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

Aegis Senior Communities LLC
AEGIS OF MADISON

,

RE: AEGIS OF MADISON License # 2241

Dear Administrator:

This letter addresses Compliance Determination(s) 80335 (Completion Date 07/13/2026) and 76131 (Completion Date 05/15/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/13/2026 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-2210-1-b, WAC 388-78A-2210-2-a, WAC 388-78A-2210-2-b, WAC 388-78A-2210-2, WAC 388-78A-2230-1-c-i, WAC 388-78A-2230-1-c-ii, WAC 388-78A-2230-1-c, WAC 388-78A-2230-2-a, WAC 388-78A-2230-2-b, WAC 388-78A-2230-2-c, WAC 388-78A-2230-2, WAC 388-78A-2600-1-b

The Department staff who did the on-site verification:
Alma Duran, Licensor
Keiko Kitano, Licensor

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

Sincerely,

Jamie Singer

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

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

Statement of Deficiencies	License #: 2241	Compliance Determination # 76131
Plan of Correction	AEGIS OF MADISON	Completion Date
Page 1 of 21	Licensee: Aegis Senior Communities LLC	05/15/2026

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

The department completed data collection for the unannounced on-site full inspection on 04/20/2026 and 04/23/2026 of:
AEGIS OF MADISON
2200 E Madison St
Seattle, WA 98112

The following sample was selected for review during the unannounced on-site visit: 10 of 81 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Alma Duran, Licensor
Keiko Kitano, Licensor

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

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Statement of Deficiencies	License #: 2241	Compliance Determination # 76131
Plan of Correction	AEGIS OF MADISON	Completion Date
Page 2 of 21	Licensee: Aegis Senior Communities LLC	05/15/2026

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Jamie Singer
Residential Care Services

05/27/2026
Date

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

Administrator (or Representative)

6/12/26
Date

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.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement systems to promote safe medication services for 4 of 4 sampled residents (Residents 3, 4, 7, and 9) who required staff management or administration with medications. This failure resulted in Residents 3, 4, 7, and 9 not receiving their medications as prescribed and placed them at risk for compromised health conditions.

Findings included...

NOTE: According to the 2026 American Diabetes Association (ADA) website, showed diabetes is a disorder in which the body has high sugar (BS) levels for prolonged periods of time. The disease may be controlled with oral medications, injectable medications

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such as insulin (used to lower BS), and by diet modification. According to the ADA Standard of Care provide evidence-based targets and management strategies for both hyperglycemia or high BS (>250 mg/dL ((milligrams per deciliter)), and hypoglycemia, or low BS (below 70 mg/dL), when the body has too little insulin or cannot use insulin properly.

Review of the ALF's policy titled Documentation Standards for Medication, revised 04/12/2021, under the section of Documentation, showed that a Medication Care Manager (MCM) would:
1. Check the eMAR to identify the five rights:
a. Right resident (by looking at the resident's photo in the eMAR)
b. Right medication
c. Right dose
d. Right route
e. Right time
3. Check the five rights once more:
a. Before they put the medication into the med cup
b. When they are putting the med package back into its storage space.

Review of the ALF's policy of "Documentation Standards for Medication", revised 04/12/2021, under the section of New Orders and Medication Order Changes, showed that if it was determined the new medication was appropriate to use, a medication change label was placed on the bottle/package.

Review of the ALF's Documentation Standards for Medication Policy, revised 04/12/2021, under Omitted Medication, showed, that if the medication is omitted for any reason, i.e., refused, or resident is "Out - Of- The - Building" or on vacation or omitted for any other reason, staff would notify physician, nurse and family of the omission.

In an interview, on 04/20/2026 at 9:30 AM, Staff A (Administrator/Director of Operation) stated that Medication Care Managers (MCMs) had been responsible for assisting residents with medications, and Wellness Nurses (WN) had been responsible for any resident's blood sugar (BS) checks and giving insulin injections.

RESIDENT 3
Record review showed the ALF admitted Resident 3 on [redacted]/2024 with multiple diagnoses including [redacted]. Review of an Individual Service Plan (ISP – equivalent to Negotiated Service Agreement), dated 07/16/2025, showed Resident 3 required WN to assist with diabetic medication management.

Review of 2026 electronic Medication Administration Records (eMARs), showed Resident 3 used a Freestyle Libre 3 Plus sensor (a device for continuously monitoring BS, instead of monitoring periodically by drawing a drop of blood from a finger), applied to the back of the upper arm and changed every 14 days.

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Review of the February, March, and April 2026 eMARs, showed boxes to document the time, amount, BS level, if glucose was given, and the injection site.

Record review of the eMARs showed Resident 3 was prescribed a standard non-sliding scale Insulin Lispro (a rapid-acting insulin analog used to treat diabetes) 100 milligram/milliliter Kwikpen to inject 10 units subcutaneously every morning (8:00 AM) before breakfast. The Insulin Lispro order had directions that if Resident 3's BS was less than (<) 151 do not give the correction insulin.

Review of the February 2026 eMAR, showed the WNs documented administering 10 units of Insulin Lispro at 8:00 AM, when Resident 3's BS was <151 and the Insulin Lispro should have been held per the physician's order:

- On 02/03/2026, BS was 114.
- On 02/07/2026, BS was 148.
- On 02/23/2026, BS was 136.
- On 02/25/2026, BS was 142.
- On 02/28/2026, BS was 124.

