 3:50 PM, Staff V, Licensed Practical Nurse, said staff should be offering hydration every 2-3 hours when they are doing rounds with ice, with meals, snacks and more often with residents with failure to thrive and at risk.On 09/30/2025 at 3:55 PM, Staff B, DNS, said (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hydration should be offered in the AM, after finishing rounds, again at the end of the shift and at meals times. Staff B said ice was passed twice per shift. When observations were explained of no beverages offered at the lunch mealtime, Staff B said this did not meet expectations.3) Resident 12 was admitted to the facility on [DATE], with diagnoses of end stage renal disease (final stage of chronic kidney disease, where kidneys can no longer function adequately) requiring dialysis (machine that filters the blood) and chronic heart failure. The Quarterly MDS, dated [DATE], showed Resident 12 was cognitively intact and dependent on staff for cares. Review of Resident 12's fluid restriction order, from 08/28/2025, showed they were on an 1800 milliliter (ml) fluid restriction. Nursing was to provide 250 ml for day shift, 250 ml for evening shift, and 100 ml for night shift. Dietary was to provide 480 ml for breakfast, 360 ml for lunch, and 260 ml for dinner. Nursing was to document total ml provided every shift, three times a day. Review of Resident 12's Medication Administration Record (MAR) by licensed nurses (LNs) and Nutritional-Fluids task list by Certified Nursing Assistants (CNAs), from 09/01/2025 to 09/26/2025, showed the documentation for the following dates exceeded the 1800 ml fluid restriction: 1. 09/02/2025: 1,670 ml by LNs + 300 ml by CNAs = 1,970 ml2. 09/04/2025: 1,540 ml by LNs + 609 ml by CNAs = 2,149 ml3. 09/06/2025: 1,560 ml by LNs + 960 ml by CNAs = 2,520 ml4. 09/07/2025: 1,560 ml by LNs + 660 ml by CNAs = 2,220 ml5. 09/09/2025: 1,430 ml by LNs + 609 ml by CNAs = 2,039 ml6. 09/10/2025: 1,620 ml by LNs + 600 ml by CNAs = 2,220 ml7. 09/16/2025: 1,670 ml by LNs + 1350 ml by CNAs = 3,020 ml8. 09/20/2025: 1,670 ml by LNs + 420 ml by CNAs = 2,090 ml9. 09/21/2025: 1,620 ml by LNs +720 ml by CNAs = 2,340 ml10. 09/23/2025: 1,720 ml by LNs + 600 ml by CNAs = 2,320 ml11. 09/25/2025: 1,570 ml by LNs + 360 ml by CNAs = 1,930 mlDuring an observation and interview on 09/25/2025 at 6:11 PM, Resident 12 reported they had only been given apple juice with their dinner, with no other fluids. Resident 12 was observed with three 8 oz bottled waters in front of them (about 710 ml) they were in the process of drinking. Resident 12 said the facility had not provided them with water since the night before, and they had to get water from their roommate. During an observation and interview on 09/30/2025 at 8:20 AM, Resident 12 was seen with only milk on their tray, in a small 5-ounce cup (approximately 150 ml, dietary was to provide 480 ml for breakfast, this was observed to be less). They had a pitcher of water next to them, which they reported was from last night/the previous day. During an interview on 09/30/2025 at 08:50 AM, Staff CC, CNA, said they were assigned to Resident 12's room, and none of their assigned residents were on a fluid restriction. Staff CC said they would document all the fluid the residents were drinking, and for Resident 12 they checked their pitcher in the morning to see if it was partially full, as they had limitations with lifting the pitcher if it was full. During an interview on 09/30/2025 at 11:08 AM, Staff Q, Licensed Practical Nurse, when asked how they chart fluid restrictions along with CNA charting, said LN and CNA charting were separate, as the LN charted what they gave, and the CNA charted what was on the meal trays. During an interview on 09/30/2025 at 11:20 AM, Staff D, Charge Nurse/Registered Nurse(RN), said staff monitor how much residents on fluid restrictions get every shift, and the kitchen (dietary) also has the fluid restriction per meal. Staff D said LNs should have a running list for their shift with each medication pass, meals, and total up at the end of their shifts.During an interview on 10/01/2025 at 9:34 AM, Staff F, Assistant Director of Nursing/ Infection Preventionist (ADON/IP), reviewed Resident 12's fluid intake for 09/02/2025 and 09/04/2025. Staff F confirmed Resident 12 went over their fluid intake both of the days they were requested to review. 4) Resident 4 was admitted to the facility on [DATE], with diagnoses of end stage renal disease (requiring dialysis) and heart failure. The Quarterly MDS, dated [DATE], showed Resident 4 was cognitively intact.During an interview on 09/23/2025 at 7:41 AM, Resident 4 said they were on a fluid restriction but were unaware of what it was. Review of Resident 4's fluid restriction order, from 04/09/2025, showed they were on a 1200 ml fluid restriction. Nursing was to provide 360 ml during the day, 240 ml in the evening and 120 ml during night shift. Dietary was to provide 240 ml at breakfast, 120 ml at lunch and dinner. Review of Resident 4's MAR by LNs and Nutritional-Fluids task list by CNAs, from 09/01/2025 to 09/26/2025, showed the documentation for the following dates (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	exceeded the 1200 ml fluid restriction: 1. 09/01/2025: 720 ml by LNs +1,000 ml by CNAs = 1,720 ml2. 09/02/2025: 1,100 ml by LNs + 840 ml by CNAs = 1,940 ml3. 09/03/2025: 1,100 ml by LNs + 540 ml by CNAs = 1,640 ml4. 09/04/2025: 1,100 ml by LNs + 600 ml by CNAs = 1,700 ml5. 09/05/2025: 1,200 ml by LNs + 400 ml by CNAs = 1,600 ml6. 09/06/2025: 1,300 ml by LNs + 1350 ml by CNAs = 2,650 ml7. 09/07/2025: 1,200 ml by LNs + 1,080 ml by CNAs = 2,280 ml8. 09/09/2025: 1,280 ml by LNs + 960 ml by CNAs = 2,240 ml9. 09/10/2025: 1,100 ml by LNs + 440 ml by CNAs = 1,540 ml10. 09/11/2025: 720 ml by LNs + 960 ml by CNAs = 1,680 ml11. 09/13/2025: 960 ml by LNs + 960 ml by CNAs = 1,920 ml12. 09/14/2025: 960 ml by LNs + 1,180 ml by CNAs = 2,140 ml13. 09/17/2025: 960 ml by LNs + 720 ml by CNAs = 1,680 ml14. 09/19/2025: 600 ml by LNs + 960 ml by CNAs = 1,560 ml15. 09/20/2025: 900 ml by LNs + 720 ml by CNAs = 1,620 ml16. 09/21/2025: 900 ml by LNs + 1,080 ml by CNAs = 1,980 ml17. 09/25/2025: 1,100 ml by LNs + 1,280 ml by CNAs =2,380 ml18. 09/26/2025: 1,100 ml by LNs + 720 ml by CNAs = 1,820 mlDuring an interview on 09/30/2025 at 11:20 AM, when asked if LNs chart 360 ml and 360 ml and CNAs chart 500 ml and 500 ml, how the facility accounts for this, Staff D said they should be adding it together. During an interview on 10/01/2025 at 9:34 AM, Staff F was asked to review Resident 4's fluid intake for 09/01/2025, and confirmed Resident 4 went over their fluid restriction. Reference F677WAC 388-97-1060 (3)(h) (i).

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, interview and record review, the facility failed to ensure residents with mental health diagnoses were given appropriate treatment and/or services, for 2 of 2 sampled residents (Residents 12 & 1) reviewed for behavior and emotion, or for Resident Council (a group of residents in the facility that meets regularly to discuss care, activities, or concerns). This failure placed residents at risk of increased symptoms, emotional distress, and a diminished quality of life. Findings included.1) Resident 12 was admitted to the facility on [DATE] with diagnoses of depression, anxiety, and muscle weakness. Review of Resident 12's Quarterly Minimum Data Set (MDS) assessment, dated 06/29/2025, showed they were dependent on staff for cares. During an interview and observation on 09/23/2025 at 10:12 AM, Resident 12 alleged physical abuse by Staff AA, Certified Nursing Assistant (CNA). Resident 12 scrunched up their face, had tears in their eyes, and cried while talking about Staff AA. During this interview, Resident 12 also said they had a recent seizure and woke up in the intensive care unit. Resident 12's roommate, Resident 67 said Resident 12 had been sleeping all night and did not wake up for the visiting cat or to eat/drink dinner. Resident 67 said they had stayed up all night watching Resident 12, and in the morning Resident 67 had unusual movement with their hands, looking like they were trying to write in the air. Review of Resident 12's electronic health record, showed they were hospitalized from [DATE] to 08/28/2025 for being unresponsive and new seizure activity. During an interview and observation on 09/24/2025 at 8:23 AM, Resident 12, while talking about Staff AA, made a wailing noise and wiped tears from their eyes as they cried. Resident 12's roommate Resident 67, said this had been happening a lot with Resident 12 before they filed a grievance.During an interview and observation on 09/25/2025 at 6:40 PM, Resident 12 said they had spoken to Staff D, Charge Nurse (also called Unit Manager at this facility, often called Resident Care Manager in other facilities)/ Registered Nurse (RN), about crying all the time and needing to go back on antidepressants. Resident 12 was observed to scrunch up their face, and have tears in their eyes as they stated, I have to [get back on antidepressants], with what's going on I have been crying for days. Resident 12 said the last three days had been horrible, then started talking about their recent seizure/hospitalization, and a concern with Staff AA. Resident 12 while crying stated, I need something. I can't handle this. Resident 12 said they wanted medication and to talk to a mental health provider because they kept crying about anything. During an observation 09/25/2025 at 7:03 PM, Resident 12 was in their room with their roommate Resident 67. From the hallway, Resident 12 was heard having a conversation with their roommate with their voice quivering, then heard sobbing. Resident 12 said to Resident 67, If it wasn't for you, I would be dead (referring to Resident 67's assistance with the events leading up to their hospitalization on 08/24/2025). At 7:14 PM, Resident 12 was heard crying as they brought up Staff AA again.Review of Resident 12's antidepressant records, showed Resident 12 was started on their most recent antidepressant on 01/23/2025, and had it discontinued on 07/31/2025. The dose was decreased, during a gradual dose reduction (GDR) attempt, on 07/24/2025 from 50 mg to 25 mg (halved). After the GDR, the antidepressant was discontinued. Review of Resident 12's progress notes, showed alert charting was in place from 07/24/2025 to 07/31/2025 for the GDR trial. No alert charting was in place afterwards, for the discontinuation of the antidepressant. Review of Resident 12's care plans, saved on 09/23/2025, showed they were still listed as taking an antidepressant. It was not updated with the GDR attempts, that Resident 12 was currently not taking any antidepressant, or any information for staff on monitoring for recurrent depression symptoms. Review of Resident 12's behavior monitor from 08/29/2025 to 09/27/2025, documented by the CNAs, showed Resident 12 was noted to have frequent crying on 09/04/2025, 09/10/2025, 09/25/2025, and 09/27/2025. Review of Resident 12's (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	behavior monitor for licensed nurses' documentation, ordered 08/28/2025, documented, TARGET MOOD: Depression: Isolation, withdraw, loss of interest from usual activities. Licensed nurses were to document the number of occurrences. Resident 12's Treatment Administration Record (TAR) for 09/01/2025 to 09/28/2025, showed no behaviors were documented by licensed nurses for signs of depression related to the order. Review of Resident 12's monitor for antidepressant side effects, ordered 08/28/2025, showed licensed nurses were documenting no side effects (dry mouth, weight gain, blurred vision, etc.) to the antidepressant medication, despite Resident 12 not currently taking an antidepressant. During an interview on 09/29/2025 at 10:03 AM, Staff D, Charge Nurse/RN, said Resident 12 had recently been more tearful for the previous week or so. Staff D said Resident 12 had a GDR of their antidepressant, which was discontinued after the GDR attempt. Staff D said they had asked Resident 12 if they had wanted to go back on their