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 10/11/2024
NAME OF PROVIDER OR SUPPLIER: Bridge Crest Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 5220 Northeast Hazel Dell Avenue Vancouver, WA 98663	

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47518 Based on interview and record review, the facility failed to ensure residents and/or resident representatives were informed and provided consent before administering a psychotropic medication (medications capable of affecting the mind, emotions, and behaviors) for 2 of 5 sampled residents (41 & 3) reviewed for unnecessary medications. This failure placed residents and/or resident representatives at risk of not being fully informed of the risks and benefits before making decisions about medications, and a diminished quality of life. Findings included . 1) Resident 41 was admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS) assessment, dated 08/21/2024, documented Resident 41 was alert and oriented, had diagnoses including schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors), and was taking antipsychotic (a class of medications used to treat symptoms of various mental disorders) and antianxiety (medications that help reduce the symptoms of anxiety) medications. A physician's order, dated 08/15/2024, documented Resident 41 was prescribed Olanzapine (a medication used to treat mental disorders). The August 2024, September 2024 and October 2024 Electronic Medication Administration Record (EMAR) showed Resident 41 received Olanzapine daily. Review of Resident 41's Electronic Health Record (EHR) Informed Consent - Psychoactive Medication form, showed Resident 41 gave initial consent for Olanzapine on 09/30/2024, 47 days after the medication was started. A physician's order, dated 08/15/2024 and updated 09/06/2024, documented Resident 41 was prescribed Clonazepam (a medication that produces a calming effect on the brain and nerves). The September 2024 and October 2024 EMAR showed Resident 41 received Clonazepam twice daily. The EHR did not show documentation of a consent from the resident or a resident representative for the administration of Clonazepam. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/2024 at 2:40 PM, Staff E, Resident Care Manager and Registered Nurse (RN), said a consent should be completed upon admission or prior to starting a psychotropic medication. Staff E said Resident 41's first consent for the Olanzapine was signed on 09/30/2024 after the medication was started. Staff E said she did not see a consent for Resident 41's Clonazepam. Staff E said consents should have been completed prior to starting the Olanzapine and Clonazepam for Resident 41. At 3:34 PM Staff B, Director of Nursing Services and RN, said she expected consents were completed prior to starting psychotropic medications. 50416 2) Resident 3 was admitted to the facility on [DATE]. The Admission MDS assessment, dated 09/15/2024, documented Resident 3 was alert and oriented, had diagnoses including dementia and depression. A physician's order, dated 09/08/2024, documented Resident 3 was prescribed Seroquel (an antipsychotic medication). A physician's order, dated 09/08/2024, documented Resident 3 was prescribed Sertraline (an antidepressant medication). Review of Resident 3's EHR showed an Informed Consent - Psychoactive Medication form signed on 09/30/2024, documenting Resident 3's consent to the administration of Seroquel and Sertraline. The informed consent was signed 22 days after the day Resident 3 started receiving the medications. On 10/11/2024 at 9:32 AM, Staff B said it was her expectation Resident 3 should have had a signed consent for Sertraline and Seroquel on the day the order was initiated. Reference WAC 388-97-0260 (1)-(3)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46751 Based on interview and record review, the facility failed to provide and/or have procedures in place to assist with completing advance directives (ADs), and obtaining and maintaining Durable Power of Attorney (DPOA) documentation for 2 of 11 sampled residents (3 & 9) reviewed for ADs. This failure place residents at risk for losing their right to have healthcare preferences and decisions honored and a diminished quality of life. Findings included . The facility's policy entitled, Advanced Directives, dated 08/01/2018, indicated, During the admission process, if it is determined that the resident does not have an advance directive and wishes to formulate one, assistance will be provided, using state specific advance directive forms. This will be documented in the medical chart along with a copy of the advance directive. 1) Resident 3 was admitted to the facility on [DATE]. The Admission 5 Day Minimum Data Set (MDS) assessment, dated 09/15/2024, showed Resident 3 was moderately cognitively impaired. Resident 3's electronic health record (EHR) did not show an AD or documentation an AD was addressed since admission. 2) Resident 9 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], showed Resident 24 was alert and oriented. Resident 9's EHR did not show an AD or documentation an AD was addressed since admission. An email, dated 10/09/2024 at 11:16 AM, from Staff A, Administrator, documented Resident 3 and Resident 9 did not have ADs in place. On 10/10/2024 at 2:58 PM, Staff X, Social Services Director, said ADs were addressed in the initial admission care conference, and if residents decline, I typically [write a] progress note to document their preference. Staff X stated, I usually ask just those two times, the initial meeting and [the] care conference [a] few days later. On 10/11/2024 at 10:13 AM, Staff A, Administrator, said it was her expectation to address AD's per facility policy. Staff A was unable to provide further documentation of ADs being addressed for Resident 3 and Resident 9. Reference WAC 388-97-0280 (3)(c)(i)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934 Based on observation, interview and record