STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Aegis Senior Communities LLC
AEGIS OF ISSAQUAH
780 NW JUNIPER STREET
ISSAQUAH, WA 98027

RE: AEGIS OF ISSAQUAH License # 1997

Dear Administrator:

This letter addresses Compliance Determination(s) 26430 (Completion Date 07/11/2023) and 23005 (Completion Date 04/27/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/11/2023 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-2600-2-k

The Department staff who did the on-site verification:
Thomas Forkgen, ALF Licensor
Michelle Yip, ALF Licensor

If you have any questions, please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

Laurie Anderson, Field Manager
Region 2, Unit D
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Statement of Deficiencies	License #: 1997	Compliance Determination #:23085
Plan of Correction	AEGIS OF ISSAQUAH	Completion Date
Page 1 of 4	Licensee: Aegis Senior Communities LLC	04/27/2023

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 follow-up on 04/25/2023, 04/25/2023, and 04/26/2023 at:
AEGIS OF ISSAQUAH
780 NW JUNIPER STREET
ISSAQUAH, WA 98027

This document references the following SOD dated: 04/27/2023

The following sample was selected for review during the unannounced on-site visit: 6 of 67 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Michelle Yip, ALF Licensor
Kathy Young, Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit D
20426 72nd Avenue S, Suite 400
Kent, WA 98032

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

05-03-2023
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.

DSHS/ALTSA
Residential Care Services

MAY 23 2023

Received

Administrator (or Representative) 05/04/23 Date

WAC 388-78A-2600 Policies and procedures.

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

(k) To prevent and limit the spread of infections consistent with WAC 388-78A-2610;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement their policy on the required respiratory protection program for 23 of 45 staff (Staff C, Staff D, Staff I, Staff J, Staff K, Staff M, Staff N, Staff O, Staff R, Staff S, Staff T, Staff X, Staff Y, Staff BB, Staff GG, Staff II, Staff JJ, Staff MM, Staff OO, Staff QQ, Staff RR, Staff TT, and Staff WW) in alignment with standared infection control practices to ensure staff did not spread infectious diseases. This failure placed all residents at risk of contracting and spreading potentially life-threatening diseases.

Findings included...

Review of the Washington State Department of Health undated publication titled "Respiratory Protection Program for Long-Term Care Facilities" (https://doh.wa.gov/public-health-healthcare-providers/healthcare-professions-and-facilities/healthcare-associated-infections/respiratory-protection-program), showed specific guidance around respiratory protection program that included medical evaluation and fit testing for respirator use. The document showed that facilities were required to identify which employees would be exposed to a respiratory hazard and to fit test those employees. Facilities were required to provide initial and annual fit tests and to provide fit-tested respirators to their employees.

RESPIRATORY PROTECTION PROGRAM
Review of the Department of Social and Health Services "Secure Tracking and Reporting System" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 02/28/2023. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 04/11/2023.

Record review of the facility's document titled, "Respiratory Protection Program" (RPP), dated 04/12/2021, showed the RPP Program Administrator's responsibilities included identifying situations that required mandatory use of respirators, ensuring the conduct of fit testing for staff, and maintaining records required by the program. The RPP document showed that the Fit Testing Trainer/Designee was responsible for ensuring that employees (including new hires) under their supervision received appropriate training, annual medical

evaluation, and were fit tested if duties involved the use of a respirator. Further review of the document showed that respirators were required for those designated staff members who cared for residents who were exposed or who were confirmed positive for airborne transmittable diseases. The document identified Associate Care Directors, Care Directors, Care managers/Medication Care Managers as employees who may be required to wear filtering facepiece respirators. The document further showed that employees who were required to wear tight-fitting respirators would be fit tested prior to wearing any tight-fitting respirator, tested annually, and when there were changes in the employee's physical condition that could affect respirator fit. The document also showed that the Program Administrator would ensure fit tests were conducted in accordance with any appropriate and Occupational Safety and Health Administration (OSHA)-approved protocol of the Respiratory Protection Standard. On 04/26/2023, review of OSHA website showed "… the employee must be fit tested with the same make, model, style, and size of respirator that will be used."

