STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

102 Ave Bellevue LLC
Aegis of Bellevue

,

RE: Aegis of Bellevue License # 2491

Dear Administrator:

This letter addresses Compliance Determination(s) 78428 (Completion Date 06/03/2026) and 74766 (Completion Date 04/02/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/03/2026 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-2485, WAC 388-78A-2485-1, WAC 388-78A-2485-2, WAC 388-78A-2485-3, WAC 388-78A-2474-2-c, WAC 388-78A-2474-2-d, WAC 388-78A-2474-2-e, WAC 388-112A-0400-4-b, WAC 388-112A-0400-4-c, WAC 388-112A-0700, WAC 388-112A-0720-2-a, WAC 388-112A-0611-1-a-iii, WAC 388-112A-0611-2, WAC 388-78A-2305-1, WAC 246-215-03309, WAC 246-215-04565-4, WAC 246-215-04700, WAC 246-215-04705, WAC 246-215-03510-1, WAC 246-215-03510-2-a, WAC 246-215-03510-2-b, WAC 246-215-03510-2-c, WAC 246-215-03510-2-d, WAC 246-215-03510-2-d-i, WAC 246-215-03510-2-d-ii, WAC 246-215-03510-2, WAC 388-78A-3040-5, WAC 388-78A-3040-7-a-iv, WAC 388-78A-2700-1-a, WAC 388-78A-2484, WAC 388-78A-2484-1, WAC 388-78A-2484-2, WAC 388-78A-2100-2-a, WAC 388-78A-2090-7-c, WAC 388-78A-2090-7-c-i, WAC 388-78A-2090-7-c-ii

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

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

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

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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

Statement of Deficiencies	License #: 2491	Compliance Determination # 74766
Plan of Correction	Aegis of Bellevue	Completion Date
Page 1 of 21	Licensee: 102 Ave Bellevue LLC	04/02/2026

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 and complaint investigation on 03/24/2026 and 03/27/2026 of:
Aegis of Bellevue
148 102nd Ave SE
Bellevue, WA 98004

This document references the following complaint numbers: 216933, 216817.

The following sample was selected for review during the unannounced on-site visit: 9 of 65 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

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Statement of Deficiencies	License #: 2491	Compliance Determination # 74766
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Page 2 of 21	Licensee: 102 Ave Bellevue LLC	04/02/2026

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.

Jim Sherman
Residential Care Services

04-07-2026
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)

4/8/26
Date

WAC 388-78A-2485 Tuberculosis Positive test result. When there is a positive result to tuberculosis skin or blood testing the assisted living facility must:

(1) Ensure that the staff person has a chest X-ray within seven days;

(2) Ensure each resident or staff person with a positive test result is evaluated for signs and symptoms of tuberculosis; and

(3) Follow the recommendation of the resident or staff person's health care provider.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to obtain a chest X-Ray to rule out active tuberculosis (TB) for 5 of 5 sampled staff (Staff F, Staff H, Staff M, Staff N, and Staff P) who tested positive for TB. The facility failed to follow the recommendation of the health care provider for 1 of 1 sampled staff (Staff H). This failure placed 65 residents at risk of potential exposure to tuberculosis and infectious disease.

Findings included..

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed 65 residents received assisted living services.

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 is a positive result to tuberculosis skin or blood testing the Assisted

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Living Facility must": ensure that the staff person has a chest X-ray within seven days and to follow the recommendation of the health care provider.

STAFF F
Review of the facility's undated Employee Roster showed that the facility hired Staff F, Lead Medication Care Manager, on 05/15/2011 . Review of Staff F's employee records showed documentation of a QuantiFERON-TB Gold Plus test (a blood test for TB) with a positive result dated 01/10/2026. The records showed Staff F completed a chest X-ray that ruled out TB disease on 03/25/2026, 74 days after a positive result to the TB blood test.

