STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

03/05/2025

Cogir Management USA Inc
Cogir Vancouver Orchards
10011 NE 118th Ave
Vancouver, WA 98682

RE: Cogir Vancouver Orchards # 2472

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 53901 (Completion Date 03/05/2025) and 50605 (Completion Date 12/12/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/05/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2660 Resident rights. The assisted living facility must:

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

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

(5) Provide care and services to each resident in compliance with applicable state statutes related to substitute health care decision making, including chapters 7.70 , 70.122, 11.88, 11.92, and 11.94 RCW;

(6) Reasonably accommodate residents consistent with applicable state and/or federal law; and

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

The Department staff who did the On Site verification:

Jacob Ubl, ALF NCI CI

If you have any questions, please contact me at (360)746-4675.

Sincerely,

Clinton Fridley

Clinton Fridley, Adult Family Home Nurse Field Manager
Region 3, Unit I
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Cogir Vancouver Orchards **Provider Type:** Assisted Living Facility

License/Cert.#: 2472
Intake ID: 153291
Compliance Determination #: 50605
Region/Unit #: RCS Region 3 / Unit I
Investigator: Jacob Ubl
Investigation Date(s): 11/19/2024 through 12/12/2024
Complainant Contact Date(s):

Allegation(s):

1. Resident/Patient/Client rights: Allegation that the facility violated the rights of an alleged victim resident.

2. Quality of Care/Treatment: Allegation that the facility failed to report alleged physical abuse of resident alleged perpetrator towards alleged victim resident.

Investigation Methods:

Sample:	Total residents: 70 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident staff Residents Family members Maintenance staff Housekeeping staff
Record Reviews:	Medical records State reporting log Incident investigation Facility policies

Investigation Summary:

1. Resident/Patient/Client rights: Failed practice identified. The facility violated the rights of a resident.

2. Quality of Care/Treatment: Failed practice identified. The facility failed to report alleged physical abuse of resident alleged perpetrator towards alleged victim

resident.

Conclusion / Action:

- [x] 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 #: 2472	Compliance Determination # 50605
Plan of Correction	Cogir Vancouver Orchards	Completion Date
Page 1 of 6	Licensee: Cogir Management USA Inc	12/12/2024

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 11/19/2024 and 12/12/2024 of:

Cogir Vancouver Orchards
10011 NE 118th Ave
Vancouver, WA 98682

This document references the following complaint number(s): 153291

The following sample was selected for review during the unannounced on-site visit: 3 of 70 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Jacob Ubl, ALF NCI CI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit I
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.

Debbie Woolery
Residential Care Services

12/16/24
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.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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Date

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Debbie Woolery
Administrator (or Representative)

12/16/24
Date

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

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(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

(5) Provide care and services to each resident in compliance with applicable state statutes related to substitute health care decision making, including chapters 7.70 , 70.122, 11.88, 11.92, and 11.94 RCW;

(6) Reasonably accommodate residents consistent with applicable state and/or federal law; and

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to uphold resident rights for 1 of 3 residents (Resident 1). This failure placed Resident 1 (R1) at risk for decreased quality of life and phycological harm.

Findings included...

In an interview on 10/30/2024 at 1:47 PM, Collateral Contact 1, (CC1), Ombuds for R1, reported that the facility did not allow R1 to live with their spouse and fellow resident, Resident 2 (R2), while R2 was on hospice services at the facility. CC1 reported that the facility decided to follow directions from R1's Power of Attorney (POA) regarding R1's desire to live with R2 and visit R2 more, violating R1's rights as their own decision maker. CC1 reported that R1's POA, Collateral Contact 2 (CC2), directed the facility to not allow R1 and R2 to live together and the facility followed that direction. CC1 reported that CC2 directed the facility to restrict access for R1 to visit R2 more frequently, while R2 was on hospice services, and the facility followed that direction.

During an unannounced visit on 11/19/2024 at 12:10 PM, Staff A, Executive Director, reported that the facility did not allow R1 to live with R2, while R2 was on hospice services. Staff A reported that the facility decided to follow directions from CC2 regarding R1's desire to live with R2 and visit R2 more. Staff A reported that CC2 directed the facility to not allow R1 and R2 to live together and the facility followed that direction. Staff A reported that CC2 directed the facility to restrict access for R1 to visit R2, while R2 was on hospice services, and the facility followed that direction. Staff A reported the facility followed CC2's instructions to allow for only daytime visitation for

Administrator (or Representative) Date

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This requirement was not met as evidenced by:

Based on interview and record review the facility failed to uphold resident rights for 1 of 3 residents (Resident 1). This failure placed Resident 1 (R1) at risk for decreased quality of life and phycological harm.

