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	08/04/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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 0755 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 interview and record review, the facility failed to acquire, administer, and accurately document a medication for 1 of 4 residents (Resident 1) reviewed for pharmacy services and drug regime. Failure to ensure the medication was received and administered placed Resident 1 at risk for delayed treatment, medical complications, and decreased quality of life Findings included.Record review of the facility's policy, titled, Section 3.2 Medication Ordering and Receiving from Pharmacy Provider-Ordering and Receiving Non-Controlled Medications, revised on 01/2023, showed section 2. Receiving medications from the pharmacy:a.A licensed nurse or appropriate personnel as required by law:Receives medication delivered to the nursing care center from the pharmacy and documents delivery on the medication delivery receipt/manifest.Verifies medication received with the prescriber orders.Promptly reports discrepancies and omissions to the issuing pharmacy and the charge nurse/supervisor.Resident 1 was admitted to the facility on [DATE] with diagnoses including Malignant Neoplasm of Unspecified Kidney (a cancer in the kidney and spread to the breast, bone and lymph nodes.) An admission Minimum Data Set (MDS- an assessment tool), date 07/01/2025, showed Resident 1 was cognitively aware and required moderate assistance with activities of daily living.A record review of Resident 1's physician's admission orders, dated 06/25/2025, included an order for Belzutifan (a medication used to treat cancer) Oral Tablet 40 milligrams (MG) to be given by mouth in the morning.A record review of Resident 1's Medication Administration Records (MAR), dated 06/25/2025 to 07/24/2025, showed licensed nurse signatures for the administration of Belzutifan 40 MG each at 07:00 AM. Above 25 of these signatures a chart code of (9) was documented instructing the reader to See Nurses Notes. Above 4 of these signatures achart code of a check mark was documented indicating the medication had been administered as ordered.Record review of the progress notes for Resident 1, dated 06/24/205 to 07/24/2025, showed a progress note on 07/18/2025 at 07:58 AM from Staff C, Registered Nurse (RN), documenting the medication Belzutifan was unavailable, and the family would provide.In an Interview on 07/23/2025 at 10:57 am, Collateral Contact 1 (CC1), a pharmacy representative, said the pharmacy was unable to supply this medication as its suppliers did not provide it. The medication would need to be obtained from a specialty pharmacy. CC1 said the pharmacy had never filled this prescription for Resident 1.In an interview on 07/24/2025 at 1:00 PM, Staff C, RN, said the chart code (9) above the nurse signature on the MAR indicated a nurse's progress note should be written. Staff C said the Belzutifan had not been given as the medication had not been received. The facility pharmacy was unable to provide the medication and Resident 1's family was going to bring it in. Staff C said they were still waiting for the medication. When asked if the Resident Care Manager (RCM) or the physician had been notified of the medication not being available, Staff C said she had just notified the RCM and was unsure if the physician had been notified.In an Interview on 07/24/205 at 01:47 PM, Staff D, RCM/Licensed Practical Nurse (LPN), said the chart code (9) above the nurse signature in the MAR means, See nursing progress note. When asked about Resident 1's medication Belzutifan she said there were no notes and there should be. She had just learned this morning the medication was unavailable. When asked about nurse expectations regarding unavailable medications Staff D said the nurses should report unavailability of medications to her as well as the physician and family. During an interview on 07/24/2025 at 03:17 PM, Resident 1 informed me she had not received her Belzutifan since she was admitted on [DATE].During an interview on 07/31/2025 at 3:00 PM, Staff E, RN, when ask about the protocol to follow if a medication was not available for administration at the time of medication pass and a chart code of (9) was documented said, I would call the pharmacy. I asked if she would make a progress note regarding this. If I can resolve it, I don't usually make a note. If not, I pass it along in report and usually let the RCM know. When asked about Resident 1 and her Belzutifan , she said she couldn't remember if she called the pharmacy, made a note, or reported to RCM.During an interview on 07/31/2025 at 3:02 PM, Staff F,LPN, when asked about the protocol to follow if a medication was not available at the time of medication pass and a chart code of (9) was documented said, I would make a note in the progress notes and call the pharmacy. When asked about Resident 1's Belzutifan , Staff F said she remembered calling the pharmacy and the family. She did not remember reporting this to the RCM or the physician.During an interview on 07/31/2025 at 3:48 PM, Staff G, LPN, when asked about the protocol to follow if a medication was not available at the time of medication pass and a chart code of (9) was documented said, This means there should be a progress note. Staff G was asked if it was protocol to notify the RCM, and physician if