Review of the facility's "Staff Roster" showed that the facility hired 66 staff responsible for providing care and services to the residents. The document showed the facility hired: Staff C, Lead Care Manager, on 09/23/2020; Staff D, Care Manager 2, on 11/23/2021; Staff I, Lead Medication Care Manager, on 03/16/2020; Staff J, Care Manager 2, on 06/03/2022; Staff K, Associate Care Director on 04/07/2022; Staff M, Medication Care Manager, on 11/08/2021; Staff N, Medication Care Manager, on 10/31/2019; Staff Q, Lead Housekeeper, on 07/14/2010; Staff R, Care Manager 1, on 02/16/2022; Staff S, Care Manager 1, on 06/14/2022; Staff T, Care Manager 1, on 08/01/2022; Staff X, Care Manager 1, on 07/05/2022; Staff Y, Wellness Nurse, on 09/05/2017; Staff BB, Care Manager 2, on 05/18/2022; Staff GG, Care Manager 1, on 01/16/2023; Staff II, Care Manager 2, on 12/20/2021; Staff JJ, Care Manager 1, on 08/29/2022; Staff MM, Care Manager 2, on 05/29/2022; Staff OO, Care Manager 1, on 12/04/2017; Staff QQ, Wellness Nurse, on 08/15/2022; Staff RR, Care Manager 1, on 10/01/2020; Staff TT, Care Manager 2, on 02/01/2020; and Staff WW, Care Manager 1, on 08/24/2020.

Review of the facility's RPP documentation showed that the facility maintained the medical evaluation and fit test results for staff who completed their medical evaluation and were fit tested. Further review of the documentation showed there were no fit test records for 22 staff (Staff C, Staff D, Staff I, Staff J, Staff M, Staff N, Staff Q, Staff R, Staff S, Staff T, Staff X, Staff Y, Staff BB, Staff GG, Staff II, Staff JJ, Staff MM, Staff OO, Staff QQ, Staff RR, Staff TT, and Staff WW). Further review showed that Staff K was fit tested for a "NIOSH/L188". The document also showed the facility no longer stocked that NIOSH/L188 mask. Additionally, the documentation showed that Staff C and Staff RR were overdue for their medical evaluation. The document showed both Staff C and Staff RR last completed their annual medical evaluation in July 2021.

During an interview on 04/25/2023 at 11:50 AM, Staff A, General Manager, stated that the facility had not completed fit testing for all staff.

During an interview on 04/25/2023 at noon, Staff G, Care Director, stated that the facility completed the medical evaluation for all staff who used a respirator mask. Staff G stated that they had not completed the respirator fit test for all staff.

Statement of Deficiencies	License # 1997	Compliance Determination # 23005
Plan of Correction	AEGIS OF ISSAQUAH	Completion Date
Page 4 of 4	Licensee: Aegis Senior Communities LLC	04/27/2023

During an interview on 04/26/2023 at 10:14 AM, Staff G confirmed that Staff C and Staff RR had not completed a current medical evaluation. During an interview on 04/26/2023 at 3:22 PM, Staff G also stated that the facility did not have the N95 mask that Staff K was fit tested to use.

This is an uncorrected deficiency previously cited on 02/28/2023 for subsection 2k.

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, AEGIS OF ISSAQUAH is or will be in compliance with this law and / or regulation on (Date) JUNE 2, 2023

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

Administrator (or Representative) — Date: 050423

DSHS/ALTSA
Residential Care Services

MAY 23 2023

Received

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Statement of Deficiencies	License #: 1997	Compliance Determination # 19507
Plan of Correction	AEGIS OF ISSAQUAH	Completion Date
Page 1 of 12	Licensee: Aegis Senior Communities LLC	02/28/2023

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 02/07/2023, 02/07/2023, 02/09/2023 and 02/09/2023 of:
AEGIS OF ISSAQUAH
780 NW JUNIPER STREET
ISSAQUAH, WA 98027

The following sample was selected for review during the unannounced on-site visit: 9 of 65 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Steven Garrett, LTC Licensor
Claudia Machado, Community Complaint Investigator
Kathy Young, Licensor
Michelle Yip, ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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 — 03-09-2023 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)

3/13/23
Date

WAC 388-78A-2600 Policies and procedures.

