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

Cogir Management USA Inc
Cogir Vancouver Orchards
10011 NE 118th Ave
Vancouver, WA 98682

RE: Cogir Vancouver Orchards License # 2472

Dear Administrator:

This letter addresses Compliance Determination(s) 58008 (Completion Date 05/16/2025) and 55878 (Completion Date 03/05/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/16/2025 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-2450-2-h-iv

The Department staff who did the on-site verification:
Jacob Ubl, ALF NCI CI

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley

Clinton Fridley, Adult Family Home Nurse Field Manager
Region 3, Unit I
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Cogir Vancouver Orchards **Provider Type:** Assisted Living Facility

License/Cert.#: 2472
Intake ID: 170113
Compliance Determination #: 55878
Region/Unit #: RCS Region 3 / Unit I
Investigator: Jacob Ubl
Investigation Date(s): 01/28/2025 through 03/05/2025
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/Treatment: Allegations that the facility staff are not knowledgeable on mandated reporting requirements.

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	staff Residents Family members
Record Reviews:	Medical records State reporting log Facility policies

Investigation Summary:

1. Quality of Care/Treatment: Failed practice identified. Facility staff failed to report correct knowledge on mandated reporting requirements.

Conclusion / Action:

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

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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 01/28/2025 of:

Cogir Vancouver Orchards
10011 NE 118th Ave
Vancouver, WA 98682

This document references the following complaint number(s): 170113

The following sample was selected for review during the unannounced on-site visit: 3 of 68 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Jacob Ubl, ALF NCI CI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit I
800 NE 136th Ave Ste 200
Vancouver, WA 98684

Statement of Deficiencies	License #: 2472	Compliance Determination # 55878
Plan of Correction	Cogir Vancouver Orchards	Completion Date
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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.

Clinton Fridley
Residential Care Services

03/07/2025
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.

Debbie Wooley
Administrator (or Representative)

3/7/25
Date

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(h) Provide staff orientation and appropriate training for expected duties, including:

(iv) How to report resident abuse and neglect consistent with chapter 74.34 RCW and assisted living facility policies and procedures;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to educate staff on how to follow through with mandatory reporting requirements to notify the Complaint Resolution Unit (CRU) of resident abuse allegations for 8 of 9 staff member (Staff B, C, D, E, F, G, H, and I). This failure placed all residents at risk of unreported abuse allegations.

Findings included...

Record review of facility policy titled, "Elder Abuse, Neglect, and Exploitation", dated 12/02/2022, showed "All staff and volunteers at Cogir Management Senior Living USA are mandated reporters" and "Reporting of any suspected, alleged, or witnessed abuse, neglect, or exploitation will be completed according to state reporting requirements." and "The assisted living facility must ensure that each staff person: Makes a report to the departments Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred."

During an unannounced visit on 1/28/2025 at 12:16 PM, Staff A, reported that facility

staff had been educated on mandatory reporting requirements. Staff A reported that all facility staff attended mandatory training, provided at the facility, as part of their plan of correction related to a previous failed compliance with mandated reporting requirements. Staff A reported that all facility staff had realized that they are individual mandated reporters that must report applicable concerns to CRU as an individual, in addition to notifying the facility management. Staff A reported that the staff training focused on their previous identified failure to make a CRU report.

In an interview on 1/28/2025 at 12:38 PM, Staff B, Health and Wellness Director, reported that if staff were to observe abuse of a resident, then staff were instructed to report the observations to management so that management then could report it to CRU for the staff member.

In an interview on 1/28/2025 at 12:44 PM, Staff C, caregiver, reported that if they were to observe abuse of a resident then they would report it to the facility management personnel, then management would report it to CRU for them.

In an interview on 1/28/2025 at 12:48 PM, Staff D, caregiver, reported that if they were to observe abuse of a resident then they would report it to the facility management personnel, then management would report it to CRU for them.

In an interview on 1/28/2025 at 12:56 PM, Staff E, medication technician, reported that if they were to observe abuse of a resident then they would report it to the facility management personnel, then management would report it to CRU for them.

In an interview on 1/28/2025 at 1:12 PM, Staff F, medication technician, reported that if they were to observe abuse of a resident then they would report it to the facility management personnel, then management would report it to CRU for them.

In an interview on 1/28/2025 at 1:40 PM, Staff G, Resident Care Coordinator, reported that if they were to observe abuse of a resident then they would report it to the facility management personnel, then management would report it to CRU for them.

In an interview on 1/28/2025 at 1:48 PM, Staff H, medication technician, reported that if they were to observe abuse of a resident then they would report it to the facility management personnel, then management would report it to CRU for them.

In an interview on 1/28/2025 at 2:02 PM, Staff I, caregiver, reported that if they were to observe abuse of a resident then they would report it to the facility management personnel, then management would report it to CRU for them.

In an interview on 2/20/2025 at 4:24 PM, Staff A, Executive Director, reported that that

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the facility will have to receive a citation for failure to educate staff on reporting requirements since staff had not shown correct knowledge on their mandated reporting requirements.

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, Cogir Vancouver Orchards is or will be in compliance with this law and / or regulation on (Date) 3/31/25.

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

Deborah Woolery — Administrator (or Representative)

3/7/25 — Date

COGIR OF VANCOUVER
PLAN OF CORRECTION

CITATION NUMBER	NAME OF SECTION	PLAN OF CORRECTION	RESPONSIBLE PERSON FOR CORRECTION
WAC 388-78A-2450	STAFF	NEW HIRES RECEIVE IN WRITING A COPY THE ABUSE, NEGLECT AND EXPLOITATION ALSO BOD DISCUSSES VERBALLY OF MANDATED REPORTING. NEW HIRES RECEIVE A MANDATORY REPORTING HOTLINE NUMBER TO BE ATTACHED TO THEIR NAME BADGE OR KEY CARD. STAFF HAVE BEEN TRAINED IN REGARDS TO MANDATORY REPORTING. THEY ARE TO REPORT VIA HOT LINE NUMBER. STAFF HAVE A MANDATORY REPORTING HOTLINE STICKER WITH PHONE NUMBER ON THE BACK OF THEIR NAME BADGE OR ON THEIR KEY CARD.	DEBBIE WOOLERY