STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Sequim SCC LLC
Cottages of Sequim
408 W Washington St
Sequim, WA 98382

RE: Cottages of Sequim License # 2699

Dear Administrator:

This letter addresses Compliance Determination(s) 75526 (Completion Date 04/06/2026) and 72377 (Completion Date 02/18/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/06/2026 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-2660-1, WAC 388-78A-2120-4, WAC 388-78A-2160

The Department staff who did the on-site verification:
Phan Pham, Complaint Investigator

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley, RN

Clinton Fridley, Community Nurse Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Cottages of Sequim
Provider Type: Assisted Living Facility
License/Cert.#: 2699
Compliance Determination #: 72377
Intake ID: 210050
Investigator: Phan Pham
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 02/02/2026 through 02/18/2026
Complainant Contact Date(s): 01/28/2026, 02/13/2026, 02/19/2026

Allegation(s):
Quality of care - Named resident had been bed ridden and developed pressure injuries.

Investigation Methods:

Sample:	Total residents: 55 Resident sample size: 4 Closed records sample size: 0
Observations:	Named resident, residents, environment, staff interactions with residents, staff members providing care and services, and safety measures.
Interviews:	Named residents, residents, staff members, administrative and member not associated with the facility.
Record Reviews:	Sampled residents and incident reports.

Investigation Summary:
An on-site investigation was conducted, and the concerns related to resident neglect, quality of care and treatments were reviewed. 1) The assisted living facility failed to ensure staff members placed boot and floated the resident's heels in accordance with the negotiated service plan to prevent worsening and/or to promote pressure injuries heeling, 2) Failed to ensure appropriate interventions to prevent worsening and/or to promote pressure injuries heeling were in placed in a timely manner, 3) Failed to ensure staff members notify and/or consulted with the resident's physician in a timely manner in accordance with the Long-term care resident rights. Additional residents reviewed had no concerns.

Conclusion / Action:

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

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800 NE 136th Ave Ste 200, Vancouver, WA 98684

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 02/02/2026 and 02/18/2026 of:

Cottages of Sequim
408 W Washington St
Sequim, WA 98382

This document references the following complaint number(s): 210003, 210050, 212022

The following sample was selected for review during the unannounced on-site visit: 4 of 55 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Phan Pham, Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.

Clinton Fridley RN
Residential Care Services

02/26/2026
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)

3/8/2026
Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the assisted living facility failed to ensure staff members notified and/or consulted with the resident's physician in a timely manner when pressure injuries were found on the resident's heels for 1 of 4 sampled residents (Resident 1). This failure placed the resident at risk of not receiving the necessary care and services required.

Findings included...

RCW 70.129.030 Notice of rights and services—Admission of individuals.
(6) Notification of changes. (a) A facility must immediately consult with the resident's physician, and if known, make reasonable efforts to notify the resident representative to the extent provided by law when there is: (i) An accident involving the resident which requires or has the potential for requiring physician intervention.

Review of Resident 1's face sheet showed the resident admitted to the facility on [redacted]/2025 with diagnoses including [redacted] and [redacted].

Review of Resident 1's negotiated service agreement (NSA) dated 11/05/2025, documented the resident was dependent on staff members for assistance with their activities of daily living, transfers and mobility. Resident 1 had memory impairment and needed assistance to communicate their needs.

Review of Resident 1's progress note dated 11/20/2025 at 9:53 PM, Staff F, Medication Tech, documented the resident had an open wound on the left heel and an unopened blister on the right foot. The wounds appeared the same as at the beginning of the shift.

Review of the assisted living facility's communication record showed on 11/26/2025 at 11:28 AM, a staff member texted Resident 1's primary care provider's office to inform them that Resident 1 had an open wound on their left heel and one starting on the right heel. The staff member requested a referral for home health wound care.

Review of Resident 1's progress note dated 11/28/2025 at 9:16 PM, Staff F documented Resident 1's heels look the same as the last time Staff F observed them on 11/26/2025 and the blister was intact. Resident 1 stated that they hurt a little.

Review of Resident 1's progress note dated 11/30/2025 at 11:43 PM, Staff C, Medication Tech, documented Resident 1's left heel was opened, their right heel had red spots, and it looked like they were about to open. Resident 1 stated their feet were hurting a lot.

Review of Resident 1's progress note dated 12/01/2025 at 12:21 AM, Staff F documented Resident 1's left heel had drainage and loose skin.

Review of Resident 1's progress note dated 12/15/2025 at 8:19 PM, Staff B, Resident Care Coordinator, documented Staff B had spoken with home health and requested urgent admission related to wound care need on Resident 1's feet.

Review of Resident 1's primary care visit summary note dated 12/15/2025, documented the resident had pressure injuries on both heels and they were unstageable.