STAFF H
Review of the facility's Employee Roster showed that the facility hired Staff H, Care Manager, on 02/27/2026. Review of Staff H's employee records showed documentation of a one-step negative TB skin test completed on 03/01/2026. Review of Staff H's record showed documentation of a second-step positive TB skin test completed on 03/21/2026. Review of Staff H's records showed instead of a chest X-ray as required, a documented positive TB blood test was completed on 03/24/2026 with a recommendation for a chest X-ray. The records showed that during the Department's visit Staff H received a chest X-ray on 03/26/2026 with a negative result.

STAFF M
Review of the facility's Employee Roster showed that the facility hired Staff M, Care Manager, on 01/29/2026. Review of Staff M's employee records showed documentation of a one-step positive TB skin test completed on 02/07/2026. The records showed that on 03/26/2026, during the Departments visit Staff M received a chest X-ray with a negative result, 47 days after the positive TB test result.

STAFF N
Review of the facility's Employee Roster showed that the facility hired Staff N, Care Manager, on 01/28/2026. Review of Staff N's employee records showed documentation of a one-step positive TB skin test was completed on 01/31/2026. The records showed that on 03/26/2026 Staff N received a chest X-ray with a negative result, 54 days after the positive TB test result.

STAFF P
Review of the facility's Employee Roster showed that the facility hired Staff P, Care Manager, on 02/13/2026. Review of Staff P's employee records showed documentation of a one-step positive TB skin test was completed on 02/14/2026. The records showed that on 03/26/2026 Staff P received a chest X-ray with a negative result, 40 days after the positive TB test result.

During an interview on 03/26/2026 at 3:45 PM, Staff V, General Manager and Staff U, Regional Health Services Director, stated that three weeks ago the corporate office developed and provided a systematic plan for all facilities to start a new orientation process for all new staff to be conducted every Thursday that would include TB testing. Staff V stated that the new program would prohibit new employees from starting work until all on-boarding requirements were met.

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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 Bellevue is or will be in compliance with this law and / or regulation on (Date) 5/17/26 .

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

Administrator (or Representative) Date 4/8/26

WAC 388-112A-0400 What is specialty training and who is required to take it?

(4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows:

(b) Dementia specialty training as described in WAC 388-112A-0440 ; and

(c) Mental health specialty training as described in WAC 388-112A-0450 .

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

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

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

(iii) A certified nursing assistant;

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

WAC 388-112A-0700 What is CPR training? Cardiopulmonary resuscitation training is training provided by an authorized CPR instructor. Trainees must successfully complete the written and skills demonstration tests.

WAC 388-112A-0720 What are the CPR and first-aid training requirements?

(2) Assisted living facilities.

(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire.

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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:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 2 sampled care staff (Staff E) completed the skills demonstration test of the Cardiopulmonary Resuscitation (CPR) training and maintained a valid first-aid card. The facility failed to ensure 1 of 2 sampled care staff (Staff E) completed the continuing education (CE) training as required. The facility failed to ensure that 2 of 3 sampled staff (Staff A and Staff C) completed the specialty training as required. These failures placed the 65 residents at risk for decreased quality of care provided by caregivers with incomplete training.

Findings included...

Review of the facility's Position Descriptions for Care Managers dated 08/31/2020 and the facility's Position Description for Medication Care Managers dated 09/19/2025 showed that the facility required all Care Managers and Medication Care Managers to provide personal care and supervision to the assisted living residents consistent with Washington State regulations. The job descriptions showed that Care Managers and Medication Care Managers were required to maintain compliance with the Home Care Aide Certification and Nursing Assistant Certification and to complete the "assigned training" that included "continued training".

CARDIOPULMONARY RESUSCITATION (CPR) AND FIRST AID

STAFF E
Review of the facility's undated Employee Roster showed that the facility hired Staff E, Care Manager, on 04/27/2015. Review of Staff E's employee records showed that on 07/14/2025, Staff E completed the Adult CPR training online. There was no documentation that showed Staff E completed the skills demonstration test for the CPR training. There was no documentation that showed Staff E maintained a valid first-aid card or certificate.

