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	12/12/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview and record review, the facility failed to develop a comprehensive care plan for 4 of 16 sampled residents (Resident 1, 73, 3, & 6) reviewed for bed rails, pressure ulcer/injury, unnecessary medications, dental, and communication/sensory needs. This failure placed residents at risk for risk of injury, unmet care needs, and a diminished quality of life. Findings included. Bed rails Resident 1 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS, an assessment tool), dated 11/14/2025, showed Resident 1 was cognitively intact. In an observation and interview on 12/09/2025 at 9:20 AM, Resident 1's bed was observed with a one quarter length bed rail on the upper left side of bed. Resident 1 said he did not remember anyone talking to him about the bed rail. In an observation on 12/09/2025 at 2:05 PM, Resident 1 was observed lying in bed with a one quarter length bed rail on the upper left side of the bed. In an observation on 12/10/2025 at 9:15 AM, Resident 's 1 bed was observed with a one quarter length bed rail on the upper left side of the bed. In an interview on 12/10/2025 at 10:34 AM, Resident 1 said no one talked to him about putting a bed rail on his bed. Resident 1 said the bed rail was on the bed when he was admitted . Record Review of Resident 1's Comprehensive Care Plans, initiation dated 11/10/2025, did not show a Focus, Goal, or Intervention related to a bed rail. In an interview on 12/10/2025 at 11:14 AM, Staff F, Nurse Manager/Registered Nurse (RN) said if a resident had rails on their bed, they needed to have a care plan for the bed rails. Staff F said there was not a care plan for Resident 1's bed rail and there should have been. In an interview on 12/10/2025 at 1:18 PM, Staff B, Director of Nursing/RN, said the bed rail on Resident 1's bed should have been on his care plan. Pressure Ulcer/Injury Resident 73 was admitted to the facility on [DATE] with multiple diagnosis to include pressure ulcer (skin/tissue damage caused by prolonged pressure) of right buttock. The admission MDS, dated (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE], showed Resident 73 was moderately cognitively impaired and had a pressure ulcer present on admission. Record review of Resident 73's NURSING - ADMISSION/readmission EVALUATION/ASSESSMENT, dated 11/29/2025, showed Resident 73 had a right buttock pressure skin issue. Record review of Resident 73's December 2025 Electronic Treatment Administration Record (ETAR) showed Resident 73 was receiving wound care to the right gluteal (buttock) pressure injury/ulcer daily and as needed. Record Review of Resident 73's Comprehensive Care Plans, initiation dated 12/01/2025, did not show a Focus, Goal, or Intervention related to skin and/or a pressure ulcer and/or injury. In an interview on 12/10/2025 at 10:55 AM, Staff M, Certified Nursing Assistant (CNA), said to get information for the care needs of a resident such as skin or wound care, assistance needed, and mobility, they used the Kardex (a nursing documentation system used to provide a summary of resident care needs). In an interview on 12/10/2025 at 10:59 AM, Staff F said after a resident admitted , the nurse would start the baseline care plan and the nurse managers would finish the comprehensive care plan making sure all the resident's diagnosis were covered. Staff F said the care plan populated the information on the Kardex for the CNAs. Staff F said if a resident had a skin concern or pressure wound, there would be a care plan addressing the skin. After looking at Resident 73's Electronic Health Record (EHR), Staff F said there was not a skin and/or pressure injury care plan and there should have been. In an interview on 12/10/2025 at 1:18 PM, Staff B said it was his expectation a care plan was in place for residents with a pressure injury. Unnecessary Medications Resident 3 was admitted to the facility on [DATE] with multiple diagnoses to include depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and lupus anticoagulant syndrome (an antibody [protein in your body made by your immune system] that makes you prone to blood clots). The admission MDS, dated [DATE], showed Resident 3 was cognitively intact and was taking antipsychotic (drugs used primarily to treat symptoms such as hallucinations and delusions), antidepressant, and anticoagulant (drugs that slow down the blood clotting process) medications. Record review of Resident 3's physician orders, dated 11/17/2025, showed Resident 3 was prescribed Lurasidone (an antipsychotic medication) 20 mg (milligrams) daily. Further review of Resident 3's physician orders showed the Lurasidone increased to 40 mg daily on 11/26/2025 and decreased back to 20 mg daily on 12/03/2025. The November 2025 and December 2025 Electronic Medication Administration Record (EMAR) showed Resident 3 was receiving Lurasidone daily. Record review of Resident 3's physician orders, dated 11/17/2025, documented Resident 3 was prescribed Apixaban (an anticoagulant) 5 mg twice daily. The November 2025 and December 2025 EMAR showed Resident 3 was receiving Apixaban twice daily. Record review of Resident 3's Electronic Health Record (EHR) provider notes, dated 12/03/2025, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented an additional diagnosis, .Generalized anxiety disorder [a mental health condition that causes fear, a constant feeling of being overwhelmed and excessive worry about everyday things] | Active | 12/03/2025. Record review of Resident 3's physician orders, dated 12/03/2025, documented Resident 3 was prescribed Clonazepam (a medication used to treat anxiety) 0.5 mg (milligrams) every 12 hours as needed. The December Electronic Medication Administration Record (EMAR) showed Resident 3 received Clonazepam on 12/06/2025 and 12/09/2025. Record review of Resident 3's physician orders, dated 12/04/2025, documented Resident 3 was prescribed Fluoxetine (a medication used to treat depression) 10 mg daily. The December 2025 Electronic EMAR showed Resident 3 received Fluoxetine 10 mg