STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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) 77760 (Completion Date 05/26/2026) and 74008 (Completion Date 04/17/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/26/2026 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-2474-1, WAC 388-78A-2474-2-c, WAC 388-78A-2474-2-d, WAC 388-78A-2474-2-e, WAC 388-78A-2474-3, WAC 388-78A-2474-5, WAC 388-78A-2474-6

The Department staff who did the off-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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies	License #: 2473	Compliance Determination #:74008
Plan of Correction	Cogir Queen Anne	Completion Date
Page 1 of 4	Licensee: Cogir Management USA Inc	04/17/2026

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 follow-up on 04/13/2026 of:
Cogir Queen Anne
805 4th Ave N
Seattle, WA 98109

This document references the following SOD dated: 04/17/2026

The following sample was selected for review during the unannounced on-site visit: 8 of 120 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Erin Steinbrenner, Nursing Consultant Institutional
Faith Le, NCI

From:
DSHS, Home and Community Living 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

04/29/2026
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)

05/04/2026
Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(1) The assisted living facility must ensure staff persons hired before January 7, 2012 meet training requirements in effect on the date hired, including requirements in chapter 388-112A WAC.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

(3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.

(5) Under RCW 18.88B.041 and chapter 246-980 WAC, certain individuals including registered nurses, licensed practical nurses, certified nursing assistants, or persons who are in an approved certified nursing assistant training program are exempt from long-term care worker basic training requirements. Continuing education requirements under chapter 388-112A WAC still apply to these individuals, except for registered nurses and licensed practical nurses.

(6) For the purpose of this section, the term "caregiver" has the same meaning as the term "long-term care worker" as defined in RCW 74.39A.009 .

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 3 sampled staff (Staff D) received facility orientation, 1 of 4 sampled staff (Staff D)

completed the required cardiopulmonary resuscitation (CPR) training, and 1 of 6 sampled staff (Staff E) had completed the required annual 12 hours of continuing education (CE). This failure placed 120 residents at risk of harm from care staff unfamiliar with the ALF, their expected duties, and improper CPR technique in the event of an emergency.

Findings included...

Facility Orientation
Note: Washington Administrative Code (WAC) 388-112A-0200 - There are two types of orientation training: Facility orientation training and long-term care worker orientation training. (1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation.

Record review showed the ALF hired Staff D (Care Partner) on 05/27/2025. Review of Staff D's records on 04/13/2026 did not show they received facility orientation.

During an interview, on 04/13/2026 at 1:55 PM, Staff A (Executive Director) stated the ALF had scheduled facility orientation, but Staff D had not attended.

NOTE: WAC 388-112A-0700 - What is CPR training? Cardiopulmonary resuscitation (CPR) training is training provided by an authorized CPR instructor. Trainees must successfully complete the written and skills demonstration tests.
NOTE: WAC 388-112A-0720 What are the CPR and first-aid training requirements?
(2) Assisted living facilities.
(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire.

Review of staff records on 04/13/2026 showed the ALF hired Staff D on 05/27/2025. Record review showed Staff D did not complete the required CPR training.

During an interview, on 04/13/2026 at 1:55 PM, Staff A stated the ALF had scheduled a CPR class, but Staff D had not attended. Staff A stated they will begin to remove staff from the schedule until they meet training requirements.

Continuing Education
WAC 388-112A-0611
Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they

be completed?
(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described in this section.
(a) The following long-term care workers must complete 12 hours of continuing education by their birthday each year:
(i) A certified home care aide;
(ii) A long-term care worker who is exempt from the 70-hour home care aide basic training under WAC 388-112A-0090 (1) and (2);
(iii) A certified nursing assistant;
(i) Must complete 12 hours of continuing education by the long-term care worker's birthday each calendar year worked thereafter

Review of staff records on 04/13/2026 showed the ALF hired Staff E (Care Partner- Nurse Assistant Certified-NAC) on 12/08/2023. Record review showed Staff E did not have the required annual 12 hours of continuing education between the years 2024 and 2025 or between the years 2025 and 2026 of Staff E's month and day of birth as required for a credential NAC. Record review showed Staff E renewed their NAC license on 02/17/2026.

During an interview, on 04/13/2026 at 12:30 PM, Staff A stated the ALF had not tracked CE's in the past and was unable to provide proof Staff E had completed the required 12 hours of continuing education within the last year of their employment. Staff A stated they recently implemented a new online training and tracking system and will remove Staff E until they complete and provide record of the required CE hours.

