STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Cogir Management USA Inc
Cogir Queen Anne
805 4th Ave N
Seattle, WA 98109

RE: Cogir Queen Anne License # 2473

Dear Administrator:

This letter addresses Compliance Determination(s) 48600 (Completion Date 10/14/2024) and 44801 (Completion Date 08/22/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/14/2024 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-2570, WAC 388-78A-2483-2, WAC 388-78A-2484, WAC 388-78A-2484-1, WAC 388-78A-2484-2, WAC 388-78A-2466-1-a, WAC 388-78A-2140-1-a, WAC 388-78A-2140-1-a-i, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2100-2-b-ii, WAC 388-78A-2100-2-b-i, WAC 388-78A-2150-1, WAC 388-78A-2150-2, WAC 388-78A-2350-7-a, WAC 388-78A-2060, WAC 388-78A-2060-1, WAC 388-78A-2060-2, WAC 388-78A-2060-3, WAC 388-78A-2060-4, WAC 388-78A-2060-5, WAC 388-78A-2060-6, WAC 388-78A-2060-7, WAC 388-78A-2060-8, WAC 388-78A-2160, WAC 388-78A-2090, WAC 388-78A-2090-1, WAC 388-78A-2090-1-a, WAC 388-78A-2090-1-b, WAC 388-78A-2090-1-c, WAC 388-78A-2090-2, WAC 388-78A-2090-2-a, WAC 388-78A-2090-2-b, WAC 388-78A-2090-2-c, WAC 388-78A-2090-3, WAC 388-78A-2090-4, WAC 388-78A-2090-4-a, WAC 388-78A-2090-4-b, WAC 388-78A-2090-5, WAC 388-78A-2090-5-a, WAC 388-78A-2090-5-b, WAC 388-78A-2090-5-c, WAC 388-78A-2090-6, WAC 388-78A-2090-6-a, WAC 388-78A-2090-6-b, WAC 388-78A-2090-6-c, WAC 388-78A-2090-6-d, WAC 388-78A-2090-6-e, WAC 388-78A-2090-7, WAC 388-78A-2090-7-a, WAC 388-78A-2090-7-b, WAC 388-78A-2090-7-c, WAC 388-78A-2090-7-c-i, WAC 388-78A-2090-7-c-ii, WAC 388-78A-2090-7-d, WAC 388-78A-2090-8, WAC 388-78A-2090-8-a, WAC 388-78A-2090-8-b, WAC 388-78A-2090-8-b-i, WAC 388-78A-2090-8-b-ii, WAC 388-78A-2090-9, WAC 388-78A-2090-10, WAC 388-78A-2090-11, WAC 388-78A-2090-11-a, WAC 388-78A-2090-11-b, WAC 388-78A-2090-11-c, WAC 388-78A-2703-3

The Department staff who did the on-site verification:

Erin Steinbrenner, Nursing Consultant Institutional
Faith Le, NCI

If you have any questions, please contact me at (253)312-1446.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Cogir Queen Anne
Provider Type: Assisted Living Facility
License/Cert.#: 2473
Compliance Determination #: 44801
Intake ID: 140230
Investigator: Erin Steinbrenner
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 07/30/2024 through 08/22/2024
Complainant Contact Date(s):

Allegation(s):

1. Assisted Living Facility (ALF) staff did not respond timely to resident care needs and call lights.
2. ALF did not have enough staffing for residents.
3. Concerns about quality and quantity of food provided by ALF.
4. ALF's rent was too high
5. ALF's laundry is not available for use.

Investigation Methods:

Sample:	Total residents: 80 Resident sample size: 10 Closed records sample size: 0
Observations:	Resident care equipment Resident rooms Breakfast and Lunch service Staff to resident interactions Resident to resident interactions Medication administration Community laundry rooms
Interviews:	Executive chef Executive Director Maintenance Director Wellness Director Line cook Care staff Residents
Record Reviews:	ALF menus Staff schedules ADL task log Call light response log Rent increase notification Assessments Negotiated Service Agreements

Investigation Summary:

According to observation, interview and record review, 1. The investigation showed sampled residents' call light response times were delayed. Failed practice was identified see Statement of Deficiencies dated 08/22/2024. 2. Observations of care staff provided appropriate care to residents. Review of care staff schedule showed sufficient staffing. No failed practice identified. 3. The breakfast and lunch meals observed showed fresh food and good-sized portions. Residents interviewed had no complaints about portion size. Staff interviewed stated residents can request additional food. No failed practice identified.4. Reviewed notification of rent increase and the facility met the requirements for notifying of their charges and timeframe. No failed practice identified.5. Observation of laundry rooms showed washers and dryers were not utilized and available for use. No failed practice identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Cogir Queen Anne
Provider Type: Assisted Living Facility
License/Cert.#: 2473
Compliance Determination #: 44801
Intake ID: 139582
Investigator: Erin Steinbrenner
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 07/30/2024 through 08/22/2024
Complainant Contact Date(s):

Allegation(s):

1. Named Resident (NR) had history of wound to sacral area. During recent home health (HH) visit NR's sacral wound noted to have worsened and a new thigh wound had developed.
2. During recent HH visit, wheelchair cushion (ROHO brand) noted to be soiled, deflated and not in use.
3. NR's hospital bed observed to have a standard mattress in place not a hospital bed mattress and HH-provided air mattress topper was disassembled and not functioning properly.
4. NR is not receiving toilet assistance four times daily as directed and ALF is not providing care as directed by HH staff.