Review of Resident 1's hospital visit summary dated 12/24/2025, showed the resident had stage 4 (full-thickness wound extending through the skin to expose muscle, tendon, or bone) pressure injury of left heel and an unstageable pressure injury of right heel.

Record review of Resident 1's outside agency service form dated 01/07/2026, showed the resident had a wound on their right heel, measured two by two inches and was unstageable. The resident's left heel wound measured three x three by one inch and was stage four.

On 02/02/2026 at 4:25 PM, Resident 1 was observed sitting in a chair in their room, neatly groomed and dressed. At 5:03 PM, Resident 1 could not provide information related to the injuries and/or the care and services received. Resident 1 repeatedly declined the Department's representative and facility's staff requests to observe their lower extremities.

On 02/18/2026 at 8:47 AM, Resident 1 was observed in bed and covered with blankets, their heels were resting on the bed and were not floating. Resident 1 stated they were hurting but could not tell where the pain was or how bad it was.

On 02/18/2026 at 9:07 AM, an observation of Resident 1's lower extremities with Staff C, Medication Tech, revealed the resident's right heel had no injury and their left heel was covered with a two-by-two inches dressing. Staff C stated that the dressing was applied by home health wound care staff.

In an interview on 02/18/2026 at 9:07 AM, Staff C, Medication Technician, stated caregivers report injuries to the medication technicians and the medication technicians were responsible for initiating the investigation, gathering information and immediately notifying the residents' physicians, management staff members, and responsible parties.

In an interview on 02/18/2026 at 9:25 AM, Staff E, Caregiver, stated caregivers were responsible for immediately notifying injuries to the medication technicians.

In an interview on 02/18/2026 at 10:20 AM, Staff B, Resident Care Coordinator, stated they received report from Staff F regarding Resident 1's pressure injuries on 11/20/2025. Staff B stated that they had asked the staff member to immediately notify the resident's physician. Staff B stated they did not hear back from the resident's physician office and followed up with a text message on 11/26/2025.

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, Cottages of Sequim is or will be in compliance with this law and / or regulation on (Date) 4/04/2026.

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

Administrator (or Representative) — 3-8-26 Date

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

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the assisted living facility failed to ensure appropriate interventions to prevent worsening and/or to promote pressure injury healing were placed in a timely manner for 1 of 4 (Resident 1) sampled residents reviewed. This failure resulted in the resident having experienced worsening pressure injuries that required outside agencies for wound interventions which placed the resident at the likelihood of harm and services not being met.

Findings included...

Review of Resident 1's face sheet showed the resident admitted to the facility on [redacted]/2025 with diagnoses including [redacted] and [redacted].

Review of Resident 1's negotiated service agreement (NSA) dated 11/05/2025, documented the resident was dependent on staff members for assistance with their activities of daily living, transfers and mobility. Resident 1 had memory impairment and needed assistance to communicate their needs. Resident 1's NSA was updated on 12/12/2025, with interventions to include staff to ensure boot placed on Resident 1's foot while in bed.

Review of Resident 1's progress note dated 11/20/2025 at 9:53 PM, Staff F, Medication Tech, documented the resident had an open wound on the left heel and an unopened blister on the right foot. The wounds appeared the same as at the beginning of the shift.

Review of the assisted living facility's communication record showed on 11/26/2025 at 11:28 AM, a staff member texted Resident 1's primary care provider's office to inform them that Resident 1 had an open wound on their left heel and one starting on the right heel. The staff member requested a referral for home health wound care.

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Review of Resident 1's progress note dated 12/01/2025 at 12:21 AM, Staff F documented Resident 1's left heel had drainage and loose skin.

Review of Resident 1's progress note dated 12/15/2025 at 8:19 PM, Staff B, Resident

Care Coordinator, documented Staff B had spoken with home health and requested urgent admission related to wound care need on Resident 1's feet.

Review of Resident 1's primary care visit summary note dated 12/15/2025, documented the resident had pressure injuries on both heels and they were unstageable.

Review of Resident 1's hospital visit summary dated 12/24/2025, showed the resident had stage four (full-thickness wound extending through the skin to expose muscle, tendon, or bone) pressure injury of left heel and an unstageable pressure injury of right heel.

Review of Resident 1's outside agency service form dated 01/07/2026, showed the resident had a wound on their right heel, measured two by two inches and was unstageable. The resident's left heel wound measured three x three by one inch and was a stage four.

On 02/02/2026 at 4:25 PM, Resident 1 was observed sitting in a chair in their room, neatly groomed and dressed. At 5:03 PM, Resident 1 could not provide information related to the injuries and/or the care and services received. Resident 1 repeatedly declined the Department's representative and facility's staff requests to observe their lower extremities.

On 02/18/2026 at 8:47 AM, Resident 1 was observed in bed and covered with blankets, their heels were resting on the bed and were not floating nor was the resident wearing their boot. A soft boot was observed sitting on a chair in the room. Resident 1 stated they were hurting but could not tell where the pain was or how bad it was.

