



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) 49621 (Completion Date 10/31/2024) and 46187 (Completion Date 09/10/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/31/2024 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-2950-6, WAC 388-78A-3090-1-a, WAC 388-78A-3090-1-c, WAC 388-78A-2130-1-b, WAC 388-78A-2130-1-c, WAC 388-78A-2130-3-a, WAC 388-78A-2130-3-b, WAC 388-78A-2130-3, WAC 388-78A-2474-2-d, WAC 388-112A-0060-1-a, WAC 388-112A-0060-1-a-i, WAC 388-112A-0060-1-a-ii, WAC 388-112A-0060-1-a-iii, WAC 388-112A-0060-1-b, WAC 388-78A-2480-1, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3

The Department staff who did the on-site verification:

Steven Garrett, LTC Licenser
Jane Hermano, NCI

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

Sincerely,

Laurie Anderson

Laurie Anderson, Field Manager
Region 2, Unit D

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

AEGIS OF ISSAQUAH # 1997

10/31/2024

Page 2 of 2

Residential Care Services

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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 # 48167
Plan of Correction	AEGIS OF ISSAQUAH	Completion Date
Page 1 of 12	Licenses: Aegis Senior Communities LLC	09/10/2024

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 08/27/2024 and 08/29/2024 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 55 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Claudia Allis, ALF Licenser
Steven Garrett, LTC Licenser
Jane Hermans, NCI

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.

Laurie Anderson

Residential Care Services

09/10/2024

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.

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



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 # 46187
Plan of Correction	AEGIS OF ISSAQUAH	Completion Date
Page 1 of 12	Licensee: Aegis Senior Communities LLC	09/10/2024

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

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AEGIS OF ISSAQUAH
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ISSAQUAH, WA 98027

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Residential Care Services

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.

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



Administrator (or Representative)

9.13.2024

Date

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

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

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure it maintained safe hot water temperatures between 105 degrees and 120 degrees Fahrenheit (F) for 8 of 27 sinks (Main Building common bathroom 1, Main Building common bathroom 2, Alder Building Laundry room, Cedar Building Laundry room, Apartment 512 bathroom, Elm Building Kitchen, Fir Building Laundry room, and Ginkgo Laundry room). This failure placed all 55 residents and visitors at risk for injury from high water temperatures.

Findings included...

Observation on 08/27/2024 showed: at 1:47 PM, the Main Building common bathroom 1 sink hot water temperature measured 98.5 degrees F. At 1:55 PM, the Main Building common bathroom 2 sink hot water temperature measured 99 degrees F. At 1:56 PM, the Alder Building Laundry room sink hot water temperature measured 120.3 degrees F. At 2:47 PM, the Apartment 512 bathroom sink hot water temperature measured 120.4 degrees F. At 2:50 PM, the Fir Building Laundry room sink hot water temperature measured 122 degrees F. At 2:58 PM, the Ginkgo Laundry room sink hot water temperature measured 121.5 degrees F.

Observation on 08/29/2024 showed: at 11:36 AM, the Main Building common bathroom 1 sink hot water temperature measured 98 degrees F. At 11:38 AM, the Main Building common bathroom 2 sink hot water temperature measured 98.2 degrees F. At 12:33 PM, the Cedar Building Laundry room sink hot water temperature measured 129.7 degrees F. At 12:45 PM, the Elm Building Kitchen sink hot water temperature measured 121.2 degrees F.

During an interview on 08/27/2024 at 3:20 PM, Staff H, Maintenance Director, stated that they routinely measure the hot water temperature amongst a sampling of sinks throughout the facility cottage buildings. Staff H stated that each cottage building had their own independent hot water system. Staff H stated that they were aware of the hot water temperature requirements.

Administrator (or Representative)

Date

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

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This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure it maintained safe hot water temperatures between 105 degrees and 120 degrees Fahrenheit (F) for 8 of 27 sinks (Main Building common bathroom 1, Main Building common bathroom 2, Alder Building Laundry room, Cedar Building Laundry room, Apartment 512 bathroom, Elm Building Kitchen, Fir Building Laundry room, and Ginkgo Laundry room). This failure placed all 55 residents and visitors at risk for injury from high water temperatures.

Findings included...