Findings included…

In an interview on 10/30/2024 at 1:47 PM, Collateral Contact 1, (CC1), Ombuds for R1, reported that the facility did not allow R1 to live with their spouse and fellow resident, Resident 2 (R2), while R2 was on hospice services at the facility. CC1 reported that the facility decided to follow directions from R1’s Power of Attorney (POA) regarding R1’s desire to live with R2 and visit R2 more, violating R1’s rights as their own decision maker. CC1 reported that R1’s POA, Collateral Contact 2 (CC2), directed the facility to not allow R1 and R2 to live together and the facility followed that direction. CC1 reported that CC2 directed the facility to restrict access for R1 to visit R2 more frequently, while R2 was on hospice services, and the facility followed that direction.

During an unannounced visit on 11/19/2024 at 12:18 PM, Staff A, Executive Director, reported that the facility did not allow R1 to live with R2, while R2 was on hospice services. Staff A reported that the facility decided to follow directions from CC2 regarding R1’s desire to live with R2 and visit R2 more. Staff A reported that CC2 directed the facility to not allow R1 and R2 to live together and the facility followed that direction. Staff A reported that CC2 directed the facility to restrict access for R1 to visit R2, while R2 was on hospice services, and the facility followed that direction. Staff A reported the facility followed CC2’s instructions to allow for only daytime visitation for

R1 to spend time with R2, but would not allow them to spend time together, alone, unsupervised, or sleep in the same room at night. Staff A reported thinking that that the facility had a record to show that R1 was not their own safe decision maker therefore CC2 needed to make all decisions for R1.

In an interview on 11/19/2024 at 12:44 PM, R1 reported that they expressed to several facility staff that they wanted to live with R2, while R2 was on hospice services but the facility staff responded that it was not allowed and did not provide a reason. R1 reported the facility only allowed daytime visitation for R1 to spend time with R2. R1 reported wanting to spend more time with R2, while R2 was on hospice services, but the facility mandated that they escort R1 to R2's room after breakfast and escort R1 from R2's room in the evening. R1 reported that the facility followed CC2's decisions for R1 instead of honoring R1's own wishes. R1 reported that R2 passed away on Hospice services the previous month.

In an interview on 11/19/2024 at 1:09 PM, Staff B, Anonymous reporter, reported that the facility only allowed daytime visitation for R1 to spend time with R2. Staff B reported that R1 wanted to spend more time with R2, while R2 was on hospice services, but the facility mandated that they escort R1 to R2's room after breakfast and escort R1 from R2's room in the evening. Staff B reported that the facility followed CC2's decisions for R1 instead of honoring R1's wishes to spend more time with R2.

In an interview on 11/22/2024 at 3:46 PM, CC2, R1's POA, reported that they coordinated with the facility for R1 to have daytime visitation with R2.

In an interview on 11/25/2024 at 12:54 PM, Staff C, Anonymous reporter, reported that the facility only allowed daytime visitation for R1 to spend time with R2. Staff B reported that R1 wanted to spend more time with R2, while R2 was on hospice services, but the facility mandated that they escort R1 to R2's room after breakfast and escort R1 from R2's room in the evening. Staff B reported that the facility followed CC2's decisions for R1 instead of honoring R1's wishes to spend more time with R2.

In an interview on 12/12/2024 at 12:01 PM, Staff A, Executive Director, reported that the facility had previously mistakenly thought that the facility had a record to show that that R1 was not their own safe decision maker therefore CC2 needed to make all decisions for R1. Staff A reported that upon another review of R1's records they realized that the record showed R1 to not be their own decision maker regarding only matters of financial decisions, not other life decisions for R1. Staff A reported that upon realizing this previous mistaken thought, they realized that the facility violated R1's rights to decide to live with and visit R2 without the restrictions desired by CC2. Staff A reported that the facility would have to receive a citation for violating R1's rights since the facility did not correctly interact directly with R1 as their own decision maker and incorrectly followed the direction of CC2 as the decision maker for R1.

Record review of R1's undated Face sheet, showed R1 was admitted to the AFH on [redacted]/2023.

Record review of R2's undated Face sheet, showed R2 was admitted to the AFH on [redacted]/2023.

Record review of facility provided record titled, "Providence Portland Medical Center", dated 06-18-2023, showed "In light of [R1's] advanced dementia [R1] is no longer able to manage [R1's] own finances and so [R1's] son, [CC2], as DPOA should be authorized to assume control of the patient's finances.".

The Facility was unable to provide documentation to show that R1 was not his own decision maker regarding matters outside of financial decisions.

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 Vancouver Orchards ~~is~~ or will be in compliance with this law and / or regulation on (Date) 01. 15. 2025.

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

Debbie Woolem — Administrator (or Representative)

12/16/24 — Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to report alleged physical abuse to the Complaint Resolution Unit (CRU) for 1 of 3 sampled residents (Resident 1). This failure to notify CRU placed all 68 of 68 Residents at risk for unreported abuse and prevented the department from evaluating facility systems in place to protect residents.

