STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

CASCADE PARK GARDENS, L.L.C.
Cascade Park Gardens, L.L.C.
4347 S UNION AVE
TACOMA, WA 98409

RE: Cascade Park Gardens, L.L.C. License # 2605

Dear Administrator:

This letter addresses Compliance Determination(s) 53931 (Completion Date 01/24/2025) and 42881 (Completion Date 07/31/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/24/2025 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-2600-1, WAC 388-78A-2600-1-a, WAC 388-78A-2600-1-b, WAC 388-78A-2600-1-c, WAC 388-78A-2600-1-d

The Department staff who did the on-site verification:
Kathy Heinz, Long Term Care Surveyor

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

Sincerely,

Manfay Chan, Allied Health Field Manager
Region 3, Unit D
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Cascade Park Gardens, L.L.C.
Provider Type: Assisted Living Facility
License/Cert.#: 2605
Intake ID: 125585
Compliance Determination #: 42881
Region/Unit #: RCS Region 3 / Unit D
Investigator: Regenia Coleman
Investigation Date(s): 06/14/2024 through 07/31/2024
Complainant Contact Date(s):

Allegation(s):
Admit/Discharge/Transfer Rights- The facility failed to accept resident back after being transferred to the hospital.

Investigation Methods:

Sample:	Total residents: 54 Resident sample size: 4 Closed records sample size: 4
Observations:	Identified resident (unable due to resident no longer residing at facility) Residents Activities Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Family members Residents Nursing staff Identified staff Identified resident (unable to interview due to resident at alternate location) Identified resident representative Collateral Contacts
Record Reviews:	Medical records Facility policies Service Encounter Records Nursing Notes Medication Administration Records

Investigation Summary:
Admission/Discharge/Transfer Rights- The facility conducted a pre-admission

assessment which identified the resident's past behaviors and the established indwelling catheter. The resident was accepted for admission into the facility's program for residents with challenging behaviors, with an identified home health agency to care for the resident's catheter. The facility failed to attempt care planned interventions prior to having the resident transferred to the hospital twice. The facility failed to follow their policies and procedures regarding Resident Rights and Discharging a resident. Allegation is substantiated. Failed facility practice identified.

Conclusion / Action:

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

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Statement of Deficiencies	License #: 2605	Compliance Determination # 42881
Plan of Correction	Cascade Park Gardens, L.L.C.	Completion Date
Page 1 of 7	Licensee: CASCADE PARK GARDENS, L.L.C.	07/31/2024

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 06/14/2024 and 07/19/2024 of:

Cascade Park Gardens, L.L.C.
4347 S UNION AVE
TACOMA, WA 98409

This document references the following complaint number(s): 125585

The following sample was selected for review during the unannounced on-site visit: 4 of 54 current residents and 4 former residents.

The department staff that investigated the Assisted Living Facility:

Regenia Coleman, ALF NCI CI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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 — 08/12/2024 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.

Administrator (or Representative)

8/15/2024
Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(b) Provide the necessary care and services for residents, including those with special needs;

(c) Safely operate the assisted living facility; and

(d) Operate in compliance with state and federal law, including, but not limited to, chapters 7.70 , 11.88, 11.92, 11.94, 69.41, 70.122, 70.129, and 74.34 RCW, and any rules promulgated under these statutes.

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to allow 1 of 4 sampled residents (Resident 1[R1]) to return to the facility after being hospitalized without proper discharge notification. This failure resulted in Resident 1 remaining in the hospital for an extended period of time causing R1 emotional distress and a diminished quality of life.

Findings included..

Record review of the facility's policy titled, Reasonable Accommodation (RA), dated 02/11/2016, noted it was the facility's policy they would reasonably accommodate a resident so they would be able to remain at the facility as long as possible. The RA policy also documented the facility would only admit a resident whose care needs they could safely meet.

Record review of the facility's policy and procedure titled, Resident Discharge, dated 02/11/2016, outlined the following procedure:
"The [ALF] will attempt through RA to avoid transfer or discharge. If the transfer or discharge is unavoidable then the [ALF] will:
a. Notify the resident and his or her representative and make reasonable efforts to notify in writing and in a language and manner that they can understand.
b. Record the reason in the resident's record.
c. Include in the notice the following items:
i. The reason for transfer/discharge
ii. The effective date of transfer/discharge

iii. The location to which the resident is transferred/discharged
v. The name, address and telephone number of the state long-term care ombudsman.
vi. For residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals.
The [ALF] will provide sufficient preparation and orientation to residents to ensure a safe and orderly transfer or discharge from the ALF.
Discharge will be recorded in the resident's register.
A resident discharged in violation of this section has the right to be readmitted immediately or as soon as the first gender-appropriate bed or apartment at [ALF] becomes available."