Review of the March 2026 eMAR, showed the WNs documented administering 10 units of Insulin Lispro at 8:00 AM, when Resident 3's BS was <151 and the Insulin Lispro should have been held per the physician's order:

- On 03/01/2026, BS was 111.
- On 03/02/2026, BS was 150.
- On 03/03/2026, BS was 139.
- On 03/12/2026, BS was 115.
- On 03/16/2026, BS was 145.
- On 03/18/2026, BS was 120.
- On 03/20/2026, BS was 150.
- On 03/26/2026, BS was 120.
- On 03/31/2026, BS was 100.

Review of the 04/01/2026 through 04/20/2026 eMAR, showed the WNs documented administering 10 units of Insulin Lispro at 8:00 AM, when Resident 3's BS was <151 and the Insulin Lispro should have been held per the physician's order:

- On 04/01/2026, BS was 141.
- On 04/03/2026, BS was 142.
- On 04/04/2026, BS was 148.
- On 04/07/2026, BS was 115.
- On 04/12/2026, BS was 111.
- On 04/13/2026, BS was 120.
- On 04/15/2026, BS was 117.

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- On 04/16/2026, BS was 150.
- On 04/19/2026, BS was 134.
- On 04/20/2026, BS was 102.

Record review of the eMARs, showed Resident 3 was prescribed a standard non-sliding scale Insulin Lispro 100 milligram/milliliter Kwikpen to inject 6 units subcutaneously at 12:00 PM and at 5:00 PM. The Insulin Lispro order had directions that if Resident 3's BS was less than (<) 151 do not give the correction insulin.

Review of the February 2026 eMAR, showed the WNs documented administering 6 units Insulin Lispro at 12:00 PM, when Resident 3's BS was <151 and the Insulin Lispro should have been held per the physician's order:

- On 02/01/2026, BS was 122.
- On 02/04/2026, BS was 124.
- On 02/05/2026, BS was 119.
- On 02/08/2026, BS was 145.
- On 02/10/2026, BS was 146.
- On 02/17/2026, BS was 108.
- On 02/25/2026, BS was 129.
- On 02/27/2026, BS was 98.
- On 02/28/2026, BS was 128.

Review of the March 2026 eMAR, showed the WNs documented administering 6 units of Insulin Lispro at 12:00 PM, when Resident 3's BS was <151 and the Insulin Lispro should have been held per the physician's order:

- On 03/01/2026, BS was 84.
- On 03/02/2026, BS was 96.
- On 03/12/2026, BS was 105.
- On 03/14/2026, BS was 120.
- On 03/17/2026, BS was 102.
- On 03/18/2026, BS was 112.
- On 03/19/2026, BS was 118.
- On 03/20/2026, BS was 106.
- On 03/24/2026, BS was 128.
- On 03/25/2026, BS was 133.
- On 03/28/2026, BS was 98.
- On 03/30/2026, BS was 130.
- On 03/31/2026, BS was 118.

Review of the April 2026 eMAR, showed the WNs documented administering 6 units of Insulin Lispro at 12:00 PM, when Resident 3's BS was <151 and the Insulin Lispro should have been held per the physician's order:

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- On 04/03/2026, BS was 104.
- On 04/04/2026, BS was 146.
- On 04/07/2026, BS was 145.
- On 04/08/2026, BS was 99.
- On 04/11/2026, BS was 149.
- On 04/12/2026, BS was 139.
- On 04/13/2026, BS was 109.
- On 04/15/2026, BS was 83.
- On 04/16/2026, BS was 108.
- On 04/17/2026, BS was 126.
- On 04/18/2026, BS was 97.

Review of the February 2026 eMAR, showed the WNs documented administering 6 units Insulin Lispro at 5:00 PM, when Resident 3's BS was <151 and the Insulin Lispro should have been held per the physician's order:

- On 02/01/2026, BS was 138.
- On 02/02/2026, BS was 142.
- On 02/27/2026, BS was 112.
- On 02/28/2026, BS was 147.

Review of the March 2026 eMAR, showed the WNs documented administering 6 units of Insulin Lispro at 5:00 PM, when Resident 3's BS was <151 and the Insulin Lispro should have been held per the physician's order:

- On 03/10/2026, BS was 126.
- On 03/11/2026, BS was 132.
- On 03/20/2026, BS was 134.
- On 03/22/2026, BS was 104.
- On 03/26/2026, BS was 146.
- On 03/27/2026, BS was 130.
- On 03/31/2026, BS was 129.

Review of the April 2026 eMAR, showed the WNs documented administering 6 units of Insulin Lispro at 5:00 PM, when Resident 3's BS was <151 and the Insulin Lispro should have been held per the physician's order:

- On 04/02/2026, BS was 138.
- On 04/03/2026, BS was 105.
- On 04/10/2026, BS was 106.
- On 04/11/2026, BS was 129.
- On 04/13/2026, BS was 106.
- On 04/14/2026, BS was 148.
- On 04/16/2026, BS was 124.
- On 04/18/2026, BS was 137.

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Record review of the eMARs showed Resident 3 was prescribed a separate sliding scale (in addition to the standard order) Insulin Lispro 100 milligram/milliliter Kwikpen inject subcutaneously three times daily before meals according to BS parameters. If BS 151 -199 - give 2 units, if BS 200-249 - give 3 units, if BS 250-299 - give 5 units, if BS 300-349 - give 7 units, and if BS greater than (>) 350 – give 8 units. The sliding scale Insulin Lispro order had directions that if Resident 3's BS was less than (<) 151 do not give the correction insulin.

Review of the February, March and April 2026 eMARs, showed WNs administered the incorrect dose of sliding scale Insulin Lispro per the physician's order based on Resident 3's BS.

