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) 79217 (Completion Date 06/18/2026) and 75113 (Completion Date 04/21/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/18/2026 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-2320-1-a, WAC 388-78A-2320-1-b, WAC 388-78A-2320-1, WAC 388-78A-2320-3-c, WAC 388-78A-2474-2-b, WAC 388-78A-2210-1-b, WAC 388-78A-2610-1, WAC 388-78A-2610-2-c, WAC 388-78A-2610-2-c-ii, WAC 388-78A-2610-2-d, WAC 388-78A-2950-6, WAC 388-78A-3090-1-a, WAC 388-78A-3090-1-b, WAC 388-78A-3090-1-c, WAC 388-78A-3090-1-d, WAC 388-78A-3090-1, WAC 388-78A-2480-1, WAC 388-78A-2620-1-a, WAC 388-78A-2620-1-b, WAC 388-78A-2620-1, WAC 388-78A-3040-2-a, WAC 388-78A-3040-2-b, WAC 388-78A-3040-2-c, WAC 388-78A-3040-2-e, WAC 388-78A-2381-2-a-iv, WAC 388-78A-2660-2, WAC 388-78A-2660-4, WAC 388-78A-2660-5, WAC 388-78A-2160, WAC 388-78A-2300-1-c-iii, WAC 388-78A-2651-1, WAC 388-78A-2651-2, WAC 388-78A-2651-2-a, WAC 388-78A-2651-2-b, WAC 388-78A-2651-2-c, WAC 388-78A-2651-3, WAC 388-78A-2651-4, WAC 388-78A-2651-4-a, WAC 388-78A-2651-4-b, WAC 388-78A-2651-5, WAC 388-78A-2651-5-a, WAC 388-78A-2651-5-b, WAC 388-78A-2651-5-c, WAC 388-78A-2651-5-d, WAC 388-78A-2651, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2371-4, WAC 388-78A-2371, WAC 388-78A-2600-1-c, WAC 388-78A-2600-1-d, WAC 388-78A-2600-2-j-i, WAC 388-78A-2600-2-j-ii, WAC 388-78A-2600-2-j-iii, WAC 388-78A-2600-2-j, WAC 388-78A-2600-2-l, WAC 388-78A-2600-3, WAC 388-78A-2120-1, WAC 388-78A-2120-2, WAC 388-78A-2120-2-a, WAC 388-78A-2120-2-b, WAC 388-78A-2120-3, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-4, WAC 388-78A-2120, WAC 388-78A-2100-2-b-ii, WAC 388-78A-2100-2-b-iii, WAC 388-78A-2100-2-b-i, WAC 388-78A-2140-1-c, WAC 388-78A-2140-1-d, WAC 388-78A-2140-1-e, WAC 388-78A-2140-2-a, WAC 388-78A-2140-3, WAC 388-78A-2130-3-a, WAC 388-78A-2130-3-b, WAC 388-78A-2130-3

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

The Department staff who did the on-site verification:
Celeste Vashey, ALF LTC Licensor
Anissa Bearden, Licensor

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Laurie Anderson

Laurie Anderson, Community Field Manager
Region 3, Unit E
Residential Care Services

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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 the unannounced on-site full inspection on 03/31/2026 and 04/02/2026 of:

Cottages of Sequim
408 W Washington St
Sequim, WA 98382

The following sample was selected for review during the unannounced on-site visit: 7 of 52 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor

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

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

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

04/27/2026
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)

5/6/2026
Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(c) Chapter 246-840 WAC, Practical and registered nursing;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to have Registered Nurse (RN) Delegation services and documentation in place for 4 of 4 residents (Resident 2, 4, 5 and 7). This failure placed all residents receiving RN delegated services at risk for receiving care and services by untrained staff.

Findings included...

Washington Administrative Code 246-840-930 "Criteria for delegation... (3) Assess the patient's nursing care needs and determine the patient's condition is stable and predictable. A patient may be stable and predictable with an order for sliding scale insulin or terminal condition. (4) Determine the task to be delegated is within the delegating nurse's area of responsibility... (11) Document in the patient's record the rationale for delegating or not delegating nursing tasks. (12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy

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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

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maintained in the patient's record that includes: (a) The rationale for delegating the nursing task; (b) The delegated nursing task is specific to one patient and is not transferable to another patient; (c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide; (d) The nature of the condition requiring treatment and purpose of the delegated nursing task; (e) A clear description of the procedure or steps to follow to perform the task; (f) The predictable outcomes of the nursing task and how to effectively deal with them; (g) The risks of the treatment; (h) The interactions of prescribed medications; (i) How to observe and report side effects, complications, or unexpected outcomes and appropriate actions to deal with them, including specific parameters for notifying the registered nurse delegator, health care provider, or emergency services; (j) The action to take in situations where medications and/or treatments and/or procedures are altered by health care provider orders, including: (i) How to notify the registered nurse delegator of the change; (ii) The process the registered nurse delegator uses to obtain verification from the health care provider of the change in the medical order; and (iii) The process to notify the nursing assistant or home care aide of whether administration of the medication or performance of the procedure and/or treatment is delegated or not; (k) How to document the task in the patient's record; (l) Document teaching done and a return demonstration, or other method for verification of competency… (15) The registered nurse delegator is accountable and responsible for the delegated nursing task. The registered nurse delegator monitors the performance of the task(s) to assure compliance with established standards of practice, policies and procedures and appropriate documentation of the task(s)… (17) The registered nurse delegator supervises and evaluates the performance of the nursing assistant or home care aide, including direct observation or other method of verification of competency of the nursing assistant or home care aide. The registered nurse delegator reevaluates the patient's condition, the care provided to the patient, the capability of the nursing assistant or home care aide, the outcome of the task, and any problems. (18) The registered nurse delegator ensures safe and effective services are provided. Re-evaluation and documentation occur at least every 90 days. Frequency of supervision is at the discretion of the registered nurse delegator and may be more often based upon nursing assessment.”

Record review of the facility’s policy titled, “Nursing Services Intermittent,” dated 10/02/2020, documented they were to provide specific nursing services based on Washington state regulations for assisted living facility to maintain and or enhance the health status of residents.

Record review of the Washington State Department of Social and Health Services document titled, Community Nurse Delegation Orientation 2026, documented if a resident was not cognitively aware they receive medications and or requires medication to be put into the resident’s mouth, must have their medication tasks delegated.

Record review on 04/01/2026 at 3:14 PM of the Registered Nurse delegation documents, showed Staff I, Registered Nurse Delegator, assumed delegation services at the facility on 07/07/2025.

Resident 2 (R2)

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

Record review of R2's medical records documented they moved into the facility on [redacted]/2026.

Record review of R2's assessment, dated 02/17/2026, documented they had multiple medical diagnoses that included [redacted] and [redacted]. Staff assisted R2 with their medication and were to notify the license nurse if R2 required increased assistance.

In an interview on 03/31/2026 at 4:15 PM, Staff E, Medication Technician, stated R2 was spoon fed their crushed mixed in applesauce medications.

In an interview on 04/01/2026 at 10:39 AM, R2 did not answer when they were asked multiple times if they took medication.

Record review on 04/01/2026 at 3:14 PM of the Registered Nurse delegation documents provided showed no documentation that staff were delegated to provide administration of medications to R2.

In an interview on 04/01/2026 at 4:05 PM, Staff G, Resident Care Coordinator, stated the medication technicians crushed and spoon fed R2's medication into their mouth.

In an observation on 04/01/2025 at 7:15 PM, Staff J, Medication Technician, crushed R2's medication, mixed in pudding and spoon fed it into R2's mouth.

Resident 4 (R4)

Record review on 04/01/2026 at 3:14 PM, of the Registered Nurse delegation documents, showed R4's eye drop medications were a nurse delegated task on the last nursing visit dated 01/26/2026. R4 was not nurse delegated for any other tasks.

In an observation on 04/01/2026 at 7:07 PM, Staff J crushed R4's medication, mixed in pudding and spoon fed it into R4's mouth.

Resident 5 (R5)

Record review of R5's medical records provided documented they moved into the

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facility on [redacted]/2025.

Record review of R5's assessment, dated 12/02/2026, documented they had multiple medical diagnoses that included dementia and required medications to be administered by nurse delegation.

Record review on 04/01/2026 at 3:14 PM of the Registered Nurse delegation documents, showed there was a nursing visit dated 01/26/2026 that R5's oral medications were delegated. There were no other nursing visits, delegation consent form or specific instruction sheets for R5's delegated tasks provided to review.

In an interview on 04/01/2026 at 3:54 PM, Staff I, Registered Nurse Delegator, stated they do not keep prior RN delegation documents for residents to review and unable to provide.

In an interview on 04/01/2026 at 4:25 PM, Staff A, Executive Director, acknowledged that R2 and R4 were not delegated for their crushed spoon-fed oral medications.

Resident 7 (R7)

Record review of R7's medical records documented they moved into the facility on [redacted]/2025 and had a medical diagnosis of [redacted].

Record review of R7's, Level of Care Assessment, dated 03/03/2026, documented R7 had red, raised and open areas on their right and left lower legs.

Record review of R7's order, dated 12/01/2025, documented R7 had an order for Bacitracin (an antibiotic ointment used to prevent infections) and facility staff were to apply to the effective areas every day for wound care orders.

Record review of R7's, Medication Administration Record (MAR), dated 01/01/2026 through 01/31/2026, documented R7 had an order for Bacitracin to be applied on R7's wound daily and they received all 31 of 31 dosages.

Record review of R7's, MAR, dated 02/01/2026 through 02/05/2026, documented R7 had an order for Bacitracin to be applied on R7's wound daily and they received all 5 of 5 dosages.

On 04/02/2026 at 10:16 AM, Staff G stated R7's order for Bacitracin was applied to R7's legs.

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

Record review of the nurse delegation binder on 04/02/2026 at 10:16 AM, showed no delegation records in the binder to review related to R7's Bacitracin orders.

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) 6/5/2026 .

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

Administrator (or Representative) 5/6/2026 Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(b) Basic;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 3 sampled staff (Staff B and C) had completed the 70-hour long term care worker basic training. This failure resulted in residents being cared for by staff without required training and at risk of harm in the event of an emergency due to staff not being trained on life saving measures, unaware of the facility's expectations, and risk of unmet care needs by untrained staff.

Findings included...

WAC 388-112A-0080 "Who is required to complete the seventy-hour long-term care worker basic training and by when? The following individuals must complete the seventy-hour long-term care worker basic training unless exempt as described in WAC 388-112A-0090... Assisted living facilities. (5) Long-term care workers in assisted living facilities within one hundred twenty days of their date of hire. Long-term care workers must not provide personal care without direct supervision until they have completed the seventy-hour long-term care worker basic training."

Record review of the facility provided document titled, "Employee," undated,

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Record review of the facility provided document titled, "Employee," undated,

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documented Staff B, Caregiver, was hired 08/24/2025 and Staff C, Caregiver, was hired 05/16/2025.

Review of the facility provided staff records on 04/01/2026 at 3:00 PM, documented Staff B and Staff C did not have any documentation that they completed the 70-hour long term care worker training.

In an interview on 04/02/2026 at 12:13 PM, Staff Q, Business Office Manager, stated Staff B and Staff C had not completed their 70-hour long term care worker training within the required timeframe of 120 days.

In an interview on 04/02/2026 at 2:17 PM, Staff A, Executive Director, stated Staff B and Staff C did not have their 70-hour long term worker training completed.

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Administrator (or Representative) — Date: 5/6/2026

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure medications were not expired, a system to identify when opened medications became expired and a system to destroy expired medications for 2 of 2 medication carts (routine medication cart and as needed medication cart) and failed to ensure residents medications were accessible only by appropriate staff for 1 of 2 areas (supply closet). These failures placed residents at risk of harm from adverse reactions due to expired medications and inconsistent and/or improper medication management.

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Findings included…

Record review of the facility provided policy titled, “Medications,” undated, showed no procedure for expired medication or destruction of medications. The policy showed that the facility would store, handle and prepare medication consistent with the board of pharmacy requirements.

<As Needed Medication Cart>

An observation of the As Needed Medication Cart on 03/31/2025 at 3:59 PM showed the following:

- 106 tablets of Tylenol (medication to help treat pain and discomfort) for Resident 9 (R9) expired on 03/01/2026.
- 26 tablets of risperidone (medication to help treat behaviors) for Resident 10 expired on 11/18/2025.
- 57 tablets of senna (medication to help stimulate bowel movement) for Resident 11 (R11) expired on 03/02/2026.
- 30 tablets of Tylenol for R11 expired on 03/02/2026.
- 120 tablets of calcium antacid (medication to help reduce stomach acid) for Resident 12 (R12) expired on 03/03/2026 and 30 tablets expired on 03/02/2026.

In an observation on 04/02/2026 at 11:52 AM, Staff G, Resident Care Coordinator, reviewed R9’s 106 tablets of Tylenol and R12 120 tablets of calcium antacid and confirmed they were expired.

<Routine Medication Cart>

An observation of the Routine Medication Cart on 03/31/2026 at 4:17 PM showed the following:

- Eight tablets of Tylenol for R11 expired on 03/02/2025.
- Four tablets of Tylenol for Resident 13 expired on 03/03/2026.
- 56 tablets of tramadol (medication to help treat pain) for Resident 8 (R8) expired on 03/17/2026.

R8

Record review of R8’s medical records showed they moved into the facility on [redacted]/2024.

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

Record review of R8's Service Plan, dated 04/10/2026, documented they were able to communicate and make their needs known independently and staff ordered, maintained and assisted R8 with their medications per physician orders.

An observation on 03/31/2026 at 4:17 PM of the Routine Medication Cart showed R8's tramadol order, that expired on 03/17/2026, was recorded in Narcotic Book One on page ten.

In an interview on 03/31/2026 at 4:30 PM, Staff E, Medication Technician, stated that R8's tramadol had expired on 03/17/2026.

Record review, on 04/02/2026, of Narcotic Book One, page ten, showed R8's tramadol was administered on 03/19/2026 and 03/31/2026.

In an interview on 04/02/2026 at 11:52 AM, Staff G stated R8's tramadol had expired. Staff G and Staff A, Executive Director, stated they both were unaware and was not notified that R8's tramadol had expired or that there were other medications expired in the medications carts.

R11

Record review of R11's medical records showed they moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted] and [redacted].

In an observation on 03/31/2026 at 4:17 PM, inside the Routine Medication Cart showed R11 had eight tablets of Tylenol that expired on 03/02/2025.

Record review of R11's Medication Administration Record (MAR), dated 03/01/2026 through 03/31/2026, showed a current order for Tylenol to be taken every eight hours as needed for pain. R11 was received doses on 03/06/2026, 03/13/2026, 03/14/2026 and 03/25/2026.

In an interview on 03/31/2026 at 4:17 PM, Staff E stated R11 used their Tylenol for break through pain two times a week and that they had given R11 Tylenol on Wednesday 03/25/2026. Staff E stated the expired Tylenol in the Routine Medication Cart was the medication they had administered.

<Supply Closet>

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

In an observation on 03/31/2026 at 1:59 PM, Staff K, Maintenance Director, unlocked and opened the dining room supply closet that had multiple medications stored for Resident 14 (R14).

