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) 25985 (Completion Date 06/29/2023) and 23579 (Completion Date 05/31/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/29/2023 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-2160, WAC 388-78A-2240

The Department staff who did the off-site verification:
Cathy Prentice, Complaint Investigator

If you have any questions, please contact me at (425)670-6070.

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 #: 23579
Intake ID: 80713
Investigator: Cathy Prentice
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 05/08/2023 through 05/31/2023
Complainant Contact Date(s): 05/04/2023, 05/31/2023

Allegation(s):

1. The Named Resident 1 (NR1) was found with saturated briefs.
2. The NR's apartment smelled strongly of urine and her chair is soiled.
3. The NR is not receiving her medications. And the facility did not have the NR's medications to give.
4. The NR's call light was not responded to.

Investigation Methods:

Sample:	Total residents: 94 Resident sample size: 14 Closed records sample size: 0
Observations:	Delivery of care and services; staff interactions with residents; residents' appearance; environment.
Interviews:	Named resident and legal representative, other residents, staff, administration
Record Reviews:	Resident care records, assessment, service agreement, investigations, facility policies, other pertinent records

Investigation Summary:

According to observation, interview and record review, 1. the facility provided care according to the assessment and negotiated service agreement at the time of the investigation when the named resident was observed multiple times on multiple days. The staff stated the named resident frequently refuses assistance with briefs and toileting. There were no saturated briefs observed and neglect was not substantiated. 2. There were no odors or soiled furniture observed during the investigation. 3. The named resident missed medications on 04/24/2023 due to unavailability of medications. Failed practice was identified. 4. The investigation showed the named resident had not used her call light in the past month and did have staff checks recorded.

Conclusion / Action:

☒ 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 #: 23579
Intake ID: 79847
Investigator: Cathy Prentice
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 05/08/2023 through 05/31/2023
Complainant Contact Date(s): 04/27/2023, 05/04/2023, 05/05/2023, 05/31/2023

Allegation(s):

1. The Named Resident 1 (NR1) was found with saturated briefs and is not receiving hygiene checks during the day.
2. The NR's apartment smelled strongly of urine and a plastic bag filled with saturated briefs next to the sink.
3. The NR's laundry is not getting done.
4. The NR was supposed to be showered on Tuesday's and Friday's but is not receiving their Friday shower.
5. The NR is not receiving her medications.
6. The NR is not receiving assistance with reminders to order food.

Investigation Methods:

Sample:	Total residents: 94 Resident sample size: 14 Closed records sample size: 0
Observations:	Delivery of care and services; staff interactions with residents; residents' appearance; environment.
Interviews:	Named resident and legal representative, other residents, staff, administration
Record Reviews:	Resident care records, assessment, service agreement, investigations, facility policies, other pertinent records

Investigation Summary:

According to observation, interview and record review, 1. the facility provided care according to the assessment and negotiated service agreement at the time of the investigation when the named resident was observed multiple times on multiple days. The staff stated the named resident frequently refuses assistance with briefs and toileting. There were no saturated briefs observed and neglect was not substantiated. 2. There were no odors or soiled furniture observed during the investigation. 3. The NSA said laundry on Tuesdays-the laundry was done and all clothes clean at the time of the investigation. 4. The resident stated she gets showers when she cannot talk the staff out of it. The records showed the resident gets showers weekly on average due to refusals and had skin checks that were clear. 5. The named resident missed medications on 04/24/2023 due to unavailability of medications. Failed practice was

identified. 6. The named resident's care plan said she is independent with eating and can order her food and only needs help if she requests it. the resident stated she gets her food if she orders it on time. there is food available all day and evening for the resident if needed.