Investigation Methods:

Sample:
Total residents: 80
Resident sample size: 10
Closed records sample size: 0

Observations:
Sample Residents (SRs)
Staff - Resident interactions
ALF common areas
SR rooms and personal equipment

Interviews:
Named resident (NR) representative
ALF staff
SRs
Collateral Contact

Record Reviews:
Resident Characteristic Roster
NR records
SRs records
Incident reports
Progress notes
ADL documentation
NR skin evaluation documentation
HH orders

Investigation Summary:

1. NR found to be out of facility at time of investigation and not expected to return due to move to a higher level of care. Based on interviews and record review, NRs wound had progressed and worsened. Record review and interviews with ALF staff and NR representative showed NR had refused wound interventions and removed original hospital bed mattress and mattress air-flow topper. NR representative interviewed and stated NR had refused care at times. NR representative stated she was content with ALF staff and care. SRs expressed contentment and satisfaction with care provided by the ALF. No deficient practice identified.
2. At time of inspection, NR was not living at the ALF and equipment not in use. Unable to assess ROHO cushion for cleanliness. SRs wheelchair cushions and DME observed to be intact and clean. No failed practice identified.
3. NR out of facility and equipment not in use. SR's medical equipment observed to be in proper working order. SRs with hospital beds noted to have corresponding mattresses. No failed practice identified.
4. ALF ADL sign off sheets showed staff provided NR with toileting assistance four times per day. No deficient practice identified.

Review of NR's assessment made no mention of wound, history of wound or skin at risk. Review of NRs Service Plan (SP-comparable to Negotiated Service Agreement) did not identify coordination of care with HH agency or include what service HH would provide and their contact information. Review of NRs SP did not show signatures from NR or NR representative to show agreement of care to be provided. Deficient practice identified see Statement of Deficiencies 08/22/2024.

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
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Licensee: Cogir Management USA Inc
Cogir Queen Anne
805 4th Ave N
Seattle, WA 98109

RE: Cogir Queen Anne License # 2473

Dear Administrator:

The Department completed a full inspection and a complaint investigation of your Assisted Living Facility on 08/22/2024 and found that your facility does not meet the Assisted Living Facility licensing requirements.

The Department:

- Wrote the enclosed Statement of Deficiencies (SOD) report; and
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- May inspect the facility to determine if you have corrected all deficiencies.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Jamie Singer, Field Manager
Residential Care Services
Region 2, Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

You May:

• Receive a letter of enforcement action based on any deficiency listed on the enclosed report.

In Addition, You May:

• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

• Please contact me at (253)312-1446.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

Enclosure

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

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 the unannounced on-site full inspection and complaint investigation on 07/30/2024 and 08/02/2024 of:
Cogir Queen Anne
805 4th Ave N
Seattle, WA 98109

This document references the following complaint numbers: 140230, 139582.

The following sample was selected for review during the unannounced on-site visit: 10 of 80 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Faith Le, NCI
Erin Steinbrenner, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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.

Jamie Singer
Residential Care Services

8/26/2024
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) 8/28/2024 Date

WAC 388-78A-2570 Notification of change in administrator. The licensee must notify the department in writing within ten calendar days of the effective date of a change in the assisted living facility administrator. The notice must include the full name of the new administrator and the effective date of the change.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to notify the Department of a change in the ALF's Administrator. This failure prevented the Department from reviewing the Administrator's qualifications.

Findings included...

Observation and interview, on 07/30/2024 at 9:40 AM, showed Staff A (Executive Director – equivalent to Administrator) in the lobby of the facility. At 9:40 AM, Staff A confirmed she was the ALF's Executive Director and had been for the last two months.

Review of staff records showed the ALF hired Staff A as Administrator on 06/04/2024.

Review of the Departments Secured Tracking and Reporting Systems, on 07/30/2024, showed Staff A was not listed as the ALF's current Administrator.

In an interview, on 07/30/2024 at 11:25 AM, Staff A stated she was unsure if the Change of Administrator form had been submitted to the Department and would follow up. On follow up, Staff A confirmed the form had not been submitted and would send it immediately.

This is a repeated deficiency previously cited on 11/22/2022.

Plan/Attestation Statement

Administrator (or Representative) Date

WAC 388-78A-2570 Notification of change in administrator. The licensee must notify the department in writing within ten calendar days of the effective date of a change in the assisted living facility administrator. The notice must include the full name of the new administrator and the effective date of the change.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to notify the Department of a change in the ALF's Administrator. This failure prevented the Department from reviewing the Administrator's qualifications.

Findings included…

Observation and interview, on 07/30/2024 at 9:40 AM, showed Staff A (Executive Director – equivalent to Administrator) in the lobby of the facility. At 9:40 AM, Staff A confirmed she was the ALF's Executive Director and had been for the last two months.

Review of staff records showed the ALF hired Staff A as Administrator on 06/04/2024.

Review of the Departments Secured Tracking and Reporting Systems, on 07/30/2024, showed Staff A was not listed as the ALF's current Administrator.

In an interview, on 07/30/2024 at 11:25 AM, Staff A stated she was unsure if the Change of Administrator form had been submitted to the Department and would follow up. On follow up, Staff A confirmed the form had not been submitted and would send it immediately.

This is a repeated deficiency previously cited on 11/22/2022.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2473	Compliance Determination # 44501
Plan of Correction	Cogir Queen Anne	Completion Date
Page 6 of 24	Licensee: Cogir Management USA Inc	08/22/2024

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, Cogir Queen Anne is or will be in compliance with this law and / or regulation on (Date) 08 4 2024

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

Administrator (or Representative) 8/28/24 Date

WAC 388-78A-2483 Tuberculosis One test. The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:

(2) A documented negative result from one skin or blood test in the previous twelve months.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 1 staff member (Staff A) completed the required one step tuberculin skin test (TST). This placed 80 residents at risk of exposure to a communicable disease.

Findings included...

Record review showed the ALF hired Staff A (Administrator) on 08/04/2024. Record review showed Staff A had documented history of a negative result from a previous two step TST completed on 10/13/2023, prior to their employment.

In interview, on 08/02/2024 at 11:00 AM, Staff A stated the one step TST had been administered within three days of hire date but was unable to locate and provide documentation.