antidepressant and were told yes. Staff D said they would bring this up to the psychiatrist the next time they were to have a meeting. During a joint interview on 09/29/2025 at 11:57 AM, Staff G, Social Services Assistant, was interviewed with Staff C, Social Services Director, present. Staff C said Staff D, Charge Nurse/RN, had talked to Resident 12 on Friday about restarting their antidepressant. When asked if Resident 12 had a therapist, Staff C said they did not think so. During an interview on 09/29/2025 at 1:04 PM, Staff HH, Psychiatrist, said after an antidepressant was discontinued, there should be ongoing monitoring for withdrawal symptoms and ongoing depression. When asked how long they should be monitored, Staff HH said with a history of depression, Resident 12 would be at risk for recurrent depression for the rest of their lives. Staff HH said the staff should know about this and have a treatment plan of risk of recurrent depression. When asked how soon after showing signs of depression should staff notify the provider, Staff HH said immediately. Staff HH said some signs of depression would be not eating, not sleeping well, and irritability. When told of Resident 12's observed crying, Staff HH said the tearfulness observed was concerning. During an observation and interview on 09/30/2025 at 8:20 AM, Resident 12 was asked about having been provided the crisis line number by the facility, Resident 12 said they had put it in their top drawer, because they could not see and could not use it. Resident 12 said they were interested in talking to a therapist, saying they needed to talk to somebody. Resident 12 said they recognized they were being mean to their roommate Resident 67 which was not fair to them, then started tearing up. On 09/30/2025 at 8:30 AM, Staff M, CNA was observed to go into Resident 12's room. Staff M asked Resident 12 what was wrong, no response was given by Resident 12, Staff M took Resident 12's meal tray out of the room. On 09/30/2025 at 8:43 AM, Resident 12 was heard from the hallway crying and venting to their roommate Resident 67. During an interview on 09/30/2025 at 8:50 AM, Staff CC, CNA, said for residents with a diagnosis of depression, it could go in and out, if the resident cried or said there was something else, Staff CC would give assurance that it was okay and would provide therapeutic touch. When asked what they do for residents that did not like therapeutic touch, Staff CC said eye to eye contact, listen and reassure. When asked about Resident 12's mental health, Staff CC said they did not have any problems with Resident 12, they got along. Staff CC said Resident 12 never verbalized anything, tended to need things, and had some memory issues. Staff CC said Resident 12 had a visual deficit. When told Resident 12 could be heard right now and sounded upset, Staff CC said they were unable to hear Resident 12 with the TV being on. Staff CC went into the room to check on Resident 12, who could be seen from the hallway with their face red and crying. After talking to Resident 12, Staff CC left the room and the interview continued. Staff CC said Resident 12 had told them of an incident in the shower with two nursing aides, about being sent to dialysis twice without a blanket, and that one of the unit managers had told Resident 12 they knew what they had been going through but Resident 12 said no they did not. Staff CC said Resident 12 was sad, they had told Resident 12 they could listen any time today and could use the call light for this. When asked about Resident 12's behavior monitor, if Staff CC would document this as frequently crying, Staff CC said Resident 12 would have to keep crying throughout the day, then they would document that Resident 12 keeps crying. During an interview on 09/30/2025 (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 9:09 AM, Staff Q, Licensed Practical Nurse, when asked about Resident 12's mental health, said currently Resident 12 did not have any problem with them or the other nursing aides. Staff Q said Resident 12 had made an allegation, and that was when there was a change. When asked how Staff Q assessed Resident 12's behaviors, said it was based off an order. Staff Q reviewed Resident 12's orders. When asked if there was a behavior monitor for licensed nurses regarding crying, Staff Q said no. When asked if Resident 12 started crying, where this would be documented, Staff Q said in a progress note. Staff Q said they had reported last week to their unit manager that Resident 12 was having the behavior of crying and hyper-anxiety. Review of Resident 12's progress notes from 09/21/2025 to 09/30/2025 at 11:31 AM, showed there were no progress notes that documented Resident 12's crying by licensed nurses, despite CNAs having documented crying on 09/25/2025 and 09/27/2025 (from behavior monitor). Resident 12, on 09/24/2025, had an alert note for monitoring psychosocial well being related to allegations of abuse and neglect, with no symptoms noted during that shift. No other alert notes were found during this period reviewed. On 09/30/2025, Resident 12 had a progress note saying they had a failed GDR due to increased tearfulness and 1:1 conversation with the resident, and antidepressant was being restarted. During a follow up interview on 10/01/2025 at 8:44 AM, Staff D Charge Nurse/RN, when asked about Resident 12's discontinuation of the antidepressant and if there was any alert charting when the medication was stopped, confirmed there was none. Staff D said they monitored for adverse side effects for the GDR for 7 days but then confirmed there was no monitor for adverse side effects after the antidepressant was discontinued. When asked if Resident 12's depression monitor was updated with behaviors for staff to look for, for potential recurrent depression, Staff D said no. Staff D was unable to find a behavior monitor, that licensed nurses would document on, that included crying for Resident 12 and said they should add that. When asked if Resident 12's depression behavior monitor was specific to their behaviors, Staff D said no. Staff D said they had the conversation of putting Resident 12 back on their antidepressant on Friday (09/26/2025) but had only put Resident 12 on an alert yesterday (09/30/2025) due to restarting the antidepressant. Staff D said Resident 12 was already on a psychosocial wellbeing alert starting on 09/23/2025 but was only able to find one progress note that mentioned the alert, and confirmed the nurses were not documenting on it. When asked if there was a reason the provider was not immediately notified of Resident 12 wanting to go back on the antidepressant, Staff D said no there was no reason.During an interview on 10/01/2025 at 11:08 AM, Staff B, Director of Nursing Services (DNS), when asked their expectation for staff when a resident was noted to have failed a GDR/discontinuation of their antidepressant, said there should be documentation, including a progress note. When asked about provider notification for this, Staff B said it should happen immediately. 2) Resident 1 was admitted to the facility on [DATE], with diagnoses of anxiety disorder, depression, and post-traumatic stress disorder (PTSD, mental health condition that develops after a person experiences or witnesses a traumatic or life-threatening event). The Quarterly MDS, dated [DATE], indicated Resident 1 was cognitively intact. On 09/22/2025 at 1:19 PM, Resident 1 said they had anxiety and PTSD, and at a resident council meeting the other day, Staff A, Administrator had been present and Resident 1 had expressed that they did not feel comfortable having male staff give them a shower because of past sexual abuse issues. Resident 1 reported Staff A said they had no control over that, and the way it was said made Resident 1 feel that Staff A did not understand what it was like to have been abused. Review of the 09/18/2025 Resident council meeting minutes documented Resident 1 had said that a male nursing aide was the only one available on some of their shower days and they did not want a male aide which was known and documented. Review of a 09/18/2025 grievance for Resident 1, filled out by Staff H, Activities Director, documented under the section for describing the nature of the grievance male aide only one available 09/13 (doesn't have male aides assist documented), Staff never rescheduled shower. Under the section for what actions or recommendations do you feel need to be taken was written, be aware of needs, reschedule when necessary. On 09/29/2025 at 10:04 AM, Staff A, Administrator, when asked what training staff (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bremerton Trails Post Acute	2701 Clare Avenue Bremerton, WA 98310

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	receives for PTSD, said he did not know. When asked if he had received training in PTSD, Staff A, said, no. When asked how he would approach it if a resident expressed concern over past sexual abuse, Staff A said, they did not know the answer because it had never come up. Staff A confirmed he had been present for the 09/18/2025 resident council meeting. When asked about Resident 1 bringing up they did not feel comfortable having a male shower aid because of past sexual abuse, Staff A said he did not recall this and with that information he would make sure Resident 1 did not have any male caregivers. Review of Resident 1's care plan as of 09/23/2025, showed there was no specific care plan for PTSD, no triggers for Resident 1, and no mention Resident 1 did not want to receive showers from male staff. On 09/26/2025 at 11:25 AM, Staff D, Charge Nurse/ RN, said if a resident had a diagnosis of PTSD there should be a specific care plan for that. When asked if Resident 1 had a care plan for PTSD that identified triggers, Staff D said there was a care plan for paranoia related to PTSD, but that there should have been a specific care plan for PTSD.On 09/26/2025 at 11:33 AM, Staff G, Social Services Assistant, when asked if a resident had a diagnosis of PTSD if there should there be a care plan specific to that, said yes and that Social Services department was responsible for putting that care plan in. When asked what the care plan would include for someone with PTSD, Staff G said it should include triggers and things that would help. When asked to review Resident 1's care plan, Staff G acknowledged there was not a care plan specific to PTSD with triggers listed, Staff G said it should have been there and been customized for Resident 1.Review of Resident 1's care plan on 10/01/2025, 13 days after resident council meeting, showed that Resident 1's preference for no male caregivers was still not on the care plan. On 10/02/2025 at 10:25 AM, Staff D, Charge Nurse/ RN, when asked if a resident said they did not want male caregivers should it be on the care plan, said yes. When told Resident 1 had make it clear they did not want male shower aids on 09/18/2025 during resident council meeting, and asked if it should be on the care plan, Staff D said it should be under Resident 1's preferences and also on the care plan and she did not see that it was in those places, and it should have been.Resident Counsel:On 09/30/2025 at 11:08 AM, when asked about counseling services provided to the residents, Staff A, Administrator, said the facility had providers that came into the building to provide counseling services for the residents as was required or as was needed. Staff A said they did not usually speak with the providers, it was the responsibility of the clinic staff, unit managers and Director of Nursing Services to deal with that. When shown a copy of the September 18th, 2025, Resident Council Meeting Minutes and asked about the volunteer counseling services, Staff A stated, I don't remember that I must have been talking about PT [physical therapy], not counseling services.On 10/01/2025 at 10:03 AM, Staff H, Activities Director, said they take notes at the Resident Council Meetings. When asked about Staff A's, Administrator, response to volunteer counseling services, Staff H said Staff A had attended the Resident Council meeting, where residents were observed being emotional, especially regarding mental health concerns and not feeling heard or valued. Staff H said a lot of residents were crying during that meeting. Staff H said Staff A directed them (Staff H) to look into volunteer counseling services that would come to the facility and provide talk therapy to the residents. Staff H said Staff A had never followed up with them, regarding any volunteer counseling services for the residents.Reference F585, F657, F610No Associated WAC.