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 #: 23579
Intake ID: 79714
Investigator: Cathy Prentice
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 05/08/2023 through 05/31/2023
Complainant Contact Date(s): 04/26/2023, 04/27/2023, 06/01/2023

Allegation(s):

1. The Assisted Living Facility (ALF) was having the following care and services issues: Resident's were being admitted from another ALF without care plans or contradicting care plans ,NR 8 requires transfer with a slide board and none of the staff have been trained for that. NR 2 switched to a walker and it wasn't documented anywhere. NR 19's dialysis shunt was not being checked as ordered. NR 35 had significant behavior issues towards staff. 2. NR 9 had an order for alcohol consumption with no way of monitoring. 3. The Assisted Living Facility had medication system issues including: NR 11 had expired medication, the Health and Wellness Director was destroying residents' narcotics and other medications without a witness including medications for NR 2, NR 3 and NR 4. Some of the medication did not have a discontinuation orders . NR 18 went without an ordered med for 2 weeks , NR 20 ran out of her medication Alendronate before it was re-ordered from the pharmacy . 4. The Assisted Living Facility (ALF) did not monitor, have documentation, or any follow- up with changes of condition or incidents including: NR 12, NR 13, NR 14, NR 15, NR 16, NR 17, NR 27 had been hospitalized and their were no progress notes. NR 21 had a burn and was sick early April and the ALF did not document how the burn occurred and did not have a care plans or monitoring for staff regarding care of the burn or his illness. NR 23 had chills and diarrhea documented in April but had no progress notes since January, NR 26 was supposed to receive a COVID booster shot but there is no documentation, NR 5 had a fall not documented , NR 22 had pain and a sore, NR 28 had a sore on his foot and pain, NR 28 had a sore on his foot, NR 30 had a skin tear, NR 32 had pain in left foot without any progress notes, NR 22 asked for an order for cut-up food and there was no follow-up by Health and Wellness Director , NR 29 had a red and swollen leg without any progress notes, NR 31 was on hospice and had multiple falls with no temporary service plan or documentation, NR 33 had dark urine in his catheter bag without documentation, 5. Response to NR 14's medical emergency was slow, 6. NR 24 and NR 25 room had a foul odor. NR 14 had briefs and clothing covered in feces left in their room. NR 12's room is in disarray and had a foul odor. 7. The ALF short staffed and care staff are working double and triple shifts, 8. The Named Staff got mad at NR 34 when he couldn't get her shoe on over her leg brace and became rough with her for the rest of the shift. 9. The Medication Technicians are being asked to verify orders and NR 2 had a discontinuation order that has been waiting to be verified. 10. Smoke Alarms are going off in the building and garage doors are open 24 hours a day.

Investigation Methods:

Sample: Total residents: 94

Resident sample size: 14
Closed records sample size: 0

Observations: Delivery of care and services; staff interactions with residents; residents' appearance; environment.

Interviews: Sample Named residents/or legal representatives, other residents, staff, administration

Record Reviews: Resident care records, assessment, service agreement, investigations, facility policies other pertinent records

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Investigation Summary:

According to observation, interview and record review, 1. the facility had an assessment and negotiated service agreement (NSA) that included a sliding board for Named Resident (NR) #8 as well as staff training, NR #2 does not use her walker; there was no physician order for NR #19 shunt check but it was being done; the facility had a NSA for Resident #35 behaviors that have improved. 2. NR #9 had an order and the alcohol is kept in the med cart for staff monitoring 3. There were no expired meds for NR #11 observed in the med cart. The facility had an accounting system for narcotics and destruction as required and had documentation;.NR 2 and 3 had no narcotics available, failed practice identified. There were no med issues for NR 4. The med for NR 18 was not ordered for two weeks and was started when the physician finalized the order. Medication for NR 20 was not available, failed practice identified. 4. The facility had incident reports and investigations for incidents for sampled residents. NR 21 had a minor burn from hot soup on her leg that was immediately treated and documented on wound care form. NR 21 was well and not sick. NR 23 was well with no illness. NR 26 received Covid and booster per record from family. NR 5 had a fall that was noted in the record. NR 22 and 28 had pain and sores treated and healed. NR 28 foot sore healed. NR 30 had a healed skin tear. NR 32 no pain. NR 22 had OT referral for cut up food and facility waited for physician order. NR 29 had no swelling. NR 31 had notes and hospice services. NR 33 does not have an indwelling catheter it was a condom catheter with clear urine. 5. NR 14 went out with change of condition and UTI. 6. NR 24 had urine odor and failed practice identified for slow call light responses. NR25 had a plan in place for urine dribbling. NR 14 was out to the hospital and room was clean. NR 12 was out to the hospital and room was clean.7. the ALF had staffing as required with some staff working doubles when there is a call in-not triples. 8. NR 34 stated the staff was not mad or abusive just did not know what to do with the brace. The facility provided training. 9. The Med tech verify physician orders and assure 5 rights are followed. NR 2 received meds as ordered. 10. The facility had smoke alarm testing and was in fire marshall compliance. The facility had a garage door on open waiting for a part for repair.

