STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

10/01/2026

Cogir SL Washington II, LLC
The Terrace at Beverly Lake
524 75th St SE
Everett, WA 98203

RE: The Terrace at Beverly Lake # 2778

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 84570 (Completion Date 10/01/2026) and 80614 (Completion Date 08/05/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/01/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2371 Investigations. The assisted living facility must:

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

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

(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

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(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.

The Department staff who did the On Site verification:
Wesler Dumecquias, Community Complaint Investigator

If you have any questions, please contact me at (253)281-1245.

Sincerely,

Anthony Devito

Anthony Devito, Field Services Administrator
Region 2, Unit Z
Residential Care Services

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Residential Care Services
Investigation Summary Report

Provider/Facility: The Terrace at Beverly Lake **Provider Type:** Assisted Living Facility

License/Cert.#: 2778
Intake ID: 233057
Compliance Determination #: 80614
Region/Unit #: RCS Region 2 / Unit D
Investigator: Wesler Dumecquias
Investigation Date(s): 07/17/2026 through 08/05/2026
Complainant Contact Date(s):

Allegation(s):
The Named Resident (NR) was hospitalized due to vomiting and not feeling well. The NR got out of their bed and on the floor. The hospital found out the NR had a fracture in their spine.

Investigation Methods:

Sample:	Total residents: 43 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Activities Resident care equipment Resident rooms Staff to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members ED Collateral contact
Record Reviews:	Facility policies Staff patterns care plans Assessments progress notes Incident reports Hospice notes medical after visit summary

Investigation Summary:
The facility failed to thoroughly investigate, document findings, and implement measures to prevent similar incidents from happening when the NR had falls prior to

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hospitalization. The additionally, the facility failed to monitor and evaluate to determine if the NR needed further interventions. Failed practices were identifed and citations issued. see Statement of Deficiencies, dated 08/05/2026.

Conclusion / Action:

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: The Terrace at Beverly Lake **Provider Type:** Assisted Living Facility

License/Cert.#: 2778
Intake ID: 231926
Compliance Determination #: 80614
Region/Unit #: RCS Region 2 / Unit D
Investigator: Wesler Dumecquias
Investigation Date(s): 07/17/2026 through 08/05/2026
Complainant Contact Date(s):

Allegation(s):
The Named Resident (NR) had an injury of unknown source.

Investigation Methods:

Sample:	Total residents: 43 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Activities Resident care equipment Resident rooms Staff to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members ED Collateral contact
Record Reviews:	Facility policies Staff patterns care plans Assessments progress notes Incident reports Hospice notes medical after visit summary

Investigation Summary:
The NR had a fracture in their right wrist. The facility failed to thoroughly investigate and document their findings in order to rule out abuse and neglect. Failed practice was identified and a citation was issued. See Statement of Deficiencies issued on 08/05/2026.

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Conclusion / Action:

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: The Terrace at Beverly Lake **Provider Type:** Assisted Living Facility

License/Cert.#: 2778
Intake ID: 233007
Compliance Determination #: 80614
Region/Unit #: RCS Region 2 / Unit D
Investigator: Wesler Dumecquias
Investigation Date(s): 07/17/2026 through 08/05/2026
Complainant Contact Date(s):

Allegation(s):
The Named Resident (NR) was hospitalized due to a cracked (fracture) in their spine area and the facility did not notify the Department case manager.

Investigation Methods:

Sample:	Total residents: 43 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Activities Resident care equipment Resident rooms Staff to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members ED Collateral contact
Record Reviews:	Facility policies Staff patterns care plans Assessments progress notes Incident reports Hospice notes medical after visit summary

Investigation Summary:
The Named Resident (NR) was admitted and hospitalized for about four days. The Department case manager reached out to the facility and informed them about admission and hospitalization, as a result, a bed hold was done. The hospital found

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out that the NR had a fracture in their spine. Records showed the NR had a two prior falls prior to their hospitalization. The facility failed to investigate the two falls and failed to monitor the NR after the two falls and after their return to the facility from the hospital. Failed practices were identified and citations were issued. See Statement of Deficiencies issued on 08/05/2026.

Conclusion / Action:

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: The Terrace at Beverly Lake **Provider Type:** Assisted Living Facility

License/Cert.#: 2778
Intake ID: 232126
Compliance Determination #: 80614
Region/Unit #: RCS Region 2 / Unit D
Investigator: Wesler Dumecquias
Investigation Date(s): 07/17/2026 through 08/05/2026
Complainant Contact Date(s):

Allegation(s):

1. The Named Resident (NR) had a large bruise on their forehead about a week old and the staff did not know what happened.
2. A resident was observed to wander around stealing personal items.

