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	04/24/2025

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 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** 44739 Based on interview and record review, the facility failed to address a new skin pressure injury, timely notify the provider, and timely implement wound treatment orders for 1 of 1 sampled residents (Resident 1) reviewed for pressure ulcers (injuries to skin and underlying tissue resulting from prolonged pressure on the skin). Resident 1 experienced harm when they developed a facility acquired pressure ulcer which deteriorated prior to staff obtaining timely orders for wound treatment and pressure reduction modalities. This failure placed residents at risk for development and/or worsening of wounds, medical complications, and a diminished quality of life. Findings included . Review of the facilities policy entitled, Skin at Risk/Skin Breakdown, revised 09/2020, showed procedure #5: Upon discovery of newly identified skin impairment (abrasion, bruise, burn, excoriation, pressure sore, rash, skin tear, surgical wound, etc.), the licensed nurse will: Notify the physician and obtain a treatment order if needed, document on the Treatment Administration Record (TAR) after implementation. The policy section entitled, Treatment/Management, showed #1: The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and applications of topical ointments. Resident 1 was admitted to the facility on [DATE] with diagnoses including Type 2 diabetes with diabetic polyneuropathy (too much sugar in the blood causing loss of feeling), and hemiplegia and hemiparesis following a cerebral infarction affecting the right dominant side (stroke that caused loss of movement). The annual Minimum Data Set assessment, dated 01/12/2025, showed Resident 1 required assistance with activities of daily living and required substantial to maximum assistance with turning and repositioning in bed. Review of a nurse progress note, dated 03/13/2025, documented Resident 1 had an open wound on their right buttock measuring 2 centimeters (cm) X 4 cm and another purple area that looked like it was going to open up laterally to it measuring 10 cm x 1 cm. Resident 1's right heel was black on the outside approximately 6 cm X 6 cm, the skin on the outside of her shin going up from the heel was warm and red. The writer noted they cleaned the wound on Resident 1's bottom and put a border dressing on it, but they [wounds] need to be assessed, and wound orders put in. Review of a nurse progress note, dated 03/14/2025, documented, Photo taken and placed in chart. Wound care also done at this time. (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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(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	Review of a nurse progress note, dated 04/01/2025 and referred to as a late entry from 03/17/2025, documented, Showed wound care physician resident's right foot and sacral area. We were placing a foam 6x6 on sacral area and zinc. Heels to be floated. The sacral area continue to treat with a cover and zinc. No written order was completed until 04/01/2025. Review of Electronic Medical Record (EHR) physician orders showed no orders were written for wound treatment or pressure reduction mattress until 04/01/2024, 20 days after wounds were identified. Review of EHR progress notes showed no notes were written for wounds identified on 03/13/2025 until 04/01/2025, 20 days after wounds were identified. Review of March 2025 and April 2025 Treatment Administration Record (TAR), from 03/13/2025 to 04/02/2025, showed no treatment was signed for until 04/01/2025, 20 days after wounds were identified. On 04/08/2025 at 3:00 PM, Staff C, Registered Nurse (RN), said if nurses identified a wound, it was their responsibility to make sure providers were notified, an order was received and noted, and residents were placed on alert status. On 04/23/2025 at 11:01 AM, Staff D, Licensed Practical Nurse (LPN), said the nursing assistants reported Resident 1's skin condition to her and she took measurements and made a progress note. Staff D said they did not notify the provider, obtain an order, or make a note on the TAR. Staff D said this was the responsibility of the wound nurse or Resident Care Manager (RCM). At 11:57 AM, Staff F, LPN, RCM, said they learned of Resident 1's wound by accident when the facility wound nurse and wound care provider were doing rounds. They had been asked to assist and note orders. The therapeutic mattress was ordered at that time. Staff F said the wounds were unstageable (dark black tissue indicative of loss of blood flow) at that time. At 1:20 PM, Staff F, LPN and Wound Nurse, said they had not written or noted orders. Staff F said they used house standing orders and completed treatments when on duty. At 2:15 PM, Staff B, DNS, said it was her expectation when licensed staff identified a wound, they reported it up the ladder, so the entire health care team was aware of the issue. The expectation was to make a progress note, place residents on alert status, and obtain an order for treatment and pressure reduction as applicable. On 04/25/2025 at 12:33 PM, Staff G, LPN, said she had completed measurements and a progress note for Resident 1. Staff G said the progress note, called a tiger text, sent a message to the healthcare team consisting of the RCM, Director of Nursing (DNS), and the provider. Staff G said she did not receive an order but placed a dressing on the wounds per nursing judgment. Staff G said she did not place Resident 1 on alert status. Reference WAC 388-97-1060 (3)(b)