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 #: 23579
Intake ID: 79459
Investigator: Cathy Prentice
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 05/08/2023 through 05/31/2023
Complainant Contact Date(s): 04/26/2023, 04/27/2023, 06/01/2023

Allegation(s):

1. The Health and Wellness Director of the Named Resident's 1 (NR2) narcotic medication without a method of destruction or second signature. NR3's narcotic medication was destroyed in March without a discontinuation order. NR4's Narcan, that wasn't expired, was disposed of without a discontinuation order.
2. The Health and Wellness director is diverting narcotic medications.
3. The Assisted Living Facility (ALF) is not documenting incidents of falls and health events.

Investigation Methods:

Sample:	Total residents: 94 Resident sample size: 14 Closed records sample size: 0
Observations:	Delivery of care and services; staff interactions with residents; residents' appearance; environment.
Interviews:	Sample of Named residents/or legal representatives, other residents, staff, administration
Record Reviews:	Resident care records, assessment, service agreement, investigations, facility policies, other pertinent records

Investigation Summary:

1. According to observation, interview and record review, the facility had a narcotic accounting system as required. The named resident #3 did not have medications available due to the destruction without re-ordering and without discontinuing the physician's order. Named resident #9 no longer had an order for Narcan. Failed practice identified for non availability of meds for named resident #3 and other residents. 2. There was no evidence of narcotic diversion. identified.
3. The facility had record of falls and health events for sampled residents.

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 #: 23579
Intake ID: 78807
Investigator: Cathy Prentice
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 05/08/2023 through 05/31/2023
Complainant Contact Date(s): 04/27/2023, 05/31/2023

Allegation(s):

1. The Assisted Living Facility (ALF) is only using non-english speaking agency as caregivers.
2. The Named Resident 5 (NR5) requirements are not being met.

Investigation Methods:

Sample:	Total residents: 94 Resident sample size: 14 Closed records sample size: 0
Observations:	Delivery of care and services; staff interactions with residents; residents' appearance; environment.
Interviews:	Named resident and legal representative, other residents, staff, administration
Record Reviews:	Resident care records, assessment, service agreement, investigations, facility policies, other pertinent records

Investigation Summary:

According to observation, interview and record review, 1. the facility provided care according to the assessment and negotiated service agreement at the time of the investigation and had staff as required with no concerns voiced by residents about language barriers. 2. The facility had long call light wait times for the named resident. Failed practice identified.

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

Statement of Deficiencies	License #: 2473	Compliance Determination # 23579
Plan of Correction	Cogir Queen Anne	Completion Date
Page 1 of 7	Licensee: Cogir Management USA Inc	05/31/2023

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 05/08/2023 and 05/11/2023 of:

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

This document references the following complaint number(s): 80713, 79847, 79714, 79459, 78807, 78208

The following sample was selected for review during the unannounced on-site visit: 14 of 84 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Cathy Prentice, Complaint Investigator

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

6/5/2023
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.

Statement of Deficiencies	License #: 2473	Compliance Determination # 23579
Plan of Correction	Cogir Queen Anne	Completion Date
Page 2 of 7	Licensee: Cogir Management USA Inc	05/31/2023

Administrator (or Representative) — Date: 6/8/23

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 2 of 2 residents (Resident 1 and 2) when call lights were not responded to in a timely manner. This failure placed Resident 1 and 2 at risk of harm and a poor quality of life.

Findings included...

