STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Aegis Senior Communities LLC
AEGIS OF MADISON
2200 E Madison St
Seattle, WA 98112

RE: AEGIS OF MADISON License # 2241

Dear Administrator:

This letter addresses Compliance Determination(s) 38585 (Completion Date 03/20/2024) and 34380 (Completion Date 02/23/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/20/2024 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-2600-2-I, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2-a

The Department staff who did the on-site verification:
Cathy Prentice, Complaint Investigator

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

Sincerely,

Jamie Singer

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

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

Residential Care Services
Investigation Summary Report

Provider/Facility: AEGIS OF MADISON
Provider Type: Assisted Living Facility
License/Cert.#: 2241
Compliance Determination #: 34380
Intake ID: 108553
Investigator: Cathy Prentice
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 12/27/2023 through 02/23/2024
Complainant Contact Date(s):

Allegation(s):
The named resident went out to see family and returned with narcotics missing.

Investigation Methods:

Sample:	Total residents: 98 Resident sample size: 4 Closed records sample size: 1
Observations:	Named resident; delivery of care and services; staff interactions with residents; residents' appearance; environment, medication narcotic accounting system.
Interviews:	Named resident, other residents, staff, administration
Record Reviews:	Resident care records, Assessment, Negotiated Service Agreement (NSA), investigations, grievances, facility policies, other pertinent records.

Investigation Summary:
According to interview and record review, the facility failed to follow medication policy/procedures when the named resident returned form leave and narcotics were not accounted for, and when the facility dispensed routine medications in nine envelopes for the named resident's leave.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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Residential Care Services
Investigation Summary Report

Provider/Facility: AEGIS OF MADISON
Provider Type: Assisted Living Facility
License/Cert.#: 2241
Compliance Determination #: 34380
Intake ID: 110128
Investigator: Cathy Prentice
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 12/27/2023 through 02/23/2024
Complainant Contact Date(s):

Allegation(s):

1. The named resident received the wrong dose of pain medication on two consecutive days. 2. The named resident had a fall on the night of the second day of wrong dose of pain medication.

Investigation Methods:

Sample:	Total residents: 98 Resident sample size: 4 Closed records sample size: 1
Observations:	Named resident; delivery of care and services; staff interactions with residents; residents' appearance; environment, medication delivery system
Interviews:	Named resident, other residents, staff, administration
Record Reviews:	Resident care records, Assessment, Negotiated Service Agreement (NSA), investigations, grievances, facility policies, other pertinent records.

Investigation Summary:

According to interview and record review, the facility 1. failed to provide medication as ordered by the physician when the facility gave the wrong dose of a pain medication on two consecutive days. 2. The named resident had an unwitnessed non-injury fall on the evening of the second wrong dose of the pain medication. Failed practice was found for medication errors.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies	License #: 2241	Compliance Determination # 34380
Plan of Correction	AEGIS OF MADISON	Completion Date
Page 1 of 5	Licensee: Aegis Senior Communities LLC	02/23/2024

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 an unannounced on-site complaint investigation on 12/27/2023 and 12/27/2023 of:

AEGIS OF MADISON
2200 E Madison St
Seattle, WA 98112

This document references the following complaint number(s): 110128, 108553, 111002

The following sample was selected for review during the unannounced on-site visit: 4 of 98 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Cathy Prentice, Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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
2/26/2024 — 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.

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Statement of Deficiencies	License #: 2241	Compliance Determination # 34380
Plan of Correction	AEGIS OF MADISON	Completion Date
Page 2 of 5	Licensee: Aegis Senior Communities LLC	02/23/2024

Administrator (or Representative) Date 2/26/24

WAC 388-78A-2600 Policies and procedures.

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

(l) To manage residents' medications, consistent with WAC 388-78A-2210 through 388-78A-2290 ; sending medications with a resident when the resident leaves the premises;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement their policy for sending medications with a resident when the resident leaves the premises for 1 of 1 residents (Resident 1). This failure resulted in Resident 1 having narcotic medications and taking them independently when they were not assessed to safely do so.

Findings included...

