STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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) 76832 (Completion Date 05/05/2026) and 73527 (Completion Date 03/18/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/05/2026 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2474-2-e, WAC 388-112A-0611-1-a-i, WAC 388-112A-0611-1-a-ii, WAC 388-112A-0611-1-a-iii, WAC 388-112A-0611-2, WAC 388-78A-2466-1-a, WAC 388-78A-2466-1-b, WAC 388-78A-2466-1, WAC 388-78A-2210-1-a, WAC 388-78A-2350-1, WAC 388-78A-2350-7-a, WAC 388-78A-2350-7-b, WAC 388-78A-2350-7

The Department staff who did the on-site verification:
Claudia Allis, ALF Licensor
Steven Garrett, LTC Licensor

If you have any questions, please contact me at (206)305-3489.

Sincerely,

Jim Sherman

James Sherman, Field Manager
Region 2, Unit D
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

HOME AND COMMUNITY LIVING ADMINISTRATION

20425 72nd Avenue S, Suite 400, Kent, WA 98032

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 03/04/2026 and 03/09/2026 of:
AEGIS OF ISSAQUAH
780 NW JUNIPER STREET
ISSAQUAH, WA 98027

The following sample was selected for review during the unannounced on-site visit: 7 of 44 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Claudia Allis, ALF Licensor
Steven Garrett, LTC Licensor

From:
DSHS, Home and Community Living 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.

Jim Sherman
Residential Care Services

03-23-2026
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative)

04/01/2026
Date

WAC 388-112A-0611 Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?

(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described below.

(a) The following long-term care workers must complete 12 hours of continuing education by their birthday each year:

(i) A certified home care aide;

(ii) A long-term care worker who is exempt from the 70-hour home care aide basic training under WAC 388-112A-0090 (1) and (2);

(iii) A certified nursing assistant;

(2) A long-term care worker who does not complete continuing education as required under this chapter must not provide care until the required continuing education is completed.

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:

(e) Continuing education.

This requirement was not met as evidenced by:

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

Findings included...

Review of facility's undated personnel records showed the facility hired Staff F, Care Staff/CAN (certified nursing assistant), on 07/21/2020.

Continuing Education
Review of Staff F's undated personnel records showed Staff F provided direct care to residents from 07/21/2020 through 03/05/2026.

Review of Staff F's undated personnel records showed Staff F provided direct care to residents from 07/21/2020 through 05/15/2025. There was no documentation in Staff F's records that showed Staff F completed the required 12 hours of continuing education between their date of birth, 05/21/2024 and 05/21/2025.

During an interview on 03/09/2026 at 2:25 PM, Staff A, Executive Director, stated that they were unaware Staff F had not completed the required 12 hours of continuing education 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) 05/02/2026

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

Administrator (or Representative) — Date: 04/01/2026

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to complete a Washington State Name and Date of Birth Background check for 2 of 6 staff (Staff E and Staff F). These failures placed 44 residents at risk of potential abuse or neglect by a caregiver with an unknown background.

Findings included....

Review of facility's undated personnel records showed the facility hired Staff E, Care Manager, on 12/20/2021 and Staff F, Care Manager, on 07/21/2020.

Review of Staff E's records showed documentation that Staff E completed a Washington State Name and Date of Birth background check on 01/03/2022. The Name and Date of Birth Background check dated 01/03/2022 expired on 01/03/2024. Review of Staff E's records showed no documentation that Staff E completed a Washington State Name and Date of Birth background check in January 2024. Review of Staff E's records showed documentation that Staff E completed a Washington State Name and Date of Birth background check on 01/06/2025. The records showed Staff E provided direct care for residents between 01/03/2022 and 01/06/2025 for 1100 days without a valid Washington State Name and Date of Birth background check.