In an interview on 03/31/2026 at 1:59 PM, Staff G stated R14's medications were to be destroyed.

In an observation on 04/01/2026 at 7:12 PM, Staff J, Medication Technician, handed Staff L, Caregiver, a set of keys that unlocked and opened the dining room supply closet door.

In an interview on 04/10/2026 at 1:28 PM, Staff A stated all resident medications were to be locked and accessible only by the medication technicians.

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) 6/5/2026.

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

Administrator (or Representative) — Date 5/4/2026

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(c) Maintain and provide staff persons with the necessary training, supplies, equipment, and personal protective equipment for preventing and controlling the spread of infections by:

(ii) Ordering supplies when necessary.

(d) Provide all resident care and services according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

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This requirement was not met as evidenced by:

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Based on observation, interview and record review, the facility failed to implement infection control practices by staff not performing hand hygiene during resident care and dinning services for 8 of 8 staff (Staff L, R, A, M, N, S, T and U), failed to have sinks accessible and suppled with hand washing materials for 2 of 2 laundry room areas (Staff Laundry Room and Resident Laundry Room), failed to implement infection control practices by staff handling linen for 2 of 2 observed areas (West Shower room and R2's room) and failed to have a system in place for sharps disposal. These failures placed all residents at risk for cross contamination and spread of infection.

Findings included…

<Hand Hygiene>

Record review of the facility's policy titled, "Infection Control," undated, documented staff would wash their hands before and after touching a resident, immediately if hands were soiled and after removing gloves. Staff were to wash hands with soap and water or use hand sanitizer unless visibly soiled then wash with soap and water immediately.

In an observation on 03/31/2026 at 2:40 PM, showed Staff L, Caregiver, pushed R3 in their wheelchair out of their room and into the hallway and parked them there, while holding a full clear trash bag, a soiled incontinence brief (disposable garments used to protect clothing from involuntary leaking from the bowel or bladder) was visible inside the garbage bag, with their bare hand. Staff L was then observed, while still holding the full clear trash bag to push a different resident, Resident 2 (R2) in their wheelchair into the dining room and set them up at a table.

In an observation on 03/31/2026 at 2:40 PM, with bare hands Staff L entered the code onto the keypad, opened the door, walked to the soiled area of the staff laundry room, threw the trash and disposed gloves away and entered the staff break room to wash their hands. Staff L was not observed to wash their hands or use hand sanitizer between each resident and before using the keypad.

In an observation on 03/31/2026 at 4:35 PM, Staff R, Caregiver, entered the kitchen and did not perform hand hygiene. Staff R used their hand to flip their hair over their shoulder to expose their name tag. Staff R did not perform hand hygiene before they retrieved silverware that was wrapped in a napkin and delivered to a resident.

In an observation on 03/31/2026 at 4:37 PM, R2 was attempting to eat an unpeeled banana when Staff A, Executive Director, with bare hands removed the banana from R2's mouth. Staff A put gloves on both hands, peeled and handed the peeled banana to R2. Staff A did not use hand sanitizer or wash their hands before they put the gloves on.

In an observation on 03/31/2026 at 4:39 PM, Staff A removed their gloves and peeled unknown name male residents' banana with their bare hands and handed and handed it

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back without washing their hands or use of hand sanitizer.

In an observation on 03/31/2026 at 4:42 PM, Staff A picked up with their bare hands soiled resident dishes.

In an observation on 03/31/2026 at 4:45 PM, Staff A entered the kitchen and did not perform hand hygiene. Staff A touched the refrigerator door handle to open the door and retrieved the rolling cart that had the desserts. Staff A was observed to leave the kitchen and started delivering dessert to the residents. At 4:47 PM, Staff A was observed to have gloves on their hands as they passed out residents desserts. Staff A touched a resident with their gloved hand. Without performing hand hygiene Staff A continued to serve other residents dessert.

In an observation on 03/31/2026 at 4:50 PM, Staff R, Caregiver, entered the kitchen and did not perform hand hygiene. Staff R touched the trash can lid to throw something away. Staff R did not perform hand hygiene before they retrieved silverware that was wrapped in a napkin and delivered to a resident.

In an observation on 04/01/2026 at 1:10 PM, Staff M, Caregiver, and Staff O, Caregiver, brought R2 into the East shower bathroom. Staff M and O were not observed to wash their hands or use hand sanitizer before they put on disposable gloves. R2 was assisted with transferring to the toilet, Staff M pulled down R2's urine soiled incontinence brief, removed their gloves, opened the door and exited the bathroom without use of hand sanitizer or hand hygiene observed.

In an observation on 04/01/2026 at 1:14 PM, Staff O removed and placed R2's urine soiled brief in the trash. At 1:15 PM, Staff M returned to the bathroom with a new incontinence brief, put on new pair of gloves without the use of hand sanitizer or hand washing observed. Staff M removed R2's soiled pants, put on the new brief, put the soiled pants back on and Staff M and O stood R2 up. Staff M cleansed R2's peri area and pulled up their brief and pants. Staff M and O with the same gloved hands, transferred R2 into their wheelchair. Staff M and O were not observed to change their gloves after removing the urine soiled brief, soiled pants and cleansing R2.

In an observation on 04/01/2026 at 1:16 PM, Staff S, Caregiver, was inside of R15's apartment, performed hand hygiene and put on their disposable gloves. Staff S dusted the crumbs off R15's pants. Staff S touched R15 with both gloved hands when they transferred R15 from their wheelchair into their bed. Staff S swung R15's legs onto their bed, took off their shoes, and used a pillow to prop their feet. Staff S asked R15 if they wanted a drink and was observed to walk over to the refrigerator and touched the handle to open the door.

In an observation on 04/01/2026 at 6:53 PM, Staff T, Care Staff, were in the hallway with bare hands holding a bag of trash that contained a soiled brief and blue disposable gloves. Staff T had entered the code onto the keypad, opened the door, walked to the

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soiled area of the staff laundry room, opened the door and threw the trash away. Without performing hand hygiene Staff T entered the code onto the keypad, opened the door and exited the area.

In an interview on 04/02/2026 at 11:15 AM, Staff U, Cook, stated if a facility staff member touched the trash can then the expectation would be for the staff to wash their hands.

<Handling of Linen>

Record review of the United States Centers for Disease Control and Prevention (CDC) document titled, “Appendix D Linen and Laundry Management,” dated 03/19/2024, documented to always place soiled linen in a designated leak proof container.

In an observation on 03/31/2026 at 1:46 PM, in the locked and unoccupied west shower room, there were five unbagged soiled bath towels on the ground.

In an observation on 03/31/2026 at 2:06 PM, in the staff laundry room soiled linen and trash area there were multiple large with no lids, grey barrels that were overflowing with unbagged soiled linens that draped over the edges of the barrels opening.

In an observation on 04/01/2026 at 1:46 PM, Staff M, Caregiver, placed R2’s unbagged soiled shirt and pants on the ground.

In an interview on 04/01/2026 at 1:49 PM, Staff N, Caregiver, stated all soiled linens were to be bagged and not on the ground.

<Hand Hygiene Supplies>

Record review of the facility’s policy titled, “Infection Control,” undated, documented staff wash their hands with soap and water. All hand-washing facilities provided staff with adequate supply of water, soap and single use of towels or hot air-drying machines.

Staff Laundry Room

In an observation on 03/31/2026 at 2:06 PM, the sink in the soiled linen and trash area had a folded large green foam that was stored in the sink. The sink was inaccessible to use. The second sink in the corner near the commercial washer had various boxes, clear jugs and items stored all around the sink. There were no paper towels available for the staff to use.

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In an observation on 04/01/2026 at 10:46 AM, the sink next to the washing machine did not have any paper towels. The sink in the soiled linen and trash area still had the folded large green foam stored inside.

In an interview on 04/02/2026 at 1:05 PM, Staff A stated the folded green foam was a mattress pad foam was not to be stored in the sink.

In an observation and interview on 04/02/2026 at 1:08 PM, Staff A washed their hands at the sink next to the washing machine and stated there were no paper towels. Staff A exited the area with wet hands and entered staff break room to dry their hands.

Resident Laundry Room

In an observation on 03/31/2026 at 1:41 PM, inside the resident laundry there was one sink that did not have any soap or paper towels available and had folded linen and clothes inside.

In an observation on 04/01/2026 at 11:26 AM, the sink in the resident laundry room did not have any paper towels or soap available for use. The linen inside the sink was higher and covered the hot and cold turn knobs and was up to the waterspout of the faucet.

In an observation on 04/02/2026 at 1:22 PM, the faucet on the sink in the resident's laundry room was not visible and covered with folded linens and clothes. There was no soap, paper towels or hand sanitizer available at the sink for staff to use.

In an interview on 04/02/2026 at 1:22 PM, Staff A stated there was no soap or paper towels at the sink for staff to wash their hands. Staff A acknowledged that the sink was full of folded linen and clothes and was inaccessible.

<Sharps Disposal>

Washington Administrative Code 296-823-14060 “Handle regulated waste properly and safely... (2) You must make sure when you move containers of contaminated sharps, the containers are: (a) Closed prior to removal or replacement to prevent spilling or protrusion of contents during handling, storage, transport, or shipping; and (b) Placed in a secondary container, if leaking is possible. The second container must be: (i) Closable; (ii) Constructed to contain all contents and prevent leakage during handling, storage, transport, or shipping; (iii) Appropriately labeled or color-coded…(5) You must dispose of all regulated waste according to applicable state and county regulations.”

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

Record review of the facility's policy titled, "Infection Control," undated, documented sharp containers were to be sealed and discarded as directed when they were two thirds to three quarters full.

In an observation on 03/31/2026 at 2:26 PM, the red square bin labeled "biohazard," was full of full red and white disposed sharp containers. The white lid of the bin was propped open with the overflowing disposed sharp containers.

In an observation on 03/31/2026 at 2:26 PM, in an open large gray barrel, there was various trash and silver tubing with five red and white full disposed sharp containers stored on top. One smaller sharps container on top, had a clear lid that was open with used disposable needles inside not secured and the lid not sealed closed. The barrel was not identified as "biohazard" and the disposed sharp containers were not covered with a lid and overflowing the barrels opening.

In an interview on 03/31/2026 at 2:26 PM, Staff K, Maintenance Director, was unsure how the disposed sharp containers were to be stored. Staff K acknowledged that the smaller sharps containers clear lid was not sealed closed.

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) 6/5/2026.

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

Administrator (or Representative) 5/6/2026 Date

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure the facility's hot water temperature did not go above 120 degrees Fahrenheit (F) in 2 of 2 resident (Resident 7 and 4) bathrooms. This failure placed Resident 4 and 7 at risk for potential skin burns, discomfort and decreased quality of life.

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

Record review of the facility's policy titled, "Infection Control," undated, documented sharp containers were to be sealed and discarded as directed when they were two thirds to three quarters full.

In an observation on 03/31/2026 at 2:26 PM, the red square bin labeled "biohazard," was full of full red and white disposed sharp containers. The white lid of the bin was propped open with the overflowing disposed sharp containers.

In an observation on 03/31/2026 at 2:26 PM, in an open large gray barrel, there was various trash and silver tubing with five red and white full disposed sharp containers stored on top. One smaller sharps container on top, had a clear lid that was open with used disposable needles inside not secured and the lid not sealed closed. The barrel was not identified as "biohazard" and the disposed sharp containers were not covered with a lid and overflowing the barrels opening.

In an interview on 03/31/2026 at 2:26 PM, Staff K, Maintenance Director, was unsure how the disposed sharp containers were to be stored. Staff K acknowledged that the smaller sharps containers clear lid was not sealed closed.

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure the facility's hot water temperature did not go above 120 degrees Fahrenheit (F) in 2 of 2 resident (Resident 7 and 4) bathrooms. This failure placed Resident 4 and 7 at risk for potential skin burns, discomfort and decreased quality of life.

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

Findings included...

R7

In an observation on 04/01/2026 at 1:39 PM, R7's bathroom faucet had a hot water temperature of 127.6 degrees F.

In an observation on 04/01/2026 at 3:04 PM, Staff K used their thermometer to check R7's bathroom hot water temperature and it was 127.8 degrees F.

In an observation on 04/01/2026 at 4:43 PM, the Department re-checked R7's bathroom hot water temperature with Staff A and Staff P, Director of Operations, present and the temperature was 124.0 degrees F.

R4

In an observation on 04/01/2026 at 1:49 PM, R4's bathroom faucet had a hot water temperature of 127.5 degrees F.

In an observation on 04/01/2026 at 3:04 PM, Staff K used their thermometer to check R4's bathroom hot water temperature and it was 124.2 degrees F.

In an interview on 04/01/2026 at 3:14 PM, Staff A stated the facility planned to turn down the hot water tank and to not use R7's and R4's sink until they were under 120 degrees F.

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) 4/5/2026.

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

Administrator (or Representative) — Date: 5/6/2026

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

Findings included...

R7

In an observation on 04/01/2026 at 1:39 PM, R7's bathroom faucet had a hot water temperature of 127.6 degrees F.

In an observation on 04/01/2026 at 3:04 PM, Staff K used their thermometer to check R7's bathroom hot water temperature and it was 127.8 degrees F.

In an observation on 04/01/2026 at 4:43 PM, the Department re-checked R7's bathroom hot water temperature with Staff A and Staff P, Director of Operations, present and the temperature was 124.0 degrees F.

R4

In an observation on 04/01/2026 at 1:49 PM, R4's bathroom faucet had a hot water temperature of 127.5 degrees F.

In an observation on 04/01/2026 at 3:04 PM, Staff K used their thermometer to check R4's bathroom hot water temperature and it was 124.2 degrees F.

In an interview on 04/01/2026 at 3:14 PM, Staff A stated the facility planned to turn down the hot water tank and to not use R7's and R4's sink until they were under 120 degrees F.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

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

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

This requirement was not met as evidenced by:

Based on interview, observation and record review, the facility failed to provide a safe, sanitary and well-maintained environment for 10 of 10 (Activities room, West Shower Bathroom, Dining Room Bathroom, East Shower Bathroom, Resident 5’s Apartment, Resident 1’s Apartment, Resident 7’s Apartment, Resident 4’s Apartment, Resident 3’s Apartment and Hallway) areas reviewed. These failures placed all residents at risk of having decreased quality of life due to unsafe, unsanitary and unmaintained living conditions.

Findings included...

Record review of the facility's document titled, “Disclosure of Services Required by RCW [Revised Code Washington] 18.20.300,” undated, documented that all assisted living facilities must maintain resident living quarters and any other areas the resident may use in a safe, clean and comfortable condition.

Record review of the facility’s document titled, “Environmental Sanitation,” undated, documented maintenance and housekeeping maintained the interior of the facility in a clean and safe manner.

Activities Room

An observation on 03/31/2025 at 1:39 PM, in the activity room, showed six ceiling lights with various debris and particles that resembled dead bugs with wings.

On 03/31/2026 at 1:39 PM, Staff K, Maintenance Director, stated that the lights were not cleaned enough and would need to check on how often they were to be cleaned.