Review of the ALF's policy, Medication Prepared for Resident Leave Protocol, dated 04/08/2015, showed when a resident checked out medications for leave they must sign medication packages back in upon their return. ALF staff were responsible to account for the medication when the resident returned. The policy Staff is not permitted to dispense medications out of the pharmacy prepared package or re-label the medication for more than one medication pass.

Review of resident records showed the ALF admitted Resident 1 on [redacted]/2021 with chronic pain syndrome and physician orders for pain medications. Review of the Individualized Service Plan dated 03/09/2022, showed Resident 1 required medication management assistance from staff.

Review of Resident 1's November 2023 Medication Administration Record showed a physician's order for oxycodone (a narcotic pain medication) 10 milligrams twice daily as needed for pain.

Review of the Individual Narcotic Record for Resident 1 showed the family signed out 56 tablets of oxycodone on 11/22/2023.

Review of a facility investigation documents, dated 11/30/2023, showed Resident 1 checked out of the ALF for Thanksgiving, taking 56 tablets of oxycodone with them. The investigation showed when Resident 1 returned to the facility, on 11/26/2023, the ALF did

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not check in and account for the Resident 1's oxycodone. The investigation stated, on 11/30/2023, it was discovered Resident 1 still had their oxycodone with them in their apartment. The investigation stated Resident 1's other medications were sent with her on 11/26/2023 without the pharmacy prepared package.

In an interview, on 12/27/2023 at 10:20 AM, Staff A (Director of Nursing DNS) confirmed Resident 1's the ALF did not check Resident 1's oxycodone back in when she returned to the facility. The staff did not realize the narcotics were missing for four days. Staff A stated the staff dispensed all routine medications in marked white envelopes rather than in the original pharmacy packs as per policy.

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) 3/11/24 .

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

Administrator (or Representative) 2/26/24 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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 2 sampled residents (Resident 1) received their medication as prescribed. This failure resulted in a Resident 1 receiving four times the dose of a high-risk medication that can cause significant harm and side-effects.

Finding Included...

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NOTE: Review of www.drug.com website showed overdose and side effects of Bupren/Nalox are: Overdose can cause pinpoint pupils, sedation, hypotension, hypoglycemia, respiratory depression, and death. Side effects of this medication are Nausea, vomiting, drowsiness, dizziness, constipation, or headache.

Review of resident records showed the ALF admitted Resident 1 on [redacted]/2021 with chronic pain syndrome and physician orders for pain medications. Review of the Individualized Service Plan dated 03/09/2022, showed Resident 1 required medication management assistance from staff.

Review of Resident 1's December 2023 Medication Administration Record showed an physician's order, dated 12/05/2023, for Bupren/Nalox Film (a combination medicine used to treat opioid addiction) 2-0.5mg, place 0.25 the film under tongue nightly as needed for pain.

Review of a facility investigation, dated 12/11/2023, showed Resident 1 was given one full film of the Bupren/Nalox rather than the ordered 0.25 (four times the dose) film on two occasions. The wrong dose of medication was given Staff B (Medication Technician) on 12/08/23 and Staff C (Medication Technician) on 12/09/23. The investigation showed Resident 1 stated she felt dizzy and fell in the kitchen during the evening after the wrong dose on 12/09/2023.

In an interview, on 12/27/2023 at 10:20 AM, Staff A (Director of Nursing DNS) stated medication error occurred because the full film of Bupren/Nalox was given instead of cutting the film for a 0.25 dose. Staff A stated the staff did not know they had to cut it to the correct dose.

In an interview, on 02/08/2024 at 11:15 AM, Staff B stated on 12/08/2023 she gave Resident 1 the full film of Bupren/Nalox. Staff B stated she thought giving the whole film was correct but she would be more careful going forward.

In an interview. on 02/09/2024 at 10:00 AM, Staff C stated he gave Resident 1 the full film of Bupren/Nalox on 12/09/2023.

Plan/Attestation Statement

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Page 5 of 5	Licensee: Aegis Senior Communities LLC	02/23/2024

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) 3/11/24 .

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

Ci Saul
Administrator (or Representative)

2/26/24
Date

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