Record review of the facility's policy and procedure titled, Resident Rights, dated 02/11/2016, outlined the following procedure:
"The Administrator or designee will notify residents in writing in a language they can understand of changes in service:
a. A minimum of 30 days prior to the effective date of the decrease in services that are beyond the facility's control,
b. A minimum of 90 days prior to the effective date of a voluntary decrease in scope of care or services that would result in the discharge of one or more residents."

According to "The Mental and Physical Effects of a Hospital Stay on Seniors," dated 08/17/2022, prolonged hospital stays have a negative impact on the mental and physical health of older adults, which continue long past the date of discharge. "A study from the American Academy of Neurology suggests cognitive [all of the different mental events involved in thinking, learning, and understanding] decline more than doubles after a hospital stay for elderly patients, negatively affecting their cognitive and mental health."
Record review of R1's Service Encounter Record (SER) notes, documented R1 remained in the hospital for 43 days while alternative placement was sought, after the facility failed to allow R1 to return after being sent to the hospital on [redacted]/2024.

Resident 1
R1 was admitted to the facility on [redacted]/2024, with multiple diagnoses including [redacted].

Record review of R1's pre-admission assessment dated 03/13/2024, documented R1 had a suprapubic catheter (a hollow flexible tube that is used to drain urine from the bladder through a cut in the stomach) related to obstructive uropathy, which required monthly changes to be done by home health (HH).

Record review of R1's Boarding Home Dementia Screening Tool (BHDST), completed

prior to admission on 03/13/2024, documented R1 had exhibited the following behaviors in the past 30 days:
History of physical injury to staff/others
Combative
Resistive to care
Inappropriate screaming, yelling, or verbal noises
Repetitive physical movements/pacing, hand wringing, and fidgeting
Aggressive/intimidating
Easily irritated/upset agitated
Seeks/demands constant attention/reassurance

Record review of R1's undated Care Plan documented R1's needs and approaches facility staff were to take in order to meet R1's needs.
Need: suprapubic catheter.
Approach(s): catheter would be changed monthly by HH; send to the ER (emergency room) if emergent change was needed between scheduled changes.
Need: history of resistance to care when agitated.
Approach(s): engage family...in chronic refusals; attempt different staff members, different approaches and modifications of task if needed.
Need: exhibited behaviors which required staff intervention (see BHDST).
Approach(s): ensure behavior was not escalating due to an unmet care need such as requiring toileting, hungry, thirsty, etc.; redirect and offer activities, snacks, or alternatives to improper behavior.

Record review of R1's nursing note dated 03/20/2024 at 10:00 AM, documented R1 refused morning medication and refused to allow the suprapubic catheter to be flushed. The nursing note failed to document attempted measures to discover the cause of R1's refusal of care. The nursing note failed to document any care planned interventions facility staff took in attempt to meet R1's care needs.

Record review of R1's nursing note dated 03/21/2024 at 7:57 AM, documented, "...medications include quetiapine (a medication used to treat mental health disorders), duloxetine (a medication used to treat depression or pain caused by nerve damage), rivastigmine (a medication used to help improve mental function in individuals with mild to moderate dementia [memory loss and mental changes]), which he has been refusing...R1 has a suprapubic catheter that R1 has been refusing to let the nurse flush as well..."

Record review of R1's March 2024 Medication Administration Record (MAR) documented:
Out of 10 possible opportunities for R1 to take Duloxetine, R1 refused the medication twice.
Out of 10 possible opportunities for R1 to take Quetiapine, R1 refused the medication once.
Out of 10 possible opportunities for R1 to take Rivastigmine, R1 refused the medication once.
R1 refused to let Staff C flush the suprapubic catheter once.

Record review of R1's nursing note dated 03/21/2024 at 1:23 PM, documented R1 said, "staff and nurse did not provide R1 care." The nursing note failed to document attempted measures by facility staff to discover the cause of R1's refusal of care. The nursing note failed to document any care planned interventions facility staff took in attempt to meet R1's care needs.

Record review of R1's nursing note dated [redacted]/2024 at 1:56 PM, documented R1 had been sent to the hospital for evaluation of R1's clogged suprapubic catheter. The nursing note did not document R1 had intentionally pulled out the suprapubic catheter.