review, the facility failed to ensure residents' medical information was maintained in a manner to ensure privacy and confidentiality when staff failed to properly secure medical records for 1 of 1 sampled resident (258) reviewed for privacy and confidentiality. These failures placed residents at risk for loss of confidential medical information and a diminished quality of life. Finding included . On 10/08/2024 at 9:22 AM, Staff S, Podiatrist, went into room [ROOM NUMBER], the room of Resident 258. At 9:34 AM, Staff S was observed providing care to Resident 258's toes nails. On Staff S's cart, in the hallway, were multiple papers. The top paper was facing up, and on it was a Podiatric Progress Note showing medical information for Resident 258. At 9:36 AM, Staff R, Registered Nurse, was observed coming out of a room from across the hallway. Staff R said resident information should not be visible to people in the hallway. When asked what she would do with visible resident information on the cart, Staff R turned the progress note over and stated, Just like this. At 1:02 PM, Staff A, Administrator, said resident medical information should not be visible to others and should be turned over. Reference WAC 388-97-0360 (1)(b)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934 Based on observation, interview and record review, the facility failed to ensure residents were free from restraints for 1 of 3 sample residents (38) reviewed for physical restraints. This failure placed residents at risk for injury and a decrease quality of life. Findings included . Resident 38 was admitted to the facility on [DATE]. The Admission Minimum Data Set assessment, dated 07/30/2024, indicated Resident 38 was severely cognitively impaired. The fall risk interventions, dated 07/26/2024, indicated bed against wall, and fall mat [mattress] on side of the bed that is not against the wall to prevent/decrease chance of injury. No consent for the bed against the wall was found in the electronic health records. On 10/07/2024 at 10:36 AM, Resident 38 was observed lying on the bed on his back. The bed was against the wall, low to the floor and had a floor mat. At 2:51 PM, Collateral Contact 1 said the bed was against the wall and the mat was on the floor because Resident 38 tried to get out of bed and had fallen. On 10/10/2024 at 9:42 AM, Staff B, Director of Nursing Services and Registered Nurse, said if the bed was against the wall the facility would get a consent. Reference WAC 388-97-0620 (1)(b)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50416 Based on interview and record review, the facility failed to ensure a written Bed Hold Notice was provided at the time of transfer to the hospital to the resident or resident representative for 1 of 2 sampled residents (7) reviewed for notice of bed hold. This failure placed residents at risk for lack of knowledge regarding their right to hold their bed while at the hospital. Findings included . Review of the facility's Bed Hold Policy and Procedure documented, The resident and/or resident representative will be informed of this policy in writing upon admission, transfer or leave of absence. If unable to provide at the time of transfer or leave of absence, the policy will be provided within 24 hours. Resident 7 was admitted to the facility on [DATE]. The Admission Minimum Data Set assessment, dated 07/23/2024, documented the resident was moderately cognitive impaired. Resident 7's electronic health records (EHR) documented an emergent transfer to an acute care hospital on 09/09/2024. The EHR showed Resident 7 returned to the facility on [DATE]. The EHR did not show documentation of Resident 7 or his representative receiving a Bed Hold Notice when Resident 7 was transferred to the hospital. On 10/09/2024 at 2:02 PM, Staff B, Director of Nursing Services and Registered Nurse, said there was no documentation of a Bed Hold Notice provided to Resident 7 or his representative when Resident 7 transferred to the hospital on 09/09/2024. Reference WAC 388-97-0120 (4)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47518 Based on observation, interview and record review, the facility failed to develop a care plan addressing an urinary catheter (a tube inserted into the bladder that drains urine into a bag outside the body) for 1 of 2 sampled residents (28) reviewed for comprehensive care plan. This failure placed residents at risk for unmet care needs and a diminished quality of life. Findings included . The facility's undated policy entitled, In-dwelling Urinary Catheter, documented .The Preliminary and In Room Care Plans (for [a healthcare software platform] Comprehensive Care Plan and Kardex [a paper or electronic system that contains a summary of a patient's care]) will be developed for indwelling urinary catheter. Resident 28 was admitted to the facility on [DATE] and readmitted on [DATE]. The Medicare - 5 day Minimum Data Set assessment, dated 08/23/2024, documented Resident 28 was alert and oriented and had an indwelling catheter. Review of Resident 28's Electronic Health Record comprehensive care plan did not show documentation of an indwelling foley catheter. On 10/07/2024 at 3:01 PM, Resident 28 was observed with a foley catheter bag hanging on the left side of the bed frame. Resident 28 said it was put in when she returned from the hospital. On 10/08/2024 at 12:29 PM, Resident 28 was observed sitting up in bed with a foley catheter bag hanging on the left side of the bed frame. On 10/09/2024 at 9:18 AM, when asked how they know the care needs of a resident, Staff D, Certified Nursing Assistant, said they got their information in the Kardex and the care plan. At 9:24 AM, Resident 28 was observed lying in bed with a foley catheter hanging on the left side of the bed frame. At 10:05 AM, Staff E, Resident Care Manager and Registered Nurse (RN), said residents with a foley catheter should have it care planned. Staff E said she could not find a care plan