RESIDENT 1

Record review of a Face Sheet and NSA, dated 03/01/2023, showed the ALF admitted Resident 1 on [redacted]2017 with a diagnosis of [redacted] and required staff assistance with toileting, and grooming/hygiene.

In an interview, on 05/08/2023 at 10:30 AM, Resident 1 stated he needed help from ALF staff changing clothing and incontinent briefs when soiled. Resident 1 stated he used his call light when he needed staff assistance. Resident 1 stated call light wait times can be over an hour. Resident 1 stated sometimes staff came and say they would be back but do not return to assist him.

In an interview, on 05/08/2023 at 10:40 AM, Resident 1's live-in spouse stated the call light wait times for Resident 1 were sometimes an hour.

Observation, on 05/08/2023 at 10:30 AM, showed Resident 1 engage his call light. Staff A (Caregiver) did not respond to the call light until 10:55 AM, 25 minutes later.

Review of a call light response record, dated 04/01/2023 through 05/08/2023, showed the following wait times for Resident 1's call light response time for Assistance Needed:

- Over 20 minutes on six occasions.
- Over 30 minutes on 13 occasions.
- Over 40 minutes on nine occasions.
- Over 50 minutes on three occasions.
- Over an hour on six occasions.
- Over two hours on five occasions.

RESIDENT 2

Record review of a Face Sheet and NSA, dated 05/05/2023, showed the ALF admitted Resident 2 on [redacted]2021. The NSA stated Resident 2 had a stroke a stroke occurs when a blood vessel that carries oxygen to the brain is either blocked by a clot or ruptures) and required staff assistance with toileting, dressing, and grooming/hygiene.

Observation and interview with Staff B (Caregiver/Medication Technician), on 05/11/2023 at 1:40PM, found Resident 2's bathroom and bedroom had a strong a urine odor. Staff B stated Resident 2 used the call light to request toileting assistance from ALF staff. Staff B stated when Resident 2 toileted independently, he dribbled urine on the bathroom floor.

In an interview, on 05/11/2023 at 1:45 PM, Resident 2's live-in spouse stated the ALF staff were slow to respond to call lights when Resident 2 needed care and it, "gets very irritating."

Review of a call light response record, dated 04/01/2023 through 05/08/2023, showed the following wait times for Resident 1's call light response time for Assistance Needed:

- Over 30 minutes on three occasions.
- Over 40 minutes on one occasion.
- Over an hour on two occasions.

In an interview, on 05/11/2023 at 11:00 AM, the Administrator stated the call light response times should be within 15 minutes or less. The Administrator stated she was not aware there were some response times recorded that were over an hour.

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) 6/8/23 .

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

Statement of Deficiencies	License #: 2473	Compliance Determination # 23579
Plan of Correction	Cogir Queen Anne	Completion Date
Page 4 of 7	Licensee: Cogir Management USA Inc	05/31/2023

Administrator (or Representative) — Date: 6/8/23

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure that 4 of 4 sampled residents (Resident 3, 4, 5, and 6) had prescribed medications available in the facility. This failure placed Resident 3, 4, 5, and 6 at risk for health issues die to missed medications.

Findings included...

Review of the Medication Services policy for, Medication Services dated 12/09/2021, showed the facility provided medication ordering and medication assistance services. The facility would ensure that medication related services required or requested by each resident were provided. Each resident was given the option to have the facility order medications through the preferred pharmacy or the pharmacy of their choice. The facility's preferred pharmacy would be used in the event that medications were needed on an emergency basis when the pharmacy of the resident's choice was unable to provide them. Staff would ensure refills were received in a timely manner. Medications were to be ordered at least 7 days before running out, or more days might be needed due to weekends and holidays.

RESIDENT 3

Record review of a Service Plan (SP- equivalent to Negotiated Service Agreement), dated 05/03/2023, showed the ALF admitted Resident 3 on [redacted] 2018 with multiple diagnoses including [redacted], high blood pressure, and mild cognitive impairment. The SP stated the ALF managed and assisted with Resident 3's medications supplied by the facility's preferred pharmacy.

