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

10/25/2024

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

RE: Alpine Way Retirement Apartments # 2141

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 49369 (Completion Date 10/25/2024) and 38357 (Completion Date 05/02/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/25/2024 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(b) Verify staff persons' work references prior to hiring;

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

The Department staff who did the On Site verification:
Pamela Horlick, NCI RN Complaint Investigator

If you have any questions, please contact me at (253)254-3190.

Sincerely,

pp

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Alpine Way Retirement Apartments
License/Cert.#: 2141
Compliance Determination #: 38357
Investigator: Pamela Horlick
Investigation Date(s): 03/15/2024 through 05/02/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 121622
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

Resident/Patient/Client Neglect: Report of four residents being left in wet briefs for extended period of time.

Investigation Methods:

Sample:	Total residents: 72 Resident sample size: 6 Closed records sample size: 0
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents Executive Director Wellness Director Family members
Record Reviews:	State reporting log Incident investigation Facility policies Care Plans Progress Notes Training records Fax to Dr Personnel files

Investigation Summary:

Facility staff failed to follow the Negotiated Service Agreement in regards to toileting needs for residents in memory care unit. Failed practice identified.
Facility failed to complete reference checks for 1 of 3 sampled staff. Failed practice

identified.
Facility failed to investigate 1 of 4 incidents of residents being left for an undetermined amount of time in a wet brief. Failed practice identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Alpine Way Retirement Apartments
License/Cert.#: 2141
Compliance Determination #: 38357
Investigator: Pamela Horlick
Investigation Date(s): 03/15/2024 through 05/02/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 122488
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

Quality of Care/Treatment: Facility report of two separate altercations involving one resident being the aggressor and initiating both incidents.

Investigation Methods:

Sample:	Total residents: 72 Resident sample size: 6 Closed records sample size: 0
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents Executive Director Wellness Director Family members
Record Reviews:	State reporting log Incident investigation Facility policies Care Plans Progress Notes Training records Fax to Dr Personnel files

Investigation Summary:

Facility failed to notify the Complaint Resolution Unit in a timely manner after two altercations occurred with the same aggressor. Failed practice identified.

Conclusion / Action:

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

STATE OF WASHINGTON
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 # 38357
Plan of Correction	Alpine Way Retirement Apartments	Completion Date
Page 1 of 9	Licensee: Cascade Living Group - Shelton, LLC	05/02/2024

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 03/15/2024 and 05/02/2024 of:

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

This document references the following complaint number(s): 121622, 122491, 122488

The following sample was selected for review during the unannounced on-site visit: 6 of 72 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator

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

05/13/2024
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.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

800 NE 136th Ave Ste 200, Vancouver, WA 98684

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

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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.

Residential Care Services _____ 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.

Trudy Hunter
Administrator (or Representative)

5/16/2024
Date

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(b) Verify staff persons' work references prior to hiring;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete reference checks for 1 of 3 employees (Staff C) reviewed. This failure placed all 72 of 72 residents at risk of receiving care and services from unqualified and/or unsuitable staff.

Findings included...

Record review of the facility policy, titled, "Recruitment and Hiring," dated 02/2014, stated, "Once a decision has been made regarding interest in hiring an applicant, an offer should be made contingent upon satisfactory completion of the reference and background checks. Using the Reference Check form, the hiring manager or the business office manager should check references for all candidates. Internal reference checks should also be conducted."

Record review of the facility policy, titled, "References and Background Checks," dated 02/2024, stated, "In evaluating and verifying and individuals qualifications for employment, Cascade Living conducts reference checks and mandatory fingerprint-based background checks for all prospective associates."

In an interview on 03/15/2024 at 4:50PM, Staff A, Executive Director, was asked why would you conduct reference checks on potential staff, Staff A stated, so we don't hire bad people and not waste everybody's time. Staff A was asked how they would document that, they stated they fill out a reference check sheet. Staff A stated they would want to know if the potential employee ever had any write ups, if they got along with others, if they were good to work with and if they would rehire them.