daily beginning 12/05/2025. Record Review of Resident 3's Comprehensive Care Plans, initiation dated 11/18/2025, did not show a Focus, Goal, or Intervention related to psychotropic medication (medications that affect the mind, emotions, and behavior) use. Record Review of Resident 3's Comprehensive Care Plans, initiation dated 11/10/2025, did not show a Focus, Goal, or Intervention related to Anxiety and/or anxiety diagnosis. Record Review of Resident 3's Comprehensive Care Plans, initiation dated 11/18/2025, did not show a Focus, Goal, or Intervention related to lupus anticoagulant syndrome and/or anticoagulant medication use. In an interview on 12/11/2025 at 3:05 PM, Staff F said there should be a care plan in place for residents taking anticoagulant medication and psychotropic medications, like an antidepressant, antianxiety, and antipsychotic. After looking at Resident 3's EHR, Staff F said she did not see any care plan addressing psychotropic medication use and there should have been. Staff F further said there was not a care plan for Resident 3's diagnosis of anxiety and there should have been. Staff said she did not see a care plan related to anticoagulation medication use and indicated there should have been. In an interview on 12/11/2025 at 4:09 PM, Staff B said it was his expectation residents on psychotropic medications had a care plan in place addressing the medication use and a diagnosis of anxiety. Staff B further said he expected there was a care plan in place for anticoagulation medication use. Dental/Communication Resident 6 was admitted to the facility on [DATE]. The Quarterly MDS dated , 11/23/2025, indicated Resident 6 was alert and oriented. In an interview on 12/08/2025 at 3:18 PM, Resident 6 indicated he had a partial upper denture plate and natural lower teeth. Record review of Resident 6's Electronic Health Record (EHR) showed no care plan indicating Resident 6 had a removable upper denture plate. In an interview on 12/09/2025 at 11:15 AM, Staff G, Nursing Assistant, said that the Kardex would (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	show items such as dentures/partials. Staff G was unable to locate information on the Kardex for Resident 6 indicating that he had a removable upper denture plate. Staff G said she was not aware that Resident 6 had partial teeth. In an interview on 12/11/2025 at 10:02 AM, Staff H, Registered Nurse and MDS Nurse said they completed the resident assessments on each resident, and the Resident Care Manager (RCM) was responsible to care plan anything specific to the residents. Staff H said she was not required to care plan findings from her assessments. In an interview on 12/11/2025 at 11:25 AM, Staff B said he would expect the care plan to indicate if patients had dentures or partial teeth. Communication In an interview on 12/08/2025 at 3:18 PM, Resident 6 indicated that he was hard of hearing (HOH) and asked for the speaker to come around to the left side of the bed so that he could hear better. Resident 6 said he had nerve damage to both ears from work around jet engines. Resident 6 stated that he had hearing aids at home but had not brought them into the facility. Record review of Resident 6's EHR showed no care plan indicating he was HOH or used any type of assistive device for communication. In an interview on 12/09/2025 at 11:15 AM, Staff G said the Kardex would show items such as hearing aids or devices. Staff G was unable to locate information on the Kardex for Resident 6 indicating a hearing deficiency or use of any type of communication device. Staff G said she thought that Resident 6 had trouble hearing because of the oxygen machine in his room. In an interview on 12/11/2025 at 10:02 AM, Staff H said they completed the resident assessments on each resident, and the RCM was responsible to care plan anything specific to the residents. Staff said she was not required to care plan findings from her assessments. In an interview on 12/11/2025 at 11:25 AM Staff B said he would expect the care plan to reflect hearing deficiencies and devices used for communication. Reference WAC 388-97-1020(1)(2)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure activities of daily living (ADLs) were provided for dependent residents for 3 of 4 sampled residents (Resident 8, 30 & 50) reviewed for ADL care. This failure placed residents at risk for poor hygiene, health complications and a diminished quality of life.Findings included .Resident 8 was admitted to the facility on [DATE]. The 5-Day Minimum Data Set, (MDS, an assessment tool), dated 11/10/2025, documented Resident 8 was alert and oriented. Record review of Resident 8's bathing record, dated 10/30/2025 to 12/09/2025, documented one shower was provided on 11/18/2025, eighteen days after being admitted . Record review of Resident 8's Electronic Health Record (EHR), did not document a shower refusal or a reason for a shower not being offered. during this period. During an interview on 12/09/2025 at 10:32 AM, Resident 8 said he did not remember the last time he received a shower. Resident 30 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 30 was alert and oriented. Record review of Resident 30's EHR, dated 11/10/2025 to 12/09/2025, documented no showers were provided during this time period. Record review of Resident 30's EHR, did not document a shower refusal or a reason for a shower not being offered during this period. During an interview on 12/08/2025, Resident 30 said she had only received four showers since being admitted . Resident 30 stated, They make a plan for a shower, then I don't get one. Resident 50 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 50 was moderately cognitively impaired. Record review of Resident 50's EHR, dated 11/22/2025 to 12/09/2025, documented one shower administered on 12/01/2025. Record review of Resident 50's EHR, did not document a shower refusal or a reason for a shower not being offered during this period. During an interview on 12/09/2025 at 8:50 AM, Resident 50 said it had been a while since she showered and would like a shower. During an interview on 12/11/2025 