Record review of R1's nursing note dated 03/24/2024 at 11:37 AM, documented R1 had stepped on their suprapubic catheter during an attempted self-transfer to the wheelchair which resulted in the catheter being dislodged. The note did not document R1 had intentionally pulled out the suprapubic catheter.
Record review of R1's March 2024 and April 2024 nursing notes failed to include the elements required for a resident discharge:
The reason for transfer or discharge.
The effective date of transfer or discharge.
The location to which the resident is transferred or discharged.
The name, address, and telephone number of the state long term care ombudsman.
For residents with mental illness, the mailing address and telephone number of the agency responsible for the protection and advocacy of individuals with mental illness established under the protection and advocacy for mentally ill individuals act.

In an interview with Collateral Contact 1 (CC1), Master of Social Work, Acute Care Hospital Case Manager, on 06/13/2024 at 3:46 PM, CC1 said the facility was made aware of R1's past behaviors and of R1's suprapubic catheter. CC1 said the facility agreed to accept R1 for admission once a home health agency was found to take care of R1's suprapubic catheter. CC1 said the facility did not follow the intervention agreed upon by the facility, home health agency, and CC1, to call the HH agency if R1 needed to have the suprapubic catheter cared for in between scheduled changes.

In a follow-up interview with CC1 on 07/15/2024 at 2:15 PM, CC1 said Puget Sound Home Health and Hospice (PSHH) agreed to accept R1 as a client and provide regular maintenance and agreed to assist with emergency care if needed.

In an interview with CC3, Bachelor of Science in Nursing, Registered Nurse, Case Manager, on 07/18/2024 at 12:03 PM, CC3 said the hospital urologist indicated R1 would need regular catheter changes once a month, since R1 had a well-established suprapubic catheter. CC3 said they found Puget Sound Home Health Care and Hospice to change R1's suprapubic catheter once a month and provide additional care in between scheduled changes if needed. CC3 said they communicated this information via email to Staff D, Director of New Horizons Program, on March 11, 2024. Staff D verified they would accept R1 for admission to the facility since CC3 had secured a HH agency to change R1's suprapubic catheter monthly.

In an interview with CC5, Director of Rehab for Puget Sound Home Health, on 07/23/2024 at 2:44 PM, CC5 confirmed they had accepted R1 as a client and agreed to provide the needed care for R1's suprapubic catheter.

In an interview with CC2, resident representative of R1, on 07/1/2024 at 3:51 PM, CC2 said R1 had been in the hospital for 2 months prior to being accepted into the facility's New Horizons Program. CC2 said the during the short time R1 stayed at the facility, they did not contact CC2 regarding any concerning behaviors or incidents. CC2 said they had not received written notification from the facility informing them R1 had been discharged from the facility. CC2 said after the facility discharged R1 it took about 2 months to find another facility that would accept R1. CC2 stated the long hospital stays are hard on R1.

In an interview with Staff C, Licensed Practical Nurse, on 07/19/2024 at 11:11 AM, Staff C stated, "the biggest issue was that [R1] kept yanking out the catheter..." Review of R1's suprapubic catheter incidents failed to document R1 intentionally pulled out the catheter.

In an interview with Staff B, Director of Resident Services, on 07/19/2024 at 11:31 AM, Staff B said the HH agency was going to come into the facility once a month for scheduled changes to R1's suprapubic catheter, as well as in between scheduled visits if needed. Staff B said facility staff did not call the HH agency when R1 pulled out the suprapubic catheter because it "didn't make sense" and they would be calling multiple times a week. When asked the reason R1 was discharged from the facility Staff B stated, "It really wasn't [R1's] behaviors that was the problem, it was the pulling out of the catheter." Review of R1's suprapubic catheter incidents failed to document R1 intentionally pulled out the catheter.

In an interview with Staff A, Administrator, on 07/19/2024 at 12:07 PM, Staff A said they were aware R1 had exhibited verbally challenging behaviors in the past such as "saying sexually inappropriate things and racist comments; these are common traits of our New Horizons residents." When Staff A was asked if R1's family was called to assist with R1's continued refusal of care, Staff B interjected and stated, "no, not that I am aware of."

In a follow-up interview with Staff A, on 07/19/2024 at 3:06 PM, Staff A said facility staff did not call the HH agency because it would have taken them 2-3 hours to get to the facility. Staff A said facility staff did not give the HH agency an opportunity to decline the needed care to R1's suprapubic catheter. Staff A said the facility did not provide R1's representative with a written discharge notice per the facility's Discharge and Resident Rights policies.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2605	Compliance Determination # 42881
Plan of Correction	Cascade Park Gardens, L.L.C.	Completion Date
Page 7 of 7	Licensee: CASCADE PARK GARDENS, L.L.C.	07/31/2024

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, Cascade Park Gardens, L.L.C. is or will be in compliance with this law and / or regulation on (Date) 09-15-2024

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

Administrator (or Representative)

08-15-2024
Date