- On 02/01/2026 at 8:00 AM, BS was 180 requiring 2 units per order and WN documented administering 14 units.
- On 02/02/2026 at 8:00 AM, BS was 195 requiring 2 units per order and WN documented administering 4 units.
- On 02/02/2026 at 12:00 PM, BS was 192 requiring 2 units per order and WN documented administering 4 units.
- On 02/03/2026 at 12:00 PM, BS was 209 requiring 3 units per order and WN documented administering 12 units.
- On 02/03/2026 at 5:00 PM, BS was 172 requiring 2 units per order and WN documented administering 10 units.
- On 02/04/2026 at 8:00 AM, BS was 159 requiring 2 units per order and WN documented administering 4 units.
- On 02/05/2026 at 8:00 AM, BS was 169 requiring 2 units per order and WN documented administering 14 units.
- On 02/05/2026 at 5:00 AM, BS was 214 requiring 3 units per order and WN documented administering 6 units.
- On 02/06/2026 at 8:00 AM, BS was 269 requiring 5 units per order and WN documented administering 10 units.
- On 02/06/2026 at 12:00 PM, BS was 169 requiring 2 units per order and WN documented administering 4 units.
- On 02/06/2026 at 5:00 PM, BS was 164 requiring 2 units per order and WN documented administering 4 units.
- On 02/07/2026 at 12:00 PM, BS was 151 requiring 2 units per order and WN documented administering 4 units.
- On 02/07/2026 at 5:00 PM, BS was 186 requiring 2 units per order and WN documented administering 4 units.
- On 02/08/2026 at 5:00 PM, BS was 184 requiring 2 units per order and WN documented administering 4 units.
- On 02/09/2026 at 8:00 AM, BS was 162 requiring 2 units per order and WN documented administering 4 units
- On 02/09/2026 at 12:00 PM, BS was 194 requiring 2 units per order and WN documented administering 4 units.
- On 02/09/2026 at 5:00 PM, BS was 225 requiring 3 units per order and WN documented administering 6 units.
- On 02/10/2026 at 8:00 AM, BS was 204 requiring 3 units per order and WN documented administering 6 units.
- On 02/10/2026 at 5:00 PM, BS was 283 requiring 5 units per order and WN

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documented administering 10 units.
- On 02/11/2026 at 8:00 AM, BS was 193 requiring 2 units per order and WN documented administering 4 units.
- On 02/11/2026 at 12:00 PM, BS was 202 requiring 3 units per order and WN documented administering 6 units.
- On 02/11/2026 at 5:00 PM, BS was 217 requiring 3 units per order and WN documented administering 6 units.
- On 02/12/2026 at 8:00 AM, BS was 169 requiring 2 units per order and WN documented administering 4 units.
- On 02/12/2026 at 12:00 PM, BS was 168 requiring 2 units per order and WN documented administering 4 units.
- On 02/12/2026 at 5:00 PM, BS was 282 requiring 5 units per order and WN documented administering 10 units.
- On 02/13/2026 at 8:00 AM, BS was 269 requiring 5 units per order and WN documented administering 10 units.
- On 02/13/2026 at 12:00 PM, BS was 213 requiring 3 units per order and WN documented administering 6 units.
- On 02/13/2026 at 5:00 PM, BS was 164 requiring 2 units per order and WN documented administering 4 units.
- On 02/14/2026 at 8:00 AM, BS was 252 requiring 5 units per order and WN documented administering 10 units.
- On 02/14/2026 at 12:00 PM, BS was 244 requiring 3 units per order and WN documented administering 6 units.
- On 02/14/2026 at 5:00 PM, BS was 168 requiring 2 units per order and WN documented administering 4 units.
- On 02/15/2026 at 8:00 AM, BS was 241 requiring 3 units per order and WN documented administering 6 units.
- On 02/15/2026 at 12:00 PM, BS was 221 requiring 3 units per order and WN documented administering 6 units.
- On 02/15/2026 at 5:00 PM, BS was 267 requiring 5 units per order and WN documented administering 10 units.
- On 02/16/2026 at 8:00 AM, BS was 213 requiring 3 units per order and WN documented administering 6 units.
- On 02/16/2026 at 12:00 PM, BS was 198 requiring 2 units per order and WN documented administering 4 units.
- On 02/16/2026 at 5:00 PM, BS was 243 requiring 5 units per order and WN documented administering 16 units.
- On 02/17/2026 at 8:00 AM, BS was 208 requiring 3 units per order and WN documented administering 6 units.
- On 02/17/2026 at 5:00 PM, BS was 282 requiring 5 units per order and WN documented administering 10 units.
- On 02/18/2026 at 8:00 AM, BS was 330 requiring 7 units per order and WN documented administering 14 units.
- On 02/18/2026 at 12:00 PM, BS was 229 requiring 3 units per order and WN documented administering 6 units.
- On 02/18/2026 at 5:00 PM, BS was 226 requiring 3 units per order and WN documented administering 6 units.
- On 02/19/2026 at 8:00 AM, BS was 209 requiring 3 units per order and WN documented administering 6 units.
- On 02/19/2026 at 12:00 PM, BS was 171 requiring 2 units per order and WN documented administering 4 units.
- On 02/19/2026 at 5:00 PM, BS was 239 requiring 3 units per order and WN