at 10:15 AM, Staff O, Certified Nursing Assistant, said residents were offered a shower twice a week. Staff O stated if residents refused showers, we try to reapproach, and track the refusals. Staff O was unable to confirm the last time residents 8, 30 and 50 showered.During an interview on 12/11/2025 at 1:22 PM, Staff B, Director of Nursing Services/Registered Nurse said residents were offered showers during their allotted time. Staff B was unable to produce documentation showing completed showers, and/or refusals. Reference WAC 388-97-1060 (2)(c)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to initiate bowel interventions for 1 of 7 residents (Resident 30) reviewed for bowel management and failed to obtain accurate weights for 3 of 9 residents (Resident 12, 41 & 50). This failure placed residents at risk for discomfort, experiencing health complications and a diminished quality of life.Findings included . Record review of the facility policy, titled, Bowel Protocol, revised February 2019, documented: At the beginning of each 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. The Licensed Nurse will review the residents' MAR (Medication Administration Record) to determine if the PRN [as needed] Bowel Protocol had been initiated by the previous shift. Bowel movements are charted every shift by the CNA. - Residents who have not had a bowel movement in three days, will be given Milk of Magnesia [laxative, a medication to help produce a bowel movement]. - If no bowel movement by the following shift, a Dulcolax suppository [laxative] is given. - If resident continues without a bowel movement by the next shift, a Fleets enema [laxative] will be given. Bowel Management Resident 30 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool) dated 11/10/2025, documented Resident 30 was alert and oriented. Record review of Resident 30's Bowel Movement (BM) task sheet, dated November- December 2025, showed documentation of Resident 30's BM activity on 11/11/2025 at 1:40 PM. Resident 30's next BM was documented on 11/18/2025 at 9:45 AM, approximately 164 hours since the last BM. Record review of Resident 30's BM task sheet, dated November- December 2025, showed documentation of Resident 30's BM activity on 11/18/2025 at 9:45 AM. Resident 30's next BM was documented on 11/22/2025 at 7:29 AM, approximately 93 hours since the last BM. Record review of Resident 30's BM task sheet, dated November- December 2025, showed documentation of Resident 30's BM activity on 11/23/2025 at 4:48 PM. Resident 30's next BM was documented on 12/03/2025 at 8:55 AM, approximately 243 hours since the last BM. Record review of Resident 30's Electronic Health Record (EHR), dated November- December 2025, did not show documentation of bowel interventions from 11/18/2025- 12/12/2025. In an interview on 12/11/2025 at 2:36 PM, Staff P, Registered Nurse, stated, Our expectation is to administer something on day 3. If not working, then Milk of Magnesia is the second choice. Staff P said the administration is then documented in the MAR. Staff P stated, this was not done. During an interview on 12/11/2025 at 1:22 PM, Staff B, Director of Nursing Services (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(DNS)/Registered Nurse said it was his expectation for staff to follow the Bowel Protocol per facility policy. Staff B was unable to produce documentation of successful bowel interventions for Resident 30. Weights Record review of the facility policy, entitled Weight monitoring and Documentation revision date 03/2025 documented: Weekly weights will be documented for a minimum of 4 weeks following admission and for residents at nutrition risk as determined by the dietitian and nutrition risk review. Resident 12 was admitted to the facility on [DATE] with multiple diagnoses to include Congestive Heart Failure (condition where the heart can't pump enough blood to meet the body's needs). The 5-day admission MDS, dated [DATE] indicated Resident 12 was moderately cognitively impaired. Record Review of Resident 12's EHR documented the following physician's order, dated 11/27/2025: One time a day for weights related to UNSPECIFIED SYSTOLIC (CONGESTIVE) HEART FAILURE (I50.20) for 4 Weeks. Record Review of Resident 12's EHR, showed 1 weight recorded since admission, on 11/28/2025. Resident 12's EHR did not show any additional documentation of weights being taken as ordered. Resident 50 was admitted to the facility on [DATE], with multiple diagnoses to include Congestive Heart Failure. The Quarterly MDS, dated [DATE], documented Resident 50 was mildly cognitively impaired. Record Review of Resident 50's EHR documented the following physician's orders, dated 09/12/2025: One time a day for weights related to UNSPECIFIED SYSTOLIC (CONGESTIVE) HEART FAILURE (I50.20) for 4 Weeks. Record Review of Resident 50's EHR documented the following physician's orders, dated 12/3/2025: Check weight daily and report to provider for > [greater than] 3lb [pounds] weight gain in 2 days or 5lb weight gain in 1 week. Record Review of Resident 50's EHR, showed one weight recorded since admission, on 11/24/2025. Resident 50's EHR did not show any additional documentation of weights being taken as ordered. In an interview on 12/10/2025 at 10:37 AM, Staff Q, Certified Nursing Assistant (CNA), said the Nursing Assistants do the weights. Staff Q stated, after we weigh, we put in the weight into the chart. In an interview on 12/10/2025 at 1:52 PM, Staff G, CNA, said the CNA's view a physical list of residents needing to be weighed. Staff G stated, We weigh the residents and put the number into the chart. During an interview on 12/11/2025 at 1:22 PM, Staff B, DNS, said it was his expectation for staff to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	weigh and document residents' weights as ordered. Resident 41 was admitted to the facility on [DATE] for rehabilitation services and wound care. The 5-day MDS, dated [DATE], indicated Resident 41 was alert and oriented. Record review of Resident 41's EHR showed one weight recorded on 11/19/2025. Record review of Resident 41's EHR showed a nutrition assessment dated [DATE], which documented Resident 41 was underweight and had a documented pressure ulcer. In an interview on 12/11/2025 at 2:30 PM with Staff J, Dietician, said she reviewed weights weekly at a nutrition at risk meeting they attend in person. Staff J said she would give the facility a list of weights needed on a flowsheet. Staff J said she would wait for the weights to be done and sent back to her. Staff J said she was only able to locate one weight in Resident 41's EHR. Staff J said that Resident 41 should have been weighed weekly since admission. Staff J said she did not have a flowsheet indicating the need for a weight to be obtained by staff from the weekly nutrition at risk meetings. In an interview on 12/11/2025 at 1:22 PM, Staff B said it was his expectation for staff to weigh and document residents' weights as ordered. WAC 388-97-1060(1)