Investigation Methods:

Sample:	Total residents: 43 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Resident care equipment Resident rooms Staff to resident interactions
Interviews:	Nursing staff Residents Family members Executive director
Record Reviews:	Facility policies Staff patterns care plans Assessments progress notes Incident reports Hospice notes

Investigation Summary:

1. The facility Licensed Nurse checked the NR and determined they had a yellowish discoloration on their forehead consistent with from a healing bruise. The NR had a fall five days prior to the discovery of the skin discoloration. The facility failed to investigated the incident and failed to monitor the NR after the alleged fall. Failed practices were identifed and citations issued. see Statement of Deficiencies, dated 08/05/2026.

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2. A sampled resident (SR) exhibited challenging behavior and picks items from other residents. The staff were aware and continuously provide redirection to the SR. Residents belongings had a mode of identification and were labeled. The staff coordinated with the SR's PCP and changes in their medication was made. The power of attorney was aware of the challenging behavior. The facility met minimum regulatory requirements.

Conclusion / Action:

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

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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Statement of Deficiencies	License #: 2778	Compliance Determination # 80614
Plan of Correction	The Terrace at Beverly Lake	Completion Date
Page 1 of 8	Licensee: Cogir SL Washington II, LLC	08/05/2026

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 07/17/2026 and 07/30/2026 of:

The Terrace at Beverly Lake
524 75th St SE
Everett, WA 98203

This document references the following complaint number(s): 229035, 232126, 233007, 231926, 233057

The following sample was selected for review during the unannounced on-site visit: 4 of 43 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Wesler Dumecquias, Community Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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Statement of Deficiencies	License #: 2778	Compliance Determination # 80614
Plan of Correction	The Terrace at Beverly Lake	Completion Date
Page 2 of 8	Licensee: Cogir SL Washington II, LLC	08/05/2026

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Jim Sherman
Residential Care Services

08-12-2026
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.

Yvonne M. L. King-Lee
Administrator (or Representative)

08/21/24
Date

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to investigate, document findings and actions, and institute interventions to prevent similar future incidents when 3 of 3 residents (Resident 1, Resident 2 and Resident 3) had an incident that required facility investigation to rule out abuse and neglect. This failure may have contributed to injuries for Resident 3's recurring falls and placed Resident 1, Resident 2 and Resident 3 at potential risk for abuse and neglect.

Findings included...

Review of facility policy titled, "Incident reports, Referenced in Policy: Internal Occurrence Investigation Report Form" dated 06/01/2025, showed injuries and unusual incidents will be reported in compliance with state regulatory requirements. An Internal Occurrence Investigation Report is completed by staff for all unusual occurrences, injuries, injuries of unknown origin, and incidents. The Internal Occurrence Investigation Report is available as an investigative post incident tool for quality assurance purposes, to assist in the prevention of future occurrences. The Community will review all Internal Occurrence Investigation reports and investigate all state-required incident reports. Investigations shall include but not be limited to, i. A review of the factors leading to the

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incident. ii. Nature of event/incident. iii. Disposition of incident. Steps to prevent similar incidents from occurring in the future. 1. Staff training on any prevention mechanisms to be set in place by the Community. Incidents are immediately reported to the resident's family/responsible party and physician.

Record review of facility policy titled, "Falls" dated 12/05/2025, showed aAll residents are evaluated for fall risk, and their Negotiated Service Agreement will be developed/updated accordingly. Should a resident experience a fall, staff will provide immediate care and follow through with Negotiated Service Agreement planning. The policy showed aA Post - Fall Evaluation is completed after any witnessed, reported, or suspected fall. The Post- Fall Evaluation is completed by the Community Nurse or designee. The Post - Fall Evaluation includes a list of possible interventions to be implemented. The Community Nurse or designee who completed the Post - Fall Evaluation may select interventions to be implemented and will communicate the implementations to care staff until a full Negotiated Service Agreement update can be completed.

Resident 1

Record review of Resident 1's face sheet showed they were admitted to the facility [redacted]/2025 with multiple diagnoses including [redacted].

