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 Gardens at Newcastle
13056 SE 76th St
Newcastle, WA 98056

RE: Aegis Gardens at Newcastle License # 2435

Dear Administrator:

This letter addresses Compliance Determination(s) 82926 (Completion Date 08/28/2026) and 79299 (Completion Date 07/07/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/28/2026 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-2700-1-a, WAC 388-78A-2700-3-f, WAC 388-78A-2305-1, WAC 246-215-04565-4, WAC 246-215-04700, WAC 388-78A-2484-1, WAC 388-78A-2100-2-a, WAC 388-78A-2466-1-a, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2140-2-a

The Department staff who did the on-site verification:
Thomas Forkgen, ALF Licensor
Michelle Yip, ALF 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

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

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 06/22/2026 and 06/25/2026 of:

Aegis Gardens at Newcastle
13056 SE 76th St
Newcastle, WA 98056

The following sample was selected for review during the unannounced on-site visit: 12 of 107 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Michelle Yip, ALF Licensor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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

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

07-10-2026
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)

7/21/2026
Date

WAC 388-78A-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(a) Maintain the premises free of hazards;

(3) The assisted living facility's emergency preparedness plan must include procedures for:

(f) Provision of essential resident needs and supplies, including water, food, medications, and personal care items; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to have a system in place to ensure that 4 of 4 hot water tanks (tank 1, tank 2, tank 3 and tank 4), identified in the disaster manual as part of the three-day emergency water supply, was readily accessible for residents in an emergency. The facility failed to ensure 1 of 1 stairwell (Northside Stairwell) roof access was secured and not accessible to residents. This failure placed the 107 residents at risk for dehydration or other health and hygiene issues secondary to a lack of safe, emergency drinking water and placed ambulatory residents at risk of potential harm.

Findings included...

EMERGENCY WATER

Review of the facility's undated disaster and emergency operation manual identified four 100-gallon hot water tanks as the facility emergency water supply. The manual showed that tools were required "wrench, hose" to drain the water from the tanks. The

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manual instructions showed that "step-by-step" instructions specific to the facility type of hot water tanks were to be posted nearby. The manual showed that the water was to be drained into containers labeled with the specific use of the water that included "drinking and cooking, washing dishes, mopping floors and bathing".

Review of the facility's Characteristics Roster showed 107 residents resided at the facility, 93 in the Assisted Living unsecured side and 16 Memory care residents in the secured memory care (Life's Neighborhood) unit.

Observation on 06/22/2026 at 12:45 PM during the environmental tour, showed four 100-gallon hot water tanks located on northside ground level accessed from outside of the facility. Observation showed each hot water tank had a valve with no handle located at the bottom of each tank. There were no tools available to open the valves on to access the emergency water. Observation showed there were no hoses available to attach to the valves. There were no buckets available to collect the water. Observation showed there was a paper with instructions hanging down covering the instructions. The instructions did not provide step-by-step instructions on how to access the water.

During an interview on 06/22/2026 at 12:45 PM, Staff K, Maintenance Assistant, and Staff A, General Manager, stated that the hot water tanks were designated as the emergency water supply for the facility. Staff K stated that the staff would access the hot water by attaching a hose to the valve of the hot water tank, place one end of the hose in a bucket, and use a tool to turn the valve on to drain the hot water tank. Staff K stated that the Maintenance Director must have used the hoses, buckets, and the wrench for something else. Staff K stated that they would notify Staff J, Maintenance Director, that each of these items was missing and needed to be replaced. Staff M was unable to locate the instructions.

STAIRWELL NORTHSIDE

Observation during the environmental tour with Staff K on 06/22/2026 at 11:23 AM, showed the Northside stairwell had access to the facility roof. Observation showed an unsecured alternating steel perforated tread stairs (alternating tread steps switch from side to side with each step, allowing for a steep incline) ladder that accessed the facility roof from the fourth floor. Observation showed that the roof hatch latch was not secured by a pad lock.

During an interview on 06/22/2026 at 11:23 AM, Staff K stated that someone forgot to replace the lock. Staff A stated that there was supposed to be a chain that hung across the entry of the ladder to prevent resident access.

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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 Gardens at Newcastle is or will be in compliance with this law and / or regulation on (Date) 8/21/2026 .