Record review of the facility staff list, undated, showed that Staff F, caregiver, was hired on 01/03/2024.

Record review of Staff F's references showed three names with addresses and phone numbers for references. There was no other documentation that showed the references had been contacted.

Administrator (or Representative) Date

WAC 388-78A-2450 Staff.

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(b) Verify staff persons' work references prior to hiring;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete reference checks for 1 of 3 employees (Staff C) reviewed. This failure placed all 72 of 72 residents at risk of receiving care and services from unqualified and/or unsuitable staff.

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Record review of the facility policy, titled, “References and Background Checks,” dated 02/2024, stated, “In evaluating and verifying and individuals qualifications for employment, Cascade Living conducts reference checks and mandatory fingerprint-based background checks for all prospective associates.”

In an interview on 03/15/2024 at 4:50PM, Staff A, Executive Director, was asked why would you conduct reference checks on potential staff, Staff A stated, so we don’t hire bad people and not waste everybody’s time. Staff A was asked how they would document that, they stated they fill out a reference check sheet. Staff A stated they would want to know if the potential employee ever had any write ups, if they got along with others, if they were good to work with and if they would rehire them.

Record review of the facility staff list, undated, showed that Staff F, caregiver, was hired on 01/03/2024.

Record review of Staff F’s references showed three names with addresses and phone numbers for references. There was no other documentation that showed the references had been contacted.

Statement of Deficiencies	License #: 2141	Compliance Determination # 38357
Plan of Correction	Alpine Way Retirement Apartments	Completion Date
Page 3 of 9	Licensee: Cascade Living Group - Shelton, LLC	05/02/2024

In an interview on 03/15/2024 at 4:50 PM, Staff B, Wellness Director, was asked if reference checks were completed for Staff F, they stated, they didn't see any in the chart.

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) 6/15/2024 .

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

Trudy Hunter
Administrator (or Representative)

5/17/2024
Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to follow and implement care as documented on the Customized Service Plan (CSP) (facility's version of the Negotiated Service Agreement) for 2 of 2 residents, (Resident 3 [R3] and Resident 4 [R4]) reviewed. This failure resulted in R3 and R4 developing skin issues, and placed all residents at risk for harm and unmet care needs.

Findings included...

Review of the facility policy, titled, "Customized Service Plan," last reviewed 10/2021, stated, "All residents living in the assisted living licensed rooms will have a Customized Service Plan (CSP) based upon their needs and preferences for service delivery, agreed upon by the community as well as by coordination of outside services, to ensure the residents needs can be safely met within the community."

Review of Department Records showed that a report was made by the facility on 03/04/2023 at 3:39PM notifying the Department that R3 and R4 were left in wet briefs and found "completely soaked with urine and did not appear to have been changed throughout the night." Staff E, caregiver, was named being the caregiver providing care to R3 and R4.

In an interview on 03/15/2024 at 4:50 PM, Staff B, Wellness Director, was asked if reference checks were completed for Staff F, they stated, they didn't see any in the chart.

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)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to follow and implement care as documented on the Customized Service Plan (CSP) (facility's version of the Negotiated Service Agreement) for 2 of 2 residents, (Resident 3 [R3] and Resident 4 [R4]) reviewed. This failure resulted in R3 and R4 developing skin issues, and placed all residents at risk for harm and unmet care needs.

Findings included…

Review of the facility policy, titled, "Customized Service Plan," last reviewed 10/2021, stated, "All residents living in the assisted living licensed rooms will have a Customized Service Plan (CSP) based upon their needs and preferences for service delivery, agreed upon by the community as well as by coordination of outside services, to ensure the residents needs can be safely met within the community."

Review of Department Records showed that a report was made by the facility on 03/04/2023 at 3:39PM notifying the Department that R3 and R4 were left in wet briefs and found "completely soaked with urine and did not appear to have been changed throughout the night." Staff E, caregiver, was named being the caregiver providing care to R3 and R4.