CONTINUING EDUCATION (CE)

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STAFF E
Review of Staff E's employee records showed Staff E maintained an active Certified Nursing Assistant credential with the first issue date 05/15/2002. The records showed that Staff E completed seven of the required 12 hours of CE approved by the Department of Social and Health Services (DSHS) between their 2024 and 2025 birthdays.

Review of the facility's care staff schedule showed that Staff E provided care and services to assisted living residents in March 2026.

During an interview on 03/25/2026 at 1:50 PM, Staff G, Area Business Office Program Manager, stated that they were unable to locate additional CPR/first aid and CE training documents for Staff E.

During an interview on 03/25/2026 at 2:50 PM, Staff D, Administrator/Care Director, stated that Staff E completed their CPR training online that did not include the required skills demonstration test. Staff D stated that Staff E did not complete the skill demonstration tests for their CPR training. Staff D stated that Staff E did not complete the first aid training. Staff D stated that Staff E completed seven CE hours between their 2024 and 2025 birthdays and Staff E was short of the CE training.

SPECIALTY TRAINING

Review of the facility undated Characteristics Roster showed that 17 resident were identified with Mental Health and identified 22 residents with dementia/Alzheimer's/cognitive impairment.

Review of the facility's undated "Disclosure of Services" showed that the facility served residents with dementia and mental health needs.

Staff A
Review of the facility's Employee Roster showed that the facility hired Staff A, Care Manager, on 10/18/2025. Review of Staff A's employee records showed no documentation that Staff A completed the Department of Social and Health Services (DSHS) Mental Health and Dementia specialty training 160 days after hire as required.

Review of the facility's care staff schedule showed that Staff A provided care and services to assisted living residents in March 2026.

STAFF C
Review of the facility's Employee Roster showed that the facility hired Staff C, Care

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Manager, on 11/06/2025. Review of Staff C's employee records showed no documentation that Staff C completed the DSHS Mental Health specialty training 141 days after hire as required

Review of the facility's care staff schedule showed that Staff C provided care and services to assisted living residents in March 2026.

During an interview on 03/27/2026 at 2:30 PM, Staff D, Care Director, stated that Staff A and Staff C did not complete the specialty training required. Staff D stated that Staff A was scheduled to take the specialty training courses required.

Review of an email dated 04/01/2026 Staff G, Area Business Office Program Manager, stated that Staff C did not complete the DSHS Mental Health specialty as required.

Plan/Attestation Statement

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

Administrator (or Representative) — Date: 4/8/26

WAC 246-215-03309 Preventing food and ingredient contamination Food storage containers, identified with common name of food (FDA Food Code 3-302.12). Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar must be identified with the common name of the food.

WAC 246-215-03510 Temperature and time control Thawing (FDA Food Code 3-501.13). **Except as specified in subsection of this section, time/temperature control for safety food must be thawed:**

(1) Under refrigeration that maintains the food temperature at 41 F (5 C) or less; or

(2) Completely submerged under running water:

(a) At a water temperature of 70 F (21 C) or below;

(b) With sufficient water velocity to agitate and float off loose particles in an overflow; and

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(c) For a period of time that does not allow thawed portions of ready-to-eatfood to rise above 41 F (5 C); or

(d) For a period of time that does not allow thawed portions of raw animal food requiring cooking as specified under WAC 246-215-03400 (1) or (2) to be above 41 F (5 C) for more than four hours including:

(i) The time the food is exposed to the running water and the time needed for preparation for cooking; or

(ii) The time it takes under refrigeration to lower the food temperature to 41 F (5 C);

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 246-215-04705 Frequency Before use after cleaning (FDA Food Code 4-702.11). utensils and food-contact surfaces of equipment must be sanitized before use and after cleaning.

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, interview, and record review, 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). The facility failed to prevent cross-contamination between dirty and clean dishes and utensils for 1 of 1 kitchen (Main Kitchen). The facility failed to properly thaw frozen beef as required for 1 of 1 kitchen (Main Kitchen). This placed the 65 residents at risk for food borne illness.

