STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505389	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Cascade Park	801 Southeast Park Crest Avenue Vancouver, WA 98683

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a safe and appropriate discharge for 1 of 3 former residents (Resident 1) reviewed for discharge. As a result of this failure, Resident 1 experienced harm when she was discharged without necessary supports, which led to complications from an existing stage 4 sacral wound requiring hospitalization for symptom management.Findings included.Resident 1 was admitted to the facility 07/09/2025 with multiple diagnoses including sepsis (a systemic infection), acute cystitis (bladder infection), encephalopathy (disease or damage of the brain) , Parkinson's (progressive movement disorder), stage 4 sacral pressure wound (deep wound exposing muscle, tendon or bone) and adult failure to thrive (gradual decline in physical and mental health leading to significant weight loss and function). The Minimum Data Set (MDS), a comprehensive assessment tool, dated 07/15/2025, documented the resident required partial to moderate assistance with upper-body dressing and oral hygiene, substantial to maximal assistance with bathing, and was dependent for toileting and lower-body dressing. On September 23, 2025, at 11:25 a.m., Collateral Contact 1 (CC1), the Home and Community Services (HCS) case manager, stated that she had concerns regarding the facility's discharge of Resident 1. CC1 stated the resident was discharged home even though hospital records from prior to Resident 1's admission reportedly indicated the resident lacked capacity to make independent decisions. CC1 reported the discharge paperwork was signed by Resident 1's daughter, who did not have legal authority to act on her behalf, and that Resident 1 was returned to a home environment that was unable to meet her care needs. Record review of Resident 1's progress notes, showed the following:On 07/11/2025 at 15:04 (3:04 p.m.), a social services note documented Resident 1 was non-verbal but able to communicate effectively by reading lips and responding to questions with a thumbs-up or thumbs-down gesture to indicate yes or no. On 08/11/2025 at 10:23 a.m., a social services note documented Resident 1's primary care provider advised the resident should not be discharged home and required a higher level of care. On 08/20/2025 at 12:17 p.m., a social services note documented ongoing barriers to discharge, including wound-care needs, cognitive decline, 24-hour care requirements, and lack of available family supports. On 08/22/2025 at 14:09 (2:09 p.m.), a nursing note documented the family planned to discharge Resident 1 home the following day against medical advice. The nurse listed risks of wound deterioration, sepsis, neglect, and the need for 24-hour care with frequent repositioning. On 08/23/2025 at 10:30 a.m., a nursing late entry documented Resident 1 was discharged home, wound-care teaching was provided to the daughter, and AMA (Against Medical Advice) paperwork was signed by the daughter. There was no documentation that Resident 1 participated in or consented to the discharge decision. Record review of Department Records, dated 09/25/2025, documented that on 08/27/2025, Resident 1 was observed lying in bed, non-verbal, and responding by raising her thumb. When asked if she was in pain and wanted medical help, Resident 1 indicated yes. Emergency medical services were contacted, and the resident was transported to the hospital. Resident 1 had been discharged from the skilled nursing facility against medical advice on 08/23/2025, and that no home health or wound-care services were in place at the time of the home visit. Record review of Resident 1's emergency department admission notes, dated 08/27/2025, showed Resident 1 was admitted from home with an infected Stage IV sacral decubitus ulcer (deep wound exposing muscle, tendon or bone) with cellulitis (skin infection causing redness swelling and pain) and symptoms of buttock pain. The documentation noted Resident 1 had recently left the skilled nursing facility against medical advice and that family members were unable to provide care at home. On 10/03/25 at 10:40 a.m., Collateral Contact 2 (CC2, Resident 1's daughter) stated she received a call from the facility social worker on 08/20/2025, who advised that insurance would no longer cover Resident 1's stay and that discharge would need to occur in three days. CC2 stated she had no suitable location prepared to receive her mother and that the social worker did not offer information regarding Medicaid or the option to remain in the facility pending coverage approval. CC2 stated Resident 1 required two-person assistance and that she told the social worker the resident's partner was not capable of providing that level of care. CC2 stated no home-health services were arranged and a low-pressure mattress promised prior to discharge was not delivered. CC2 later discovered the facility had documented the discharge as against medical advice (AMA), which she denied initiating, stating she believed the discharge was premature and unsafe. CC2 stated she obtained power of attorney following Resident 1's hospitalization, allowing her to complete the Medicaid application. On 10/03/2025 at 2:16 p.m., Collateral Contact 3 (CC3, Resident 1's significant other) stated he was