<R3>

Review of R3's face sheet, dated 04/04/2024, showed that R3 was admitted to the facility on [redacted]/2023.

Record review of R3's Customized Service Plan (care plan), last reviewed on 11/30/2023, under the "Toileting" category stated, "Resident requires total assistance for toileting and incontinence care."

Record review of R3's progress notes, dated 03/04/2024 at 3:00PM, showed R3 was left wet in urine for an undetermined amount of time causing skin concerns to the R3's peri (genital) area. R3 was to be checked and changed every 2 hours around the clock.

<R4>

Review of R4's face sheet, dated 03/04/2024, showed that R4 was admitted to the facility on [redacted]/2022.

Record review of R4's Customized Service Plan (care plan), last reviewed on 10/26/2023, under the "Toileting" category stated, "Resident requires assistance to toilet before/after meals, PRN and HS. Staff to assist with Peri care after toileting, as resident is known to irritate peri area by wiping back to front if not assisted."

Record review of R4's progress notes, dated on 03/04/2024 at 9:04PM, showed R4 had complaints of some pain during personal cares.

Record review of R4's incident report, dated 03/04/2024, showed that it was discovered in the morning that residents vulva was noted to be reddened and irritated along with the crack of her buttocks.

Record review of R4's "incident/Accident Report Conclusion,", dated 03/04/2024, showed R4 was noted to be very wet with urine and dried bowel movement. R4's vulva was reddened and irritated along with the buttocks crease being irritated. Staff E was suspended pending investigation.

In an interview on 03/15/2024 at 4:01PM, Staff C, Licensed Practical Nurse (LPN), was asked what the process was for NOC (night) shift when checking on residents. Staff C stated, care staff should be checking on the residents every two hours to make sure they are ok, they should be checking and changing (toileting needs such as a brief change).

<R3>

Review of R3's face sheet, dated 04/04/2024, showed that R3 was admitted to the facility on [redacted]/2023.

Record review of R3's Customized Service Plan (care plan), last reviewed on 11/30/2023, under the "Toileting" category stated, "Resident requires total assistance for toileting and incontinence care."

Record review of R3's progress notes, dated 03/04/2024 at 3:00PM, showed R3 was left wet in urine for an undetermined amount of time causing skin concerns to the R3's peri (genital) area. R3 was to be checked and changed every 2 hours around the clock.

<R4>

Review of R4's face sheet, dated 03/04/2024, showed that R4 was admitted to the facility on [redacted]/2022.

Record review of R4's Customized Service Plan (care plan), last reviewed on 10/26/2023, under the "Toileting" category stated, "Resident requires assistance to toilet before/after meals, PRN and HS. Staff to assist with Peri care after toileting, as resident is known to irritate peri area by wiping back to front if not assisted."

Record review of R4's progress notes, dated on 03/04/2024 at 9:04PM, showed R4 had complaints of some pain during personal cares.

Record review of R4's incident report, dated 03/04/2024, showed that it was discovered in the morning that residents vulva was noted to be reddened and irritated along with the crack of her buttocks.

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In an interview on 03/15/2024 at 4:01PM, Staff C, Licensed Practical Nurse (LPN), was asked what the process was for NOC (night) shift when checking on residents, Staff C stated, care staff should be checking on the residents every two hours to make sure they are ok, they should be checking and changing (toileting needs such as a brief change).

When asked what kind of services do R3 and R4 get, Staff C stated they both need to be checked routinely, changed and repositioned every couple hours to making sure they were dry. Staff C was asked if they knew what happened when R3 and R4 developed new skin issues, they stated all they knew was that someone didn't do what they were supposed to be doing. Staff C was asked if there was documentation done showing that services were completed for R3 and R4, they stated the caregivers just know that it needs to be done every two hours. Staff C stated they have set times that they round to check on the residents.