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medications were necessary by providing residents with non-pharmacological interventions (NPIs, non-medication interventions) for pain management, documenting side effect monitors, and/or to reassess the necessity of medication on admission for 5 of 7 residents (Resident 2, 105, 1, 7, & 8) reviewed for unnecessary medication and pain. This failure placed residents at risk of unmet care needs, unnecessary medication, increased pain, and a diminished quality of life. Findings included .1) Resident 2 was admitted to the facility on [DATE]. The Significant Change Minimum Data Set (MDS, an assessment tool), dated 07/13/2025, documented Resident was severely cognitively impaired and required maximum assistance with cares. Review of a physician's order for Resident 2, dated 08/19/2025, showed an order for oxycodone (an opioid), at 5 milligrams (mg) once every 6 hours as needed for moderate to severe pain, with pain scale of 6-10 out of 10. Review of the September 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR), documented Resident 2 was given oxycodone on the following dates when the pain scale criteria was not met:1. September 2nd (at 9:31AM) -pain scale 0.2. September 3rd (at 2:42 PM) -pain scale 5.3. September 4th (at 4:45 PM) -pain scale 5. 4. September 5th (at 7:20 AM) -pain scale 5.5. September 6th (at 7:15 AM) -pain scale 5.6. September 6th (at 1:20 PM) -pain scale 5.7. September 7th (at 10:14 AM) -pain scale 5.8. September 20th (at 9:33PM) -pain scale 5. 9. September 23rd (at 6:54 AM) -pain scale 5.10. September 23rd (at 6:46 PM) -pain scale 5. 11. September 24th (at 6:15 AM) -pain scale 5.12. September 24th (at 7:09 AM) -pain scale 5. 13. September 25th (at 6:50 PM) -pain scale 0.14. September 26th (at 4:59 PM) -pain scale 4. Review of the September 2025 MAR and TAR, documented Resident 2 was given oxycodone on the following dates/times outside of the ordered timeframes (once every 6 hours):September 22nd at 10:25 PM1. September 23rd at 12:30 AM (only 2 hours 5 minutes from last dose)2. September 23rd at 2:37 AM (only 2 hours 7 minutes from last dose)3. September 23rd at 6:54 AM (only 4 hours 17 minutes from last dose)September 23rd at 6:46 PM 1. September 24th at 12:25 AM (only 5 hours 39 minutes from last dose)2. September 24th at 6:15 AM (only 5 hours 50 minutes from last dose)September 26th at 1:00 AM1. September 26th at 6:28 AM (only 5 hours 28 minutes from last dose)September 26th at 4:59 PM1. September 26th at 10:08 PM (only 5 hours 9 minutes from last dose) A physician's order, dated 02/13/2025, documented for staff to provide NPIs that included 1=Repositioning; 2=Relaxation; 3=Diversional activities; 4=Redirection and document the number used and the effectiveness of the intervention.Review of Resident 2's September 2025 MAR and TAR, documented they were given oxycodone on the following dates with no NPIs attempted: 1. September 1 (twice), no NPIs documented. 2. September 2 (once), no NPIs documented.3. September 3 (twice), no NPIs documented.4. September 22 (once), no NPIs documented.5. September 23 (four times), no NPIs documented. 6. September 24 (three times), no NPIs documented.7. September 25 (twice), no NPIs documented.On 09/29/2025 at 1:21 PM, when asked what staff must do prior to administering pain medication, Staff J, Charge Nurse (also called Unit Manager at this facility, often called Resident Care Manager in other facilities) /Licensed Practical Nurse (LPN), said to follow resident rights, check to make sure it was the right resident, then document their current pain level and location, and double check the medication for the correct dose, route and last time administered. Staff J said they could double check the electronic health system and the narcotic book, as a double check system. Staff J said NPIs, including repositioning, relaxing and redirection, should be attempted prior to administering pain medication. When shown the oxycodone order for Resident 2 was given outside the ordered timeframes and asked if it was acceptable to give the medication as frequently as documented on the MAR/TAR, Staff J said no it was not, the order was not followed and should have been. When asked if the medication should have been given outside the pain level parameter of the order, Staff J said no. When asked about concerns of resident sedation, Staff J said yes, and they (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	needed to notify the DNS and provider immediately of the duplicate doses. When asked if NPIs should have been attempted prior to administration of the medication, Staff J said yes, the nurses did not document NPIs. Staff J said giving the medication outside of order parameters did not meet their expectation.On 09/30/2025 at 1:42 PM, Staff B, Director of Nursing Services (DNS), said Resident 2 should have received their medication within the parameters of the order, including pain level, and correct timeframes. Staff B said NPIs should have been documented for Resident 2, which did not occur. When asked how they were preventing other residents from possible sedation, Staff B said they were doing an investigation into Resident 2's pain medication and would be conducting an audit.2) Resident 105 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 105 was mildly cognitively impaired.A physician's order, dated 09/16/2025, documented Resident 105 was to be given oxycodone 5 mg, every four hours as needed, for pain levels 5 through 7 out of 10.A physician's order, dated 09/16/2025, documented Resident 105 was to be given oxycodone 10 mg, every four hours as needed, for pain levels 8 through 10 out of 10.Review of Residents 105's September 2025 MAR, showed their oxycodone order, for one 5 mg with pain levels between 5-7, had no entries documented. Review of Resident 105's September 2025 MAR, showed their oxycodone order, for two 5 mg with pain levels between 8-10, documented Resident 105 had been given two oxycodone doses with varying pain levels (outside of parameter orders) on the following dates:1. September 17th at 3:56 AM - pain level 7.2. September 21st at 2:12 PM - pain level 0. 3. September 21st at 9:49 PM - pain level 4. 4. September 22nd at 8:23 PM - pain level 4.5. September 25th at 2:48 PM - pain level 4. 6. September 28th at 9:50 PM - pain level 0.7. September 29th at 8:48 AM - pain level 0.On 09/30/2025 at 10:40 AM, when asked to review Resident 105's September 2025 MAR, Staff K, Charge Nurse/LPN, said the oxycodone order parameters were not followed and should have been. On 09/30/2025 at 1:42 PM, Staff B, DNS, said when administering an opioid for pain, staff should check the resident's pain level, document the pain level and assess the effectiveness of the medication 60 minutes after administration. When shown Resident 105's September 2025 MAR, Staff B, confirmed the medication was given outside the order parameters and said it should not have been given outside the order parameters, especially with a pain score of zero.3) Resident 8 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], showed Resident 8 was cognitively intact. During an observation and interview on 09/22/2025 at 3:18 PM, Resident 8 opened their top drawer of their dresser and three white pills were seen in a medicine cup. At 3:34 PM, Staff Q, LPN, came into the room and Resident 8 said the three pills were melatonin. Review of Resident 8's September 2025 MAR, showed Resident 8 had melatonin ordered on 9/16/2025 for once a night at bedtime. From the MAR, Resident 8 had 6 documented nights of receiving melatonin, 09/17/2025 to 09/21/2025, before they were found with 3 of the pills (3 out of 6 nights were not taken).During an interview on 09/26/2025 at 10:04 AM, Staff D, Charge Nurse/ Registered Nurse (RN), when asked about the melatonin order starting on 09/16/2025 and Resident 8 being found with 3 pills on 09/22/2025, if the necessity of daily melatonin was reassessed, said no it was not. Staff D said they do monitor residents for sleep. Resident 8's electronic health record (EHR) was reviewed on 09/27/2025 at 12:16 PM, with no sleep monitor found. During an interview on 09/29/2025 at 3:19 PM, Staff B, DNS, said Resident 8's medication should have been reassessed, and that they do sleep monitoring for residents taking insomnia (difficulty sleeping) medications. After reviewing the EHR, Staff B said they were unable to find a sleep monitor for Resident 8. 4) Resident 1 was admitted to the facility on [DATE], with a diagnosis of chronic pain syndrome. The Quarterly MDS, dated [DATE], indicated Resident 1 was cognitively intact. Resident 1 had a provider order, dated 08/19/2025, for oxycodone, every 4 hours as needed for pain level 6-10/10 for 30 days. A second order, dated 09/19/2025, was also for oxycodone every 4 hours as needed, for pain level 6-10/10 for 30 days. Review of Resident 1's MAR and TAR from 09/01/2025 through 09/23/2025, showed Resident 1 received oxycodone 18 times for pain scores from 0 to 5, not within the prescribed order of pain score between 6-10. Additionally the record showed no NPIs were ordered for Resident (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. On 10/01/2025 at 10:45 AM, Staff D, Charge Nurse/RN, said that NPIs should be ordered and attempted prior to administration of as needed pain medications. When asked if Resident 1 had NPIs ordered for as needed oxycodone, said she did not see any and they should have been attempted and documented. After reviewing the MAR administration of oxycodone, Staff D acknowledged the oxycodone had been given outside of the ordered parameters and said it should not have happened. 5) Resident 7 re-admitted to the facility on [DATE], with a diagnosis of pain, unspecified. The Medicare 5-day MDS, dated [DATE], indicated Resident 7 was cognitively intact. Resident 7 had a pain medication order, dated 07/15/2025, for acetaminophen (mild pain reliever), every 4 hours as needed for pain (without specified parameters). Resident 7 had a second order, dated 07/15/2025, to provide NPIs to reduce pain and document effectiveness. These included 1-repositioning, 2-relaxation, 3-diversional activities, and 4-redirection. Staff were instructed to document the number used and effectiveness, as needed. Review of Resident 7's care plan showed that NPI measures would be used as alternative to pain (medication) when appropriate, dated 07/15/2025. Review of Resident 7's pain record from 09/01/2025 through 09/23/2025, showed they had documented pain scores on the following days without acetaminophen given, or that acetaminophen was given with no NPI documented as indicated: 09/22/2025 score 4, no documentation of acetaminophen given.09/20/2025 score 2, no documentation of acetaminophen given.09/20/2025 score 6, acetaminophen was given, no NPI documented09/20/2025 score 5, no documentation of acetaminophen given. 09/16/2025 score 5, acetaminophen was given, no NPI documented09/08/2025 score 7, no documentation of acetaminophen given.09/05/2025 score 6, acetaminophen was given, no NPI documented09/052025 score 3, no documentation of acetaminophen given.Review of the MAR from 09/01/025 through 09/23/2025 showed the area to document NPIs was left blank.On 10/01/2025 at 10:36 AM, Staff D, Charge Nurse/RN, when asked if staff should be attempting NPIs and documenting if these were helpful for as needed pain medication for Resident 7, said yes. Staff D said she did not see any documentation that NPIs were attempted for the month of September for Resident 7. Reference WAC 388-97 -1060 (3)(k)(i).