Record review of R2's undated Face sheet, showed R2 was admitted to the AFH on [redacted]/2023.

Record review of facility provided record titled, "Providence Portland Medical Center", dated 06-18-2023, showed "In light of [R1's] advanced dementia [R1] is no longer able to manage [R1's] own finances and so [R1's] son, [CC2], as DPOA should be authorized to assume control of the patient's finances.".

The Facility was unable to provide documentation to show that R1 was not his own decision maker regarding matters outside of financial decisions.

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Findings included…

In an interview on 10/30/2024 at 1:47 PM, Collateral Contact 1 (CC1), Ombuds for Resident 1 (R1), reported that the facility did not notify CRU of R1 allegedly being physically abused by R1's spouse and fellow resident, Resident 2 (R2).

During an unannounced visit on 11/19/2024 at 12:18 PM, Staff A, Executive Director, reported that they always report abuse to CRU but, when R2 allegedly physically abused R1, they failed to report the alleged abuse, at the time that the alleged abuse occurred, and didn't report the alleged abuse to CRU until several months after the alleged abuse occurred. Staff A reported that they did not have a record to show that they ever made the report to CRU about the alleged abuse. Staff A reported that the facility will have to receive a citation for this failure to notify CRU about R2's alleged abuse of R1.

In an interview on 11/19/2024 at 12:44 PM, R1 reported that R2 physically hit him in various ways frequently and "That's just the way our marriage was and I'm okay with that". R1 reported that R2 passed away on Hospice services the previous month.

In an interview on 11/19/2024 at 1:09 PM, Staff B, Anonymous reporter, reported that if they were to observe abuse of a resident then they would report it to the facility management personnel, then management would report it to CRU for them. Staff B reported that facility management has verbally told staff to not report anything to CRU, and instead, report their concerns to facility management so that the facility management can investigate it and make a CRU report for them.

In an interview on 11/19/2024 at 1:17 PM, Staff D, Caregiver, reported that if they were to observe abuse of a resident then they would report it to the facility management personnel, then management would report it to CRU for them.

In an interview on 11/25/2024 at 12:54 PM, Staff C, Anonymous reporter, reported that if they were to observe abuse of a resident then they would report it to the facility management personnel, then management would report it to CRU for them. Staff E reported that facility management has verbally told staff to not report anything to CRU, and instead, report their concerns to facility management so that the facility management can investigate it and make a CRU report for them.

In an interview on 11/26/2024 at 1:22 PM, Staff E, Caregiver, reported that when they observed R2 hit R1 repeatedly on the head with a shoe, they reported it to the facility management personnel, then they assumed management reported it to CRU for them. Staff F reported that facility management has verbally told staff to not report anything to CRU, and instead, report their concerns to facility management so that the facility management can investigate it and make a CRU report for them.

Record review of the Department of Social and Health Services book, "Assisted Living Guidebook", dated February 2018, showed facilities were required to report 24 hours a day, seven days a week to the Departments CRU hotline via phone or online for any reasonable cause to believe violations involving abuse or neglect.

Record review of facility policy titled, "Elder Abuse, Neglect, and Exploitation", dated 12-02-2022, showed "All staff and volunteers at Cogir Management Senior Living USA are mandated reporters" and "Reporting of any suspected, alleged, or witnessed abuse, neglect, or exploitation will be completed according to state reporting requirements." and "The assisted living facility must ensure that each staff person: Makes a report to the departments Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred".

The Facility was unable to provide documentation to show that CRU was notified of R1 allegedly being physically abused by R2.

Plan/Attestation Statement

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Debbie Dooley — Administrator (or Representative)

12/16/24 — Date

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Record review of facility policy titled, “Elder Abuse, Neglect, and Exploitation”, dated 12-02-2022, showed “All staff and volunteers at Cogir Management Senior Living USA are mandated reporters” and “Reporting of any suspected, alleged, or witnessed abuse, neglect, or exploitation will be completed according to state reporting requirements.” and “The assisted living facility must ensure that each staff person: Makes a report to the departments Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred”.

The Facility was unable to provide documentation to show that CRU was notified of R1 allegedly being physically abused by R2.

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COGIR OF VANCOUVER
PLAN OF CORRECTION
12/16/2024

CITATION NUMBER	NAME OF SECTION	PLAN OF CORRECTION	RESPONSIBLE PERSON FOR CORRECTION
WAC 388-78A-2660	RESIDENT RIGHTS	STAFF INSERVICE ON RESIDENT RIGHTS.	EXECUTIVE DIRECTOR NURSE HWD
WAC 388-78A-2630	REPORTING ABUSE AND NEGLECT	STAFF TRAINING ON MANDATED REPORTING. STAFF WILL SIT WITH ED TO REPORT ABUSE ONLINE. ED WILL FOLLOW UP WITH A PRINTED COPY FOR FILE.	EXECUTIVE DIRECTOR