STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

Cogir Management USA Inc
Cogir at The Narrows
802 N Laurel Ln
Tacoma, WA 98406

RE: Cogir at The Narrows License # 2654

Dear Administrator:

This letter addresses Compliance Determination(s) 29172 (Completion Date 08/30/2023) and 24050 (Completion Date 05/18/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/30/2023 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-2420-5, WAC 388-78A-2160, WAC 388-78A-2703-5

The Department staff who did the on-site verification:
Woodetta Maulana,

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Manfay Chan, Field Manager
Region 3, Unit D
Residential Care Services

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: Cogir at The Narrows
Provider Type: Assisted Living Facility
License/Cert.#: 2654
Compliance Determination #: 24050
Intake ID: 51979
Investigator: Woodetta Maulana
Region/Unit #: RCS Region 3 / Unit D
Investigation Date(s): 09/28/2022 through 05/18/2023
Complainant Contact Date(s):

Allegation(s):

1) First responders unable to open door to facility causing a 10 minute delay.
2) Named resident was not provided services according to care plan.
3) Staff sleeping when first responders arrived and did not assist to help resident.

Investigation Methods:

Sample:	Total residents: 37 Resident sample size: 4 Closed records sample size: 3
Observations:	staff to resident interaction residents general observation of the facility
Interviews:	staff residents others not associated with the facility
Record Reviews:	resident records

Investigation Summary:

1) Based on observation and interview, the assisted living facility failed to have the door key readily available when first responders arrived at the facility.
2) Based on interview and record review the facility failed to provide care and services as agreed upon in the negotiated service agreement for resident 1.
3) Interviewed caregiver who stated they were on break and put their head down but was not sleeping. Stated they saw first responders enter the facility and first responders went directly to the resident's room. Interviewed Executive director who stated caregiver is not allowed back into facility.

Conclusion / Action:

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: Cogir at The Narrows
Provider Type: Assisted Living Facility
License/Cert.#: 2654
Compliance Determination #: 24050
Intake ID: 60412
Investigator: Woodetta Maulana
Region/Unit #: RCS Region 3 / Unit D
Investigation Date(s): 09/28/2022 through 05/18/2023
Complainant Contact Date(s):

Allegation(s):

1)Facility failed to provide care and services as agreed upon in the negotiated service agreement for named resident .
2) When first responders arrived to the facility the doors were locked and staff did not have a key to open the door.

Investigation Methods:

Sample:	Total residents: 37 Resident sample size: 4 Closed records sample size: 3
Observations:	staff to resident interaction residents general observation of the facility
Interviews:	staff residents others not associated with the facility
Record Reviews:	resident records

Investigation Summary:

1) Based on interview and record review the facility failed to provide care and services as agreed upon in the negotiated service agreement for named resident
2) Based on observation and interview, the assisted living facility failed to have the door key readily available when first responders arrived at the facility.

Conclusion / Action:

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: Cogir at The Narrows
Provider Type: Assisted Living Facility
License/Cert.#: 2654
Compliance Determination #: 24050
Intake ID: 50841
Investigator: Woodetta Maulana
Region/Unit #: RCS Region 3 / Unit D
Investigation Date(s): 09/28/2022 through 05/18/2023
Complainant Contact Date(s):

Allegation(s):
1) Named resident had a fall due to facility's neglect.

Investigation Methods:

Sample:	Total residents: 37 Resident sample size: 4 Closed records sample size: 3
Observations:	staff to resident interaction residents general observation of the facility
Interviews:	staff others not associated with the facility
Record Reviews:	n/a

Investigation Summary:
1) Based on interview and record review, as the most recent licensee, the assisted living facility failed to ensure records of former named resident was available for review by the department.

Conclusion / Action:

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

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DSHS RCS REG. 3
LAKEWOOD
JUN 13 2023
RECEIVED

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

Statement of Deficiencies	License #: 2654	Compliance Determination # 24050
Plan of Correction	Cogir at The Narrows	Completion Date
Page 1 of 5	Licensee: Cogir Management USA Inc	05/18/2023

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 09/28/2022 and 02/07/2023 of:

Cogir at The Narrows
802 N Laurel Ln
Tacoma, WA 98406

This document references the following complaint number(s): 51979, 61360, 60412, 51550, 50841, 49219

The following sample was selected for review during the unannounced on-site visit: 4 of 37 current residents and 3 former residents.

The department staff that investigated the Assisted Living Facility:

Woodetta Maulana,

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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 — 06/01/2023 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.

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Administrator (or Representative) Date

WAC 388-78A-2420 Record retention.

(5) If an assisted living facility ceases to operate as a licensed assisted living facility, the most recent licensee must make arrangements to ensure that the former residents' records are retained according to the times specified in this section and are available for review by department staff and other authorized individuals.

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to ensure records of 1 of 1 former resident (Resident 2) was available for review by the department. This failure obstructed the department from conducting a complete and thorough investigation to rule out abuse and neglect.

Findings included...