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

Administrator (or Representative) — Date: 7/21/2026

WAC 246-215-04565 Equipment Manual and mechanical warewashing equipment, chemical sanitization Temperature, pH, concentration, and hardness (FDA Food Code 4-501.114). A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times specified under WAC 246-215-04710 must meet the requirements specified under WAC 246-215-07220 , must be used in accordance with the EPA-registered label use instructions, and must be used as follows:

(4) If another solution of a chemical specified under subsections (1) through (3) of this section is used, the permit holder shall demonstrate to the regulatory authority that the solution achieves sanitization and the use of the solution must be approved;

WAC 246-215-04700 Objective Food-contact surfaces and utensils (FDA Food Code 4-701.10). equipment, food-contact surfaces, and utensils must be sanitized.

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to test the sanitation solution to determine if the solution was at the correct concentration required to prevent contamination of clean equipment, counter surfaces, tables, and utensils for 1 of 1 kitchen (Main Kitchen). This failure placed 107 residents at risk of consuming contaminated food and contracting foodborne illnesses.

Findings included...

Review of the facility's "Surface Cleaning and Sanitation Policy" dated 10/24/2024 showed that Food residues on food-contact surfaces and equipment could provide an ideal environment for the growth of disease-causing bacteria, which can contaminate other foods. The policy showed that soiled wiping cloths could become a "breeding

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ground for bacteria" that could be transferred to other surfaces. The policy showed that food residues that are not cleaned within the required time frame the bacteria could multiply to "dangerous levels". The Policy showed that routine cleaning and sanitizing of food-contact surfaces and equipment was necessary to prevent the growth of bacteria. The policy showed that surfaces must be cleaned after each use. Further review showed that sanitizing surfaces reduces bacteria and viruses to a "safer level". The policy showed it was necessary to follow manufacturer's directions as "concentration and time on a surface are important to reducing bacteria and viruses". The policy showed to test solutions with test strips regularly to ensure that the proper sanitization solution strength was maintained. Sanitization buckets were to be changed every two to four hours or more as needed to keep the water clean, and that a record log should be used to track every time the sanitizer bucket was changed. Review of the policy showed that the sanitization solution should be changed when the concentration gets weak or the solution becomes cloudy.

Review of the facility's undated "Resident Characteristics Roster" showed residents currently resided at the facility and received Assisted Living services.

SANITIZATION BUCKETS

Observation and interview on 06/22/2026 at 12:35 PM during the environmental tour, showed Staff L, Sous Chef, used test strips to test the sink and surface sanitization solution contained in red buckets which were used to sanitize the main kitchens counter surfaces. Observation showed Staff L removed a test strip from a container labeled with the concentration ranges in several shades of blue, green, and tan which indicated the concentration strength level of the sanitization solution. The test strip container showed that dark blue and green was the effective range 272 -700 parts per million (ppm). Staff L tested a sanitization solution bucket located under the cooking/serving counter. Observation showed that the test strip showed 0 ppm. Staff L stated that the sanitization bucket was not changed out after the four-hour expiration timeframe. Staff L tested a second sanitization bucket that showed 0 ppm. Staff L tested the sanitization solution directly from the sanitization dispenser which showed 0 ppm. Observation showed the two main containers of sanitization solution connected to the dispenser were nearly full. Staff L stated that they did not always test the sanitization solution when they changed out the buckets. Staff L stated they would speak to Staff M, Culinary Services Director, to contact the vendor to assess the sanitization system.

Review of an undated invoice from the sanitization vendor showed the technician adjusted the metering tip on the dispenser.

During an interview on 06/24/2026 at 11:15 AM, Staff M stated that the sanitization company technician came out on 06/23/2026 to determine why the sanitizer solution failed to register within the effective range on the test strips. Staff M stated that the technician identified the alcohol level in the sanitization solution was too low which caused the sanitization solution to be ineffective. When asked to test the sanitization buckets Staff M was unable to find any test strips. Staff M stated that they filled the sanitization buckets that morning without testing the solution to ensure the

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concentration level was within effective range. Staff M stated that they changed the sanitization buckets every two to four hours or more often if the solution concentration was below the effective range. Staff M stated that they did not record the results when the sanitization buckets were tested.

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 Gardens at Newcastle is or will be in compliance with this law and / or regulation on (Date) 8/21/2026.

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

Administrator (or Representative) — Date: 7/21/2026

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete 1 of 4 sampled staff (Staff B) skin test or a blood test for Tuberculosis (TB), within three days of hire, as required. This failure placed 107 residents at risk of potential exposure to tuberculosis and infectious disease.

Findings included...

