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

Cogir SL Washington II, LLC
Where The Heart Is
410 S NORRIS ST
BURLINGTON, WA 98233

RE: Where The Heart Is License # 2780

Dear Administrator:

This letter addresses Compliance Determination(s) 82533 (Completion Date 08/20/2026) and 78280 (Completion Date 07/02/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/20/2026 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-2980-2, WAC 388-78A-2980, WAC 388-78A-2980-3, WAC 388-78A-2430-1, WAC 388-78A-2430, WAC 388-78A-2430-2

The Department staff who did the on-site verification:
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: Where The Heart Is
Provider Type: Assisted Living Facility
License/Cert.#: 2780
Compliance Determination #: 78280
Intake ID: 225977
Investigator: Helen Fisher
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 06/03/2026 through 07/02/2026
Complainant Contact Date(s): 06/02/2026

Allegation(s):

1) The Named Resident (NR) may have been neglected and personally exploited by the Assisted Living Facility (ALF).
2) ALF staff were making the Named Resident (NR) unwanted changes of incontinent briefs even the NR refused.
3) ALF staff had been telling the NR's Power of Attorney (POA) the NR needed to be moved memory care unit.
4) The NR had a fall and sustained bruise which remained for two weeks.
5) The NR belonging was not moved to memory care where the NR's staying.
6) The NR's old room smelled like human waste, had fecal matter in the toilet, had garbage in the drawer and heavy dust in areas of the room. NR's new room entry light was broken.
7) ALF staff took a long time to respond to call for assistance.

Investigation Methods:

Sample:	Total residents: 47 Resident sample size: 5 Closed records sample size: 0
Observations:	Residents Environment
Interviews:	Residents Collateral Contact (CC) Nursing Staff (NS) Care Staff (CS) Executive Director Health Services Director (HSD)
Record Reviews:	Resident records. Incident report investigation.

Investigation Summary:

1) The NR's lower extremities were dry and flaky, toenails were thick, long jagged, yellowish brown in colors, distorted toes slightly curled downwards were observed during an unannounced onsite visit at the ALF. Interviews indicated that the HSD was unaware of the NR's toenails condition and would notify hospice. HSD stated

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that the NR's Representative did not sign a consent for footcare. Review of care plan showed no toe nail care was agreed upon by representative. Toenails were trimmed by hospice. No failed practice was identified.
2) Interviews indicated that staff were changing NR's wet incontinent briefs when the NR was refusing to cooperate. The NR denied being mistreated or forced to do things they did not want to do. The NR stated that they felt safe at the facility. Staff stated that they used redirections and reapproach when the NR refused to receive care. No failed practice was identified.
3) According to the ED, they were unaware of what staff were telling the NR's POA. The ED stated that they had a conversation with the NR's POA who gave consent to move the NR to the memory care unit. No failed practice was identified.
4) Review of the investigative records showed the ALF staff implemented facility's fall policy and procedures and interventions. Abuse and neglect were ruled out. The NR sustained injuries to faces and forehead and was not transported to Emergency Department by hospice instruction. The NR was placed on alert charting to monitor bruises. Interviews indicated that NR had no safety awareness. No failed practice was identified.
5) Interviews and record reviews showed that the NR's family was responsible for moving belongings to the NR's new room. No failed practice was identified.
6) Observations showed the NR's ceiling and bathroom lighting were non-operational during unannounced onsite visit at the ALF. Four residents' living quarters were clean. Housekeeping staff stated that they cleaned the NR's room and bathroom once a week. Staff stated that the NR's bathroom cleaning had been difficult because the bathroom light was not working. Staff stated that they used flashlights when helping residents in apartment [redacted] because of the lighting issues. Failed practice. A citation was written for noncompliance with Washington Administrative Code 388-78A-2980 Lighting.
7) The emergency call system in the residents' room and bathrooms was activated with response time of 2 to 3 minutes. Review of the emergency call response report showed response time between 2 to 8 minutes average. No failed practice was identified. Sampled residents stated that staff respond to their call quickly. No failed practice was identified.

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: Where The Heart Is
Provider Type: Assisted Living Facility
License/Cert.#: 2780
Compliance Determination #: 78280
Intake ID: 229130
Investigator: Helen Fisher
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 06/03/2026 through 07/02/2026
Complainant Contact Date(s): 06/23/2026

Allegation(s):

1) The Assisted Living Facility (ALF) had not release the Named Resident (NR) requested records.
2) The NR may had been "raped".
3) The NR had not been seen by a podiatrist.

Investigation Methods:

Sample:	Total residents: 47 Resident sample size: 5 Closed records sample size: 0
Observations:	Residents Environment
Interviews:	Residents Collateral Contacts (CC1, CC2) Nursing Staff (NS) Care Staff Executive Director
Record Reviews:	Residents' records Incident Investigations.