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to provide appetizing and palatable food when reviewed for kitchen services. This failure placed the residents at risk for a diminished dining experience, dissatisfaction with food served, a potential for less than adequate nutritional intake and weight loss.Findings included .Observation of the test/sample lunch tray on 09/24/2025 at 12:46 PM, showed a chicken patty, potato wedges, carrots, and coleslaw. The chicken patty was sampled and found to be difficult to chew and lacked palatability. In an interview on 09/24/2025 at 1:12 PM, Staff FF, Certified Nursing Assistant, said the chicken patty served for lunch was dry and difficult for residents to chew. On 09/24/2025 at 2:58 PM, Resident 107 was sitting in their wheelchair with the bedside table in front of them. When asked how lunch was, Resident 107 stated, the salmon was dry (lunch meal was chicken patty). Resident 107 said there was some sort of sauce (did not know what kind of sauce it was) but they had to pour it on the salmon to get the salmon burger to go down because it was so dry.In an interview on 09/25/2025 at 1:37 PM, Staff GG, Dietary Manager, said he was not aware of the chicken being difficult to chew. Staff GG said he would address it by doing an in-service on baking times. In an interview on 09/26/2025 at 9:59 AM, Staff B, Director of Nursing Services/Registered Nurse, said he expected meals to be palatable and easy to consume for residents.Reference WAC 388-97-1100(1).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to ensure food items were labeled and dated when opened in 1 of 1 walk-in kitchen refrigerators. This failure placed residents at risk for food borne illness, and a diminished quality of life.Findings included .Record review of the facility policy, titled, Food Receiving and storage, revision date November 2022, documented, Refrigerated foods are labeled, dated and monitored so they are used by their 'use-by' date, frozen, or discarded.During an observation on 09/22/2025 at 10:14 AM, the walk-in kitchen refrigerator, was observed with the following expired, opened items: 1. Plastic Tupperware container of Coleslaw- labeled with a use by date of 07/10/20252. Plastic Tupperware container of Chicken Salad- labeled with a use by date of 09/18/20253. Plastic container of Thousand Islands Dressing - labeled with an open date of 06/17/20254. Plastic Ziplock bag containing several hot dogs- labeled with a use by date of 09/06/2025In an interview on 09/22/2025 at 10:26 AM, Staff GG, Dietary Manager, said the items placed into the refrigerators should be labeled right away, kept until the use by date, and then disposed of by the use by date. Staff L stated, We keep it in the fridge for three days. Staff GG proceeded to throw away the expired items.In an interview on 09/26/2025 at 9:59 AM, Staff B, Director of Nursing/Registered Nurse, said he expected food items in the refrigerators to be labeled accurately and discarded by the use by date. Reference WAC 388-97-1100 (3) & 2980.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide Occupational Therapy (treatment that evaluates and treats people who have injuries, illnesses, or disabilities to help them live as self-sufficiently as possible by developing, recovering, or maintaining skills needed for everyday activities of life) for 2 of 3 (Resident 112 and 69) residents reviewed for therapy services. This failure placed residents at risk of decreased physical function, delay in returning home, and decreased quality of life.Findings included .RESIDENT 112Resident 112 was admitted on [DATE] with fractures from a motor vehicle accident. Resident 112's physician order, dated 08/26/2025, showed an order for OT [occupational therapy] evaluation and treat. Resident 112's medical provider admit visit, dated 08/27/2025, showed the assessment/plan was for OT eval and treat.On 11/05/2025 at 2:20 PM, Staff QQ, Occupational Therapist, said they had completed Resident 112's evaluation on 09/18/2025. When asked why Resident 112's occupational therapy evaluation was not completed upon admission, Staff QQ said there were no occupational therapists available.Resident 112's occupational therapy evaluation, dated 09/18/2025, showed Resident 112's start of care was 09/18/2025.On 11/05/2025 at 3:19 PM, Staff RR, Director of Rehabilitation (DOR), said Resident 112 had an order for occupational therapy on admission but the facility did not have an occupational therapist available. Staff RR said Resident 112 did not receive occupational therapy until 09/18/2025. Staff RR said they did not know if the medical provider was notified.RESIDENT 69Resident 69 was admitted on [DATE] with back fractures.Resident 69's physician orders, dated 08/29/2025, showed an order for OT [occupational therapy] evaluation and treatment.Resident 69's medical provider notes, dated 09/05/2025 and 09/09/2025, showed the assessment and plan was to continue OT.Resident 69's occupational therapy evaluation, dated 09/16/2025, showed the start of care was 09/16/2025.On 11/10/2025 at 11:46 AM, Staff RR, DOR, said they were unable to initiate occupational therapy for Resident 69 on admission because they did not have an occupational therapist available. Staff RR said they initiated occupational therapy for Resident 69 on 09/16/2025. Staff RR said they were unaware if the medical provider was informed of the delay in initiating occupational therapy for Resident 69.FINAL INTERVIEWOn 11/10/2025 at 2:52 PM, Staff A, Administrator, said they expected when a resident had a physician order for therapy it would be provided. Staff A said they had the resources to obtain occupational therapy services. Staff A said they were unaware the facility did not have an Occupational Therapist available for Resident 112 and Resident 69.Reference WAC 388-97-1280(1)(a)(b)(4).

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. .Based on interview and record review, the facility failed to provide accurate and complete access to all resident records for 1 of 1 annual recertification survey. These failures had the potential risk of causing a delay in the survey process, not addressing resident concerns and a diminished quality of life. Findings included .On 09/22/2025 at 9:50 AM, the survey team entered Bremerton Trails Post Acute. The survey teams' business cards were provided to Staff B, Director of Nursing Services, for access to Point Click Care (PCC, the electronic health care (EHR) system used for record maintenance). On 09/22/2025 at 10:09 AM, during the Entrance Conference with Staff A, Administrator, and Staff B, Director of Nursing Services (DNS), they were reminded that surveyors needed access to all medical records within required timeframe. The Grievance log was also requested at this time. On 09/22/2025 at 11:33 AM, the Grievance log was provided with the last date of entry documented as 09/08/2025. On 09/22/2025 at 2:17 PM, PCC access was provided to surveyors.On 09/23/2025 at 8:37 AM, Staff A and Staff B were informed that the PCC access provided did not have access to all medical records, including Medication Administration Records (MAR), Treatment Administration Records (TAR), various assessments, care plans, nutritional reports and laboratory results. Staff A and Staff B said they did not know why and would address the problem immediately.On 09/24/2025 at 8:49 AM, Staff A and Staff B were again informed that surveyors still did not have access to all medical records, including various assessments, nutritional reports and laboratory results.On 09/24/2025 at 3:57 PM, Staff A was updated about continued lack of access to the complete medical record Staff A said they did not know what the problem was and did not know what to do. Staff A said it was out of their hands. On 09/26/2025 at 9:28 AM, Staff B was informed of continued lack of access to complete medical record. Staff B said that they were told by their corporate office that the ownership company was hesitant to give access to all medical records. On 09/26/2025 at 11:04 AM, a second log in was provided to allow visualization of laboratory results. On 09/29/2025 at 8:20 AM, Staff A was emailed, requesting an updated Grievance log and Accident and Incident Log, including all entries up to date (09/28/2025). On 09/29/2025 at 9:05 AM, the exact same Grievance log received on 09/22/2025 was provided.On 09/30/2025 at 2:12 PM an updated Grievance log (through 09/30/2025) was provided but was still missing reported Grievances.Reference F585.Reference WAC 388-97-1720

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	505123	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. .Based on observation, interview and record review, the facility failed to ensure infection control practices met professional standards regarding their Water Management Program, the laundry room, obtaining consent for vaccination for 4 of 5 residents (Residents 9, 1, 7, & 10) reviewed for vaccinations, and ensuring enhanced barrier precautions were followed for 1 of 3 observations (Resident 3) for transmission based precautions. These failures placed residents at risk of transmittable diseases, lack of informed consent, and a diminished quality of life. Findings included. Water Management Program: Review of the Centers for Disease Control and Prevention (CDC) toolkit titled, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings, dated 06/24/2021, documented its purpose was to help buildings develop and implement a water management program to reduce the spread of Legionella (a bacteria that lives in water and can make people sick when contaminated water is inhaled). The toolkit provided a list of where Legionella can grow in the building water system, which included: hot and cold water storage tanks, water heaters, water-hammer arrestors, expansion tanks, electronic/manual faucets, aerators, faucet flow restrictors, showerheads and hoses, pipes, valves and fittings, humidifiers, atomizers, eye wash stations, ice machines, and medical devices including CPAP machines (continuous positive airway pressure machines to treat sleep apnea, and keep airways open during sleep). The toolkit recommends facilities develop a process flow diagram, where facilities outline the flow of water throughout the building by identifying where water moves, as it goes from receiving to cold water distribution, to heating, to hot water distribution, and then to waste. Using this flow diagram, then facilities can identify potentially hazardous conditions (areas where Legionella can grow), and from these hazardous conditions they should identify control measures (things done to limit the growth and spread of Legionella, which can include heating, adding disinfectant, or cleaning) to be implemented. The facility should identify corrective actions to be taken in response to systems performing outside of control limits, and contingency responses (often involve several steps and follow up) to control measures that are persistently outside of control limits or events that pose an immediate risk to control of the building water systems. For implementing and monitoring control measures, facilities should take corrective actions to get conditions back to within an acceptable range. For routine monitoring, the control point should have a control measure, there should be routine monitoring to ensure they are within limits, and should document results. When outside of control limits, then the facility should document the results, implement a corrective action, document results, have enhanced monitoring, and if within limits then can document and return to routine monitoring. If still outside of the limits, the facility should document results, implement corrective action, and continue the process until within limits. The toolkit recommends Water Management Programs document and communicate all the activities of their program. Review of the facility's policy titled, Legionella Water Management Program, last revised 09/2022, documented the water management program was to have a detailed description and diagram of the water system in the facility, including listing: receiving, cold water distribution, heating, hot water distribution, and waste. The Water Management Program was to identify the areas that Legionella could grow in, including storage tanks, water heaters, filters, aerators, shower heads and hoses, misters, atomizers, air washers, and humidifiers, and CPAP machines. The program was also to identify situations that could lead to Legionella growth such as construction, water main breaks, and changes in municipal water quality. Review of the facility's Water Management Plan for [former name of facility], undated, showed the areas of concern for the building only listed the following: ice machines, HVAC units/water collection and condensation areas, shower heads, water break pipe break, toilets, sinks, washing machines. During an interview on 09/24/2025 at 7:40 AM, Staff F, Infection Preventionist/ Assistant Director of Nursing/ Licensed Practical Nurse (IP/ADON/LPN), when asked how the facility identified and investigated Legionnaires' cases, said they would refer to their policy, pulled up their policy, and then said they (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would have to follow up on it. During an interview on 09/24/2025 at 12:07 PM, Staff E, Maintenance Director, reported the facility was performing one Legionella test monthly on a rotation of different parts of the building, but was unable to provide any documentation of where the test had been conducted. Staff E was able to provide a facility map, but was unable to provide a flow diagram showing the various stages of where water was moving throughout the building (receiving, cold water distribution, heating, hot water distribution, and waste) with where controls were in place. When asked to verbally explain where controls were, Staff E was only able to provide controls at the hot water distribution location of the building water management plan, as the one monthly Legionella water test, and for running sinks and flushing toilets in areas that did not have patients using the restroom. When asked about the shower heads, identified by the facility as an area of concern, Staff E said their cleaning process was a part of maintenance and they were not documenting this. When given an example of a control measure failing, such as they identified