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

04/08/2025

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

RE: Cogir at The Narrows # 2654

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 57674 (Completion Date 04/08/2025) and 48791 (Completion Date 01/09/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/08/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2381 General design requirements for memory care.

(2) The facility must provide common areas, including at least one resident accessible common area outdoors. Such common areas should accommodate and offer the opportunity of social interaction, stimulate activity, contain areas with activity supplies and props to encourage engagement, and have safe outdoor paths to encourage exercise and movement.

(a) These areas must have a residential atmosphere and must accommodate and offer opportunities for individual or group activity including:

(iv) Ensuring residents have access to their own rooms at all times without staff assistance.

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(3) Evaluate, in order to determine if there is a need for further action:

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

WAC 388-78A-2210 Medication services.

(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

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, Allied Health Field Manager
Region 3, Unit D
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Cogir at The Narrows
Provider Type: Assisted Living Facility
License/Cert.#: 2654
Compliance Determination #: 48791
Intake ID: 156641
Investigator: Woodetta Maulana
Region/Unit #: RCS Region 3 / Unit D
Investigation Date(s): 10/15/2024 through 01/09/2025
Complainant Contact Date(s):

Allegation(s):
1) Named resident did not receive their prescribed medication

Investigation Methods:

Sample:	Total residents: 125 Resident sample size: 7 Closed records sample size: 0
Observations:	staff to resident interaction resident general observation of the facility
Interviews:	staff residents
Record Reviews:	resident records

Investigation Summary:
1) The Assisted Living failed to ensure that named residents received their medication as prescribed.

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 at The Narrows
Provider Type: Assisted Living Facility
License/Cert.#: 2654
Compliance Determination #: 48791
Intake ID: 147854
Investigator: Woodetta Maulana
Region/Unit #: RCS Region 3 / Unit D
Investigation Date(s): 10/15/2024 through 01/09/2025
Complainant Contact Date(s):

Allegation(s):

1) Staff often speak to residents unkindly
2) Staff would ignore clients when they had to use the restroom, staff would move clients aside in their wheelchair when they asked to use the restroom instead of assisting them to the restroom
3) Staff would lock clients out of their rooms during the day. Residents would have to find a staff member to get access to the bathroom in the room and for the clients in memory care that was not an option as they didn't understand to ask for help to get into their rooms to use their bathrooms.
4) Named resident would often have bruising on her wrists and arms
5) Named resident had multiple falls, including tripping over a scale that was left in the middle of the floor by a staff member
6) When named resident passed away they had a fractured rib

Investigation Methods:

Sample:	Total residents: 125 Resident sample size: 7 Closed records sample size: 0
Observations:	staff to resident interaction resident to resident interaction residents general observation of the facility
Interviews:	staff others not associated with the facility
Record Reviews:	resident records

Investigation Summary:

1) Unable to substantiate failed facility practice
2) Unable to substantiate failed facility practice
3) The Assisted Living Facility failed to ensure residents always had access to their own rooms without staff assistance.
4) Unable to substantiate failed facility practice
5) The facility failed to determine a need for further action when named resident

had an accident that could adversely affect their well-being.
6) Named resident moved out of the facility and the broken rib was discover after named resident moved into a different facility. Unable to substantiate failed facility practice

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Conclusion / Action:

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

Rec'd 1/28/25
per P.O. date stamp JC.

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 # 46791
Plan of Correction	Cogir at The Narrows	Completion Date
Page 1 of 5	Licensee: Cogir Management USA Inc	01/09/2025

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 10/15/2024 and 12/12/2024 of:

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

This document references the following complaint number(s): 147319, 147854, 156641

The following sample was selected for review during the unannounced on-site visit: 7 of 125 current residents and 0 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.

Jody Just
Residential Care Services

01/21/2025
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.

A. Livingston
Administrator (or Representative)

1/23/2025
Date

WAC 388-78A-2381 General design requirements for memory care.

(2) The facility must provide common areas, including at least one resident accessible common area outdoors. Such common areas should accommodate and offer the opportunity of social interaction, stimulate activity, contain areas with activity supplies and props to encourage engagement, and have safe outdoor paths to encourage exercise and movement.

(a) These areas must have a residential atmosphere and must accommodate and offer opportunities for individual or group activity including:

(iv) Ensuring residents have access to their own rooms at all times without staff assistance.

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to ensure 3 of 5 sample residents (Residents 1, 2 &3), always had access to their own rooms without staff assistance. Failure to provide residents access to their rooms without staff assistance did not promote quality of life and dignity.

Findings included...,

On 12-12-2024 at 3:00 p.m., observation of the memory care unit showed Residents 1, 2 and 3 room doors were locked.

On 12-12-2024 at 3:20 p.m., during an interview, the medication technician (Staff C) stated when residents want to enter their rooms, care staff unlock the resident's room doors. When asked, Staff C confirmed Residents 1, 2, and 3 did not have a key to their rooms.

On 12-12-2024 at 3:40 p.m., during an interview, the resident care coordinator (Staff B) stated the room doors were kept locked to prevent residents from wandering in and out of their peer's room.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2654	Compliance Determination # 48791
Plan of Correction	Cogir at The Narrows	Completion Date
Page 3 of 5	Licensee: Cogir Management USA Inc	01/09/2025

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) 2/5/2025 .

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

A. Livingston — Administrator (or Representative)

1/23/2025 — Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(3) Evaluate, in order to determine if there is a need for further action:

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to determine a need for further action when 1 of 2 sample residents (Resident 4) had an accident that could adversely affect their well-being. This failure placed the resident at risk for further harm.

Findings included...,

Review of the facility incident report dated 2/4/2024, documented, "Care staff reported that resident was laying on the floor in the hallway... Resident complained of pain in their right hip... Resident also stated they hit their head." Further documentation review showed an incident report dated 7/2/2024, that documented, "Resident was in the dining room and tripped over the weight scale and fell. Resident hurt their right knee and left wrist."

Review of the care plan dated 2/17/2024, did not show staff updated the negotiated service agreement following Resident 4's fall on 2/4/2024 and fall on 7/2/2024.

On 1/9/2024 at 1:25 p.m., during an interview, the resident care coordinator (Staff B) confirmed staff did not update the negotiated service agreement to show that Resident 4 was at risk for falls.

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) 2/5/2025 .

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

A. Livingston — Administrator (or Representative)

1/23/2025 — Date

WAC 388-78A-2210 Medication services.

(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

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to ensure that 1 of 2 sample residents (Resident 5) received their medication as prescribed. Failure to give the resident their medication as prescribed placed the resident at risk for health complications.

Findings included...,

Review of the medication administration record (MAR) showed that Resident 5 did not receive their coumadin (medication to treat or prevent blood clots) on November 16th, 18th 19th and 20th of 2024.

On 12-12-2024 at 3:40 p.m., during an interview with Staff A, the resident care coordinator, confirmed Resident 5 did not receive their prescribed coumadin medication.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2654	Compliance Determination # 48791
Plan of Correction	Cogir at The Narrows	Completion Date
Page 5 of 5	Licensee: Cogir Management USA Inc	01/09/2025

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) 2/5/2025 .

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

A. Lewington 1/23/2025

Administrator (or Representative) Date