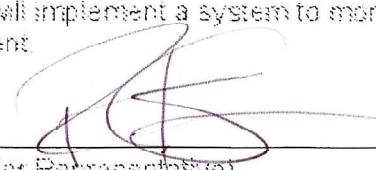
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Observation on 08/29/2024 showed: at 11:36 AM, the Main Building common bathroom 1 sink hot water temperature measured 96 degrees F. At 11:38 AM, the Main Building common bathroom 2 sink hot water temperature measured 96.2 degrees F. At 12:33 PM, the Cedar Building Laundry room sink hot water temperature measured 129.7 degrees F. At 12:45 PM, the Elm Building Kitchen sink hot water temperature measured 121.2 degrees F.

During an interview on 08/27/2024 at 3:20 PM, Staff H, Maintenance Director, stated that they routinely measure the hot water temperature amongst a sampling of sinks throughout the facility cottage buildings. Staff H stated that each cottage building had their own independent hot water system. Staff H stated that they were aware of the hot water temperature requirements.

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) October 25, 2024

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


Administrator (or Representative)

9.13.24
Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

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

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure the ventilation fans in 6 of 21 laundry rooms and resident apartment bathrooms (Alder Building Laundry room, Apartment 110 bathroom, Apartment 211 bathroom, Apartment 410 bathroom, Apartment 512 bathroom, and Apartment 706 bathroom) were operational and provided proper air flow and ventilation to the outside of the facility. This failure placed all 55 residents at risk of diminished quality of life and potential respiratory illnesses from improper air circulation in the buildings.

Findings included...

NOTE: In accordance with WAC 388-78A-3090 to provide a safe and sanitary environment, WAC 388-78A-3090 and 388-78A-3040 require facilities to provide mechanical ventilation to the outside of the assisted living facility, in bathrooms and laundry rooms.

Observation on 08/27/2024 between 1:35 PM and 3:23 PM and on 08/29/2024 between 12:24 PM and 12:58 PM, showed the air exchange vents in the Alder building laundry room, Apartment 110 bathroom, Apartment 211 bathroom, Apartment 410 bathroom, Apartment 512 bathroom, and Apartment 706 bathroom were not functioning.

During an interview on 08/29/2024 at 12:58 PM, Staff H, Maintenance Director, stated that they were aware that the ventilation fans in the Alder building laundry room, Apartment 110 bathroom, Apartment 211 bathroom, Apartment 410 bathroom, Apartment 512 bathroom, and Apartment 706 bathroom were not functioning properly.

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Administrator (or Representative)

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This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure the ventilation fans in 6 of 21 laundry rooms and resident apartment bathrooms (Alder Building Laundry room, Apartment 110 bathroom, Apartment 211 bathroom, Apartment 410 bathroom, Apartment 512 bathroom, and Apartment 706 bathroom) were operational and provided proper air flow and ventilation to the outside of the facility. This failure placed all 55 residents at risk of diminished quality of life and potential respiratory illnesses from improper air circulation in the buildings.

Findings included...

NOTE: In accordance with WAC 388-78A-3090 to provide a safe and sanitary environment, WAC 388-78A-3030 and 388-78A-3040 require facilities to provide mechanical ventilation to the outside of the assisted living facility, in bathrooms and laundry rooms.

Observation on 08/27/2024 between 1:35 PM and 3:23 PM and on 08/29/2024 between 12:24 PM and 12:58 PM, showed the air exchange vents in the Alder building laundry room, Apartment 110 bathroom, Apartment 211 bathroom, Apartment 410 bathroom, Apartment 512 bathroom, and Apartment 706 bathroom were not functioning.

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Plan/Attestation Statement

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


Administrator (or Representative)

9.13.24
Date

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

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document a plan to monitor and address interventions required to meet the communication needs for 1 of 9 residents (Resident 9). This failure placed Resident 9 at risk for unmet care needs and potential harm.

Findings included...

Review of Resident 9's Face Sheet showed the facility admitted Resident 9 on [REDACTED] 2024

Plan/Attestation Statement

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Administrator (or Representative)

Date

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 - (b) Identifies the resident's immediate needs; and
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 - (a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and
 - (b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document a plan to monitor and address interventions required to meet the communication needs for 1 of 9 residents (Resident 9). This failure placed Resident 9 at risk for unmet care needs and potential harm.

Findings included...

Review of Resident 9's Face Sheet showed the facility admitted Resident 9 on [REDACTED]/2024.

Observation of Resident 9's apartment door showed a community welcome notice with a brief list of Resident 9's background, family members, and interests. The welcome notice showed that Resident 9 did not speak English. The welcome notice showed that Resident 9's understanding of the English language was limited.