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

(k) To prevent and limit the spread of infections consistent with WAC 388-78A-2610 ;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to implement their policy on the required respiratory protection program for 44 of 66 staff (Staff B, Staff C, Staff D, Staff F, Staff G, Staff I, Staff J, Staff L, Staff M, Staff N, Staff O, Staff Q, Staff R, Staff S, Staff T, Staff U, Staff V, Staff W, Staff X, Staff Y, Staff Z, Staff AA, Staff BB, Staff CC, Staff DD, Staff EE, Staff FF, Staff GG, Staff HH, Staff II, Staff JJ, Staff KK, Staff LL, Staff MM, Staff NN, Staff OO, Staff PP, Staff QQ, Staff RR, Staff SS, Staff TT, Staff UU, Staff VV, and Staff WW) in alignment with appropriate infection control practices. Additionally, the facility failed to follow their Aerosol Generating Procedures for 2 of 2 sampled residents (Resident 5, Resident 10). These failures placed all residents at risk of contracting and spreading a potentially life-threatening disease.

Findings included...

The Centers for Disease Control and Prevention (CDC) developed guidelines for agencywide response to the COVID-19 pandemic. The Washington State Governor's Office, the Washington State Department of Social and Health Services (DSHS), the Washington State Department of Health (DOH), and the Washington State Department of Labor and Industries (L&I), established the current standards of infection control to prevent and control the spread of COVID-19 in the community.

Review of the DOH publication, titled "Interim Recommendations for SARS-CoV-2 Infection Prevention and Control in Healthcare Settings" (https://doh.wa.gov/sites/default/files/2022-06/420-391-SARS-CoV-2-InfectionPreventionControlHealthcareSettings.pdf?uid=635fe3e51bc64), dated October 31, 2022, showed specific guidance around respiratory protection program that included medical evaluation and fit testing for respirator use. The documents showed that facilities were required to identify which employees will be exposed to a respiratory hazard and to fit test those employees who could potentially be exposed to a respiratory hazard. Facilities were required to provide initial and annual fit tests and to provide fit-tested respirators to their employees. The DOH publication also included specific guidance around Aerosol Generating Procedure (AGP). The document listed Continuous Positive Airway Pressure (CPAP) (a machine provides air at a pressure to prevent the collapse of airway) as AGP.

RESPIRATORY PROTECTION PROGRAM

Review of the facility's document titled "Respiratory Protection Program" (RPP), dated 04/12/2021, showed that the RPP Program Administrator's responsibilities included identifying situations that required mandatory use of respirators, ensuring the conduct of fit testing for staff, and maintaining records required by the program. The RPP document showed that the Fit Testing Trainer/Designee was responsible for ensuring that employees (including new hires) under their supervision received appropriate training, annual medical evaluation, and were fit tested if duties involved the use of a respirator. Further review of the document showed that respirators were required for those designated staff members who cared for residents who were exposed or who were confirmed positive for COVID-19. The document identified Associate Care Directors, Care Directors, Care managers/Medication Care Managers as employees who may be required to wear filtering facepiece respirators. The document further showed that employees who were required to wear tight-fitting respirators would be fit tested prior to wearing any tight-fitting respirator, tested annually, and when there were changes in the employee's physical condition that could affect respirator fit. The document also showed that the Program Administrator would ensure fit tests were conducted in accordance with any appropriate and Occupational Safety and Health Administration (OSHA)-approved protocol of the Respiratory Protection Standard.

