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

Cascade Living Group - Cottage, LLC
The Cottage
3210 Rickey Rd NE
Bremerton, WA 98310

RE: The Cottage License # 2246

Dear Administrator:

This letter addresses Compliance Determination(s) 62118 (Completion Date 07/07/2025) and 57748 (Completion Date 04/25/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/07/2025 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-2930-1-a, WAC 388-78A-2930-1-a-i, WAC 388-78A-2930-1-a-ii, WAC 388-78A-2930-1-a-iii

The Department staff who did the off-site verification:
Nikolas Jennings, Community Nurse Complaint Investigator

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: The Cottage
Provider Type: Assisted Living Facility
License/Cert.#: 2246
Compliance Determination #: 57748
Intake ID: 171930
Investigator: Nikolas Jennings
Region/Unit #: RCS Region 3 / Unit D
Investigation Date(s): 04/15/2025 through 04/25/2025
Complainant Contact Date(s):

Allegation(s):

1) Quality of care/treatment- Resident call light was not answered in a timely manner
2) Misappropriation of property- Resident glucose monitor was removed prior to discharge

Investigation Methods:

Sample:	Total residents: Resident sample size: 3 Closed records sample size: 2
Observations:	Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Call light system
Interviews:	Identified resident Identified staff Nursing staff Residents Family members
Record Reviews:	Medical records Incident investigation Facility policies State reporting log

Investigation Summary:

1) Quality of care/treatment- Resident call light was not answered in a timely manner. Call light system operates on a switchboard at the front of the facility and is unable to be monitored during the night while both care staff are busy. Call bell in identified resident room observed to be in good working condition and worked appropriately when pulled. When call bell is pulled, observed that staff are unable to hear the call bell due to the location of the switchboard depending on where they

are at. Failed practice identified.

2) Misappropriation of property- Resident glucose monitor was removed prior to discharge. Resident unable to explain what happened to glucose monitor and facility was unable to explain where monitor disappeared to. Record review shows that new monitor was provided to resident the following day after discharge to ensure that resident could continue to monitor blood sugars. Based off interview and record review there is insufficient evidence to support failed practice.

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
PO Box 99258, Lakewood, WA 98496

Statement of Deficiencies	License #: 2246	Compliance Determination #: 577481
Plan of Correction	The Cottage	Completion Date
Page 1 of 4	Licensee: Cascade Living Group - Cottage, LLC	04/25/2025

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 04/16/2025 of:

The Cottage
3210 Rickey Rd NE
Bremerton, WA 98310

This document references the following complaint number(s): 171930

The following sample was selected for review during the unannounced on-site visit: 3 of 8 current residents and 2 former residents.

The department staff that investigated the Assisted Living Facility:

Nikolas Jennings, Community Nurse Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99258
Lakewood, WA 98496

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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 04/15/2025 of:

The Cottage
3210 Rickey Rd NE
Bremerton, WA 98310

This document references the following complaint number(s): 171930

The following sample was selected for review during the unannounced on-site visit: 3 of 0 current residents and 2 former residents.

The department staff that investigated the Assisted Living Facility:

Nikolas Jennings, Community Nurse Complaint Investigator

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

Statement of Deficiencies	License #: 2245	Compliance Determination #: 577 48
Plan of Correction	The Cottage	Completion Date
Page 2 of 4	Licensee: Cascade Living Group - Cottage, LLC	04/25/2025

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 for Manfay Chan
Residential Care Services

04/28/2025
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)

5/2/25
Date

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

(i) Bathrooms and toilet rooms;

(ii) Resident living rooms and resident sleeping rooms; and

(iii) Corridors, as well as common and outdoor areas accessible to residents.

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to ensure a system was in place for residents to summon on-duty staff for assistance for 1 of 3 sampled residents (Resident 1 [R1]). This failure placed all residents at risk for unmet care needs and led to a fall for Resident 1.

Findings included...

In an observation on 04/18/2025 at 2:35PM, Complaint investigator pulled the call light in the room of R1. While the board at the front of the facility showed that the call light was on, I was unable to hear the call light going off near the room of R1.

Record review of the facility incident report dated 03/15/2025 for "Was call bell/alarm available and use?" showed the box was checked yes.

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.

Administrator (or Representative) | Date

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Findings included…

In an observation on 04/18/2025 at 2:35PM, Complaint Investigator pulled the call light in the room of R1. While the board at the front of the facility showed that the call light was on, I was unable to hear the call light going off near the room of R1.