Record review of progress notes dated 07/05/2026 showed the staff got a fall alert from their Nobi fall detection equipment (Nobi is an Artificial Intelligence (AI)-powered smart ceiling lamp designed for elderly care and fall prevention. that a fall was detected in Resident 1's apartment. The progress notes showed the staff found Resident 1 sitting down on the floor of their apartment without an injury. The progress notes showed the staff helped Resident 1 back into their bed.

Record review of an Iincident report (IR) dated 07/10/2026, five days after the fall on 07/05/2026, showed Resident 1 had a yellowish discoloration on their forehead that extended to their hairline.

Further record review for Resident 1 did not show an Investigation Report form or Post – Fall Evaluation form was completed regarding the fall on 07/05/2026 and discoloration (bruising) of skin found on the resident's forehead on 07/10/2026.

Resident 2

Record review of Resident 2's face sheet showed they were admitted to the facility [redacted]/2022 with multiple diagnoses including [redacted].

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Record review of an IR dated 07/09/2026 showed Resident 2 reported to staff a sudden onset of pain and swelling on their right wrist.

Record review of Resident 2's progress notes showed they were sent out by the facility to the hospital and were diagnosed with [redacted]

Review of Resident 2's records did not show any documentation of their investigative findings to be able to rule out abuse and neglect; and implement preventative measures as necessary.

Resident 3

Record review of Resident 3's face sheet showed they were admitted to the facility [redacted]/2024 with multiple diagnoses including [redacted].

Record review of an IR) dated 07/06/2026 showed the Staff was notified through their Nobi fall detection equipment that a fall was detected in Resident 3's room. The IR showed staff found Resident 3 on the floor of their apartment. The IR showed Resident 3 told staff that they slipped and fell down.

Record review of Resident 3's progress notes showed on 07/10/2026, they complained of backache and fever; on 07/11/2026, they complained that their back was still hurting; and on 07/13/2026, they complained of hip pain and nausea.

Record review of an IR dated [redacted]/2026 showed Resident 3 had a possible fall as detected by the facility's Nobi fall detection prevention equipment. The report showed Resident 3 was observed in the facility's Nobi video that they had swung their legs out of bed and down onto their knees. The report showed Resident 3 was sent to the hospital due to vomiting and complaints of back pain.

Record review of Resident 3's medical record dated [redacted]/2026 to [redacted]/2026 showed they were admitted to the hospital due to frequent falls and was diagnosed with [redacted].

Record review for Resident 3 did not show an IR or Post – Fall Evaluation form was completed regarding the fall on 07/06/2026 and [redacted]/2026 falls respectively.

During an interview on 07/17/2026 at 1:44 PM, about the Incidents and falls with Resident 1, Resident 2, and Resident 3, Staff A, Executive Director stated that if there

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was an incident, the Medication Technician (MT) would fill out the IR. The IR would then be reviewed and investigated by Staff A. Staff A then stated that they spoke with the staff and Resident 1 but there was no documentation and there were no interventions to prevent similar incidents that were put in place. Additionally, Staff A stated that they did not have any documentation of their investigation regarding Resident 2's incident. Staff A stated that they were unaware of any Post-Fall Evaluation that was completed.

In a separate interview on 07/30/2026 at 1:04 PM, Staff A stated that they did not have an investigation into Resident 3's fall incidents on 07/06/2026 and [redacted]/2026.

During an Interview on 07/17/2026 at 2:57 PM, Staff B, Resident Care Coordinator, stated that incident investigation was done by Staff A. Staff B stated that they do not do investigations.

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, The Terrace at Beverly Lake is or will be in compliance with this law and / or regulation on (Date) 09/19/26 .

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

Gwonnem L-Kingkee — Administrator (or Representative)

08/21/26 — Date

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

(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.

This requirement was not met as evidenced by:

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Based on interview and record review, the facility failed to observe, monitor and evaluate to determine if further action was needed for 2 of 3 residents (Resident 1 and Resident 3) that had falls with injuries. This failure placed Resident 1 and Resident 3 at risk for unmet care needs and potential harm and injury. Additionally, this failure may have contributed to Resident 3's continued falls with injury.

Findings included...

Record review of facility policy titled, "Falls" dated 12/05/2025, showed all residents are evaluated for fall risk, and their Negotiated Service Agreement will be developed/updated accordingly. Should a resident experience a fall, staff will provide immediate care and follow through with Negotiated Service Agreement planning. The policy showed that for forty-eight (48) hours after any fall, the Health & Wellness Director or designee on each shift will monitor the residents and make a brief narrative charting entry.