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 Queen Anne is or will be in compliance with this law and / or regulation on (Date) OCT 4 2024

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

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 Queen Anne 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

WAC 388-78A-2483 Tuberculosis One test. The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:

(2) A documented negative result from one skin or blood test in the previous twelve months.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 1 staff member (Staff A) completed the required one step tuberculin skin test (TST). This placed 80 residents at risk of exposure to a communicable disease.

Findings included…

Record review showed the ALF hired Staff A (Administrator) on 06/04/2024. Record review showed Staff A had documented history of a negative result from a previous two step TST completed on 10/13/2023, prior to their employment.

In interview, on 08/02/2024 at 11:00 AM, Staff A stated the one step TST had been administered within three days of hire date but was unable to locate and provide documentation.

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 Queen Anne 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.

Statement of Deficiencies	License #: 2473	Compliance Determination # 44501
Plan of Correction	Cogir Queen Anne	Completion Date
Page 6 of 24	Licensee: Cogir Management USA Inc	08/22/2024

Administrator (or Representative) 8/28/2024 Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 6 staff members (Staff D) completed the required two-step tuberculin skin test (TST). This placed 80 residents at risk of exposure to a communicable disease.

Findings included...

Review of records showed the ALF hired Staff D (Care Partner) on 08/18/2023. Record review showed Staff D had a one-step completed after date of hire on 08/18/2023. Record review showed Staff D did not have the two-step TST completed.

In interview, on 07/31/2024 at 10:20 AM, Staff A (Administrator) confirmed they were unable to provide documentation for Staff D's second step TST.

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 Queen Anne is or will be in compliance with this law and / or regulation on (Date) 10/4/2024

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

Administrator (or Representative) 8/28/2024 Date

Administrator (or Representative) Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 6 staff members (Staff D) completed the required two-step tuberculin skin test (TST). This placed 80 residents at risk of exposure to a communicable disease.

Findings included…

Review of records showed the ALF hired Staff D (Care Partner) on 08/18/2023. Record review showed Staff D had a one-step completed after date of hire on 08/19/2023. Record review showed Staff D did not have the two-step TST completed.

In interview, on 07/31/2024 at 10:20 AM, Staff A (Administrator) confirmed they were unable to provide documentation for Staff D's second step TST.

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 Queen Anne 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

Statement of Deficiencies	License #: 2473	Compliance Determination # 44801
Plan of Correction	Cogir Queen Anne	Completion Date
Page 7 of 24	Licensee: Cogir Management USA Inc	08/22/2024

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure the Washington State name and date of birth background inquiry (BGI) for 1 of 8 sampled staff (Staff E) was renewed before the two-year expiration. This placed 80 residents at risk for receiving care from staff whose criminal background history was unknown

Findings included...

Review of records for Staff E (Housekeeper), hired on 03/15/2021, showed their BGI expired as of 03/12/2023.

In an interview, on 07/30/2024 at 10:30 AM, Staff A (Administrator) stated she agreed Staff E's BGI renewal had expired and stated her team is working to review all staff files.

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 Queen Anne is or will be in compliance with this law and / or regulation on (Date) OCT 4 2024

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

Administrator (or Representative) 8/28/2024 Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure the Washington State name and date of birth background inquiry (BGI) for 1 of 6 sampled staff (Staff E) was renewed before the two-year expiration. This placed 80 residents at risk for receiving care from staff whose criminal background history was unknown.

Findings included…

Review of records for Staff E (Housekeeper), hired on 03/15/2021, showed their BGI expired as of 03/12/2023.

In an interview, on 07/30/2024 at 10:30 AM, Staff A (Administrator) stated she agreed Staff E's BGI renewal had expired and stated her team is working to review all staff files.

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 Queen Anne 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

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the

agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to identify and document in the Service Plan (SP- equivalent to the Negotiated Service Agreement) interventions that supported the care needs of 5 of 10 sampled residents (Resident 1, Resident 3, Resident 4, Resident 5 and Resident 8). These failures placed Residents 1 and 8 at risk of health complications related to use of anti-coagulant medication (medication that thins the blood to prevent clots), Resident 4 at risk for care needs not met related to an indwelling catheter and Residents 3 and 5 at risk for complications related to diabetes mellitus (a disorder in which the body has high sugar levels for prolonged periods of time).

Findings included…

Resident 1
Record review of Resident 1's Face Sheet, dated 07/31/2024, showed the ALF admitted Resident 1 on [redacted]/2023 with multiple diagnoses to include [redacted] and [redacted]. Review of an Assessment, dated 02/01/2024, showed Resident 1 was assessed as a fall risk due to history of fall with injury, diagnosis of [redacted] and [redacted].

Record review of Resident 1's May, June and July 2024 Medication Administration Record (MAR) showed a physician's order for once daily warfarin (anti-coagulant medication).

Review of an SP, dated 02/01/2024, showed no information or interventions on how to monitor for the increased risk of bleeding or bruising related to warfarin medication. Resident 2's SP did not include signs or symptoms to alert staff to changes in the resident's condition related to risk of bleeding or bruises related to the medication.

Resident 8
Review of a medical record and a Face Sheet, dated 07/31/2024, showed the ALF

admitted Resident 8 on [redacted]/2024 with primary diagnosis of a [redacted] and [redacted]. Review of an Assessment, dated 06/19/2024, showed Resident 8 is independent with medication management.

Record review of Resident 8's June and July 2024 MAR showed a physician's order for twice daily administration of Eliquis (an anti-coagulant medication).

Record review of Resident 8's SP, dated 06/28/2024, showed no information and did not identify that Resident 8 was taking an anti-coagulant medication. There were no instructions for staff regarding what to observe, report, or monitor and the bleeding risks associated when caring for Resident 8 while taking an anti-coagulant.