Review of the facility's Characteristic Roster, dated 08/26/2024, showed that Resident 9 admitted with behavior issues and cognitive impairment. The roster showed that Resident 9 admitted with no communication issues.

Review of Resident 9's Assessment and Service Plan, created on 07/16/2024, showed Resident 9 was independent with most activities of daily living (eating, drinking, and mobility). The service plan showed Resident 9 had a history of wandering and exit seeking behaviors. The service plan documented guidance for staff to allow Resident 9 to engage in activity in safe areas and redirect if found near exit doors.

Review of Resident 9's Individualized Service Plan (combined assessments/service plans), created on 07/16/2024, showed Resident 9 did not speak English. The plan showed that Resident 9 understood "limited amounts of English" when spoken to by others. There was no documentation that provided staff with specific written behavioral interventions and communication methods for interactions with Resident 9. There was no documentation that provided staff with specific behavioral interventions and communication methods to be used when Resident 9 exhibited exit-seeking behaviors.

During an interview at on 08/29/2024 at 10:45 AM, Staff J, Care Manager, stated that the facility staff used a translator application on facility provided staff phones to communicate with Resident 9.

During an interview on 09/29/2024 at 2:40 PM, Staff A, Administrator, and Staff I, Regional Health Services Director, stated that they were unaware that Resident 9's combined assessments/service plans lacked instructions and guidance for caregivers about the communication needs and interventions related to Resident 9's inability to speak and understand the English language.

Plan/Attestation Statement

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

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During an interview on 08/29/2024 at 2:40 PM, Staff A, Administrator, and Staff I, Regional Health Services Director, stated that they were unaware that Resident 9's combined assessments/service plans lacked instructions and guidance for caregivers about the communication needs and interventions related to Resident 9's inability to speak and understand the English language.

Plan/Attestation Statement

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Administrator (or Representative)

9.13.2024
Date

WAC 388-112A-0060 What are the training and certification requirements for volunteers and long-term care workers in assisted living facilities and assisted living facility administrators?

(1) The following chart provides a summary of the training and certification requirements for a volunteer, an administrator or designee, and a long-term care worker in an assisted living facility:

Who	Status	Facility orientation	Safety/ orientation training	Seventy-hour long-term care worker basic training	Specialty training	Continuing education (CE)	Required credential
Volunteer							
Administrator or designee							
Long-term care worker							

(a) Long-term care worker in assisted living facility.

(i) An APRN, RN, LPN, NA-C, HCA, NA-C student or other professionals listed in WAC 388-112A-0090 . Required per WAC 388-112A-0200 (1) . Not required. Not required. Required per WAC 388-112A-0400 . Not required of APRNs, RNs, or LPNs in chapter 388-112A WAC. Required. Twelve hours per WAC 388-112A-0611 for NA-Cs, HCAs, and other professionals listed in WAC 388-112A-0090 , such as an individual with special education training with an endorsement granted by the superintendent of public instruction under RCW 29A.380.010 . Must maintain in good standing the certification or credential or other professional role listed in WAC 388-112A-0090 .

(ii) A long-term care worker employed on January 6, 2012, or was previously employed sometime between January 1, 2011, and January 5, 2012, and has completed the basic training requirements in effect on the date of hire. WAC 388-112A-0090 . Required per WAC 388-112A-0200 (1) . Not required. Not required. Required per WAC 388-112A-0400 . Required. Twelve hours per WAC 388-112A-0611 . Not required.

(iii) Employed in an assisted living facility and does not meet the criteria in subsection (1)(a) or (b) of this section. Meets the definition of long-term care worker in WAC 388-112A-0010 . Not required. Required. Five hours per WAC 388-112A-0200 (2) and 388-112A-0220 . Required. Seventy-hours per WAC 388-112A-0300 and 388-112A-0340 . Required per WAC 388-112A-0400 . Required. Twelve hours per WAC 388-112A-0611 . Home care aide certification required per WAC 388-112A-0105 within two hundred days of the date of hire as provided in WAC 246-980-050 (unless the department of health issues a provisional certification under WAC 246-060-065).

(b) Assisted living facility administrator or administrator designee. A qualified assisted living facility administrator or administrator designee who does not meet the criteria in subsection (1)(a)(i), (ii), or (iii) of this section. Not required. Required. Five hours per WAC 388-112A-0200 (2) and 388-112A-0220 . Required. Seventy-hours per WAC 388-112A-0300 and 388-112A-0340 . Required per WAC 388-112A-0400 . Required. Twelve hours per WAC 388-112A-0611 . Home care aide certification required per WAC 388-112A-0105 .