that the weekly flush of sinks in areas not being used did not happen, and asked for next steps, Staff E said they would audit the flushing of the rooms. When asked if they had corrective actions for the facility to take when control measures were not met, Staff E said audit. When asked for a contingency response, for a room that has been under construction for 6 months, what the steps were during and after construction to prevent Legionella growth, Staff E said covering water waste and flushing. During an interview on 09/24/2025 at 1:09 PM, Staff A, Administrator, when asked about the facility map not including areas that Legionella could grow nor controls identified for these locations, said their expectation was for it to have been there. When asked their expectation for documentation of the Water Management Program, Staff A said for it to be documented as required. When asked about there being no documentation of where the Legionella tests were tested and how the facility would know it was done in a rotation, Staff A said they would not know. When asked what their expectation was for a contingency response, Staff A said to put together a system and process, to implement and educate, to audit those control areas and see where they failed and come up with a plan to fix it. When asked their expectation for identifying areas Legionella could grow, Staff A said that they audit and follow a system and then acknowledged the current system they use for documenting would need to be edited for areas done. Laundry Room:During an observation and interview on 09/25/2025 at 10:36 AM, Staff X, Housekeeping Supervisor, gave a tour of the laundry room, with Staff Y, Laundry Aide, nearby to answer any additional questions. The ceiling ventilation/fan did not work in the soiled linen room nor the main laundry room. Three soiled linen containers were observed in the main laundry room, in the area between the soiled linen room and the washing machines. In the corner between the soiled linen room and the washing machines, there was a clean storage container with a linen draped over it. Staff X explained that this box was full of clean linen for housekeeping. For Staff X to pull the top linen cover open, they were observed to touch one of the dirty linen container's lid. On top of the first washing machine, cleaning supplies were seen which included a decontaminate spray and two different stacks of microfiber rags, one stack on the right side was dry and folded, with the other stack on the left side that appeared moist and wrinkled/tussled. Staff Y said all of the rags were clean. When asked about the stack of microfiber rags that appeared to have been used and asked if they were reusing the rags, Staff Y said yes. When asked about the pillows seen on top of the washing machine, Staff Y said they were clean and air drying. When asked about storing a clean item on a dirty location, Staff X said okay. When asked about the ceiling ventilation being off, Staff X said the fans were usually on. The fans were not on during this observation, and the log Staff X reviewed of the fans being cleaned, showed they were not signed for staff dusting them. In the corner closest to the dryers, a staff mini refrigerator was seen, with cups located next to the fridge on one side, and coffee creamers seen on the other side on the counter. During an interview on 09/25/2025 at 12:30 PM, Staff F, IP/ADON/LPN, said items should not be stored on the washing machines. When asked about reusing rags to wipe the washing machine and dirty linen container's lid, Staff F said staff should not be reusing rags. During an interview on 09/29/2025 at 3:26 PM, Staff B, Director of Nursing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Services (DNS), when asked their expectation for the laundry room, said it should be spotless. When asked if the laundry room should have a staff refrigerator in it, Staff B said no. When asked if the laundry room should have working ventilation on the ceiling, Staff B said yes. Vaccination Consent: Review of the vaccine records on 09/24/2025, showed Resident 1 had a flu (influenza) vaccine with documentation saying no education was provided. Resident 7 had refused both a pneumococcal and covid vaccine, with documentation of no education provided. Reviewed of the vaccine audit form on 09/25/2025, showed Resident 9 had recently consented on the audit form for the flu and covid vaccines, but no dates were listed for consent. Resident 10 had consented to the flu and covid vaccines, also with no dates listed. During an interview on 09/25/2025 at 12:30 PM, Staff F, IP/ADON/LPN, said they were responsible for educating residents on vaccinations. When asked what residents were educated on, Staff F said recommendations of being vaccinated in a communicable space. Staff F said for the flu vaccine, they had let everyone know in Resident Council that the season was coming up, it was recommended, and they would be coming to get consents. When asked about consent, what education was provided, Staff F said if the vaccine was due or was annual, and if they could have their consent. When asked about there not being documentation of risk or benefits being reviewed with residents, Staff F acknowledged this. When asked if the Vaccine Information Statements (VIS, informational sheets that explain risk and benefits of each vaccine) were provided to residents, Staff F said if needed, if they refused. Staff F then said the VIS should be given with admission paperwork. When asked if it was a standard for the VIS to be given when a resident consented to a vaccine, said no. During this interview, Staff F reviewed Resident 9's information on the recent vaccine audit form and said Resident 9 had consented sometime during the week of August 15th (was unable to find an exact date) and confirmed they had only asked the resident if they wanted the vaccine. When reviewing Resident 9's pneumococcal vaccination documented from 05/29/2025, Staff F acknowledged the education provided said no, and said that the floor nurse would have done that. For Resident 10, when asked when they had consented to the recent vaccine audit for flu and covid, Staff F was unable to provide an exact date for consent and reported they most likely shredded their sheet with additional information. For Resident 1's flu vaccination on 10/08/2024, when asked about it saying no education was provided, Staff F was unsure why they did that and thought they may have made a mistake while clicking the boxes. For Resident 7's pneumococcal and covid vaccination refusals on 07/17/2025, when asked if it met expectations that no education provided was documented, Staff F said they did not know why they did that, they remembered educating the resident. During an interview on 09/25/2025 at 2:14 PM, Staff V, LPN, said they/nurses reviewed admission paperwork with the residents, acknowledged they were only asking residents if they wanted the vaccinations, and showed documentation of what the facility was providing during admission. Staff V said they were not providing residents with the VIS form, as that was the IP's role. Review of the admission paperwork provided on 09/25/2025 at 2:14 PM, showed the vaccine paperwork did not go over risk and benefits, but did say the VIS was provided. The VIS was not found as part of the packet reviewed with Staff V. During an interview on 09/25/2025 at 3:26 PM, Staff B, DNS, said they expected staff to review risk and benefits. Staff B said their expectation was for residents that came into the facility, would on admission be educated by staff on the spot, then the IP would follow up with consent and should make sure the resident was educated and reinforce education. Enhanced Barrier Precautions: Review of the facility's policy titled, Enhanced Barrier Precautions [EBP] showed staff were required to use a gown and gloves for urinary catheter (tube that drains urine from the bladder) device use or care. During an observation on 10/01/2025 at 11:31 AM, Staff W, Certified Nursing Assistant, was seen going into Resident 3's room. The signage outside of the door showed Resident 3 was on EBP, which indicated staff should be wearing a gown and gloves for high contact resident care. Staff W was seen only taking gloves into the room, no gown. During an interview on 10/01/2025 at 11:35 AM, Staff W said they were helping Resident 3 by emptying their catheter bag, and then by getting them ice. Staff W confirmed they had not worn a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gown, and said the gowns were not available in their size. During an interview on 10/01/2025 at 11:40 AM, Staff F, IP/ADON/LPN, said staff emptying a catheter should use EBP, which involved a gown and gloves. WAC 388-97 -1320 (2)(b).

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. . Based on interview and record review, the facility failed to ensure antibiotic stewardship practices met professional standards for 3 of 3 months (Months June 2025, July 2025, and August 2025) reviewed for antibiotic line list (an infection control surveillance list that tracks and reviews antibiotics). This failure placed residents at unnecessary antibiotic usage, risk of developing Multi-Drug Resistant Organisms, and a diminished quality of life.Findings included.Review of a document titled Surveillance Criteria, dated 07/07/2022, showed the facility was using Loeb criteria to initiate antibiotic usage, as the minimum set of signs or symptoms that a resident likely had an infection and antibiotics were likely indicated, without confirmation of diagnostic testing. The facility was also using McGeer criteria, for definitive infection criteria, using diagnostic information. During an interview on 09/25/2025 at 12:30 PM, Staff F, Infection Preventionist/ Assistant Director of Nursing/Licensed Practical Nurse, said the point of antibiotic stewardship was to prevent unnecessary antibiotic usage. Staff F said they ensured antibiotic usage was valid, by making sure criteria was met. If criteria was not met, Staff F said the provider should have been notified to stop the antibiotic. Staff F said an antibiotic timeout should occur 48-72 hours after an antibiotic had been started to make sure it was effective and there were no adverse side effects of the medication. When asked how they used antibiotic monitoring to educate the staff, Staff F said when they saw increases in infections like urinary tract infections (UTIs), they educated in some way such as on encouraging fluids if applicable, peri care, and precautions. For symptoms on the antibiotic line lists, Staff F said it should be comprehensive with all symptoms the resident had. When asked their expectation for infection evaluations to be completed, Staff F said they should be completed prior to antibiotics being initiated. 1) Review of the June 2025 Antibiotic Line List, showed Resident 56 had onset of symptoms starting on 05/21/2025, went to the hospital, and when they returned to the facility received an antibiotic from 06/05/2025 to 06/09/2025. During an interview on 09/25/2025 at 12:30 PM, Staff F was unable to find documentation that Resident 56 was reviewed for antibiotic usage when they returned from the hospital or that they did or did not meet criteria for antibiotic usage. 2) Review of the July 2025 Antibiotic Line List, showed Resident 83 had a UTI listed from 07/13/2025, with no other symptoms. Resident 83 was listed with an onset date of 07/13/2025. Review of Resident 83's progress notes showed that they had a urine sample collected on 07/07/2025. Review of Resident 83's antibiotic stewardship progress note, dated 08/11/2025, showed Resident 83 was reviewed for their antibiotic usage after they had already completed their antibiotic course. Review of the July 2025 Antibiotic Line List, showed Resident 76 started antibiotics on 07/25/2025, for tooth pain starting that day. Review of Resident 76's infection screening showed it was not done until 07/29/2025 and did not evaluate if the resident met any criteria. During an interview on 09/25/2025 at 12:30 PM, Staff F, when asked how the facility was assessing the necessity of antibiotics if the review happened after the antibiotic had completed, said they sometimes did not put their notes in, in a timely manner. When asked if they had reviewed the organisms from the urine culture for Resident 83, as possible education points for staff, Staff F said no. When asked what education was provided to staff or to Resident 83, Staff F said none. When asked if Resident 83's listed onset of symptoms date was accurate, due to the urine sample collection on 07/07/2025, Staff F said they put the wrong date on the list. Staff F reviewed Resident 83's symptoms for criteria, and said Resident 83 was asymptomatic so they did not meet McGeers or Loebs criteria. When asked what they did when Resident 83 did not meet criteria, Staff F said they did not have a conversation with the provider due to Resident 83 having a positive urinalysis. Staff F said no to if Resident 76 had been screened for antibiotic criteria, that they did not have screening for tooth pain, and they should have notified the provider. 3) Review of the August 2025 Antibiotic Line list, showed Resident 72 was listed as having a UTI on 08/16/2025, with no other symptoms listed and no urine sample results. Further review of the August 2025 Antibiotic Line list, showed Resident 79 was on the list for cough/aspiration (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pneumonia starting on 08/25/2025, with a negative X-ray result. During an interview on 09/25/2025 at 12:30 PM, Staff F said they had looked into Resident 72's antibiotic usage and did not see any symptoms either, Resident 72 had gone for a doctor's appointment and came back with orders. Staff F confirmed there was no evaluation for criteria having been met, and there were no uploaded results for the urine test. Staff F said Resident 79 had a persistent cough, with no productive sputum and they believed the resident had possible aspiration or pneumonia. Staff F acknowledged Resident 79 did not meet criteria for antibiotic usage. During an interview on 09/29/2025 at 3:26 PM, Staff B, Director of Nursing Services, said their expectation for antibiotic criteria being reviewed with antibiotic usage, was as soon as the antibiotic was started, that staff should fill out the infection evaluation. Staff B said the infection preventionist should investigate and see if the residents really needed to be on the antibiotic, or if the facility could call the provider to try something else before initiating antibiotics for residents with chronic symptoms. Staff B said they needed to make sure residents met criteria for antibiotic usage. No Associated WAC.