Review of the facility's "Resident Characteristic Roster", dated 02/07/2023, showed that the facility provided care and services to 66 assisted living residents. Review of the facility's "Staff Roster" showed that the facility hired 66 employees to provide care and services to the assisted living residents. The document showed that the facility hired Staff B, Health Services Director, on 12/19/2022; Staff C, Lead Care Manager, on 09/23/2020; Staff D, Care Manager 2, on 11/23/2021; Staff F, Lead Medication Care Manager, on 03/31/2009; Staff G, Care Director, on 03/23/2016; Staff I, Lead Medication Care Manager, on 03/16/2020; Staff J, Care Manager 2, on 06/03/2022; Staff L, Care Manager 2, on 12/16/2022; Staff M, Medication Care Manager, on 11/08/2021; Staff N, Medication Care Manager, on 10/31/2019; Staff O, Medication Care Manager, on 12/23/2019; Staff Q, Lead Housekeeper, on 07/14/2010; Staff R, Care Manager 1, on 02/16/2022; Staff S, Care Manager 1, on 06/14/2022; Staff T, Care Manager 1, on 08/01/2022; Staff U, Care Manager 1, on 09/28/2022; Staff V, Care Manager 1, on 02/01/2023; Staff W, Care Manager 2, on 04/19/2022; Staff X, Care Manager 1, on 07/05/2022; Staff Y, Wellness Nurse, on 09/05/2017; Staff Z, Care Manager 2, on 02/02/2022; Staff AA, Care Manager 1, on 10/13/2022; Staff BB, Care Manager 2, on 05/18/2022; Staff CC, Maintenance Director, on 03/04/2022; Staff DD, Care Manager 2, on 01/21/2023; Staff EE, Care Manager 2, on 01/23/2023; Staff FF, Maintenance Assistant, on 04/19/2022; Staff GG, Care Manager 1, on 01/16/2023; Staff HH, Associate Care Director, on 08/25/2013; Staff II, Care Manager 2, on 12/20/2021; Staff JJ, Care Manager 1, on 08/29/2022; Staff KK, Care Manager 1, on 10/27/2021; Staff LL, Care Manager 1, on 12/05/2022; Staff MM, Care Manager 2, on 05/29/2022; Staff NN, Lead Care Manager, on 11/14/2022; Staff OO, Care Manager 1, on 12/04/2017; Staff PP, Care Manager 2, on 03/19/2014; Staff QQ, Wellness Nurse, on 08/15/2022; Staff RR, Care Manager 1, on 10/01/2020; Staff SS, Care Manager 1, on 01/05/2023; Staff TT, Care Manager 2, on 02/01/2020; Staff UU, Care Manager 1, on 10/13/2022; Staff VV, Care Manager 1, on 08/25/2022; and Staff WW, Care Manager 1, on 08/24/2020.

Review of the facility's RPP documentation showed that the facility maintained the medical evaluation and fit test results for staff that were tested. Closer review of the RPP records showed some of the staff fit test records were unavailable. Further review of the documentation showed that there was no medical evaluation and no fit test records documentation for 35 staff (Staff B, Staff F, Staff I, Staff J, Staff L, Staff M, Staff N, Staff O, Staff Q, Staff R, Staff S, Staff T, Staff U, Staff V, Staff W, Staff X, Staff Z, Staff AA, Staff BB, Staff CC, Staff DD, Staff EE, Staff FF, Staff GG, Staff JJ, Staff KK, Staff LL, Staff MM, Staff NN, Staff QQ, Staff SS, Staff TT, Staff UU, Staff VV, and Staff WW). Additionally, there was no documentation of the fit test records for three staff (Staff D, Staff G, and Staff II). The documentation showed that six staff (Staff C, Staff Y, Staff HH, Staff OO, Staff PP, and Staff RR) were overdue for their annual fit test.

During an interview on 02/07/2023 at 3:15 PM, Staff A, General Manager, stated that the facility's last COVID-19 positive resident was out of isolation on 01/27/2023. During the same interview, Staff A stated that the facility designated Staff G, Care Director, as the RPP Program Administrator and Fit Test Trainer.

During an interview on 02/08/2023 at 9:10 AM, Staff G stated that they were familiar with their facility's RPP. Staff G stated that the facility required all care staff, housekeepers, and maintenance staff, with potential for respiratory hazard exposure, be fit tested for respirators. Staff G stated that on 05/05/2022, the facility completed respirator fit tests for some staff. Staff G confirmed that staff without the fit test documentation in the facility's files were not fit tested for a respirator. Staff G stated that they were unable to find any evaluator to perform respirator fit tests. Staff G stated that they had not provided any further fit tests for those staff who had not completed it.

AEROSOL GENERATING PROCEDURE
Review of the facility's document titled "Aerosol Generating Procedures Guidance", revised 12/09/2021, showed that the facility's policy aligned with the DOH's recommendations for AGPs. The facility's AGP policy listed CPAP as a procedure that required nurses, medication care managers, housekeeping, and care staff to follow the AGP precautions.