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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** Based on interview and record review, the facility failed to obtain written consent prior to administering psychotropic medications (medications that affect the mind, emotions, and behavior) for 2 of 5 residents (Residents 3 & 4) reviewed for unnecessary medications. This failure placed residents at risk of not being informed of psychotropic medication risks and benefits and a decreased quality of life.Findings included . Record review of the facility's policy titled, Psychoactive Medications, undated, documented, 2. On admission the resident's medication regimen is reviewed for psychoactive medication orders. a. Prior to the administration of psychotropic medication, consent is obtained from the resident or resident representative. 4. The risks/benefits of the drug use and informed consent is obtained from resident/resident representative prior to administration of any psychoactive medication initiation or dose increase. Resident 3 was admitted to the facility on [DATE] with multiple diagnoses to include depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The admission MDS (Minimum Data Set, an assessment tool), dated 11/24/2025, showed Resident 3 was cognitively intact and was taking antidepressant medication. Record review of Resident 3's Electronic Health Record (EHR) provider notes, dated 12/03/2025, documented an additional diagnosis, .Generalized anxiety disorder [a mental health condition that causes fear, a constant feeling of being overwhelmed and excessive worry about everyday things] | Active | 12/03/2025. Record review of Resident 3's physician orders, dated 12/03/2025, documented Resident 3 was prescribed Clonazepam (a medication used to treat anxiety) 0.5 mg (milligrams) every 12 hours as needed. The December 2025 Electronic Medication Administration Record (EMAR) showed Resident 3 received Clonazepam on 12/06/2025 and 12/09/2025. Review of Resident 3's EHR did not show documentation of an informed consent completed for the administration of Clonazepam. Record review of Resident 3's physician orders, dated 12/04/2025, documented Resident 3 was prescribed Fluoxetine (a medication used to treat depression) 10 mg daily. The December 2025 Electronic EMAR showed Resident 3 received Fluoxetine 10 mg daily beginning 12/05/2025. Review of Resident 3's EHR INFORMED CONSENT - Psychoactive Medication, dated 12/09/2025, showed Resident 3 gave consent for Fluoxetine on 12/09/2025, four days after the medication was started. In an interview on 12/11/2025 at 3:05 PM, Staff F, Nurse Manager/Registered Nurse (RN), said an informed consent was needed prior to a resident starting a psychotropic medication. Staff F said Resident 3 did not have a consent for Fluoxetine completed when it started on 12/05/2025. Staff F said Resident 3 should have signed consent before he started taking the Fluoxetine. In an interview on 12/11/2025 at 4:09 PM, Staff B, Director of Nursing/RN, said it was his expectation residents on psychotropic medications have consents signed prior to administration of the medication. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/12/2025 at 9:22 AM, Staff B said a consent was not completed for Resident 3's Clonazepam and there should have been. Resident 4 Resident 4 was admitted to the facility on [DATE], with multiple diagnoses to include borderline personality disorder (a mental health condition). The Quarterly MDS, dated [DATE], showed Resident 4 was alert and oriented. Record review of Resident 4's physician's order for psychotropic medication, dated 12/18/2024, showed Cariprazine HCl [hydrochloride salt] Oral Capsule 3 MG [milligram]. Give 3 mg by mouth at bedtime for clear thoughts. related to BORDERLINE PERSONALITY DISORDER (F60.3). Record review of Resident 4's EHR did not show a psychotropic medication informed consent form completed prior to administration of cariprazine. Record review of Resident 4's EHR showed a signed consent form titled, *INFORMED CONSENT - Psychoactive Medication - V 4.0, dated 06/23/2025, 6 months after cariprazine was initiated. In an interview on 12/11/2025 at 3:26 PM, when asked if Resident 4 had a signed consent for cariprazine, Staff B reviewed Resident 4's EHR but was unable to locate an informed consent for when the cariprazine was started on 12/18/2025. Staff B said it was the expectation that an informed consent for the psychotropic medication was signed prior to the medication being administered. Reference WAC 388-97-0260