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documented administering 6 units.
- On 02/20/2026 at 8:00 AM, BS was 332 requiring 7 units per order and WN documented administering 14 units.
- On 02/20/2026 at 12:00 PM, BS was 291 requiring 5 units per order and WN documented administering 10 units
- On 02/20/2026 at 5:00 PM, BS was 161 requiring 2 units per order and WN documented administering 4 units.
- On 02/21/2026 at 8:00 AM, BS was 304 requiring 7 units per order and WN documented administering 14 units.
- On 02/21/2026 at 12:00 PM, BS was 223 requiring 3 units per order and WN documented administering 6 units
- On 02/21/2026 at 5:00 PM, BS was 251 requiring 5 units per order and WN documented administering 10 units.
- On 02/22/2026 at 8:00 AM, BS was 248 requiring 3 units per order and WN documented administering 6 units.
- On 02/22/2026 at 12:00 PM, BS was 178 requiring 2 units per order and WN documented administering 4 units
- On 02/22/2026 at 5:00 PM, BS was 251 requiring 5 units per order and WN documented administering 10 units.
- On 02/23/2026 at 12:00 PM, BS was 171 requiring 2 units per order and WN documented administering 4 units
- On 02/23/2026 at 5:00 PM, BS was 281 requiring 5 units per order and WN documented administering 10 units.
- On 02/24/2026 at 8:00 AM, BS was 236 requiring 3 units per order and WN documented administering 6 units.
- On 02/24/2026 at 12:00 PM, BS was 238 requiring 3 units per order and WN documented administering 6 units
- On 02/24/2026 at 5:00 PM, BS was 292requiring 5 units per order and WN documented administering 10 units.
- On 02/25/2026 at 5:00 PM, BS was 220 requiring 3 units per order and WN documented administering 6 units.
- On 02/26/2026 at 8:00 AM, BS was 244 requiring 3 units per order and WN documented administering 6 units.
- On 02/26/2026 at 12:00 PM, BS was 170 requiring 2 units per order and WN documented administering 4 units
- On 02/26/2026 at 5:00 PM, BS was 181 requiring 2 units per order and WN documented administering 4 units.
- On 02/28/2026 at 8:00 AM, BS was 164 requiring 2 units per order and WN documented administering 4 units.
- On 03/01/2026 at 5:00 PM, BS was 212 requiring 3 units per order and WN documented administering 6 units.
- On 03/02/2026 at 5:00 AM, BS was 172 requiring 2 units per order and WN documented administering 4 units.
- On 03/03/2026 at 12:00 PM, BS was 164 requiring 2 units per order and WN documented administering 4 units
- On 03/03/2026 at 5:00 PM, BS was 166 requiring 2 units per order and WN documented administering 4 units.
- On 03/04/2026 at 8:00 AM, BS was 284 requiring 5 units per order and WN documented administering 10 units.
- On 03/04/2026 at 12:00 PM, BS was 305 requiring 7 units per order and WN documented administering 14 units.
- On 03/10/2026 at 8:00 AM, BS was 316 requiring 7 units per order and WN

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documented administering 14 units.
- On 03/10/2026 at 12:00 PM, BS was 243 requiring 3 units per order and WN documented administering 6 units.
- On 03/11/2026 at 8:00 AM, BS was 292 requiring 5 units per order and WN documented administering 10 units.
- On 03/11/2026 at 12:00 PM, BS was 171 requiring 2 units per order and WN documented administering 4 units.
- On 03/13/2026 at 8:00 AM, BS was 234 requiring 3 units per order and WN documented administering 6 units.
- On 03/13/2026 at 12:00 PM, BS was 151 requiring 2 units per order and WN documented administering 4 units
- On 03/13/2026 at 5:00 PM, BS was 271 requiring 5 units per order and WN documented administering 10 units.
- On 03/14/2026 at 8:00 AM, BS was 228 requiring 3 units per order and WN documented administering 6 units.
- On 03/15/2026 at 8:00 AM, BS was 167 requiring 2 units per order and WN documented administering 4 units.
- On 03/15/2026 at 12:00 PM, BS was 197 requiring 2 units per order and WN documented administering 4 units
- On 03/16/2026 at 5:00 PM, BS was 185 requiring 2 units per order and WN documented administering 4 units.
- On 03/17/2026 at 8:00 AM, BS was 162 requiring 2 units per order and WN documented administering 4 units.
- On 03/17/2026 at 5:00 PM, BS was 191 requiring 2 units per order and WN documented administering 4 units.
- On 03/18/2026 at 5:00 PM, BS was 171 requiring 2 units per order and WN documented administering 4 units.
- On 03/19/2026 at 8:00 AM, BS was 154 requiring 2 units per order and WN documented administering 4 units.
- On 03/19/2026 at 5:00 PM, BS was 254 requiring 5 units per order and WN documented administering 10 units.
- On 03/21/2026 at 8:00 AM, BS was 227 requiring 3 units per order and WN documented administering 6 units.
- On 03/21/2026 at 12:00 PM, BS was 192 requiring 2 units per order and WN documented administering 4 units
- On 03/21/2026 at 5:00 PM, BS was 152 requiring 2 units per order and WN documented administering 4 units.
- On 03/22/2026 at 8:00 AM, BS was 310 requiring 7 units per order and WN documented administering 14 units.
- On 03/22/2026 at 12:00 PM, BS was 154 requiring 2 units per order and WN documented administering 4 units
- On 03/23/2026 at 8:00 AM, BS was 260 requiring 5 units per order and WN documented administering 10 units.
- On 03/23/2026 at 12:00 PM, BS was 195 requiring 2 units per order and WN documented administering 4 units
- On 03/23/2026 at 5:00 PM, BS was 206 requiring 3 units per order and WN documented administering 6 units.
- On 03/24/2026 at 8:00 AM, BS was 186 requiring 2 units per order and WN documented administering 4 units.
- On 03/24/2026 at 5:00 PM, BS was 280 requiring 5 units per order and WN documented administering 10 units.
- On 03/25/2026 at 8:00 AM, BS was 169 requiring 2 units per order and WN