for Resident 28's foley catheter, stating, It should have been in her care plan, too. At 10:15 AM, Staff B, Director of Nursing Services and RN, said it was her expectation care plans were in place addressing residents with foley catheters. Refer to F690 Reference WAC 388-97-1020(1), (2)(a)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident’s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47518 Based on interview and record review, the facility failed to ensure the physician's orders in the Electronic Health Record (EHR) were updated to accurately reflect the resident's wishes for Cardiopulmonary Resuscitation (CPR) status as directed by the Physician Orders for Life Sustaining Treatment (POLST) form for 1 of 1 sampled resident (13) reviewed for CPR. This failure placed residents at risk for not receiving care in accordance with the resident's and/or resident's representative decision-making if their heart stopped beating or breathing stopped. Findings included . Resident 13 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set assessment, dated [DATE], documented Resident 13 was alert and oriented. Review of Resident 13's Advance Directive POLST care plan, revised [DATE], documented, Advanced Directive POLST in place . [Resident 13] states that the orders on the POLST reflect their advance directive wishes . Review of Resident 13's POLST, dated [DATE], signed by Resident 13 and a physician, documented, Use of Cardiopulmonary Resuscitation (CPR) .NO - Do Not Attempt Resuscitation (DNAR)/Allow Natural Death. Review of Resident 13's Medications Post Hospital Discharge orders from a local hospital, dated [DATE], documented, .DNAR [do not attempt resuscitation]/Full Treatment: If cardiopulmonary arrest occurs, do NOT perform CPR . Review of Resident 13's EHR physician orders, revised [DATE], documented, CPR - Attempt Cardiopulmonary Resuscitation. Review of physician's progress note, dated [DATE], documented, Do Not Attempt Resuscitation (DNR [do not resuscitate]/no CPR) Limited Additional Interventions Comfort primary . Pt [patient] and family agreed to discuss advance directive. Details: Confirmed DNR/DNI [do not intubate]/limited interventions, comfort care focus. On [DATE] at 1:53 PM, when asked how they determined a resident's CPR status, Staff G, Registered Nurse (RN) said they looked at the orders in the EHR. Staff G pointed to the computer screen with Resident 13's EHR displayed and stated, See right here, CPR. At 3:00 PM, Staff H, RN, said she determined a resident's CPR status by the orders in the EHR. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 3:04 PM, Staff E, Resident Care Manager and RN, said when a resident was admitted , they would fill out a POLST form and their wishes for CPR were put into the EHR like an order. When asked if Staff E would look at Resident 13's EHR for CPR orders, Staff E said Resident 13 had an advance directive order to attempt CPR. When asked if Staff E would look at Resident 13's POLST form and after looking at the POLST, Staff E stated, This is wrong. The POLST says do not resuscitate. Staff E stated the physician order . should have been do not resuscitate . It says in the last provider progress note DNR no CPR. At 3:16 PM, Staff B, Director of Nursing Service and RN, said the physician orders for CPR should reflect the resident's wishes on the POLST. Reference WAC [DATE] (1)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934 Based on interview and record review, the facility failed to perform ongoing neurological assessments (assesses the nervous system and identifies any abnormalities that affect function and activities of daily living) for residents after an unwitnessed fall for 1 of 3 sampled residents (38), and failed to ensure bowel interventions were initiated for 4 of 6 sampled residents (10, 11, 28 & 41) reviewed for quality of care. These failures placed residents at risk of having unidentified injuries, a delay in treatment, at risk for worsening conditions, health complications and a diminished quality of life. Findings included . <Neurological Assessments> Resident 38 was admitted to the facility on [DATE]. The Admission Minimum Data Set assessment, dated 07/30/2024, indicated Resident 38 was severely cognitively impaired. The electronic health record (EHR) showed Resident 38 had unwitnessed falls on 08/24/2024, 09/05/2024, 09/14/2024, 09/25/2024 and 09/28/2024. No neurological assessments were located with the fall investigations or in the EHR. On 10/10/2024 at 9:42 AM, Staff B, Director of Nursing Services and Registered Nurse (RN), said if a resident had an unwitnessed fall or the resident hit their head, a neurological assessment should be initiated and completed. Staff B said if the resident refused the neurological assessment, it should be documented every time. 46751 <Bowel Management> The Facility Bowel Management Policy, entitled Bowel Protocol, updated 02/2019, showed, 1. At the beginning of each shift (based on an eight-hour shift), the Licensed Nurse will pull the Resident Bowel Management Report and identify residents that have not had a BM [bowel movement] for 3 days. (please run the report for last 7 days and check the box Include residents regardless of Bowel Alert Status). The Licensed Nurse will review the resident's MAR to determine if the PRN Bowel Protocol had been initiated by the previous shift. Bowel movements are charted every shift by CNA (Certified Nursing Assistant). 2. Residents who have not had a bowel movement in three days will be given Milk of Magnesia [a laxative]. 4. If no bowel movement by the following shift, a Dulcolax [a laxative] suppository is given. 5. If resident continues without a bowel movement by the next shift a Fleets enema [a laxative] will be given. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1) Resident 10 was admitted to the facility on [DATE]. The Annual MDS assessment, dated 07/23/2024, documented the resident was alert and oriented. The Bowel and Bladder Elimination task sheet documented Resident 10 had a BM on 10/05/2024 at 7:34 PM, and did not have another BM documented until 10/09/2024 at 7:59 PM, over 96 hours between BMs (4 days). Physician order, dated 06/04/2024, documented to administer Milk of Magnesia Suspension 400 MG [milligrams]/5 ML[milliliters] (Magnesium Hydroxide). Give 30 ml by mouth as needed for no BM in 3 days. Review of Resident 10's October 2024 Medication Administration Record (MAR) showed the bowel protocol and interventions were not initiated. 2) Resident 11 was admitted to the facility on [DATE]. The Annual MDS assessment, dated 07/18/2024, documented the resident was alert and oriented. The Bowel and Bladder Elimination task sheet documented Resident 11 had a BM on 09/16/2024 at 9:37 PM, and did not have another BM until 09/21/2024 at 12:46 PM, over 92 hours between BMs (over 3 days and 20 hours). The Bowel and Bladder Elimination task sheet documented Resident 11 had a BM on 09/30/2024 at 4:39 PM, and did not have another BM until 10/04/2024 at 1:31 PM, over 111 hours between BMs (over 4 days and 15 hours). Physician orders, dated 05/21/2024, documented to administer Milk of Magnesia Suspension 400 MG /5 ML (Magnesium Hydroxide). Give 30 ml by mouth as needed for no BM in 3 days. Review of Resident 11's September 2024 and October 2024 MAR showed the bowel protocol was not initiated. 47518 3) Resident 28 was admitted to the facility on [DATE]. The Medicare - 5 day MDS assessment, dated 08/23/2024, documented Resident 28 was alert and oriented. Review of Resident 28's Task: Bowel Continence record, dated 09/12/2024 to 10/11/2024, documented No Bowel Movement on 09/23/2024, 09/24/2024, 09/25/2024, 09/26/2024, 09/27/2024, 09/28/2024, 09/29/2024, and 09/30/2024, for 8 days. The EHR showed Resident 28 had physician orders, dated 08/16/2024, for: 1. Bisacodyl Laxative Rectal Suppository 10 MG (Bisacodyl) Insert 1 application rectally every 24 hours as needed for constipation 2. Senna Tablet [a laxative] 8.6 MG (Sennosides) Give 17.2 mg [milligrams] by mouth every 12 hours as needed for bowel care-narcotic use 3. Senna Tablet 8.6 MG (Sennosides) Give 8.6 mg by mouth every 12 hours as needed for bowel care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 28's September 2024 MAR did not show any PRN (as needed) constipation medications were given from 09/23/2024 to 09/30/2024. Resident 28's Progress Notes, dated 09/23/2024 to 09/30/2024, did not show documentation of BMs, constipation, or use of PRN constipation medications. On 10/11/2024 at 9:55 AM, when asked about Resident 28's BM record, Staff E, Resident Care Manager (RCM) and RN, said no BMs were documented from 09/23/2024 to 09/30/2024. Staff E said she did not see that PRN bowel medications were given to Resident 28. Staff E said she did not see any refusals of medication for Resident 28 and stated, She should have been offered a PRN bowel med. 4) Resident 41 was admitted to the facility on [DATE]. The Admission MDS assessment, dated 08/21/2024, documented Resident 41 was alert and oriented. Review of Resident 41's Task: Bowel Continence record, dated 09/12/2024 to 10/11/2024, documented No Bowel Movement on 09/27/2024, 09/28/2024, 09/29/2024, 09/30/2024, and 10/01/2024, for 5 days. The EHR showed Resident 41 had physician orders, dated 08/15/2024, for: 1) Geri-kot Tablet [a laxative] 8.6 MG [milligrams] (Sennosides) Give 17.2 mg by mouth every 12 hours as needed for No BM x 3 days 2) Geri-kot Tablet 8.6 MG (Sennosides) Give 8.6 mg by mouth every 12 hours as needed for No BM x 2 days. Resident 41's September 2024 and October 2024 MAR did not show any PRN constipation medications were given from 09/27/2024 to 10/01/2024. Resident 41's Progress Notes, dated 09/23/2024 to 09/30/2024, did not show documentation of BMs, constipation, or use of PRN constipation medications. On 10/11/2024 at 9:55 AM, Staff E said a report was pulled every morning for residents that did not have a BM for 48-72 hours. Staff E said she would ask the resident if they had a BM, and if the resident did not, the resident would go on alert and the nurse would start them on bowel medications and the bowel protocol. When asked about Resident 41's BM record, Staff E said no BMs were documented from 09/27/2024 to 10/01/2024. Staff E said Resident 41 did not have any PRN bowel medications given and there should have been. On 10/11/2024 at 9:44 AM, Staff G, RN, said if there are more than three days since residents' BM, a bowel assessment is done, and Milk of Magnesia is administered. Staff G could not provide documentation of BM protocol being initiated for either Resident 28 or Resident 41. Staff G stated, We would chart it on the MAR [if initiated]. At 10:12 PM, Staff B said she would expect the BM protocol to be initiated after three days of no BM. Staff B was unable to provide further documentation of bowel interventions being initiated for Resident 10, Resident 1, Resident 28 and Resident 41. Reference WAC 388-97-1060 (1), (3)(c)

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47518 Based on observation, interview and record review, the facility failed to obtain urinary catheter (a tube inserted into the bladder that drains urine into a bag outside of the body) physician orders for 1 of 2 sampled residents (28) reviewed for urinary catheter. This failure placed residents at risk for infection, unmet care needs, and a diminished quality of life. Findings included . The facility's undated policy entitled, In-dwelling Urinary Catheter, documented .orders will be reviewed to include medical justification for the catheter use, catheter size, and frequency of catheter, bag and tubing changes and catheter irrigations if appropriate . Resident 28 was admitted to the facility on [DATE] and readmitted [DATE]. The Medicare - 5 day Minimum Data Set assessment, dated 08/23/2024, documented Resident 28 was alert and oriented and had an indwelling catheter. Review of