In interview, on 08/02/2024 at 11:55 AM, Staff G (Health Services Director) confirmed the risks of taking Warfarin and Eliquis should be included in Residents 1 and 8's SP.

Resident 4
Review of a Face Sheet showed the ALF admitted Resident 4 on [redacted]/2021 with a primary diagnosis of [redacted] and [redacted].

Review, on 07/30/2024, of the ALF's Resident Characteristic Roster indicated Resident 4 had an indwelling catheter (a hollow partially flexible tube that collects urine from the bladder and leads to a drainage bag).

Review of a Progress Note, dated 05/27/2024, indicated Resident 4's catheter bag drained darkly colored urine.

Record review of Resident 4's SP, dated 06/05/2024, showed no mention of an indwelling catheter or related care needs.

On 08/13/2024 at 3:52 PM, in electronic mail communication, Staff N (Regional Director of Health and Wellness) confirmed Resident 4's catheter was placed in April of 2024. Staff N indicated the hospice nurse manages routine catheter changes and ALF care staff empty the catheter bag each shift.

Resident 3
Review of a Face Sheet showed the ALF admitted Resident 3 on [redacted]/2023 with a diagnosis of [redacted].
Review of an Assessment, dated 02/02/2024, showed Resident 3 required staff assistance with insulin administration and blood glucose checks.

Observation, on 07/31/2024 at 8:05 AM, showed Staff M (Medication technician) check Resident 3's blood glucose level. Staff M then provided Resident 3 with an insulin pen for the Resident to self-administer.

In interview, on 07/31/2024 at 8:10 AM, Staff M was unable to list specific signs a resident may exhibit with low or high blood sugar levels.

Review of Resident 3's SP, dated 02/02/2024, showed no mention of signs to monitor for low or high blood sugar levels.

Resident 5
Review of records showed the ALF admitted Resident 5 on [redacted]/2023 with a primary diagnosis of [redacted] Review of an Assessment, dated 01/18/2024, showed Resident 5 was prescribed an oral diabetic medication and had family assistance with medication administration.

Review of Resident 5's SP, dated 01/30/2024, showed no mention of signs of low or high blood sugar levels in which to monitor and report.

In interview, on 08/02/2024 at 12:08 PM, Staff H (Regional Health and Wellness Specialist) confirmed signs of low and high glucose levels for staff to monitor would normally be included in the resident's SP.

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 Queen Anne is/or will be in compliance with this law and / or regulation on (Date) 09/4/2024.

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

Administrator (or Representative) 8/28/2024 Date

Observation, on 07/31/2024 at 8:05 AM, showed Staff M (Medication technician) check Resident 3's blood glucose level. Staff M then provided Resident 3 with an insulin pen for the Resident to self-administer.

In interview, on 07/31/2024 at 8:10 AM, Staff M was unable to list specific signs a resident may exhibit with low or high blood sugar levels.

Review of Resident 3's SP, dated 02/02/2024, showed no mention of signs to monitor for low or high blood sugar levels.

Resident 5
Review of records showed the ALF admitted Resident 5 on [redacted]/2023 with a primary diagnosis of [redacted]. Review of an Assessment, dated 01/18/2024, showed Resident 5 was prescribed an oral diabetic medication and had family assistance with medication administration.

Review of Resident 5's SP, dated 01/30/2024, showed no mention of signs of low or high blood sugar levels in which to monitor and report.

In interview, on 08/02/2024 at 12:08 PM, Staff H (Regional Health and Wellness Specialist) confirmed signs of low and high glucose levels for staff to monitor would normally be included in the resident's SP.

Plan/Attestation Statement

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

_____ _____
Administrator (or Representative) Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to complete an ongoing assessment for a new skin issue for 1 of 1 sampled resident (Resident 2) and use of side rails and oxygen orders for 1 of 1 sampled resident (Resident 4). This placed Resident 2 at risk for worsening skin breakdown and related health issues and Resident 4 at risk for injury and unmet health needs.

Findings included...

Resident 2
Review of a Face Sheet showed the ALF admitted Resident 2 on [redacted]/2016 with a primary diagnosis of [redacted]

Review of a Temporary Care Plan (TCP), dated 05/14/2024, showed Resident 2 had redness to their buttock area and required toileting assistance four times during the day and evening shifts. Staff were directed on the TCP to apply protective barrier to the affected area.

In interview, on 08/01/2024 at 2:00 PM, Staff L (Resident Care Coordinator) confirmed Resident 2 had a history of skin breakdown and had received Home Health (HH) wound care. Staff L stated a care conference with Resident 2, ALF staff and HH representatives had been held in May 2024 to discuss interventions for wound healing and prevention. Staff L confirmed the wound had healed but the skin area had recently re-opened.

Review of Resident 2's Assessment, dated 05/10/2024, showed no mention of a history of or current wound in the skin evaluation section.

Resident 4
Review of a Face Sheet showed the ALF admitted Resident 4 on [redacted]/2021 with a primary diagnosis of [redacted] and [redacted]

[redacted]

Observation and interview, on 08/01/2024 at 10:00 AM, showed Resident 4 with a nasal cannula (a tube that delivers O2 through the nostrils) connected on one end to an oxygen tank and the other end draped over her ears and secured to the nasal area. Resident 4 stated she uses oxygen when she sleeps and when she is in her apartment. Resident 4 confirmed the care staff assist her with turning the oxygen tank on and securing the tubing.

Observation of Resident 4's bed on 08/01/2024 at 10:10 AM showed half-length side rails bolted to the upper right and left sides of the hospital bed. Each side rail measured 32 inches in length and 18 inches in height with vertical bars spaces two inches apart.

In interview on 08/01/2024 at 10:10 AM, Resident 4 stated the side rails had been installed when she moved in and are used for getting in and out of bed.