WAC 388-79A-2474 Training and home care aide certification requirements.

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

_____ Administrator (or Representative)	_____ Date
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WAC 388-112A-0060 What are the training and certification requirements for volunteers and long-term care workers in assisted living facilities and assisted living facility administrators?

(1) The following chart provides a summary of the training and certification requirements for a volunteer, an administrator or designee, and a long-term care worker in an assisted living facility:

Who	Status	Facility orientation	Safety/ orientation training	Seventy-hour long-term care worker basic training	Specialty training	Continuing education (CE)	Required credential
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(a) Long-term care worker in assisted living facility.

(i) An ARNP, RN, LPN, NA-C, HCA, NA-C student or other professionals listed in WAC 388-112A-0090 . Required per WAC 388-112A-0200 (1). Not required. Not required. Required per WAC 388-112A-0400 . Not required of ARNPs, RNs, or LPNs in chapter 388-112A WAC. Required. Twelve hours per WAC 388-112A-0611 for NA-Cs, HCAs, and other professionals listed in WAC 388-112A-0090 , such as an individual with special education training with an endorsement granted by the superintendent of public instruction under RCW 28A.300.010 . Must maintain in good standing the certification or credential or other professional role listed in WAC 388-112A-0090 .

(ii) A long-term care worker employed on January 6, 2012, or was previously employed sometime between January 1, 2011, and January 6, 2012, and has completed the basic training requirements in effect on the date of hire. WAC 388-112A-0090 . Required per WAC 388-112A-0200 (1). Not required. Not required. Required per WAC 388-112A-0400 . Required. Twelve hours per WAC 388-112A-0611 . Not required.

(iii) Employed in an assisted living facility and does not meet the criteria in subsection (1)(a) or (b) of this section. Meets the definition of long-term care worker in WAC 388-112A-0010 . Not required. Required. Five hours per WAC 388-112A-0200 (2) and 388-112A-0220 . Required. Seventy-hours per WAC 388-112A-0300 and 388-112A-0340 . Required per WAC 388-112A-0400 . Required. Twelve hours per WAC 388-112A-0611 . Home care aide certification required per WAC 388-112A-0105 within two hundred days of the date of hire as provided in WAC 246-980-050 (unless the department of health issues a provisional certification under WAC 246-980-065).

(b) Assisted living facility administrator or administrator designee. A qualified assisted living facility administrator or administrator designee who does not meet the criteria in subsection (1)(a)(i), (ii), or (iii) of this section. Not required. Required. Five hours per WAC 388-112A-0200 (2) and 388-112A-0220 . Required. Seventy-hours per WAC 388-112A-0300 and 388-112A-0340 . Required per WAC 388-112A-0400 . Required. Twelve hours per WAC 388-112A-0611 . Home care aide certification required per WAC 388-112A-0105 .

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

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

to:

(d) Cardiopulmonary resuscitation and first aid; and

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 1 of 8 staff (Staff C) completed all required training to perform their job duties and responsibilities. This failure placed all 63 residents at risk of unmet care needs from staff with incomplete training.

Findings included...

Review of facility's personnel records showed the facility hired Staff C on 03/25/2024.

Review of Staff C's personnel records showed no documentation that Staff C completed the required cardio-pulmonary resuscitation (CPR) training with skills check and first aid training.

During an interview on 09/30/2024 at 2:35 PM, Staff A, Administrator, stated that they were unaware that Staff C did not complete all the regulatory training requirements.

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) October 25, 2024

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

Administrator (or Representative)

9.18.24
Date

WAC 388-76A-2480 Tuberculosis Testing Required.

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

This requirement was not met as evidenced by:

to:

(d) Cardiopulmonary resuscitation and first aid; and

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 1 of 6 staff (Staff C) completed all required training to perform their job duties and responsibilities. This failure placed all 63 residents at risk of unmet care needs from staff with incomplete training.

Findings included...

Review of facility's personnel records showed the facility hired Staff C on 03/25/2024.

Review of Staff C's personnel records showed no documentation that Staff C completed the required cardio-pulmonary resuscitation (CPR) training with skills check and first aid training.

