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

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

RE: Cogir Vancouver Orchards License # 2472

Dear Administrator:

This letter addresses Compliance Determination(s) 78179 (Completion Date 05/29/2026) and 72969 (Completion Date 04/02/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/29/2026 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-2160, WAC 388-78A-2120-1, WAC 388-78A-2120-2-b, WAC 388-78A-2120-4

The Department staff who did the on-site verification:
Jacob Ubl, ALF NCI CI

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

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

Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2472
Intake ID: 212586
Compliance Determination #: 72969
Region/Unit #: RCS Region 3 / Unit E
Investigator: Jacob Ubl
Investigation Date(s): 02/13/2026 through 04/02/2026
Complainant Contact Date(s):

Allegation(s):

1. Resident/Patient/Client Neglect: Allegation that the facility neglected to appropriately identify and seek treatment for a Resident Alleged Victim's wound.

Investigation Methods:

Sample:	Total residents: 56 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 Identified staff
Record Reviews:	Medical records Hospital records State reporting log Incident investigation Facility policies Staff training records Staff patterns

Investigation Summary:

1. Resident/Patient/Client Neglect: Failed practice identified. The facility failed to appropriately identify and seek treatment for a Resident Alleged Victim's wound.

Conclusion / Action:

[X] Failed Provider Practice Identified / Citation(s) Written

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

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2472
Intake ID: 212591
Compliance Determination #: 72969
Region/Unit #: RCS Region 3 / Unit E
Investigator: Jacob Ubl
Investigation Date(s): 02/13/2026 through 04/02/2026
Complainant Contact Date(s):

Allegation(s):

1. Resident/Patient/Client Neglect: Allegation that the facility neglected to appropriately identify and seek treatment for a Resident Alleged Victim's wound.

Investigation Methods:

Sample:	Total residents: 56 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 Identified staff
Record Reviews:	Medical records Hospital records State reporting log Incident investigation Facility policies Staff training records Staff patterns

Investigation Summary:

1. Resident/Patient/Client Neglect: Failed practice identified. The facility failed to appropriately identify and seek treatment for a Resident Alleged Victim's wound.

Conclusion / Action:

[X] Failed Provider Practice Identified / Citation(s) Written

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

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2472
Intake ID: 212703
Compliance Determination #: 72969
Region/Unit #: RCS Region 3 / Unit E
Investigator: Jacob Ubl
Investigation Date(s): 02/13/2026 through 04/02/2026
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/Treatment: Allegation that the facility neglected to appropriately identify and seek treatment for a Resident Alleged Victim's wound.

Investigation Methods:

Sample:	Total residents: 56 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 Identified staff
Record Reviews:	Medical records Hospital records State reporting log Incident investigation Facility policies Staff training records Staff patterns

Investigation Summary:

1. Quality of Care/Treatment: Failed practice identified. The facility failed to appropriately identify and seek treatment for a Resident Alleged Victim's wound.

Conclusion / Action:

[X] Failed Provider Practice Identified / Citation(s) Written

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

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
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 02/13/2026 and 04/02/2026 of:

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

This document references the following complaint number(s): 212586, 212591, 212703

The following sample was selected for review during the unannounced on-site visit: 3 of 56 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Jacob Ubl, ALF NCI CI

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

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Statement of Deficiencies	License #: 2472	Compliance Determination #72959
Plan of Correction	Cogir Vancouver Orchards	Completion Date
Page 2 of 7	Licensee: Cogir Management USA Inc	04/02/2026

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

04/13/2026
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.

Debbie Woolery
Administrator (or Representative)

4/17/26
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 facility failed to complete or maintain documentation of weekly skin checks for 1 of 3 residents (Resident 1) reviewed. This failure resulted in Resident 1 (R1) not receiving skin checks per the Negotiated Service Agreement (NSA), contributed to the delay of treatment of an unidentified wound for R1 that required emergent medical care and placed R1 at risk for pain, further and unidentified deterioration of skin integrity, and a decreased quality of life.

Findings included...

Record review of a facility policy, dated 12/13/2024, titled, "Wound and Skin Care", showed that any residents receiving assistance with bathing or dressing, determined on their NSA, would have their skin checked by staff during bathing and dressing assistance.

Record review of an undated face sheet showed Resident 1 (R1) admitted to the facility on 06/10/2022.

Record review of R1's NSA, dated 11/21/2025, showed R1 required extensive assistance with bathing weekly and required weekly skin checks performed by staff. Documented

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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 | 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-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 facility failed to complete or maintain documentation of weekly skin checks for 1 of 3 residents (Resident 1) reviewed. This failure resulted in Resident 1 (R1) not receiving skin checks per the Negotiated Service Agreement (NSA), contributed to the delay of treatment of an unidentified wound for R1 that required emergent medical care and placed R1 at risk for pain, further and unidentified deterioration of skin integrity, and a decreased quality of life.