Record review of the facility incident report dated 03/15/2025 for “Was call bell/alarm available and use?” showed the box was checked yes.

Record review of the facility progress notes for R1 dated 02/17/2025 - 03/25/2025, stated for 03/15/2025 at 8:12AM, "Actions taken/follow up : Resident placed on 30-minute safety checks due to the location of resident's room to the alarm bell located at front desk. Will continue to monitor."

In an interview on 04/03/2025 at 2:10PM with CC1, Family Member, stated, "When the med tech called me and explained why they couldn't get there in time, they said the alarm system is only at the front desk and they were at the back and said they couldn't hear the alarm going off."

In an interview on 04/03/2025 at 2:10PM with R1, R1 stated they called their son to notify them that they needed to use the bathroom and that their call light hadn't been answered. R1 stated that they went to the bathroom because they were desperate where they urinated on the floor and then sat down on the floor because they were out of their mind. R1 stated that they had to shout, and the next thing they knew they heard people saying that they had fallen.

In an interview on 04/15/2025 at 1:03PM with Staff B, Executive Director, when asked what the policy was for call light response time, Staff B stated, "I don't know if there is a written policy. We do have standards. We like to see our call times, 5 minutes or less, is the standard that we preach."

In an interview on 04/24/2025 at 10:19PM with Staff A, Medication Technician, regarding R1 falling, Staff A stated, "We found her in her room, and she was very upset, said she was calling for hours. We do checks every couple of hours. She was upset, we helped her back to her bed, apologized for not seeing her sooner. Explained no one heard her alarm going off because we were on the other side of the building." Staff A further stated that they were away from the alarm for "Maybe an hour." When asked if they were unable to hear the call lights going off, Staff A stated approximately four hours of an eight-hour shift they are unable to hear the call lights going off. When asked if being unable to hear the call bell contributed to the fall, Staff A stated, "I would say yes. She said she needed to go to the restroom, no one was answering, was blind and was easily confused in that room."

In an interview on 04/25/2025 at 9:44AM with Staff B, when asked if there was a problem with the communication system on night shift, Staff B stated, "I would agree to that."

Record review of the facility progress notes for R1 dated 02/17/2025 - 03/25/2025, stated for 03/15/2025 at 8:12AM, “Actions taken/follow up : Resident placed on 30-minute safety checks due to the location of resident's room to the alarm bell located at front desk. Will continue to monitor.”

In an interview on 04/09/2025 at 2:10PM with CC1, Family Member, stated, “When the med tech called me and explained why they couldn't get there in time, they said the alarm system is only at the front desk and they were at the back and said they couldn't hear the alarm going off.”

In an interview on 04/09/2025 at 2:10PM with R1, R1stated they called their son to notify them that they needed to use the bathroom and that their call light hadn’t been answered. R1 stated that they went to the bathroom because they were desperate where they urinated on the floor and then sat down on the floor because they were out of their mind. R1 stated that they had to shout, and the next thing they knew they heard people saying that they had fallen.

In an interview on 04/15/2025 at 1:03PM with Staff B, Executive Director, when asked what the policy was for call light response time, Staff B stated, “I don't know if there is a written policy. We do have standards. We like to see our call times, 5 minutes or less, is the standard that we preach.”

In an interview on 04/24/2025 at 10:19PM with Staff A, Medication Technician, regarding R1 falling, Staff A stated, “We found her in her room, and she was very upset, said she was calling for hours. We do checks every couple of hours. She was upset, we helped her back to her bed, apologized for not seeing her sooner. Explained no one heard her alarm going off because we were on the other side of the building.” Staff A further stated that they were away from the alarm for “Maybe an hour.” When asked if they were unable to hear the call lights going off, Staff A stated approximately four hours of an eight-hour shift they are unable to hear the call lights going off. When asked if being unable to hear the call bell contributed to the fall, Staff A stated, “I would say yes. She said she needed to go to the restroom, no one was answering, was blind and was easily confused in that room.”

In an interview on 04/25/2025 at 9:44AM with Staff B, when asked if there was a problem with the communication system on night shift, Staff B stated, “I would agree to that.”

Statement of Deficiencies	License #: 2246	Compliance Determination #:57748
Plan of Correction	The Cottage	Completion Date
Page 4 of 4	Licensee: Cascade Living Group - Cottage, LLC	04/25/2025

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, The Cottage is or will be in compliance with this law and / or regulation on (Date) June 14th 2025.

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

Administrator (or Representative)

5/2/25
Date

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, The Cottage 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