In an interview on 03/15/2024 at 4:20PM, Staff D, Caregiver, was asked what kind of services do R3 and R4 get, Staff D stated, we do everything for them. We dress and feed them, and check and change [their brief.]

In an interview on 03/15/2024 at 4:50PM, Staff B, Wellness Director, was asked what was expected of night shift care staff when providing toileting needs, Staff B stated, for residents who cant get out of bed or remember to, they are to be checked and changed every two hours. Staff B stated the report they received was that R3 and R4 were completely saturated through the brief, clothing and bedding. Staff B stated, "it obviously means they weren't changed two hours ago or even four hours after NOC shift started."

Record review of an email sent to the department, on 03/21/2024 at 3:04PM, Staff B stated, staff are required to read and sign the service plans which are kept with the daily charting sheets.

In an interview on 03/21/2024 at 4:20PM, Staff B was asked when staff were required to read and sign the service plans, they stated, the process was that staff were to read the service plan daily and then initial that they saw it.

Record review of R3's CSP showed, Staff E initialed the CSP, indicating they were aware of R3's toileting needs.

Record review of R4's CSP showed, Staff E initialed the CSP, indicating they were aware of R4's toileting needs.

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) 6/15/2024 .

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

When asked what kind of services do R3 and R4 get, Staff C stated they both need to be checked routinely, changed and repositioned every couple hours to making sure they were dry. Staff C was asked if they knew what happened when R3 and R4 developed new skin issues, they stated all they knew was that someone didn't do what they were supposed to be doing. Staff C was asked if there was documentation done showing that services were completed for R3 and R4, they stated the caregivers just know that it needs to be done every two hours. Staff C stated they have set times that they round to check on the residents.

In an interview on 03/15/2024 at 4:20PM, Staff D, Caregiver, was asked what kind of services do R3 and R4 get, Staff D stated, we do everything for them. We dress and feed them, and check and change [their brief.]

In an interview on 03/15/2024 at 4:50PM, Staff B, Wellness Director, was asked what was expected of night shift care staff when providing toileting needs, Staff B stated, for residents who cant get out of bed or remember to, they are to be checked and changed every two hours. Staff B stated the report they received was that R3 and R4 were completely saturated through the brief, clothing and bedding. Staff B stated, "it obviously means they weren't changed two hours ago or even four hours after NOC shift started."

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Record review of R3's CSP showed, Staff E initialed the CSP, indicating they were aware of R3's toileting needs.

Record review of R4's CSP showed, Staff E initialed the CSP, indicating they were aware of R4's toileting needs.

Plan/Attestation Statement

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

Administrator (or Representative) 5/17/2024 Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to follow policies and procedures after an incident occurred requiring staff to notify the Complaint Resolution Unit (CRU) in a timely manner for 2 of 2 residents, (Resident 1 [R1] and Resident 2 [R2]). This failure placed these residents at risk for harm and unmet care needs.

Findings included...

Record review of the facility policy, titled, "Abuse & Neglect," dated 09/2017, stated, "All alleged/suspected abandonment, abuse or neglect is investigated by the executive director or designee and timely reported following the Washington Reporting Requirements for Assisted Living.

Record review of the Department of Social and Health Services, "Assisted Living Guide Book", dated February 2018, Chapter one, showed facilities were required to report 24 hours a day, seven days a week to the departments Complaint Resolution Unit (CRU) hotline via phone or online for any reasonable cause to believe violations involving abuse or neglect. Under the section "What to Report to The Department", stated where there was reasonable cause to believe violations had occurred involving abuse and neglect.

Record review of the facility policy, titled, "Incident/Accident Management" dated 11/2023, stated, "Cascade Living strives to provide an environment for its residents and associates minimizes the potential for accident or injury. If, however, an accident or injury occurs, a thorough report of the circumstances surrounding the incident is completed by the associate having first hand knowledge of the incident. This is done soon after the incident as possible. It is the responsibility of the department supervisor or executive director to review the report to be sure it is completely and correctly written." Under Section titled, "For Resident Events, it stated, "If the incident/accident requires notifying state agency, complete and submit the required form. The wellness director or executive director will ensure the state hotline report is made on behalf of the community."