During an interview on 08/30/2024 at 2:35 PM, Staff A, Administrator, stated that they were unaware that Staff C did not complete all the regulatory training requirements.

Plan/Attestation Statement

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Administrator (or Representative)

Date

WAC 388-78A-2480 Tuberculosis Testing Required.

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

This requirement was not met as evidenced by:

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

Based on interview and record review, the facility failed to ensure 2 of 8 staff (Staff A and Staff D) were screened for Tuberculosis (TB), as required. This failure placed all 63 residents at risk of exposure to Tuberculosis, an infectious disease.

Findings included...

Review of the facility's personnel records showed the facility hired Staff A, Administrator and Health Services Director, on 08/05/2024 and Staff D, Care Manager, on 02/26/2024.

Review of the facility's staff schedule showed that from 08/05/2024 through 08/30/2024, Staff A worked at the facility providing oversight of the care and services for residents. Review of Staff A's personnel records showed no documentation that Staff A completed TB screening and testing when they started service at the facility.

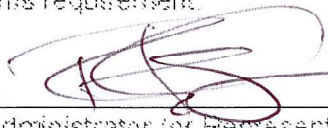
Review of the facility's staff schedule showed that from 02/26/2024 through 08/30/2024, Staff D worked at the facility providing care and services for residents. Review of Staff D's personnel records showed no documentation that Staff D completed TB screening and testing when they started service at the facility.

During an interview on 08/29/2024 at 2:25 PM, Staff A stated that they were aware that they did not complete any TB test upon hire or starting service. Staff A stated that they were not aware that Staff D was not tested for TB upon hire or starting service.

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) October 25, 2024

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



Administrator (or Representative)

9.13.24

Date

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

- (1) The care and services necessary to meet the resident's needs, including:
 - (a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

Based on interview and record review, the facility failed to ensure 2 of 6 staff (Staff A and Staff D) were screened for Tuberculosis (TB), as required. This failure placed all 63 residents at risk of exposure to Tuberculosis, an infectious disease.

Findings included...

Review of the facility's personnel records showed the facility hired Staff A, Administrator and Health Services Director, on 08/05/2024 and Staff D, Care Manager, on 02/26/2024.

Review of the facility's staff schedule showed that from 08/05/2024 through 08/30/2024, Staff A worked at the facility providing oversight of the care and services for residents. Review of Staff A's personnel records showed no documentation that Staff A completed TB screening and testing when they started service at the facility.

Review of the facility's staff schedule showed that from 02/26/2024 through 08/30/2024, Staff D worked at the facility providing care and services for residents. Review of Staff D's personnel records showed no documentation that Staff D completed TB screening and testing when they started service at the facility.

During an interview on 08/29/2024 at 2:25 PM, Staff A stated that they were aware that they did not complete any TB test upon hire or starting service. Staff A stated that they were not aware that Staff D was not tested for TB upon hire or starting service.

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)_____.

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

Administrator (or Representative)

Date

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

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

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

(ii) The resident's full assessments;

(iii) On-going assessments of the resident

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document in 4 of 8 residents' (Resident 1, Resident 4, Resident 8, and Resident 9) Negotiated Service Agreements (NSA) the care needs and interventions for diagnoses and physician ordered medical treatments. This failure placed Resident 1, Resident 4, Resident 8, and Resident 9 at risk for unmet care needs and worsening of medically diagnosed conditions.

Findings included...

Review of the facility's policy titled, "Assessment and Service Planning Meeting Process", revised 09/30/2022, showed assessments defined the resident's current functional and health needs, and the service plan defined the care services. The policy showed the assessments were completed prior to move-in and scheduled 14 days after admission, quarterly, and as needed. The policy showed that the completed service plan should be personalized for the resident and contained instructions for the staff to assist the resident according to their preferences and needs.

RESIDENT 1

Review of Resident 1's Move in Record showed that facility admitted Resident 1 on [REDACTED] 2022.

Review of the incident reports showed Resident 1 sustained falls on 06/13/2024, 07/13/2024, and 07/30/2024.

Review of Resident 1's combined assessment/service plan (NSA), dated 08/11/2024, showed Resident 1 required assistance with dressing, grooming, transfers, and bathing. Review of the service plan showed Resident 1 was identified as a risk for falls. The service plan showed no staff instructions or safety plan to reduce Resident 1's risk of recurrent falls.

