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 Ballard
949 NW Market St
Seattle, WA 98107

RE: Aegis Living Ballard License # 2689

Dear Administrator:

This letter addresses Compliance Determination(s) 50576 (Completion Date 11/21/2024) and 49454 (Completion Date 10/31/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/21/2024 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-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

# Residential Care Services
## Investigation Summary Report

**Provider/Facility:** Aegis Living Ballard
**Provider Type:** Assisted Living Facility
**License/Cert.#:** 2689
**Compliance Determination #:** 49454
**Intake ID:** 152716
**Investigator:** Cathy Prentice
**Region/Unit #:** RCS Region 2 / Unit J
**Investigation Date(s):** 10/28/2024 through 10/31/2024
**Complainant Contact Date(s):**

**Allegation(s):**

The Named Resident (NR) had a seizure in the dining room and went to the hospital on [redacted]/2024. The NR missed 5 doses of seizure medication due to med unavailability.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 41<br>Resident sample size: 3<br>Closed records sample size: 0 |
| **Observations:** | Named Resident (NR); delivery of care and services; staff interactions with residents; residents' appearance; environment; medication system. |
| **Interviews:** | Named Resident, other residents, staff, administration |
| **Record Reviews:** | Resident care records, Assessment, Negotiated Service Agreement (NSA), investigations, grievances, facility policies, other pertinent records. |

**Investigation Summary:**

Observation, interview and record review showed, the facility completed an Assessment and Negotiated Service Agreement as required. The NR missed five doses of an anti-seizure medication that may have lead to a seizure and hospital visit. The facility failed to have the medications available to be given to the NR. The failed to implement their system for obtaining medications for the NR when the medications ran out. See Statement of Deficiency dated 10/31/2024.

**Conclusion / Action:**

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

STATE OF WASHINGTON

# DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

***20311 52nd Ave W, Suite 100, Lynnwood, WA 98036***

| | | |
|---|---|---|
| Statement of Deficiencies | License #: 2689 | Compliance Determination # 49454 |
| Plan of Correction | Aegis Living Ballard | Completion Date |
| Page 1 of 4 | Licensee: Aegis Senior Communities LLC | 10/31/2024 |

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 10/28/2024 and 10/28/2024 of:

Aegis Living Ballard
949 NW Market St
Seattle, WA 98107

This document references the following complaint number(s): 152716, 149888, 149214

The following sample was selected for review during the unannounced on-site visit: 3 of 41 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

11/4/2024 — 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.

| Statement of Deficiencies | License #: 2689 | Compliance Determination # 49454 |
|---|---|---|
| Plan of Correction | Aegis Living Ballard | Completion Date |
| Page 2 of 4 | Licensee: Aegis Senior Communities LLC | 10/31/2024 |

Paul Shapard
Administrator (or Representative)

11-09-24
Date

**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 were available for 1 of 3 residents sampled (Resident 1). This failure resulted in Resident 1 missing doses of an anti-seizure medication and may have contributed to Resident 1 experiencing a seizure.

Findings included...

NOTE- Medlineplus.gov stated the medication levetiracetam (Keppra) is used in combination with other medications to treat seizure in adults. Levetiracetam should be taken at around the same time(s) every day. Follow the directions on your prescription label carefully. Take levetiracetam exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor. Do not stop taking levetiracetam without talking to your doctor. If you suddenly stop taking levetiracetam, your seizures may become worse.

Review of facility policy Obtaining/Filling Medication Orders/Re-orders protocol, dated 04/09/2022, showed medications provided by a non-preferred pharmacy needed to be re-ordered for refills. Order refills were processed no later than when a 7-day supply remained. Review of the facility Medication Not Available Policy, dated 04/18/2015, showed the Medication Care Manager was responsible for taking action when he/she had given the last dose of a medication and could not see replacement on site for the next dose. The facility had a system in place for implementing the emergency back-up medication process when the last dose of a medication had been administered and there was not a replacement in-house for the last dose, including when the resident gets medications from a different pharmacy.

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 09/29/2024, showed Resident 1 required ALF staff assistance with medications.

