STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505341	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridge Crest Post Acute	5220 Northeast Hazel Dell Avenue Vancouver, WA 98663

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 0770 Level of Harm - Actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44739 Based on interview and record review, the facility failed to ensure timely laboratory services were provided for 1 of 1 sampled residents (1) reviewed for laboratory services. Resident 1 experienced a critically elevated white blood cell (WBC) count and was sent to the emergency department with increased swelling and discomfort in both lower legs and left arm. This failure placed residents at risk for delay in treatment and a diminished quality of life. Findings included . Resident 1 was readmitted to the facility on [DATE] with diagnoses including Chronic Myelomonocytic Leukemia, a rare blood cancer originating in the bone marrow and is characterized by an overproduction of white blood cells. The Minimum Data Set assessment, dated 12/26/2024, showed resident was cognitively aware and required moderate assistance with activities of daily living. The hospital discharge orders, dated 12/20/2024, documented, Future lab orders at Skilled Nursing Facility [SNF]. Complete by 12/27/2024, Completed Blood Count, [CBC], and Basic Metabolic Panel [BMP]. A review of Resident 1's electronic medical record showed the hospital discharge orders had not been noted and the lab draw had not been completed by 12/27/2024. A physician order, dated 12/31/2024 at 7:15 AM, showed Resident 1 was to have a lab draw for a CBC and BMP to be completed for three consecutive days, on 12/31/2024, on 01/01/2025, and on 01/02 2025. Resident 1's December 2024 and January 2025 Medication Administration Record (MAR) showed the lab draw, ordered on 12/31/2024, was signed as completed on 12/31/2024 only. The results of the 12/31/2024 lab draw were not located in Resident 1's medical record. Resident 1's medical record showed a lab draw for CBC and BMP was completed on 01/03/2025 at 10:48 AM. A laboratory report showing the lab draw results, dated 01/03/2025 at 12:55 PM, identified abnormal values including a critically elevated WBC count of 47.4. (a normal WBC count range is 3.8-10.1.) The report for Resident 1 documented to repeat analysis with a new blood sample. (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 0770 Level of Harm - Actual harm Residents Affected - Few	The January 2025 MAR showed Resident 1 did not have any orders for the lab draws to repeat analysis of CBC and BMP on 01/04/2025 and 01/05/2025. A physician order, dated 01/06/2025 at 11:15 AM, was written for a lab draw for a CBC to be completed for three consecutive days on 01/06/2025, on 01/07/2025 and on 01/08/2025. The January 2025 MAR showed the lab draw was signed as completed on 01/06/2025. A lab report, dated 01/07/2025 at 8:15 PM, identified Resident 1 had abnormal values including a critically elevated WBC count of 55.0. A nursing progress note, dated 01/07/2025 at 2:50 PM, Resident 1 was sent to the emergency department the morning of 01/07/2025 with increased swelling and discomfort to both lower legs and left arm. Resident 1's medical record showed the resident did not return to the facility. On 01/23/2025 at 2:42 PM, when asked about the facility's process for implementing lab orders upon admission, Staff C, Licensed Practical Nurse (LPN), said it was sometimes the nurse who helped with admissions, or sometimes medical records, but usually it was the floor nurses who initiated lab orders when a resident was admitted from hospital. Staff C said the nurses review the hospital orders for labs, verify orders with the provider, and activate the orders in the electronic medical record (EMR). On 01/28/205 at 3:38 PM, when asked who oversees noting lab orders for new admissions, Staff D, LPN, said the nurse on duty would enter the lab order into EMR for the specified time. Then the Resident Care Manager (RCM) would review the orders and make sure they were noted and faxed to the lab and the order was placed in the lab book. Staff D said the expectation was for the floor nurses to know if there was a lab due on their shift. If so, they signed for this on the MAR when the lab was completed. Staff D said if the lab did not show up to complete the lab, they either called them or reported this to the RCM for further action. At 4:07 PM, Staff D, Registered Nurse (RN) and Previous Admissions Nurse, said the lab orders went in with the medication orders in EMR, and the nurses also had a copy of the admissions orders. Staff D said it was up to the floor nurses to get the lab orders into the lab app (place to document lab orders that can be seen by the facility nurses and the lab). If they were not able to get the orders into the app, they could also call the orders into the lab. Staff D said the nurses were responsible to communicate to others if the lab could not be drawn, resident refused, or the resident went to the hospital. (continued on next page)

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F 0770 Level of Harm - Actual harm Residents Affected - Few	On 02/05/2025 at 3:00 PM, Staff B, Interim Director of Nursing Services and RN, said she had not been at the facility at the time of Resident 1's admission and discharge. However, she had inquired with staff if they knew anything about missed lab work for Resident 1. Staff B said a staff member informed her that during a morning clinical meeting Resident 1's labs were discussed, and it was realized they had been missed. The labs were reordered and then missed again. Staff B this was brought to the attention of the previous Director of Nursing Services and the Resident Care Manager for Resident 1. Staff B said she had implemented a system where labs were discussed each morning; and verification of orders, completion of lab draws, and lab results were brought forward for review by herself and the interdisciplinary team. Reference WAC 388-97-1620 (2)(b)(i)(ii)(6)(b)(i)(ii)