Findings included…

Record review of a facility policy, dated 12/13/2024, titled, “Wound and Skin Care”, showed that any residents receiving assistance with bathing or dressing, determined on their NSA, would have their skin checked by staff during bathing and dressing assistance.

Record review of an undated face sheet showed Resident 1 (R1) admitted to the facility on [redacted]/2022.

Record review of R1’s NSA, dated 11/21/2025, showed R1 required extensive assistance with bathing weekly and required weekly skin checks performed by staff. Documented

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R1 has a history of wounds.

Record review of R1's progress notes as of 02/11/2026, showed no documentation of any skin wounds to the buttocks.

Record review of R1's Progress Note, dated 02/13/2026, showed Staff B, Director of Nursing, completed a limited assessment of the buttocks on 02/09/2026 and noted two open skin areas on the residents' buttocks. Documents that on [redacted]/2026 the home health nurse and wound practitioner discovered another wound that required R1 to the transported to the hospital via ambulance for treatment.

Record review of R1's facility medical records on 02/13/2026 showed no documentation that staff completed skin checks.

On 02/13/2026 at 11:54 PM, Staff B stated that they should have done a full skin assessment by assisting R1 into bed, like the home health nurse did, but didn't because transferring the resident into bed was painful for R1. Staff B stated that prior to [redacted]/2026, the facility failed to do a full skin assessment on R1.

On 02/13/2026 at 1:18 PM, Staff C, Caregiver, stated R1 was too weak to stand long enough for staff to do a full skin check while receiving a shower. Staff C stated that staff had only been doing limited skin checks on R1 and hadn't done a full skin check in a long time.

On 02/13/2026 at 1:41 PM Staff D, Medication Technician, stated that R1 had sagging skin folds that made it difficult to look under every skin fold while giving showers. Staff D stated that they did not know the last time R1 had a full skin check.

On 02/13/2026 at 1:46 PM Staff E, Resident Care Coordinator, stated staff did not fully check R1's skin during dressing and shower assistance because it caused R1 pain to be in the body positions necessary to fully check R1's skin.

Record review of the Hospital Admission Summary showed R1 admitted to the hospital on [redacted]/2026 with the diagnosis of [redacted] and [redacted] R1's condition upon arrival at the hospital was serious, emergent and a hospice (end-of-life care) referral was initiated.

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

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) 5/28/2026 17TN dw

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

Deanne Wooten — Administrator (or Representative)

4/17/26 — Date

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

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff observed residents consistent with their assessed needs and failed to identify changes in resident functioning for 1 of 3 sampled residents (Resident 1). This failure resulted in Resident 1 (R1) not receiving skin checks, contributed to an undiscovered unstageable pressure injury that required emergent hospitalization and initiation of hospice (end-of-life care) referral, and placed R1 at risk for unidentified issues, pain, and a decreased quality of life.

Findings included...

Record review of a facility policy titled, "Wound and Skin Care," dated 12/13/2024, showed that any residents receiving assistance with bathing or dressing, determined on their NSA, would have their skin checked by staff during bathing and dressing assistance.

Record review of an undated face sheet showed Resident 1 (R1) admitted to the facility on [redacted]/2022.

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

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)_____ .

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

_____ _____

Administrator (or Representative) Date

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

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff observed residents consistent with their assessed needs and failed to identify changes in resident functioning for 1 of 3 sampled residents (Resident 1). This failure resulted in Resident 1 (R1) not receiving skin checks, contributed to an undiscovered unstageable pressure injury that required emergent hospitalization and initiation of hospice (end-of-life care) referral, and placed R1 at risk for unidentified issues, pain, and a decreased quality of life.

Findings included…

Record review of a facility policy titled, “Wound and Skin Care,” dated 12/13/2024, showed that any residents receiving assistance with bathing or dressing, determined on their NSA, would have their skin checked by staff during bathing and dressing assistance.

Record review of an undated face sheet showed Resident 1 (R1) admitted to the facility on [redacted]/2022.

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Record review of R1's Negotiated Service Agreement (NSA), dated 11/21/2025, showed R1 needed extensive assistance with bathing weekly and dressing daily. NSA showed that R1 needed their skin checked by facility staff weekly and that R1 had a history of wound development.

Record review of R1's Progress Note, dated [redacted]/2026, showed R1 had a limited skin assessment done by Staff B, Director of Nursing, on 02/09/2026 and that on [redacted]/2026, Collateral Contact 2 (CC2), Home Health Nurse for R1, did a full skin assessment to reveal that R1 had a deep wound under their right leg skin fold.