Record review of Resident 4's Assessment, dated 04/30/2024, showed no mention of a side rail assessment or indication of oxygen usage.

In interview, on 08/02/2024 at 11:59 AM, Staff G (Health and Wellness Director) confirmed an assessment for side rails was not completed and should be completed to evaluate the risk and benefits. Staff G also confirmed oxygen was not on Resident 4's assessment and should be included in the assessment.

This is a repeated deficiency previously cited on 11/22/2022.

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 Queen Anne is or will be in compliance with this law and / or regulation on (Date) OCT 4 2024.

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

Administrator (or Representative) — Date: 8/28/2024

[redacted].

Observation and interview, on 08/01/2024 at 10:00 AM, showed Resident 4 with a nasal cannula (a tube that delivers O2 through the nostrils) connected on one end to an oxygen tank and the other end draped over her ears and secured to the nasal area. Resident 4 stated she uses oxygen when she sleeps and when she is in her apartment. Resident 4 confirmed the care staff assist her with turning the oxygen tank on and securing the tubing.

Observation of Resident 4's bed on 08/01/2024 at 10:10 AM showed half-length side rails bolted to the upper right and left sides of the hospital bed. Each side rail measured 32 inches in length and 18 inches in height with vertical bars spaces two inches apart.

In interview on 08/01/2024 at 10:10 AM, Resident 4 stated the side rails had been installed when she moved in and are used for getting in and out of bed.

Record review of Resident 4's Assessment, dated 04/30/2024, showed no mention of a side rail assessment or indication of oxygen usage.

In interview, on 08/02/2024 at 11:59 AM, Staff G (Health and Wellness Director) confirmed an assessment for side rails was not completed and should be completed to evaluate the risk and benefits. Staff G also confirmed oxygen was not on Resident 4's assessment and should be included in the assessment.

This is a repeated deficiency previously cited on 11/22/2022.

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 Queen Anne 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

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

(2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and

This requirement was not met as evidenced by:

Based on interview and record reviews, the Assisted Living Facility (ALF) failed to ensure the residents' or their representatives signed the Service Plans (SP-equivalent to the Negotiated Service Agreement) at least annually for 5 of 10 sampled residents (Residents 2, 4, 5, 7 and 8). This placed Residents 2, 4, 5, 7 and 8 at risk for receiving or not receiving care and services that had been agreed upon.

Findings included…

Review of a Face Sheet showed the ALF admitted Resident 2 on [redacted]/2016 with multiple diagnoses. Review of Resident 2's SP dated 06/18/2024, showed no signature from the resident or the resident representative.

Review of a Face sheet showed the ALF admitted Resident 4 on [redacted]/2021 with multiple diagnoses. Review of Resident 4's SP, dated 06/05/2024, showed no signature from the resident or the resident representative.

Review of a Face sheet showed the ALF admitted Resident 5 on [redacted]/2023 with multiple diagnoses. Review of Resident 5's SP, dated 01/30/2024, showed no signature from the resident or the resident representative.

Review of a Face sheet showed the ALF admitted Resident 7 on [redacted]/2024 with multiple diagnoses. Review of Resident 7's SP, dated 07/09/2024, showed no signature from the resident or the resident representative.

Review of a Face sheet showed the ALF admitted Resident 8 on [redacted]/20/24 with multiple diagnoses. Review of Resident 8's SP, dated 06/28/2024, showed no signature from the resident or the resident representative.

In interview on 08/02/2024 at 1:25 PM, Staff H (Regional Health and Wellness Nurse) confirmed the ALF did not have signed service plans for Residents 2, 4, 5, 7, and 8.

Statement of Deficiencies	License #: 2473	Compliance Determination # 44801
Plan of Correction	Cogir Queen Anne	Completion Date
Page 14 of 24	Licensee: Cogir Management USA Inc	08/22/2024

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 Queen Anne is or will be in compliance with this law and / or regulation on (Date) OCT 1 2024

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

Administrator (or Representative) 8/28/2024 Date

WAC 388-78A-2350 Coordination of health care services.

(7) When coordinating care or services, the assisted living facility must:

(a) Integrate relevant information from the external provider into the resident's preadmission assessment and reassessment, and when appropriate, negotiated service agreement; and

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to ensure coordination of care with outside providers for 3 of 3 sample residents (Resident 2, Resident 4 and Resident 7) receiving home health (HH) or hospice services. This failure placed Residents 2, 4 and 7 at risk for unmet needs and increased health issues

Findings included...

Resident 2
Review of a Face Sheet showed the ALF admitted Resident 2 on [redacted]/2016 with multiple health conditions to include [redacted].

In interview, on 08/01/2024 at 2:00 PM, Staff L (Resident Care Coordinator) stated an interdisciplinary care conference occurred on 05/04/2024 and included HH clinicians, Resident 4 and their Representative and ALF management staff to discuss Resident 4's care and interventions for skin at risk of injury.

Record review of a treatment order originally sent on 05/16/2024, from a HH provider, showed instructions for ALF staff to assist with placement of a ROHO cushion in 4's wheelchair and maintain an air flow mattress topper on the bed.

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 Queen Anne 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

WAC 388-78A-2350 Coordination of health care services.

(7) When coordinating care or services, the assisted living facility must:

(a) Integrate relevant information from the external provider into the resident's preadmission assessment and reassessment, and when appropriate, negotiated service agreement; and

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to ensure coordination of care with outside providers for 3 of 3 sample residents (Resident 2, Resident 4 and Resident 7) receiving home health (HH) or hospice services. This failure placed Residents 2, 4 and 7 at risk for unmet needs and increased health issues.

Findings included…

Resident 2
Review of a Face Sheet showed the ALF admitted Resident 2 on [redacted]/2016 with multiple health conditions to include [redacted].