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observations, interviews, and record reviews, the facility failed to ensure adequate living space was available for 1 of 3 residents (Resident 41) reviewed for accommodation of needs/preferences. This failure placed residents at risk of restricted mobility and potential for a decreased quality of life.Findings included.Resident 41 was admitted to the facility on [DATE] for rehabilitation services. The 5-day Minimum Data Set, an assessment tool, dated 11/18/2025, indicated Resident 41 was cognitively intact.In an interview on 12/08/2025 at 11:16 AM, Resident 69 said that he gets tired of his roommate (Resident 41) backing his wheelchair into his bed when trying to open the room door to leave. Resident 69 said that the room is too small for 3 patients in wheelchairs.During an observation on 12/08/2025 at 11:35 AM, Resident 41 was attempting to transfer from his bed into his wheelchair. Resident 41 was unable to move the wheelchair closer to his bed due to his tray table obstructing the path. Resident 41 turned on his call light to have staff move the table so he could transfer into the wheelchair. Resident 41 then demonstrated how difficult it was to get out of his room. Resident 41 backed his wheelchair into the room's door to close it. Resident 41 was then able to roll out from between the bed and the wall which was obstructed by the open door. Resident 41 said it is extremely difficult to navigate the room because of how the room is arranged.In an observation and interview, on 12/11/2025 at 11:15AM, Staff B, Director of Nursing, looked at Resident 41's room and said it did look cramped and probably could be set up better. WAC 388-97-0860(2)

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	505341	A. Building B. Wing	12/12/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and interview, the facility failed to ensure residents' medical information was maintained in a manner to ensure privacy and confidentiality when staff failed to properly secure the Electronic Health Record (EHR) for 1 of 4 medication cart computers (Number Two medication cart) reviewed for privacy and confidentiality. This failure placed residents at risk for loss of confidential medical information and a diminished quality of life.Findings included.In an observation and interview on 12/10/2025 at 2:43 PM, in the Expressions dining room, the Number Two medication cart computer screen was observed open and unlocked displaying the Point Click Care (PCC, a healthcare software platform, offering an EHR to manage clinical, financial, and operational aspects) access page logged in. No nursing and/or facility staff were observed within view of the medication cart and computer. A resident was observed sitting alone in the dining room six feet away from the medication cart and computer. A visitor was observed to walk into the Expressions dining room while the computer was unlocked, and no staff were present. After 1 minute, Staff D, Licensed Practical Nurse, and Staff E, Registered Nurse (RN), entered the Expressions dining room. When asked about the computer on top of the Number Two medication cart open and unlocked to PCC access without staff in view, Staff E said the computer should have been locked. Staff D nodded his head yes and said the computer should have been locked. Staff E stepped over and locked the computer screen. In an interview on 12/10/2025 at 2:50 PM, Staff C, Director of Clinical Services/RN, said it was her expectation computer screens were covered, minimized, or locked when no staff were present so no one could access resident's medical records. In an interview on 12/10/2025 at 2:55 PM, Staff B, Director of Nursing/RN, said a computer screen should be locked when no nurse was present.Reference WAC 388-97-0360 (1) (2)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility 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 [drugs used primarily to treat symptoms such as hallucinations and delusions]) for 2 of 5 sampled residents (Resident 3 & 4) reviewed for unnecessary medications. This failure placed residents at risk for adverse medication side-effects, medical complications, and a diminished quality of life.Findings included. Review of the facility's policy titled, Psychotropic Medications [drugs that affect a person's thoughts, emotions, and behaviors] – AIMS, revised March 2019, documented, .1. Licensed staff will assess all residents receiving antipsychotic medications and Reglan [a medication that carries a risk of developing severe movement disorders] at a minimum: On admission Prior to initiation of a new antipsychotic or Reglan Every 6 months while receiving the medication . Resident 3 was admitted to the facility on [DATE] with multiple diagnoses to include depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The admission MDS (Minimum Data Set, an assessment tool), dated 11/24/2025, showed Resident 3 was cognitively intact and was taking antipsychotic medication. Record review of Resident 3's physician orders, dated 11/17/2025, showed Resident 3 was prescribed Lurasidone (an antipsychotic medication) 20 mg (milligrams) daily. Further review of Resident 3's physician orders showed the Lurasidone increased to 40 mg daily on 11/26/2025 and decreased back to 20 mg daily on 12/03/2025. The November 2025 and December 2025 Electronic Medication Administration Record (EMAR) showed Resident 3 was receiving Lurasidone daily. Review of Resident 3's Electronic Health Record (EHR) did not show documentation of an AIMS test completed for the administration of Lurasidone. In an email (electronic mail) on 12/11/2025 at 2:19 PM, Staff A, Administrator, said it did not appear there was an AIMS test completed for Resident 3. In an interview on 12/11/2025 at 3:05 PM, Staff F, Nurse Manager/Registered Nurse (RN), said an AIMS test was not done prior to the administration of Resident 3's Lurasidone and there should have been. Staff F said she just learned about the AIMS test and did not know it was supposed to be done. In an interview on 12/11/2025 at 4:09 PM, Staff B, Director of Nursing/RN, said it was his expectation an AIMS test was completed for residents taking antipsychotic medications. Resident 4 Resident 4 was admitted to the facility on [DATE], with multiple diagnoses to include borderline (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	personality disorder (a mental health condition). The Quarterly MDS, dated [DATE], showed Resident 4 was alert and oriented. Record review of Resident 4's physician's order for psychotropic medication, dated 12/18/2024, showed Cariprazine HCl [hydrochloride salt] Oral Capsule 3 MG [milligram]. Give 3 mg by mouth at bedtime for clear thoughts. related to BORDERLINE PERSONALITY DISORDER (F60.3). Record review of Resident 4's EHR shows an AIMS test titled B. ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS) - V 2.1 completion date of 03/28/2025, 6 months after cariprazine was started. In an interview on 12/11/2025 at 3:26 PM, Staff B said AIMS tests were completed for residents on antipsychotics on admission and every 6 months. When asked if an AIMS test was completed for Resident 4, Staff B reviewed Resident 4's EHR and said the first documented AIMS test was completed on 03/28/2025. Staff B said the AIMS test was not done on admission, and it should have been. Reference WAC 388-97-1060(3)(k)(i)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide a written bed hold notice (a way for the resident to reserve their bed when away from the facility) at the time of transfer or within 24 hours for 1 of 1 sampled residents (Resident 77) reviewed for hospitalization. This failure placed the residents at risk for not being informed of their right to hold their bed while in the hospital, protection of resident rights during transfer, and decreased quality of life.Findings included .Record Review of the facility's Bed Hold Policy and Procedure, dated 08/01/2024, documented, The resident and/or resident representative is 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 is provided within 24 hours. It also said, . If nursing is unable to provide notification at time of transfer or discharge the Social Services Director or designee contacts the resident and/or resident representative to notify them of facility policy and obtain a decision.Record review of Resident 77's admission Minimum Data Set (MDS- an assessment tool), dated 08/18/2025, documented Resident 77 was admitted on [DATE] and assessed as alert and oriented.Record review of Resident 77's Progress Notes, dated 09/22/2025, stated, .Due to decreased O2 stats [oxygen saturation] and no orders for breathing treatments res [resident] sent out via 911 EMTs. 0210 [by emergency transport at 2:10 am].Record Review of Resident 77's Electronic Medical Records showed no documentation of a written Bed Hold Notice at the time of transfer or within 24 hours.Record Review of Resident 77's Nursing Home Discharge MDS, dated [DATE], documented Resident 77 had an unplanned discharge on [DATE] with return anticipated.In an email correspondence on 12/10/2025 at 4:15 PM, Staff A, Administrator, stated, As for [Resident 77's] bed hold, we looked but it appears that one was missed.In a joint interview on 12/12/2025 at 11:15 AM, Staff B, Director of Nursing/Registered Nurse (RN) and Staff F, Nurse Manger/RN, said when a resident was transferred to the hospital they should be sent with a bed hold form that included the cost to hold their bed and the resident's decision. Staff B and Staff F said if a resident was transferred to the hospital emergently, the manager and/or Social Services would take care of the bed hold form the next day. Reference WAC 388-97-0120 (4)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to accurately assess oral care status and communication needs for 1 of 20 residents (Resident 6) reviewed for accuracy of assessments. This failure placed residents at risk of having unmet needs, ineffective communication and a diminished quality of life. Findings included .Resident 6 was admitted to the facility on [DATE] after a hospitalization. The Quarterly Minimum Data Set (MDS), an assessment tool, dated 11/23/2025, indicated Resident 6 was alert and oriented and had no oral care devices or concerns; and indicated no hearing impairment or devices.In an interview on 12/08/2025 at 3:18 PM, Resident 6 indicated he had an upper partial denture plate that needed repair. Resident 6 said he had natural lower teeth.In an interview on 12/11/2025 at 10:02 AM, Staff H, Registered Nurse/MDS Nurse, said she did not think Resident 6 had teeth. Staff H said she does a face-to-face interview with the residents during their assessment. Staff H said she had completed the assessment and incorrectly coded the MDS.Communication In an interview on 12/08/2025 at 3:18 PM, Resident 6 indicated that he was hard of hearing (HOH) and asked for the speaker to come around to the left side of the bed so that he could hear better. Resident 6 said he had nerve damage to both ears from work around jet engines. Resident 6 stated he had hearing aids at home but had not brought them into the facility. Record review of Resident 6's electronic health record, dated 05/20/2025, showed a diagnosis of hearing loss in both ears.In an interview on 12/11/2025 at 10:02 AM, Staff H said she did not think Resident 6 had a hearing deficiency. Staff H said she tended to talk loud and maybe did not notice the hearing deficiency. Staff H said they were aware Resident 6 used a hearing amplifier device at times to communicate. Staff H said she had completed the assessment and incorrectly coded the MDS.In an interview on 12/11/2025 at 11:25 AM Staff B, Director of Nursing/Registered Nurse, said he would expect the MDS assessment to be accurate and reflect the specific needs of the residents. Reference WAC 388-97-1000(1)(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident care plans were reviewed, revised, and accurately reflected residents' care needs for 1 of 20 residents (Resident 30) whose care plans were reviewed. These failures placed residents at risk for unidentified/ unmet care needs and a diminished quality of life.Findings included .Resident 30 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool) dated 11/10/2025, documented Resident 30 was alert and oriented. Review of Resident 30's physician's order, dated 09/17/2025, documented Resident 30 was using a BiPAP [Bilevel Positive Airway Pressure, Non-invasive ventilation used for breathing support]. Review of Resident 30's comprehensive care plan, initiated 09/17/2025, showed no care plan was developed to address Resident 30's BiPap. During an interview on 12/12/2025 at 12:22 PM, Staff R, Resident Care Manage/Registered Nurse, said residents can bring their own medical equipment, which was assessed for residents' use and care planned. Staff R stated, Her care plan was never changed from cPAP [Continuous Positive Airway Pressure, Non-invasive ventilation used for breathing support] to BiPap. That would not be best practice. During an interview on 12/12/2025 at 1:22 PM, Staff B, Director of Nursing Services/ Registered Nurse said Resident 30's biPap should have been care planned. Reference WAC 388-97-1020(2)(c)(d)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide resident centered activities incorporating the resident's preferences for 3 of 3 sampled resident (Resident 7, 14 & 62) reviewed for activities. This failure placed residents at risk of unmet needs and a decreased quality of life.Findings included.Record review of facility's policy, titled, Activity Programs, revised June 2018, documented, .2. Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident.Record review of facility's activities calendars from September 2024 through December 2025 did not show any resident bus outings.Resident 7Resident 7 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 11/14/2025, documented Resident 7 was alert and oriented.In an interview on 12/08/2025 at 11:35 AM, when asked about activities she enjoyed, Resident 7 stated, there is a bus, and they don't use it. Would be nice to just get out. Resident 7 said the facility had not offered opportunities to go out into the community. Resident 14Resident 14 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 14 was alert and oriented. Record review of Resident 14's care plan, dated 09/10/2025, documented, .Activities: Resident 14 enjoys Bingo, reading on her tablet, cards, family visits, word-search and crossword puzzles, listening to Old Country music, pet visits, trips/outings, walking and watching Old Shows and action on TV. Alert and orient .In an interview on 12/08/2025 at 3:21 PM, when asked what activities the facility offered, Resident 14 stated we used to get a bus ride to the park, but it has been a year. Resident 62Resident 62 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 62 was alert and oriented.In an interview on 12/10/2025 at 9:15 AM, Resident 62 stated, we used to go for outings, sometimes to the lake but not anymore. In an interview on 12/11/2025 at 10:20 AM, when asked if the facility offered and/or provided residents opportunity to go out into the community, Staff N, Activities Director, said there had not been outings on the activities calendar since September 2024. Staff N said that after the new company took over, the bus previously used was being used by the Oregon facilities. In an interview on 12/11/2025 at 3:59 PM, Staff A, Administrator said the bus that was in use under the previous facility owner was being used by sister facility in Portland.Reference WAC 388-97-0940(1)(2)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain a Bed Rail/Bed Enabler and Device Consent and Evaluation for 1 of 4 sampled residents (Resident 1) reviewed for accidents. This failure placed residents at risk of injury, unmet needs, and a diminished quality of life.Findings included. Record review of the facility's policy, titled, Physical Restraints and Enablers/Devices, date revised July 2023, documented, .a. Devices may include but are not limited to the following: i. Bed rails (quarter, 1/2, 3/4 full) .5. The resident and/or resident representative is provided risks/benefits of restraint use or enabler/device use, and consent obtained prior to implementation of the device.6. The care plan is updated for the device use with the goal for the least restrictive measures. The Kardex is updated to identify restraint or enabler use and identifies other interventions put into place addressing the medical symptoms, environmental, safety, and psychosocial concerns. Resident 1 was admitted to the facility on [DATE]. The admission Minimum Data Set (an assessment tool), dated 11/14/2025, showed Resident 1 was cognitively intact. In an observation and interview on 12/09/2025 at 9:20 AM, Resident 1's bed was observed with a one quarter length bed rail on the upper left side of bed. Resident 1 said he did not remember anyone talking to him about the bed rail. In an observation on 12/09/2025 at 2:05 PM, Resident 1 was observed lying in bed with a one quarter length bed rail on the upper left side of the bed. In an observation on 12/10/2025 at 9:15 AM, Resident ?s 1 bed was observed with a one quarter length bed rail on the upper left side of the bed. In an interview on 12/10/2025 at 10:34 AM, Resident 1 said no one talked to him about putting a bed rail on his bed. Resident 1 said the bed rail was on the bed when he was admitted . Review of Resident 1's Electronic Health Record (EHR) showed no Bed Rail/Bed Enabler and Device Consent and Evaluation related to bed rails was completed. Record Review of Resident 1's Comprehensive Care Plans, initiation dated 11/10/2025, did not show a Focus, Goal, or Intervention related to a bed rail. In an interview on 12/10/2025 at 11:14 AM, Staff F, Nurse Manager/Registered Nurse (RN), said for residents that used assistive devices like bed rails, they needed to have an evaluation and consent, and care plan in place. After looking at Resident 1's EHR, Staff F said she did not see an evaluation, consent, or a care plan for Resident 1's bed rail and there should have been. In an interview on 12/10/2025 at 1:18 PM, Staff B, Director of Nursing/RN, said it was his expectation an evaluation, consent, order, and care plan was in place for bed rails on a resident's bed. Reference WAC 388-97-0260

