



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) 60007 (Completion Date 05/27/2025) and 56302 (Completion Date 03/24/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/27/2025 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:  
WAC 388-78A-2630-1-b

The Department staff who did the on-site verification:  
Hayley Pinkham, ALF Licenser

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

Sincerely,

  
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 Ballard

**Provider Type:** Assisted Living Facility

**License/Cert.#:** 2689

**Compliance Determination #:** 56302

**Intake ID:** 169780

**Investigator:** Hayley Pinkham

**Region/Unit #:** RCS Region 2 / Unit J

**Investigation Date(s):** 03/13/2025 through 03/24/2025

**Complainant Contact Date(s):**

### Allegation(s):

1) The Named Resident 1 (NR1) followed the Named Resident 2 (NR2) to her apartment and attempted to kiss the NR2. When the NR2 resisted the NR1 struck and choked the NR2.

### Investigation Methods:

|                        |                                                                                                                                         |
|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| <b>Sample:</b>         | Total residents: 53<br>Resident sample size: 3<br>Closed records sample size:                                                           |
| <b>Observations:</b>   | Identified resident<br>Residents<br>Activities<br>Resident rooms<br>Staff to resident interactions<br>Resident to resident interactions |
| <b>Interviews:</b>     | Identified resident<br>Nursing staff<br>Residents<br>Family members                                                                     |
| <b>Record Reviews:</b> | Medical records<br>Incident investigation                                                                                               |

### Investigation Summary:

1) The NR1 was not at the ALF during the visit. Interview with the NR2 showed she could remotely recall some of the altercation. No significant signs of sampled resident's health and welfare issues were identified during the visit. The ALF immediately separated the NR1 and NR2 at the time of the altercation. The ALF investigated the altercation, notified the collateral contacts, and reported to the department per guidelines. The ALF failed to report the physical assault to the local police department per the reporting regulation. Deficient practice identified. See Statement of Deficiencies dated 03/24/2025.

### Conclusion / Action:

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- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A



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|                           |                                        |                                 |
|---------------------------|----------------------------------------|---------------------------------|
| Statement of Deficiencies | License #: 2689                        | Compliance Determination #56302 |
| Plan of Correction        | Aegis Living Ballard                   | Completion Date                 |
| Page 1 of 3               | Licensee: Aegis Senior Communities LLC | 03/24/2025                      |

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

The department completed data collection for an unannounced on-site complaint investigation on 03/13/2025 of:

Aegis Living Ballard  
949 NW Market St  
Seattle, WA 98107

This document references the following complaint number(s): 169780

The following sample was selected for review during the unannounced on-site visit: 3 of 53 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Hayley Pinkham, ALF Licenser

From:  
DSHS, Aging and Long-Term Support Administration  
Residential Care Services, Region 2, Unit J  
20311 52nd Ave W, Suite 100  
Lynnwood, WA 98036

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| Page 2 of 3               | Licensee: Aegis Senior Communities LLC | 03/24/2025                       |

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.

|                                                                                   |                  |
|-----------------------------------------------------------------------------------|------------------|
|  | <u>3/25/2025</u> |
| Residential Care Services                                                         | 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.

|                                                                                   |                  |
|-----------------------------------------------------------------------------------|------------------|
|  | <u>4/09/2025</u> |
| Administrator (or Representative)                                                 | Date             |

#### WAC 388-78A-2630 Reporting abuse and neglect.

- (1) The assisted living facility must ensure that each staff person:
- (b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

#### This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to immediately report an incident of physical abuse involving 2 of 2 sampled residents (Resident 1 and 2) to law enforcement. This caused a delay in criminal investigation or interventions and placed the safety of Resident 2 at risk.

#### Findings included...

Record review of the ALF's "Abuse, Neglect and Exploitation Policy", revised 12/21/2017, showed mandated reporters must report to law enforcement when there was a reason to suspect physical assault has been committed against a resident. The policy showed there was no exception when an injury appears on the back, face or head or if there was an attempt to choke a resident.

Record review showed Washington Administrative Code (WAC) 388-78A-2020 – Definitions - defined "Physical abuse" as the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, or prodding.

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.

  
Residential Care Services

3/25/2025

Date

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

\_\_\_\_\_  
Administrator (or Representative)

\_\_\_\_\_  
Date

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|                           |                                        |                                 |
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| Page 3 of 3               | Licensee: Aegis Senior Communities LLC | 03/24/2026                      |

Record review showed the ALF admitted Resident 1 to the Memory Care Unit on [REDACTED]/2024 with a primary diagnosis of [REDACTED].

Record review showed the ALF admitted Resident 2 to the Memory Care Unit on [REDACTED]/2015 with a primary diagnosis of [REDACTED].

Record review of an ALF Progress Note (PN), dated 03/04/2025, showed that on 03/03/2025 Resident 1 followed Resident 2 to her apartment, Resident 1 began to argue with Resident 2. The PN showed Resident 1 hit Resident 2 in her mouth and face. The PN showed when Resident 2 backed away from Resident 1, Resident 1 proceeded to choke Resident 2. The PN showed Resident 2 sustained mild facial swelling to the left cheek and a laceration (a wound that is produced by the tearing of soft body tissue) to her lip.

Record review showed no documentation the ALF notified law enforcement as required following the altercation between Resident 1 and Resident 2.

In interview, on 03/24/2025 at 12:02 PM, Staff A (Health Service Director) confirmed she believed the altercation between Resident 1 and Resident 2 was physical assault. Staff A stated the ALF did not notify law enforcement the physical assault occurred.

#### 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) 4/05/25.

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



Administrator (or Representative)

4/05/25

Date

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\_\_\_\_\_  
Administrator (or Representative)

\_\_\_\_\_  
Date