

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505389	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026
NAME OF PROVIDER OR SUPPLIER Avamere Rehabilitation of Cascade Park		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a safe and orderly discharge for 1 of 1 residents (Resident 1) reviewed for admission, transfer, and discharge. This failure placed residents at risk of lack of stable housing and disruption of continuity of care. Findings included. Record review of facility policy Discharge Planning, dated 01/09/2002, stated that once discharge was anticipated, Social Services shall arrange or assist in arranging necessary services and shall identify discharge location, supports, and equipment arranged. The policy further stated that for residents without an identified discharge location, the facility will enlist the support of the assigned Medicaid case manager and other public agencies to secure appropriate housing. Resident 1 was admitted to the facility on [DATE] with diagnoses including atherosclerosis of coronary artery bypass graft(s) (plaque buildup and narrowing in blood vessels that were surgically placed to improve blood flow to the heart). Record review of Resident 1's Nursing Home Transfer or Discharge Notice, dated 01/29/2026, showed the facility issued an emergency discharge effective 01/29/2026 under the reason that the safety of other individuals in the facility was endangered. The discharge location was documented as Car (Personal), with the address listed as NA. The record did not identify an established discharge address or confirmed housing placement where Resident 1 could access shelter or hygiene facilities. On 02/12/2026 at 1:10 PM, Staff A, Administrator, stated the discharge was processed as an emergency discharge and that law enforcement was present when the discharge notice was delivered. Staff A stated Resident 1 packed his belongings and left the facility that same day. On 02/12/2026 at 1:25 PM, Staff C, Social Worker, stated the discharge was processed as an immediate discharge. Staff C stated the discharge location was documented as Car on the discharge notice. Staff C stated no confirmed housing placement was secured prior to discharge. On 03/02/2026 at 1:45 PM, Resident 1 stated he was escorted from the facility by police on 01/29/2026. Resident 1 stated his POA (Power of Attorney) secured motel lodging for several days following discharge and stated he was currently staying with a friend. On 03/04/2026 at 2:45 PM, Staff A acknowledged that discharge to a hotel would have been preferable to discharge to Resident 1's vehicle. Reference WAC 388-97-0120(1)(2)(a)-(d)(3)(a)(4)(b)(5); 388-97-0080; 388-97-0140(1)(a)-(c)(i)-(iii)</p>

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
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