STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505290	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Terrace	560 Lebo Boulevard 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40914 Based on interview and record review, the facility failed to accurately assess and identify a change in urinary incontinence, ensure a plan for treatment and services to restore as much normal bladder and/or bowel function as possible for 2 of 3 residents (5 & 6) reviewed for urinary incontinence. Failure to identify and assess/determine causative factors of urinary incontinence placed residents at risk for unmet care needs and decreased quality of life. Findings included . <Resident 5> Resident 5 was admitted to the facility on [DATE] with diagnoses including a fracture of the arm. The admission Minimum Data Set (MDS/an assessment tool), dated 01/28/2025, documented Resident 5 had no cognitive impairment and was frequently incontinent of urine. The Bowel and Bladder Evaluation, dated 01/31/2025, documented Resident 5 was continent of urine. No further assessment or interventions were implemented. Care Plan, dated 02/25/2025, documented Resident 5 was occasionally incontinent of bladder related to diuretic (medication that draws excess fluid from the body via urine) use, muscle weakness, urgency, and frequency. Staff will provide briefs for the resident and check the resident for incontinence. Progress notes, dated 01/31/2025, documented Resident 5 voiced concerns about staff assisting them to the toilet. The resident was able to maintain continence and brought themselves to the toilet. Progress note, dated 02/03/2025, documented Resident 5 was started on oxybutynin (a medication used to treat an overactive bladder) for frequent urination and bladder spasms. Progress notes, dated 02/04/2025, documented the resident was voiding nine times a shift. Progress notes, dated 02/19/2025, documented Resident 5 asked to discontinue the oxybutynin. During the resident's stay, no new reassessment or monitoring was implemented nor were appropriate interventions initaited for the resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/01/2025 at 4:35 PM, Staff B, Registered Nurse (RN) and Director of Nursing (DNS), could not indicate Resident 5's type of incontinence. Staff B said the facility did not reassess the resident or address the inconsistencies in Resident 5's bladder incontinence. <Resident 6> Resident 6 was admitted to the facility on [DATE] with diagnoses including a cognitive communication deficit. The quarterly MDS, dated [DATE], documented Resident 6 had no cognitive impairment and was frequently incontinent of urine. The Bowel and Bladder Evaluation, dated 02/06/2025, documented Resident 6 was continent of urine. No further assessment or interventions were implemented. Care Plan, dated 01/24/2025, lacked documentation related to Resident 6's bladder status. Progress notes, dated 02/10/2025, documented Resident 6 had a urinary tract infection requiring treatment. On 04/01/2025 at 3:50 PM, Staff D, Nursing Assistant, said Resident 6 was incontinent of urine. Sometimes the resident dribbled a small amount of urine and other times it was large amounts. The resident could bring themselves to the bathroom, but staff checked on Resident 6 due to incontinence. At 4:35 PM, Staff B, Registered Nurse (RN) and Director of Nursing (DNS), could not indicate Resident 6's type of incontinence. Staff B said the care plan was not updated. The facility did not reassess the resident nor address the inconsistencies in Resident 6's bladder incontinence. Reference WAC 388-97-1060 (3)(c)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40914 Based on interview and record review, the facility failed to provide pain management to adequately control residents pain for 1 of 3 sampled residents (1) when reviewed for pain management. This failure put residents at risk of uncontrolled pain and a diminished quality of life. Findings included . Resident 1 was admitted to the facility on [DATE] with respiratory failure and chronic obstructive pulmonary disease (a lung disease with limits air flow and breathing). On 02/27/2025 at 3:46 PM, Resident 1 said when they were discharged , the facility sent them with a large bag full of medication. It was very overwhelming for Resident 1 to be given a bag with many different medications. Because Resident 1 was so overwhelmed, they did not notice any concerns with their pain medication. Resident 1 discovered once home they were sent home with only three oxycodone (a narcotic pain medication). Resident 1 experienced pain until they could get to the appointment with their community provider. No prescription was sent with the resident, and they were not told they would only have three tablets of oxycodone. Physician orders, dated 01/15/2025, documented Resident 1 could take oxycodone every eight hours as needed. Progress notes, dated 01/16/2025, documented Resident 1 received oxycodone for back and abdominal pain. Provider notes, dated 01/17/2025, documented Resident 1 reported abdominal pains with some relief from oxycodone. Tenderness was found upon abdominal exam. The provider increased administration of oxycodone to every six hours as needed. Progress notes, dated 01/17/2025, documented Resident 1's pain originated in the chest from coughing. Provider notes, dated 01/20/2025, documented Resident 1 continued to complain of abdominal pain. Oxycodone was continued every six hours as needed. Progress notes, dated 01/20/2025, documented Resident 1's pain originated from osteoporosis. Doing art projects in room eased pain. The care plan, dated 01/25/2025, documented Resident 1 had acute pain from osteoporosis. Staff wwere to assess pain each shift, monitor pain quality and severity of pain, and document side effects from pain medication. The January 2025 Medication Administration Record (MAR), documented Resident 1 received one tablet of oxycodone two to three times a day during their stay the facility. The resident's pain ranged from a 4-7 on a scale of 1-10 (1 is mild pain and 10 is severe pain). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Discharge Resident Medication Transfer Record, dated 01/22/2025, documented Resident 1 was sent home with three oxycodone. No prescription was provided to the resident to ensure they had sufficient oxycodone until Resident 1 was assessed by their community provider. On 04/01/2025 at 4:35 PM, Staff B, Registered Nurse (RN) and Director of Nursing (DNS), said the resident did not get sufficient oxycodone upon discharge. Staff B said a prescription should have been sent with the resident, but Staff B was unable to locate a prescription. Staff B said a new staff member discharged Resident 1 and may have missed this. Reference WAC 388-97-1060 (1)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40914 Based on interview and record review the facility failed to repeatedly implement antibiotic protocols to ensure antibiotics were appropriately prescribed for 1 of 3 sampled residents (1), reviewed for antibiotic use. This failure placed residents at risk of development of antibiotic-resistant organisms, adverse side effects, and diminished quality of life. Findings included . Resident 1 was admitted to the facility on [DATE] with respiratory failure and chronic obstructive pulmonary disease. On 02/27/2025 at 3:46 PM, Resident 1 said when they were sent home they were sent with a large bag full of medications. They did not know what all of the medications were for, and it was very confusing. Resident 1 went to their doctor and went through everything. They found two antibiotics that had many pills left. Resident 1 said they were never told to discontinue the medication but thinks they should have since they were getting these medications in the hospital. Resident 1 said it was very confusing. The Hospital Discharge Summary, dated 01/15/2025, documented Resident 1 should take cefuroxime (antibiotic), twice daily, for 14 doses. Resident 1 should take metronidazole (antibiotic), two times daily, for 14 doses. The Order Summary Report, dated 01/15/2025, documented the resident would receive cefuroxime twice daily and metronidazole two times daily. The medications did not have a date noted when the medications should be continued. The Discharge Resident Medication Transfer Record, dated 01/22/2025, documented Resident 1 was sent home with 46 tablets of cefuroxime and metronidazole. On 04/01/2025 at 4:35 PM, Staff B, Registered Nurse (RN) and Director of Nursing (DNS), said cefuroxime and metronidazole should have an end date noted and this should have been communicated upon discharge. No associated WAC.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40914 Based on interview and record review, the facility failed to ensure the pneumococcal vaccine (used to prevent pneumonia and sepsis), was provided for 1 of 3 residents (1), reviewed for immunizations. This failure placed the resident at risk of acquiring, transmitting, and/or experiencing potentially avoidable complications from influenza disease. Findings included . Resident 1 was admitted to the facility on [DATE] with respiratory failure and chronic obstructive pulmonary disease. The Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination, dated 01/15/2025, documented Resident 1 wished to receive the pneumococcal vaccine. The documents were signed by the nurse on the same day. Review of Resident 1's electronic health record showed no documentation that Resident 1 was provided a pneumococcal vaccination. On 04/01/2025 at 4:35 PM, Staff B, Registered Nurse (RN) and Director of Nursing (DNS), said there was a consent signed from the resident indicating they would like the vaccine. Staff B said the vaccine was not given. Staff B said the vaccine should have been given. Reference (WAC) 388-97-1340 (1)(2)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40914 Based on interview and record review, the facility failed to ensure the COVID-19 (a highly transmissible infectious virus that causes respiratory illness and in severe cases can cause difficulty breathing and could result in impairment or death) vaccine was provided for 1 of 3 residents (1), reviewed for immunizations. The failure to provide the COVID-19 vaccination placed the resident at risk for contracting the COVID-19 virus and related complications. Findings included . Resident 1 was admitted to the facility on [DATE] with respiratory failure and chronic obstructive pulmonary disease. The Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination dated 01/15/2025, documented Resident 1 wished to receive the COVID-19 vaccine. The documents was signed by the nurse on the same day. Review of Resident 1's electronic health record showed no documentation that Resident 1 was provided a COVID-19 vaccination. On 04/01/2025 at 4:35 PM, Staff B, Registered Nurse (RN) and Director of Nursing (DNS), said there was a consent signed from the resident indicating they would like the vaccine. Staff B said the vaccine was not given. Staff B said the vaccine should have been given. No reference WAC