Resident 28's Electronic Health Record did not have a physician's order for an indwelling foley catheter. On 10/07/2024 at 3:01 PM, Resident 28 was observed with a foley catheter bag hanging on the left side of the bed frame. Resident 28 said it was put in when she returned from the hospital. On 10/08/2024 at 12:29 PM, Resident 28 was observed sitting up in bed with a foley catheter bag hanging on left side of bed frame. On 10/09/2024 at 9:24 AM, Resident 28 was observed lying in bed with a foley catheter hanging on left side of the bed frame. At 10:03 AM, Staff F, Licensed Practical Nurse, said residents with a foley catheter would have a physician's order with details such as catheter size, catheter bag changes, and care. At 10:05 AM, Staff E, Resident Care Manager and Registered Nurse (RN), said residents with a foley catheter would have a physician's order with details like the size of the catheter, if you should flush it or not, and if it could be replaced if it got blocked. Staff E said she could not find physician orders for Resident 28's foley catheter and there should have been. At 10:15 AM, Staff B, Director of Nursing Services and RN, said it was her expectation residents with foley catheters had physician orders for them. Reference WAC 388-97-1260 (12)(b)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50416 Based on interview and record review, the facility failed to identify and address weight loss for 1 of 7 sampled residents (3) reviewed for nutrition. This failure placed residents at risk for inadequate nutrition and diminished quality of life. Findings included . Resident 3 was admitted to the facility on [DATE]. The Admission Minimum Data Set assessment, dated 09/15/2024, showed Resident 3 was alert and oriented. Resident 3's nutrition care plan, initiated 09/18/2024, showed Resident 3 Will maintain adequate nutritional status as evidenced by stable weight. Care plan interventions included Obtain weights as ordered, report significant changes to physician and RP [Responsible Party]. Residents 3's electronic health record (EHR) showed the following weights: On 09/27/2024 at 12:05 PM 163.5 Lbs Wheelchair On 09/28/2024 at 1:51 PM 145.0 Lbs Chair Scale On 09/29/2024 at 7:13 AM 144.2 Lbs Standing On 09/30/2024 at 9:21 AM 159.2 Lbs Wheelchair On 10/03/2024 at 12:27 PM 149.0 Lbs Wheelchair On 10/10/2024 at 9:48 AM, Staff I, Resident Care Manager and Licensed Practical Nurse, said if a resident was losing weight, Staff I would notify the dietician and the provider. At 1:26 PM, Staff J, Certified Nurse Assistant, said she would weigh Resident 3 while in her wheelchair, assist resident back to bed and then weigh the wheelchair to get the difference in weight which she would then record in the EHR. On 10/11/2024 at 8:41 AM, Staff B, Director of Nursing Services and Registered Nurse, said it was her expectation if a resident was losing weight, the provider would be notified. Staff B was unable to find provider notification of Resident 3's weight loss in the EHR. Reference WAC 388-97-1060 (3)(h)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 37934 Based on interview and record review, the facility failed to provide at least eight hours of Registered Nurse (RN) supervision for 3 of 30 days. This failure placed residents at risk for not receiving needed care and supervision. Findings included . The Aging and Long-Term Support Administration (ALTSA) Staffing Pattern, and the facility's Daily Nurse Staffing Forms, dated 09/07/2024 through 10/07/2024, showed the facility did not have an RN on duty for all the three shifts (day, evening & night) on 09/29/2024, 10/05/2024 and 10/06/2024. On 10/11/2024 at 9:37 AM, Staff T, Staffing Coordinator, said they don't always have 24 hours of RN coverage but they are currently recruiting. At 10:18 PM, Staff B, Director of Nursing Services and Registered Nurse, said they have been attempting to recruit RNs, were using online hiring services and would be working on submitting an exception for staffing. Reference WAC 388-97-1080 (3)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 37934 Based on observation, interview and record review, the facility failed to ensure nursing hours were accurately posted daily for 4 of 30 days reviewed for nurse staff postings. This failure placed residents, resident representatives, and visitors at risk of not being fully informed of the current staffing levels and census. Findings included . The nurse staff postings, dated 09/07/2024 through 10/07/2024, were reviewed. On 10/07/24 at 10:27 AM, the nurse staff posting displayed Friday, 10/04/2024, with a census 67. On 10/08/2024 at 8:07 AM, the nurse staff posting displayed Friday, 10/04/2024, with a census of 67. On 10/11/2024 at 9:37 AM, Staff T, Staffing Coordinator, said the overnight charge nurse were supposed to change the postings over the weekend. At 10:18 AM, Staff B, Director of Nursing Services and Registered Nurse, said the night shift nurse was supposed to change the posting. No Associated WAC

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47518 Based on interview and record review, the facility failed to ensure a licensed pharmacist completed a monthly Medication Regimen Review (MRR) for 4 of 5 sampled residents (28, 41, 12, & 26) reviewed for unnecessary medications. This failure placed residents at risk for delays in necessary medication changes, adverse side effects, and receiving medications without required pharmacist oversight. Findings included . 1) Resident 28 was admitted to the facility on [DATE]. The Medicare - 5 day Minimum Data Set (MDS) assessment, dated 08/23/2024, documented Resident 28 was alert and oriented, and was receiving medications including an antipsychotic (medication used to treat symptoms of various mental disorders), an antidepressant (medication used to treat depression), a hypnotic (medication used to reduce anxiety or to induce sleep), an anticoagulant (medication that prevents or treats blood clots), a diuretic (medication to helps get rid of excess fluid), and an opioid (medication to help with pain relief). 