Review of the facility's "Resident Characteristic Roster," dated 02/07/2023, showed that the facility admitted Resident 5 in [redacted] 2021. Review of Resident 5's "Face Sheet" showed that Resident 5's medical diagnoses included [redacted] Review of Resident 5's "Individualized Service Plan", dated 02/07/2023, showed that Resident 5 used a CPAP.
Review of the facility's "Resident Characteristic Roster," dated 02/07/2023, showed that the facility admitted Resident 10 in [redacted] 2021. Review of Resident 5's "Individualized Service Plan", dated 02/07/2023, showed that Resident 5 used a CPAP.

Observation on 02/08/2023 at 3:50 PM of Resident 5's room showed a CPAP machine placed on the bedside table. Observation showed that a mask and a tubing were connected to the CPAP machine.

Observation on 02/09/2023 at 1:30 PM of Resident 5 and Resident 10's apartment doors

showed no signage of AGP precautions. Further observation showed there was no PPE available at Resident 5 and Resident 10's apartment.

During an interview on 02/08/2023 at 9:10 AM, Staff G, stated that two assisted living residents, Resident 5 and Resident 10, used a CPAP machine. Staff G stated that they were unfamiliar with the DOH's recommendation for AGPs. Staff G stated that they were unaware of Resident 5 and Resident 10's CPAP scheduled use. Staff G also stated that they were unaware of the ventilation clearance time needed for the residents' rooms after the procedure. Staff G stated that the facility never posted the required "Aerosol Precautions" signage on Resident 5 and Resident 10's apartment doors to alert others AGPs were in use. Staff G also stated that the facility had not placed any PPE at the residents' apartments for staff and visitors to use when they entered the apartments.

During an interview on 02/08/2023 at 3:50 PM, Staff XX, Caregiver, stated that Resident 5 used a CPAP at nighttime. Staff XX stated that in the evening, they helped Resident 5 to put on the mask and then turned on the CPAP machine. Staff XX stated that in the morning, they helped Resident 5 to remove the mask and stopped the CPAP machine. Staff XX further stated that they were unaware of the AGP precautions. Staff SS stated there were no signs posted on the apartment door and no care instructions documented in Resident 5's care plan.

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, AEGIS OF ISSAQUAH is or will be in compliance with this law and / or regulation on (Date)_ 4/11/23

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

Administrator (or Representative) — Date 3/13/23

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 1 of 1 sampled resident (Resident 5) with two staff assisted mechanical transfers as agreed upon in the Negotiated Service Agreement (NSA). This failure placed the resident at risk for unsafe transfers and injury.

Findings included...

Review of the facility's "Resident Characteristic Roster," dated 02/07/2023, showed that the facility admitted Resident 5 in [redacted] 2021. Review of Resident 5's "Individualized Service Plan" (ISP), dated 08/22/2022, showed Resident 5 used a Hoyer Lift for all transfers. Further review of the ISP showed Resident 5 required two staff members for all mechanical transfers.

Review of the facility's document titled "Transfer Policy", dated 01/13/2023, showed that the facility trained staff on the use of mechanical lifts prior to operating any lift with residents. The policy also stated that the facility required two staff members to use any mechanical lift within the community, whether the lift was facility-owned or resident-owned.

Review of the facility's training document, dated 02/08/2023, titled "Care Manager Activities of Daily Living (ADL) Competency Checklist – Lift with Hoyer" showed that the training instructions included "two staff members are required to operate lift". Further review of the document showed that Staff XX, Caregiver, completed the "Lift with Hoyer" training.

Observation on 02/09/2023 at 12:45 PM showed that Staff XX independently operated the Hoyer lift to transfer Resident 5 from the wheelchair to the hospital bed for personal care. Further observation showed that after Staff XX completed the personal care, Staff XX again independently operated the Hoyer lift to transfer Resident 5 from the hospital bed to the wheelchair. Observation showed that Staff XX never called any other care staff to request assistance with the transfers.

During an interview on 02/08/2023 at 4:10 PM, Staff G, Care Director, stated that the facility provided initial training to all staff that included one on one training on how to use the Hoyer lift to transfer residents.