Review of Resident 1's stability or fall risk assessment, dated 08/24/2024, showed Resident 1 was identified as a high risk for fall. The assessment showed that Resident 1 sustained greater than two repeated falls, every month or every quarter. The assessment showed the fall risk factors included diagnoses of [REDACTED]

and [REDACTED]

[REDACTED]. The assessment showed the use of medications for depression and anxiety contributed to Resident 1's fall risk.

- (ii) The resident's full assessments;
- (iii) On-going assessments of the resident;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document in 4 of 9 residents' (Resident 1, Resident 4, Resident 8, and Resident 9) Negotiated Service Agreements (NSA) the care needs and interventions for diagnoses and physician ordered medical treatments. This failure placed Resident 1, Resident 4, Resident 8, and Resident 9 at risk for unmet care needs and worsening of medically diagnosed conditions.

Findings included...

Review of the facility's policy titled, "Assessment and Service Planning Meeting Process", revised 09/30/2022, showed assessments defined the resident's current functional and health needs, and the service plan defined the care services. The policy showed the assessments were completed prior to move-in and scheduled 14 days after admission, quarterly, and as needed. The policy showed that the completed service plan should be personalized for the resident and contained instructions for the staff to assist the resident according to their preferences and needs.

RESIDENT 1

Review of Resident 1's Move in Record showed that facility admitted Resident 1 on [REDACTED]/2022.

Review of the incident reports showed Resident 1 sustained falls on 06/13/2024, 07/13/2024, and 07/30/2024.

Review of Resident 1's combined assessment/service plan (NSA), dated 08/11/2024, showed Resident 1 required assistance with dressing, grooming, transfers, and bathing. Review of the service plan showed Resident 1 was identified as a risk for falls. The service plan showed no staff instructions or safety plan to reduce Resident 1's risk of recurrent falls.

Review of Resident 1's stability or fall risk assessment, dated 08/24/2024, showed Resident 1 was identified as a high risk for fall. The assessment showed that Resident 1 sustained greater than two repeated falls, every month or every quarter. The assessment showed the fall risk factors included diagnoses of [REDACTED] ([REDACTED]) and [REDACTED] ([REDACTED]). The assessment showed the use of medications for depression and anxiety contributed to Resident 1's fall risk.

During an interview on 08/28/2024 at 9:11 AM, an unidentified staff stated that Resident 1 required escort to meals and activities for safety due to fall risk assessment. The unidentified staff stated that Resident 1 had periods of disorientation to time and place and balance difficulties.

RESIDENT 4

Review of Resident 4's June 2024, July 2024, August 2024 Medication Administration Records (MAR) showed that Resident 4 received five milligrams (mg) of Eliquis (medication used to prevent blood clots), twice daily, by mouth, for a diagnosis of [REDACTED] ([REDACTED]).

Review of Resident 4's NSA, dated 08/01/2024, showed no guidance for the staff about possible side effects from the use of Eliquis, such as an increased risk of bleeding or bruising. The service plan showed no instructions for staff about what actions were needed if Resident 4 experienced any side effects. There were no instructions about when to report the signs and symptoms of any side effects to the nurse.

RESIDENT 8

Review of Resident 8's June 2024, July 2024, and August 2024 Medication Administration Records (MARs) showed Resident 8 received 125 mg capsule of Divalproex DR (delayed release), three times daily, by mouth, for mood and extreme anxiety.

Review of Resident 8's NSA, dated 03/29/2024, showed no guidance for the staff about the potential side effects of the medication. The service plan showed no instructions for staff about what to document in Resident 8's medical record or when to report to the nursing staff if Resident 8 experienced any physical or behavioral side effects of the medication.

RESIDENT 9

Review of Resident 9's July 2024 and August 2024 Medication Administration Records (MAR) showed that Resident 9 received five mg of Eliquis, twice daily, by mouth, for a diagnosis of [REDACTED] ([REDACTED]).

Review of Resident 9's NSA, dated 07/16/2024, showed no guidance for the staff about possible side effects from the use of Eliquis, such as an increased risk of bleeding or bruising. The service plan showed no instructions for staff about what actions were needed if Resident 9 experienced any side effects. There were no instructions about when to report the signs and symptoms of any side effects to the nurse.

During an interview on 08/29/2024 at 2:40 PM, Staff A, Administrator, stated that they were unaware that Resident 1, Resident 4, Resident 8, and Resident 9's combined assessments/service plans lacked the staff guidance about the care needs and interventions related to the diagnoses and physician ordered medical treatments.