Record review of Resident 1's October 2024 Medication Administration Record (MAR)

Administrator (or Representative) Date

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Record review of Resident 1's October 2024 Medication Administration Record (MAR)

showed a physician's order, dated 08/15/2024, for levetiracetam 500 milligrams ER (Extended Release) by mouth twice daily. The October 2024 MAR showed Resident 1 missed five doses of the ordered levetiracetam; two doses on 10/21/2024 and 10/22/2024, and on dose on [redacted]/2024. The MAR noted the levetiracetam was not given as it was unavailable on the above dates.

Record review of Investigative Documents (ID), dated [redacted]/2024, showed Resident 1 had a seizure in the dining room at breakfast and was transported to the hospital. The ID showed that Staff A (Health Services Director) was informed at the time that Resident 1 did not receive the five doses of the physician ordered levetiracetam.

In an interview, on 10/29/2024 at 3:30 PM, Staff B (Medication Technician) stated she gave the last levetiracetam on 10/20/2024 and did not call the pharmacy for an emergency supply. Staff B stated she reported the unavailable anti-seizure medication to Staff C (Licensed Nurse). Staff B also stated she noted the anti-seizure medication was also not available the next day on 10/21/2024 and reported to Staff C again.

In an interview, on 10/29/2024 at 12:00 PM, Staff C stated she observed the empty bottle of anti-seizure medication when she received the report it was unavailable on 10/21/2024 and did not call the pharmacy for an emergency supply. Staff C stated she faxed the physician hoping he would send a refill request first thing the next morning and the medication would arrive.

In an interview, on 10/28/2024 at 12:35 PM, Staff A stated she was not aware the anti-seizure medication was not available until [redacted]/2024 when Resident 1 had a seizure. On 10/29/2024 at 4:00 PM Staff A confirmed no one called the pharmacy for an emergency supply of the levetiracetam from 10/20/2024 to [redacted]/2024. Staff A confirmed no one called the pharmacy when there were seven days left of the medication. Staff A confirmed Resident 1 missed five doses of the levetiracetam

**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 Ballard is or will be in compliance with this law and / or regulation on (Date) 11-09-24 .

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

showed a physician's order, dated 08/15/2024, for levetiracetam 500 milligrams ER (Extended Release) by mouth twice daily. The October 2024 MAR showed Resident 1 missed five doses of the ordered levetiracetam; two doses on 10/21/2024 and 10/22/2024, and on dose on [redacted]/2024. The MAR noted the levetiracetam was not given as it was unavailable on the above dates.

Record review of Investigative Documents (ID), dated [redacted]/2024, showed Resident 1 had a seizure in the dining room at breakfast and was transported to the hospital. The ID showed that Staff A (Health Services Director) was informed at the time that Resident 1 did not receive the five doses of the physician ordered levetiracetam.

In an interview, on 10/29/2024 at 3:30 PM, Staff B (Medication Technician) stated she gave the last levetiracetam on 10/20/2024 and did not call the pharmacy for an emergency supply. Staff B stated she reported the unavailable anti-seizure medication to Staff C (Licensed Nurse). Staff B also stated she noted the anti-seizure medication was also not available the next day on 10/21/2024 and reported to Staff C again.

In an interview, on 10/29/2024 at 12:00 PM, Staff C stated she observed the empty bottle of anti-seizure medication when she received the report it was unavailable on 10/21/2024 and did not call the pharmacy for an emergency supply. Staff C stated she faxed the physician hoping he would send a refill request first thing the next morning and the medication would arrive.

In an interview, on 10/28/2024 at 12:35 PM, Staff A stated she was not aware the anti-seizure medication was not available until [redacted]/2024 when Resident 1 had a seizure. On 10/29/2024 at 4:00 PM Staff A confirmed no one called the pharmacy for an emergency supply of the levetiracetam from 10/20/2024 to [redacted]/2024. Staff A confirmed no one called the pharmacy when there were seven days left of the medication. Staff A confirmed Resident 1 missed five doses of the levetiracetam

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| Page 4 of 4 | Licensee: Aegis Senior Communities LLC | 10/31/2024 |

Administrator (or Representative)

11-05-24

Date

Administrator (or Representative) Date