During an interview on 02/09/2023 at 01:00 PM, Staff XX stated that the facility hired them as an agency caregiver. Staff XX stated that the facility provided them training on the use of Hoyer lift. Staff XX stated that they were unaware of the facility policy that required two-person assistance in with all mechanical transfers. Staff XX further stated that when they used the Hoyer lift to transfer Resident 5, they independently completed the mechanical transfers.

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, AEGIS OF ISSAQUAH is or will be in compliance with this law and / or regulation on (Date)_ 4/1/23

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

Administrator (or Representative) 3/13/23 Date

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to obtain an order for oxygen therapy for 1 of 2 sampled residents (Resident 1). This failure placed Resident 1 at risk for not receiving oxygen therapy as ordered. 02

Findings included...

The policy showed that the prescribed flow rate liters per minute (LPM) will be documented on the resident's Medication Administration Record (MAR).

Review of the facility's Review of the facility's undated "Assisted Living Facility Resident Characteristics Roster and Sample Selection," showed that the facility admitted Resident 1 in [redacted] 2017.

Review of Resident 1's "Progress Notes", dated [redacted]/2022, showed Resident 1 discharged from hospital and arrived at the facility at 2:00 PM. The progress note showed Resident 1 returned to the facility on two liters of oxygen via a portable oxygen concentrator (machine that takes room air filters out the nitrogen to provide a higher amount of oxygen). The progress note did not show if the oxygen was to be continuous or PRN (as needed). The progress note was signed by Staff B, Registered Nurse Delegator, Health Services Director.

Review of Resident 1's medical chart found no record of an order for oxygen.

Review of Resident 1's electronic Medication Administration Record dated February 1, 2023, to February 7, 2023, showed no documentation of an order for oxygen.

Observation on 02/08/2023 at 10:50 AM, showed Resident 1 received oxygen via a nasal cannula (a two-pronged hollow plastic tubing positioned in the nostrils to deliver supplemental oxygen) connected to an oxygen concentrator machine. Observation of the flow rate gage showed it was set in between 2 and 2.5 liters per minute.

During an interview on 02/09/2023 at 1:00 PM, Staff G, Resident Care Director, stated that they checked with the nurses about the order for oxygen. Staff G stated they were told the facility did not have an order for Resident 1's oxygen.

During an interview on 02/09/2023 at 12:38 PM, Staff P, Registered Nurse, Regional Nurse, and Staff B stated that there was not an order for Resident 1's oxygen. Staff P stated that Resident 1's primary care physician was contacted for an oxygen order once they realized there was no order.

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, AEGIS OF ISSAQUAH is or will be in compliance with this law and / or regulation on (Date) APRIL 11, 2023

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

Administrator (or Representative) — Date: 3/13/23

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:

(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:

(a) Chapter 18.79 RCW, Nursing care;

(b) Chapter 18.88A RCW, Nursing assistants;

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

(d) Chapter 246-841 WAC, Nursing assistants; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility Registered Nurse Delegator failed to follow the nurse delegation regulations for proper delegation to qualified Staff for 2 of 2 sampled Residents (Resident 1 and Resident 7). This failure placed Resident 1 and Resident 7 at risk for not receiving the services required.

Findings included...

Review of the facility "Oxygen Safety & Assistance Policy," dated 03/08/2015, showed "in the event that a resident requires the use of oxygen to manage a medical condition, Aegis staff will offer assistance as ordered by the resident's healthcare practitioner (or in WA, nurse delegation) as needed." The policy showed "oxygen therapy must be reviewed by the Health Services Director (HSD) on a regular basis and care staff providing assistance (or assistance under the nurse delegation in WA)". In addition, the policy showed "only... a Medication Care Manager (MCM) under nurse delegation (WA only) ... may adjust the oxygen flow rate for portable tanks/devices or oxygen concentrators or enrichers". The policy showed that the prescribed flow rate liters per minute (LPM) will be documented on the resident's Medication Administration Record (MAR). The policy showed that "changing the oxygen liter flow is considered a nurse delegated task".

RESIDENT 1
Review of the facility's undated "Assisted Living Facility Resident Characteristics Roster and Sample Selection" showed that the facility admitted Resident 1 in [redacted] 2017.