West Shower Bathroom

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

An observation on 03/31/2026 at 1:49 PM, in the west shower room bathroom, showed a vent that had a thick fuzzy grey substance protruding out of the vent.

On 03/31/2026 at 1:49 PM, Staff K, while in the west shower room bathroom, Staff K looked up at the vent and stated “not enough” when asked how often the vents were cleaned.

Dining Room Bathroom

An observation on 03/31/2026 at 1:58 PM of the bathroom located off the dining room revealed a noticeable odor of urine and feces upon entering. Inside the bathroom revealed the toilet, the bowel of the toilet had brown fecal matter scattered around the inside perimeter of the bowl. There was an unknown brown substance smeared on the floor next to the toilet. The toilet paper dispenser was broken off the wall, and the toilet paper was placed on top of the hand-washing sink. The white door had a variety of brown markings near the door handle and at the bottom of the door. The top of the door on the lever had a thick yellow substance attached. The vent on the ceiling had thick white fuzzy matter that protruded throw the vent.

On 03/31/2026 at 1:58 PM, Staff K, while inside the dining room bathroom, acknowledged the brown substance on the ground, stated they were unsure what the yellow substance was on the door’s lever and that the bathroom was dirty and was scheduled to be cleaned daily.

An observation on 04/01/2026 at 10:42 AM of the dining room bathroom showed there was a pungent smell that resembled urine.

East Shower Bathroom

An observation on 03/31/2026 at 2:14 PM showed the east shower room bathroom had thick fuzzy grey substance protruding out of the vent. The light fixture cover was cracked, and half of the light bulbs did not work.

On 03/31/2026 at 2:14 PM, Staff K stated they were unaware the light fixture cover was broken and acknowledged half of the light bulbs did not work in the east shower room bathroom.

On 04/02/2026 at 1:18 PM, Staff A, Executive Director, acknowledged the fuzz inside of the vents were thick in the east shower room bathroom.

Resident 5 (R5)’s Apartment

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

An observation on 04/01/2026 at 11:00 AM, showed that R5's apartment door was opened and the room smelled of urine. One of two closet doors were off the hinges and propped against the wall behind the resident's recliner. R5's window screen was not attached to the window.

On 04/01/2026 at 11:00 AM, Staff M, Caregiver, stated R5's room "smells funky." Staff M stated they were unsure how long the closet door had been off the hinges and propped up against the wall.

An observation on 04/01/2026 at 1:33 PM in R5's bathroom showed the cover to the thermostat was missing, the floor made a tacky noise while walking on it and a pungent smell that resembled urine was noticeable.

An observation on 04/01/2026 at 2:56 PM inside of R5's bathroom showed the toilet paper dispenser was broken off the wall.

On 04/01/2026 at 2:56 PM, Staff K, while in R5's bathroom, stated they did not have knowledge that the toilet paper dispenser was broken, closet door was off the hinges or that the screen was not attached to the window.

On 04/02/2026 at 8:57 AM, Collateral Contact 1 (CC1), Power of Attorney for R5, stated R5's room smells of urine since R5 and their roommate both urinate on the bathroom floor.

Resident 1 (R1)'s Apartment

An observation on 04/01/2026 at 11:27 AM inside of R1's bathroom showed it smelled of urine and feces. The toilet was unflushed and urine and feces were visible inside the toilet. R1's towel rack was broken and off the wall and the hardware and bar to the towel rack were located inside of R1's shower. At 11:30 AM, R1's doorknob inside of their apartment was loose and the circular plate around the doorknob was loose.

On 04/01/2026 at 2:58 PM, Staff K, while in R1's bathroom, acknowledged the towel rack was broken and that R1's apartment door's doorknob was loose.

Resident 7 (R7)'s Apartment

An observation on 04/01/2026 at 1:42 PM in R7's apartment showed two of three window blinds were missing blinds and that the blinds were not uniform creating openings in the blinds even when closed.

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

Resident 4 (R4)'s Apartment

An observation on 04/01/2026 at 1:49 PM inside of R4's bathroom showed the toilet paper dispenser was broken off the wall and the hardware laid on top of the bathroom counter.

Resident 3 (R3)'s Apartment

An observation on 04/01/2026 at 1:57 PM in R3's apartment showed that the window blinds were missing multiple blinds creating openings in the blinds even when closed.

Hallway

An observation on 04/01/2026 at 4:43 PM at the double locked doors to the main lobby showed there was a pungent smell that resembled urine.

An observation on 04/01/2026 at 7:30 PM the hallway in the memory care unit next to the main entrance showed there was a fuzzy substance embedded into the wall.

On 04/02/2026 at 1:25 PM, Staff A acknowledged the hallway wall had fuzz embedded into it.

Plan/Attestation Statement

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

Administrator (or Representative) — Date: 5/6/2026

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

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

Resident 4 (R4)'s Apartment

An observation on 04/01/2026 at 1:49 PM inside of R4's bathroom showed the toilet paper dispenser was broken off the wall and the hardware laid on top of the bathroom counter.

Resident 3 (R3)'s Apartment

An observation on 04/01/2026 at 1:57 PM in R3's apartment showed that the window blinds were missing multiple blinds creating openings in the blinds even when closed.

Hallway

An observation on 04/01/2026 at 4:43 PM at the double locked doors to the main lobby showed there was a pungent smell that resembled urine.

An observation on 04/01/2026 at 7:30 PM the hallway in the memory care unit next to the main entrance showed there was a fuzzy substance embedded into the wall.

On 04/02/2026 at 1:25 PM, Staff A acknowledged the hallway wall had fuzz embedded into it.

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 1 of 2 new Staff (Staff D) were screened for Tuberculosis (infectious bacterial disease of the lungs) within three days of employment. This failure placed all residents at risk for exposure to Tuberculosis (TB).

Findings included...

Record review of the facility's policy titled, "Tuberculosis Testing", dated 01/17/2024, documented the facility was to test or verify the staff member met the requirements for TB regulation within three days of hire.

Staff C

Record review of Staff C, Caregiver, employee file showed a hire date of 05/16/2025 and had their first TB test conducted on 05/23/2025.

Staff D

Record review of Staff D's, Medication Technician, employee file showed a hire date of 11/23/2025 and no documentation that a TB test was completed.

On 04/21/2026 at 10:01 AM, Staff Q stated that they only had records that Staff D had been tested for TB, via a blood test, prior to employment. Staff Q verified the facility did not have records showing Staff D completed any TB skin tests or screening to identify what type and how many tests were required for TB testing after they were hired.

Plan/Attestation Statement

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Administrator (or Representative) — Date 5/6/2026

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This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 1 of 2 new Staff (Staff D) were screened for Tuberculosis (infectious bacterial disease of the lungs) within three days of employment. This failure placed all residents at risk for exposure to Tuberculosis (TB).

Findings included…

Record review of the facility's policy titled, "Tuberculosis Testing", dated 01/17/2024, documented the facility was to test or verify the staff member met the requirements for TB regulation within three days of hire.

Staff C

Record review of Staff C, Caregiver, employee file showed a hire date of 05/16/2025 and had their first TB test conducted on 05/23/2025.

Staff D

Record review of Staff D's, Medication Technician, employee file showed a hire date of 11/23/2025 and no documentation that a TB test was completed.

On 04/21/2026 at 10:01 AM, Staff Q stated that they only had records that Staff D had been tested for TB, via a blood test, prior to employment. Staff Q verified the facility did not have records showing Staff D completed any TB skin tests or screening to identify what type and how many tests were required for TB testing after they were hired.

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_____ _____

Administrator (or Representative) Date

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

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(1) Develop, implement and disclose to potential and current residents, policies regarding:

(a) The types of pets that are permitted in the assisted living facility; and

(b) The conditions under which pets may be in the assisted living facility.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to implement pet policies for 2 of 2 pets (Pet 1 and 2) that reside at the facility. This failure placed all residents, staff and visitors at risk of being exposed to diseases which could impact their health and not having a system in place for pets residing at the facility.

Findings included…

Record review of the facility provided document titled, “Code of Conduct for Family, Friends and Visitors,” undated, showed that documented well behaved pets with a leash were welcome in the facility. The grassy areas outside of the building were to be used for potty breaks and the owner must pick up any waste the pet left behind.

On 03/31/2026 at 5:10 AM, Staff A, Executive Director, stated the facility did not have a specific pet policy.

An observation on 04/01/2026 at 10:40 AM showed Resident 12 walking in the hallway with their dog.

On 04/01/2026 at 7:15 PM, Staff J, Medication Technician, stated there were two dogs that resided at the facility and was unsure what the policy was for pets.

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

Plan/Attestation Statement

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Administrator (or Representative) — Date: 5/6/2026

WAC 388-78A-3040 Laundry.

(2) The assisted living facility must handle, clean, and store linen according to acceptable methods of infection control. The assisted living facility must:

(a) Provide separate areas for handling clean laundry and soiled laundry;

(b) Ensure clean laundry is not processed in, and does not pass through, areas where soiled laundry is handled;

(c) Ensure areas where clean laundry is stored are not exposed to contamination from other sources;

(e) Have a utility sink and a table or counter for folding clean laundry.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure 2 of 2 laundry rooms (Staff and Resident Laundry room) had appropriate infection control practices to keep clean and soiled laundry separated. This failure resulted in residents not having clean clothing, wearing other resident clothing, placing all residents at risk of clean clothing being contaminated and a decreased quality of life.

Findings included...

Record review of the facility provided policy titled, "Personal Laundry," undated, documented it was the facility's policy to provide per the resident's service plan laundry services to promote good hygiene, provide access to clean clothing and enhance or maintain self-esteem. The policy did not include the procedure to process and store resident linen and laundry.

Record review of an email sent to the Department by Staff A, Executive Director, on 04/10/2026 at 10:39 AM, showed the facility did not have a policy in place for laundry storage.

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

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-3040 Laundry.

(2) The assisted living facility must handle, clean, and store linen according to acceptable methods of infection control. The assisted living facility must:

(a) Provide separate areas for handling clean laundry and soiled laundry;

(b) Ensure clean laundry is not processed in, and does not pass through, areas where soiled laundry is handled;

(c) Ensure areas where clean laundry is stored are not exposed to contamination from other sources;

(e) Have a utility sink and a table or counter for folding clean laundry.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure 2 of 2 laundry rooms (Staff and Resident Laundry room) had appropriate infection control practices to keep clean and soiled laundry separated. This failure resulted in residents not having clean clothing, wearing other resident clothing, placing all residents at risk of clean clothing being contaminated and a decreased quality of life.

Findings included…

Record review of the facility provided policy titled, “Personal Laundry,” undated, documented it was the facility’s policy to provide per the resident’s service plan laundry services to promote good hygiene, provide access to clean clothing and enhance or maintain self-esteem. The policy did not include the procedure to process and store resident linen and laundry.

Record review of an email sent to the Department by Staff A, Executive Director, on 04/10/2026 at 10:39 AM, showed the facility did not have a policy in place for laundry storage.

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

Staff Laundry Room

In an observation on 03/31/2026 at 2:06 PM, the door to the soiled linen trash area was propped open. There was one large grey barrel in the entry way of the door, eight other large grey barrels and three stacked plastic chairs that filled that area without a walking path or a means to walk through the area. There were six barrels with unbagged clothing that overflowed and draped on the sides of the barrels opening. Three barrels without lids overflowed with disposed trash bags.

In an observation on 03/31/2026 at 2:06 PM, there was a folded large green foam inside the sink in the soiled linen and trash area.

In an interview on 03/31/2026 at 02:06 PM, Staff K, Maintenance Director, stated bagged trash and soiled linen were to be placed into the grey barrels, staff were to go through the soiled area, and exit through the clean side door.

In an observation on 03/31/2026 at 2:06 PM, through the other side of the soiled linen trash area the second sink had various boxes, clear jugs and items stored all around the sink. Staff K had to move items on the ground and reached to access the faucet to see if there was running water.

In an observation on 04/01/2026 at 10:46 AM, the folded green foam was still inside the sink.

In an observation on 04/01/2026 at 10:46 AM, there were six large grey barrels without lids, that had unbagged soiled linen and clothing.

In an interview on 04/02/2026 at 1:18 PM, inside the soiled linen and trash area, Staff A stated the green foam was a mattress pad that should not be stored in the sink.

In an interview on 04/02/2026 at 1:08 PM, Staff A stated staff were to bring all trash and soiled linen bagged into the soiled area and discard in the grey barrels with lids. Staff A stated the staff were to go through the soiled linen area, wash their hands and exit out the clean side door.

In an observation on 04/02/2026 at 1:08 PM, Staff A walked through the soiled linen trash area on their tip toes around the large grey barrels. When Staff A walked through the soiled area, Staff A attempted to move the barrels aside with little movement. The barrels rubbed against Staff A’s upper legs and hip areas. Staff A washed their hands at the second sink and exited out the clean side door.

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Resident Laundry Room

In an observation on 03/31/2026 at 1:41 PM, upon walking into the room, against three of four walls were shelving units that had folded linens and clothing. There were folded linens and clothing on the ground, on boxes, on top of the dryer and inside the sink. There were no specific designated areas for soiled or clean linen.

In an observation on 04/01/2026 at 11:26 AM, the room remained the same with more folded linen and clothing stacked inside the sink up to the top of the faucet and covered the water knobs. On the ground and on top of boxes there was folded linen and clothing stacked halfway up the wall and as tall as the sink. The ground had large amounts of debris and grey lint.

In an observation and interview on 04/02/2026 at 1:22 PM, with Staff A the room remained the same with more folded linen and clothing stacked higher inside the sink with the faucet being fully covered and not visible. Staff A stated staff do not use the laundry room. The ground remained to have large amounts of debris and grey lint and various linen and clothing particles around.

In an interview on 04/02/2026 at 1:22 PM, Staff A stated all the linen on the shelving on the three walls were clean. Staff A stated all the linen on the ground and in the sink were soiled. Staff A stated staff were to place the soiled linen inside the washer and acknowledged that the clean linen folded on top of the dryer was touching the washer and risked contamination by the soiled linen.

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) 6/5/2026 .

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

Administrator (or Representative) — Date: 5/6/2026

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

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Resident Laundry Room

In an observation on 03/31/2026 at 1:41 PM, upon walking into the room, against three of four walls were shelving units that had folded linens and clothing. There were folded linens and clothing on the ground, on boxes, on top of the dryer and inside the sink. There were no specific designated areas for soiled or clean linen.

In an observation on 04/01/2026 at 11:26 AM, the room remained the same with more folded linen and clothing stacked inside the sink up to the top of the faucet and covered the water knobs. On the ground and on top of boxes there was folded linen and clothing stacked halfway up the wall and as tall as the sink. The ground had large amounts of debris and grey lint.

In an observation and interview on 04/02/2026 at 1:22 PM, with Staff A the room remained the same with more folded linen and clothing stacked higher inside the sink with the faucet being fully covered and not visible. Staff A stated staff do not use the laundry room. The ground remained to have large amounts of debris and grey lint and various linen and clothing particles around.