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation and interview, the facility failed to ensure the kitchen's walk-in freezer was in good working condition in 1 of 1 facility kitchen. This failure placed residents at risk of food-borne illness, and a diminished quality of life.Findings included On 09/22/2025 at 10:05 AM, the kitchen's walk-in freezer door was observed to have ice and frost build up at the bottom right corner, preventing the door from closing completely. The opening measured approximately one inch. On 09/23/2025 at 10:05 AM, the kitchen walk-in freezer was observed to have the same ice buildup, and door was not shut completely. In an interview on 09/22/2025 at 10:32 AM, Staff GG, Dietary Manager, said the freezer door had been has been like this forever. Staff GG stated, the door has been broken ever since I started working here- about three months ago. Staff GG said as a result of the freezer door not shutting, the kitchen was responsible for maintaining proper temperatures in the freezer and refrigerator, completing the temperature logs, and scraping the ice twice per shift.In an interview on 09/22/2025 at 12:17 PM, Staff U, Maintenance Assistant, said the facility received a few estimates on the freezer door replacement, but no order had been made. In an interview on 09/26/2025 at 09:27 AM, Staff B, Director of Nursing, said he had been aware of the issue, but could not provide additional information regarding freezer door replacement.Reference WAC [PHONE NUMBER]0 (2) .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of abuse within the required timeframe(s) for 2 of 5 residents (Residents 3 & 12) reviewed for abuse/neglect investigations. This failure placed residents at risk of abuse, fear and a decreased quality of life. Findings included .Findings included . Review of the facility policy titled, Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property, undated, documented the facility was to report all alleged violations immediately but no later than two hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in seriously bodily injury. If the events that caused the allegation were not involving abuse, or if the reported events did not result in serious bodily injury, this could be reported in twenty-four hours to the Executive Director and to others. Resident 3 Resident 3 was admitted on [DATE] with diagnoses of anxiety and post-traumatic stress disorders. Resident 3's Minimum Data Set (MDS) Assessment, dated 08/05/2025, showed Resident 3 was cognitively intact. Resident 3's progress notes, dated 11/09/2025, showed CNA [certified nursing assistant] reported to LN [licensed nurse] that the resident told her that he took a staff's photo using his phone inside the room, and was told by that staff that he shouldn't take a photo, then he responded that it's okay because some of the staff has sent him nude photos, and that half of the staff here in this facility he had a romantic relationship with and already slept with. On 11/10/2025 at 12:51 PM, Staff B, Director of Nursing, Registered Nurse, said they were unaware Resident 3 had alleged they had nude photos of staff and had sexual relations with staff members. Staff B said they were not notified of the allegation by Resident 3. Staff B said they had read the allegation that morning in Resident 3's progress notes. Staff B said it was an allegation of sexual abuse, and the staff member should have reported the allegation immediately to the state agency and management. Staff B said after discovering the allegation in the progress notes they were in the process of initiating an investigation and making a report to the state agency. On 11/10/2025 at 2:52 PM, Staff A, Administrator, said they were not aware of Resident 3's allegation that staff had sent them nude photos and they had romantic relationships with staff. When asked if the staff should have reported the allegations, Staff A said an allegation of sexual abuse should be reported to management and the state agency immediately. Resident 12 Resident 12 was admitted to the facility on [DATE] with diagnoses of depression, anxiety, and muscle weakness. Review of Resident 12's Quarterly MDS, dated [DATE], showed they were cognitively intact and dependent on staff for cares. Review of Resident 12's electronic health record, showed on 09/22/2025, Resident 12 had asked to (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	speak to Staff R, Activities Aide, while staff was handing out daily papers (Resident 12 was not at the facility that morning after 10 AM due to dialysis treatment (filtering of the blood) outside of the facility). The progress note by Staff R, on 09/22/2025, documented Resident 12 had an issue with a nursing aide, and both the Administrator (Staff A) and Assistant Director of Nursing (Staff F) were notified about the situation. During an interview on 09/23/2025 at 10:12 AM, Resident 12 alleged physical abuse by Staff AA, Certified Nursing Assistant (CNA), and neglect by Staff BB, CNA. On 09/23/2025 at 11:19 AM (over 24 hours since the initial progress note regarding allegation), Staff A, Administrator, was informed by this writer of the allegations by Resident 12 about Staff AA, regarding physical abuse, and Staff BB, regarding neglect. During an interview on 09/29/2025 at 9:43 AM, Staff R clarified they were informed by Resident 12 about the physical abuse allegation at about 9:30 AM on 09/22/2025. Review of the facility's investigation for Resident 12, showed the physical abuse allegation investigation was started on 09/22/2025. The investigation included the time the allegations were submitted to the online mandatory reporting line, on 09/23/2025 at 2:05 PM. During an interview on 09/30/2025 at 12:01 PM, Staff F, Assistant Director of Nursing/ Infection Preventionist/ Licensed Practical Nurse, when asked if they had reported the allegation to the state when the investigation started, said they had not. When asked why not, Staff F said that from the statements received from Resident 12, it did not look like it was abuse or neglect. Staff F also acknowledged they were unable to interview Resident 12 until 09/23/2025. During an interview on 09/30/2025 at 12:45 PM, Staff B, Director of Nursing Services, said the facility had 24 hours to report an allegation of abuse that did not result in injury. When asked if it met expectations that the facility was made aware by Resident 12 of an allegation of abuse at 9:30 AM on 09/22/2025, but the facility did not report until 09/23/2025 in the afternoon, Staff B said it was reported the next day so they felt that was within the appropriate timeframe. Reference F610Reference WAC 388-97 -0640(5)(a).

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	505123	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bremerton Trails Post Acute	2701 Clare Avenue Bremerton, WA 98310

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to ensure abuse or neglect investigations were thorough and complete for 2 of 2 residents (Residents 12 & 3) reviewed for abuse or neglect. This failure placed residents at risk of potential continuation of abuse or neglect, unidentified care needs, and a diminished quality of life. Findings included.1) Resident 12 was admitted to the facility on [DATE] with diagnoses of depression, anxiety, and muscle weakness. Review of Resident 12's Quarterly Minimum Data Set (MDS) assessment, dated 06/29/2025, showed they were dependent on staff for cares. During an interview on 09/23/2025 at 10:12 AM, Resident 12 alleged physical abuse by Staff AA, Certified Nursing Assistant (CNA). Resident 12 said Staff EE, CNA, was a witness to the incident with Staff AA, which happened in the bathroom last Saturday and involved Staff AA allegedly twisting their right nipple and laughing afterwards. Resident 12 said they screamed, Get away! During this interview, Resident 12's roommate, Resident 67, said they had previously witnessed Staff AA come into the room and tickle Resident 12's feet to wake them up and heard Resident 12 say, No don't touch me. Resident 12 said Staff AA thought it was funny, but they (Resident 12) did not find it funny and would kick in response. Resident 12 started to cry, with tears seen on their scrunched-up face. Resident 12 stated, he used to be one of my favorite people, I can't. During this interview, Resident 12 also alleged neglect by Staff BB, CNA. Resident 12 said they had waited too long over the weekend for Staff BB to change them, as they were waiting in urine and stool. Resident 12 said they generally would not see Staff BB from 6:00 PM until 8:00 or 9:00 PM. Resident 12 said Staff BB would come to the room and say they could not come in, leaving residents sitting in stool. On 09/23/2025 at 11:19 AM, Staff A, Administrator, was informed of the allegations by Resident 12 about Staff AA regarding physical abuse and Staff BB regarding neglect. Review of Resident 12's electronic health record (EHR), showed that on 09/22/2025 Resident 12 had asked to speak to Staff R, Activities Aide, while staff was handing out daily papers. On 09/23/2025, Staff F, Assistant Director of Nursing/ Infection Preventionist/ Licensed Practical Nurse (ADON/IP/LPN), wrote a progress note saying that during the investigation, a grievance was received from Resident 67 regarding Resident 12 not being cleaned right away. Review of the facility's investigation for Resident 12, showed the physical abuse allegation investigation was started on 09/22/2025. The investigation showed that abuse and neglect was ruled out on 09/22/2025 due to, Staff named by patient worked on another unit and had no interaction with the resident last weekend. No additional comments were found about abuse and neglect being ruled out regarding Staff BB. During an interview on 09/24/2025 at 8:09 AM, Resident 67 (Resident 12's roommate), was asked clarifying questions. When asked if the incident with Staff AA occurred the previous weekend on 09/20/2025, Resident 67 said they thought it occurred the week before. Resident 67 said Staff AA was not professional for grabbing Resident 12's feet and they thought it was strange. Resident 67 stated, He might be doing that to other people. When asked how many times they had seen Staff AA tickle Resident 12's feet, said they had witnessed it at least three times. When asked the last time Resident 67 had witnessed Staff AA tickle Resident 12's feet, Resident 67 said it was when Resident 12 yelled at Staff AA to stop, which was soon after Resident 12 had gotten out of the hospital. During an interview on 09/24/2025 at 8:11 AM, Resident 12 was asked clarifying questions. Resident 12 said they had asked Staff AA to wrap their dialysis access site, located on their right upper chest, as they were going to shower on Saturday, it was their shower day. Resident 12 could not confirm the incident happened the most recent Saturday, 09/20/2025, and said they believed the incident was over a week ago. At 8:23 AM, Resident 12 began crying, making a wailing noise and observed to wipe tears from their eyes. During an interview on 09/24/2025 at 8:47 AM, Staff R, Activities Aide, said they had filed a grievance last Thursday or Friday regarding Staff AA being too comfortable and tickling Resident 12's feet when sleeping. Staff R said that on Monday (09/22/2025), Resident 12 alleged physical abuse by Staff AA and they reported it to their (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supervisors. When asked if Resident 12 was having issues with any of the nursing aides, Staff R said Staff BB (referred by two different names by the two residents) was an ongoing issue, and they had been filing a grievance about once a week. Review of Resident 12's investigation showed there were no grievances related to Staff AA tickling Resident 12's feet. Review of Resident 12's Brief Interview for Mental Status, completed on 09/23/2025, showed Resident 12 was only able to repeat 2 of 3 words, and for recall had required queuing for 2 of 3 words. The screening listed Resident 12 as cognitively moderately impaired. Review of Resident 12's investigation showed the staffing coordinator was interviewed, and the 2 staff members named in the incident did not take care of the resident during the time stated. A handwritten document showed the two staff who were looked at for their schedule were Staff AA and Staff EE, reviewed for 09/20/2025 and 09/21/2025, which both dates they were working at the facility but were not assigned to Resident 12. No other dates were included in the investigation. Review of staffing logs from 09/13/2025, the Saturday before, showed Staff EE was assigned to Resident 12's room, and Staff AA was nearby. Review of Resident 12's progress notes on 09/13/2025, showed they had returned from the hospital at around 6:05 PM, before the end of Staff EE's shift and while Staff AA was still working. This was not reviewed in the investigation file. Continued review of Resident 12's investigation showed no other staff, besides those named, were interviewed. The investigation had included a staff name of a CNA that was assigned to Resident 12 on 09/20/2025, but no interview was included. No general CNA interviews were conducted. A staff statement from Staff EE, said they were not involved in Resident 12's care on 09/20/2025, no additional comments were made on if they had witnessed any physical abuse by Staff AA. A staff statement from Staff AA regarding the alleged physical abuse, said they never went into the resident's room, their assigned rooms were 32-35 (on 09/20/2025). A staff statement from Staff AA, regarding the foot tickling, stated, [.] anytime in the past that I have assisted with feet care, washing her feet for showers, moisturizing her feet, or putting on socks she tries to/ will kick, bite, or hit staff during these occurrences, I just try to give the proper care. She also would laugh and find it funny when any staff touched/touches her feet. No other staff interviews or roommate interviews were found to investigate this statement. The statement from Staff BB, regarding the alleged neglect, was only about 09/21/2025 in regards to Resident 12 needing to be changed. A staff statement from Staff A, Administrator, after being told about the allegations was included in the investigation. Staff A documented that Resident 12 had told this writer that Staff BB did not change them for hours, and would sit in their own stool. Staff A also included that Resident 12 reported they did not take Metamucil (a fiber supplement) because they had been sitting in stool. Review of the other resident general interviews for Resident 12's investigation to rule out abuse or neglect, showed residents were asked questions on general safety and environment, staff interaction, and closing comments on safety. Resident 33 was interviewed for both Resident 12's abuse and neglect investigations on 09/23/2025, and Resident 3's neglect investigation on 09/19/2025. During Resident 12's investigation questions, Resident 33 had no concerns for the questions asked, including a question under the category of staff interaction, that asked, Do staff respond when you or others ask for help? During Resident 3's neglect investigation questions, Resident 33 was asked a different set of questions. The questions for Resident 3's investigation directly asked about care needs and the timeliness of how they were addressed. Those questions were as follows: 1. Do you feel safe in the facility? 