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 of Glenwood Place
5500 NE 82nd Ave
Vancouver, WA 98662

RE: Cogir of Glenwood Place License # 2645

Dear Administrator:

This letter addresses Compliance Determination(s) 79618 (Completion Date 07/07/2026) and 75985 (Completion Date 05/15/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/07/2026 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-2640-1-a, WAC 388-78A-2640-1-b, WAC 388-78A-2640-3-a, WAC 388-78A-2640-3-b

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

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Nursing Home Allied Health 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 of Glenwood Place
Provider Type: Assisted Living Facility

License/Cert.#: 2645
Intake ID: 218988
Compliance Determination #: 75985
Region/Unit #: RCS Region 3 / Unit E
Investigator: Jacob Ubl
Investigation Date(s): 04/15/2026 through 05/15/2026
Complainant Contact Date(s):

Allegation(s):
1. Nursing services: Facility report of a resident change in condition.

Investigation Methods:

Sample:	Total residents: 212 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident representative Identified staff staff Residents Family members
Record Reviews:	Medical records Hospital records Incident investigation Facility policies

Investigation Summary:
1. Nursing services: failed practice identified. Facility failed to notify resident representative and physician of resident change in condition

Conclusion / Action:

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

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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 04/15/2026 and 05/15/2026 of:

Cogir of Glenwood Place
5500 NE 82nd Ave
Vancouver, WA 98662

This document references the following complaint number(s): 218988, 219734

The following sample was selected for review during the unannounced on-site visit: 3 of 212 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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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

05/18/2026
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)

5/18/26
Date

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(b) The resident is relocated to a hospital or other health care facility; or

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify the residents physician and representative when the resident had a significant change in condition for 1 of 3 residents (Resident 1). This failure resulted in the resident's physician and representative not being notified and being unable to decide if any changes to the plan of care were required as a result of the change in condition, an infected toe that required emergent hospitalization with toe [redacted], initiation of hospice (end-of-life care) referral, and placed the resident at risk of unmet care needs and a decreased quality of life.

Findings included...

Record review of facility policy titled, "Change in Resident Status," dated 12/05/2025,

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showed that after a resident change in condition, staff were to notify the residents physician and representative(s).

Record review of an undated face sheet showed Resident 1 (R1) admitted to the facility on [redacted]/2020.

Record review of hospital emergency department discharge instructions, dated 03/23/2026, showed that R1's Physician was to be notified and R1 was to be returned to the hospital emergency department immediately if new concerns were to arise with R1's infected toe.

Record review of R1's progress notes, dated 03/27/2026, showed that staff identified R1's infected toe was worsening, had turned black, was cold to the touch and did not show that any parties had been notified of the concerns.

Record review showed that R1 was hospitalized for an infected toe on [redacted]/2026 after R1's representative, Collateral Contact 1 (CC1), notified Staff B, Licensed Practical Nurse, that R1's infected toe had a significant decline in appearance and there was no mention that R1's physician had been notified of the incident.

Record review of facility records showed that R1 returned to the facility on [redacted]/2026 after a hospitalization for an infected toe removal and there was no mention that R1's physician had been notified of the incident.

In an interview on 04/15/2026 at 11:01 AM, Staff A, Executive Director, stated that the facility failed to notify R1's physician and representative of R1's infected toe decline on 03/27/2026. Staff A stated that the facility did not notify CC1 of R1's infected toe decline and that it was CC1 that notified Staff B of R1's infected toe decline concerns. Staff A stated that R1 was hospitalized and R1's infected toe was [redacted] during the hospitalization.

In an interview on 04/15/2026 at 2:12 PM, Staff C, Resident Care Coordinator, stated that facility staff had documented that R1's infected toe was getting worse on 03/27/2026 yet they didn't notify anyone.

In an interview on 04/15/2026 at 2:30 PM, Staff B, Licensed Practical Nurse, stated that CC1 notified them on [redacted]/2026 of concerns that R1's infected toe had gotten worse, Staff B agreed that it was worsening and Staff B proceed to initiate R1's transportation to a hospital. Staff B stated the facility had been documenting R1's infected toe deterioration concerns for about 24 hours prior to that but failed to notify anyone of the concerns.

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In an interview on 04/16/2026 at 2:44 PM, CC1 stated that they notified Staff B when they noticed R1's infected toe was worsening on [redacted]/2026 and felt that the facility should have caught it sooner and notified them before the entire toe turned black. CC1 stated that R1's infected toe had to be cut off in the hospital and that R1 was expected to be transitioned to hospice services soon as hospice referral had been initiated.

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 of Glenwood Place is or will be in compliance with this law and / or regulation on (Date) 5/30/2026 .

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

Administrator (or Representative) — Date: 5/18/26

This was corrected before the investigation and we will complete another training on Company policy no later than 5/21/2026.

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