

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/25/2025
NAME OF PROVIDER OR SUPPLIER Bridge Crest Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written notice of discharge for 1 of 4 residents (Resident 1) reviewed for transfer and discharge requirements. This failure placed residents at risk of uninformed discharge plans, psychological distress, and decreased quality of life. Finding included. Record review of a facility policy and procedure titled, Notice of Transfer or Discharge, dated 04/2020 showed, POLICY:It is the policy of this center to provide written notice of transfer/discharge in accordance with state and federal regulations. Notice of transfer/discharge shall be made 30-days prior to transfer/discharge unless the health and/or safety of the resident or resident's residing in this center are endangered. Additionally, a procedure showed,PROCEDURE:1. The facilities interdisciplinary team validate transfers and discharges occur in a manner that maintains or improves the resident's physical, mental and psychosocial well-being.2. Transfers and discharges may occur for any of these reasons:a. The residents' welfare and the residents' needs cannot be met at the center.c. The safety of individuals in the center is endangered due to the clinical or behavioral status of the resident.d. The health of others within the center would otherwise be endangered. Resident 1 was admitted to the facility on [DATE]. A quarterly Minimum Data Set [MDS], an assessment tool, dated 06/29/2025, showed Resident 1 was cognitively intact, able to make her own decisions, and needed moderate assistance with activities of daily living. Record review of an interdisciplinary progress note for Resident 1, dated 07/16/2025 at 6:35 PM, written by Staff C, Social Service Director, showed, Residents care needs have surpassed the scope of services the facility is able to provide at Bridge Crest Post Acute. Due to ongoing and active substance use, including nicotine, methamphetamines, and methadone, her medical condition has become increasingly complex and unstable, making it unsafe for us to manage within our current level of care. Resident has exhibited a pattern of leaving the facility and returning in a medically compromised state, often experiencing withdrawal symptoms and episodes of lethargy and intermittent unconsciousness. She has also been declining care and eating inconsistently. Given her history of diabetes, these behaviors have led to both hyperglycemic and hypoglycemic events requiring medical intervention. Additionally, residents' current behaviors and choices present significant safety risks to herself, the staff, and other residents. For these reasons, we believe a higher level of care is necessary to appropriately meet her medical and behavioral health needs. In collaboration with the methadone clinic, steps have been taken to increase residents' success with current treatment in place and to prevent the potential for resident selling her methadone or over medicating herself before returning from the methadone clinic each day. However, the resident continues to display an overall medical decline with no expressed interest in remedying the situation with available options such as inpatient drug rehab or complying with simple requests to ensure her safety as well as others in the facility. At this time, resident is not appropriate to return to facility for the overt concerns stated above. In an interview on 08/21/2025 at 2:43 PM, when asked if a written discharge notice was given to Resident 1 at the time of discharge, Staff C, Social Service Director, said No, I don't think so. In an interview on 08/21/2025 at 2:50 PM, Collateral Contact 1(CC1), a Methadone clinic employee, said Resident 1 was sent to the hospital the morning of 07/15/2025 at 8:57 AM. CC1 said she had received a call from an employee at the facility stating Resident 1 had wanted to go to the hospital to have her legs assessed for an infection. It was arranged for Resident 1 to be taken by a medical transportation service to the hospital instead of back to the facility. CC1 said Resident 1 was alert, oriented, and receiving two antibiotics for infection to her lower legs. Resident 1 was agreeable to the transfer to the hospital on [DATE]. In an interview on 08/22/2025 at 12:50 PM, Collateral Contact 2 (CC2), a case manager supervisor at the hospital, said Resident 1 was admitted on [DATE]. The hospital received notice that the facility would not be readmitting Resident 1 on 07/16/2025. In an interview on 08/25/2025 at 4:14 PM, Staff A, Administrator, said the interdisciplinary team had met and discussed Resident 1 on the evening of 07/16/2025. Staff A said that in the future they would deliver a written discharge notice immediately upon discharge. Reference WAC 388-97-0080.</p>		