Record review of Resident 1's Medication Administration Record (MAR), dated April 2023, showed a prescription for: Calcium Carbonate 600 milligrams (mg)/400 international unit (IU) tablet once a day, Desvenlafaxine Succinate 50mg tablet once daily for depressive disorder, Hydrochlorothiazide 12.5mg capsule once daily for high blood pressure, Loratadine 10mg tablet once daily for allergies, Telmisartan 40mg tablet once daily for heart irregularity, Turmeric Curcumin 500mg capsule once daily as a supplement. The April MAR showed these medications were not given as ordered on 04/24/2023. The MAR

showed documentation that these medications were not given because the medication was not in the medication cart.

In an interview, on 05/11/2023 at TIME, the Director of Nurse (DNS) stated the staff reordered medications at least seven days before they were due to be refilled and the pharmacy did automatic cycle refills. The DNS stated she was not sure why Resident 3 did not have those medications available on 04/24/2023.

RESIDENT 4

Record review of a SP, dated 04/28/2023, showed the ALF admitted Resident 4 on [redacted]/2021 with multiple diagnoses including [redacted]. The SP stated the ALF managed and assisted with Resident 4's medications supplied by the facility's preferred pharmacy.

Record review of Resident 4's MAR, dated April 2023, showed a prescription for Alendronate Sodium 70mg tablet to be given by mouth once a week for osteoporosis. The April MAR showed this medication was not given on 04/06/2023. The MAR showed documentation that this medication was not given because the medication was not available/had not been delivered to the facility.

In an interview, on 05/11/2023at 11:00 AM , the DNS stated she was not sure why Resident 4 did not have this medication available on 04/06/2023.

RESIDENT 5

Record review of a SP, dated 05/12/2023, showed the ALF admitted Resident 5 on [redacted]2017 with multiple diagnoses including [redacted]. The SP stated the ALF managed and assisted with Resident 5's medications supplied by the facility's preferred pharmacy.

Record review of Resident 5's MAR, dated May 2023, showed a prescription for Oxycodone 5mg tablet, every 6 hours as needed for pain not controlled by Tylenol. The MAR showed documentation that this medication was not given in May 2023.

Observation, on 05/11/2023 at 2:00 PM, showed there was no Oxycodone tablets for Resident 5 in the medication cart and no entry for this medication in the narcotic book.

In an interview, on 05/11/2023 at 11:00 AM, the DNS stated she destroyed the narcotics

for Resident 5 because she had not used them in a few months. The DNS stated she thought the policy was to destroy any narcotic pain medication not used in 60-90 days. The DNS also stated she did not notify the physician or obtain a discontinuation order for this medication for Resident 5.

The medication was not available if Resident 5 had pain not controlled by Tylenol as ordered.

RESIDENT 6

Record review of a SP, dated 04/27/2023, showed the ALF admitted Resident 6 on [redacted]/2019 with multiple diagnoses including [redacted]. The SP stated the ALF managed and assisted with Resident 6's medications supplied by the facility's preferred pharmacy.

Record review of Resident 6's MAR, dated May 2023, showed a prescription for Hydrocodone-Acetaminophen 5-325mg every 6 hours as needed for pain. The May MAR showed this medication was not given in May 2023.

Observation, on 05/11/2023 at 2:00 PM, showed there was no Hydrocodone tablets for Resident 6 in the medication cart and no entry for this medication in the narcotic book.

In an interview, on 05/11/2023 at 11:00AM, the Director of Nurse (DNS) stated she destroyed the narcotics for Resident 6 because she had not used them in a few months. The DNS also stated she did not notify the physician or obtain a discontinuation order for this medication for Resident 6.

The medication was not available if Resident 6 had pain that needed controlled by the narcotic.

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) 6/8/23 .

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

Statement of Deficiencies	License #: 2473	Compliance Determination # 23579
Plan of Correction	Cogir Queen Anne	Completion Date
Page 7 of 7	Licensee: Cogir Management USA Inc	05/31/2023

Administrator (or Representative)

6/8/23
Date