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 Living Greenwood
10000 Holman Rd NW
Seattle, WA 98177

RE: Aegis Living Greenwood License # 2617

Dear Administrator:

This letter addresses Compliance Determination(s) 47373 (Completion Date 09/20/2024) and 43341 (Completion Date 08/05/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/20/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210-2-a, WAC 388-78A-2210-1, WAC 388-78A-2210-1-a, WAC 388-78A-2210-1-b, WAC 388-78A-2240

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

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

Sincerely,

Jamie Singer

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

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Aegis Living Greenwood
Provider Type: Assisted Living Facility

License/Cert.#: 2617
Intake ID: 135203
Compliance Determination #: 43341
Region/Unit #: RCS Region 2 / Unit J
Investigator: Cathy Prentice
Investigation Date(s): 06/27/2024 through 08/05/2024
Complainant Contact Date(s):

Allegation(s):
There was a medication error for the named resident when the resident received half of the ordered medication since 03/02/24.

Investigation Methods:

Sample:	Total residents: 70 Resident sample size: 6 Closed records sample size: 0
Observations:	Named resident; delivery of care and services; staff interactions with residents; residents' appearance; environment.
Interviews:	Named resident, other residents, staff, administration, collateral contacts.
Record Reviews:	Resident care records, Assessment, Negotiated Service Agreement (NSA), investigations, grievances, facility policies, other pertinent records.

Investigation Summary:
Observation, interview and record review showed, the facility completed an Assessment and Negotiated Service Agreement that included the facility would manage and assist with medications for the named resident as well as receive medications from the facility pharmacy upon admission. The facility completed a thorough investigation to rule out abuse/neglect that substantiated medications errors of the wrong dose of an anticonvulsant medication from 03/02/24 through 06/15/24 due to a transcription error by a nurse. According to the state agency investigation, the named resident also missed medications 04/20/24 through 05/01/24 due to unavailability of the medication. The total doses of Depakote missed for Resident 1 was 92 doses due to transcription error and 22 doses due to medication unavailability for a total of 114 missed doses of Depakote due to transcription error and unavailability of medication on the part of the facility (does not include refused doses.) The facility failed to provide the named resident medications according to the physician prescribed medication order. See Statement of Deficiencies dated 08/05/2024.

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

Conclusion / Action:

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

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

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 #: 2617	Compliance Determination # 43341
Plan of Correction	Aegis Living Greenwood	Completion Date
Page 1 of 5	Licensee: Aegis Senior Communities LLC	08/05/2024

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

The department completed data collection for an unannounced on-site complaint investigation on 06/27/2024 and 06/27/2024 of:

Aegis Living Greenwood
10000 Holman Rd NW
Seattle, WA 98177

This document references the following complaint number(s): 134630, 135518, 135203, 140186

The following sample was selected for review during the unannounced on-site visit: 6 of 70 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

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

8/6/2024 — Date

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

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

Administrator (or Representative)

8/12/2024
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 :

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 2 sampled residents (Resident 1), who required medication assistance, received their medication as prescribed. This failure resulted in Resident 1 receiving less doses of the medication ordered and placed them at risk of harm.

Findings included...

NOTE- Medlineplus.gov stated the medication Divalproex (Depakote) is in a class of medications called anticonvulsants. It works by increasing the amount of a certain natural substance in the brain. Directions include: Take valproic acid at around the same time(s) every day. Follow the directions on your prescription label carefully. Do not stop taking valproic acid without talking to your doctor. Take valproic acid exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor.

Record review of a Face Sheet, showed the ALF admitted Resident 1 on [redacted]/2024 with a diagnosis of [redacted] ([redacted].) Review of an Assessment/Negotiated Service Agreement (NSA), dated 03/14/2024, showed Resident 1 required ALF staff assistance with medications.

Record review of Resident 1's Medication Administration Record (MAR) dated March, April, May and June 2024, showed an order dated 03/02/2024 for Divalproex Tab 500mg

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

DR (Depakote) one tablet by mouth twice daily for unspecified convulsions. The order had been transcribed into the MAR with one time slot for the medication at 10AM daily, not twice daily as ordered. The MARs showed the medication was given once a day, not twice daily, from [redacted]/2024 through 06/15/2024. Resident 1 missed a total of 92 doses of Depakote for convulsions.

Record review of Investigative Documents (ID), dated 06/16/2024, showed Resident 1's Depakote was given once daily instead of twice as ordered since admission [redacted]/2024. The error was discovered by a Medication Technician (MT). The facility concluded the error was due to the transcription of the twice daily medication to the MAR. A facility nurse transcribed only one daily time slot for the administration of the medication on the MAR.

In an interview, on 06/27/2024 at 1:30 PM, Staff A (Health Services Director) stated a nurse transcribed the Depakote order for Resident 1 into the MAR to be given twice daily as ordered but transcribed the administration time for only once per day. Staff A stated the transcription error was done on admission in [redacted] 2024 and was caught in June 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 Living Greenwood is or will be in compliance with this law and / or regulation on (Date) 9/1/2024.

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

Administrator (or Representative) — Date 8/12/2024

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure physician's ordered medication was available for 1 of 2 residents sampled (Resident 1). This failure led to Resident 1 missing 22 doses of an ordered and placed them at risk of harm.

Findings included...

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

NOTE- Medlineplus.gov stated the medication Divalproex (Depakote) is used alone or with other medications to treat certain types of seizures. Divalproex is in a class of medications called anticonvulsants. It works by increasing the amount of a certain natural substance in the brain. Directions include: Take valproic acid at around the same time(s) every day. Follow the directions on your prescription label carefully, Do not stop taking valproic acid without talking to your doctor. Take valproic acid exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor.

Review of facility policy Limited Supply Ordering Back-up Medications Process, dated 03/17/2015, showed the facility had a system in place to help eliminate situations where residents did not have prescribed medication available by re-ordering when a seven-day supply remained, and implementing the emergency back-up medication process when the second to the last dose of a medication had been administered and there was not a replacement in-house for the last dose.

Record review of a Face Sheet, showed the ALF admitted Resident 1 on [redacted]/2024 with a diagnosis of [redacted] Review of an Assessment/Negotiated Service Agreement (NSA), dated 03/14/2024, showed Resident 1 required ALF staff assistance with medications including obtaining medications from the facility pharmacy.

Record review of Resident 1's Medication Administration Record (MAR) dated April 20204 and May 2024, showed an order, dated 03/02/2024, for Divalproex Tab 500mg DR (Depakote) one tablet by mouth twice daily for unspecified convulsions.

Record review of Resident 1's Medication Administration Record (MAR) dated April 2024 and May 2024, showed Resident 1 did not receive the ordered medication Depakote from 04/20/2024 through 05/01/2024 for a total of 22 missed doses due to the medication noted as unavailable.

In an interview, on 07/26/2024 at 2:20 PM, Staff A (Health Services Director) stated the medication was unavailable because it had run out on 04/19/2024. Staff A was unsure why there was no note of attempts to refill the medication sooner than the day. Staff A stated the staff should have called for refill or prescription renewal at least 7 days before the medication ran out.

In an interview, on 07/30/2024 at 9:15 AM, Collateral Contact 1 (CC1 - the Legal Representative for Resident 1) stated medications from home were brought to the facility at admission on [redacted]/2024 and it was understood the facility would manage the medications including getting needed refills or prescription renewals as needed.

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

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Aegis Living Greenwood is or will be in compliance with this law and / or regulation on (Date) 9/1/2024 .

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

Administrator (or Representative) — Date: 8/12/2024

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