STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Cascade Living Group - Shelton, LLC
Alpine Way Retirement Apartments
900 W Alpine Way
Shelton, WA 98584

RE: Alpine Way Retirement Apartments License # 2141

Dear Administrator:

This letter addresses Compliance Determination(s) 46701 (Completion Date 09/05/2024) and 40253 (Completion Date 04/25/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/05/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2120, WAC 388-78A-2120-2, WAC 388-78A-2120-2-a, WAC 388-78A-2120-3, WAC 388-78A-2120-3-a, WAC 388-78A-2120-4, WAC 388-78A-2660, WAC 388-78A-2660-1, WAC 388-78A-2660-2, WAC 388-78A-2660-3, WAC 388-78A-2660-4

The Department staff who did the on-site verification:
Paul Aube, ALF NCI

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Manfay Chan, Field Manager
Region 3, Unit E
Residential Care Services

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: Alpine Way Retirement Apartments
License/Cert.#: 2141
Compliance Determination #: 40253
Investigator: Paul Aube
Investigation Date(s): 04/24/2024 through 04/25/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 128055
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

Restraints/Seclusion - General: Facility report of a resident allegation of abuse from staff, including physically restraining the resident.

Investigation Methods:

Sample:	Total residents: 80 Resident sample size: 1 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions Dining
Interviews:	Identified resident Nursing staff Management
Record Reviews:	Facility policies Staff Personnel Files Staff Training Records Incident Report and Investigation Care Plans Progress Notes/Alert Charting

Investigation Summary:

Restraints/Seclusion - General: Facility suspended employee pending investigation. Facility investigated incident, and unsubstantiated claims of abuse made by resident. However, review of multiple staff statements, and review of progress notes showed resident was physically restrained by staff during care. Facility also failed to monitor the resident for psychological harm and document monitoring in the resident record after incident. Failed Practice Identified.

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Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 2141	Compliance Determination # 40253
Plan of Correction	Alpine Way Retirement Apartments	Completion Date
Page 1 of 8	Licensee: Cascade Living Group - Shelton, LLC	04/25/2024

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 04/24/2024 and 04/24/2024 of:

Alpine Way Retirement Apartments
900 W Alpine Way
Shelton, WA 98584

This document references the following complaint number(s): 128055

The following sample was selected for review during the unannounced on-site visit: 1 of 80 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Cory Cisneros
Residential Care Services

05/08/2024
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

This document was prepared by Residential Care Services for the Locator website.

Trudy Hunter
Administrator (or Representative)

5/8/2024
Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to identify changes in condition and evaluate the need for further action after a resident experienced abuse for 1 of 1 resident (Resident 1 [R1]) reviewed. This failure resulted in R1 not being monitored for his emotional distress after an incident, and placed R1 at risk for further distress, unidentified care needs, and decreased quality of life.

Findings included...

Review of a facility policy titled, "Abuse & Neglect", dated 09/2017, stated, "The Executive Director or designee investigates all cases of alleged/suspected abuse or neglect All associates are educated on abuse and neglect Any associate hearing or witnessing any abandonment, abuse or neglect in the community, and has reasonable cause to believe the incident is reportable, must report, without fear of reprisal..."

Review of a facility policy titled, "Incident/Accident Management", dated 09/2011, stated, "For Resident Events: To assess the resident status, Wellness Notes will be written as indicated."

In an interview on 04/25/2024 at 9:51AM, Staff A, the Executive Director, was asked what types of things residents were placed on alert (Wellness Notes) for. Staff A stated, "Resident-to-resident incidents, new move-ins, falls, other injuries such as skin tears, new medications, room moves, deaths in family, other significant life events." Staff A was asked if residents were placed on alert after an allegation of abuse. Staff A stated, "Yes, a resident would be placed on alert for allegations of abuse." Staff A was asked what staff were instructed to monitor the resident for and document for allegations of abuse. Staff A stated, "Verbal and non-verbal signs and symptoms of distress, change in mood, changes

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Administrator (or Representative) Date

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in behavior." Staff A was asked how long residents were placed on alert, and how often staff were required to document in the resident record. Staff A stated, "A minimum of 72-hours or until resolved. Staff are required to document every shift."

In an interview on 04/24/2024 at 11:39AM, Staff E, the facility Nurse, was asked what they would do if a resident reported to them an allegation of abuse from staff. Staff E stated, "If resident reports abuse, first I go to resident and see what happened. Talk to them. Make a chart note about it. Inform the DON [Director of Nursing] and the ED [Executive Director]. We have an incident report that we fill out. We fax the doctor and call the family. We do a head-to-toe assessment and put the resident on alert for 72 hours." Staff E was asked how long, and often the alert charting would be completed. Staff D stated, "It is a minimum of 72-hours, and it is charted on every shift."

Review of R1's Face Sheet showed that R1 was admitted to the facility on [redacted]/2024.