Review of Staff F's records showed documentation that Staff F completed a Washington State Name and Date of Birth background check on 07/21/2020. Review of Staff F's records showed documentation that Staff F completed a Washington State Name and Date of Birth background check on 08/24/2023. The records showed Staff F provided direct care for residents between 07/21/2022 and 08/24/2023 for 400 days without a valid Washington State Name and Date of Birth background check. Review of Staff F's records showed documentation that Staff F completed a Washington State Name and Date of Birth background check on 07/11/2025

During an interview on 03/05/2026 at 2:55 PM, Staff A, Executive Director, stated that the facility was aware that staff needed Washington State Name and Date of Birth background checks upon hire and then every 2 years.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 04/01/2026

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 7 residents (Resident 3) received medications with complete dosing directions. This failure placed Resident 3 at risk for compromised health due to incomplete medication dosing.

Findings included...

Note: RCW 69.41.050(1) Labeling requirements -- Penalty. (1) To every box, bottle, jar, tube, or other container of a legend drug, which is dispensed by a practitioner authorized to prescribe legend drugs, there shall be affixed a label bearing the name of the prescriber, complete directions for use, the name of the drug either by the brand or generic name and strength per unit dose, name of the patient and date: PROVIDED, That the practitioner may omit the name and dosage of the drug if he or she determines that his or her patient should not have this information and that, if the drug dispensed is a trial sample in its original package and which is labeled in accordance with federal law or regulation, there need be set forth additionally only the name of the issuing practitioner and the name of the patient.

Review of the facility's policy titled, "Documentation Standards for Medication Policy (WA only)", dated 04/12/2021, showed that all new medication orders are properly written per regulations before submitting to the pharmacy. The policy showed that dosage should be very clear to anyone preparing the medication.

RESIDENT 3
Review of Resident 3's information document showed the facility admitted Resident 3 on [redacted]/2026. The records showed Resident 3 admitted with a diagnosis of [redacted] The records showed facility staff maintained all of Resident 3's medications and provided Resident 3 with medication assistance care services.

Review of Resident 3's physician orders, dated 02/10/2026, showed Diclofenac Sodium External Gel 1% (topical pain medication) to be applied topically to left shoulder four times a day. The orders showed no indication as to the number of grams (gm) of Diclofenac Sodium Gel 1% to apply to Resident 3's left shoulder.

Observation on 03/09/2026 at 11:57 AM, showed Staff I, Caregiver/Lead Medication Care Manager, dispense medications for Resident 3. Observation showed Staff I reviewed the electronic medication administration record (eMAR), which showed an order for Diclofenac Sodium Gel 1% to be applied topically to the left shoulder, four times a day. Observation showed Staff I squeezed an unknown amount of Diclofenac Sodium Gel 1% onto their fingers and applied the gel to Resident 3's left shoulder. During an interview at the time, Staff I stated that they were aware of the dosing of Diclofenac Sodium Gel 1% in gm's of applied gel through the use of a measurement device. Staff I stated that they were unaware of the amount of Diclofenac Sodium Gel 1% to apply to Resident 3's left shoulder. Observation showed Staff I did not use the measurement device with the Diclofenac Sodium Gel 1% to measure the amount of gel applied to Resident 3's left shoulder.

During an interview on 03/09/2026 at 11:55 AM, Staff J, Care Director, stated that all new medication orders are reviewed by facility nurses before being sent to the facilities contracted pharmacy for dispensing. Staff J stated that the nurses clarify any new medication orders prior to sending them to the pharmacy for processing.

During an interview on 03/09/2026 at 1:10 PM, Staff H, Regional Health Services Director, stated that they were aware of the dosing parameters for Diclofenac Sodium Gel 1% and the measuring of the gm's of gel to be applied topically. Staff H stated they were unaware that Resident 3's order for Diclofenac Sodium Gel 1% did not indicate the amount of gm's of gel to be applied.

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) — Date: 04/01/2026

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.

(7) When coordinating care or services, the assisted living facility must:

(a) Integrate relevant information from the external provider into the resident's preadmission assessment and reassessment, and when appropriate, negotiated service agreement; and

(b) Respond appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to organize and manage care and services or obtain clarification with 1 of 7 residents' (Resident 2) healthcare provider orders. This failure placed Resident 2 at risk for potential health complications and diminished care and services for medical diagnoses related to changes in conditions.

Findings included...

Review of Resident 2's information document showed the facility admitted Resident 2 on [redacted]/2024. The records showed Resident 2 admitted with a diagnosis of [redacted] and [redacted].