In interview, on 08/01/2024 at 2:00 PM, Staff L (Resident Care Coordinator) stated an interdisciplinary care conference occurred on 05/04/2024 and included HH clinicians, Resident 4 and their Representative and ALF management staff to discuss Resident 4's care and interventions for skin at risk of injury.

Record review of a treatment order originally sent on 05/16/2024, from a HH provider, showed instructions for ALF staff to assist with placement of a ROHO cushion in 4's wheelchair and maintain an air flow mattress topper on the bed.

Record review of Resident 2's Service Plan (SP) dated 06/18/2024, did not show Resident 2 received services from any outside providers such as Home Health.

Resident 4
Review of a Face Sheet showed the ALF admitted Resident 4 on [redacted]/2021 with multiple health conditions to include [redacted] and [redacted] The body may not get the oxygen it needs).

Record review of the Resident Characteristic Roster, provided on 07/30/2024, showed the resident was on hospice (care provided to the terminally ill) services.

Review of a Progress Note, dated 05/10/2024, showed Resident 4 had a visit from a hospice nurse related to recent medication change.

Staff N (Regional Director of Health and Wellness) confirmed, on 08/13/2024 at 3:52 PM through electronic mail, Resident 4 had been enrolled in hospice services on 04/17/2024 and on 08/01/2024 had changed to a different hospice provider. Staff N confirmed Resident 4's was routinely visited by a hospice nurse.

Record review of Resident 4's SP, dated 06/05/2024, did not show Resident 4 received services from any outside providers such as HH or hospice.

Resident 7
Review of a SP, dated 07/09/2024, showed the ALF admitted Resident 7 on [redacted]/2024 with multiple medical conditions to include chronic pain.

Review of a therapy order form, dated 03/14/2024, showed treatments for physical therapy (PT) and occupational therapy (OT).

Review of a Progress Note, dated 06/03/2024, showed Resident 7 received PT.

Review of Resident 7's SP showed no information and did not identify Resident 7 was receiving PT or OT.

In an interview, on 08/02/2024 at 12:00 PM, Staff G (Health Services Director) confirmed Residents 2, 4 and 7's services with home health or hospice agencies were not documented in their SPs and that outside providers, such as hospice and PT should be included in a residents SP to coordinate care with the ALF.

Statement of Deficiencies	License #: 2473	Compliance Determination # 44801
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Page 16 of 24	Licensee: Cogir Management USA Inc	08/22/2024

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, Cogir Queen Anne is or will be in compliance with this law and / or regulation on (Date) OCT 4 2024

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

Administrator (or Representative) — 8/28/2024 Date

WAC 388-78A-2060 Preadmission assessment. The assisted living facility must conduct a preadmission assessment for each prospective resident that includes the following information, unless unavailable despite the best efforts of the assisted living facility:

(1) Medical history;

(2) Necessary and contraindicated medications;

(3) A licensed medical or health professional's diagnosis, unless the prospective resident objects for religious reasons;

(4) Significant known behaviors or symptoms that may cause concern or require special care;

(5) Mental illness diagnosis, except where protected by confidentiality laws;

(6) Level of personal care needs;

(7) Activities and service preferences; and

(8) Preferences regarding other issues important to the prospective resident, such as food and daily routine.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to complete a Pre-Admission Assessment (PA) for 1 of 2 sampled residents (Residents 8). This placed Resident 8 at risk for not receiving a level of care appropriate for their needs.

Findings included...

Review of a medical record and a Face Sheet, dated 07/31/2024, showed the ALF admitted Resident 8 on [redacted] 2024. Review of records showed an Initial Assessment was conducted for Resident 8 on their date of moved-in, [redacted] 2024. There was no PA

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 Queen Anne 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

WAC 388-78A-2060 Preadmission assessment. The assisted living facility must conduct a preadmission assessment for each prospective resident that includes the following information, unless unavailable despite the best efforts of the assisted living facility:

(1) Medical history;

(2) Necessary and contraindicated medications;

(3) A licensed medical or health professional's diagnosis, unless the prospective resident objects for religious reasons;

(4) Significant known behaviors or symptoms that may cause concern or require special care;

(5) Mental illness diagnosis, except where protected by confidentiality laws;

(6) Level of personal care needs;

(7) Activities and service preferences; and

(8) Preferences regarding other issues important to the prospective resident, such as food and daily routine.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to complete a Pre-Admission Assessment (PA) for 1 of 2 sampled residents (Residents 8). This placed Resident 8 at risk for not receiving a level of care appropriate for their needs.

Findings included…

Review of a medical record and a Face Sheet, dated 07/31/2024, showed the ALF admitted Resident 8 on [redacted]/2024. Review of records showed an Initial Assessment was conducted for Resident 8 on their date of moved-in, [redacted]/2024. There was no PA

done for Resident 8 prior to [redacted]/2024.

During an interview, on 08/02/2024 at 10:25 AM, Staff H (Regional Health and Wellness) stated he could not locate a PA for Resident 8's admission and it was not in the Resident's file

Plan/Attestation Statement

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

Administrator (or Representative) — 8/28/2024 Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to provide the agreed upon care and services in the Negotiated Service Agreements (NSA) for 5 of 5 residents (Resident 3, 4, 5, 8, and 10) when call lights were not responded to in a timely manner. This failure placed Resident 3, 4, 5, 8, and 10 at risk of harm and a poor quality of life.

Findings included...

Resident 3
Review of a Face Sheet showed the ALF admitted Resident 3 on [redacted]/2023 with a primary diagnosis of [redacted]. Review of a Service Plan (SP – equivalent to an NSA), dated 02/02/2024, showed Resident 3 required two staff assistance for transfers with mechanical lift, toileting and bathing

In interview, on 08/01/2024 at 10:30 AM, Resident 3 stated he needs two care staff and the use of a Hoyer lift (a brand of mobility tool used to safely transfer persons with

done for Resident 8 prior to [redacted]/2024.