This is an uncorrected deficiency previously cited under subsections (1),(2)(d)(e), (3), (5), and (6) on 02/17/2026.

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) 05/15/2026 .

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

Administrator (or Representative) 05/04/2026 Date

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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 on 01/27/2026 and 01/29/2026 of:
Cogir Queen Anne
805 4th Ave N
Seattle, WA 98109

The following sample was selected for review during the unannounced on-site visit: 12 of 118 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, Home and Community Living 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.

Janice Sirugen
Residential Care Services

2/23/2026
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)

02.27.2026
Date

WAC 388-78A-2210 Medication services:

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs - Prescription drugs, and other applicable statutes and administrative rules; and

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250:

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure safe medication systems were implemented when 3 of 12 resident (Residents 7, 8 and 12) did not get their medications as prescribed and 1 of 1 resident (Resident 11) who could not safely self-administer medication had unsecured medications in their room. These failures resulted in Residents 7, 8 and 12 not receiving their medications as prescribed and placed Resident 11 at risk of medication errors and deteriorated health condition.

Findings included...

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

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure safe medication systems were implemented when 3 of 12 resident (Residents 7, 8 and 12) did not get their medications as prescribed and 1 of 1 resident (Resident 11) who could not safely self-administer medication had unsecured medications in their room. These failures resulted in Residents 7, 8 and 12 not receiving their medications as prescribed and placed Resident 11 at risk of medication errors and deteriorated health condition.

Findings included…

Record review showed the ALF had an electronic Medication Administration Record (eMAR) for each resident with a box for initials of the staff member to document that the medication was given.

Resident 7

Review of a Face Sheet showed that the ALF admitted Resident 7 on [redacted]/2024 with multiple medically disabling conditions including cerebral infarction (occurs when a vessel supplying blood to the brain is blocked), hemiplegia/hemiparesis (loss of strength in the arm, leg, and sometimes face on one side of the body), and encephalopathy (a dysfunction of the level or contents of consciousness due to brain dysfunction). Review of an Assessment, dated 12/26/2025, showed Resident 7 required medication administration assistance three or more times daily.

Review of Resident 7's December 2025 eMAR showed no staff initials indicating Resident 7 received gabapentin (used to treat pain) on 12/10/2025 at 12:00 PM.

Review of Resident 7's January 2026 eMAR, showed no staff initials indicating Resident 7 received gabapentin on 01/02/2026 at 12:00 PM.

Resident 8

Review of a Face Sheet showed that the ALF admitted Resident 8 on [redacted]/2022 with multiple medically disabling conditions including type 2 diabetes (a condition characterized by high blood sugar levels caused by either a lack of insulin or the body's inability to use insulin efficiently), chronic kidney disease (severe loss of kidney function), and heart disease. Review of an Assessment, dated 10/30/2025, showed Resident 8 required medication administration assistance two times daily.

Review of Resident 8's December 2025 eMAR showed no staff initials indicating Resident 8 received Glargine insulin (used to treat diabetes) on 12/12/2025 at 8:00 PM.

Resident 12

Review of a Face Sheet showed that the ALF admitted Resident 12 on [redacted]/2024 with multiple medically disabling conditions including dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and cerebral infarction. Review of an Assessment, dated 11/26/2025, showed Resident 12 required medication administration assistance.

Review of Resident 12's December 2025 eMAR showed no staff initials indicating

Resident 12 received acetaminophen (used to treat pain) on 12/01/2025 at 12:00 PM and gabapentin on 12/01/2025 at 1:30 PM.

In an interview, on 01/28/2026 at 11:43AM, Staff G (Health and Wellness Director) clarified that an unsigned eMAR box signifies that the medication was either not administered or not recorded. Staff G could not confirm if the medication was given.

Resident 11

Record review of a Facesheet showed the ALF admitted Resident 11 on [redacted]/2023 with multiple diagnoses including [redacted] and [redacted].

Review of Resident 11's Assessment, dated 12/11/2025, showed Resident 11 required staff assistance with medication management.

Observation and interview, on 01/28/2026 at 12:22 PM, showed an opened tube of ketoconazole (used to treat infections caused by a fungus) cream and an opened jar of hydrocortisone (used to treat skin conditions that cause swelling, redness, itching and rashes) cream on Resident 11's bedside table. Further observation showed eight additional tubes of ketoconazole on Resident 11's bookshelf at the end of her bed. Resident 11 stated the creams were used to treat a fungal infection.

