STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
***20311 52nd Ave W, Suite 100, Lynnwood, WA 98036***

08/10/2026

Cogir SL Washington II, LLC
The Bellingham at Orchard
848 West Orchard Dr
Bellingham, WA 98225

RE: The Bellingham at Orchard # 2779

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 81671 (Completion Date 08/10/2026) and 77247 (Completion Date 06/09/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/10/2026 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

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

**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.**

The Department staff who did the On Site verification:

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

Helen Fisher, Complaint Investigator

If you have any questions, please contact me at (253)312-1446.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

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

# Residential Care Services
## Investigation Summary Report

**Provider/Facility:** The Bellingham at Orchard **Provider Type:** Assisted Living Facility

**License/Cert.#:** 2779
**Intake ID:** 223891
**Compliance Determination #:** 77247
**Region/Unit #:** RCS Region 2 / Unit J
**Investigator:** Helen Fisher
**Investigation Date(s):** 05/12/2026 through 06/09/2026
**Complainant Contact Date(s):**

**Allegation(s):**

1) The Named Resident (NR) was taken into the room by the Named Staff (NS) and left behind closed doors in severe respiratory distress.
2) The NR was found by a family member wheezing, struggling to breathe with the oxygen level of 82-85 percent. The NR was transferred to the hospital as per family's instruction.
3) The facility failed to address NR's family concerns about the NS.
4) NS had been left the NR in the room unsupervised with doors closed.
5) The NR was wearing heavy long sleeve sweatshirt in 80 degrees weather.
6) The NR had an open wound bleeding on the right elbow.
7) The NR had a left side bruising.
8) The facility had not been sanitizing dining tables in between meals though there were cases of respiratory infections.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 68<br>Resident sample size: 3<br>Closed records sample size: 0 |
| **Observations:** | Residents<br>Environment |
| **Interviews:** | Residents<br>Nursing Staff (NS)<br>Care Staff (CS)<br>Collateral Contact<br>Executive Director<br>Kitchen Staff (KS) |
| **Record Reviews:** | Residents' records<br>Incident Policy and Procedures<br>Staffing schedule |

**Investigation Summary:**

1) Review of medical records showed that the NR had [redacted] diagnosis. Interviews and record reviews showed the NR started wheezing and had a shortness

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of breath shortly after shower. CS stated after the NR was observed to struggle with breathing and wheezing, they immediately reported to the med tech. The NR was given nebulizer treatment and noted to be as effective. The NR preferred to remain in the room while the CS left to help other residents. Review of the medication administration records showed the NR received medication for wheezing and breathing and was charted as effective. Review of the negotiated service agreement showed the NR was not on frequent checks. No failed practice was identified.
2) The NR oxygen level was not checked twice daily as the Negotiated Service Agreement (NSA) to determine further action. Failed Practice. A citation was written for noncompliance with Washington Administrative Code 388-78A-2160 Implementation of negotiated service agreement.
3) According to the ED, they had a care conference with the NR's family and discussed care concerns and preferences. The facility made staff changes to accommodate family requests. No failed practice was identified.
4) Interviews indicated that facility staff were giving the NR options and preferences regarding where they wanted to go. The NR was able to express preferences. It was also indicated that the NR chose to remain in the room after breathing treatment. Facility staff stated that they were following the instructions given to keep the door closed to prevent other residents from entering the room. No failed practice identified.
5) NR was capable of dressing and undress self. Staff were re-educated to monitor and encourage NR with clothing choice as appropriate for the weather. No failed practice was identified.
6) Observations of the NR right elbow skin tear was on the healing process. Review of the alert charting showed the skin tear was being looked at, covered with a bandage and being monitored for signs of infection. NR's family stated that they were taking the NR to the doctor for right elbow wound management. NS stated that they tended to the wound while the NR was in bed. NS was unaware of how the NR sustained the injury. The HSD stated that investigation was not done to determine the source of the injury. Failed practice. A citation was written for noncompliance with Washington Administrative Code 388-78A- 2371 Investigation.
7) The NR left side of abdomen bruise was not investigated and source was not known. Failed practice. A citation was written for noncompliance with Washington Administrative Code 388-78A- 2371 Investigation.
8) Observations before and after meal showed KS was cleaning and sanitizing dining table surfaces and sweeping the floor. KS stated that cleaning and sanitizing dining room was the kitchen staff responsibility while care staff were responsible after dinner. The facility staff indicated that they had a couple cases of common colds, and they were making sure housekeeping was getting done in between meals. No failed practice was identified.

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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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| | | |
|---|---|---|
| Statement of Deficiencies | License #: 2779 | Compliance Determination # 77247 |
| Plan of Correction | The Bellingham at Orchard | Completion Date |
| Page 1 of 5 | Licensee: Cogir SL Washington II, LLC | 06/09/2026 |

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 05/12/2026 of:

The Bellingham at Orchard
848 West Orchard Dr
Bellingham, WA 98225

This document references the following complaint number(s): 223891

The following sample was selected for review during the unannounced on-site visit: 3 of 68 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Helen Fisher, Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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| Statement of Deficiencies | License #: 2779 | Compliance Determination # 77247 |
|---|---|---|
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| Page 2 of 5 | Licensee: Cogir SL Washington II, LLC | 06/09/2026 |

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.