Findings included...

Review of the facility's undated "Resident Characteristics Roster" showed 65 residents currently resided in the facility.

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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 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 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. The policy showed that sanitization buckets should 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 "Dishwasher" job description dated 09/18/2025 showed that the dishwasher was responsible to prepare the dishwasher machine and to clean the dishes and pots. The job description showed that the dishwasher was responsible for cleaning the dishwasher machine and the floor.

SANITIZATION BUCKETS

Observation on 03/24/2026 at 1:00 PM, showed Staff Y, Culinary Services Director, used a test strip to test the solution in two sanitization buckets, one located in the service line/cooking area and the second bucket in the dishwasher area. Observation showed Staff Y removed a test strip from a container that was labeled with a concentration range in several shades of blue that indicated the concentration strength level of the sanitization solution. Staff Y confirmed in a statement that the test strips were the correct test strips for the sanitization solution. After Staff Y stirred the test strip for over a minute in the sanitization solution Staff Y removed the test strip and compared the color on the test strip with the concentration level chart on the test strip container. Observation showed that the test strip showed the sanitation concentration strength was below the range required to be effective. The test strip showed the sanitization solution was at the lowest level when compared to the concentration chart. Observation showed Staff Y tested a second bucket of sanitization solutions which showed similar results as the first bucket of sanitization solution.

During an interview on 03/24/2026 at 1:00 PM, Staff Y stated that the sanitization solution buckets were changed every two hours. Staff Y stated that there was no documentation log that showed when the sanitization solution buckets were changed. Observation showed Staff Y changed out the sanitization solution in the buckets and retested each bucket. The test strips showed that the solution was within the required range to be effective for sanitization.

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Observation and interview on 03/26/2026 at 11:30 AM, showed a red sanitization bucket on the bottom shelf of the serving counter. Observation showed Staff Y tested the sanitization solution in the bucket with a test strip to determine the sanitization concentration level of the solution. Staff Y compared the test strip with the concentration level chart on the test strip container and the sanitization solution tested below the required concentration range to be effective. Staff Y changed out the sanitization solution and refilled the sanitization bucket with new solution from the main dispenser. Staff Y stated that the mixer valve did not always draw the concentrated solution from the main sanitization container into the mixing valve which caused the solution concentration to be weaker. Staff Y tested the new sanitization solution which measured within the effective range.

DIRTY UTENSILS

STAFF R
Review of the facility's Staff Roster showed that the facility hired Staff R, Dishwasher, on 01/28/2022.

Observation on 03/26/2026 at 12:09 PM, showed Staff R, Dishwasher, worked in the dishwasher area of the facility's main kitchen. Observation showed Staff R completed tasks that included handling dirty dishes and clean dishes. Observation showed Staff R did not wear gloves to remove food debris from dirty dishes with a sanitization rag and sprayer. Staff R placed the dirty dishes in a dish rack on the dirty side of the commercial dishwasher and then inserted the rack into the dishwasher to be cleaned and sanitized. Observation showed Staff R removed the cleaned dishes from the dishwasher from the clean side of the dishwasher. Observation showed Staff R returned to the dirty side of the dishwasher and reloaded a dish rack with dirty dishes and inserted the rack into the dishwasher. Observation showed Staff R returned to the clean side and removed the clean dishes and put them away. Staff R did not wash their hands in between handling dirty dishes and clean dishes. Observation showed Staff R repeated the process several times.

Observation on 03/26/2026 at 12:09 PM showed Staff R used a sanitization cloth from a sanitization bucket and wiped down the dirty side counter area of the dishwasher. Observation showed Staff R removed a large whisk from a clean utensil rack located on the opposite wall of the dishwasher and placed a sanitization cloth over the head of the whisk. Staff R proceeded to wipe down the walls covered with stainless steel on the dirty side of the dishwasher. Observation showed Staff R then removed the sanitization cloth and replaced the whisk back on the clean utensil rack without cleaning the whisk.

STAFF S
Review of the facility's Staff Roster showed that the facility hired Staff S, Dishwasher, on 10/05/2024.