In an interview on 04/02/2026 at 1:22 PM, Staff A stated all the linen on the shelving on the three walls were clean. Staff A stated all the linen on the ground and in the sink were soiled. Staff A stated staff were to place the soiled linen inside the washer and acknowledged that the clean linen folded on top of the dryer was touching the washer and risked contamination by the soiled linen.

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Administrator (or Representative) Date

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

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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, interview and record review, the facility failed to allow residents access to their rooms without staff assistance for observed 7 of 7 residents (Resident 8, 1, 17, 18, 7, 2 and 16). This failure placed all memory care residents at risk of decreased quality of life and independence of not having free will to go into their room at any given time.

Findings included…

Washington Administrative Code (WAC), "388-110-220 Enhanced adult residential care service standards. (3) In an assisted living facility with an enhanced adult residential care-specialized dementia (brain impairment that affects memory, ability to make decisions, and interrupts ability to perform daily activities) care services contract, for residents served under that contract, the contractor must… (n) Ensure residents have access to their own rooms at all times without staff assistance."

R8

Record review of R8's facility medical records document they moved into the facility on [redacted]/2024.

Record review of R8's Service Plan, dated 04/10/2026, documented they were able to communicate and make their needs known independently and independently walked with their walker.

An observation on 03/31/2026 at 2:38 PM showed R8 standing outside their apartment door and asked staff to let them into their room. Staff H, Activities Director, was observed to use a key to unlock and opened R8's apartment door to let them in.

In an interview on 03/31/2026 at 2:38 PM, R8 stated, "I'm so tired of this place," when Staff H unlocked and opened their bedroom door.

An observation on 04/01/2026 at 11:02 AM showed R8's door was locked and Staff V, Housekeeper, had to use a key to unlock the door for the Department to talk to the resident.

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

In an interview on 04/01/2026 at 11:02 AM, R8 stated they did not have a key or was offered a key to their bedroom door. R8 stated they get frustrated when they cannot get into their room when they want to because the doors are locked and often must wait for a long time for staff to unlock the door to get inside.

R1

Record review of R1's facility medical records documented they moved into the facility on [redacted]/2026.

Record review of R1's Service Plan, dated 02/04/2026, documented they required minimal assistance from staff to effectively communicate and required minimal staff assistance with ambulating with their four-wheel walker.

An observation on 03/31/2026 at 2:17 PM showed R1 outside their apartment, raised their arm and hand and stated that they could not get into their room. Staff K, Maintenance Director, used a key to unlock and open R1's apartment door. R1 stated, "I just get so frustrated."

An observation on 04/02/2026 at 1:14 PM showed R1 and their child were outside of their apartment door and Staff A had to use a key to unlock and open R1's bedroom door to let them inside the room.

Resident 17 (R17)

Record review of R17's facility medical records document they moved into the facility on [redacted]/2025.

An observation on 04/01/2026 at 12:59 PM showed R17 requesting that their bedroom door be unlocked. R17 stated they had two keys that did not work to their bedroom door. R17 stated they waited until a staff member walked by to unlock their door. At 1:07 PM, R17 was let into their room when Staff O used a key to unlock R17's bedroom door.

Resident 18 (R18)

Record review of R18's facility medical records document they moved into the facility on [redacted]/2023.

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

An observation on 04/01/2026 at 1:00 PM showed R18 requesting that their bedroom door be unlocked and did not have a key to unlock their bedroom door. At 1:07 PM, R18 was let into their room when Staff O used a key to unlock R18's bedroom door.

Resident 7 (R7)

Record review of R7's facility medical records documented they moved into the facility on [redacted]/2025.

Record review of R7's Service Plan, dated 04/01/2026, documented they were independent with their communication and could meet their needs known. R7 required assistance with ambulation in their manual wheelchair.

An observation 03/31/2026 at 2:38 PM showed R7 outside their apartment with three visitors. Staff H came and unlocked and opened R7's apartment door.

On 03/31/2026 at 2:38 PM, Staff H stated the visitors were R7's two children and a home health representative. Staff H stated they were unsure why some residents had keys to their room while others did not. Staff H stated that when residents stood in front of their apartment door, they did their best to let residents into their rooms. Staff H stated some residents could vocalize when they wanted in their rooms.

On 04/01/2026 at 10:52 AM, Staff M, Caregiver, stated every resident's door in the facility was always locked. Staff M stated residents asked the facility staff to open their apartment rooms when they wanted to be let in.

On 04/01/2026 at 11:22 AM, Staff O, Caregiver, stated residents informed the facility staff when they wanted into their apartment rooms and the staff unlock and open their apartment doors for them.

Resident 2 (R2)

In an interview on 04/08/2026 at 2:15 PM, R2's bedroom door was always locked and had to have a staff member unlock the door to go in and visit R2.

Resident 16 (R16)

Record review of R16's provided medical records document they move in the facility on [redacted]/2025.

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

In an observation on 04/01/2026 at 3:28 PM, R16 approached Staff L, Caregiver, and stated they tried to open their apartment door but could not because it was locked. Staff L used their key and unlocked R16's apartment door for them.

In an interview on 04/01/2026 at 11:00 AM, Staff M stated all residents' rooms doors were locked to keep a resident from opening them.

Plan/Attestation Statement

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

Administrator (or Representative) [signature] Date 5/6/2026

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

(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 and 70.122 RCW;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide dignified care for 2 of 2 resident (Resident 5 and 2), failed to ensure 1 of 1 resident (Resident 4) grievances were addressed and failed to ensure 4 of 4 residents (Resident 3, 1, 7 and 5) had the right to retain and use their property. This failure resulted in all residents not receiving hygiene care, living in unsanitary conditions and placed the residents at risk for experiencing decreased quality of life.

Findings included...

Revised Code of Washington (RCW) 70.129.140 "Quality of life—Rights. (1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her

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In an observation on 04/01/2026 at 3:28 PM, R16 approached Staff L, Caregiver, and stated they tried to open their apartment door but could not because it was locked. Staff L used their key and unlocked R16's apartment door for them.

In an interview on 04/01/2026 at 11:00 AM, Staff M stated all residents' rooms doors were locked to keep a resident from opening them.

Plan/Attestation Statement

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Administrator (or Representative) Date

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

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(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 and 70.122 RCW;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide dignified care for 2 of 2 resident (Resident 5 and 2), failed to ensure 1 of 1 resident (Resident 4) grievances were addressed and failed to ensure 4 of 4 residents (Resident 3, 1, 7 and 5) had the right to retain and use their property. This failure resulted in all residents not receiving hygiene care, living in unsanitary conditions and placed the residents at risk for experiencing decreased quality of life.

Findings included…

Revised Code of Washington (RCW) 70.129.140 "Quality of life—Rights. (1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her

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individuality… (5) A resident has the right to: (a) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered."

RCW 70.129.140 "(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality."

Record review of the facility's policy titled, "Dementia Care-Specialized Areas," undated, documented the facility staff were responsible to ensure residents were neat and clean that included hygiene, grooming and clean clothes.

<Care and Services>

Resident 5 (R5)

Record review of R5's provided medical records documented they moved into the facility on [redacted]/2025.

Record review of R5's Service Plan, dated 03/06/2026, documented they would be dressed in clean, appropriate and comfortable clothing when they were in common areas.

In an observation on 04/02/2026 at 10:25 AM, R5 was sitting in a hallway chair. On the sides of R5's pant legs, the front bottom trim of their shirt and both hands there was a large amount of brown substance. R5 had a strong odor that resembled feces.

In an interview on 04/02/2026 at 10:55 AM, R5 stated "it is what it smells like," when they were asked what that smell was. R5 stated "it doesn't smell good."

In an observation on 04/02/2026 during the times 10:25 AM through 11:32 AM, R5 walked the hallways and checked the dining room bathroom door and other doors multiple times with multiple staff observed to say hi to them and walk by R5 without any assistance provided.

In an interview on 04/02/2026 at 11:43 AM, R5 came out of the bathroom with Staff M, Caregiver, with clean clothes and their hands and fingers with brown coloring.

In an interview on 04/02/2026 at 8:57 AM, Collateral Contact 1 (CC1), Power of Attorney for R5, stated often when they visited R5, they were in soiled clothing and needed a shower.

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Resident 2 (R2)

Record review of R2's provided medical records documented they moved into the facility on [redacted]/2026.

Record review of R2's Service Plan, dated 01/28/2026, documented they would be dressed appropriately when in the common areas.

In an observation on 03/31/2026 at 2:27 PM, R2 sat in a wheelchair with eyes closed, leaning to the right with blood on their lip and chin. There was saliva dripping from R2's mouth onto their clothing.

In an observation on 03/31/2026 at 2:30 PM, R2 was wheeled into the activity room and set up for the painting activity with the salvia on their clothing and blood on their lip and chin. There were multiple other residents in the activity room for the painting activity.

In an observation on 03/31/2026 at 2:54 PM, R2 sat at a dining room table waiting for lunch. R2's shirt had red and brown wet substances on it.

In an observation on 04/01/2026 at 10:39 AM, R2 sat at a dining room table in their wheelchair leaning to the right with salvia dripping from their mouth and onto their pants and long hair on their chin.

In an observation and interview on 04/01/2026 at 1:10 PM, R2 was assisted to the bathroom by Staff O, Caregiver, and Staff M, Caregiver. Staff O told R2 they needed to change their pants as they were soiled as there was saliva from R2's mouth and other substances. Staff M put a new incontinence brief and their soiled pants on, assisted them to their wheelchair and parked R2 in the hallway with other residents.

In an observation on 04/02/2026 at 11:02 AM, R2 sat in their wheelchair with their eyes closed, mouth open, leaning to the right and saliva dripping from their mouth and onto their teal shirt. R2 had hair on their chin.

In an interview on 04/08/2026 at 2:15 PM, Collateral Contact 6 (CC6), Spouse of R2, stated R2 needed the staff to brush their teeth more often. CC6 stated they came in one morning, woke R2 up in bed and R2 had food in their mouth and on their teeth from dinner the night before. CC6 stated R2's eyes were "caked" with something and needed to be wiped by the caregivers. CC6 stated R2's clothes were often dirty and the facility did not shave the hair on R2's chin. CC6 stated they had to stay on top of the staff to ensure they complete these tasks for R2.

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<Grievance>

RCW 70.129.060 Grievances. “A resident has the right to: (1) Voice grievances. Such grievances include those with respect to treatment that has been furnished as well as that which has not been furnished; and (2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.”

Record review of the facility's policy titled, “Complaints/Grievances,” undated, documented it was the facility policy to ensure employees and resident representatives knew how to report grievances. The report would be initiated from the person who received the complaint, the administrator would be notified, steps taken to investigate the complaint, the findings including the conclusion would be documented by the administrator and the person making the complaint would receive the response regarding action taken by the facility within 30 days.

Resident 4 (R4)

Record review of R4’s provided medical records documented they moved into the facility on [redacted] 2025.

On 04/01/2026 at 6:12 PM, Collateral Contact 2 (CC2), R4’s Power of Attorney, stated R4’s light wooded nightstand went missing one year ago and still does not know why it disappeared. CC2 stated they brought it up again a few months ago to Staff M, Caregiver.

On 04/02/2026 at 11:04 AM, Staff M stated they had not seen R4’s nightstand since R4’s admission into the facility. Staff M stated CC2 inquired about R4’s nightstand a couple of months ago.

On 04/02/2026 at 1:27 PM, Staff A, Executive Director, stated grievances should be resolved within a few days of being reported and staff were to fill out a grievance form if a concern was reported to them. Staff A did not know that R4’s nightstand had been missing for over a year.

<Personal Property>

RCW 70.129.100 Personal property—Storage space. “(1) The resident has the right to retain and use personal possessions, including some furnishings and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.”

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Resident 3 (R3)

On 04/07/2026 at 11:45 AM, Collateral Contact 4 (CC4), R3's Resident Representative, stated they labeled all of R3's laundry to try and prevent clothing from going missing. CC4 stated R3 wore other residents' clothing, and they were under the assumption other residents wore R3's clothing.

Resident 1 (R1)

On 04/07/2026 at 8:11 AM, Collateral Contact 3 (CC3), R1's Power of Attorney, stated they labeled all R1's laundry to try and prevent the clothing from going missing. CC3 stated R1 was missing their clothing and wore clothing that did not belong to them.

Resident 7 (R7)

On 04/01/2026 at 12:19 PM, Collateral Contact 5 (CC5), R7's Power of Attorney, stated they quit trying to label R7's clothes with a sharpie to identify the clothes that belonged to R7. CC5 stated that R7 wore other residents clothing, and they have seen other residents wearing R7's clothes.

R5

Record review of R5's provided medical records documented they moved into the facility on [redacted]2025.

Record review of R5's Service Plan, dated 03/06/2026, documented they required total assistance from staff to wash, dry, fold and put away R5's personal laundry weekly and as needed.

In an observation on 04/01/2026 at 1:33 PM, R5 asked where their clothes were, opened the closet and showed the Department there were multiple empty hangers and just three shirts.

In an interview on 04/02/2026 at 8:57 AM, Collateral Contact 1 (CC1), Power of Attorney for R5, stated most times when they visited R5, none of R5's clothes were in their room. CC1 stated often R5 was wearing another resident's clothes that are too big and do not fit properly. CC1 stated they had bought R5 four pairs of sweatpants and t-shirts that have since disappeared. CC1 stated it was unlikely another resident that took R5's clothes as all the residents' room doors were locked.

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Plan/Attestation Statement

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Administrator (or Representative) — Date: 5/6/2026

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 facility failed to provide the agreed upon care, as noted in the resident service plan (facilities version of the negotiated service agreement [NSA]), for 6 of 6 residents (Resident 5, 2, 1, 3, 4 and 7). This failure impacted the residents' quality of life by not having their care needs provided.

Findings included...

Record review of the facility's policy titled, "Negotiated Service Plan Agreements," undated, documented the negotiated service agreement was reviewed and updated as necessary, was based on the assessed needs and wishes for each resident and included the care and services necessary to meet the resident's care and services.

Record review of the facility's policy titled, "Dementia Care- Specialized Areas," undated, documented the facility would have staff ensure residents were neat and clean with their hygiene, grooming and clothing.

Record review of an email sent to the Department by Staff A, Executive Director, on 04/10/2026 at 10:39 AM, documented the facility was unable to produce shower logs for Resident 1, 2, 3, 4, 5 and 7.

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Plan/Attestation Statement

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Administrator (or Representative) Date

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This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide the agreed upon care, as noted in the resident service plan (facilities version of the negotiated service agreement [NSA]), for 6 of 6 residents (Resident 5, 2, 1, 3, 4 and 7). This failure impacted the residents' quality of life by not having their care needs provided.

Findings included...

Record review of the facility's policy titled, "Negotiated Service Plan Agreements," undated, documented the negotiated service agreement was reviewed and updated as necessary, was based on the assessed needs and wishes for each resident and included the care and services necessary to meet the resident's care and services.

Record review of the facility's policy titled, "Dementia Care- Specialized Areas," undated, documented the facility would have staff ensure residents were neat and clean with their hygiene, grooming and clothing.

Record review of an email sent to the Department by Staff A, Executive Director, on 04/10/2026 at 10:39 AM, documented the facility was unable to produce shower logs for Resident 1, 2, 3, 4, 5 and 7.