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documented administering 4 units.
- On 03/25/2026 at 5:00 PM, BS was 206 requiring 3 units per order and WN documented administering 6 units.
- On 03/26/2026 at 12:00 PM, BS was 188 requiring 2 units per order and WN documented administering 4 units.
- On 03/27/2026 at 8:00 AM, BS was 197 requiring 2 units per order and WN documented administering 4 units.
- On 03/27/2026 at 12:00 PM, BS was 203 requiring 3 units per order and WN documented administering 6 units.
- On 03/28/2026 at 8:00 AM, BS was 201 requiring 3 units per order and WN documented administering 6 units.
- On 03/28/2026 at 5:00 PM, BS was 198 requiring 2 units per order and WN documented administering 4 units.
- On 03/29/2026 at 8:00 AM, BS was 152 requiring 2 units per order and WN documented administering 4 units.
- On 03/29/2026 at 12:00 PM, BS was 163 requiring 2 units per order and WN documented administering 4 units
- On 03/29/2026 at 5:00 PM, BS was 268 requiring 5 units per order and WN documented administering 10 units.
- On 03/30/2026 at 8:00 AM, BS was 167 requiring 2 units per order and WN documented administering 4 units.
- On 03/30/2026 at 5:00 PM, BS was 169 requiring 2 units per order and WN documented administering 4 units.
- On 04/01/2026 at 12:00 PM, BS was 160 requiring 2 units per order and WN documented administering 4 units
- On 04/01/2026 at 5:00 PM, BS was 218 requiring 3 units per order and WN documented administering 6 units.
- On 04/02/2026 at 8:00 AM, BS was 270 requiring 5 units per order and WN documented administering 10 units.
- On 04/02/2026 at 12:00 PM, BS was 189 requiring 2 units per order and WN documented administering 4 units.
- On 04/04/2026 at 5:00 PM, BS was 222 requiring 3 units per order and WN documented administering 6 units.
- On 04/04/2026 at 8:00 AM, BS was 179 requiring 2 units per order and WN documented administering 4 units.
- On 04/05/2026 at 12:00 PM, BS was 188 requiring 2 units per order and WN documented administering 4 units
- On 04/05/2026 at 5:00 PM, BS was 170 requiring 3 units per order and WN documented administering 6 units.
- On 04/06/2026 at 8:00 AM, BS was 222 requiring 3 units per order and WN documented administering 6 units.
- On 04/06/2026 at 12:00 PM, BS was 163 requiring 2 units per order and WN documented administering 4 units
- On 04/06/2026 at 5:00 PM, BS was 268 requiring 5 units per order and WN documented administering 10 units.
- On 04/07/2026 at 5:00 PM, BS was 192 requiring 2 units per order and WN documented administering 4 units.
- On 04/08/2026 at 5:00 PM, BS was 214 requiring 3 units per order and WN documented administering 6 units.
- On 04/09/2026 at 8:00 AM, BS was 324 requiring 7 units per order and WN documented administering 14 units.
- On 04/09/2026 at 12:00 PM, BS was 312 requiring 7 units per order and WN

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documented administering 14 units.
- On 04/09/2026 at 5:00 PM, BS was 258 requiring 5 units per order and WN documented administering 10 units.
- On 04/10/2026 at 8:00 AM, BS was 173 requiring 2 units per order and WN documented administering 4 units.
- On 04/10/2026 at 12:00 PM, BS was 158 requiring 2 units per order and WN documented administering 4 units
- On 04/11/2026 at 8:00 AM, BS was 216 requiring 3 units per order and WN documented administering 6 units.
- On 04/12/2026 at 5:00 PM, BS was 210 requiring 3 units per order and WN documented administering 6 units.
- On 04/14/2026 at 8:00 AM, BS was 175 requiring 2 units per order and WN documented administering 14 units.
- On 04/14/2026 at 12:00 PM, BS was 167 requiring 2 units per order and WN documented administering 4 units.
- On 04/15/2026 at 5:00 PM, BS was 168 requiring 2 units per order and WN documented administering 4 units.
- On 04/17/2026 at 8:00 AM, BS was 201 requiring 3 units per order and WN documented administering 6 units.
- On 04/17/2026 at 5:00 PM, BS was 172 requiring 2 units per order and WN documented administering 4 units.
- On 04/18/2026 at 8:00 AM, BS was 175 requiring 2 units per order and WN documented administering 4 units.
- On 04/19/2026 at 12:00 PM, BS was 192 requiring 2 units per order and WN documented administering 4 units.
- On 04/19/2026 at 5:00 PM, BS was 210 requiring 3 units per order and WN documented administering 6 units.
- On 04/20/2026 at 12:00 PM, BS was 279 requiring 5 units per order and WN documented administering 10 units.

In an interview, on 05/05/2026 at 3:45 PM, Staff H (Health Service Director) acknowledged inaccurate insulin administration documentation for Resident 3.

RESIDENT 4
NOTE: Washington Administrative Code (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.

Record review showed that the ALF admitted Resident 4 on [redacted]/2024 with multiple diagnoses including [redacted] every Monday, Wednesday, and Friday. Review of an ISP, dated 07/15/2025, showed that Resident 4 independently managed her medications except for the prescribed eye drop solutions.

Observation and interview, on 04/23/2026 at 10:15 AM, showed Resident 4 seated in her wheelchair in their apartment. Resident 4 stated that they managed majority of her medications except for eye drops due to limited shoulder movement.