Jennie Seigen
Residential Care Services

6/11/2026
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)

6/19/26
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

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

**This requirement was not met as evidenced by:**

Based on observations, interviews and record reviews, the Assisted Living Facility (ALF) failed to ensure an investigation was conducted for 1 of 3 sampled residents (Resident 1) who sustained skin tears and bruising. These failures placed Resident 1 at risk not receiving protection, treatment and interventions required to prevent similar future incidents.

Findings included...

Record review of ALF policy titled, "Incident Report", dated 06/01/2025, stated: 1. An Internal Occurrence Investigation Report is completed by staff for all unusual occurrences, injuries, injuries of unknown origin, and incidents. 2. 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. a. All Internal Occurrence Investigation Reports are reviewed by the Health & Wellness Director and Administrator/Executive Director. b. The Internal Occurrence Investigation Report is maintained for quality assurance purposes and is not provided to any outside

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parties or agencies. c. Internal Occurrence Investigation Reports are maintained in a binder located in the Administrator/Executive Director's office. 3. An Incident Report is completed in the electronic health record (EHR), including all that are state reportable or require modifications to resident monitoring or plans of care. a. The Incident Report or applicable state form is used to submit written reports to state agencies. b. The Health & Wellness Director or designated staff will complete incident reports. 4. The Community will review all Internal Occurrence Investigation reports and investigate all state-required incident reports. a. Investigations shall include but not be limited to i. A review of the factors leading to the incident. ii. Nature of event/incident. iii. Disposition of incident. Clinical Policy and Procedure Manual – Washington 137 iv. 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. 5. Incidents are immediately reported to the resident's family/responsible party and physician.

Record review of an undated face sheet showed the ALF admitted Resident 1 on [redacted]/2025 with multiple medical diagnoses to include [redacted] and [redacted].

Observations on 05/12/2026 at 1:04 PM showed Resident 1 had a right lateral elbow wound approximately three quarter inch in diameter covered with yellowish slough (fibrous dead tissue that forms in the bed wound) and a purple bruise on left side of the abdomen approximately two inches by one inch in diameter.

Review of the Progress Notes (PN), dated 05/04/2026 at 1:19 AM, showed Resident 1, "denies discomfort, bandage dry and intact".

Record reviews showed the ALF had no investigation documentation on Resident 1's injuries.

In an interview, on 05/12/2026 at 12:20 PM, Staff A, Health Services Director, stated that there was no investigation done on how Resident 1 sustained the right elbow skin tear and abdominal bruise. Staff A stated that they were aware of the bruise but unsure if staff were monitoring.

In an interview on 05/12/2026 at 12:51 PM, Staff B, Medication Technician, stated that they were informed by another staff member about Resident 1's bruise but there was no documentation found.

In an interview on 05/12/2026 at 2:14 PM, Staff C, Executive Director stated that they were unaware that Resident 1's injuries were not investigated.

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| Plan of Correction | The Bellingham at Orchard | Completion Date |
| Page 4 of 5 | Licensee: Cogir SL Washington II, LLC | 06/09/2026 |

**Plan/Attestation Statement**

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Bellingham at Orchard is or will be in compliance with this law and / or regulation on (Date) 7/24/26 .

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

Administrator (or Representative) Date 6/19/26

**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 interviews and record reviews, the Assisted Living Facility (ALF) failed to ensure 1 of 3 residents (Resident 1) received care as stated in the Negotiated Service Agreement (NSA) when Peripheral Oxygen Saturation (SPO2) was not checked. This placed Resident 1 at risk of not receiving care related to respiratory issues.

Findings included...

Record review of an undated face sheet showed the ALF admitted Resident 1 on [redacted]/2025 with multiple medical diagnoses to include [redacted] and [redacted].

Review of NSA, dated 04/06/2026, showed Resident 1's SPO2 was to be monitored twice daily. The NSA directed that if the SPO2 was found to be below 91 percent (%) on room air (RA) the response was to ask Resident 1 to take deep breathe then recheck. If the RA remained at below 91% the ALF was to notify Resident 1's Power of Attorney (POA).

Review of records showed Resident 1's SPO2 was recorded as taken on four times in April of 2026 in the Medication Administration Record. No other documentation shown Resident 1's SPO2 reading was completed twice daily as agreed upon in the NSA.

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In an interview on 05/12/2026 at 12:20 PM. Staff A (Health Services Director) stated that they agreed to check Resident 1's SPO2 due to Resident 1's lungs problem, however, were not doing so.

In an interview on 05/22/2026 at 8:41 AM, Staff D (Medication Technician) stated that they were not checking Resident 1's SPO2 twice daily.

**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 Bellingham at Orchard is or will be in compliance with this law and / or regulation on (Date) 7/24/26.

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

Administrator (or Representative) Date 6/19/26

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