During an interview on 08/28/2024 at 9:11 AM, an unidentified staff stated that Resident 1 required escort to meals and activities for safety due to fall risk assessment. The unidentified staff stated that Resident 1 had periods of disorientation to time and place and balance difficulties.

RESIDENT 4

Review of Resident 4's June 2024, July 2024, August 2024 Medication Administration Records (MAR) showed that Resident 4 received five milligrams (mg) of Eliquis (medication used to prevent blood clots), twice daily, by mouth, for a diagnosis of [REDACTED] ([REDACTED]).

Review of Resident 4's NSA, dated 08/01/2024, showed no guidance for the staff about possible side effects from the use of Eliquis, such as an increased risk of bleeding or bruising. The service plan showed no instructions for staff about what actions were needed if Resident 4 experienced any side effects. There were no instructions about when to report the signs and symptoms of any side effects to the nurse.

RESIDENT 8

Review of Resident 8's June 2024, July 2024, and August 2024 Medication Administration Records (MARs) showed Resident 8 received 125 mg capsule of Divalproex DR (delayed release), three times daily, by mouth, for mood and extreme anxiety.

Review of Resident 8's NSA, dated 03/29/2024, showed no guidance for the staff about the potential side effects of the medication. The service plan showed no instructions for staff about what to document in Resident 8's medical record or when to report to the nursing staff if Resident 8 experienced any physical or behavioral side effects of the medication.

RESIDENT 9

Review of Resident 9's July 2024 and August 2024 Medication Administration Records (MAR) showed that Resident 9 received five mg of Eliquis, twice daily, by mouth, for a diagnosis of [REDACTED] ([REDACTED]).

Review of Resident 9's NSA, dated 07/16/2024, showed no guidance for the staff about possible side effects from the use of Eliquis, such as an increased risk of bleeding or bruising. The service plan showed no instructions for staff about what actions were needed if Resident 9 experienced any side effects. There were no instructions about when to report the signs and symptoms of any side effects to the nurse.

During an interview on 08/29/2024 at 2:40 PM, Staff A, Administrator, stated that they were unaware that Resident 1, Resident 4, Resident 8, and Resident 9's combined assessments/service plans lacked the staff guidance about the care needs and interventions related to the diagnoses and physician ordered medical treatments.

Plan/Attestation Statement

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

Administrator (or Representative)

9.13.24
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 observations, interviews, and record reviews, the facility failed to complete an investigation when a missing controlled medication was reported. This failure placed all 56 residents at risk of financial exploitation and potential medication errors for missed medications that were unavailable.

Findings included...

Observation on 08/26/2024 between 1:46 PM and 2:16 PM, showed seven of the buildings were identified as "cottages", each with separate names (Alder, Birch, Cedar, Dogwood, Elm, Fir, and Gingko). Each cottage used a medication cart, and each cottage used its own narcotic book kept in the cart with the narcotic or controlled medications. Each narcotic lock box contained residents' narcotic medication cards. Observation showed that each medication card was numbered to match the pages of the narcotic book. The narcotic book included a shift audit record with staff signatures that verified the correct count of the narcotic medications.

Review of the Gingko Cottage August 2024 narcotic shift audit record showed that the medication card labeled page 55, matched to page 55 of the narcotic book, was first reported "missing" on 08/18/2024. Review of the record showed the lost medication card contained Lorazepam (a narcotic drug used to treat anxiety).

Plan/Attestation Statement

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This requirement was not met as evidenced by:

Based on observation, interviews, and record reviews, the facility failed to complete an investigation when a missing controlled medication was reported. This failure placed all 56 residents at risk of financial exploitation and potential medication errors for missed medications that were unavailable.

Findings included...

Observation on 08/28/2024 between 1:46 PM and 2:16 PM, showed seven of the buildings were identified as "cottages", each with separate name (Alder, Birch, Cedar, Dogwood, Elm, Fir, and Ginkgo). Each cottage used a medication cart, and each cottage used its own narcotic book kept in the cart with the narcotic or controlled medications. Each narcotic lock box contained residents' narcotic medication cards. Observation showed that each medication card was numbered to match the pages of the narcotic book. The narcotic book included a shift audit record with staff signatures that verified the correct count of the narcotic medications.

Review of the Ginkgo Cottage August 2024 narcotic shift audit record showed that the medication card labeled page 55, matched to page 55 of the narcotic book, was first reported "missing" on 08/18/2024. Review of the record showed the lost medication card contained Lorazepam (a narcotic drug used to treat anxiety).