Review of the progress note dated 07/01/2022 provided by family (collateral contact 2) showed Resident 2 had a fall while in the facility.

During an interview on 01/24/2023 at 2:45 p.m., the Executive Director (Staff A) stated the new owner did not keep records of discharged residents and only kept records on residents who were active. Staff A stated she would talk with their corporate office about Resident 2's medical records.

During an interview on 02/07/2023 at 11:20 a.m., Staff A stated she located the files of previous residents but had to search through them to find the requested records.

During a phone interview on 05/08/2023 at 11:57 a.m., Staff A stated she was unable to find any records for Resident 2.

Plan/Attestation Statement

This document was prepared by Residential Care Services for the Locator website.

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 at The Narrows is or will be in compliance with this law and / or regulation on (Date) 6-9-2023

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

A-Livingston — Administrator (or Representative)

6-9-2023 — Date

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to provide care and services as agreed upon in the negotiated service agreement for 1 of 2 sampled residents (Resident 1). This failure caused harm when Resident 1 had a fall with injury.

Findings included...

Review of the facility's incident report dated 09/26/2022 documented "husband stated that he found Resident 1 (R1) on the floor and called 911."

Record review of the facility's progress noted dated 09/30/2022, documented "R1 currently admitted at the hospital due to recent fall. Admission diagnosis [redacted]."

Review of the care plan, dated 05/03/2022, identified R1 was at risk for falls and directed, "staff to provide assistance with transfers, toileting and showering to reduce risk of falls. The care plan further documented "Resident requires physical assistance with all tasks related to toileting. Resident wears pull ups for incontinence. Staff will assist to transfer to toilet and clean up after. Staff will offer toileting assistance upon waking, before and after meals and at bedtime. Staff will wake to toilet between 1:00 a.m.– 2:00 a.m. and between 4:00 a.m. – 5:00 a.m. per residents' preference."

During an interview on 02/07/2023 at 11:05 a.m., R1's family member (Collateral Contact 1), stated an unidentified medication technician came to the room at 8:00 p.m. (09/25/2022), to give the resident their medication. CC1 stated per the normal routine an

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unidentified caregiver came to the room about 9:30 p.m. to assist the resident with getting ready for bed. CC1 stated they normally come again to assist with the resident's care about 1:00 a.m. and 4:00 a.m. When asked, CC1 stated no one came to the room to assist after 9:30 p.m. According to CC1 no one showed up at the 1:00 a.m. time, so R1 tried going to the bathroom herself at approximately 3:00 a.m. CC1 stated that the resident got up by herself, walked in the bathroom and fell. CC1 stated they called 911 and first responders arrived within 15-20 minutes.

On 02/07/2023 at 10:30 a.m., Staff B, Caregiver, stated that they did not receive a report from prior caregiving staff upon starting their shift. Staff B stated that they did not know which residents needed care or what type of care was needed. Staff B stated that they did not receive a walkie talkie, which was one way staff was able to determine which residents had requested assistance. Staff B stated that they decided to do rounds (go room to room to check on residents). Staff B stated that she did not assist Resident B to the toilet when she checked on her at 12:40 AM because the family member responded that they were all good.

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 at The Narrows is or will be in compliance with this law and / or regulation on (Date) 6-9-2023

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

A. Livingston — Administrator (or Representative)

6-9-2023 — Date

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

(5) Providing and informing staff persons of a means of emergency access to resident-occupied bedrooms, toilet rooms, bathing rooms, and other rooms.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Assisted Living Facility (ALF) failed to inform staff on how to use the door's panic bar when keys were not available to let first responders into the facility when 911 was called to assist 1of 1 resident (Resident 1) who had fallen in their room. This failure caused a delay for Resident 1 to receive emergency services and placed all residents at risk for a delay to receive emergency services.

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Findings included...

Review of Tacoma Fire department's "Prehospital Care Report" dated 09/26/2022, documented "...arrived on scene, spent 10 minutes talking to staff on the phone (stating they could not open front door and directed to find another entrance). Staff reported they could not let crews in because they did not have keys or a way to unlock the doors. EMS were able to force entry into the building by activating the sliding glass doors emergency exit mode."

Observations on 09/28/2022 at 2:50 p.m. showed there were two sets of automatic sliding glass doors to enter or exit the facility.

On 09/28/2022 at 2:50 p.m., the Executive Director (Staff A) stated the primary door from the outside to the inside of the building is locked after hours. Staff A stated the door is not locked from the inside and staff are able to open the door from the inside.

On 09/28/2023 at 2:50 p.m., Maintenance Staff (Staff C) stated the lock to the automatic doors should have been in the position to allow the doors to open from the inside. Staff C stated the receptionist inadvertently locked the door in a position that did not allow staff to open the doors from the inside and locked the key away when they left for the day. Staff C stated staff did not know how to activate the panic bar that allow the doors to open without the key.

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 at The Narrows is or will be in compliance with this law and / or regulation on (Date) 6-9-2023.

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

A. Livingston — Administrator (or Representative)

6-9-2023 — Date

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