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Observation on 03/27/2026 at 1:01 PM, showed Staff S washed dirty dishes, placed them into a dish rack and insert the dishes into the dishwasher. Observation showed Staff S returned to the dirty side of the dishwasher and proceed to wash additional dirty dishes and placed them in a dish wrack. Observation showed that Staff S then removed the clean dish rack with clean dishes from the dishwasher and insert the rack of dirty dishes into the dishwasher. Staff S returned to the clean side of the dishwasher and removed the clean dishes from the dish rack and put them away. Staff S repeated the process three additional times without washing their hands when going from dirty dishes to clean dishes.

During an interview on 03/27/2026 at 1:20 PM, Staff Y stated that Staff S did not follow the proper protocol for prevention of cross contamination.

THAWING FROZEN BEEF

During the kitchen observation on 03/26/2026 at 12:00 PM, showed two large packages of frozen meat in plastic bags under running cold water with one package completely submerged and one package partially submerged in a 22-quart container filled with cold water.

Observation and interview on 03/26/2026 at 12:00 PM, showed Staff CC, Sous Chef, sliced beef strips into smaller cubes. Staff CC stated that the frozen packages were beef that was being thawed and then cut up into smaller cubes for dinner later that evening. Staff CC stated that the frozen packages of beef should be completely submerged in water.

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 Bellevue is or will be in compliance with this law and / or regulation on (Date) 5/17/26 .

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Administrator (or Representative) — Date: 4/8/26

WAC 388-78A-3040 Laundry.

(5) The assisted living facility must ventilate laundry rooms and areas to the outside of the assisted living facility, including areas or rooms where soiled laundry is held for processing by off site commercial laundry services.

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

(7) The assisted living facility must provide a laundry area or develop and implement policy and procedure to ensure residents have access to an area where residents' may do their personal laundry that is:

(a) Equipped with:

(iv) Mechanical ventilation to the outside of the assisted living facility.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure 5 of 5 laundry room ventilation fans (1st floor secured memory care laundry room vent, 3rd floor two laundry room vents, 4th floor two laundry room vents,) were functioning as required. This failure caused poor ventilation in the residents' laundry rooms and the commercial laundry facilities.

Findings included...

Review of the facility's undated "Characteristics Roster" showed that 65 residents resided in the facility at the time of the Department of Social and Health Services inspection.

Observation during the facility initial physical plant tour on 03/24/2026 between 11:54 AM and 1:30 PM, showed that five laundry room vents, were not functioning, the secured memory care (Life's Neighborhood) laundry room vent, 3rd floor two laundry room vents, 4th floor two laundry room vents. Each vent was tested and each vent failed to draw and hold a paper towel and a tissue when placed over the ventilation grill to indicate negative pressure. Observation showed that all laundry room vents were covered with debris.

During an interview on 03/24/2026 at 12:30 PM, Staff T, Maintenance Director, stated they did not know why the ventilation systems were not pulling air as required to ventilate the laundry rooms.

During an interview on 03/27/2026 at 1:30 PM, Staff T stated that a technician came out to the facility and looked at all the laundry vents. Staff T stated that all the laundry vents were operational except for the Memory Care laundry vent and the one vent fan on the third floor. Staff T stated that new motors were ordered for the two bad ventilation fans.

Review of the technician inspection report dated 03/27/2026 showed that Laundry room on the first floor and one fan on the third had bad motors. The report showed that third floor fan blades were "cleaned of heavy debris" and the blades of the two ventilation fans in the 4th floor laundry room were cleaned which improved air flow.

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Administrator (or Representative) Date 4/8/26

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

(1) The assisted living facility must:

(a) Maintain the premises free of hazards;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure 6 of 6 storage doors (disinfectant storage room door, infectious waste room door, fenced storage areas entry gates, Emergency generator room door, Dry Kitchen storage door, and Memory Care laundry room door,) to areas with hazards to residents were secured. The facility failed to ensure 1 of 2 Housekeeping carts (Memory Care Housekeeping Cart) were secured to prevent resident access. This failure placed 65 residents at risk of harm.