Review of Resident 2's oxygen therapy order, dated 06/05/2024, showed oxygen flow rate to target peripheral capillary oxygen saturation (SpO2) (measurement of the percentage of oxygen saturated hemoglobin in the blood compared to total hemoglobin,

typically 95%-100% range, indicating efficient oxygen delivery throughout the body) to be greater than 92%.

Review of Resident 2's physician's orders, dated 04/17/2025, showed treatment orders for oxygen 2 liters per minute continuously and monitoring of SpO2. The orders showed no documentation for facility staff to provide monitoring of SpO2 to meet target parameters, actions to take regarding flow rate adjustments for given SpO2 readings and reporting of SpO2 readings to the physician.

Review of Resident 2's Individualized Service Plan (ISP) (equivalent to the negotiated service agreement) showed Resident 2 received assistance from staff for supplemental oxygen therapy. The ISP showed staff assisted with storage of oxygen equipment and supplies, changing tubing, placing of nasal cannula (small, flexible tube inserted into the nose to deliver supplemental oxygen), and setting flow rate for the oxygen concentrator (device used to filter surrounding air to deliver 90%-95% pure oxygen for patients with breathing conditions, using a nasal cannula).

Review of Resident 2's December 2025, January 2026, February 2026, and March 2026 Medication Administration Record (MAR) showed documentation of Resident 2's SpO2 daily monitoring readings. The MAR records showed 30 daily SpO2 readings below 92%, between December 1, 2025 and March 4, 2026. The records showed no documentation of actions facility staff took for SpO2 readings below 92%. The records showed no documentation facility staff communicated with Resident 2's physician when Resident 2's SpO2 readings fell below 92%.

Observation on 03/06/2026 at 11:30 AM, showed Resident 2 in their apartment, laying in bed with their nasal cannula inserted in their nostrils and receiving supplemental oxygen from their oxygen concentrator device. In an interview at the time, Resident 2 stated that facility staff assist with their oxygen therapy, tubing and oxygen concentrator settings.

During an interview on 03/09/2026 at 1:10 PM, Staff H, Regional Health Services Director, stated they were aware Resident 2 was receiving oxygen therapy assistance from facility staff. Staff H stated they were unaware that Resident 2's oxygen therapy services did not have parameters for SpO2 monitoring, actions for staff to take when SpO2 readings fell below parameters, and reporting of SpO2 readings to Resident 2's physician.

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) 05/02/2026

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

Administrator (or Representative) — Date: 04/01/2026

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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 # 1997

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 03/18/2026 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 Return the Plan/Attestation Statement and report with signatures to:

James Sherman, Field Manager
Residential Care Services
Region 2, Unit D
Preferred methods:

eFax: (253) 395-5071
Email: rcsregion2email@dshs.wa.gov
Optional method:
20425 72nd Avenue S, Suite 400
Kent, WA 98032

• Complete correction(s) within 45 calendar days of Last Date of Data Collection (03/18/2026), no later than 05/02/2026 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-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

The hot water temperatures in three-bathroom sinks (two common bathrooms in main building, and one common bathroom in the Dogwood cottage), used by residents and visitors, were not within the required 105 F and 120 F requirements. During the inspection, facility staff adjusted the temperatures and brought the faucet water temperatures within the range of required regulatory guidelines. This deficiency was corrected by the exit conference.

WAC 388-78A-3030 Toilet rooms and bathrooms.

(2) The assisted living facility must provide each toilet room and bathroom with:

(e) Provide mechanical ventilation to the outside; and

There was one common bathroom (Dogwood cottage bathroom next to the medication cart) that had an inoperable fan to ventilate to the outside. During the inspection, facility staff repaired the fan to make it operational and ventilate to the outside. This deficiency was corrected by the exit conference.

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 You can make an IDR request and find directions on the IDR web page at: https://www.dshs.wa.gov/altsa/idr

If You Have Any Questions:
• Please contact me at (206)305-3489.

Sincerely,

Jim Sherman

James Sherman, Field Manager
Region 2, Unit D
Residential Care Services

Enclosure