Record review of Residential Care Services Online Incident Report, dated 03/11/2024 at 2:

Administrator (or Representative) Date

WAC 388-78A-2600 Policies and procedures.

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Record review of Residential Care Services Online Incident Report, dated 03/11/2024 at 2:

47PM, showed a report was received to the Complaint Resolution Unit (CRU) regarding an incident that occurred on 03/09/2024 at 3:42AM involving R1 and R2.

Review of R1's face sheet, dated 03/11/2024, showed that R1 was admitted to the facility on [redacted]/2022.

Record review of R1's incident/investigation, dated 03/09/2024, showed that a resident dug their fingernails into the hand/wrist of R1 to try to take their walker and punched R1 in the chest twice.

Record review of R1's progress notes, dated 03/09/2024, showed R1 had bruises on their right hand.

Review of R2's face sheet, dated 03/11/2024, showed that R2 was admitted to the facility on [redacted]/2022.

Record review of R2's incident/investigation, dated 03/09/2024, showed that R2 was heard screaming. Upon entry to R2's room, caregiver noted R2 was lying on their back while another resident was standing over R2 and was holding R2's forearms and pushing R2 into their mattress. Other resident was heard yelling "shut up" to R2.

Record review of R2's progress notes, dated 03/10/2024, showed R2 sustained bruising to both forearms.

In an interview on 03/15/2024 at 4:50PM, Staff B, Wellness Director, was asked what was expected of staff when there was a resident to resident altercation, Staff B stated, they were to make sure the residents were safe. Staff B stated CRU was notified within 24 hours. They stated they will do the state report from home if it is on the weekend. Staff B was asked why one was not completed, they stated they were unavailable. Staff B stated it was reported two days later and it should have been done right away. When asked if the incident should have been reported sooner, Staff B stated, yes.

Plan/Attestation Statement

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

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Record review of R1's progress notes, dated 03/09/2024, showed R1 had bruises on their right hand.

Review of R2's face sheet, dated 03/11/2024, showed that R2 was admitted to the facility on [redacted]/2022.

Record review of R2's incident/investigation, dated 03/09/2024, showed that R2 was heard screaming. Upon entry to R2's room, caregiver noted R2 was lying on their back while another resident was standing over R2 and was holding R2's forearms and pushing R2 into their mattress. Other resident was heard yelling "shut up" to R2.

Record review of R2's progress notes, dated 03/10/2024, showed R2 sustained bruising to both forearms.

In an interview on 03/15/2024 at 4:50PM, Staff B, Wellness Director, was asked what was expected of staff when there was a resident to resident altercation, Staff B stated, they were to make sure the residents were safe. Staff B stated CRU was notified within 24 hours. They stated they will do the state report from home if it is on the weekend. Staff B was asked why one was not completed, they stated they were unavailable. Staff B stated it was reported two days later and it should have been done right away. When asked if the incident should have been reported sooner, Staff B stated, yes.

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)_____ .

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

Statement of Deficiencies	License #: 2141	Compliance Determination # 38357
Plan of Correction	Alpine Way Retirement Apartments	Completion Date
Page 8 of 9	Licensee: Cascade Living Group - Shelton, LLC	05/02/2024

Trudy Wurster
Administrator (or Representative)

5/17/2024
Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to investigate and document investigative actions and findings for an incident for 1 of 3 residents (Resident 3 [R3]). This failure placed R3 at risk for unmet care needs.

Findings included...

Record review of the facility policy, titled, "Abuse & Neglect," dated 09/2017, stated, "All alleged/suspected abandonment, abuse or neglect is investigated by the executive director or designee and timely reported following the Washington Reporting Requirements for Assisted Living."