Findings included...

Review of the facility's undated Characteristics Roster showed that 65 residents resided at the facility. The characteristics roster identified five memory care residents as exit seeking and wandering and three residents as wanderers. The characteristics roster identified 14 residents with Dementia, Alzheimer's, and/Mental Health concerns.

On 03/24/2026 at 10:10 AM during the entrance conference, Staff D, Care Director, stated that there were residents who still owned and drove vehicles parked in the facility's parking garage.

During the environmental tour on 03/24/2026 at 12:51 PM, with Staff T, Maintenance Director, observation showed multiple storage closet doors, emergency generator door and a fenced off storage area gate located in the parking garage that were found to be unlocked. Staff T identified the storage area as both facility storage and resident storage.

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Observation on 03/24/2026 at 12:51 PM with Staff T showed that the unsecured storage closets and fenced off storage areas belonged to the facility:

Observation showed the door to a storage closet marked Disinfectants with multiple cleaning chemicals that included four bottles of biocide, 11 bottles of Clorox all-purpose bleach, several bottles of 409 multi-surface cleaner, and disinfectant degreaser was unlocked and accessible to residents. The bottles were each labeled with hazard warnings and to keep out of reach of children.

Observation showed the door to the Infectious Waste closet was unlocked with hazardous waste containers inside and accessible to residents.

Observation showed that an entry gate to a fenced off storage area which contained an air compressor, vacuum, mattress, wheelchair, buckets, Halloween decorations, and other items was unlocked and accessible to residents.

Observation showed the Emergency Generator door with a posted sign that stated "caution: Flammable combustible fuel storage was unlocked and accessible to residents.

Observation showed the Kitchen dry storage room door with a posted sign taped to the door that stated to "keep locked at all times was unlocked and slightly ajar and was accessible to residents.

Observation showed that the secured Memory Care Unit (Life's Neighborhood) laundry room door was observed to be unlocked and accessible to cognitively impaired residents. Observation showed that the washing machines and dryers were operating at the time of the observation. Liquid laundry detergent was observed inside of the unsecured room. Observation showed several residents wandered about the secured memory care unit.

During an interview on 03/24/2026 at 12:38 PM and at 1:15 PM, Staff T stated that the laundry room in the Memory Care was used to wash the residents' clothes and should always be locked. Staff T stated that the generator room equipped with a lockable door handle and with a pad lock latch at the top of the door was supposed to be locked as well as the facility storage closets.

Observation on 03/26/2026 at 11:44 AM, showed an unlocked housekeeper cart located in the secured memory care unit next to the fish tank. Observation showed several cleaning solutions inside of the cart. Observation showed a housekeeper in an apartment located adjacent to the Memory Care office. Observation showed that the housekeeper did not have line of sight to ensure that wandering memory care residents did not access the housekeeping cart. Observation at 12:00 PM, an unidentified

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housekeeper exited the apartment, glanced over at the Department Licensor and immediately walked over and locked and removed the housekeeping cart.

Observation on 03/27/2026 at 1:15 PM showed that the fenced facility storage room, kitchen dry storage room with the door slightly ajar, and the emergency generator room all remained unlocked.

Plan/Attestation Statement

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

Administrator (or Representative) — Date: 4/8/26

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

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to test 4 of 14 staff (Staff A, Staff B, Staff I, and Staff X) for tuberculosis (TB) within three days of hire as required and failed to perform a second-step TB test one to three weeks after the first test for 4 of 4 staff (Staff L, Staff J, Staff K, and Staff O) for TB. This failure placed 65 residents at risk of potential exposure to tuberculosis, an 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.

ONE-STEP TB TEST

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STAFF A
Review of the facility's Employee Roster showed that the facility hired Staff A, Care Manager, on 10/18/2025. Review of Staff A's employee records showed documentation of a one-step negative TB skin test was completed on 10/26/2025 eight days after hire.