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

Review of the eMARs for February, March, and April 2026, showed Resident 4 was prescribed four medicated eye drop solutions: Brimonidine solution (used to lower eye pressure in glaucoma or ocular hypertension and to relieve eye redness caused by minor irritation) three times day, Dorzolamide solution (used to lower high eye pressure in conditions like glaucoma and ocular hypertension by reducing fluid production in the eye) twice daily, Latanoprost (used to treat certain kinds of glaucoma) every evening, and Refresh (used to provide temporary relief to dry, burning, and irritated eyes) eye drops three times a day.

Review of February 2026 eMAR, showed staff circled 10 doses, indicating Brimonidine eye solution was not given at 12:00 PM and 2:00 PM, and nine doses for Refresh eye solution at 12:00 PM and 5:00 PM was not given. In March 2026 eMAR showed staff circled 12 doses indicating Refresh eye solution was not given at 12:00 PM and 5:00 PM, Dorzolamide at 7:00 PM, Latanoprost at 8:00 PM, and four doses for Brimonidine was not given. In April 2026 eMAR showed staff circled 12 doses, indicating Brimonidine was not given at 8:00 AM, 12:00 PM and 2:00PM, and 11 doses for Refresh eye drop solution was not given at 12:00 PM and 5:00 PM. The eMARs showed the circled doses reflected that Resident 4 was "not available" due to being at dialysis.

Review of records showed the ALF had no plan in place to ensure Resident 4 received their eye drops while at the dialysis center.

Review of the progress notes, showed no documentation to indicate that ALF staff evaluated Resident 4's condition. There was no documentation that ALF staff notified the physician for instructions or directions on how to address omitted or missed eye medications when Resident 4 was on dialysis treatment.

RESIDENT 7
Records review showed that the ALF admitted Resident 7 on [redacted]/2026 with multiple diagnoses, including [redacted] and [redacted].

Review of Resident 7's ISP, dated [redacted]/2026, showed that trained medication staff were to assist and/or licensed/delegated staff were to administer medications as ordered. The ISP showed that Licensed Nurses or trained staff would monitor, assist, and/or perform blood glucose monitoring for Resident 7 as ordered by a physician.

Records review of physician's orders, dated 03/25/2026, showed that Resident 7 was prescribed to take venlafaxine (used to treat depression) 37.5 milligrams (mg) two capsules (a total of 75 mg) by mouth daily, for six days and then discontinue.

Review of the March 2026 eMAR showed that on 03/28/2026, Staff K (MCM) signed that

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they had given Resident 7 two tablets of venlafaxine 37.5 mg at 8:00 AM. However, review of a Progress Note (PN), dated 03/28/2026 at 4:37 PM, showed, "Resident 7 received the wrong dose of routine venlafaxine this morning." The PN showed that Resident 7 had received a total of 225 mg (instead of 75 mg).

In an interview, on 04/23/2026 at 9:10 AM, Staff L (WN) stated that when moving into the ALF, Resident 7 brought medication packages (bingo-card/bubble packs, where pills are sealed in individual plastic bubbles on a card, organized by day and time) from a previous facility. Staff L stated that the dosage for venlafaxine was correctly transcribed into the March 2026 eMARs. Staff L stated that Staff K did not follow physician's order instead gave medications straight from medication packages without checking the order. Staff L stated that the old bubble packs brought to the facility contained a higher dosage venlafaxine then was prescribed. Staff L confirmed Resident 7 received the wrong dose of venlafaxine.

Review of the April 2026 eMARs showed that Resident 7 had been prescribed a standard order of 10 units Insulin Lispro (fast acting insulin that lowers BS) three times daily before meals at 9:00 AM, 12:00 PM, and 5:00 PM. On, dated 04/08/2026, the physician ordered parameters that Insulin Lispro should be held when Resident 7's BS level was lower than 130.

Review of the April 2026 eMARs showed that on 04/18/2026, the 12:00 PM dose of Insulin Lispro was not held when Resident 7's BS was 86, and on 04/19/2026, the 9:00 AM dose of Insulin Lispro was not held when Resident 7's BS was 116.

In an interview, on 04/23/2026 at 2:30 PM, Staff H confirmed that on 04/18/2026 and 04/19/2026, the Insulin Lispro was not held as prescribed by the physician.

Review of the April 2026 eMARs showed that Resident 7 had been prescribed a standard order for Insulin Lantus (long-acting insulin) 22 units every morning.

The April eMARs showed that a WN documented they gave only 10 units (instead of the prescribed 22 units) of Insulin Lantus on 04/16/2026.

In an interview, on 04/23/2026 at 2:30 PM, Staff H acknowledged that the WN documented they had given 10 units of Lantus instead of 22 units.

RESIDENT 9
Records review showed that the ALF admitted Resident 9 on [redacted]/2026 with multiple diagnoses including diabetes. Review of Resident 9's ISP, dated [redacted]/2026, showed that trained medication staff and/or licensed/delegated staff would administer medications to Resident 9 as ordered. The ISP showed that Licensed Nurses or trained staff would monitor, assist, and/or perform BS monitoring for Resident 9 as ordered by the physician.

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Review of the March and April 2026 eMARs showed that Resident 9 was prescribed to take Glutose gel (a fast-acting oral glucose supplement used to treat low blood sugar) as needed if their BS level was lower than 70.

The March and April 2026 eMARs showed that on 03/31/2026 at 2:19 PM and 04/20/2026 at 8:40 AM, MCMs signed they gave Glutose to Resident 9. There was no documentation of what Resident 9's BS was prior to giving the Glutose on 03/31/2026 or 04/20/2026.

In an interview, on 04/22/2026 at 10:15 AM, Staff M (Regional Health Service Director) stated that they were not aware that the MCMs documented they gave Glutose to Resident 9 on those days.