2. Do you feel like your care needs are being met? 3. Do you feel staff respond in a timely manner? Resident 33 said no to question 3. During an interview on 09/29/2025 at 11:26 AM, Staff G, Social Services Assistant, and Staff C, Social Services Director, were interviewed on Resident 12's abuse and neglect investigation. Staff G said they were not involved in interviewing other staff, only other residents and they customize the questionnaires for residents to be specific to the resident's investigation. Staff G and Staff C were told Resident 33 had been interviewed for two investigations, both with an allegation of neglect but with different questions, with one screen resulting with a no response to staff responding timely, and the other screen resulting without any concerns. When (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	questioned on if the questions for other residents for Resident 12's investigation were more geared towards abuse than neglect, Staff G said, gotcha. When asked about general questions for staff related to the investigations, Staff C said they can interview staff present in the hallway or staff that may have been witness or heard anything. Staff G said they had talked with Resident 12 with Staff F (ADON/IP/LPN) to get clarification, as there were a few parts Resident 12 said they did not remember. When asked how they helped confirm the dates that were in question, Staff G said Staff F was trying to figure out the timeline, that Resident 12 had said it was during a shower, the nursing aide (Staff EE) needed help (by Staff AA). Staff C said they interviewed Resident 67 (Resident 12's roommate) as a potential witness, and handed the interview over to Staff B, Director of Nursing Services (DNS). When asked if they had interviewed Resident 67 as a potential witness, Staff C said they had asked Resident 67 the same questions as the other general resident interviews, but Resident 67 had concerns they vocalized, so those quotes were written down on the paper. Resident 12's investigation showed no statement was found by Resident 12's roommate, Resident 67. No resident general interview was found for Resident 67. A grievance was found from Resident 67 on 09/22/2025, that documented Resident 67 believed there was a delay in care for Resident 12 by Staff BB. During an interview on 09/30/2025 at 12:01 PM, Staff F, ADON/IP/LPN, said they assisted with Resident 12's investigation by reaching out to the named CNAs for statements and initiating the incident report. Staff F said they started with the roommate, Resident 67, who said something, then with that got statements from the CNAs, then spoke to Resident 12 with social services. Staff F said they only started the investigation, they did not finish it, that was the role of Staff B. Staff F said Resident 12 was unable to confirm a specific timeline, as Resident 12 initially said they did not know what their roommate was talking about, then after more questions was all over the place with their answers. When asked if Resident 12 could have been talking about the weekend before 09/20/2025, and if they had considered that the incident occurred on an alternative weekend, Staff F said it could have been. When asked if the facility had followed up with Resident 12 reporting they had missed their Metamucil dose (due to sitting in stool), and Resident 12's nurse believing Resident 12 actually meant their Miralax (a stool softener) dose, Staff F said no they did not. Staff F said they would have been responsible for general interviews for the CNAs, and they did not do any and they should have. When specifically asked about Staff AA's statement on the feet tickling and if other staff were interviewed on this, Staff F said no. Staff F said they did not interview Resident 67, that someone else had. When asked about questions for Resident 12 regarding Staff BB, if they were general or specific to the weekend, Staff F said they were specific to the weekend because of Resident 67's grievance. When asked if they had gotten the statement from Staff A, Administrator, and considered this for Staff F's interview with Resident 12, Staff F said no. Staff F said Staff BB had told them they never had any issues with Resident 12, and in general there had never been any issues between them. During an interview on 09/30/2025 at 12:45 PM, Staff B, DNS, said they and the unit manager were responsible for Resident 12's investigation. Staff B when asked about the neglect allegation not having a determination on if abuse or neglect was ruled out, said they should have written 09/22/2025 to 09/23/2025 for ruling out abuse and neglect. When asked if there were any other grievances reviewed for the investigation, other than Resident 67's, Staff B said no, this was the only one they had. When asked where the grievance was that Staff R filled out the week before regarding Resident 12 not liking Staff AA tickling their feet, Staff B said they did not have it here. When asked where the interview was for Resident 67 that was completed by social work, Staff B said it was with the unit manager and they would see what they did with it. Staff B said the investigation should have Resident 67's interview by social services. Staff B said Resident 12 had ups and downs, they sometimes reported concerns about dialysis and it sounded like the incident happened at this facility; they did not remember it was at dialysis and not here. When asked their expectation for interviewing CNA staff on general abuse or neglect questions, Staff B said they and the unit manager would go to the unit, pull the report on staff and who worked, get their statements, get the statement from the resident, (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sometimes a statement from the roommate, then could go to another unit but normally focus on that unit, focus on that shift, and if need be another shift. When asked if any other CNAs were interviewed, that were not named during the allegations, Staff B said they believed they were by Staff F or the unit manager. When asked about Staff AA's statement on feet tickling, Staff B said the unit manager had gone to assess Resident 12 and they were not ticklish that day. When pointed out that the statement from Staff AA could be interpreted as the resident was showing physical signs they did not want Staff AA to touch their feet, Staff B said the resident was ticklish by the staff member and the patient still needed to be taken care of, and they did not see any comment in the statement by Staff AA that said the resident told them to stop touching their feet or were in pain. At 1:28 PM, Staff B called Staff D, Charge Nurse (also called Unit Manager at this facility, often called Resident Care Manager in other facilities) into their office. Staff D said they had no part in the investigation, they attempted to talk to Resident 12 once, and that was it. At 1:29 PM, the interview with Staff B was continued. When asked about Staff BB's statement being specific to the weekend, Staff B acknowledge this. When asked if Staff BB was interviewed on general care for Resident 12, said they did not see it here. When asked about the investigation concluding, without Resident 67's screening interview being reviewed with concerns and quotes, said there was something missing here. When asked if this was a complete and thorough investigation, Staff B said something was missing. 2) Resident 3 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 3 was cognitively intact and dependent on staff for toileting hygiene.On 09/22/2025 at 2:32 PM, Resident 3 said they were lying in bed, in feces, from 6:30 PM until 10:10 PM waiting for their call light to be answered.A review of the facility's incident log, dated 09/29/2025, listed Resident 3 as alleged abuse on 09/19/2025.A review of the facility investigation, dated 09/19/2025, showed sample resident interviews, a signed statement by the Staff A, Administrator, an online incident report to residential care services, a progress note by Staff B, DNS, and notes listing a history and investigation. The investigation did not include additional staff interviews working 09/19/2025.On 09/25/2025 at 11:12 AM Staff B, DNS, said when asked if his investigation was complete, yes but there were things not provided.On 09/25/2025 at 11:39 AM, a statement from Staff DD, CNA, assigned to Resident 3, dated 09/19/2025, was provided. Staff DD had been assisted by another CNA and their statement was not included.On 09/25/2025 at 1:11 PM, a documented titled CALL LIGHT AUDIT dated 09/19/2025 was provided.On 09/25/2025 at 1:33 PM, a document titled INSERVICE EDUCATION SUMMARY dated 09/19/2025 TOPIC: Call Light Courtesy was provided.On 09/29/2025 at 12:57 PM, Staff B, DNS said he reviewed the evening staffing on 09/19/2025, interviewed additional sample staff and interviewed Resident 3 as a follow-up after Staff A, Administrator, reported the allegation. Staff B said he would provide these additional items for the facility investigation.As of 11/18/2025 3:15 PM, no additional documentation had been provided.Reference F585, F609, F742Reference WAC 388-97-0640 (6)(a)(b).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, interview and record review the facility failed to ensure services provided met professional standards of practice by ensuring residents were provided scheduled medication, were updated promptly of medication unavailability, and/or were observed during medication administration, for 2 of 22 sampled residents (Residents 3 & 8) reviewed for professional standards, and to appropriately label multiuse medications for 1 of 3 medication carts (Olympic 2 cart) reviewed for medication storage observation. This failure placed residents at risk for medication complications, for receiving expired medication, and a diminished quality of life. Findings included.1) Resident 3 was admitted to the facility on [DATE], with diagnoses of hypertension (a condition where the force of blood against the artery walls is consistently too high) and heart failure (a condition where the heart cannot pump blood effectively enough to meet the body's demands). The Quarterly Minimum Data Set (MDS, an assessment tool), dated [DATE], documented Resident 3 was cognitively intact. Resident 3's electronic health record (EHR) showed an order, dated [DATE], for eplerenone, to treat congestive heart failure and hypertension, scheduled once a day.A review of Resident 3's July Medication Administration Record (MAR), showed eplerenone had a blank box, no documentation, on [DATE] and [DATE]. A review of Resident 3's [DATE] MAR, showed eplerenone had an x documented, in the box, on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. A review of Resident 3's EHR, showed a progress note by the provider, dated [DATE], documenting Resident 3's medication eplerenone was on hold due to pharmacy availability. A progress note dated [DATE], documented eplerenone was on hold. A progress note dated [DATE], documented Resident 3 reported a concern about not receiving eplerenone, and the pharmacy, provider and resident were notified.On [DATE] at 12:21 PM, Resident 3 said they were not getting their blood pressure pill, eplerenone, every morning and the staff never told them why. Resident 3 said they should have told me what was going on.On [DATE] at 2:03 PM, Staff D, Charge Nurse (also called Unit Manager at this facility, often called Resident Care Manager in other facilities) / Registered Nurse (RN), reviewed Resident 3's [DATE] MAR with blanks and acknowledged it. Staff D said her expectation was for the staff to write a progress note on [DATE]th and 20th and there were no progress notes. Staff D said Resident 3's [DATE] MAR had an x on the 4th and 8th - 18th and this meant the medication was not given. Staff D said the medication was not available from the pharmacy and there were no progress notes documenting this until the 16th. Staff D said the nurse should have charted the provider was notified, the blood pressure was stable and they were waiting on medication from pharmacy. Staff D said there were no progress notes documenting why it was not given until, [DATE], [DATE], and [DATE]. Staff D said the resident should have been notified by the staff that the medication was not available. Staff D said she did not see a progress note that documented the resident was notified. On [DATE] at 2:27 PM, Staff B, Director of Nursing Services (DNS), said while looking at Resident 3's [DATE] MAR, he did not see anything in the notes and it looked like Resident 3 missed this medication. Staff B said while looking at the [DATE] MAR, there should have been a note from the nurse documenting the medication was not available and documented the provider and pharmacy were contacted. Staff B said the nursing staff could have notified the provider and received a new order or put the medication on hold. Staff B said there was a hold order for the medication on the 17th and 18th and there were progress notes by the nursing staff charting the medication was not given on the 16th-18th. Staff