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) 61773 (Completion Date 06/27/2025) and 59144 (Completion Date 05/14/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/27/2025 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210-1-a, WAC 388-78A-2210-1-b, WAC 388-78A-2210-1, WAC 388-78A-2210-2, WAC 388-78A-2210

The Department staff who did the on-site verification:
Lisa Hauk, Complaint Investigator

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 #: 59144
Intake ID: 177995
Investigator: Lisa Hauk
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 05/06/2025 through 05/14/2025
Complainant Contact Date(s): 05/14/2025

Allegation(s):

1. The Assisted Living Facility (ALF) did not position the Named Resident (NR) in bed properly and this may have contributed to skin breakdown.
2. The NR had medications in the apartment that had not been swallowed and laid in bed on dirty linens and had dirty clothing at the ALF.

Investigation Methods:

Sample:	Total residents: 115 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Activities Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Residents Family members Business office manager
Record Reviews:	Medical records Facility policies

Investigation Summary:

1. Interview, observation and record review showed the NR was bedbound. The ALF assessed the NR and put interventions in place to for the NR including, home health visits, a turn schedule, wedges for positioning and skin monitoring all noted on the Service Plan. Observation showed an air mattress for the NR's bed had been delivered and was being set up. Interview showed sampled residents voiced no concerns of care or safety issues at the ALF. No violation of regulations identified.

2. Observation showed residents were clean and well dressed with clean apartments and clean linens on their beds. Interview showed sampled residents were pleased with their care at the ALF and denied any issues with dirty clothing or linen. Interview confirmed the NR had medications left at the bedside at the ALF and that the NR had missed that dose of medication. See citation 388-78A-2210.

Conclusion / Action:

- ☐ Failed Provider Practice Identified / Citation(s) Written
- ☒ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A

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Statement of Deficiencies	License #: 2473	Compliance Determination # 59144
Plan of Correction	Cogir Queen Anne	Completion Date
Page 1 of 3	Licensee: Cogir Management USA Inc	05/14/2025

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

The department completed data collection for an unannounced on-site complaint investigation on 05/06/2025 of:

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

This document references the following complaint number(s): 177995, 176944

The following sample was selected for review during the unannounced on-site visit: 3 of 115 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Lisa Hauk, 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 Seizer
Residential Care Services

5/15/2025
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative)

5/19/25
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 :

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 residents (Resident 1) took their medications as prescribed. This failure resulted in Resident 1 missing a dose of prescribed medications.

Findings included...

Record review of the ALF's undated 'Documenting Medication Pass' policy showed that when assisting a resident with medications, the Medical Technician (MT) would observe the resident to ensure all medications scheduled for the med pass were consumed by the resident and that no medication could be left with a resident to self-administer at a later time.

Record review an undated 'Face Sheet' showed the ALF admitted Resident 1 on

[redacted]/2018 with [redacted] and other medically disabling diagnoses. Review of the Assessment, dated 03/05/2025. showed Resident 1 required assistance with medications.

Record review of a May 2025 eMAR showed Resident 1 had physician's orders for Tylenol and Furosemide (a medication that causes the kidneys to make more urine) at 12:00 pm.

In interview, on 05/05/2025 at 5:00 PM, Collateral Contact 1 (CC1- Resident 1's Legal Representative) stated that, on DATE, found Resident 1's 12:00 PM medication (Tylenol and Furosemide) sitting on a side table in their apartment. CC1 stated they took the found medications and gave them to Staff A (MT).

In interview, on 05/06/2025 at 1:43 PM, Staff A stated that this was not the first occasion medications had been left in a resident's apartment. Staff A confirmed that CC1 brought them medications found in Resident 1's apartment on 05/04/2025.

In interview, on 05/14/2025 at 9:54 AM Staff B (Health and Wellness Director) stated that she was unaware of the incident and would investigate.

This is a recurrent 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) June 6, 2025.

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

Administrator (or Representative) 5/19/25 Date