2) Resident 41 was admitted to the facility on [DATE]. The Admission MDS assessment, dated 08/21/2024, documented Resident 41 was alert and oriented, and was taking medications including an antipsychotic, an antianxiety (medication to help reduce the symptoms of anxiety), and a hypoglycemic (medication to help control blood sugars). 37934 3) Resident 12 was admitted to the facility on [DATE]. The quarterly MDS assessment, dated 07/08/2024, documented Resident 12 was alert and oriented, and was taking medications including an antianxiety, an antidepressant, and an anticoagulant. 46751 4) Resident 26 was admitted to the facility on [DATE]. The Significant Change MDS, assessment, dated 07/05/2024, documented Resident 12 was alert and oriented, and was taking medications including an antianxiety, an antidepressant, and an anticoagulant. Record review of the Electronic Health Record and MRR binder showed no monthly pharmacist medication reviews for the months of June 2024, July 2024, August 2024, September 2024, and October 2024. On 10/09/2024 at 12:13 PM, Staff B, Director of Nursing Services and Registered Nurse, said they did not have any monthly pharmacy MRRs since April for any resident and stated, We just missed it. We were not getting them. Reference WAC 388-97-1300 (1)(c)(iii)(iv)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50416 Based on interview and record review, the facility failed to ensure targeted behaviors (desired responses to prescribed drugs) were monitored for 1 of 3 sampled residents (3) and failed to complete an AIMS (Abnormal Involuntary Movement Scale) Test (a rating scale used to assess the severity of involuntary movements that sometimes develop as a side effect of treatment with antipsychotic medications) for 2 of 5 sampled residents (3 & 41) reviewed for unnecessary psychotropic medications. These failures placed residents at risk of receiving unnecessary medications, experience adverse side effects and a diminished quality of life. Findings included . <Targeted Behaviors> Resident 3 was admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS) assessment, dated 09/15/2024, documented Resident 3 was alert and oriented, and had diagnoses including dementia and depression. A review of Resident 3's Electric Health Record (EHR) did not show a record of targeted behaviors being monitored. On 10/11/24 at 9:32 AM, Staff B, Director of Nursing Services and Registered Nurse (RN), said it was the expectation residents were monitored every shift for targeted behaviors related to the use of psychotropic medications. <AIMS Test> 1) A physician's order, dated 09/08/2024, documented Resident 3 was prescribed Seroquel (an antipsychotic medication). A physician's order, dated 09/08/2024, documented Resident 3 was prescribed Sertraline (an antidepressant medication). A review of Resident 3's EHR did not show a record of an AIMS test being completed prior to the administration of psychotropic medications. On 10/11/2024 at 9:32 AM, Staff B said it was her expectation that an AIMS assessment was completed by the floor nurse and/or by the Resident Care Manager (RCM) on admission. 47518 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident 41 was admitted to the facility on [DATE]. The Admission MDS assessment, dated 08/21/2024, documented Resident 41 was alert and oriented, had diagnoses including schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors), and was taking an antipsychotic medication (a medication used to treat symptoms of various mental disorders). A physician's order, dated 08/15/2024, documented Resident 41 was prescribed Olanzapine (an antipsychotic medication used to treat mental disorders). The August 2024, September 2024 and October 2024 Electronic Medication Administration Record showed Resident 41 was receiving Olanzapine daily. Resident 41's EHR did not show documentation of an AIMS test completed for the administration of Olanzapine. On 10/10/2024 at 2:40 PM, Staff E, RCM and RN, said an AIMS test should be completed for residents receiving antipsychotic medications upon admission and when a new antipsychotic medication was started. Staff E said she could not find an AIMS test completed on Resident 41 and it should have been. At 3:34 PM, Staff B said she expected an AIMS test to be completed on residents taking an antipsychotic medication. Reference WAC 388-97-1060 (3)(k)(i)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50416 . Based on observation, interview and record review, the facility failed to ensure medication refrigerators were monitored for appropriate temperatures on 2 of 2 sampled units (West Hall & TCU (Transitional Care Unit)) reviewed for medication storage. This failure placed the residents at risk of receiving unsafe or ineffective medication. Findings included . On 10/09/2024 at 3:26 PM, the medication refrigerator in [NAME] Hall medication room was observed with Staff H, Registered Nurse (RN). Medications were stored in the [NAME] Hall medication refrigerator. A review of the temperature log on the refrigerator door showed temperature readings were not documented on 10/03/2024, 10/04/2024 and 10/05/2024. On 10/10/2024 at 1:42 PM, the medication refrigerator in the TCU medication room was observed with Staff K, Licensed Practical Nurse. Medications were stored in the refrigerator. A temperature monitoring log was not located in the medication room or on the medication refrigerator in the TCU medication room. Staff K said night shift was supposed to check the refrigerator temperatures. Staff K was unable to locate a temperature log for the TCU medication refrigerator. On 10/11/2024 at 8:51 AM, Staff B, Director of Nursing Services and RN, said it was her expectation the refrigerator temperature in the medication rooms were checked twice a day. Staff B said the temperature log for [NAME] Hall