Review of the facility's "Tuberculosis" Policy dated 07/08/2024 showed that the facility followed the Washington Administrative Code (WAC) for TB screening and testing requirements. The policy showed that Washington state staff were required to receive a TB test within three days of employment. The policy showed that the type of tests approved included intradermal (skin) test or a blood test. The policy showed that when there was a positive result to tuberculosis skin or blood test the Assisted Living Facility "must" ensure the staff person received a chest X-ray within seven days and followed the recommendation of the health care provider.

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed 107 residents received assisted living services.

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Review of the facility's Employee Roster showed the facility hired Staff B, Care Manager Level 2, on 12/24/2025. Review of Staff B's personnel file showed that a blood test was done on 12/29/2026 six days after hire and completed on 12/31/2025. Review of the blood test result showed it was positive for TB. Staff B's personnel record showed that a chest X-ray to rule out active TB was completed on 01/26/2026 with negative results.

During an interview on 06/24/2026 at 11:00 AM, Staff G, Area Business Office Manager, stated that Staff B informed them that they had a history of a positive reaction to a TB skin test. Staff G stated a blood test was completed instead of a TB skin test. Staff G stated that Staff B did not keep copies of the previous positive TB test or chest X-ray results done over 20 years ago. Staff G stated that Staff B's first day worked for pay was on 12/24/2025. Staff G stated that they realized the blood test for TB was not done within three days of hire as required.

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 Gardens at Newcastle is or will be in compliance with this law and / or regulation on (Date) 9/21/2026.

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

Administrator (or Representative) — Date: 7/21/2026

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to assess the resident's ability to safely use medical devices for 1 of 12 residents (Resident 8). This failure placed Resident 8 at risk for possible unmet care needs and injury.

Findings included...

Review of the facility's document titled "Side Rail/Enabler Device Policy", dated 03/15/2023, showed that the facility allowed "enabler devices" including bed side rails.

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Resident 8's ability to safely use the side rails.

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 Gardens at Newcastle is or will be in compliance with this law and / or regulation on (Date) 8/21/2026 .

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

Administrator (or Representative) — Date: 7/21/2026

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a Washington State name and date of birth (WNDOB) background check (BGI) every two years for 2 of 2 sampled staff (Staff E and Staff F). This failure placed 107 Assisted Living residents at risk for potential abuse or neglect by staff with an unknown background.

Findings included...

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that 107 residents received assisted living services.

STAFF E

Review of the facility's undated employee list showed that the facility hired Staff E, Lead Medication Care Manager, on 10/14/2018. Review of Staff E's employee records showed their previous WNDOB BGI expired on 09/14/2024. The records showed that the facility submitted and completed the current WNDOB BGI on 09/16/2024, two days after the previous WNDOB BGI expired.

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The document showed that the facility required an assessment of the enabler device before it was placed into use and then reviewed it annually, or upon any significant change in the resident's condition. The document showed that the Health Services Director or licensed nurses were responsible for assessing and determining the resident's ability to use the device appropriately and safely. The document showed that prior to implementing any enabler device, a licensed nurse was responsible for completing an assessment and documenting assessment results in the resident's health records, and obtaining written consent from the resident or their Power of Attorney. The document showed that a physician's order should be obtained and the use of the enabler device should be documented on the resident's individualized service plan. The document showed the facility's care staff and maintenance were responsible for monitoring the enabler device and ensuring the device was properly covered and secured.

Note: Washington Administrative Code (WAC) 388-78A-2090, Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause: (6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including: (e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

RESIDENT 8
Observation on 06/24/2026 at 11:30 AM, inside Resident 8's apartment, showed two metal framed side rails attached from the head of the bed and extended to the mid-way of the bed, one side rail on each side of the bed. Observation showed Resident 8 was not in bed. Observation showed the two side rails were covered with a fabric cover and were in a raised position. During the observation, Collateral Contact 1 (CC1), Resident 8's family member stated that the bed and the side rails belonged to Resident 8. CC1 stated that when Resident 8 moved into the facility, they brought the bed and the side rails. CC1 stated that the facility staff provided them with the fabric covers for the side rails. CC1 stated that Resident 8 used the bed and the side rails every day.

Review of Resident 8's records showed that the facility admitted Resident 8 in [redacted] 2025. The records showed that on 04/30/2025, 09/25/2025, 01/28/2026 and 04/04/2026, the facility completed assessments for Resident 8. The assessments showed Resident 8 required physical assistance with transfer. The records showed that Resident 8 used assistive devices. There was no documentation that showed the facility assessed Resident 8's ability to safely use side rails. There was no documentation that showed the facility obtained the physician's order and the written consent from the resident and their family representative. There was no documentation that instructed the care staff and maintenance staff to monitor and maintain the side rails.

