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	11/18/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure recommendations of gradual dose reductions were followed for 3 of 4 sampled residents (1, 2, & 3) reviewed for gradual dose reductions. These failures placed residents at risk of taking unnecessary medications, avoidable medication side effects, and a diminished quality of life. Findings included.Resident 1Resident 1 was admitted to the facility on [DATE] with diagnoses of vascular dementia and anxiety disorder. The quarterly minimum data set (MDS), an assessment tool, dated 08/19/2025, documented Resident 1 has severe cognitive impairment and required substantial to maximal assistance with activities of daily living (ADL).The care plan, dated 11/22/2024, documented staff would monitor target behaviors and monitor for side effects. The care plan, dated 05/15/2025, documented Resident 1 would receive hospice services and staff will assess the resident's coping strategies and respect their wishes.On 09/15/2025 at 12:39 pm, Resident 1 was observed sitting in their wheelchair in the hallway. The resident was twisting and pulling at their clothing. The resident had a grimace on their face.Consultation Report, dated 06/16/2025, documented the Consulting Pharmacist recommended Resident 1's medication, escitalopram (a antidepressant used to treat anxiety and depression), for a gradual dose reduction (a reduction or discontinuation of a medication to see if symptoms can be managed at a lower dose).On 06/26/2025, the medical provider checked that they accept these recommendations.Progress notes, dated 06/30/2025, documented Resident 1's Guardian was informed of the intent to discontinue the escitalopram. The Guardian did not want the reduction in medication because they felt the resident was stable, not wanting symptoms to reappear. The Guardian said this would be distressing to Resident 1. If the provider had questions, they could contact the Guardian.The Medication Administration Record (MAR), dated July 2025, documented Resident 1's escitalopram was discontinued on 07/15/2025. The MAR documented Resident 1 needed Ativan (an anxiety reducing medication) one time during the period when Resident 1 was not taking the medication.The MAR, dated August 2025, documented Resident 1 required Ativan three times until restarting the medication on 08/08/2025.Progress notes, dated 07/17/2025, showed the resident had a fall to the floor, trying to go outside. There was no injury to the resident. The resident was combative with staff who were trying to assist the resident.Progress notes, dated 07/24/2025, documented Resident 1 was different and was not smiling doesn't want to do things the resident did before. The change occurred after the discontinuation of escitalopram.Progress notes, dated 07/25/2025, documented the resident was different doesn't interact like [they] did before. just sits there doesn't smile. Progress notes, dated 08/03/2025, documented Resident 1 had shown worsening behaviors since discontinuation of escitalopram. Resident 1 had been hitting, calling names, pinching, punching and scratching staff. The resident was medicated with Ativan, and the resident did calm down. Hospice was consulted.Progress notes, dated 08/04/2025, documented Resident 1 was upset and crying unrelated to pain. Resident spoke of upsetting past experiences. One on one time given.Progress notes, dated 08/05/2025, documented Resident 1 had episodes of being terribly upset and crying. As needed medications given.Progress notes, dated 08/08/2025, documented Resident 1 was given orders to restart escitalopram. When staff called Resident 1's Guardian for consent to restart escitalopram, the Guardian voiced they were upset the medication was ever stopped and to not stop it again and said the resident was on hospice and should be happy and comfortable.On 10/07/2025 at 4:07 pm, Staff B, Registered Nurse and Director of Nursing, said he could not explain why they discontinued the escitalopram. Staff B said they should have made sure the provider had a discussion with the Guardian to discuss the GDR or discussed keeping the resident on the medication. Either way there should have been a discussion.Resident 2Resident 2 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease and Alzheimer's disease. The quarterly MDS, dated [DATE], documented Resident 2 has no cognitive impairment and was dependent on staff with assistance with ADL.The care plan, dated 09/03/2025, document Resident 2 had a history of anxiety and depression. Staff would monitor the residents' target behaviors of no appetite or refusing food and negative verbalizations.The Consultation Report, dated 06/13/2025, documented Resident 2 was due for a GDR on aripiprazole (an anti-psychotic used to treat bipolar disease and Schizophrenia). The recommendation included reducing the amount of aripiprazole to 2 mg daily. The Physician's Response was checked I accept the recommendations above, please implement as written. No directions on the medication were written by the medical provider. The provider signed the document on 06/26/2025 Order