In interview, 01/28/2025 at 1:02 PM, Staff G confirmed Resident 11 was on medication services and agreed she should not have unsecured medications in her apartment. Staff G stated they would check on Resident 11 and remove the medications right away.

This deficiency was previously cited on 05/14/2025.

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, Cogir Queen Anne is or will be in compliance with this law and / or regulation on (Date) 04.03.2026.

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

Administrator (or Representative) — Date: 02.27.2026

Resident 12 received acetaminophen (used to treat pain) on 12/01/2025 at 12:00 PM and gabapentin on 12/01/2025 at 1:30 PM.

In an interview, on 01/28/2026 at 11:43AM, Staff G (Health and Wellness Director) clarified that an unsigned eMAR box signifies that the medication was either not administered or not recorded. Staff G could not confirm if the medication was given.

Resident 11

Record review of a Facesheet showed the ALF admitted Resident 11 on [redacted]/2023 with multiple diagnoses including [redacted] and [redacted].

Review of Resident 11's Assessment, dated 12/11/2025, showed Resident 11 required staff assistance with medication management.

Observation and interview, on 01/29/2026 at 12:22 PM, showed an opened tube of ketoconazole (used to treat infections caused by a fungus) cream and an opened jar of hydrocortisone (used to treat skin conditions that cause swelling, redness, itching and rashes) cream on Resident 11's bedside table. Further observation showed eight additional tubes of ketoconazole on Resident 11's bookshelf at the end of her bed. Resident 11 stated the creams were used to treat a fungal infection.

In interview, 01/29/2025 at 1:02 PM, Staff G confirmed Resident 11 was on medication services and agreed she should not have unsecured medications in her apartment. Staff G stated they would check on Resident 11 and remove the medications right away.

This deficiency was previously cited on 05/14/2025.

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, 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-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(b) Provide the necessary care and services for residents, including those with special needs;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to implement their policies and procedures related to care and safety needs for 5 of 12 residents (Resident 2, 3, 7,10, and 12) who had bed side rails (BSR). This failure placed Resident 2, 3, 7, 10, and 12 at risk for improper use of equipment, injury and entrapment.

Findings included…

Review of the ALF's policy detail for "Bed Rails and Enablers", dated 06/01/2024, showed "Side rail risks and benefits will be outlined to the resident and family. Use of rails will be documented in the resident's Negotiated Service Agreement (NSA) along with instructions for monitoring."

Resident 2

Review of a Face Sheet showed that the ALF admitted Resident 2 on [redacted]/2025 with multiple medically disabling conditions to include mild cognitive impairment.

Observation, on 01/29/2026 at 11:10 AM, showed a quarter length BSR at the top right side of Resident 2's bed with stabilizing prongs slid under the mattress.

Review of Resident 2's January 2026 Medication Administration Record, showed a physician order for a right-side BSR to ease with bed mobility and transfers. Review of a Service Plan (SP- equivalent to a Negotiated Service Agreement), dated 12/03/2025, showed no mention of a BSR or instructions for staff to monitor placement or safety.

Resident 3

Review of a Face Sheet showed that the ALF admitted Resident 3 on [redacted]/2025 with multiple medically disabling conditions to include hemiplegia (a condition that causes weakness or paralysis on one side of the body).

Observation, on 01/29/2026 at 11:35 AM, showed bilateral half-length BSRs installed on

Resident 3's bed.

Review of Resident 3's SP, dated 09/09/2025, showed mention of enabling devices used for mobility and ambulation. Resident 3's SP showed no specific mention of bilateral half-length BSRs or instructions for staff to monitor the use of BSR.

Resident 7

Review of a Face Sheet showed that the ALF admitted Resident 7 on [redacted]/2024 with multiple medically disabling conditions including cerebral infarction (occurs when a vessel supplying blood to the brain is blocked), hemiplegia/hemiparesis (loss of strength in the arm, leg, and sometimes face on one side of the body), and encephalopathy (a dysfunction of the level or contents of consciousness due to brain dysfunction).

Observation, on 01/29/2026 at 1:55 PM, showed steel BSR installed on both sides of Resident 7's bed.

Review of Resident 7's SP, dated 12/26/2025, showed Resident 7 used a BSR, but there were no instructions for staff to monitor placement or safety.

Resident 10

Review of a Face Sheet showed that the ALF admitted Resident 10 on [redacted]/2025 with multiple medically disabling conditions including chronic kidney disease, stage 4 (severe loss of kidney function) and type 2 diabetes (a condition characterized by high blood sugar levels caused by either a lack of insulin or the body's inability to use insulin efficiently).