Record review of R1's progress notes as of 02/11/2026, showed no documentation of any skin wounds to the buttocks.

Record review of R1's Home Health Notes, dated [redacted]/2026, showed CC2 discovered that R1 had a newly discovered wound on [redacted]/2026 at 11:00 AM located on R1's right ischium (lower back part of the hip bone). The wound was an unstageable pressure injury (Wound caused by prolong pressure and covered with dead tissue) that measured six centimeters in length, five centimeters in width, and three centimeters in depth. R1 needed to be immediately hospitalized to address the severity of the wound.

Record review of a Hospital Admission Summary showed R1 was admitted to the hospital on [redacted]/2026 with a visit diagnosis of [redacted]. R1's condition upon arrival to the hospital was serious, emergent and a hospice referral had been initiated.

Record review of R1's facility medical records as of [redacted]/2026 showed no documentation that staff completed skin checks.

On [redacted]/2026 at 10:59 AM, Collateral Contact 1 (CC1), R1's representative, stated that the facility had asked CC2 to look at R1's back side as the facility was concerned about potential skin breakdown. CC1 stated that CC2 discovered a very deep concerning wound, that had been there a long time, that resulted in R1 being immediately hospitalized yesterday, [redacted]/2026. CC1 stated that they were very upset because the facility should have looked for the wound earlier, should not have waited to ask CC2 to look for it, and that R1 was paying a lot of money to live at a facility that would make this egregious of a mistake that was causing R1 a lot of pain.

On [redacted]/2026 at 11:54 AM, Staff B stated that they should have done a full skin assessment by assisting R1 into bed, like CC2 did, but didn't because it was painful for R1 to be transferred into a bed. Staff B stated that prior to [redacted]/2026, the facility failed to do a full skin assessment on R1. Staff B stated that they felt that R1's wound had been there a long time, R1 was at high risk of developing pressure ulcers due to

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spending most of their time sitting in a chair and that the facility didn't have a process in place to identify residents at high risk of pressure ulcer development that needed closer skin monitoring.

On [redacted]/2026 at 1:18 PM, Staff C, Caregiver, stated R1 was too weak to stand long enough during shower for staff to do a full skin check. Staff C stated that staff had only been doing limited skin checks on R1 and hadn't done a full skin check in a long time. Staff C stated that the facility provided the same standard skin checks to all residents and there weren't any residents identified as high risk for skin deterioration that required closer skin monitoring.

On [redacted]/2026 at 1:41 PM Staff D, Medication Technician, stated that R1 had sagging skin folds that made it difficult to look under every skin fold while giving showers. Staff D stated that they did not know the last time R1 had a full skin check.

On [redacted]/2026 at 1:46 PM Staff E, Resident Care Coordinator, stated staff did not fully check R1's skin during dressing and shower assistance because it caused R1 pain to be in the body positions necessary to fully check R1's skin. Staff E stated that the facility didn't have a system in place to show what residents were at higher risk of skin breakdown or if there were residents that staff needed to more closely monitor their skin. Staff E stated that the facility should have this type of system in place to provide appropriate interventions to individual residents rather than a standardized approach that doesn't meet all the resident's needs.

On 02/27/2026 at 4:26 PM, CC2 stated that the facility had asked them to look at R1's buttocks area on [redacted]/2026 as the facility was concerned about skin breakdown. CC2 stated they observed a severe deep wound on R1's right ischium that seemingly had been developing for a while and required immediate hospitalization. CC2 stated that the facility should have assessed the area for the wound earlier and not have waited to ask CC2 to assess it. CC2 stated that Staff B expressed being upset because they had done a limited skin assessment earlier in the week but not thoroughly enough to assess R1's skin to discover the right ischium wound and Staff B regretted not getting R1 in bed for a full skin assessment like CC2 had done.

In an interview on 04/02/2026 at 3:38 PM, Staff A, Executive Director, stated the facility failed to have processes in place to identify residents at high risk for skin breakdown, perform more frequent nursing skin assessments on those residents identified as high risk, and failed to do a full skin assessment on R1 prior to [redacted]/2026.

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Statement of Deficiencies	License #: 2472	Compliance Determination # 72963
Plan of Correction	Cogir Vancouver Orchards	Completion Date
Page 7 of 7	Licensee: Cogir Management USA Inc	04/02/2026

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) 5/28/2026 17th MW

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

Debbie Woolery — Administrator (or Representative)

4.17.26 — Date

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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)_____ .

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

_____ _____

Administrator (or Representative) Date

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