During an interview, on 08/02/2024 at 10:25 AM, Staff H (Regional Health and Wellness) stated he could not locate a PA for Resident 8's admission and it was not in the Resident's file.

Plan/Attestation Statement

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

_____ _____
Administrator (or Representative) Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to provide the agreed upon care and services in the Negotiated Service Agreements (NSA) for 5 of 5 residents (Resident 3, 4, 5, 6, and 10) when call lights were not responded to in a timely manner. This failure placed Resident 3, 4, 5, 6, and 10 at risk of harm and a poor quality of life.

Findings included...

Resident 3
Review of a Face Sheet showed the ALF admitted Resident 3 on [redacted]/2023 with a primary diagnosis of [redacted]. Review of a Service Plan (SP – equivalent to an NSA), dated 02/02/2024, showed Resident 3 required two staff assistance for transfers with mechanical lift, toileting and bathing.

In interview, on 08/01/2024 at 10:30 AM, Resident 3 stated he needs two care staff and the use of a Hoyer lift (a brand of mobility tool used to safely transfer persons with

mobility challenges) for transfer to and from his bed. Resident 3 stated some mornings if they are short staffed, he has waited 45 minutes to an hour for assistance.

Review of a call light response record, dated 07/02/2024 through 08/01/2024, showed the following wait times for Resident 3's call light response time for Assistance Needed:

• Over 20 minutes on 15 occasions.
• Over 30 minutes on six occasions.
• Over 40 minutes on two occasions.
• Over 50 minutes on one occasion.

Resident 4
Review of a Face Sheet showed the ALF admitted Resident 4 on [redacted]/2021 with multiple diagnoses. Review of a SP, dated 06/05/2024, showed Resident 4 required one staff to assist her with dressing and toileting tasks.

In interview, on 08/01/2024 at 10:00 AM, Resident 4 stated she usually needs to wait a half hour to 45 minutes for staff to answer her call light.

Review of a call light response record, dated 07/02/2024 through 08/01/2024, showed the following wait times for Resident 4's call light response time for Assistance Needed:

• Over 20 minutes on 26 occasions.
• Over 30 minutes on 17 occasions.
• Over 40 minutes on five occasions.
• Over 50 minutes on two occasions.
• Over an hour on two occasions.

Resident 5
Review of a Face Sheet showed the ALF admitted Resident 5 on [redacted]/2023 with multiple diagnoses. Review of a SP, dated 01/30/2024, showed Resident 5 required two care staff to assist with transfers, dressing and toileting tasks.

Review of a call light response record, dated 07/02/2024 through 08/01/2024, showed the following wait times for Resident 5's call light response time for Assistance Needed:

• Over 20 minutes on 17 occasions.
• Over 30 minutes on six occasions.
• Over 40 minutes on four occasions.
• Over 50 minutes one occasion.
• Over an hour on two occasions.

Resident 6
Record review of a SP, dated 05/25/2024, showed the ALF admitted Resident 6 on [redacted]/2021with multiple medical conditions to include a diagnosis of [redacted]

[redacted], and [redacted].

In an interview, on 08/02/2024 at 1:50 PM, Resident 6 stated she needed help from ALF staff to get her to the bathroom to toilet. Resident 6 stated she used her call light when she needed staff assistance. Resident 6 stated call light wait times can be up to an hour, often her clothes are soiled due to long wait times.

Review of a call light response record, dated 07/02/2024 through 08/01/2024, showed the following wait times for Resident 6's call light response time for Assistance Needed:

- Over 20 minutes on 56 occasions.
- Over 30 minutes on 19 occasions.
- Over 40 minutes on 13 occasions.
- Over 50 minutes on three occasions.
- Over an hour on six occasions.
- Over three hours on one occasion.

Resident 10
Review of medical records, dated 08/02/2024, showed the ALF admitted Resident 10 on [redacted]/2024, with multiple medical conditions to include end-stage renal disease (the final, permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own) and dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and required hands-on staff assistance with bathing, mobility/ambulation, and transferring.

In an interview, on 08/01/2024 at 10:00 AM, Resident 10's live-in spouse stated the ALF staff were slow to respond to call lights when Resident 10 needed care. Call light wait times can be up to 45 minutes or staff never responded.

Further interview, on 08/01/2024 at 11:24 AM, Resident 10 confirmed call light response times are very long, and his clothes got soiled when ALF took too long to respond.

Review of a call light response record, dated 07/02/2024 through 08/01/2024, showed the following wait times for Resident 10's call light response time for Assistance Needed:

- Over 20 minutes on 21 occasions.
- Over 30 minutes on 10 occasions.

- Over 40 minutes on eight occasions.
- Over 50 minutes on three occasions.
- Over one hour on four occasions.
- Over two hours on one occasion.
- Over four hours on one occasion.
- Over five hours on one occasion
- Over nine hours on one occasion.

In an interview, on 08/22/2024 at 8:32 AM, Staff A (Administrator) stated call light response times should be within 10 minutes.

This is a repeated deficiency previously cited on 05/31/2023.

Plan/Attestation Statement

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

Administrator (or Representative) — 8/28/2024 Date

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(1) Individual's recent medical history, including, but not limited to:

(a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons;

(b) Chronic, current, and potential skin conditions; or

(c) Known allergies to foods or medications, or other considerations for providing care or services.

(2) Currently necessary and contraindicated medications and treatments for the individual, including:

(a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and accurately direct others to administer to him/her;

• Over 40 minutes on eight occasions.
• Over 50 minutes on three occasions.
• Over one hour on four occasions.
• Over two hours on one occasion.
• Over four hours on one occasion.
• Over five hours on one occasion.
• Over nine hours on one occasion.

In an interview, on 08/22/2024 at 8:32 AM, Staff A (Administrator) stated call light response times should be within 10 minutes.