Review of an Incident/Accident Report for R1, dated 04/23/2024 at 7:00AM, stated, "Resident reported to AM caregiver that, 'That guy was pulling and ripping on my underwear, so I kicked at him, and he started hitting me.' Resident reported to AM caregiver that he wanted a shower but 'I am worried that guy will come back.'"

Review of the "Alleged Abuse Investigation Summary" for R1 for the incident on 04/23/2024, stated, "After the 2 staff went into the room to change [R1] who had been incontinent. Everything was fine while they removed [their] bedding and pants. When they started removing [R1's] brief, [R1] started kicking. [R1] was soaked with urine so one [caregiver] held onto [R1's] legs while the other removed the soiled brief. When they tried to place a dry one, [R1] punched one staff in the shoulder, at which point a staff held [R1's] arms only long enough to secure the brief and they left the room." Under the section titled, "Summarize interviews, investigation, and preventative measures" it stated, "Nightshift aide called, placed on suspension, and interview appointment set up. Nightshift aide came in for interview, entire event was witnessed by a second aide (Caregiver). Wrote a statement. Interview scheduled with second aide."

Review of an undated witness statement for Staff C, a Caregiver, it stated, "April 23 about 0430. While trying to change [R1] me and [Staff D, another Caregiver] told [R1] [they] were wet, and we needed to change [them]. [Staff D] grabbed [R1's] supplies while I removed [their] pants. There were no issues while taking off [R1's] pants. When [R1's] brief on once side was torn, [R1] became aggressive and tried to kick me. [Staff D] came over to start putting the new brief on, while I controlled [R1's] legs. I moved closer towards [R1's] upper body so [Staff D] could get [R1's] brief on. When I moved up, [R1] attempted to punch me. I grabbed [R1's] arm by his wrist and held it above [their] head and grabbed [their] other arm as well. [R1] squeezed [their] legs together to prevent [Staff D] from getting [their] brief all the way on. After a minute or so, [R1] calmed down. [R1] asked me to get off [them]. I replied, 'I will let you go if you do not try to hit me.' [R1] never answered that. [R1] just asked me to get off [them]. I slowly moved back and let go of both [of R1's] wrists."

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During an interview with R1 on 04/24/2024 at 11:28AM, R1 was asked if they remembered an altercation with a staff person recently. R1 stated, "Yeah, they just forced me down." R1 was asked what happened. R1 stated, "Yea they hit me. They hit me in the back of the head." R1 was asked how this made them feel. R1 stated, "I was scared, I wanted to avoid anything that was causing a problem." R1 was asked if they recalled not wanting to shower that evening. R1 stated, "I was worried that man was going to be there."

Review of Progress Notes for R1, dated 04/23/2024 at 11:22AM, it stated, "AM caregiver reported to this nurse that [they] received report from [Staff C] stating that resident was combative with care and kicking caregiver. AM caregiver states when [they] entered resident's room, [R1] was crying and stated, 'Is that guy gone?' AM caregiver asked resident if [they] were ok. Resident stated, 'That guy was pulling on and ripping my underwear, so I kicked at him, and he started hitting me.' Resident stated [they] wanted a shower but didn't want a shower in the evening because "I'm worried that guy will come back." AM caregiver comforted resident and asked if [R1] would like [them] to complete [their] shower. AM caregiver came to report to this nurse and this nurse completed head to toe assessment during resident's shower. Bruise noted to left side of face 3cm x 2cm. Wellness Director notified, Executive Director Notified, PCP (Primary Care Provider) notified... Monitor in place, alert 72-hours." This note addressed R1's bruise but did not address R1's psychosocial wellbeing related to the incident. Further review of R1's progress notes showed there was no alert charting in the resident record documenting monitoring of the resident for symptoms of distress, changes in mood, or changes in behavior, nor any documentation of actions taken after the facility became aware of the allegation.

This was a previous consultation on 11/03/2022 for subsections (2)(3).

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Alpine Way Retirement Apartments is or will be in compliance with this law and / or regulation on (Date) 6/6/2024.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Tracy Hunter — Administrator (or Representative)

5/9/24 — Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(3) Not use restraints on any resident;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129

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During an interview with R1 on 04/24/2024 at 11:23AM, R1 was asked if they remembered an altercation with a staff person recently. R1 stated, "Yeah, they just forced me down." R1 was asked what happened. R1 stated, "Yea they hit me. They hit me in the back of the head." R1 was asked how this made them feel. R1 stated, "I was scared. I wanted to avoid anything that was causing a problem." R1 was asked if they recalled not wanting to shower that evening. R1 stated, "I was worried that man was going to be there."

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Administrator (or Representative) Date

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RCW;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff did not restrain a resident for 1 of 1 resident (Resident 1, [R1]) reviewed. This failure resulted in R1 experiencing fear and distress due to being restrained, and placed the resident at risk for injury, and decreased quality of life.

Findings included...