medication room refrigerator was not up to date. Reference WAC 388-97-1300 (2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49452 Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP) when providing medical device care and wound care for 3 of 3 sampled residents (13, 28 & 107) and the facility failed to ensure staff properly donned (putting on) and doffed (removing) personal protective equipment (PPE) for 1 of 1 staff (S) reviewed for infection prevention and control. These failures placed residents, staff, and visitors at risk for contracting infectious diseases, developing infections and a decreased quality of life. Findings included . <Enhanced Barrier Precautions (EBP)> Record review of the Centers for Medicare and Medicaid Services (CMS) Memorandum (Ref: QSO-24-08-NH), dated 03/20/2024, with the subject of: Enhanced Barrier Precautions in Nursing Homes explains that: --EBP recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. --Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP. --For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, and wound care of any skin opening requiring a dressing. It is also indicated for device care or use of a central line, urinary catheter, feeding tube, or a tracheostomy/ventilator. Record review of the facility's policy entitled Transmission Based Precautions, dated 08/01/2024, documented .Residents requiring enhanced barrier precautions regardless of confirmed MDRO [multidrug-resistant organism] status include: Residents with wounds . Residents with enteral tubes [a tube inserted into the stomach through a surgically created opening in the abdomen that allows liquid nutrients and fluid to enter the stomach] . Residents with a urinary catheter [a tube inserted into the bladder that drains urine into a bag outside of the body] . 1) Resident 28 was admitted to the facility on [DATE]. The Medicare - 5 day Minimum Data Set (MDS) assessment, dated 08/23/2024, documented Resident 28 was alert and oriented and had an indwelling urinary catheter. On 10/07/2024 at 3:01 PM, Resident 28 was observed with a urinary catheter bag hanging on the left side of the bed frame. No EBP signage was observed on Resident 28's door or entrance to the room. No PPE (personal protective equipment) was observed at entrance of room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/08/2024 at 12:29 PM, Resident 28 was observed sitting up in bed with a urinary catheter bag hanging on left side of bed frame. No EBP signage was observed on Resident 28's door or entrance to the room. No PPE (personal protective equipment) was observed at entrance of room. On 10/09/2024 at 9:24 AM, Resident 28 was observed lying in bed with a urinary catheter hanging on left side of the bed frame. No EBP signage was observed on Resident 28's door or entrance to the room. No PPE (personal protective equipment) was observed at entrance of room. 2) Resident 13 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 13 was alert and oriented and had a feeding tube. Review of Resident 13's physician's order, dated 06/03/2024, documented Enteral Feed, every shift for entry site check EVERY shift Enteral Tube Site Check: Enteral tube entry site without signs of skin irritation, discomfort, leakage, s/s [signs and symptoms] infection or skin ulceration. Monitoring of signs of complications shall occur prior to EVERY feeding, tube flush or medication administration. Review of Resident 13's comprehensive care plans documented, [Resident 13] requires tube feeding via g [gastrostomy] tube r/t [related to] Dysphagia. Date Initiated: 04/04/2024. On 10/08/2024 at 8:42 AM, no EBP signage was observed on Resident 13's door or entrance to the room. No PPE (personal protective equipment) was observed at entrance of room. At 12:38 PM, Resident 13 was observed sitting up in her wheelchair watching TV in her room. No EBP signage was observed on Resident 13's door or entrance to the room. No PPE was observed at entrance of room. On 10/09/2024 at 11:39 AM, Resident 13 was observed lying in bed. No EBP signage was observed on Resident 13's door or entrance to the room. No PPE was observed at entrance of room. At 2:05 PM, when asked if about awareness of which residents required the use of EBP, Staff C, Infection Preventionist and Licensed Practical Nurse (LPN), said residents with needs such as urinary catheters, wounds, tube feedings, and PICC (peripherally inserted central catheter, a tube that is inserted into a vein in the arm and threaded into a large vein above the heart) lines required EBP. Staff C stated, They have failed to roll out EBP . Its not happening in this building. There are no residents on EBP. Staff C said Resident 28 and Resident 13 should have been on EBP and they were not. At 3:14 PM, Staff B, Director of Nursing Services and Registered Nurse, said she expected residents requiring the use of EBP were placed on precautions, such as Residents 28 and Resident 13. 3) Resident 107 was admitted to the facility on [DATE]. The Annual MDS assessment, dated 09/16/2024, documented Resident 107 was alert and oriented, and was being treated for a Stage 3 (full thickness injury involving the outer two layers of skin as well as fatty tissue) pressure ulcer (pressure injuries of the skin also called bed sores). