

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/23/2026
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medications were provided to meet the immediate needs of 1 of 3 sampled residents (Resident 1) reviewed for pharmacy services when the resident's prescribed pain medication was unavailable following admission. The facility failed to utilize available medication access procedures or contact the provider for an alternative medication order. This failure placed the resident at risk for untreated pain and delayed medication administration. Resident 1 was admitted to the facility on [DATE] with diagnoses including intervertebral disc degeneration with back pain and lower extremity pain (degeneration of the discs between the bones of the spine that can cause back and leg pain). Resident 1's medication administration record (MAR) documented an order for oxycodone-acetaminophen 10/325 mg, one tablet every 8 hours as needed for pain related to intervertebral disc degeneration with back pain and lower extremity pain. The MAR documented this medication was not administered during Resident 1's stay on 7/11/2026 and 7/12/2026. A progress note dated 7/11/2026 at 11:21 PM documented Resident 1 reported severe neck pain due to spinal compression (pressure on the spinal cord or nerves). The note documented the pharmacy was contacted to request an estimated time of arrival for the medication and staff were advised the medication was expected to arrive around 12:00 AM. On 07/21/2026 at 12:00 PM, Collateral Contact A (CCA) stated Resident 1 had a prescription for oxycodone-acetaminophen for pain and did not receive the medication during her stay. CCA stated nursing staff advised there was an issue obtaining the medication from the pharmacy. CCA stated Resident 1 was in significant pain and was crying. CCA stated the family removed Resident 1 from the facility AMA approximately 24 hours after admission due to concerns regarding the resident's care, including Resident 1 not receiving the prescribed oxycodone-acetaminophen. On 07/23/2026 at 11:00 AM, Staff A, Registered Nurse/Director of Nursing Services (DNS), stated medications ordered for newly admitted residents are sent to the pharmacy for dispensing and delivery to the facility. Staff A stated that when an ordered medication is needed before delivery, nursing can contact the pharmacy to obtain a code to access available medications from the facility's automated medication dispensing system. Staff A stated nursing may also request immediate medication delivery from the pharmacy. On 07/23/2026 at 12:35 PM, Staff B, Registered Nurse, stated she provided care to Resident 1 during the evening shift on 07/11/2026. Staff B stated Resident 1 reported severe neck pain and the prescribed pain medication was not available. Staff B stated she contacted the pharmacy and was advised the medication was expected to arrive around midnight. Staff B stated she was unaware that narcotic pain medication could be accessed through the facility's automated medication dispensing system and was also unaware that she could contact the provider to obtain an alternative pain medication order when the prescribed medication was unavailable. Staff B stated she believed (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	Resident 1's prescribed pain medication could not be administered until it arrived from the pharmacy. On 07/23/2026 at 1:40 PM, Staff A stated the medication was delivered to the facility shortly after Resident 1 had discharged AMA. Staff A stated that when the ordered medication was not available, the nurse could have contacted the pharmacy to obtain a code to access available medications from the facility's automated medication dispensing system. Staff A stated the ordered oxycodone-acetaminophen 10/325 mg was not available in the automated medication dispensing system; however, immediate-release oxycodone 5 mg and 10 mg were available. Staff A stated the nurse could have contacted the provider for an alternative order, including an order for available oxycodone with acetaminophen administered separately. Staff A stated this would have allowed Resident 1 to receive an alternative pain medication while awaiting delivery of the originally ordered medication. Reference WAC 388-97-1300		