Review of Resident 1's "Progress Notes" (facility nursing notes), dated [redacted]/2022, showed Resident 1 discharged from hospital and arrived at the facility at 2:00 PM. The progress note showed Resident 1 returned to the facility on two liters of oxygen via a portable oxygen concentrator (machine that takes room air filters out the nitrogen to provide a higher amount of oxygen). The progress note did not show if the oxygen was to be continuous or PRN (as needed). The progress note was signed by Staff B, Registered Nurse Delegator, Health Services Director. Review of Resident 1's electronic Medication Administration Record dated February 1, 2023, to February 7, 2023, showed no documentation of an order for oxygen.

Review of Resident 1's "Individualized Service Plan", (ISP) dated [redacted]/2022, showed Resident 1 discharged from hospital on oxygen. The service plan showed "Staff to ensure [oxygen] working appropriately and set to 2L." Resident 1's ISP also showed "Skilled or Delegated Staff Lay assist with flow rate adjustment as needed."

Review of the facility's Registered Nurse Delegator (RND) Nurse Delegation Binder on 02/08/2023 and 02/09/2023 found no documentation to show the facility staff were delegated to adjust the oxygen flow rate for Resident 1.

Review of the facility's Resident 1's "Nurse Delegation: Instructions for Nursing Task" form dated 02/09/2023 and received via email on 02/10/2023 after the Department's on-site visit, showed "Oxygen 2L/MIN [2 liters per minute]." The Nurse Delegation showed a

physician ordered verification date of 02/09/2023. The Nurse Delegation nursing task showed a procedure for the delegated staff to follow for oxygen delegation. The form did not show if the oxygen was to be continuous or PRN. The form was signed by Staff B, Registered Nurse Delegator (RND), Health Services Director.

Review of the facility's copy of the "Nurse Delegation: Nursing Visit" form, dated 02/09/2023, showed that 11 staff were delegated by Staff B, RND through observation or demonstration, verbal description, and record review to adjust Resident 1's oxygen flow rate. The form was signed by Staff B, RND.

Observation on 02/08/2023 at 10:50 AM, showed Resident 1 received oxygen via a nasal cannula (a two-pronged hollow plastic tubing positioned in the nostrils to deliver supplemental oxygen) connected to an oxygen concentrator machine. Observation of the flow rate gage showed it was set between 2 and 2.5 liters per minute.

During an interview on 02/08/2023 at 11:12 AM, Staff L, Care Manger 2, stated that they do not adjust Resident 1's oxygen flow rate or manage any aspects of Resident 1's oxygen. Staff L stated that if there was an issue with Resident 1's oxygen, they would notify the Medication Care Manger or the Licensed nurse on duty.

During an interview on 02/08/2023 at 12:32 PM, Staff M, Medication Care Manager, stated that they were not delegated to adjust the oxygen flow rate for Resident 1. Staff M stated that if there was a problem with Resident 1's oxygen they would contact the licensed nurse on duty.

During an interview on 02/09/2023 at 9:45 AM, Staff P, Regional Registered Nurse, confirmed that they were unable to find any nurse delegation records for Resident 1.

During a telephonic interview on 02/10/2023 at 4:54 PM, Staff N, Medication Care Manager, stated that they were instructed to notify the licensed nurse on duty if the oxygen tank was low and needed to be changed. Staff N stated that on 02/09/2023, they were not delegated for oxygen flow rate adjustment.

During a telephonic interview on 02/13/2023 at 9:59 AM, Staff M stated that after an interview with the Licensor on 02/08/2023, they spoke with Staff G, Resident Care Director, and was told all staff who were currently delegated were considered delegated to adjust the oxygen flow rate for all residents who received oxygen. Staff M stated that they had not received oxygen delegation instructions from the RND on 02/09/2023 or on 02/10/2023. Staff M stated that they needed to review the oxygen management delegation materials received during a nurse delegation class previously attended. The class allowed Staff M to obtain their Department of Social and Health Services approved nurse delegation certificate, which was required, in order to be delegated by a RND.