On 02/18/2026 at 9:07 AM, an observation of Resident 1's lower extremities with Staff C, Medication Tech, revealed the resident's right heel had no injury and their left heel was covered with a two-by-two inches dressing. Staff C stated that home health wound care staff applied the dressing. Staff C stated Resident 1's heels were not floating and Resident 1 was not wearing the boot while in bed.

In an interview on 02/18/2026 at 9:25 AM, Staff D, Caregiver, stated Resident 1 required assistance with activities of daily living and repositioning. Staff D said the resident's NSA had information related to the care and services the resident needed. Staff D stated staff members were responsible for reviewing and following the residents' NSAs when assigned to assist the residents.

In an interview on 02/18/2026 at 10:00 AM, Staff A, Executive Director, said they and/or Staff B were responsible for updating the residents' NSAs and communicating with staff of changes made. Staff A stated they were late updating Resident 1's NSA.

In an interview on 02/18/2026 at 10:20 AM, Staff B, Resident Care Coordinator, stated they received report from Staff F regarding Resident 1's pressure injuries on 11/20/2025. Staff B said Resident 1's NSA did not include interventions to prevent worsening and/or to promote healing of the pressure injuries until 12/12/2026 because staff were trying to find something that would work for the resident.

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, Cottages of Sequim is or will be in compliance with this law and / or regulation on (Date) 4-4-2026 .

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

Administrator (or Representative) — Date: 3-8-26

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 observation, interview and record review, the assisted living facility failed to ensure staff members placed boot and floated the resident's heels in accordance with the negotiated service plan to prevent worsening and/or to promote pressure injury healing for 1 of 4 (Resident 1) sampled residents reviewed. These failures placed the resident at the likelihood of harm and services not being met.

Findings included...

Review of Resident 1's face sheet showed the resident admitted to the facility on [redacted]/2025 with diagnoses including [redacted] and [redacted].

Review of Resident 1's negotiated service agreement (NSA) dated 11/05/2025, documented the resident was dependent on staff members for assistance with their activities of daily living, transfers and mobility. Resident 1 had memory impairment and needed assistance to communicate their needs. Resident 1's NSA was updated on 12/12/2025, with interventions to include staff to ensure boot placed on Resident 1's

foot while in bed.

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Review of Resident 1's outside agency service form dated 01/07/2026, showed the resident had a wound on their right heel, measured two by two inches and was unstageable. The resident's left heel wound measured three x three by one inch and was stage four.

On 02/02/2026 at 4:25 PM, Resident 1 was observed sitting in a chair in their room, neatly groomed and dressed. At 5:03 PM, Resident 1 could not provide information related to the injuries and/or the care and services received. Resident 1 repeatedly

declined the Department's representative and facility's staff requests to observe their lower extremities.

On 02/18/2026 at 8:47 AM, Resident 1 was observed in bed and covered with blankets, their heels were resting on the bed and were not floating nor was the resident wearing their boot. A soft boot was observed sitting on a chair in the room. Resident 1 stated they were hurting but could not tell where the pain was or how bad it was.

On 02/18/2026 at 9:07 AM, an observation of Resident 1's lower extremities with Staff C, Medication Tech, revealed the resident's right heel had no injury and their left heel was covered with a two-by-two inches dressing. Staff C stated that home health wound care staff applied the dressing. Staff C stated Resident 1's heels were not floating and Resident 1 was not wearing the boot while in bed. Staff C received permission from Resident 1 and was observed placing the soft boot on the left foot and floating the residents heels.

In an interview on 02/18/2026 at 9:07 AM, Staff C stated Resident 1 had pressure injuries to both heels and staff members were responsible for placing the boot on the resident's left foot and keeping the resident's heels floating while in bed. Staff C stated that the interventions were in the resident's NSA and staff members were responsible for following the NSA when assisting the resident.

In an interview on 02/18/2026 at 9:25 AM, Staff D, Caregiver, stated Resident 1 required assistance with activities of daily living, repositioning, and putting on the soft boot and floating their heels. Staff D said the resident's NSA had information related to the care and services the resident needed. Staff D stated staff members were responsible for reviewing and following the residents' NSAs when assigned to assist the residents.

In an interview on 02/18/2026 at 10:20 AM, Staff B, Resident Care Coordinator, stated Resident 1's NSA was updated 12/12/2025 to include wearing a soft boot and to keep heels floating while in bed to prevent worsening and/or to promote healing of pressure injuries. Staff B stated that they routinely observed resident and staff members assisting residents to ensure NSAs are being followed.

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, Cottages of Sequim is or will be in compliance with this law and / or regulation on (Date) 4/4/26 .

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

Administrator (or Representative) — Date: 3-8-26