B said he did not see documentation Resident 3 was notified the medication was not available.2) Resident 8 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], showed Resident 8 was cognitively intact. During an observation and interview on [DATE] at 3:18 PM, Resident 8 opened their top drawer of their dresser and three white pills were seen in a medicine cup. At 3:34 PM, Staff Q, Licensed Practical Nurse (LPN), came into the room and Resident 8 said the three pills were melatonin. Review (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Resident 8's [DATE] MAR, showed Resident 8 had melatonin ordered on [DATE] for once a night at bedtime. From the MAR, Resident 8 had 6 documented nights of receiving melatonin, [DATE] to [DATE], before they were found with 3 of the pills (3 out of 6 nights were not taken).During an interview on [DATE] at 10:04 AM, Staff D, Charge Nurse/RN, said their expectation for nurses regarding watching residents take their medication, was that nurses would stay in the room with the resident until all their medications had been correctly administered. During an interview on [DATE] at 3:19 PM, Staff B, DNS, said the nurse should make sure residents have taken their medication, fully swallowed, before they leave the room. MEDICATION WITHOUT OPEN DATE:On [DATE] at 12:25 PM, during medication cart review an insulin pen was located in the top drawer in the Olympic 2 cart. The insulin pen had a sticker where staff were to put the date opened, which was left blank.On [DATE] at 12:39 PM, Staff Z, LPN, said that insulin pens are to be dated when taken out of the refrigerator and used. Staff Z confirmed that a date was not on the insulin pen and said it should be. Staff Z said she would discard the insulin because she did not know when it was opened.On [DATE] at 10:21 AM, Staff B, DNS/RN, was told of the undated insulin pen located in Olympic 2 med cart. Staff B said it should have had an open date on it. Reference WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation, interview and record review, the facility failed to ensure residents were assisted with activities of daily living (ADLs) including bathing and meal preparation assistance for 3 of 6 sampled residents (Resident 107, 12 & 55) reviewed for ADLs and choices. The failure to provide assistance with bathing and meal set up for residents who were dependent on staff for provision of such care, placed the residents at risk for poor hygiene, embarrassment, diminished self-image, weight loss and a decreased quality of life.Findings included .1) Resident 107 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS, an assessment tool), documented still in progress. On 09/23/2025 at 9:57 AM, Resident 107 said they had not received a shower since being admitted to the facility and they wanted their fingernails clipped. The electronic health record (EHR) documented Resident 107 was given a shower on 09/20/2025 at 7:52 AM and 09/22/2025 at 12:32 AM and 6:29 PM. On 09/24/2025 at 2:58 PM, Resident 107 confirmed they had still not received a shower, even though the EHR documented they had received multiple showers. On 09/29/2025 at 8:50 AM, the Shower folder, the Shower binder and Skin Assessment sheets were reviewed since admission; there was no documentation to support that Resident 107 had received a shower.On 09/29/2025 at 10:05 AM, Staff K, Charge Nurse (also called Unit Manager at this facility, often called Resident Care Manager in other facilities) /Licensed Practical Nurse (LPN), said residents were assigned shower days based on halls and received a shower twice a week, more if needed or required. Staff K said staff completed a skin assessment sheet every time the resident took a shower, to assess for new skin concerns. When asked what Resident 107's shower days were, Staff K said Mondays and Thursdays. When asked if Resident 107 had received a shower, Staff K reviewed the EHR and said Resident 107 had a shower on 09/22/2025. When it was explained that the resident reported they have not had a shower since admission, Staff K reviewed the Shower folder, Shower binder and the Skin Assessment sheets and confirmed there were no skin assessments completed. Staff K said they could not confirm if the resident had a shower or not. When asked if the resident should have had more than one alleged shower since admission, Staff K said yes. On 09/30/2025 at 1:42 PM, Staff B, Director of Nursing Services (DNS), said residents received showers ordered by halls, at least twice a week, more if needed. When explained that Resident 107 had not received a shower since admission, Staff B said Resident 107 should have been offered a shower on their assigned days.2) Resident 12 was admitted to the facility on [DATE] with diagnoses of hemiplegia (one-sided paralysis or weakness) and hemiparesis (one-sided muscle weakness) following cerebral infarction (stroke, when a blood vessel in the brain was blocked) affecting right dominant side and muscle weakness. Review of Resident 12's Quarterly MDS, dated [DATE], showed they were cognitively intact, dependent on staff for cares, and required set up or clean-up assistance with meals. During an observation and interview on 09/30/2025 at 8:20 AM, Resident 12 was observed with whipped spread (butter) on their tray, that was unopened. Resident 12 said they could only use one of their hands for eating, so they were unable to open the butter themselves, and was observed to leave their toast on their tray uneaten. When asked about their orange/tangerine cup having a lid, Resident 12 said they could not see the fruit cup and did not know it was there, but they were unable to open lids on fruit cups anyways. Resident 12 said they were frequently not assisted with their breakfast tray. During an interview on 09/30/2025 at 8:40 AM, Staff M, Certified Nursing Assistant (CNA), said the nursing aide that brought Resident 12 their tray should have offered to butter Resident 12's toast. When asked how Resident 12 opened fruit lids, Staff M said the nursing aide should have asked or assisted. Staff M confirmed it did not appear like Resident 12 had been assisted with their butter or oranges and did not eat any of their toast. During an interview on 10/01/2025 at 8:44 AM, Staff D, Charge Nurse/ RN, when told of Resident 12 not having assistance with their butter or fruit cup lid or being able to see the fruit cup, said their expectation was for the nursing aides to help with set up and assist. 3) (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	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bremerton Trails Post Acute	2701 Clare Avenue Bremerton, WA 98310

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 55 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia and nutritional deficiency. The Quarterly MDS, dated [DATE], documented Resident 55 was severely cognitively impaired. Review of Resident 55's provider orders showed their diet order, dated 03/20/2025, included cut-up assistance.On 09/30/2025 at 12:58 PM, during an observation of Resident 55 eating lunch with Staff KK, CNA present, showed on their plate was a whole ham and grilled cheese sandwich. Resident 55 was picking up the sandwich and placing it back on the plate but did not eat it. The sandwich was not cut up for Resident 55. When asked if Resident 55 required cut-up assistance for their meal, Staff KK said they did not believe so, it should have said on their ticket if they did and it did not say it there. Staff KK said if Resident 55's food needed to be cut up it would have come precut.On 10/01/2025 at 12:14 PM, Staff B, DNS, said that Resident 55's order for cut up assistance should have been noted on the meal ticket and the Kardex (directions for CNA's) and acknowledged it was not. Reference WAC 388-97-1060 (2)(c).

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide resident centered activities that incorporated the resident's preferences for 1 of 1 sample residents (Resident 78) reviewed for activities. This failure placed residents at risk for a diminished quality of life.Findings included .Resident 78 was admitted to the facility on [DATE] with a diagnosis of Parkinson's Disease (Progressive neurodegenerative disorder that affects movement, balance, and coordination). The Admission/ 5-Day Minimum Data Set, an assessment tool, dated 09/08/2025, documented Resident 78 was severely cognitively impaired. Review of Resident 78's Activities Preferences, dated 09/09/2025, showed Resident 78 enjoyed social visits, conversations, news, gardening, outdoor activities, and other activities of interest.Review of Resident 78's care plan, revised date 09/10/2025, documented the following interventions: Invite resident to social activities to do things with groups of people in a social setting.Offer resident snacks between meals.Provide opportunities for the resident to keep up with the news.Provide resident an opportunity to participate in their favorite activities.Review of Resident 78's Planned Activities task, from the time of admission on [DATE], did not document Resident's participation in any activities. The following observations took place:- On 09/22/2025 at 11:42 AM, Resident 78 was observed to be sitting in a wheelchair, across from the nurses station. Resident 78 was awake, looking downward, with no stimulation.- On 09/24/2025 at 10:36 AM, Resident 78 was observed to be sitting in a wheelchair, across from the nurses station. Resident 78 was awake, with no stimulation.- On 09/26/2025 at 8:52 AM, Resident 78 was observed to be sleeping in wheelchair at the nurses' station. Head slouched down.- On 09/26/2025 at 1:50 PM, Resident 78 was observed to be sitting in a wheelchair, across from the nurses station. Resident 78 was awake, looking downward, with no stimulation.- On 09/29/2025 at 2:11 PM, Resident 78 was observed to be sleeping in wheelchair at the nurses' station. Head slouched down.In an interview on 09/22/2025 at 11:46 AM, Resident 78 said he enjoyed watching football, and planned on watching a game later that day. When asked about other activities he participates in, Resident 78 stated, As far as I know, there are no activities.In an interview on 09/30/2025 at 11:50 AM, Staff H, Activities Director, said she was not able to document any Residents' participation in activities due to technical issues. Staff H stated, I told the administration may times. In the meantime, I chart on paper and in progress notes. Staff H said Resident 78 participates in activities daily but was unable to provide documentation of Resident 78's participation.In an interview on 09/30/2025 at 3:12 PM, Staff B, Director of Nursing Services/ Registered Nurse, said resident activities should be documented. Reference WAC 388-97-0940 (1)(2).

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to comprehensively assess the use of bedrails/side rails for 1 of 1 residents (Resident 67) reviewed for side rails. This failure placed residents at risk of accident hazards, unmet care needs, and a diminished quality of life. Findings included .The facility's policy entitled, Bed Safety and Bed Rails, Revised 2022, documented: The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent.Resident 67 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (an assessment tool), dated 06/30/2025, documented the resident was alert and oriented.Review of the Physician's order, dated 12/06/2024, documented Resident 67 was to have Bilateral bed mobility bars to assist with bed mobility.Review of Resident 67's electronic health record, did not show documentation of comprehensive, ongoing, and periodic assessments for the mobility bars. During an observation and interview on 09/22/2025 at 1:49 PM, Resident 67 was observed with mobility bars on their bed. Resident 67 said the mobility bars hurt their shoulder because the bed was not wide enough for them, and they wished they did not have them. On 09/25/2025 at 11:04 AM, Resident 67 was observed in bed with mobility bars.In an interview on 09/25/2025 at 11:05 AM, Resident 67 stated, I don't like the bars placed where they are, they hurt my shoulder. Resident 67 said they had asked staff to remove the mobility bars since December 2024. In an interview on 09/29/2025 at 1:55 PM, Staff D, Charge Nurse (also called Unit Manager at this facility, often called Resident Care Manager in other facilities) / Registered Nurse (RN), said standard practice was to obtain consent and evaluate a resident for the use of a bed mobility bars. Staff D was unable to provide documentation showing periodic evaluations were completed for Resident 67's mobility bars. In an interview on 9/30/2025 at 10:31 AM, Staff B, Director of Nursing/RN, said he expected mobility bars should only be used with a consent, evaluations and follow ups. Staff B was unable to provide documentation of completed periodic mobility bars evaluations. Reference WAC 388-97-0230.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. .Based on interview and record review, the facility failed to show evidence the Quality Assurance and Performance Improvement program plan (QAPI, a program that focused on the full range of care and services provided by the facility that included clinical care, quality of life and resident choice) was reviewed and updated with the current leadership. The facility failed to provide evidence that the committee staff and medical director participated in the QAPI program meetings. This failure placed residents at risk for adverse events and/or decreased quality of care and quality of life.Findings included .Record review of the document titled, QAPI Plan, listed annual review on 12/01/2022 and 12/01/2023. The document also listed QAPI committee members, and the name of the administrator listed was not the name of the current administrator.On 11/18/2025 at 1:39 PM, Staff A, Administrator, said, I do not have a new QAPI plan. Staff A stated, I was not here in 2023, that is old stuff.Review of the QAPI Meeting Minutes on 11/18/2025 at 2:13 PM, did not record the staff who were present and if the medical director attended.On 11/18/2025 at 2:13 PM, Staff A said he did not have an updated QAPI plan and it would be updated by the end of today. Staff A said he did not have a sign-in sheet or documentation on the QAPI meeting minutes of the staff or medical director that attended the meetings. Staff A said, Going forward we will be doing that.Reference: WAC 388-97-1760 (1)(2).