In an interview, on 04/22/2026 at 1:30 PM, Staff H stated that MCMs could not have given the medication because they did not have access to Glutose which had been stored in the WN's medication cart. Staff H acknowledged that when the MCMs documented the Glutose in the eMARs, the MCMs had not followed the ALF's medication policy of "five rights" for documenting "Right resident for Right medication".

Review of the April eMARs showed Resident 9 had a physician's order for Insulin Lispro (short-acting insulin) 10 units three times daily before meals at 9:00 AM, 1:00 PM, and 6:00 PM.

The April eMARs showed that WNs documented on 04/11/2026 at 6:00 PM, they gave 30 units of Insulin Lispro, on 04/14/2026 at 6:00 PM 14 units of lispro, and on 04/15/2026 at 6:00 PM, they had given 15 units of lispro. All doses greater than the ordered 10 units.

In an interview, on 04/23/2026 at 2:30 PM, Staff H acknowledged that WNs documented that they had given Resident 9 the wrong dosages of [redacted].

This is a recurring deficiency previously cited on 02/23/2024, 09/27/2024, and 08/05/2025.

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

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 MADISON is or will be in compliance with this law and / or regulation on (Date) 6/29/26 .

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

Administrator (or Representative) 6/12/26 Date

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

(i) Conducts an evaluation; and

(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

(2) The assisted living facility must comply with subsection (1) of this section, unless the prescriber or primary care practitioner has provided the assisted living facility with:

(a) Specific directions for addressing the refusal of the identified medication;

(b) The assisted living facility documents such directions; and

(c) The assisted living facility is able to fully comply with such directions.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to notify the physician or evaluate for outcome when 1 of 1 sampled resident (Resident 3) refused prescribed medication. This failure placed Resident 3 at risk for exacerbation of health conditions and compromised medical status.

Findings included...

Review of the ALF's policy titled Resident Refusal of Medication Policy (WA only), revised

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04/12/2021, showed that when a resident refuses to take a medication the Medication Care Manager (MCM) must ask or find out why the resident does not wish to take the medication. Refused medications will be noted on the eMAR (electronic Medication Administration Record). The Health Services Director (HSD) or Wellness Nurse would follow up on the refusal of medication, particularly if this is a pattern of refusal. The HSD or Wellness Nurse will contact the resident's prescribing practitioner if the medication refusal was repetitive and documented in the Health Record. The physician could discontinue the medication or change the medication to something that might work better for the resident. All Physician Visit Reports and Physician FAX reports would ask the Health Care Practitioner how they wanted medication refusals investigated.

Record review showed the ALF admitted Resident 3 on [redacted]/2024 with multiple health conditions. Review of an Individual Service Plan (ISP – equivalent to Negotiated Service Agreement), dated 07/16/2025, showed Resident 3 required staff assistance for medication management.

Review of the February, March, and April 2026 electronic Medication Administration Records (eMARs) showed that Resident 3 was prescribed Hydrocortisone Cream 1% apply to affected areas twice daily for rash and other nonspecific skin eruption. The eMARs showed that Resident 3 refused the prescribed Hydrocortisone cream seven days in February 2026, two days in March 2026, and 10 days in April 2026. There was no documentation the physician was notified of or that Resident 3 was evaluated following repeated medication refusals.

In an interview, on 04/23/2026 at 08:40 AM, Staff J (Medication Technician -MT) stated that when a resident refused medication, MTs were required to document the resident's medication refusal in the eMARs and report it to the nurse.

In an interview, on 04/22/2026 at 2:30 PM, Staff H (Director of Health Services) acknowledged that the physician was not notified about Resident 3's pattern of refusing the hydrocortisone. Staff H confirmed there was no documentation that Resident 3's condition was evaluated whether there was a need for the skin treatment or had resolved.

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Page 18 of 21	Licensee: Aegis Senior Communities LLC	05/15/2026

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, AEGIS OF MADISON is or will be in compliance with this law and / or regulation on (Date) 6/29/26 .

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

Administrator (or Representative) Date 6/12/26

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(b) Provide the necessary care and services for residents, including those with special needs;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed implement its policy to evaluate and take appropriate action for the changing needs for 3 of 3 sampled residents (Residents 3, 4, and 7) who experienced unintended/unplanned weight loss or gain. This failure placed Residents 3, 4, and 7 at risk for further weight loss or gain and compromised health status due to inadequate monitoring and follow-up of significant weight changes.

Findings included...

NOTE: Washington Administrative Code (WAC) 388-78A-2120 Monitoring residents' well-being. The assisted living facility must: (2) Identify any changes in the resident's physical, emotional, and mental functioning that are a: (a) Departure from the resident's customary range of functioning; (3) Evaluate, in order to determine if there is a need for further action: (a) The changes identified in the resident per subsection (2) of this section; (4) Take appropriate action in response to each resident's changing needs.

Review of the ALF's "Weight Monitoring Protocol" (WMP), dated 04/12/2021, under the section of "Change in Weight", showed that any weight (Wt.) change of five pounds (lbs.) or more in a 30-day period would be reported by the care staff to the Health Services Director (HSD). Any weight change of 10 lbs. or more in a 180-day period needed to be reported to the HSD, the primary physician, the resident's responsible party, and the Regional Health Service Coordinator/Vice President of Nursing. The WMP

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showed that prior to reporting the change, the care staff would re-weigh the resident to verify the change. If the HSD determines that the weight change is unexpected or unplanned, the HSD would notify the resident's health care practitioner and the resident's responsible party.