Observation, on 01/29/2026 at 11:30 AM, showed steel BSR installed on Resident 10's bed.

Review of Resident 10's SP, dated 12/16/2025, showed Resident 10 used a BSR, but there were no monitoring instructions for staff on the use of BSR.

Resident 12

Review of a Face Sheet showed that the ALF admitted Resident 12 on [redacted]2024 with multiple medically disabling conditions including dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and cerebral infarction.

Observation, on 01/29/2026 at 12:02 PM, showed steel BSR installed on Resident 12's bed.

Review of Resident 12's SP, dated 11/26/2025, showed Resident 12 used a BSR, but there were no monitoring instructions for staff on the use of BSR.

In interview, on 01/29/2025 at 2:54PM, Staff A (Executive Director) reported instruction for monitoring and use of bed rails needed to be documented in resident's NSA and acknowledged the ALF did not implement their policy for BSR for Resident 2, 3, 7,10, and 12.

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) 04.03.2026.

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

Administrator (or Representative) — Date: 02.27.2026

WAC 388-78A-2474 Training and home care aide certification requirements.

(1) The assisted living facility must ensure staff persons hired before January 7, 2012 meet training requirements in effect on the date hired, including requirements in chapter 388-112A WAC.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

(3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.

(5) Under RCW 18.88B.041 and chapter 246-980 WAC, certain individuals including registered nurses, licensed practical nurses, certified nursing assistants, or persons who are in an approved certified nursing assistant training program are exempt from long-term care worker basic training requirements. Continuing education requirements under

Observation, on 01/29/2026 at 12:02 PM, showed steel BSR installed on Resident 12's bed.

Review of Resident 12's SP, dated 11/26/2025, showed Resident 12 used a BSR, but there were no monitoring instructions for staff on the use of BSR.

In interview, on 01/29/2025 at 2:54PM, Staff A (Executive Director) reported instruction for monitoring and use of bed rails needed to be documented in resident's NSA and acknowledged the ALF did not implement their policy for BSR for Resident 2, 3, 7,10, and 12.

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-2474 Training and home care aide certification requirements.

(1) The assisted living facility must ensure staff persons hired before January 7, 2012 meet training requirements in effect on the date hired, including requirements in chapter 388-112A WAC.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

(3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.

(5) Under RCW 18.88B.041 and chapter 246-980 WAC, certain individuals including registered nurses, licensed practical nurses, certified nursing assistants, or persons who are in an approved certified nursing assistant training program are exempt from long-term care worker basic training requirements. Continuing education requirements under

chapter 388-112A WAC still apply to these individuals, except for registered nurses and licensed practical nurses.

(6) For the purpose of this section, the term "caregiver" has the same meaning as the term "long-term care worker" as defined in RCW 74.39A.009 .

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 3 of 6 sampled staff (Staff B, C, and D) received facility orientation, 4 of 6 sampled staff (Staff A, B, D and E) completed the required cardiopulmonary resuscitation (CPR) training, 1 of 6 sampled staff (Staff D) had the necessary specialized training to fulfill their expected responsibilities and 1 of 6 sampled staff (Staff E) had completed the required annual 12 hours of continuing education. This failure placed 118 residents at risk of harm and injury from care staff unfamiliar with the ALF and their expected duties, improper CPR technique in the event of an emergency and untrained and unqualified staff.

Findings included…

Facility Orientation
Note: Washington Administrative Code (WAC) 388-112A-0200 - There are two types of orientation training: Facility orientation training and long-term care worker orientation training. (1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation.

Record review showed the ALF hired Staff B (Care Partner) on 12/24/2025. Staff B’s records did not show they received facility orientation.

Record review showed the ALF hired Staff C (Care Partner) on 10/06/2025. Staff C’s records did not show they received facility orientation.

Record review showed the ALF hired Staff D (Care Partner) on 05/27/2025. Staff D’s records did not show they received facility orientation.

During an interview, on 01/29/2026 at 4:50 PM, Staff A (Executive Director) stated she was unable to locate any facility orientation records for Staff B, C and D.

CPR

NOTE: WAC 388-112A-0700 - What is CPR training? Cardiopulmonary resuscitation (CPR) training is training provided by an authorized CPR instructor. Trainees must successfully complete the written and skills demonstration tests.