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R5

Record review of provided medical records for R5 documented they moved into the facility on [redacted]/2025.

Record review of R5's assessment, dated 12/02/2026, documented they had multiple medical diagnoses that included dementia (brain impairment that affects memory, ability to make decisions, and interrupts ability to perform daily activities).

<Showers>

Record review of R5's NSA, dated 03/06/2026, documented they required total assistance from staff for bathing due to physical or cognitive limitations. R5's showers and/or bathing would be completed upon R5's preference to days and time.

In an observation on 04/01/2026 at 11:32 AM, R5 was walking in the hallways with a black shirt that had large amount of white flaky substance on the front of it towards the upper chest area.

In an interview on 04/02/2026 at 8:57 AM, Collateral Contact 1 (CC1), Power of Attorney for R5, stated the facility was to provide R5 their showers. CC1 stated the facility was unable to answer when R5's shower days were and who completed them. CC1 stated often when they visited R5 they were in soiled clothing and needed a shower.

Record review of R5's provided medical records as of 04/15/2026, showed there was no documentation to show R5 was provided showers.

<Nails>

Record review of R5's NSA, dated 03/06/2026, documented R5 was incontinent of bowel and bladder and required routine toileting assistance. R5 required staff assistance to trim and file fingernails and toenails.

In an observation on 04/02/2026 at 11:29 AM, R5's fingernails were long with brown substance underneath them.

<Mouth Care>

Record review of R5's NSA, dated 03/06/2026, documented R5 had dentures that they did not use and their own teeth. R5 required moderate assistance from staff to ensure

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personal hygiene and activities of daily living needs were completed.

In an observation on 04/01/2026 at 12:50 PM, R5 had white substance on the gums and base of their teeth.

In an observation on 04/02/2026 at 11:29 AM, when R5 smiled or talked there were large amounts of white substance at the base of their teeth and gums.

R2

Record review provided medical records for R2 documented they moved into the facility on [redacted]/2026.

Record review of R2's NSA, dated 01/28/2026, documented they needed staff assistance with daily personal hygiene needs to ensure it was completed and they were dressed appropriately when in the common areas.

In an observation on 04/02/2026 at 11:02 AM, R2 sat in a wheelchair in the dining room with their hair unkept and both eyes had dried yellow crusted substances on the upper and lower eyelashes. When R2 smiled there was a large amount of thick white substances on the upper and lower back teeth and gums.

Record review of R2's provided medical records as of 04/15/2026, showed there was no provided documentation when R2 was provided a shower.

R1

Record review of R1's provided medical records documented they moved into the facility on [redacted]/2026.

Record review of R1's Service Plan, dated 02/04/2026, documented R1 had occasional incontinence of either their bowel or bladder. R1 required extensive assistance with one staff member to complete bathing due to physical or cognitive limitation. Shower or bathing assistance would be offered to at R1's preference as to days and time. R1's preference days and times were not documented.

On 04/07/2026 at 8:11 AM, Collateral Contact 3 (CC3), R1's Power of Attorney, stated R1 was incontinent of their bowels and their number one priority was the facility staff helping R1 with their personal hygiene.

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

Record review of an email sent to the Department on 04/10/2026 at 10:39 AM, Staff A stated they could not provide the requested shower log documentation that R1 received their showers from 01/01/2026 through 04/08/2026.

R3

Record review of R3's provided medical records documented they moved into the facility on [redacted]/2024.

Record review of R3's NSA, dated 02/04/2026, documented R3 was incontinent of their bladder and bowels. R3 required total assistance with one staff member to complete bathing once a week due to physical or cognitive limitation.

In an observation on 04/01/2026 at 7:05 PM, R3 blue sweatpants had unknown white substances and food particles on the right and left thigh.

Record review of an email sent to the Department on 04/10/2026 at 10:39 AM, documented Staff A could not provide the requested shower log documentation that R3 received their showers from 01/01/2026 through 04/08/2026.

On 04/07/2026 at 11:45 AM, Collateral Contact 4 (CC4), R3's Resident Representative, stated R3 could not feel when they urinated. CC4 stated they were unsure when the facility staff helped R3 shower.

R4

Record review of R4's provided medical records documented they moved into the facility on [redacted]/2025.

Record review of R4's NSA, dated 04/01/2026, documented R4 had occasional incontinence of either their bowel or bladder. R4 required extensive assistance from staff to complete bathing once weekly due to physical or cognitive limitationd. R4 required staff assistance to trim and file their fingernails and toenails.

In an observation on 04/02/2026 at 1:12 PM, R4's fingernails were long with unknown brown substance under multiple nails.

Record review of an email sent to the Department on 04/10/2026 at 10:39 AM, Staff A stated they could not provide the requested shower log documentation that R4 received their showers from 01/01/2026 through 04/08/2026.

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

R7

Record review of R7's provided medical records documented they moved into the facility on [redacted]/2025.

Record review of R7's NSA, dated 04/01/2026, documented R7 was incontinent of their bladder and bowels. R7 requires extensive assistance from staff for bathing once weekly due to physical or cognitive limitations. R7 required staff to trim and file their finger and toenails on their shower days.

On 04/01/2026 at 12:19 PM, Collateral Contact 5 (CC5), R7's Power of Attorney, stated R7 was incontinent of their bladder and bowels. CC5 stated R7 was showered once a week.

On 04/01/2026 at 10:52 AM, Staff M, Caregiver, stated they were unsure of R7's shower schedule. Staff M stated the facility staff helped R7 cut their finger and toenails when R7 allowed it because they refused care often.

Record review of an email sent to the Department on 04/10/2026 at 10:39 AM, Staff A stated they could not provide the requested shower log documentation that R7 received showers from 01/01/2026 through 04/08/2026.

On 04/01/2026 at 10:52 AM, Staff M, Caregiver, stated they used to provide residents their showers, but they were unsure of the process on how resident's scheduled showers were completed because Staff N, Caregiver, was the shower aid.

On 04/02/2026 at 11:34 AM, Staff S, Caregiver, stated Staff N was the shower aide and the facility staff member to complete resident showers.

<Oral Care>

Record review of R7's NSA, dated 04/01/2026, documented R7 had their own teeth and required moderate assistance from staff to ensure personal hygiene and activities of daily living needs were completed.

In an observation on 04/01/2026 at 10:54 AM, R7 had a foul odor when they talked from their mouth. There was thick white and cream-colored substance on their teeth.

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

Plan/Attestation Statement

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

Administrator (or Representative) — Date: 5/6/2026

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(c) Ensure all menus:

(iii) Include all food and snacks served that contribute to nutritional requirements;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure menus were posted with all food that contributed to nutritional requirements for 1 of 1 facility kitchens reviewed. This failure placed all residents at risk of their nutritional needs not being met and diminished quality of life.

Findings included...

In an observation on 03/31/2026 at 2:50 PM, the Weekly Menu, dated 03/29/2026 through 04/04/2026, was posted outside of the dining room and documented for 03/31/2026 lunch was roast beef, pickled beets, roasted red potatoes, roll and dessert and dinner was Cincinnati chili with honey peanut butter sandwiches, orange wedge and dessert. On 04/01/2026 lunch was country friend chicken, mashed potatoes and gravy, buttered corn, roll and dessert and dinner was beef taco pie, salsa and sour cream, Mexican style slaw and dessert. The menu showed fresh fruit and snacks were always available.

On 03/31/2026 at 4:07 PM, Staff W, Dietary Manager, stated snacks were not documented on the posted menu.

On 04/02/2026 at 11:15 AM, Staff U, Cook, acknowledged the posted menu did not specify what the dessert and snacks were.

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

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

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(c) Ensure all menus:

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Based on observation and interview, the facility failed to ensure menus were posted with all food that contributed to nutritional requirements for 1 of 1 facility kitchens reviewed. This failure placed all residents at risk of their nutritional needs not being met and diminished quality of life.

Findings included...

In an observation on 03/31/2026 at 2:50 PM, the Weekly Menu, dated 03/29/2026 through 04/04/2026, was posted outside of the dining room and documented for 03/31/2026 lunch was roast beef, pickled beets, roasted red potatoes, roll and dessert and dinner was Cincinnati chili with honey peanut butter sandwiches, orange wedge and dessert. On 04/01/2026 lunch was country friend chicken, mashed potatoes and gravy, buttered corn, roll and dessert and dinner was beef taco pie, salsa and sour cream, Mexican style slaw and dessert. The menu showed fresh fruit and snacks were always available.

On 03/31/2026 at 4:07 PM, Staff W, Dietary Manager, stated snacks were not documented on the posted menu.

On 04/02/2026 at 11:15 AM, Staff U, Cook, acknowledged the posted menu did not specify what the dessert and snacks were.

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Plan/Attestation Statement

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

Administrator (or Representative) — Date: 5/6/2026

WAC 388-78A-2651 Written residency agreement Residents with medicaid as a payor.

(1) For the purposes of this section "residency agreement" means a legally enforceable written document prepared by the assisted living facility that contains the rights and responsibilities of the facility and the resident specific to transfer and discharge and is signed by both parties.

(2) For residents with medicaid as a payor the facility must complete a signed written residency agreement with each resident that:

(a) Is signed by the resident or their legal representative and the facility upon admission of the resident to the facility;

(b) Requires the facility to agree to comply with the long-term care residents rights statute transfer and discharge requirements pursuant to RCW 70.129; and

(c) Requires the facility to provide notice to residents before transfer and discharge that includes information about available legal resources, and notice that, subject to legislative appropriation, residents have the right to legal counsel at public expense upon notice of transfer or discharge.

(3) For residents whose payor status changes from medicaid to private pay, a new residency agreement is required if the resident's payor status returns to medicaid.

(4) A copy of the residency agreement that is signed and dated by both parties must be:

(a) Kept in the resident record; and

(b) Provided to the resident or their representative.

(5) The residency agreement must be in substantially the following form: Residency agreement residents with medicaid as a payor.

(a) [facility name] agrees to comply with the long-term care residents rights statute transfer and discharge requirements pursuant to RCW 70.129.

(b) Subject to legislative appropriation [resident name] has a right to a free lawyer to help them in response to a notice of transfer or discharge. If they want a free lawyer to help them, they must call the long-term care discharge defense screening line at [phone

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Plan/Attestation Statement

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Administrator (or Representative) Date

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(b) Requires the facility to agree to comply with the long-term care residents rights statute transfer and discharge requirements pursuant to RCW 70.129; and

(c) Requires the facility to provide notice to residents before transfer and discharge that includes information about available legal resources, and notice that, subject to legislative appropriation, residents have the right to legal counsel at public expense upon notice of transfer or discharge.

(3) For residents whose payor status changes from medicaid to private pay, a new residency agreement is required if the resident's payor status returns to medicaid.

(4) A copy of the residency agreement that is signed and dated by both parties must be:

(a) Kept in the resident record; and

(b) Provided to the resident or their representative.

(5) The residency agreement must be in substantially the following form: Residency agreement residents with medicaid as a payor.

(a) [facility name] agrees to comply with the long-term care residents rights statute transfer and discharge requirements pursuant to RCW 70.129.

(b) Subject to legislative appropriation [resident name] has a right to a free lawyer to help them in response to a notice of transfer or discharge. If they want a free lawyer to help them, they must call the long-term care discharge defense screening line at [phone

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number].

(c) [Signature of resident/legal representative and date].

(d) [Signature of facility and date]. [Statutory Authority: RCW 18.20.090 , 70.97.230 , 70.128.040 , 74.09.520 (2), 74.39A.007 , 42 C.F.R. 441.530 (a)(1)(vi)(A), and 441.301 (c)(4)(vi)(A). WSR 25-18-037, s 388-78A-2651, filed 8/25/25, effective 1/1/26.]

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to have a written residency agreement for 4 of 4 Medicaid residents (Resident 1, 4, 5 and 7). This failure placed all Medicaid residents and the residents' representatives at risk of not knowing their rights and the facilities responsibilities as a Medicaid resident.

Findings included...

Record request on 03/31/2026 at 3:45 PM, the Department requested Resident 1 (R1), Resident 4 (R4), Resident 5 (R5) and Resident 7 (R7)'s signed residency agreement to review.

In an interview on 04/02/2026 at 10:28 AM, Staff A, Executive Director, stated they were not aware that all Medicaid residents needed to have a signed residency agreement and they could not provide R1, R4, R5 and R7's signed residency agreements to review.

In an interview on 04/02/2026 at 10:45 AM, Staff A stated they were not aware of the residency agreement that was to be completed for all current, new and transitioning Medicaid residents.

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) 6/5/2026 .

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

Administrator (or Representative) — Date: 5/6/2026

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or

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number].

(c) [Signature of resident/legal representative and date].

(d) [Signature of facility and date]. [Statutory Authority: RCW 18.20.090 , 70.97.230 , 70.128.040 , 74.09.520 (2), 74.39A.007 , 42 C.F.R. 441.530 (a)(1)(vi)(A), and 441.301 (c)(4)(vi)(A). WSR 25-18-037, s 388-78A-2651, filed 8/25/25, effective 1/1/26.]

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to have a written residency agreement for 4 of 4 Medicaid residents (Resident 1, 4, 5 and 7). This failure placed all Medicaid residents and the residents' representatives at risk of not knowing their rights and the facilities responsibilities as a Medicaid resident.

Findings included...

Record request on 03/31/2026 at 3:45 PM, the Department requested Resident 1 (R1), Resident 4 (R4), Resident 5 (R5) and Resident 7 (R7)'s signed residency agreement to review.

In an interview on 04/02/2026 at 10:28 AM, Staff A, Executive Director, stated they were not aware that all Medicaid residents needed to have a signed residency agreement and they could not provide R1, R4, R5 and R7's signed residency agreements to review.

In an interview on 04/02/2026 at 10:45 AM, Staff A stated they were not aware of the residency agreement that was to be completed for all current, new and transitioning Medicaid residents.

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)_____ .

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

_____ _____
Administrator (or Representative) Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or

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suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to investigate and document actions and findings for any accident or incident jeopardizing residents' health for 2 of 5 residents (Resident 7 and 5) reviewed. This failure resulted in the facility being unable to determine the circumstances of the event, institute and document appropriate measures to prevent similar situations, and protect the resident during the course of the investigation.

Findings included...

Record review of the document titled, "Assisted Living Facility Guidebook Partners in Protection," dated "02/2018," documented all significant injuries of unknown source must be thoroughly investigated to determine what occurred and to make necessary changes to the provision of care and services to prevent reoccurrence. A thorough investigation was a systemic collection and review of information and facts that described and explained and event and determine if abuse and neglect occurred and how to prevent further occurrences.

Record review of the facility's policy titled, "Accidents and Incidents," undated, documented an accident was an unexpected and unintended event that would cause a resident injury, and an incident was an event that could cause a resident injury. The resident's event and outcome would be documented in the resident's record.

Record review of an email sent to the Department on 04/15/2026 at 4:20 PM, Staff A, Executive Director, stated the facility did not have a specific policy on resident incident reports and investigations to provide to review.