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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 routine pain medication was acquired timely for 1 of 6 residents (Resident 53) reviewed for pain management. This failure placed residents at risk for increased pain and diminished quality of life. Findings included .Resident 53 was admitted to the facility on [DATE] with diagnosis including chronic pain. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 11/12/2025, documented Resident 53 was alert and oriented and was almost constantly in pain which occasionally interfered with her day-to-day activities.Record review of Resident 53's physician order, dated 10/02/2025, showed Buprenorphine Transdermal Patch [pain medication] Weekly 20 MCG/HR [micrograms/hour] (Buprenorphine) Apply 1 patch transdermally in the evening every Thu [Thursday] for chronic pain and remove per schedule.Record review of Resident 53's electronic medication administration record (EMAR) did not show Buprenorphine transdermal patch was administered on Thursday December 4th, 2025, as scheduled. In an interview on 12/09/2025 at 10:02 AM, Resident 53 said she did not receive her Buprenorphine pain patch the previous week (12/04/2025) and had not received it since. Resident 53 rated her pain at 10/10 at the time of the interview. In an interview on 12/10/2025 at 2:44, Staff L, Registered Nurse (RN), said if a medication was not available in the cart, the nurse would pull it out of Omnicell (medication dispenser) or call the pharmacy to have it delivered immediately. Staff L said the missed medication would be documented in the EMAR and the oncoming nurse would be made aware to follow-up on its delivery. In an interview on 12/10/2025 at 3:14 PM, Staff B, Director of Nursing/RN, reviewed Resident 53's 12/04/2025 EMAR and said Buprenorphine was not signed off as administered. Staff B said it was his expectation that if a medication was not available, the EMAR was signed off, the provider notified and staff coordinated with pharmacy to have the medication delivered. Reference WAC 388-97-1300(1)(a)

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer medications as directed by the physician's orders for 2 of 5 residents (Resident 4 & 32) reviewed for unnecessary medications. This failure placed residents at risk for increased side effects and a diminished quality of life.Findings included. Resident 4 Resident 4 was admitted to the facility on [DATE], with multiple diagnoses to include Type 2 Diabetes Mellitus with Hyperglycemia (condition where the body either doesn't make enough insulin or can't use insulin properly). The Quarterly Minimum Data Set (MDS, an assessment tool), dated 09/19/2025, showed Resident 4 was alert and oriented. Record Review of Resident 4's physician order, dated 11/13/2025, showed Insulin Glargine Subcutaneous Solution 100 UNIT/ML [milliliter] (Insulin Glargine) Inject 17 unit subcutaneously in the morning related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65) HOLD FOR BG< [blood glucose less than] 100. Record review of Resident 4's December 2025 electronic medication administration record (EMAR) showed Resident 4 received Insulin glargine on 12/07/2025 with 82 BG,12/08/2025 with 82 BG, and 12/09/2025 with 86 BG. In an interview on 12/11/2025 at 3:26 PM, Staff B, Director of Nursing and Registered Nurse (RN), Reviewed Resident 4's insulin order and December 2025 EMAR and said insulin was administered on 12/07/2025, 12/08/2025 and 12/09/2025 outside the order parameters to hold the medication. Staff B said it was his expectation that staff held the medication and notified the provider. Resident 32 Resident 32 was admitted to the facility on [DATE] after hospitalization. The Quarterly MDS, dated [DATE], indicated Resident 32 was alert and oriented. Record review of Resident 32's EHR showed a physician order, dated, 07/30/2025, for oxycodone (narcotic pain medication) to be administered between the hours of 9:00 PM and 6:00 AM for pain not relieved by scheduled medication. Resident 32's Medication Administration Record (MAR) showed oxycodone given on 12/01/2025 at 10:48 AM, 12/08/2025 at 2:25 PM, and 12/09/2025 at 12:53 PM which was outside of the physician's time parameters. In an interview on 12/11/2025 at 3:45 PM, Staff I, Registered Nurse/Resident Care Manager said the order indicated oxycodone should only be administered between the hours permitted in the order. Staff I said the nurses must not have been reading the entire order for the directions. In an interview on 12/12/2025 at 11:34 AM with Staff B said he was not aware of the medication administration discrepancy in Resident 32's MAR. Staff B said he would expect the nurses to follow the physicians' orders. Reference WAC 388-97-1060(3)(k)(i)

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	12/12/2025

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 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. Based on observation and interview, the facility failed to secure medications in 1 of 4 sampled medication carts (Number Two medication cart) reviewed for medication storage. This failure placed residents at risk of misappropriation of medication and a diminished quality of life. Findings included .In an observation and interview on 12/10/2025 at 2:43 PM, the Number Two medication cart was observed in the Expressions dining room unlocked. No nursing and/or facility staff were observed within view of the medication cart. The drawers of the unlocked medication cart were able to be opened, with access to multiple bottles of medicine and residents' prescription medications. A resident was observed sitting alone in the dining room six feet away from the unlocked medication cart. A visitor was observed to walk into the Expressions dining room while cart was unlocked, and no staff were present. After 1 minute, Staff D, Licensed Practical Nurse, and Staff E, Registered Nurse (RN), entered the Expressions dining room. When asked what their practice was for locking a medication cart when the cart was not in view, Staff D said the cart should have been locked and it was not. Staff D said they were changing nursing shifts. When asked who had the keys to the unlocked medication cart, Staff D jingled the keys and said he did. Staff E said the cart should have been locked when they stepped away from the cart. In an interview on 12/10/2025 at 2:50 PM, Staff C, Director of Clinical Services/RN, said it was her expectation medication carts were kept locked when no staff were present and within view of a medication cart. In an interview on 12/10/2025 at 2:55 PM, Staff B, Director of Nursing/RN, said a medication cart should be locked when no nurse was present.Reference WAC 388-97-1300 (2)