Investigation Summary:

1) Interviews indicated showed that the request of the NR’s records was sent on June 9, 2026, and was not responded to by the ALF. Records showed that the records requested had been released to the NR’s Power of Attorney. Failed practice. A citation was written for noncompliance with Washington Administrative Code 388-78A-2430 Resident review of records.
2) The NR had cognitive impairment. The NR denied being sexually assaulted, stated they felt safe at the facility. CC1 stated that the NR's rape allegations happened approximately a year before and around November of 2025. CC2 stated that the NR's brief was being changed without the NR's cooperation which may had been one of the reasons why the NR felt like they were being raped. Interventions were in place when the NR refused care. The ED and HSD were unaware since they were hired after the reported allegation. Review of the progress notes dated November 2025 to June 2026 showed that no documentation or reports of sexual

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assault. However, a referral to seeing a Mental Health Professional was made regarding obsessive behaviors. There were no documentation or reports of sexual assault found. The sexual assault allegation was unsubstantiated. No failed practice was identified.
3) The NR's lower extremities were dry and flaky, toenails were thick, long jagged, yellowish brown in colors, distorted toes slightly curled downwards were observed during an unannounced onsite visit at the ALF. Interviews indicated that the HSD was unaware of the NR's toenails condition and would notify hospice. HSD stated that the NR's Representative did not sign a consent for footcare. Review of care plan showed no toe nail care was agreed upon by representative. Toenails were trimmed by hospice. No failed practice was identified.

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

20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

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 06/03/2026 and 06/25/2026 of:

Where The Heart Is
410 S NORRIS ST
BURLINGTON, WA 98233

This document references the following complaint number(s): 225977, 229130

The following sample was selected for review during the unannounced on-site visit: 5 of 47 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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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.

Jeannie Singer
Residential Care Services

7/7/2026
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.

Debi J Nutt
Administrator (or Representative)

7/16/26
Date

WAC 388-78A-2980 Lighting.

(2) The assisted living facility must maintain electric light fixtures and lighting necessary for the comfort and safety of residents and for the activities of residents and staff.

WAC 388-78A-2980 Lighting.

(3) The assisted living facility must provide enough lighting in each resident's room to meet the resident's needs, preferences and choices.

This requirement was not met as evidenced by:

Based on observations and interviews, the Assisted Living Facility (ALF) failed to maintain a working light fixture in 1 of 5 apartment's bathroom and main living area (Apartment [redacted]). This failure resulted in Resident 1 and Resident 2, who share the bathroom in Apartment [redacted], not having adequate lighting and placed them at risk of injury, poor quality of life and privacy issues.

Finding included...

Record review of an undated face sheet showed the ALF admitted Resident 1 on [redacted]/2021 with multiple diagnoses to include [redacted] and [redacted].

Record review of an undated face sheet showed the ALF admitted Resident 2 on [redacted]/2024 with multiple diagnoses to include [redacted] and [redacted].

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[redacted].

Record review showed Resident 1 and Resident 2 shared apartment [redacted].

Observations, on 06/03/2026 at 2:06 PM, showed the main living area where both Resident 1 and Resident 2's beds were located had a light fixture in the ceiling that was not operational. The shared bathroom had a light fixture located on the ceiling that was not operational. Resident 2 was observed in the bathroom, sitting on the toilet in the dark, and the bathroom door was open to allow some light in.

In an interview, on 06/01/2026 at 9:34 AM, Collateral Contact 1 (CC1– Resident 2's Family Member) stated that Resident 1 and Resident 2's lights were not operational since 05/23/2026,10 days ago.

In an interview, on 06/03/2026 at 2:09 PM, Resident 2 stated that they were having a hard time seeing in the dark and staff were trying to use their flashlights to help them.

In an interview, on 06/03/2026 at 2:12 PM, Staff D (Care Staff) stated that Resident 1's and Resident 2's lightings were on and off for at least a week and the maintenance department was notified. Staff D stated that the bathroom door was open because it was dark inside while Resident 2 was sitting on the toilet. Staff D stated that they used flashlights at times so they could see when helping both residents.

In an interview, on 06/01/2026 at 3:10 PM, Staff C (Executive Director) stated that they were unaware of the Resident 1 and Resident 2 lighting issues.

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, Where The Heart Is is or will be in compliance with this law and / or regulation on (Date) 8-16-26 .

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

Odel I Wade — Administrator (or Representative)

7/16/26 — Date

WAC 388-78A-2430 Resident review of records.

(1) The assisted living facility must assemble all records pertaining to a resident and make them available to a resident within twenty-four hours of the resident's or the

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resident's representative's request to review the resident's records per RCW 70.129.030 .

(2) The assisted living facility must provide to the resident or the resident's representative, photocopies of the records or any portions of the records pertaining to the resident, within two working days of the resident's or resident's representative's request for the records.

This requirement was not met as evidenced by:

Based on interview and records reviews, the Assisted Living Facility (ALF) failed to release records for 1 of 1 resident (Resident 1) within two working days of the request. This failure caused a delay in Resident 1's legal representative reviewing records pertaining to Resident 1's care.

Findings included...

Record review of an undated face sheet showed the ALF admitted Resident 1 on [redacted]/2021 with multiple diagnoses to include [redacted] and [redacted].

In an Interview on 06/18/2026 at 1:58 PM, Collateral Contact (CC2 – Resident 1's Legal Representative) stated that they emailed a written request to release Resident 1's records to Staff C (Executive Director) on 06/09/2026. CC2 stated Staff C had not responded to her email or records request.

In an interview on 06/23/2026 at 1:09 PM, Staff C stated that they did not recall receiving a record request and would check their email.

Review of an email, on 06/25/2026, from CC2 confirmed an emailed record request was sent to Staff C on 06/09/2026 at 3:14 PM.

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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, Where The Heart Is is or will be in compliance with this law and / or regulation on (Date) 8-16-26 .

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

Administrator (or Representative) Debi Wert Date 7-21-26

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