Resident 7 (R7)

Record review of R7's provided medical records documented they moved into the facility on [redacted]/2025. R7 had a medical diagnosis of [redacted]

Record review of R7's Service Plan, dated 04/01/2026, documented they were able to

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communicate and make their needs known. R7 used a manual wheelchair and required maximum staff assistance for ambulation.

Record review of R7's document titled, "Progress Notes New," dated 02/28/2026 at 1:36 PM Staff J, Medication Technician, documented R7 was on alert monitoring from return from the emergency room with a diagnosis of knee pain caused by a fall with a head strike. R7 knee was sore and they did not remember why so the facility staff redirected R7 to try and sit and relax.

Record review on 04/07/2026 at 10:00 AM, of all R7's provided investigations showed there was not a completed investigation to review for R7's fall with injury on 02/28/2026.

On 04/01/2026 at 2:35 PM, Staff B, Caregiver, stated if a resident had a fall with injury an incident report should be completed.

On 04/02/2026 at 10:40 AM, Staff G, Resident Care Coordinator, stated if a resident had a fall and hit their head, then an incident report should be completed.

R5

Record review of R5's provided medical records documented they moved into the facility on [redacted]/2025.

Record review of R5's assessment, dated 12/02/2026, documented they had multiple medical diagnoses that included [redacted]

In an observation on 03/31/2026 at 2:51 PM, R5 was sitting in a hallway chair with their eyes closed. On R5's left upper forearm area there was a brown band aid that had "3/27 10:06 RP," handwritten on it.

In an interview on 03/31/2026 at 4:32 PM, Staff E, Medication Technician, stated last week, R5 had gotten a skin tear on their left upper forearm.

In an interview on 03/31/2026 at 4:32 PM, Staff E stated a progress note would have been written for R5's skin tear and placed on the medication administration record for the medication technicians to look at.

In an observation on 04/02/2026 at 10:25 AM, the same band aid was on R5's left upper forearm. R5 removed the band aid and that showed there was a scabbed half circle skin

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tear.

In an interview on 04/02/2026 at 2:11 PM, Staff G stated R5 scratched their skin causing a skin tear last week. Staff G stated a skin sheet was completed that documented where the skin tear was, how it occurred and what the facility was doing for it.

Record review of R5's Skin Sheet, dated 03/26/2026, documented they had a skin tear that was two inches long, half inch wide on the inside of their elbow. R5 stated "it itched so I scratched." Band aid was placed. There was nothing else documented on the sheet.

Record review of R5's provided medical records documented there was no investigation findings and circumstances of the event, action taken or that abuse and neglect was ruled out.

On 04/02/2026 at 10:40 AM, Staff G stated if a resident had a skin tear, then an incident report should be completed.

In an interview on 04/02/2026 at 1:28 PM, Staff A stated an incident report would be completed for a skin tear that was not related to another event and would be completed within 48 hours.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 5/6/2026

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(c) Safely operate the assisted living facility; and

(d) Operate in compliance with state and federal law, including, but not limited to, chapters 7.70 , 69.41, 70.122, 70.129, and 74.34 RCW, and any rules promulgated under these statutes.

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tear.

In an interview on 04/02/2026 at 2:11 PM, Staff G stated R5 scratched their skin causing a skin tear last week. Staff G stated a skin sheet was completed that documented where the skin tear was, how it occurred and what the facility was doing for it.

Record review of R5's Skin Sheet, dated 03/26/2026, documented they had a skin tear that was two inches long, half inch wide on the inside of their elbow. R5 stated "it itched so I scratched." Band aid was placed. There was nothing else documented on the sheet.

Record review of R5's provided medical records documented there was no investigation findings and circumstances of the event, action taken or that abuse and neglect was ruled out.

On 04/02/2026 at 10:40 AM, Staff G stated if a resident had a skin tear, then an incident report should be completed.

In an interview on 04/02/2026 at 1:28 PM, Staff A stated an incident report would be completed for a skin tear that was not related to another event and would be completed within 48 hours.

Plan/Attestation Statement

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Administrator (or Representative) Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(c) Safely operate the assisted living facility; and

(d) Operate in compliance with state and federal law, including, but not limited to, chapters 7.70 , 69.41, 70.122, 70.129, and 74.34 RCW, and any rules promulgated under these statutes.

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(2) The assisted living facility must develop, implement, and train staff persons on policies and procedures to address what staff persons must do:

(j) To appropriately respond to aggressive or assaultive residents, including, but not limited to:

(i) Actions to take if a resident becomes violent;

(ii) Actions to take to protect other residents; and

(iii) When and how to seek outside intervention.

(l) To manage residents' medications, consistent with WAC 388-78A-2210 through 388-78A-2290 ; sending medications with a resident when the resident leaves the premises;

(3) The assisted living facility must make the policies and procedures specified in subsection (2) of this section available to staff persons at all times and must inform residents and residents' representatives of their availability and make them available upon request.

This requirement was not met as evidenced by:

Based on interview, observation and record review, the facility failed to implement and develop facility policy and procedures for expired medications, medications destruction, resident incidents and investigations, wander and consultative resources to address behavioral issues for residents for 4 of 4 sampled residents (Resident 8, 11, 5 and 7). These failures resulted in the residents not being evaluated and monitored for care and safety needs and placed all residents at risk of harm and staff untrained of the expected procedures to follow

Findings included...

<Medications Services>

Record review of the facility’s policy titled, “Medications,” undated, documented the policy explained and gave guidance on independent self-medication administration, assistance with medication, and medication administration and the procedure on how to identify what kind of medication assistance the resident required.

On 03/31/2026 at 3:59 PM, in two medication carts there were multiple expired medications.

In an interview on 03/31/2026 at 4:05 PM, Staff E, Medication Technician, stated the Executive Director or the Resident Care Coordinator were to destroy medications with the medication technicians. Staff E was unsure how often expired medications were to be destroyed.

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In an interview on 04/02/2026 at 11:52 AM, Staff A, Executive Director, stated the night medication technician was to go through the medication carts monthly and quarterly the pharmacy audits the medication carts.

In an interview on 04/02/2026 at 1:28 PM, Staff A stated every 30 days the facility would check the medication carts and destroy any expired medications.

On 04/10/2026 at 11:49 AM, the facility was requested to send their policy and procedure for medication storage and expired medications.

Record review of an email sent to the Department on 04/13/2026 at 10:57 AM, from Staff A, Executive Director, documented the “medications” policy was the only policy on medications the facility had.

Refer to WAC 288-78a-2210(1)(b).

<Behaviors SDC contract>

Washington Administrative Code (WAC) 388-110-220 Enhanced adult residential care service standards… (3) In an assisted living facility with an enhanced adult residential care-specialized dementia care services contract, for residents served under that contract, the contractor must… (c) Develop and implement policies and procedures: (i) To manage residents who may wander… and (iii) To obtain consultative resources to address behavioral issues for residents. The contractor must include a plan that identifies the professional (i.e., clinical psychologist, psychiatrist, psychiatric nurse practitioner, or other behavioral specialist familiar with care of persons with dementia with complex or severe problems) who will provide the consultation, and when and how the consultation will be utilized.”

Record review of the Departments database on 03/31/2026, documented the facility had an active Specialized Dementia Care and Enhanced Adult Residential care contracts.

Record review of the facility’s medical records provided on 03/31/2026 showed they had 50 dementia residents.

On 03/31/2026 at 5:11 PM, Staff A stated they did not have a policy on consultation resources that address behavioral issues to provide to review.

On 03/31/2026 at 5:11 PM, Staff G, Resident Care Coordinator, stated the facility did not have a policy on consultation resources that address behavioral issues to provide to review. Staff G stated the facility staff would contact the resident's physician.

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

<Wandering>

Record review of the facility's provided medical records on 03/31/2026 showed they had one resident that wandered and 50 residents with dementia.

Record review of Resident 5's (R5) provided medical records documented they moved into the facility on [redacted]/2025.

In an observation on 04/02/2026 at 11:02 AM through 11:34 AM, R5 was walking up and down the hallways checking multiple doors.

In an observation on 04/01/2026 at 3:20 PM, an unknown resident was observed walking up and down the hallway attempting to open multiple doors.

On 03/31/2026 at 5:11 PM, Staff A stated they could not find a wandering policy to provide to review.

<Resident incident reports and investigations>

Record review of the facility's policy titled, "Accidents and Incidents," undated, documented an accident was an unexpected and unintended event that would cause a resident injury, and an incident was an event that could cause a resident injury. The resident's event and outcome would be documented in the resident's record.

Record review of an email sent to the Department on 04/15/2026 at 4:20 PM, Staff A stated the facility did not have a specific policy on resident incident reports and investigations to provide to review.

Record review of resident records showed there was no investigation for Resident 7's fall on 02/28/2026 and R5's skin tear documented on 03/26/2026.

In an interview on 04/02/2026 at 1:28 PM, Staff A stated an incident report would be completed for a skin tear that was not related to another event and would be completed within 48 hours.

Record review of an email sent to the Department by Staff A on 04/15/2026 at 4:20 PM, documented the facility policy titled, "Incidents and Accidents," was the only policy and procedure the facility had on resident's incidents and investigation.

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

Refer to WAC 388-78a-2371-(1)(2)(3)(4).

Plan/Attestation Statement

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

Administrator (or Representative) — Date 5/6/2026

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:

(a) Departure from the resident's customary range of functioning; or

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

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

(a) The changes identified in the resident per subsection (2) of this section; and

(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.

(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 facility failed to monitor the resident's well-being after a resident ate paint, drank paint water, when a resident endured an injury and change in behavior for 4 of 5 residents (Resident 2, 4, 3 and 5). This failure placed residents at risk for unmet and unidentified care needs.

Findings included...

Record review of the facility's policy titled, "Accidents and Incidents," undated

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

Refer to WAC 388-78a-2371-(1)(2)(3)(4).

Plan/Attestation Statement

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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:

(a) Departure from the resident's customary range of functioning; or

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

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

(a) The changes identified in the resident per subsection (2) of this section; and

(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.

(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 facility failed to monitor the resident’s well-being after a resident ate paint, drank paint water, when a resident endured an injury and change in behavior for 4 of 5 residents (Resident 2, 4, 3 and 5). This failure placed residents at risk for unmet and unidentified care needs.

Findings included…

Record review of the facility’s policy titled, “Accidents and Incidents,” undated

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

documented an incident was an event that could cause a resident injury, and an accident was an unexpected and unintended event that could cause a resident injury. All events and outcomes were to be documented in the resident's record.

Record review of the facility's policy titled, "Alert Monitoring of Resident," undated, documented residents were to be placed on alert monitoring for a minimum of 72 hours when a resident exhibited change of condition or deviation from baseline functioning. Residents on alert would be documented on every shift after it was initiated. Alert monitoring would be initiated for any of the following skin injury, return from hospital or urgent care and change in resident's baseline health, cognition or behavior.

Record review of the facility's policy titled, "Change of Condition- Monitoring and Reporting," undated, documented staff were to report any significant changes in resident's health, physical abilities, cognition, or emotional wellbeing and document in the resident's health record. The resident would be placed on alert charting.

Resident 2 (R2)

Record review of R2's provided medical records documented they moved into the facility on [redacted]/2026.

<Paint in Mouth>

In an observation on 03/31/2026 at 2:35 PM, Staff H was wiping R2's mouth that had teal saliva coming out. Staff H requested assistance from Staff G, Resident Care Coordinator, over their radio.

In an observation on 03/31/2026 at 2:54 PM, R2 was sitting at one of the dining room tables with teal saliva coming out of their mouth.

In an interview on 04/01/2026 at 11:35 PM, Staff H stated that R2 had placed the paint brush full of teal paint in their mouth. Staff H stated R2 had never done that before.

In an interview on 04/02/2026 at 11:41 AM, Staff H stated they reported to Staff G that R2 had put the paint brush of teal pain in their mouth during the activity on 03/31/2026.

Record review of R2's provided medical records as of 04/06/2026, showed there was no documentation that R2 had put pain in their mouth, monitor or that R2's spouse or physician was contacted about the event.

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

In an interview on 04/08/2026 at 2:15 PM, Collateral Contact 6 (CC6), Spouse for R2, stated no one from the facility called and reported that R2 had put paint in their mouth on 03/31/2026.

<Swallowing changes>

Record review of R2's Progress Note, dated 02/26/2026 at 8:33 PM, Staff G documented care staff reported that R2 was holding their food in their mouth at meals and it was difficult to get R2 to swallow the food before taking another bite. Staff were to encourage R2 to take drinks to help swallow the food. There was no other documentation before or after the progress note about R2's swallowing difficulties.

Record review of R2's Progress Note, dated 03/17/2026 at 4:13 PM, documented R2 had a history of swallowing difficulties prior to admitting to the facility and was recently noted to have been coughing at meals. Home health was ordered and physical therapy for strength building. Home health had a 21-day delay before they could start. There was no other documentation prior or after the progress note about R2 coughing with meals or any need for any weakness.

Resident 4 (R4)

Record review of R4's provided medical records documented they moved into the facility on [redacted]/2025. R4 had a medical diagnosis of [redacted].

Record review of R4's Service Plan, dated 04/01/2026, documented R4 needed staff assistance with cuing to communicate their needs effectively. R4 had a history of poor judgment and required staff assistance to make safe choices. R4 required staff monitoring three to four times a shift for their safety.

In an observation on 03/31/2026 at 2:59 PM in the activity room, R4 picked up and drank the blue disposable cup full of water that was used to clean the paint brushes. Staff H took the cup away from R4 and discarded it in the trash.

Record review of R4's, "Progress Notes New," dated 01/01/2026 through 04/01/2026, showed no documentation that R4 was monitored after they consumed paint water on 03/31/2026.

On 04/01/2026 at 6:12 PM, Collateral Contact 2, R4's Power of Attorney, stated no one from the facility notified them that R4 consumed paint water on 03/31/2026.

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

Resident 3 (R3)

Record review of R3's provided medical records documented they moved into the facility on [redacted]/2024. R3 had a medical diagnosis of [redacted]

Record review of R3's, "Service Plan Report," dated 02/04/2026, R3 was independent with their communication and could make their needs known. R3 used a wheelchair for assistance with ambulation and required moderate assistance from staff with ambulating. R3 was a low fall risk when transferring and ambulating. R3 required total assistance from one facility staff member three to four times per shift. The service plan did not indicate R3 had behaviors.

<R3 Behaviors>

Record review of R3's, "Progress Notes New," dated 01/24/2026, Staff O, Caregiver, documented R3 punched them out of the blue when they asked R3 to stand up during toileting. There was no other documentation before or after the progress note about R3's behaviors.

Record review of R3's, "Progress Notes New," dated 01/27/2026, Staff G documented a late entry that showed R3's medical doctor was at the facility, and a referral was made to mental health due to their behaviors.

<R3 Referral>

Record review of R3's Incident Report, dated 03/15/2026, documented, they had a fall with injury to their head as they fell forward in their wheelchair because they were losing core strength to remain in the seated position. Staff G documented the facility requested a physical therapy and occupational therapy referral from R3's medical provider.

Record review of an email sent on 03/25/2026 at 10:57 AM, documented Staff G requested an appointment with R3's medical provider to discuss a referral for physical therapy and occupational therapy for home health due to increased falls.

