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) 66424 (Completion Date 10/01/2025) and 62980 (Completion Date 08/05/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/01/2025 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-2210-2-b, WAC 388-78A-2210-1, WAC 388-78A-2210-1-a, WAC 388-78A-2210-1-b

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

Residential Care Services
Investigation Summary Report

Provider/Facility: AEGIS OF MADISON
Provider Type: Assisted Living Facility
License/Cert.#: 2241
Compliance Determination #: 62980
Intake ID: 187952
Investigator: Cathy Prentice
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 07/23/2025 through 08/05/2025
Complainant Contact Date(s):

Allegation(s):

1. Named Resident (NR) 1 did not have pain patch applied on 07/20/2025 and NR 2 missed bedtime insulin on 07/20/2025 because there was no nurse on duty.

Investigation Methods:

Sample:	Total residents: 84 Resident sample size: 5 Closed records sample size: 0
Observations:	Named Residents (NR); delivery of care and services; staff interactions with residents; residents' appearance; environment. I
Interviews:	Named Resident, other residents, staff, administration
Record Reviews:	Resident care records, Assessment, Negotiated Service Agreement (NSA), investigations, grievances, facility policies

Investigation Summary:

Observation, interview and record review showed, the facility completed Assessments and Negotiated Service Agreements for the NR's as required. The facility failed to have a nurse on duty in the evening of 07/20/2025 and 07/21/2025 due to a nurse vacation, and two residents missed medications during that time. NR1 missed insulin and blood sugar check and NR2 missed application of a pain patch. See Statement of Deficiencies dated 08/05/2025.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: AEGIS OF MADISON
Provider Type: Assisted Living Facility
License/Cert.#: 2241
Compliance Determination #: 62980
Intake ID: 186212
Investigator: Cathy Prentice
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 07/23/2025 through 08/05/2025
Complainant Contact Date(s): 07/14/2025, 08/05/2025

Allegation(s):
1. The facility is understaffed and leaves nurses at risk to take care of 80 plus residents.

Investigation Methods:

Sample:	Total residents: 84 Resident sample size: 5 Closed records sample size: 0
Observations:	Observed ALF residents, delivery of care and services; staff interactions with residents; residents' appearance; environment.
Interviews:	Interviewed ALF residents, staff, administration.
Record Reviews:	Resident care records, Assessment, Negotiated Service Agreement (NSA), investigations, grievances, facility policies, other pertinent records.

Investigation Summary:
According to observation, interview and record review, the facility had Registered Nurses and Licensed Practical Nurses on duty seven days per week for twelve hour shifts. The facility failed to have a nurse on duty in the evening of 07/20/2025 and 07/21/2025 due to a nurse vacation, and two residents missed medications during that time. See Statement of Deficiencies dated 08/05/2025.

Conclusion / Action:

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

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 # 62980
Plan of Correction	AEGIS OF MADISON	Completion Date
Page 1 of 4	Licensee: Aegis Senior Communities LLC	08/05/2025

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 07/23/2025 and 07/25/2025 of:

AEGIS OF MADISON
2200 E Madison St
Seattle, WA 98112

This document references the following complaint number(s): 186212, 187952

The following sample was selected for review during the unannounced on-site visit: 5 of 84 current residents and 0 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

Statement of Deficiencies	License #: 2241	Compliance Determination # 62980
Plan of Correction	AEGIS OF MADISON	Completion Date
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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

08/18/2025
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)

9/9/2025
Date

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

(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 :

(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 ensure 2 of 5 sampled residents (Resident 1 and 2), who required medication administration, received their medication as prescribed. This failure resulted in Residents 1 and 2 not receiving physician's ordered medication and placed them at risk of harm.

Findings included...

NOTE: Washington Administrative Code (WAC) 388-78A-2450 Staff. (1) Each assisted living facility must provide sufficient, trained staff persons to:(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement.

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RESIDENT 1

NOTE- Medlineplus.gov stated the medication Insulin Lispro injection and glargine (Basagler) insulin were products used to treat diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood). Use insulin lispro and glargine injection products exactly as prescribed.

Record review of a Face Sheet, showed the ALF admitted Resident 1 on [redacted] 2025 with a diagnosis of [redacted]. Review of an Individualized Service Plan (ISP - equivalent to a Negotiated Service Agreement, dated 06/18/2025, showed Resident 1 required ALF staff assistance with medications.

Record review of Resident 1's July 2025 Medication Administration Record (MAR) showed an order, dated 07/12/2025, for Insulin Lispro 100/ml Kwikpen (Humalog Kwikpen) 2 Units injectable four times daily before meals and at bedtime, hold for blood sugar less than 120. The MAR stated the Lispro was to be given at 9:00 PM by nurse only. The MAR showed the Lispro was not given at 9:00 PM on 07/21/2025, and it was documented it was not given due to no nurse being available in the ALF. The MAR also showed the blood sugar check was not charted as done.

Record review of Resident 1's July 2025 showed an order, dated 06/20/2025, for Basagler Kwikpen (Insulin) 100 Units/ml inject 8 Units nightly at bedtime. The MAR stated Basagler insulin was to be given at 9:00 PM by nurse only. The MAR showed the Basagler was not given at 9:00 PM on 07/21/2025, and it was documented it was not given due to no nurse being available in the ALF.

In an interview, on 07/25/2025 at 9:45 AM, Resident 1 confirmed he had missed his blood sugar check and bedtime insulins, on 07/21/2025, and he was told the nurse was on vacation.

RESIDENT 2

NOTE- Medlineplus.gov stated the medication fentanyl topical patches were used to relieve severe and persistent pain in people who were tolerant (used to the effects of the medication) to narcotic pain medications and who were expected to need pain medication around the clock that cannot be treated with other medications. Fentanyl patches should not be stopped without talking to a doctor.

Record review of a Face Sheet, showed the ALF admitted Resident 2 on [redacted] 2022 with a diagnosis of [redacted]. Review of an ISP, dated 07/03/2025, showed Resident 2 required ALF staff assistance with medications and was receiving service from

Statement of Deficiencies	License #: 2241	Compliance Determination # 62980
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hospice (care provided to the terminally ill).

Record review of Resident 2's July 2025 MAR showed an order, dated 03/05/2024, for Fentanyl patch to be applied topically every 72 hours and to, "date and initial patch." The MAR showed the patch was not applied as ordered on 07/20/2025.

Record review of Resident 2's July 2025 MAR showed Staff A (Licensed Nurse) documented the Fentanyl patch that she removed on 07/23/2025, was dated 07/17/2025.

In an interview, on 07/25/2025 at 2:04 PM, Staff B (Health Services Director) stated the missed medications and blood sugar checks for Resident 1 and the missed pain patch for Resident 2 in July were due to no licensed nurse working in the evening after 7:00 PM on 07/20/2025 and 07/21/2025.

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

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) 9/19/2025.

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

Administrator (or Representative) — Date: 9/9/2025