During a teleconference interview on 02/13/2023 at 3:30 PM, Staff G confirmed the

conversation regarding oxygen delegation with Staff M that occurred on 02/08/2023.

During an interview on 02/10/2023 at 5:12 PM, Staff O, Medication Care Manager, stated that they worked on-call for the facility and the last time they worked at the facility was the week prior to Thanksgiving of 2022. Staff O stated that they were not delegated at any time to adjust the oxygen flow rate for Resident 1. Staff O stated that on 02/09/2023, they were not delegated for the oxygen management of Resident 1.

RESIDENT 7
Review of the facility's undated "Assisted Living Facility Resident Characteristics Roster and Sample Selection showed that the facility admitted Resident 7 in [redacted] 2022.

Review of Resident 7's "physician's orders", dated 10/25/2022, showed Resident 7 received oxygen, 2-liter flow rate via nasal cannula, prn (as needed) for signs and symptoms of shortness of breath and discomfort.

Review of Resident 7's assessment, completed by Staff B, Health Services Director, dated 01/20/2023, showed no documentation that Resident 7 needed any oxygen services. Review of Resident 7's individualized plan of care, completed by Staff G, Care Director, dated 02/08/2023, showed no documentation that Resident 7 required oxygen or received any oxygen services.

Observation of Resident 7's apartment on 02/08/2023 at 11:50 AM, showed an "oxygen in use" sign posted on the entry door. Further observation showed Resident 7's room had an oxygen concentrator machine (machine that concentrates oxygen from room air), two oxygen tanks stored in a rolling rack, and oxygen tubing and supplies stored along the wall, across the room from Resident 7's bed.

During an interview on 02/13/2023 at 10:02 AM, Staff J, Care Manager 2, stated that they were not delegated to adjust the oxygen flow rate for Resident 7. Staff J stated that they were not delegated by the delegation nurse on 02/09/2023 or 02/10/2023.

During an interview on 02/13/2023 at 9:45 AM, Staff H, Medication Care Manager, stated that they were not delegated to adjust the oxygen flow rate for Resident 7. Staff H reported that they had not been delegated to adjust oxygen flow rates for any resident in the facility. Staff H stated that they had not received training and were not delegated by the delegation nurse on 02/09/2023 or on 02/10/2023.

During an interview on 02/13/2023 at 9:54 AM, Staff I, Lead Medication Care Manager, stated that they were not delegated to adjust the oxygen flow rate for Resident 7. Staff I stated that "it's (the oxygen) just if needed for comfort, the hospice people use it, maybe... ". Staff I stated that they were not delegated by the delegation nurse on 02/09/2023 or on 02/10/2023.

During an interview on 02/13/2023 at 10:12 AM, Staff C, Lead Care Manager, stated that they were not delegated to adjust the oxygen flow rate for Resident 7. Staff C stated the facility nurses "do adjustments to the oxygen if needed...". Staff C stated that they were not delegated by the delegation nurse on 02/09/2023 or on 02/10/2023.

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, AEGIS OF ISSAQUAH is or will be in compliance with this law and / or regulation on (Date)__ 4/11/23 _

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

Administrator (or Representative) _____ Date 3/13/23

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

03/09/2023

CERTIFIED MAIL

9489 0090 0027 6382 8690 26

Aegis Senior Communities LLC
AEGIS OF ISSAQUAH
780 NW JUNIPER STREET
ISSAQUAH, WA 98027

RE: AEGIS OF ISSAQUAH # 1997

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 02/28/2023 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Laurie Anderson, Field Manager
Residential Care Services
Region 2, Unit D
20425 72nd Avenue S, Suite 400

Kent, WA 98032

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s): EXP.

In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

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.

The facility failed to ensure that 2 of 7 Medication carts did not contain expired medications for three residents. The facility Medication Care Managers removed the expired medications during the medications system review. The facility had a policy and procedure in place to audit the medications carts which was missed during the week of the inspection. The facility staff corrected the error while the Department representative was on site.

You Are Not: NOT

• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

DSHS/ALTSA
Residential Care Services
APR 12 2023
Received

If You Have Any Questions:

- Please contact me at (253)234-6020.

Sincerely,

Laurie Anderson, Field Manager
Region 2, Unit D
Residential Care Services

Enclosure