Record review of an email sent on 03/25/2026 at 11:55 AM, documented R3's medical providers office responded and stated they attached the scheduler to the email, and they would assist Staff G with setting up R3's appointment.

Record review of an email sent to the Department on 04/08/2026 at 10:38 AM,

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documented Staff G requested a referral for R3 to have home health for physical therapy and occupational therapy for increased falls in their wheelchair.

Record review of R3's provided medical records documented that they did not receive an order for physical therapy home health until 04/08/2026.

R5

Record review of R5's provided medical records documented they moved into the facility on [redacted]/2025.

Record review of R5's assessment, dated 12/02/2026, documented they had multiple medical diagnoses that included [redacted].

In an observation on 03/31/2026 at 2:51 PM, R5 was sitting in a hallway chair with their eyes closed. On R5's left upper forearm area there was a brown band aid that had "3/27 10:06 RP," handwritten on it.

In an interview on 03/31/2026 at 4:32 PM, Staff E, Medication Technician, stated last week, R5 had gotten a skin tear on their left upper forearm.

In an interview on 03/31/2026 at 4:32 PM, Staff E stated they a progress note would have been written for R5's skin tear and placed on the medication administration record for the medication technicians to look at.

In an interview on 03/31/2026 at 4:32 PM Staff E stated it was not documented on the Medication Administration Record (MAR), they just apply a band aid with A and D ointment and date it to know that it was changed daily.

In an observation on 04/01/2026 at 7:04 PM, the same band aid was on R5's left upper forearm unchanged.

In an observation on 04/02/2026 at 10:25 AM, the same band aid was on R5's left upper forearm. R5 removed the band aid and that showed there was a scabbed half circle skin tear.

In an interview on 04/02/2026 at 2:11 PM, Staff G stated R5 scratched their skin causing a skin tear last week. Staff G stated a skin sheet was completed that documented where the skin tear was, how it occurred and what the facility was doing for it.

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

Record review of R5's Skin Sheet, dated 03/26/2026, documented they had a skin tear that was two inches long, half inch wide on the inside of their elbow. R5 stated "it itched so I scratched." Band aid was placed. There was nothing else documented on the sheet.

Record review of R5's provided medical records documented there was no further follow up about the skin tear, R5's physician was notified and a system in place to ensure the skin tear was monitored.

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) 6/5/2026 .

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

Administrator (or Representative) 5/6/2026 Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

(iii) When the resident has an injury requiring the intervention of a practitioner.

This requirement was not met as evidenced by:

Based on observation, interview and record review the facility failed to complete an on-going assessment focused on residents identified problems, a change of condition and when they had an injury requiring practitioner intervention for 3 of 7 sampled residents (Resident 2, 7 and 3). This failure placed the residents at risk for unmet care needs by staff untrained of the most updated care and service needs for the residents.

Findings included...

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

Record review of R5's Skin Sheet, dated 03/26/2026, documented they had a skin tear that was two inches long, half inch wide on the inside of their elbow. R5 stated "it itched so I scratched." Band aid was placed. There was nothing else documented on the sheet.

Record review of R5's provided medical records documented there was no further follow up about the skin tear, R5's physician was notified and a system in place to ensure the skin tear was monitored.

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)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

(iii) When the resident has an injury requiring the intervention of a practitioner.

This requirement was not met as evidenced by:

Based on observation, interview and record review the facility failed to complete an on-going assessment focused on residents identified problems, a change of condition and when they had an injury requiring practitioner intervention for 3 of 7 sampled residents (Resident 2, 7 and 3). This failure placed the residents at risk for unmet care needs by staff untrained of the most updated care and service needs for the residents.

Findings included...

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

Record review of the facility's document titled, "Assessments - Change in Condition," undated, documented the facility completed assessments when a resident had a change of condition with their service plan no longer addressed their current needs and when a resident had an injury and illness that required intervention from their medical doctor. Once an ongoing assessment is completed the resident's service plan would be updated to reflect the changes.

Resident 2 (R2)

Record review of R2's provided medical records documented they moved into the facility on [redacted]/2026.

<Medication>

Record review of R2's level of Care Assessment, dated 02/17/2026, documented it was a 14-day assessment and they were assisted with their medications.

In an interview on 03/31/2026 at 4:15 PM, Staff E, Medication Technician, stated R2 took their medications crushed mixed in applesauce and spoon fed.

<Activities of Daily Living Needs> (ADL's)

Record review of R2's level of Care Assessment, dated 02/17/2026, documented they walked steadily independent within the facility, they independent repositioned self without assistance in bed, required minimal assistance with transferring, set up assistance with dressing, set up assistance with personal hygiene and did not require use of an assistive device.

In an observation on 04/01/2026 at 7:15 PM, Staff J, Medication Technician, crushed R2's bedtime

medication mixed it in chocolate pudding and spoon fed the medication to R2. Staff J stated they had to wait with R2 to ensure they swallowed the medication as they had been keeping the medication and food on the inside of their cheek and not swallowing.

In an observation on 03/31/2026 at 2:27 PM, R2 sat in a wheelchair with eyes closed, leaning to the right with saliva dripping from R2's mouth onto their clothing.

In an observation on 03/31/2026 at 2:30 PM, R2 was pushed in their wheelchair into the activity room and set up for the painting activity with the salvia on their clothing and blood on their lip and chin.

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In an observation on 04/01/2026 at 10:39 AM, R2 sat at a table in their wheelchair leaning to the right in the dining room with salvia dripping from their mouth and onto their pants.

In an observation on 04/01/2026 at 1:10 PM, R2 was pushed backwards in their wheelchair with their feet sliding on the ground.

In an observation and interview on 04/01/2026 at 1:10 PM, R2 was unable to walk and was transferred to the toilet by both Staff M, Caregiver, and Staff O's, Caregiver, physical assistance. R2 stood with one-person physical assistance while another staff member cleaned R2. Staff M changed R2's incontinent brief and clothing without R2's assistance. R2 used a wheelchair to go to and from the bathroom pushed by Staff O.

In an observation on 04/01/2026 at 1:46 PM, R2 was physically assisted to stand from their wheelchair by Staff N, Caregiver, and Staff M by R2's arms and pants and transferred onto their bed. R2 was left go and instantly fell to the right on their side. Staff N and M assisted R2 to sit back upright on the side of the bed when Staff M removed R2's soiled clothing. Staff M and N physically assisted without R2's assistance, to lay down in bed and cover up.

In an interview on 04/02/2026 at 11:25 AM, Staff O stated for the last two months R2 has been unable to stand and walk independently and used a wheelchair to get around. Staff O stated in the last month, R2 needed two staff members to help them transfer.

In an observation on 04/02/2026 at 3:31 PM, Staff L, Caregiver, entered R2's apartment, performed hand hygiene and at 3:32 PM inquired if they were ready to get up from sleeping and get ready for dinner. R2 nodded yes. Staff L put on their disposable gloves and asked R2 if they wanted to use the bathroom and they did not respond. Staff L stated they would put R2's shoes on them and they placed R2's wheelchair next to them. R2 did not verbally respond. Staff L then placed one hand in a cupped position behind R2's neck and sat them on up in bed. During the position change R2 made an agonizing groan "ohh." R2 sat upright in their bed and within the same minute Staff L asked if they were ready to stand. R2 did not verbally respond as Staff L started to count "one, two, three, up doing good." Both of Staff L's hands were wrapped around R2's under arms and their hands were opened with their fingertips on either side of R2's shoulders. Staff L assisted R2 to stand, R2 appeared to be limp as Staff L helped get R2 in a seated position in their wheelchair.

<Swallowing>

Record review of R2's level of Care Assessment, dated 02/17/2026, documented R2 ate a regular texture diet with thin liquids and no restrictions. R2 required staff to prepare all meals and snack and only needed set up, stand by and cueing from staff to ensure

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R2 completed their meals. There was no documentation of any difficulties eating or swallowing.

Record review of R2's Progress Note, dated 02/26/2026 at 8:33 PM, Staff G, Resident Care Coordinator, documented care staff reported that R2 was holding their food in their mouth at meals and it was difficult to get R2 to swallow the food before taking another bite. Staff were to encourage R2 to take drinks to help swallow the food.

Record review of R2's Progress Note, dated 03/17/2026 at 4:13 PM, documented R2 had a history of swallowing difficulties prior to admitting to the facility and was recently noted to have been coughing at meals. Home health was ordered and physical therapy for strength building. Home health had a 21-day delay before they could start.

In an interview on 04/02/2026 at 1:28 PM, Staff A, Executive Director, stated they would complete a change of condition assessment for any resident that had three or more significant activities of daily living need changes.

Record review of R2's provided medical records as of 04/05/2026, documented there was no change of condition assessment completed for R2's changes.

Resident 7 (R7)

Record review of R7's provided medical records documented they moved into the facility on [redacted]/2025. R7 had a medical diagnosis of [redacted]

Record review of R7's, Level of Care Assessment, dated 03/03/2026, documented, it was a six-month assessment. For activities of daily living transfers R7 had a steady gait, used a wheelchair and needed one-person physical assistance for all wheelchair ambulation for mobility and escorts. R7 may wander in their wheelchair. R7 required maximum staff assistance for ambulation. R7 required maximum assistant to get up and down from a seated position. R7 had one to two falls within the last three months and documented R7 was a low fall risk when transferring and ambulating.

Record review of R7's, "Service Plan Report," dated 04/01/2026, documented, R7 used a wheelchair and required maximum staff assistance for ambulation. R7 required maximum staff assistance to get up and down from a seated position. R7 was a low fall risk for falls when they transferred or ambulated. R7 had an unwitnessed fall on 02/11/2026.

Record review of R7's, After Visit Summary, dated 03/26/2026, documented R7 was seen for a fall, knee and hip pain. R7 was diagnosed with [redacted], and [redacted]

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[redacted]. R7 was toe touch (a medical restriction where only the toes of the affected foot are allowed to touch the floor, primarily to maintain balance) only.

Record review of R7's document titled, "Progress Notes New," dated 02/28/2026 at 1:36 PM Staff J documented R7 was on alert monitoring from return from the emergency room with a diagnosis of [redacted]. R7 knee was sore and they did not remember why so the facility staff redirected R7 to try and relax and sit.

In an observation on 04/01/2026 at 10:45 AM, R7 propelled themself in their manual wheelchair. R7 had a cast on their right foot. R7 sat in their wheelchair at the dining table and attempted to stand independently. Staff S, Caregiver, was in the vicinity and provided R7 assistance with finishing standing up. Staff S encouraged R7 to not put weight on their right ankle and helped R7 sit down.

On 04/01/2026 at 10:52 AM, Staff M stated prior to R7's fall, that caused their right ankle to be fractured, they encouraged R7 to ambulate using their walker.

On 04/01/2026 at 11:24 AM, Staff O stated after R7's fall that caused their right ankle to fracture they now used a wheelchair to ambulate. Staff O stated the facility staff tried using two facility staff members to stand R7 up from a seated position, if R7 did not independently stand up themselves. Staff O stated R7 had a fall last night on 03/31/2026.

On 04/01/2026 at 1:25 PM, Staff S stated R7 had a fall on 03/31/2026.

On 04/02/2026 at 10:40 AM, Staff G stated R7 had a fall on 03/31/2026.

On 04/02/2026 at 2:35 PM, Staff B, Caregiver, stated R7 used their walker when they had the fall that caused their fracture. Staff B stated R7 often forgot to use their walker when they ambulated. Staff B stated R7 now used a wheelchair and at times stood up on their own.

On 04/02/2026 at 1:12 PM, R7 was ambulating independently in the hallway without their wheelchair or facility staff assistance. The Department informed Staff A who immediately went to R7 and informed them they were not supposed to put weight on their ankle and encouraged them to sit down. Staff A located R7's wheelchair inside of the dining room.

Record review of R7's provided medical records as of 04/05/2026, documented there was no change of condition assessment completed for R7's fall with fracture on 03/26/2026.

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

Resident 3 (R3)

Record review of R3's provided medical records documented they moved into the facility on [redacted]/2024.

Record review of R3's, Level of Care Assessment, dated 02/04/2026, documented it was a six-month assessment. The as needed side rail (a safety devices attached to the bed that can be used to help with repositioning) section was blank.

Record review of R3's, "Service Plan Report," dated 02/04/2026, documented R3 medical equipment they used was a wheelchair. The service plan did not include that R3 used a side rail.

In an observation on 04/02/2026 at 1:57 PM, R3's right side of their bed had a side rail attached.

Review of R3's provided medical records showed the provided side rail order and side rail assessment was not completed until after the Department requested it to review.

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) 6/5/2026 .

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

Administrator (or Representative) — Date: 5/6/2026

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;

(d) The plan to provide necessary health support services, if provided by the assisted living facility;

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Resident 3 (R3)

Record review of R3's provided medical records documented they moved into the facility on [redacted]/2024.

Record review of R3's, Level of Care Assessment, dated 02/04/2026, documented it was a six-month assessment. The as needed side rail (a safety devices attached to the bed that can be used to help with repositioning) section was blank.

Record review of R3's, "Service Plan Report," dated 02/04/2026, documented R3 medical equipment they used was a wheelchair. The service plan did not include that R3 used a side rail.

In an observation on 04/02/2026 at 1:57 PM, R3's right side of their bed had a side rail attached.

Review of R3's provided medical records showed the provided side rail order and side rail assessment was not completed until after the Department requested it to review.

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)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;

(d) The plan to provide necessary health support services, if provided by the assisted living facility;

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(e) The resident's preferences for how services will be provided, supported and accommodated by the assisted living facility.

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

(3) The times services will be delivered, including frequency and approximate time of day, as appropriate;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to document in the resident's service plan (facilities version of the Negotiated Service Agreements [NSA]) the plan to provide the care and services necessary to support the residents care needs, the plan to provide assistance with activities of daily living, and the plan to provide intermittent nursing services for 7 of 7 sampled residents (Resident 2, 5, 6, 4, 7, 3 and 1). This failure placed the residents at risk for unmet care needs.

Findings included…

Record review of the facility's policy titled, "Negotiated Service Plan Agreements," undated, documented they were based on the residents' assessed needs and the resident's preference. The NSA was to clearly define respective roles and responsibilities the facility staff with time of day and frequency of the services were to be completed.

Resident 2 (R2)

Record review of R2's provided medical records documented they moved into the facility on [redacted]/2026.

<Shower>

Record review of R2's NSA, dated 02/04/2026, documented R2 shower and bathing assistance would be offered at the residents' preference as to days and time of day. R2 required extensive assistance from one staff member to complete their showers. There were no specific preferences of days or times listed on the NSA to notify the caregivers when to provide R2 their showers.

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

<Housekeeping Services>

Record review of R2's NSA, dated 02/04/2026, documented they would be provided weekly room cleaning and linen changes. There was no specific day listed.

<Laundry Services>

Record review of R2's NSA, dated 02/04/2026, documented that staff would provide weekly room cleaning and linen changes. There was no specific day listed.

<Oral Care>

Record review of R2's NSA, dated 02/04/2026, documented they have their own teeth. There was no direction as to how much assistance if any that R2 required for oral care.

