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

02/25/2026

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

RE: Cogir Queen Anne # 2473

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 73070 (Completion Date 02/25/2026) and 70049 (Completion Date 01/13/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/25/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2371 Investigations. The assisted living facility must:

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

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 #: 70049
Intake ID: 204476
Investigator: Lisa Hauk
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 12/12/2025 through 01/13/2026
Complainant Contact Date(s): 01/13/2026

Allegation(s):

The Assisted Living Facility (ALF) readmitted a newly blind Named Resident (NR) from the hospital and the NR had several falls because the ALF was not able to care for the NR.

Investigation Methods:

Sample:
Total residents: 123
Resident sample size: 4
Closed records sample size: 2

Observations:
Residents
Dining
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Administration
Nursing staff
Residents
Family members

Record Reviews:
Medical records
Hospital records
Incident investigation
Facility policies

Investigation Summary:

Record review showed the facility had appropriate staffing however did not have a care plan in place with interventions that would reduce the risk of falls. Interview and record review showed that after the NR had repeated falls, the ALF did not follow their policy and did not determine the circumstances of the falls or put interventions in place to prevent similar falls in the future after each fall, possibly resulting in the further falls. Failed practice identified. See citation written WAC 388-78A-2371(1)(2)(3).

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 an unannounced on-site complaint investigation on 12/12/2025 of:

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

This document references the following complaint number(s): 203390, 204476, 205190

The following sample was selected for review during the unannounced on-site visit: 4 of 123 current residents and 2 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

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: 01.19.26

WAC 388-78A-2371 Investigations. The assisted living facility must:

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to document the circumstance of falls or implement interventions to prevent future incidents when 1 of 1 residents (Resident 1), who was recently diagnosed with [redacted]. This failure may have contributed to Resident 1 falling on multiple occasions, sustaining injuries and placed them at risk for future falls.

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.

Jamie Singer
Residential Care Services

1/15/2026
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)

Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to document the circumstance of falls or implement interventions to prevent future incidents when 1 of 1 residents (Resident 1), who was recently diagnosed with [redacted]. This failure may have contributed to Resident 1 falling on multiple occasions, sustaining injuries and placed them at risk for future falls.

Findings included...

Record review of an Incident Report (IR) policy, dated 06/01/2025, showed that investigations would include steps to prevent similar incidents from occurring in the future.

Record review of an undated Face Sheet showed the ALF admitted Resident 1 on [redacted]/2024 with [redacted] and other multiple medically disabling diagnoses.

Record review of a Progress Note (PN) showed that on 11/06/2025, the ALF sent Resident 1 to the hospital after a fall with a right eye injury. A PN, dated [redacted]/2025, showed the ALF readmitted Resident 1 from the hospital on hospice (care provided to the terminally ill) with blindness after a right-side globe rupture (a severe emergency where the outer wall of the eye is torn or punctured, causing internal contents to leak, often from blunt force trauma, leading to pain and vision loss).

Review of a Negotiated Service Plan (NSA), dated [redacted]/2025, showed when Resident 1 returned from the hospital on [redacted]/2025, Resident 1 was blind and deaf and required maximum assistance with all activities of daily living (a term used in healthcare to refer to people's daily self-care activities such as bathing, grooming, ambulation, etc.) including eating, toileting, dressing and transferring.

Record review of an IR, dated [redacted]/2025, showed ALF staff found Resident 1 on the floor in her apartment at 6:00 PM. The IR did not have any documentation that determined the circumstances of the fall. The IR incorrectly indicated that Resident 1 did not have a sensory impairment, decreased mental functioning or health problems that could have contributed to the fall.

Record review showed the ALF did not document or institute measures to prevent similar future falls. Record review showed there were no preventative interventions instituted following the fall on [redacted]/2025.

Record review of an IR, dated 11/22/2025, showed Resident 1 had a second fall and ALF staff found them on the floor in her apartment at 7:30 PM. The IR did not have any documentation that determined the circumstances of the fall. The IR incorrectly indicated that Resident 1 did not have a sensory impairment, decreased mental functioning or health problems that could have contributed to the fall.

Record review showed, following the second fall on 11/22/2025, the ALF did not document or institute appropriate measures to prevent similar future falls. Record review showed there were no preventative interventions instituted following the fall on 11/22/2025.

Record review of an IR, dated 11/24/2025, showed Resident 1 had a third fall and ALF staff found her sitting on the edge of her bed at 12:50 AM with blood on her body from head to toe with a large pool of blood on the floor. The IR stated Resident 1 had a deep wound on the left side of her head that split her left ear. The IR did not have any documentation that determined the circumstances of the fall.

In interview, on 12/09/2025 at 03:51 PM, Collateral Contact 1 (Resident 1’s Family Representative) stated that Resident 1 fell three times in five nights and after the third fall, Resident 1 ended up back in the hospital to have her ear stitched up.

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) 02.03.2026.

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

Administrator (or Representative) [signature] Date 01.19.2026

In interview, on 12/18/2025 at 11:43 am, Staff B (Wellness Nurse) stated that staff were supposed to put interventions in the care plan after falls, but it was not done.

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