STAFF B
Review of the facility's Employee Roster showed that the facility hired Staff B, Care Manager, on 03/29/2025. Review of Staff B's employee records showed documentation of a one-step positive TB skin test was completed on 07/26/2025 119 days after hire.

STAFF I
Review of the facility's Employee Roster showed that the facility hired Staff I, Care Manager, on 01/29/2026. Review of Staff I's employee records showed documentation of a one-step negative TB skin test was completed on 02/18/2026 13 days after hire.

STAFF X
Review of the facility's Employee Roster showed that the facility hired Staff X, Care Manager, on 01/28/2026. Review of Staff X's employee records showed no documentation that the facility completed a TB test within three days of employment as required.

TWO- STEP TB TEST

STAFF L
Review of the facility's Employee Roster showed that the facility hired Staff L, Care Manager, on 02/13/2026. Review of Staff L's employee records showed a one-step negative TB test was completed on 02/12/2026. Review of Staff L's record showed no documentation that a second-step TB test was completed 43 days after the facility completed a second-step TB test.

STAFF J
Review of the facility's Employee Roster showed that the facility hired Staff J, Host, on 02/14/2026. Review of Staff J's employee records showed documentation of a one-step negative TB skin test was completed on 02/15/2026. Review of Staff J's record showed no documentation that a second-step TB test was completed 41 days after hire.

STAFF K
Review of the facility's Employee Roster showed that the facility hired Staff K, Cook, on 02/06/2026. Review of Staff K's employee records showed documentation of a one-step negative TB skin test was completed on 02/08/2026. Review of Staff K's record showed no documentation that a second-step TB test was completed 49 days after hire.

STAFF O
Review of the facility's Employee Roster showed that the facility hired Staff O,

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Maintenance Assistant, on 01/31/2026. Review of Staff O's employee records showed documentation of a one-step negative TB skin test was completed on 01/31/2026. Review of Staff O's record showed no documentation that a second-step TB test was completed 55 days after hire.

During an interview on 03/26/2026 at 3:45 PM, Staff V, General Manager and Staff U, RN, Regional Health Servies Director, stated that they recognized there was a problem with their system for TB testing. Staff V stated that three weeks ago the corporate office developed and provided a systematic plan for all facilities to start a new orientation process for all new staff to be conducted every Thursday that would include TB testing. Staff V stated the new program would prohibit new employees from starting work until all on-boarding requirements were met.

During the exit conference interview on 03/27/2026 at 2:00 PM, Staff W, Vice President of Clinical Operations, stated that the corporate office was aware of the TB deficiencies and developed a plan of correction to address the TB systems failure for the facility.

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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 screen and document dementia screening for 6 of 7 sampled residents (Resident 2, Resident 3, Resident 5, Resident 6, Resident 8, and Resident 9). This failure placed Resident 2, Resident 3, Resident 5, Resident 6, Resident 8, and Resident 9, at risk for unmet care needs.

Findings included...

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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: (7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of: (c) Dementia. While screening a resident for dementia, the assisted living facility must: (i) Base any determination that the resident has short-term memory loss upon objective evidence; and (ii) Document the evidence in the resident's record.

RESIDENT 2
Observation inside the Life's Neighborhood (secured memory care unit) between 03/24/2026 and 03/27/2026 showed Resident 2 received assisted living services.

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that the facility admitted Resident 2 in [redacted] 2024.

Review of Resident 2's records showed that on 02/17/2026, the facility completed a full assessment for Resident 2. The records showed no documentation that the facility screened dementia and evaluated the related special needs for Resident 2.

RESIDENT 3
Observation inside the Life's Neighborhood between 03/24/2026 and 03/27/2026 showed Resident 3 received assisted living services.

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that the facility admitted Resident 3 in [redacted] 2023.

Review of Resident 3's records showed that on 02/06/2026, the facility completed a full assessment for Resident 3. The records showed no documentation that the facility screened dementia and evaluated the related special needs for Resident 3.