NOTE: WAC 388-112A-0720 What are the CPR and first-aid training requirements?
(2) Assisted living facilities.
(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire.
(b) Licensed nurses working in assisted living facility must have and maintain a valid CPR card or certificate within thirty days of their date of hire.

Review of staff records showed the ALF hired Staff A (Executive Director) on 07/22/2024. Record review showed Staff A did not complete the required CPR training.

Review of staff records showed the ALF hired Staff B (Care Partner) on 12/24/2025. Record review showed Staff B did not complete the required CPR training.

Review of staff records showed the ALF hired Staff D (Care Partner) on 05/27/2025. Record review showed Staff D did not complete the required CPR training.

Review of staff records showed the ALF hired Staff E (Care Partner) on 12/08/2023. Record review showed a CPR training certificate with an expiration date of 03/25/2025. Further review showed no current CPR certificate for Staff E.

During an interview, on 01/29/2026 at 4:50 PM Staff A confirmed she along with Staff B, D and E did not have current CPR training and had scheduled a class.

Continuing Education

WAC 388-112A-0611
Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?

(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described in this section.
(a) The following long-term care workers must complete 12 hours of continuing education by their birthday each year:
(i) A certified home care aide;
(ii) A long-term care worker who is exempt from the 70-hour home care aide basic training under WAC 388-112A-0090 (1) and (2);

(iii) A certified nursing assistant;
(i) Must complete 12 hours of continuing education by the long-term care worker's birthday each calendar year worked thereafter; or

Review of staff records showed the ALF hired Staff E (Care Partner- Nurse Assistant Certified-NAC) on 12/08/2023. Record review showed Staff E did not have the required annual 12 hours of continuing education between the years 2024 and 2025 of Staff E's month and day of birth as required for a credential NAC.

During an interview, on 01/29/2026 at 4:50 PM, Staff A stated the ALF was unable to provide proof Staff E had completed the required 12 hours of continuing education within the last year of their employment.

Specialized Training

NOTE: Washington Administrative Code (WAC) 388-78A-2500 - Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.

NOTE: WAC 388-78A-2510 - Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090(7).

Review of a Resident Characteristic Roster, showed the ALF provided care and services to 118 residents of which seven had a diagnosis of [redacted] and four had a [redacted] diagnosis.

Review of staff records showed the ALF hired Staff D (Care Manager) on 05/27/2025. Review of staff records on 01/28/2026 showed Staff D did not have the required specialized dementia and mental health training.

During an interview, on 01/29/2026 at 4:50 PM, Staff A stated the ALF was unable to provide Dementia and Mental Health specialized training for Staff D and would follow up.

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) 04.03.2026.

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

Administrator (or Representative) — Date: 02.27.2026

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 8 staff members (Staff D) completed the required two-step tuberculin skin test (TST). This placed 118 residents at risk of exposure to a communicable disease.

Findings included...

Review of staff records showed the ALF hired Staff D (Care Partner) on 05/27/2025. Record review showed Staff D had a one-step completed on 05/17/2025. Review showed Staff D did not have the two-step TST completed.

In an interview, on 01/29/2026 at 4:50 PM, Staff A (Administrator) stated tuberculosis testing oversight had been moved to the nursing department and was unable to locate documentation for Staff D's second step TST.

This is a repeated deficiency previously cited on 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) Date

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(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 118 residents at risk of exposure to a communicable disease.

Findings included…

Review of staff records showed the ALF hired Staff D (Care Partner) on 05/27/2025. Record review showed Staff D had a one-step completed on 05/17/2025. Review showed Staff D did not have the two-step TST completed.

In an interview, on 01/29/2026 at 4:50 PM, Staff A (Administrator) stated tuberculosis testing oversight had been moved to the nursing department and was unable to locate documentation for Staff D's second step TST.

This is a repeated deficiency previously cited on 08/22/2024.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 02.27.2026

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

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

(2) A national fingerprint background check is valid for an indefinite period of time. The assisted living facility must ensure there is a valid national fingerprint background check completed for all administrators and caregivers hired after January 7, 2012. To be considered valid, the national fingerprint background check must be initiated and completed through the department's background check central unit after January 7, 2012.

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 118 residents at risk for receiving care from staff whose criminal background history was unknown.

Findings included...

Review of records for Staff E (Care Partner), hired on 12/08/2023, showed their BGI

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

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(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:

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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 118 residents at risk for receiving care from staff whose criminal background history was unknown.

Findings included…

Review of records for Staff E (Care Partner), hired on 12/08/2023, showed their BGI

expired as of 12/08/2025.