Resident 5 (R5)

Record review of R5's provided medical records documented they moved into the facility on [redacted]/2025.

<Showers>

Record review of R5's NSA, dated 03/06/2026, documented R5 required total assistance from staff to shower. Staff were to offer showers or bath per the resident's preference. There were no days or times listed to direct the care staff when to provide R5 their showers.

<Housekeeping>

Record review of R5's NSA, dated 03/06/2026, documented they required weekly housekeeping without any specific days listed.

<Laundry>

Record review of R5's NSA, dated 03/06/2026, documented they required weekly laundry services without out any specific days listed to direct the care staff when to wash their clothes.

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

<Nurse Delegation>

Record review of R5's NSA, dated 03/06/2026, documented that they required medications to be administered. There was no documentation that showed which medications were nurse delegated.

<Nail Care>

Record review of R5's NSA, dated 03/06/2026, documented they required staff assistance to trim and file their fingernails and toenails with no specific days listed.

Resident 6 (R6)

Record review of R6's provided medical records documented they moved into the facility on [redacted]/2025.

<Laundry>

Record review of R6's NSA, dated [redacted]/2026, documented they required staff total assistance to complete their personal laundry weekly and as needed.

In an interview on 04/01/2026 at 11:12 AM, R6 stated that their daughter washed their laundry, not the facility staff.

<Housekeeping>

Record review of R6's NSA, dated [redacted]/2026, documented they required weekly room and linen changing. There were no specific dates listed when the weekly service was to be completed.

<Showers>

Record review of R6's NSA, dated [redacted]/2026, documented they required staff to provide reminders for their showers on R6's preferred days and time. There were no days and times listed and did not have clear direction how much assistance R6 required to complete their showers.

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

Resident 4 (R4)

Record review of R4's provided medical records documented they moved into the facility on [redacted]/2025.

<Laundry>

Record review of R4's NSA, dated 04/01/2026, documented they required weekly laundry services without out any specific days listed to direct the care staff when to wash their clothes.

<Housekeeping>

Record review of R4's NSA, dated 04/01/2026, documented they would be provided weekly room cleaning and linen changes without out any specific days listed to direct the care staff when to wash their clothes.

<Showers>

Record review of R4's NSA, dated 04/01/2026, documented they required total assistance from one staff member to complete their showers once weekly in the afternoon. There were no days listed to direct the care staff of when to provide R4 their showers.

Resident 7 (R7)

Record review of R7's provided medical records documented they moved into the facility on [redacted]/2025.

<Falls>

Record review of R7's, NSA, dated 04/01/2026, documented that they were a low fall risk when transferring and ambulating. R7 had a documented fall on 02/11/2026.

Record review of R7's provided medical records documented R7 had falls on 02/28/2026, 03/26/2026, and 03/31/2026 that were not incorporated into R7's current service plan.

<Wounds>

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

Record review of R7's, NSA, dated 04/01/2026, documented R7 had wounds on their lower extremities that required staff intervention.

Record review of an email sent to the Department on 04/15/2026 at 4:20 PM, Staff A, Executive Director, stated R7's wound was currently wrapped and managed by home health.

<Laundry>

Record review of R7's, NSA, dated 04/01/2026, documented they required weekly laundry services without out any specific days listed to direct the care staff when to wash their clothes.

<Housekeeping>

Record review of R7's, NSA, dated 04/01/2026, documented they would be provided weekly room cleaning and linen changes without out any specific days listed to direct the care staff when to wash their clothes.

<Showers>

Record review of R7's, NSA, dated 04/01/2026, documented they required total assistance from one staff member to complete their showers once weekly in the afternoon. There were no days listed to direct the care staff of when to provide R7 their showers.

Resident 1 (R1)

Record review of R1's provided medical records documented they moved into the facility on [redacted]/2026.

<Laundry>

Record review of R1's, NSA, dated 02/04/2026, documented they required weekly laundry services without out any specific days listed to direct the care staff when to wash their clothes.

<Showers>

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Record review of R1's, NSA, dated 02/04/2026, documented they required extensive assistance from one staff member to complete their showers on R1's preference days and times. There were no days or times listed to direct the care staff of when to provide R1 their showers.

<Housekeeping>

Record review of R1's, NSA, dated 02/04/2026, documented they would be provided weekly room cleaning and linen changes without out any specific days listed to direct the care staff when to wash their clothes.

<Nail Care>

Record review of R1's, NSA, dated 02/04/2026, documented they were legally blind. R1 was independent with their nail and toe care.

On 04/07/2026 at 8:11 AM, Collateral Contact 3 (CC3), R1's Power of Attorney, stated their number one priority was the facility staff helping R1 with their personal hygiene. CC3 stated they had vision impairments and were unsure if the facility helped R1 with their nail care.

Resident 3 (R3)

Record review of R3's provided medical records documented they moved into the facility on [redacted]/2024.

<Side Rail>

Record review of R3's, NSA, dated 02/04/2026, documented R3 medical equipment they used did not include that they used a side rail (a safety device attached to the bed that can be used to help with repositioning).

In an observation on 04/02/2026 at 1:57 PM, R3's right side of their bed had a side rail attached.

<Nightly Routine>

Record review of R3's, NSA, dated 02/04/2026, documented R3 preferred to go to bed

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around 8:00 PM. The service plan did not incorporate that Collateral Contact 4 (CC4), R3's Power of Attorney, assisted with R3's nighttime routine. The service plan did not include the backup plan if CC4 were unable to be present.

Record review of R3's Incident Report, dated 01/24/2026, documented R3 had an unwitnessed fall in the living room by the fireplace. R3 had the fall due to being tired, R3 was used to going to bed earlier, and CC4 usually came in nightly to put R3 to bed after dinner. The facility staff were to assist R3 to bed after dinner if CC4 was not present to reduce the risk of R3's falls in the evening.

On 01/24/2026 at 11:45 AM, CC4 stated they visited R4 almost nightly to help them with their nighttime routine.

<Laundry>

Record review of R3's NSA, dated 02/04/2026, documented they required weekly laundry services without out any specific days listed to direct the care staff when to wash their clothes.

<Housekeeping>

Record review of R3's NSA, dated 02/04/2026, documented they would be provided weekly room cleaning and linen changes without out any specific days listed to direct the care staff when to wash their clothes.

<Showers>

Record review of R3's NSA, dated 02/04/2026, documented they required total assistance from one staff member to complete their showers in the morning once a week. There were no days listed to direct the care staff of when to provide R3 their showers.

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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, Cottages of Sequim is or will be in compliance with this law and / or regulation on (Date) 6/5/2026 .

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

Administrator (or Representative) — Date: 5/6/2026

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on interview, observation and record review, the facility failed to update the Negotiated Service Agreement (NSA) after the resident had a change of condition for 2 of 2 sampled residents (Resident 2 and 7). This failure placed both residents at risk for unmet care needs by staff unaware of most updated care and services for the residents and decreased quality of life.

Findings included...

Record review of the facility's policy titled, "Change of Condition- Monitoring and Reporting," undated, documented the residents service plan would be updated based on permanent or unresolved changes the resident was exhibiting.

Record review of the facility's policy titled, "Negotiated Service Plan Agreements," undated, documented the NSA would be reviewed and updated when the NSA no longer met the needs and desires of the resident.

Resident 2 (R2)

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Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on interview, observation and record review, the facility failed to update the Negotiated Service Agreement (NSA) after the resident had a change of condition for 2 of 2 sampled residents (Resident 2 and 7). This failure placed both residents at risk for unmet care needs by staff unaware of most updated care and services for the residents and decreased quality of life.

Findings included…

Record review of the facility’s policy titled, “Change of Condition- Monitoring and Reporting,” undated, documented the residents service plan would be updated based on permanent or unresolved changes the resident was exhibiting.

Record review of the facility’s policy titled, “Negotiated Service Plan Agreements,” undated, documented the NSA would be reviewed and updated when the NSA no longer met the needs and desires of the resident.

Resident 2 (R2)

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

Record review of R2's provided medical records documented they moved into the facility on [redacted]/2026.

<Activities of Daily Living Needs>

Record review of R2's Service Plan (facility's version of the NSA), dated 02/04/2026, documented it was R2 current updated NSA. R2 required set up, stand-by and cueing assistance from staff to ensure R2 completed their dressing needs. R2 was independent with walking without an assistive device, needed minimal assistance with transfers, was able to reposition self in bed independently and needed stand by assistance for personal hygiene needs.

In an observation on 03/31/2026 at 2:27 PM, R2 sat in a wheelchair with eyes closed, leaning to the right with saliva dripping from R2's mouth onto their clothing.

In an observation on 03/31/2026 at 2:30 PM, R2 was pushed in their wheelchair into the activity room.

In an observation on 04/01/2026 at 10:39 AM, R2 sat at a table in their wheelchair leaning to the right in the dining room with salvia dripping from their mouth and onto their pants.

In an observation on 04/01/2026 at 1:10 PM, R2 was pushed backwards in their wheelchair with their feet sliding on the ground as R2 did not life them up.

In an observation on 04/01/2026 at 1:10 PM, R2 was unable to walk and was transferred to the toilet by both Staff M, Caregiver, and Staff O, Caregiver physical assistance. R2 stood with one-person physical assistance while another staff member cleaned up. R2 used a wheelchair to go to and from the bathroom pushed by Staff O.

In an observation on 04/01/2026 at 1:46 PM, R2 was physically assisted to stand from their wheelchair by Staff N, Caregiver, and Staff M by their arms and pants and transferred R2 onto their bed. R2 was left go and instantly fell to the right on their side. Staff N and M assisted R2 to sit back upright on the side of the bed. Staff M removed R2's soiled clothing when Staff N assisted R2 to stay upright. Staff M and N physically assisted without R2's assistance, in their bed in a lying position and covered.

In an observation on 04/02/2026 at 11:02 AM, R2 sat in a wheelchair in the dining room with their hair unkept and both eyes had dried yellow crusted substances on the upper and lower eyelashes. When R2 smiled there was a large amount of thick white substances on the upper and lower back teeth and gums.

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In an interview on 04/02/2026 at 11:25 AM, Staff O stated for the last two months R2 has been unable to stand and walk independently and used a wheelchair to get around. Staff O stated last month R2 needed two staff members to help them transfer.

In an observation on 04/02/2026 at 3:31 PM, Staff L, Caregiver, entered R2's apartment, Staff L asked R2 if they wanted to use the bathroom without R2 responding. Staff L placed one hand in a cupped position behind R2's neck and sat them on the side of the bed. During the position change R2 made an agonizing groan "ohh." Staff L asked R2 if they were ready to stand. R2 did not verbally respond as Staff L started to count and then wrapped their hands around R2's under arms with their fingertips on either side of R2's shoulders. Staff L stood R2 up and seated them into their wheelchair. R2 appeared to be limp as Staff L transferred them.

<Medications>

Record review of R2's NSA, dated 02/04/2026, documented they required assistance with their medications.

In an interview on 03/31/2026 at 4:15 PM, Staff E, Medication Technician, stated R2 took their medications crushed mixed in applesauce and spoon fed.

In an observation on 04/01/2026 at 7:15 PM, Staff J, Medication Technician, crushed R2's bedtime

medication mixed it in chocolate pudding and spoon fed the medication to R2. Staff J stated they had to wait with R2 to ensure they swallowed the medication as they had been keeping the medication and food on the inside of their cheek and not swallowing.

<Diet/Swallowing>

Record review of R2's NSA, dated 02/04/2026, documented they required set up, stand-by and cueing assistance from staff to ensure R2 completed meals.

Record review of R2's Progress Note, dated 02/26/2026 at 8:33 PM, Staff G, Resident Care Coordinator, documented care staff reported that R2 was holding their food in their mouth at meals and it was difficult to get R2 to swallow the food before taking another bite. Staff were to encourage R2 to take drinks to help swallow the food.

Record review of R2's Progress Note, dated 03/17/2026 at 4:13 PM, documented R2 had a history of swallowing difficulties prior to admitting to the facility and was recently noted to have been coughing at meals. Home health was ordered and physical therapy for strength building. Home health had a 21-day delay before they could start.

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Resident 7 (R7)

Record review of R7's provided medical records documented they moved into the facility on [redacted]/2025. R7 had a medical diagnosis of [redacted]

Record review of R7's, "Service Plan Report," dated 04/01/2026, documented, R7 used a wheelchair and required maximum staff assistance for ambulation. R7 required maximum staff assistance to get up and down from a seated position. R7 was a low fall risk for falls when they transferred or ambulated. R7 had an unwitnessed fall on 02/11/2026.

Record review of R7's provided medical records documented R7 had falls on 02/28/2026, 03/26/2026, and 03/31/2026 that were not incorporated into R7's current service plan.

Record review of R7's, After Visit Summary, dated 03/26/2026, documented R7 was seen for a fall, knee and hip pain. R7 was diagnosed with [redacted], and [redacted]. R7 was toe touch (a medical restriction where only the toes of the affected foot are allowed to touch the floor, primarily to maintain balance) only.

In an observation on 04/01/2026 at 10:45 AM, R7 propelled themself in their manual wheelchair. R7 had a cast on their right foot. R7 sat in their wheelchair at the dining table and attempted to stand independently. Staff S, Caregiver, was in the vicinity and provided R7 assistance with finishing standing up. Staff S encouraged R7 to not put weight on their right ankle and helped R7 sit down.

On 04/01/2026 at 10:52 AM, Staff M stated prior to R7's fall that caused their right ankle to be fractured they encouraged R7 to walk using a walker.

On 04/01/2026 at 11:24 AM, Staff O stated after R7's fall that caused their right ankle to fracture they now used a wheelchair to ambulate. Staff O stated the facility staff tried using two facility staff members to stand R7 up from a seated position, if R7 did not independently stand up themselves. Staff O stated R7 had a fall last night on 03/31/2026.

On 04/01/2026 at 1:25 PM, Staff S stated R7 had a fall on 03/31/2026.

On 04/02/2026 at 10:40 AM, Staff G stated R7 had a fall on 03/31/2026.

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On 04/02/2026 at 2:35 PM, Staff B, Caregiver, stated R7 used their walker when they had the fall that caused their fracture. Staff B stated R7 often forgot to use their walker when they ambulated. Staff B stated R7 now used a wheelchair and at times stood up on their own.

On 04/02/2026 at 1:12 PM, R7 was ambulating independently in the hallway without their wheelchair or facility staff assistance. The Department informed Staff A, Executive Director, who immediately went to R7 and informed them they were not supposed to put weight on their ankle and encouraged them to sit down. Staff A located R7's wheelchair inside of the dining room.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 5/6/2026

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On 04/02/2026 at 2:35 PM, Staff B, Caregiver, stated R7 used their walker when they had the fall that caused their fracture. Staff B stated R7 often forgot to use their walker when they ambulated. Staff B stated R7 now used a wheelchair and at times stood up on their own.

On 04/02/2026 at 1:12 PM, R7 was ambulating independently in the hallway without their wheelchair or facility staff assistance. The Department informed Staff A, Executive Director, who immediately went to R7 and informed them they were not supposed to put weight on their ankle and encouraged them to sit down. Staff A located R7's wheelchair inside of the dining room.

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