WAC 388-78A-2020 Definitions. "'Abuse' means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult, which have the following meanings... 'Restraint' means any method or device used to prevent or limit free body movement... "

RCW 70.129.120 Restraints-Physical or chemical. "The resident has the right to be free from physical restraint or chemical restraint. This section does not require or prohibit facility staff from reviewing the judgment of the resident's physician in prescribing psychopharmacologic medications."

Review of a facility policy titled, "Abuse & Neglect", last reviewed on 09/2017, stated, "ABUSE is the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a resident. In instances of abuse of a resident who is unable to express or demonstrate physical harm, pain or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation of a resident, which has the following meanings... PHYSICAL ABUSE is the willful act of inflicting bodily injury or physical mistreatment. This includes but is not limited to striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints unless the restraints are consistent with licensing requirements."

Review of R1's Face Sheet showed that R1 was admitted to the facility on [redacted]/2024.

Review of R1's Negotiated Service Agreement, which was signed by a facility representative on 03/28/2024, and R1's representative on 04/05/2024, showed under the "Cognitive/Behavioral Support/Mental Health" section, "Resident can make decisions about needs, preferences, and routine but requires assistance with formal decision making... Resident has episodes of resisting ADL's [Activities of Daily Living], asking resident questions, crowded areas. Redirect, distract, or validate using the following interventions: 2 Staff assist with all care, offer snacks, offer to call [family] to talk to [them]

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.... Walk away and reapproach."

Review of an Incident/Accident Report for R1, dated 04/23/2024 at 7:00AM, stated, "Resident reported to AM caregiver that, 'That guy was pulling and ripping on my underwear, so I kicked at him, and he started hitting me.' Resident reported to AM caregiver that he wanted a shower but 'I am worried that guy will come back.'"

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Review of Staff C's personnel file showed receipt and acknowledgement via signature of facility policy titled "Abuse & Neglect" on 03/31/2023.

Review of an undated witness statement for Staff D stated, "At 4:15AM I and [Staff C] entered R1's room. [R1] was sleeping in [their] bed. We woke [R1] up. When [R1] woke up [they] [were] calm, and we explain [to them] that we are going to check [their] brief. [Staff C] was taking off [R1's] pants. I was standing next to [R1's] bed. After [Staff C] took off [R1's] pants, [R1] got angry and started kicking and hitting with [their] hands. [Staff C] grabbed [R1's] hands so [R1] didn't hit us. I removed [R1's] brief. It was very difficult to remove it because [R1's] legs were closed very tightly. After finishing, [R1] said that [Staff C] already killed him. We explained to [R1] that we do not want to hurt [them]. Then [R1] yelled at us and told us to get out of [their] room."

Review of Staff D's personnel file showed receipt and acknowledgement via signature of

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facility policy titled "Abuse & Neglect" on 07/21/2023.

Review of R1's Progress Notes, dated 04/23/2024 at 11:22AM, stated, "AM caregiver reported to this nurse that [they] received report from [Staff C] stating that resident was combative with care and kicking caregiver. AM caregiver states when [they] entered resident's room, [R1] was crying and stated, 'Is that guy gone?' AM caregiver asked resident if [they] were ok. Resident stated, 'That guy was pulling on and ripping my underwear, so I kicked at him, and he started hitting me.' Resident stated [they] wanted a shower but didn't want a shower in the evening because 'I'm worried that guy will come back.'"

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In an interview on 04/24/2024 at 8:50AM, Staff B, the Wellness Director, was asked if the investigation into the incident and allegation of abuse of R1 was complete. Staff B stated, "The investigation is done. [Staff C] is suspended, [they] did not work last night." Staff B stated that they spoke with both Staff C and Staff D and stated that per Staff D's statement that "[Staff D] corroborated what [Staff C] told me." Staff B stated, "I believe what they are telling me, and we will let [Staff C] come back to work with some education." Staff B was asked if they were aware that physically restraining a resident against their will was considered abuse. Staff B gave no response.

Review of Department Records showed a report made by the facility on 04/23/2024 of an allegation of abuse made by R1, about Staff C. In this report, Staff B stated they were "confident no abuse occurred."

During an interview with Staff B on 04/24/2024 at 12:22PM, Staff B was asked how and why they ruled out abuse in their investigation when Staff C and Staff D both confirmed that they restrained the resident during care. Staff B stated, "I am absolutely wrong it is not even what I teach my staff." Staff B was asked if they would consider holding down a resident against their will during care, a physical restraint. Staff B stated, "Yes, and we do not restrain residents as a standard."

Plan/Attestation Statement

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Statement of Deficiencies	License # 2141	Compliance Determination # 40253
Plan of Correction	Alpine Way Retirement Apartments	Completion Date
Page 8 of 8	Licensee: Cascade Living Group - Shelton, LLC	04/25/2024

Administrator (or Representative) — Date: 5/9/24

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