In an interview, on 01/29/2026 at 4:50 PM, Staff A (Executive Director) confirmed there was no current BGI for Staff E and would get it renewed.

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) 04.03.2026.

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

DNa — Administrator (or Representative)

02.27.2026 — 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 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 1 of 12 sampled residents (Resident 4). This failure placed Resident 4 at risk of health complications related to use of anti-coagulant medication (medication that thins the blood to prevent clots) and history of falls.

expired as of 12/06/2025.

In an interview, on 01/29/2026 at 4:50 PM, Staff A (Executive Director) confirmed there was no current BGI for Staff E and would get it renewed.

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 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 1 of 12 sampled residents (Resident 4). This failure placed Resident 4 at risk of health complications related to use of anti-coagulant medication (medication that thins the blood to prevent clots) and history of falls.

Findings included:

Record review of a Face Sheet showed the ALF admitted Resident 4 on [redacted] 2024 with multiple diagnoses to include [redacted] Review of an Assessment, dated 11/06/2025, showed Resident 4 to be at high risk for falls. Further review showed Resident 4 to be prescribed an anticoagulant medication. Record review of a progress note dated 11/26/2025 showed Resident 4 had an unwitnessed fall.

Record review of Resident 4's November and December 2025 Medication Administration Record (MAR) and January 2026 MAR showed a physician's order for once daily warfarin (anti-coagulant medication that reduces risk of clots forming by slowing the blood's clotting ability).

Review of an SP, dated 11/06/2025, showed no information or interventions on how to monitor the increased risk of bleeding or bruising related to warfarin medication. Resident 4'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 or as it related to their fall history and risk.

In interview, on 01/27/2026 at 4:40 PM, Staff A (Executive Director) confirmed the risks of taking warfarin should be included in Resident 4's SP.

This is a repeated deficiency previously cited on 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) 04.03.2026.

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

Administrator (or Representative) — Date: 02.27.2026

Findings included…

Record review of a Face Sheet showed the ALF admitted Resident 4 on [redacted]/2024 with multiple diagnoses to include [redacted]. Review of an Assessment, dated 11/06/2025, showed Resident 4 to be at high risk for falls. Further review showed Resident 4 to be prescribed an anticoagulant medication. Record review of a progress note dated 11/26/2025 showed Resident 4 had an unwitnessed fall.

Record review of Resident 4's November and December 2025 Medication Administration Record (MAR) and January 2026 MAR showed a physician's order for once daily warfarin (anti-coagulant medication that reduces risk of clots forming by slowing the blood's clotting ability).

Review of an SP, dated 11/06/2025, showed no information or interventions on how to monitor the increased risk of bleeding or bruising related to warfarin medication. Resident 4'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 or as it related to their fall history and risk.

In interview, on 01/27/2026 at 4:40 PM, Staff A (Executive Director) confirmed the risks of taking warfarin should be included in Resident 4's SP.

This is a repeated deficiency previously cited on 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)_____ .

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

_____ _____

Administrator (or Representative) Date

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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 # 2473

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 02/17/2026 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

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 Return the Plan/Attestation Statement and report with signatures to:

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

eFax: (206) 971-6791
Email: rcsregion2email@dshs.wa.gov
Optional method:
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

• Complete correction(s) within 45 calendar days of Last Date of Data Collection (02/17/2026), no later than 04/03/2026 or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):

In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-2800 Changes in licensed bed capacity.

(1) To change the licensed bed capacity in an assisted living facility, the assisted living facility must:

(a) Submit a completed request for approval to the department at least one day before the intended change;

(b) Submit the prorated fee for additional beds to DSHS within thirty calendar days, if applicable;

(c) Update the resident register pursuant to WAC 388-78A-2440 upon making the intended change;

(d) Post an amended license obtained from the department, indicating the new licensed bed capacity; and

(e) Meet the additional requirements under WAC 388-78A-2810 .

The Assisted Living Facility submitted a request and payment to The Department for an increase in licensed bed capacity from 115 to 130 but failed to wait for receipt of updated license before admitting three residents above current capacity.

You Are Not:

• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

• Contact me for clarification of the deficiency or deficiencies found.

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 You can make an IDR request and find directions on the IDR web page at:
    https://www.dshs.wa.gov/altsa/idr

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

• 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 You can make an IDR request and find directions on the IDR web page at: https://www.dshs.wa.gov/altsa/idr

If You Have Any Questions:
• Please contact me at (253)312-1446.

Sincerely,

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

Enclosure