During an interview on 06/25/2026 at 1:40 PM, Staff I, Registered Nurse/Health Services Director, stated that they were unaware Resident 8 using side rails. Staff I stated that they were unable to locate a physician order for the side rails and the documentation of the side rails assessment in Resident 8's records. Staff I stated that they did not assess

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STAFF F
Review of the facility's undated employee list showed that the facility hired Staff F, Medication Care Manager, on 08/10/2018. Review of Staff F's employee records showed that their previous WNDOB BGI expired on 09/14/2024. The records showed that the facility submitted and completed the current WNDOB BGI on 10/08/2024, 24 days after the previous WNDOB BGI expired.

During an interview on 06/23/2026 at 3:20 PM, Staff G, Area Business Office Manager, stated that they completed the Washington State name and date of birth background check late for Staff E and Staff F when their previous background checks expired.

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 Gardens at Newcastle is or will be in compliance with this law and / or regulation on (Date) 8/21/2026 .

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

Administrator (or Representative) — Date: 7/21/2026

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

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

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

(iii) On-going assessments of the resident;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

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This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to develop and document a monitoring plan and care instructions for the use of medical devices in the resident's service plan for 2 of 2 sampled residents (Resident 5 and Resident 9). The facility failed to document the care and services provided by external care providers in the resident's service plan for 5 of 12 sampled residents (Resident 2, Resident 5, Resident 7, Resident 9, and Resident 10). These failures placed Resident 2, Resident 5, Resident 7, Resident 9, and Resident 10 at risk for unmet care needs.

Findings included...

During the entrance conference on 06/22/2026 at 9:56 AM, Staff I, Health Services Director, stated that the facility did not staff with 24-hour licensed nurse coverage. Staff I stated that in the evening and at night shifts, there were only Medication Care Mangers and Care Mangers on duty.

RESIDENT 2
Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that the facility admitted Resident 2 in [redacted] 2019.

Review of Resident 2's Service Plan, dated 05/21/2026, showed that Resident 2 received Hospice care services (end of life care). The Service Plan did not identify the Hospice provider or provide contact information for the care managers.

RESIDENT 5
Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that the facility admitted Resident 5 in [redacted] 2022. The Characteristic Roster showed that Resident 2 resided in the secured memory care unit (Life's Neighborhood).

Observation on 06/25/2026 at 9:00 AM, showed Resident 5 seated in a tilt-n-space wheelchair (a wheelchair that keeps posture the same while the entire seat of the wheelchair tilts backward to allow for redistribution of pressure away from the hips and onto a larger body surface area) at the dining room table in the secured memory care unit. Observation showed an unidentified care manager fed Resident 5 their breakfast.

Review of Resident 5's Service Plan, dated 05/31/2026, showed that Resident 5 received Hospice care services. The Service Plan did not identify the Hospice provider or provide contact information should the Care Managers need to contact Hospice. The Service Plan showed that Resident 5 used a manual wheelchair. The Service Plan did not show Resident 5 used a tilt-n-space wheelchair. The Service Plan did not provide instructions for the use of the tilt-n-space wheelchair or show the frequency of when the Care Managers were to readjust the wheelchair to relieve pressure on Resident 5's body.

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During an interview on 06/25/2026 at 1:30 PM, Staff I stated that the Hospice information for both Resident 2 and Resident 5 was listed on the front of the residents' physical charts. Staff I stated that the physical charts were accessible to the Licensed Nurses. Staff I acknowledged that the Care Managers and Medication Care Managers accessed service plans electronically when they needed to find out the information about a resident. Staff I stated that the Service Plan did not identify Resident 5 used a tilt-n-space wheelchair and there were no instructions provided.

RESIDENT 7
Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that the facility admitted Resident 7 in [redacted] 2023. Review of Resident 7's records showed that Resident 7 had a wound on the sacrum (lower back) and coccyx (tailbone) area. The records showed that Resident 7 required wound management.

During an interview on 06/25/2026 at 11:00 AM, Staff O, Wellness Nurse, stated that Resident 7 received wound management from an external home health provider. Staff O stated that the external home health provider provided wound care twice weekly. Staff O stated that the facility's nurse coordinated with the external home health provider and provided wound care as back-up.

Review of Resident 7's Service Plan, dated 05/26/2026, showed that the facility's care staff and licensed nurses provided monitoring and back-up assistance in the wound management. The Service Plan showed the facility staff coordinated the wound management with the external home health provider. The Service Plan showed no documentation of which home health provider provided the service and the instructions for staff communicating with the home health provider.