Record review of the facility policy, titled, "Incident/Accident Management" dated 11/2023, stated, "Cascade Living strives to provide an environment for its residents and associates minimizes the potential for accident or injury. If, however, an accident or injury occurs, a thorough report of the circumstances surrounding the incident is completed by the associate having first hand knowledge of the incident. This is done soon after the incident as possible. It is the responsibility of the department supervisor or executive director to review the report to be sure it is completely and correctly written." Under Section titled, "For Resident Events", it stated, "If the incident/accident requires notifying state agency, complete and submit the required form. The wellness director or executive director will ensure the state hotline report is made on behalf of the community."

Review of R3's face sheet, dated 03/04/2024, showed that R3 was admitted to the facility on [redacted]/2023.

Record review of Residential Care Services Online Incident Report, dated 03/04/2024 at 3:39 PM, showed a report was received to the Complaint Resolution Unit (CRU) regarding an incident where R3 was left in a wet brief and was "completely soaked with urine and did not appear to have been changed throughout the night shift." R3 had excoriation to their buttock crease and peri area.

Administrator (or Representative) Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to investigate and document investigative actions and findings for an incident for 1 of 3 residents (Resident 3 [R3]). This failure placed R3 at risk for unmet care needs.

Findings included…

Record review of the facility policy, titled, “Abuse & Neglect,” dated 09/2017, stated, “All alleged/suspected abandonment, abuse or neglect is investigated by the executive director or designee and timely reported following the Washington Reporting Requirements for Assisted Living.”

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Review of R3’s face sheet, dated 03/04/2024, showed that R3 was admitted to the facility on [redacted]/2023.

Record review of Residential Care Services Online Incident Report, dated 03/04/2024 at 3:39 PM, showed a report was received to the Complaint Resolution Unit (CRU) regarding an incident where R3 was left in a wet brief and was “completely soaked with urine and did not appear to have been changed throughout the night shift.” R3 had excoriation to their buttock crease and peri area.

Statement of Deficiencies	License #: 2141	Compliance Determination # 38357
Plan of Correction	Alpine Way Retirement Apartments	Completion Date
Page 9 of 9	Licensee: Cascade Living Group - Shelton, LLC	05/02/2024

Record review of R3's progress notes, dated 03/05/2024, showed R3 was left wet in urine for an undetermined amount of time, causing skin concerns to resident's peri area.

During a record request to the facility on 03/15/2024 at 11:53AM, an investigation for the incident on 03/04/2024 was requested and not provided for R3. There was no investigation documentation provided concerning the incident for R3 addressing investigative actions and findings for the incident.

In an interview on 03/20/2024 at 12:40PM, Staff B, Wellness Director, was asked what types of incidents would require an investigation to be conducted, Staff B stated, for any situations where there was a complaint of abuse or neglect. Staff B was asked when an investigation would be conducted for abuse or neglect incidents, they stated it should start immediately. Staff B was asked if R3 being left in a wet brief was a form of neglect, they stated yes.

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) 6/15/2024.

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

Trudy Wexler — Administrator (or Representative)

5/17/2024 — Date

Record review of R3's progress notes, dated 03/05/2024, showed R3 was left wet in urine for an undetermined amount of time, causing skin concerns to resident's peri area.

During a record request to the facility on 03/15/2024 at 11:53AM, an investigation for the incident on 03/04/2024 was requested and not provided for R3. There was no investigation documentation provided concerning the incident for R3 addressing investigative actions and findings for the incident.

In an interview on 03/20/2024 at 12:40PM, Staff B, Wellness Director, was asked what types of incidents would require an investigation to be conducted, Staff B stated, for any situations where there was a complaint of abuse or neglect. Staff B was asked when an investigation would be conducted for abuse or neglect incidents, they stated it should start immediately. Staff B was asked if R3 being left in a wet brief was a form of neglect, they stated yes.

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date