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 107's physicians/treatment order, dated 10/09/2024, noted for the wound to the buttocks/sacrum [an area at the base of the spine] to cleanse, cover Sacrum with foam dressings, D/C if consistently saturated, and apply liberal layer of HS zinc cream every morning and at bedtime for Skin Care. On 10/09/2024 at 3:10 PM, no EBP signage or PPE was observed at the door or entrance to the room of Resident 107. At 3:30 PM, Staff U, LPN, was observed providing wound care to Resident 107's buttocks/sacrum. Staff U entered the room with a mask on and donned (put on) clean gloves. After the wound care was completed, Staff U removed their dirty gloves and preformed hand hygiene. No gown was used during wound care. On 10/10/2024 at 12:41 PM, Staff U said they knew they forgot to wear a gown yesterday during wound care on Resident 107. Staff U said if a resident was on EBP's normally, I would wear one [gown] for wound care/dressing changes, and if helping with giving care. <Transmission Based Precautions (TBP)> The facility's Aerosol Contact Precautions sign, revised 02/18/2022, showed Everyone must: including visitors, doctors & staff. Clean hands when entering and leaving room. Respirator Use a NIOSH [National Institute for Occupational Safety and Health] -approved N95 or equivalent or higher-level respirator especially during aerosolizing procedures. Wear eye protection (face shield or goggles) gown and gloves at door. On 10/08/2024 at 9:11 AM, Staff S, Podiatrist, was observed walking in the hallway wearing a gown and a respirator. Staff S stopped at room [ROOM NUMBER] and then entered the room. Outside the room door was a sign indicating Aerosol Contact Precaution. At 9:17 AM, Staff S, Podiatrist was observed providing foot care to Resident 47. At 9:20 AM, Staff S was observed coming out of the room [ROOM NUMBER] wearing the same gown and respirator. At 9:22 AM, Staff S was observed entering room [ROOM NUMBER]. The room had a sign outside the door indicating Aerosol Caution Precaution. Staff S introduced himself to the resident by the door. Staff S had not doffed his PPE from the previous room or donned a new set of PPE. At 9:25 AM, Staff C said staff should follow the signage outside the room door. Staff C said staff should don full PPE before entering the room. Staff C said when leaving the room staff should doff the PPE and sanitize their hands. At 9:34 AM, Staff S was observed providing care to Resident 258 while wearing the PPE from room [ROOM NUMBER]. At 9:44 AM, Staff S was observed leaving room [ROOM NUMBER]. Staff S said when entering and exiting rooms with precautions he was supposed to follow the sign's order. When asked about not removing his PPE when leaving room [ROOM NUMBER], Staff S stated, I may have done it. (continued on next page)

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 10/11/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1:02 PM, Staff A, Administrator, said staff need to don and doff PPE as indicated by the signage. Staff A said the steps should be repeated when entering another room. Reference WAC 388-97-1320 (1)(a)(2)(b)

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	10/11/2024

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

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46751 Based on interview and record review, the facility failed to ensure residents were offered, educated and provided the risks and benefits of Pneumococcal, Influenza and COVID-19 vaccines for 1 of 5 sampled residents (15) reviewed for immunizations. This failure placed residents at risk for developing Pneumonia, Influenza and/or COVID-19, with potential negative outcomes. Findings included . Facility's Influenza and Pneumococcal Immunizations policy, revised 02/02/2022 documented: 1. a. Residents: The center reviews risks and benefits of the vaccine with residents/Resident Representatives via the Vaccine Informed Consent. 2. The resident, resident's representative, or employee can refuse the Immunizations. Vaccine declinations and reason for declination are recorded in the resident medical record. Resident 15 was admitted to the facility on [DATE]. The Admission Minimum Data Set assessment, dated 07/31/2024, documented the resident was alert and oriented. Review of Resident 15's electronic health record (EHR) did not show documentation of the resident's immunization status. The EHR did not document whether the resident was offered, and educated on the risk and benefits of Pneumococcal, Influenza and COVID-19 vaccines. On 10/11/2024 at 10:02 AM, Staff C, Infection Preventionist and Licensed Practical Nurse, said if residents agreed to receive immunization, she completed a consent form with residents, and administered the vaccine as soon as I can. Staff C was unable to provide any consents for Resident 15. Staff C stated, It doesn't look that there is any more documents, or consents. There should be. On 10/21/2024 at 10:57 PM, Staff A, Administrator, said she expected residents to be vaccinated per facility's policies. Reference WAC 388-97-1340 (1), (2), (3)

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 10/11/2024
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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934 Based on observation and interview, the facility failed to conduct routine inspections of beds and/or bed rails throughout the facility to identify loose bed rails or areas of possible entrapment due to gaps between the mattress and side rail for 1 of 3 sampled residents (106) reviewed resident beds. This failure placed residents at risk of entrapment and injury. Findings included . Resident 106 was admitted to the facility on [DATE]. The resident's Electronic Health Record showed Resident 106 was alert and oriented. On 10/07/2024 at 2:36 PM, Resident 106 said the bed rail made her feel safe but was concerned about of it being loose. On 10/11/2024 at 9:06 AM, Resident 106's bed rail was observed to be loose. The rail had about six to eight inches of movement. At 9:10 AM, after observing Resident 106's bed and bed rail, Staff L, Resident Care Manager and Licensed Practical Nurse, said it was loose. At 10:18 AM, Staff B, Director of Nursing Services and Registered Nurse, said if there was an issue with a bed rail, the nurses knew to send a request to maintenance through the TELLS (electronic work order) system. Staff B said some of the nurses knew how to tighten bed rails. At 10:27 AM, while inspecting Resident 106's bed and bed rail, Staff Q, Maintenance Director, said it was loose and the gap was wider than the entrapment zone. Reference WAC 388-97-2100