RESIDENT 9
Observation on 06/24/2026 at 1:13 PM showed that Staff N, Medication Care Manager, propelled Resident 9 in the wheelchair into the resident's room. Observation showed Resident 9 sat on a Roho cushion (a pressure relief cushion that is made of soft, flexible air cells to decrease the amount of pressure on the sitting area) in the wheelchair. Observation showed Staff N transferred Resident 9 from the wheelchair to the sofa.

Observation on 06/25/2026 at 1:26 PM, inside Resident 9's apartment, showed that Resident 9 was seated on the sofa. Observation showed that Staff H, Medication Care Manager, assessed the Roho cushion on the wheelchair. Observation showed Staff H pressed on top of the Roho cushion and squeezed the individual air cells of the cushion. During an interview at this time, Staff H stated that the Roho cushion was not properly inflated. Staff H stated that they were responsible for ensuring the Roho cushion was properly inflated when in use. Staff H stated that they were unfamiliar with the routine monitoring and care instructions for the Roho cushion. Staff H stated that they kept a pump for the Roho cushion in the medication cart. Staff H stated that they were unable to locate the care instructions for the Roho cushion anywhere in the medication cart and the resident's records.

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Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that the facility admitted Resident 9 in [redacted] 2022 with a medical diagnosis of [redacted]. Review of Resident 9's records showed that on 09/21/2025, 12/23/2025 and 06/03/2026, the facility completed an assessment for Resident 9.

Review of Resident 9's Individualized Service Plan dated 09/21/2025 and 12/23/2025 and Resident 9's Service Plan dated 06/03/2026, showed that Resident 9 received hospice care. The service plans showed no documentation of which hospice agency provided the service and the instructions for staff communicating with the hospice agency. The service plans showed Resident 9 used a manual wheelchair. There were no instructions for staff about how to evaluate and maintain the Roho cushion for proper use and inflation.

During an interview on 06/25/2026 at 1:40 PM, Staff I stated that Resident 9's family brought the Roho cushion for the resident. Staff I stated that they were unaware Resident 9 used a Roho cushion. Staff I stated that they did not document the monitoring and care instructions of the Roho cushion in the resident's service plan.

RESIDENT 10
Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that the facility admitted Resident 10 in [redacted] 2024 with a medical diagnosis of [redacted]. The records showed that on 10/30/2025, the facility completed an assessment for Resident 10. The assessment showed that Resident 10 used a suprapubic urinary catheter (a tube inserted into the bladder to drain urine) and Resident 10 required assistance with catheter management.

During an interview on 06/25/2026 at 11:15 AM, Staff O stated that Resident 10 received catheter management from an external home health provider. Staff O stated that the external home health provider inserted and replaced the urinary catheter. Staff O stated that the facility's nurses did not insert and replace the urinary catheter. Staff O stated that the facility's nurse and care staff were responsible for emptying the urinary bag, ensuring the catheter remained unblocked, and changing the dressing at the catheter insertion site. Staff O stated that the facility's care staff were responsible for coordinating the catheter management with the external home health provider.

Review of Resident 10's Individualized Service Plan dated 04/07/2026 and Resident 10's Service Plan dated 06/03/2026 showed that the facility's care staff and licensed nurses provided monitoring and back-up assistance in the catheter management. The service plans showed the facility staff coordinated the catheter management with the external home health provider. The service plans showed no documentation of which home health provider provided service and the instructions for communicating with the home health provider.

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During an interview on 06/25/2026 at 1:40 PM, Staff I stated that the facility's nurses were responsible for updating the residents' service plans. Staff I stated that they did not know they were required to document, and that they did not document the external health providers and the health provider's care responsibilities in the resident's service plan.

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 Gardens at Newcastle is or will be in compliance with this law and / or regulation on (Date) 9/21/2026 .

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

Administrator (or Representative) — Date: 7/21/2026

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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 Gardens at Newcastle
13056 SE 76th St
Newcastle, WA 98056

RE: Aegis Gardens at Newcastle # 2435

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 07/07/2026 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:

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

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 (07/07/2026), no later than 08/21/2026 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-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.

Two care staff (Staff B, Home Care Aide/Care Manager, and Staff F, Certified Nursing Assistant/Medication Care Manager) did not complete the required 12 hours of continuing education between their recent birthday to birthday period, when they provided care and services to the assisted living residents. On 06/22/2026, during the Department's licensing inspection, Staff B and Staff F completed the continuing education.

The 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

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

- 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

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