Review of the facility's policy titled, "Event/Incident Investigation Guidelines (NV/WA only)", revised 05/23/2019, showed the facility staff followed two phases of investigation. The initial investigation was done within the first 24 hours of the reported incident. And if required, the facility staff extended the investigation after the first 24 hours. The policy showed that if a thorough investigation established a reasonable cause for the incident, an immediate intervention was initiated, and documented measures were implemented to prevent repeat incidents.

Review of the facility's policy titled, "Controlled/Scheduled Medication Protocol (All State)", dated 10/23/2019, showed the facility staff kept an accurate inventory and record of use for handling and accountability of medications with a potential for abuse. The policy showed two Medication Care Manager (MCM) counted the controlled medications at the beginning and end of each shift. The incoming MCM performed the actual count of the narcotic drugs and the outgoing MCM verified the count matched from the documented record on the medication cards. If there was a discrepancy in the count of medications, the policy showed the Health Services Director, and the General Manager were notified immediately. The policy showed the incident required an immediate investigation and notification to the Licensing Agency and responsible party based on investigation outcome.

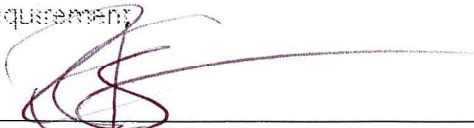
During an interview on 08/29/2024 at 10:58 AM, Staff G, Associate Director, stated that the MCM notified them on 08/11/2024 about the incorrect count and missing controlled medications. Staff G stated that the investigation was initiated. Staff G stated the investigation was incomplete and needed additional staff interviews. Staff G stated that they did not follow through with the process. Staff G stated that they did not consider notification to the responsible party was needed. Staff G stated that the investigation showed no documented safety plan to prevent similar future incidents.

During an interview on 08/28/2024 at 1:46 PM, Staff A, Health Services Director, stated that they were unaware of the incident. Staff A stated that they did not receive any report of the missing narcotic medication.

Plan/Attestation Statement

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During an interview on 08/29/2024 at 10:56 AM, Staff G, Associate Director, stated that the MCM notified them on 08/11/2024 about the incorrect count and missing controlled medications. Staff G stated that the investigation was initiated. Staff G stated the investigation was incomplete and needed additional staff interviews. Staff G stated that they did not follow through with the process. Staff G stated that they did not consider notification to the responsible party was needed. Staff G stated that the investigation showed no documented safety plan to prevent similar future incidents.

During an interview on 08/29/2024 at 1:46 PM, Staff A, Health Services Director, stated that they were unaware of the incident. Staff A stated that they did not receive any report of the missing narcotic medication.

Plan/Attestation Statement

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Administrator (or Representative)

Date



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

09/10/2024

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 09/10/2024 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

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



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

09/10/2024

Aegis Senior Communities LLC
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 - 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

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

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):

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

WAC 388-78A-3010 Resident units. The assisted living facility resident units must have the following:

(8) Miscellaneous: Each sleeping room must have:

(a) A lockable drawer, cupboard or other secure space measuring a least one-half cubic foot with a minimum dimension of four inches,

The facility failed to provide lockable drawers or cabinets for sampled unoccupied resident apartments. During the inspection, facility staff ordered locks for installation in the unoccupied sampled resident apartment drawers and cabinets. Facility staff installed locks on the unoccupied sampled resident apartment drawers and cabinets to meet regulatory requirements.

You Are 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

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):

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

WAC 388-78A-3010 Resident units. The assisted living facility resident units must have the following:

(8) Miscellaneous: Each sleeping room must have:

(e) A lockable drawer, cupboard or other secure space measuring a least one-half cubic foot with a minimum dimension of four inches;

The facility failed to provide lockable drawers or cabinets for sampled unoccupied resident apartments. During the inspection, facility staff ordered locks for installation in the unoccupied sampled resident apartment drawers and cabinets. Facility staff installed locks on the unoccupied sampled resident apartment drawers and cabinets to meet regulatory requirements.

You Are 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.

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In Addition, You May:

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 - 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

AEGIS OF ISSAQUAH # 1997

09/10/2024

Page 3 of 3

If You Have Any Questions:

- Please contact me at (253)234-6026.

Sincerely,

Laurie Anderson

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

Enclosure

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

AEGIS OF ISSAQUAH # 1997

09/10/2024

Page 3 of 3

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

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