RESIDENT 5
Observation inside Resident 5's apartment in Life's Neighborhood on 03/26/2026 at 11:58 AM showed Staff BB, Care Manager, assisted Resident 5 up from the bed and provided standby assistance with ambulation to the secured memory care dining room for lunch. Observation showed Resident 5 received assisted living services.

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that the facility admitted Resident 5 in [redacted] 2018.

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Review of Resident 5's Individualized Service Plan (ISP) dated 03/25/2026 showed that Resident 5 was diagnosed with [redacted] and resided in the secured Memory Care unit (Life's Neighborhood). The records showed no documentation that the facility screened Resident 5 for dementia.

RESIDENT 6
Observation on 03/26/2026 at 1:49 PM, showed Staff Z, Care Manager, and Staff AA, Medication Care Manager, used a mechanical lift to transfer Resident 6 from the wheelchair to the bed . Resident 6 was observed to be non-verbal and required all aspects of care provided by staff.

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that the facility admitted Resident 6 in [redacted] 2021.

Review of Resident 6's records showed that the ISP was updated on 03/24/2026. The (ISP) showed a diagnosis of [redacted] and [redacted]. The ISP showed that Resident 6 resided with their spouse in the Assisted Living side of the facility. Review of Resident 6's records found no documentation of a dementia screening for Resident 6.

RESIDENT 8
Observation and interview on 03/27/2026 at 11:00 AM, showed Resident 8 in the activity room Observation showed Resident 8 was ambulatory. Resident 8 stated that they received medication services from the facility and emotional support from the staff.

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that the facility admitted Resident 8 in [redacted] of 2023.

Review of Resident 8's ISP dated 02/23/2026 showed Resident 8 received medication services from the facility. Review of Resident 8's records showed no documentation that the facility screened for dementia.

RESIDENT 9
Observation on 03/27/2026 at 10:44 AM showed Resident 9 laid in a hospital bed and received feeding assistance from a private caregiver.

During an interview on 03/27/2026 at 10:44 AM, Resident 9 stated that the facility Care Managers assisted with transfers from the bed to the electric wheelchair. Resident 9 stated that the Care Managers assisted them with all aspects of care.

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that the facility admitted Resident 9 in [redacted] 2022.

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Review of Resident 9's ISP dated 07/25/2025 showed Resident 9 was diagnosed with [redacted] and [redacted]. There was no documentation that showed the facility screened for dementia.

During an interview on 03/26/2026 at 11:35 AM, Staff U, Registered Nurse/Regional Health Services Director, stated that they were unable to locate any documentation of dementia screening for Resident 2 and Resident 3. Staff U stated that the facility did not screen and document dementia screening for several assisted living residents.

Plan/Attestation Statement

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Administrator (or Representative) 4/8/26 Date

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:

(7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:

(c) Dementia. While screening a resident for dementia, the assisted living facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(ii) Document the evidence in the resident's record.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to screen and document dementia screening for 1 of 1 sampled resident (Resident 4). This failure placed Resident 4 at risk for unmet care needs.

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Statement of Deficiencies	License #: 2491	Compliance Determination # 74766
Plan of Correction	Aegis of Bellevue	Completion Date
Page 21 of 21	Licensee: 102 Ave Bellevue LLC	04/02/2026

Findings included...

RESIDENT 4
Observation inside Resident 4's apartment on 03/26/2026 at 11:10 AM showed Resident 4 received assisted living services.

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that the facility admitted Resident 4 in [redacted] 2025.

Review of Resident 4's records showed that on 07/31/2025 and 01/28/2026, the facility completed a full assessment for Resident 4. The records showed no documentation that the facility screened dementia and evaluated special needs for Resident 4.

During an interview on 03/26/2026 at 11:35 AM, Staff U, Registered Nurse/Regional Health Services Director, stated that they were unable to locate any documentation of dementia screening for Resident 4. Staff U stated that the facility did not screen and document dementia screening for Resident 4.

Plan/Attestation Statement

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[redacted] 4/8/26

Administrator (or Representative) Date

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