Resident 1

Record review of Resident 1's face sheet showed they were admitted to the facility [redacted]/2025 with multiple diagnoses including [redacted].

Record review of Resident 1's Assessment dated 06/01/2026 showed Resident 1 required skin checks.

Record review of progress notes dated 07/05/2026 showed the staff got a fall alert for Resident 1 from the Nobi fall detection equipment (Nobi is an Artificial Intelligence (AI) - powered smart ceiling lamp designed for elderly care and fall prevention.)

Record review of an Incident report (IR) dated 07/10/2026, five days after the fall on 07/05/2026, showed Resident 1 had a yellowish discoloration on their forehead that extended to their hairline.

Review of Resident 1's records did not show any documentation that staff monitored Resident 1 for any potential injuries from the fall that occurred on 07/05/2026 and did not show any monitoring of skin. The record did not show the resident was evaluated by the Health and Wellness Director, following the fall.

Resident 3

Record review of Resident 3's face sheet showed they were admitted to the facility [redacted]/2024 with multiple diagnoses including [redacted].

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Review of Resident 3's Care plan dated 05/27/2026 showed Resident 3 required cues and prompts for safety during ambulation and use of a four-wheeled walker.

Record review of an IR dated 07/06/2026 showed the Staff was notified through the Nobi fall detection equipment that a fall was detected in Resident 3's room. The IR showed staff found Resident 3 on the floor of their apartment. The IR showed Resident 3 told staff that they slipped and fell down.

Record review of Resident 3's progress notes showed on 07/10/2026, they complained of backache and fever; on 07/11/2026, they complained that their back was still hurting; on 07/13/2026, they complained of hip pain and nausea; on [redacted]/2026, they were not feeling well, vomited, and the staff sent them to the hospital. The progress notes showed on [redacted]/2026 at 8:17 PM, Resident 3 returned to the facility from the hospital and then on [redacted]/2026 at 9:30 PM, less than an hour from when they returned to the facility, Resident 3 was found by the staff on the floor of their apartment.

Record review of an IR dated [redacted]/2026 showed Resident 3 had a possible fall as detected by the facility's Nobi fall detection prevention equipment. The report showed Resident 3 was sent to the hospital due to vomiting and complaints of back pain.

Review of Resident 3's medical record dated [redacted]/2026 to [redacted]/2026 showed they were admitted to the hospital due to frequent falls and was diagnosed with [redacted].

Review of Resident 3's records did not show any documentation that staff monitored Resident 1 for any potential injuries from the fall on 07/07/2026; [redacted]/2026; and [redacted]/2026. There were no records that showed staff monitored resident 3's initial complaints of nausea on 07/13/2026 until they were sent to the hospital on [redacted]/2026 due to vomiting and feeling weak. The record did not show the resident was evaluated by the Health and Wellness Director, following the multiple falls.

During an interview on 07/17/2026 at 2:51 PM, Staff A, Executive Director, stated that staff would monitor residents who had prior incidents, like falls, by charting it in the residents' progress notes. Staff A stated that they do not use temporary care plans or Interim Service plans for monitoring residents' incidents.

During an interview on 07/17/2026 at 2:57 PM, Staff B, Resident Care Director, stated that Medication Technicians monitor resident incidents by charting in their progress notes. Additionally, on 08/05/2026 at 9:06 AM, Staff B confirmed that there was no alert charting for monitoring Residents 1's fall and skin discoloration and Resident 3's fall incidents and feeling unwell and nauseated.

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Statement of Deficiencies	License #: 2778	Compliance Determination # 80614
Plan of Correction	The Terrace at Beverly Lake	Completion Date
Page 8 of 8	Licensee: Cogir SL Washington II, LLC	08/05/2026

During an interview on 08/05/2026 at 9:12 AM, Staff G, Medication Technician, stated that they did chart Resident 3's complaint of nausea on 07/13/2026 but did not report it to the Resident Care Director because it was resolved.

During an interview on 07/30/2026 at 1:04 PM, Staff A stated that they currently did not have a Health and Wellness Director. Staff A stated that they had a nurse from their sister facility that visits their facility one time a week for clinical concerns.

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, The Terrace at Beverly Lake is or will be in compliance with this law and / or regulation on (Date) 09/19/26 .

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

Yvonne M & King Lee
Administrator (or Representative)

09/21/26
Date

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