This is a repeated deficiency previously cited on 05/31/2023.

Plan/Attestation Statement

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

_____ _____
Administrator (or Representative) Date

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(1) Individual's recent medical history, including, but not limited to:

(a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons;

(b) Chronic, current, and potential skin conditions; or

(c) Known allergies to foods or medications, or other considerations for providing care or services.

(2) Currently necessary and contraindicated medications and treatments for the individual, including:

(a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and accurately direct others to administer to him/her;

(b) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to self-administer when he/she has the assistance of a caregiver; and

(c) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is not able to self-administer, and needs to have administered to him or her.

(3) The individual's nursing needs when the individual requires the services of a nurse on the assisted living facility premises.

(4) Individual's sensory abilities, including:

(a) Vision; and

(b) Hearing.

(5) Individual's communication abilities, including:

(a) Modes of expression;

(b) Ability to make self understood; and

(c) Ability to understand others.

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(a) History of substance abuse;

(b) History of harming self, others, or property; or

(c) Other conditions that may require behavioral intervention strategies;

(d) Individual's ability to leave the assisted living facility unsupervised; and

(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

(7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:

(a) Mental illness, or needs for psychological or mental health services, except where protected by confidentiality laws;

(b) Developmental disability;

(c) Dementia. While screening a resident for dementia, the assisted living facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(ii) Document the evidence in the resident's record.

(d) Other conditions affecting cognition, such as traumatic brain injury.

(8) Individual's level of personal care needs, including:

(a) Ability to perform activities of daily living;

(b) Medication management ability, including:

(i) The individual's ability to obtain and appropriately use over-the-counter medications; and

(ii) How the individual will obtain prescribed medications for use in the assisted living facility.

(9) Individual's activities, typical daily routines, habits and service preferences.

(10) Individual's personal identity and lifestyle, to the extent the individual is willing to share the information, and the manner in which they are expressed, including preferences regarding food, community contacts, hobbies, spiritual preferences, or other sources of pleasure and comfort.

(11) Who has decision-making authority for the individual, including:

(a) The presence of any advance directive, or other legal document that will establish a substitute decision maker in the future;

(b) The presence of any legal document that establishes a current substitute decision maker; and

(c) The scope of decision-making authority of any substitute decision maker.

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to ensure a system was in place to perform a 14-day assessment, after moving into the ALF for 1 of 3 sample residents (Resident 10) who was admitted to the ALF in the past six months. This failure placed Resident 10 at risk for unmet needs and a decreased quality of life.

Findings included…

Review of medical records, dated 08/02/2024, showed the ALF admitted Resident 10 on [redacted]/2024, with multiple medical conditions to include end-stage renal disease (the final, permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own) and dementia (a group of symptoms that affects memory, thinking and interferes with daily life)

Record review of Resident 10’s medical chart showed the most recent Assessment was performed on 12/07/2023 as the Initial Assessment. There was no Initial Assessment created within fourteen days of Resident 10's admit date of [redacted]/2024.

In an interview, on 08/02/2024 at 10:25 AM, Staff H (Regional Health and Wellness) confirmed no initial Assessment was completed after Resident 10 was admitted into the

ALF.

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 Queen Anne is or will be in compliance with this law and / or regulation on (Date) OCT 4 2024

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

Administrator (or Representative) — Date: 8/28/24

WAC 388-78A-2703 Safety of the built environment. The assisted living facility must provide a safe environment and promote the safety of each resident whenever the resident is on the premises or under the supervision of staff persons consistent with the resident's negotiated service agreement, and must maintain the premises and equipment used in resident care so as to be free of hazards, including:

(3) Keeping exterior grounds, assisted living facility structures, and component parts safe, sanitary, and in good repair.

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to promote a safe environment and ensure a furnace/utility room was clear of standing water. This failure placed residents at a potential risk for an electrical fire in the ALF.

Findings included...

An observation and interview, on 07/30/2024 at 11:15 AM, with Staff A (Administrator) and Staff O (Maintenance Director) during the environmental tour showed a utility room located on the Parking Level floor. The utility room had a non-working overhead light fixture and contained a furnace with standing water on the floor. Near the standing water showed a condensate pump and a table lamp sitting on the floor that was plugged in, and providing light to the room, with its electrical cord laying six inches from the standing water. Staff O stated he is unsure how long the standing water had been on the floor, and the lamp should not be placed on the floor.

ALF.

Plan/Attestation Statement

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

_____ _____
Administrator (or Representative) Date

WAC 388-78A-2703 Safety of the built environment. The assisted living facility must provide a safe environment and promote the safety of each resident whenever the resident is on the premises or under the supervision of staff persons consistent with the resident's negotiated service agreement, and must maintain the premises and equipment used in resident care so as to be free of hazards, including:

(3) Keeping exterior grounds, assisted living facility structures, and component parts safe, sanitary, and in good repair.

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to promote a safe environment and ensure a furnace/utility room was clear of standing water. This failure placed residents at a potential risk for an electrical fire in the ALF.

Findings included…

An observation and interview, on 07/30/2024 at 11:15 AM, with Staff A (Administrator) and Staff O (Maintenance Director) during the environmental tour showed a utility room located on the Parking Level floor. The utility room had a non-working overhead light fixture and contained a furnace with standing water on the floor. Near the standing water showed a condensate pump and a table lamp sitting on the floor that was plugged in, and providing light to the room, with its electrical cord laying six inches from the standing water. Staff O stated he is unsure how long the standing water had been on the floor, and the lamp should not be placed on the floor.

Statement of Deficiencies	License #: 2473	Compliance Determination # 44801
Plan of Correction	Cogir Queen Anne	Completion Date
Page 24 of 24	Licensee: Cogir Management USA Inc	08/22/2024

Plan/Attestation Statement

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

Administrator (or Representative) 8/28/2024 Date

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date