RESIDENT 3
Record review showed the ALF admitted Resident 3 on [redacted]2024 with multiple health conditions. Review of the undated Resident Characteristic Roster, showed Resident 3 required maximum assistance with activities of daily living (ADLs - a term used in healthcare to refer to people's daily self-care activities such as bathing, grooming, ambulation, etc.).

Review of the eMARs for February, March, and April 2026, showed staff to check Wt. monthly, and to notify Wellness Nurse (WN) if resident had lost or gained more than five pounds.

Review of February 2026 eMAR, showed Resident 3 weighed 200 pounds (lbs.). In March, the eMAR showed Resident 3 weighed 193 lbs., a seven lb. Wt. loss within one month. Review of the Progress Notes, showed no documentation that staff had notified the WN of Resident 3's seven lbs. Wt. loss to initiate weekly weights per ALF's policy.

Review of the April 2026 eMAR, showed no recorded Wt. for Resident 3.

RESIDENT 4
Record review showed that the ALF admitted Resident 4 on [redacted]/2024 with multiple diagnoses including [redacted].
Review of Resident 4's ISP, dated 01/30/2026, showed that Resident 4 had been on dialysis treatments.

During observation and interview on 04/23/2026 at 10:15 AM, showed Resident 4 seated in a wheelchair in her apartment. Resident 4 stated that they received dialysis treatment three times a week. When questioned regarding her Wt., Resident 4 stated she was weighed at the dialysis center.

Review of the electronic Medication Administration Records (eMARs) for January, February, March, and April 2026, showed staff were instructed to check and document monthly Wt. and notify nursing to reschedule if unable to complete this task.

Review of the January 2026 eMARs showed Resident 4 weighed 214 lbs. Review of the March eMAR, showed Resident 4 weighed 228 lbs., a 14-pound Wt. gain. There were no weights recorded in February or April 2026 for Resident 4. There was no documentation that Resident 4's 14-pound weight gain was reported to the WN to initiate weekly weights per ALF's policy.

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In an interview, on 04/23/2026 at 11:40 AM, Staff I, Wellness Nurse, stated that Medication Technicians (MTs) were responsible for weighing the residents, recording, and reporting for significant Wt. changes. Staff I acknowledged that weights should have been taken and recorded monthly for Resident 3 and Resident 4.

RESIDENT 7
Records review showed that the ALF admitted Resident 7 on [redacted]/2026 with multiple medical diagnoses including [redacted]. Records showed that Resident 7 had been hospitalized due to heart conditions and returned to the ALF on [redacted]/2026.

Review of a discharge order, dated [redacted]/2026, showed that a physician ordered Resident 7's Wt. to be checked every morning.

In an interview, on 04/23/2026 at 08:10 AM, when asked monitored Resident 7's Wt. Staff J (Medication Care Manager - MCM) stated, "MCMs have been checking Resident 7's Wt. every morning and documented the results into the computer." Staff J stated that if there was a Wt. loss or gain, an MCM would report it to a nurse.

Review of Resident 7's April 2026 electronic Medication Administration Records (eMAR)s showed the following:
*On 04/09/2026 Wt. was 225.7 lbs.
*On 04/10/2026 Wt. was 205.6 lbs. (a loss of 20 lbs. in one day).
*On 04/11/2026 Wt. was 204.9 lbs.
*On 04/12/2026 Wt. was 132 lbs. (a loss of 72 lbs. in one day).
*On 04/13/2026 Wt. was 233.2 lbs. (a gain of 101 lbs. in one day).
*On 04/14/2026 Wt. was 125 lbs. (a loss of 108 lbs. in one day).
*On 04/16/2026 Wt. was 125 lbs.
*On 04/17/2026 Wt. was 235 lbs. (a gain of 110 lbs. in one day).
*On 04/19/2026 Wt. was 226 lbs. (a loss of 9 lbs. in two days).
*On 04/20/2026 Wt. was 237 lbs. (a gain of 11 lbs. in one day).

Review of Resident 7's active records showed no information as to whether the care staff re-weighed Resident 7 to verify the changes, whether nurses had evaluated Resident 7's Wt. loss or gain, or reported the issue to the physician per the ALF protocol.

In an interview, on 04/23/2026 at 2:30 PM, Staff H (Health Services Director) confirmed that Resident 7's weight changes had not been evaluated per the ALF's weight monitoring protocol.

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Statement of Deficiencies	License #: 2241	Compliance Determination # 76131
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Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, AEGIS OF MADISON is or will be in compliance with this law and / or regulation on (Date) 6/29/26 .

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

Administrator (or Representative) Date 6/12/26

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

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

Aegis Senior Communities LLC
AEGIS OF MADISON

,

RE: AEGIS OF MADISON # 2241

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 05/15/2026 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:

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

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eFax: (206) 971-6791
Email: rcsregion2email@dshs.wa.gov
Optional method:
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

• Complete correction(s) within 45 calendar days of Last Date of Data Collection (05/15/2026), no later than 06/29/2026 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-2300 Food and nutrition services.

(2) The assisted living facility must plan in writing, prepare on-site or provide through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC, and serve to each resident as ordered:

(a) Prescribed general low sodium, general diabetic, and mechanical soft food diets according to a diet manual. The assisted living facility must ensure the diet manual is:

(i) Available to and used by staff persons responsible for food preparation;

(ii) Approved by a dietitian; and

(iii) Reviewed and updated as necessary or at least every five years.

The Assisted Living Facility failed to maintain a diet manual for prescribed diets, approved by a dietitian, reviewed, and updated at least every five years. This placed 81 residents at risk of not receiving food that met nutritional standards.

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.

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

- 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 (253)312-1446.

Sincerely,

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

Enclosure

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