STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Aegis Senior Communities LLC
AEGIS SENIOR INN OF REDMOND
7480 W LAKE SAMMAMISH PKWY NE
REDMOND, WA 98052

RE: AEGIS SENIOR INN OF REDMOND License # 1804

Dear Administrator:

This letter addresses Compliance Determination(s) 61427 (Completion Date 06/23/2025) and 58612 (Completion Date 05/07/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/23/2025 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-2210-2-a, WAC 388-78A-2130-3, WAC 388-78A-2130-3-a, WAC 388-78A-2130-3-b, WAC 388-78A-2120-1, WAC 388-78A-2120-2-a, WAC 388-78A-2120-3, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-4, WAC 388-78A-2120-2-b, WAC 388-78A-2120-2, WAC 388-78A-2120, WAC 388-78A-2703-4-a

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

If you have any questions, please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

Laurie Anderson, Community Field Manager
Region 2, Unit D
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Statement of Deficiencies	License #: 1804	Compliance Determination #:58812
Plan of Correction	AEGIS SENIOR INN OF REDMOND	Completion Date
Page 1 of 11	Licensee: Aegis Senior Communities LLC	05/07/2025

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 the unannounced on-site full inspection on 04/29/2025 and 04/30/2025 of:
AEGIS SENIOR INN OF REDMOND
7480 W LAKE SAMMAMISH PKWY NE
REDMOND, WA 98052

The following sample was selected for review during the unannounced on-site visit: 7 of 40 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility.

Thomas Forkgen, ALF Licensor
Kathy Young, Licensor
Michelle Yip, ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT 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 04/28/2025 and 04/30/2025 of:
AEGIS SENIOR INN OF REDMOND
7480 W LAKE SAMMAMISH PKWY NE
REDMOND, WA 98052

The following sample was selected for review during the unannounced on-site visit: 7 of 40 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Kathy Young, Licensor
Michelle Yip, ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
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Statement of Deficiencies	License #: 1804	Compliance Determination #:58612
Plan of Correction	AEGIS SENIOR INN OF REDMOND	Completion Date
Page 2 of 11	Licensee: Aegis Senior Communities LLC	05/07/2025

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.

Laurie Anderson — Residential Care Services

05/08/2025 — 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)

5/13/25 — Date

WAC 388-78A-2210 Medication services.

(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 observation, interview, and record review, the facility failed to administer oral and topical medications as prescribed for 1 of 1 resident (Resident 4). This failure placed Resident 4 at risk for compromised health.

Findings included...

Review of the facility's policy titled, "Assisting Resident with Medication Protocol", dated 12/04/2017, showed all topical medications were administered according to the facility's procedures and State regulations.

Review of the facility's policy titled, "Administration of Topical medications", dated 03/20/2015, showed that staff were expected to check the Medication Administration Record for medication instructions.

Review of the facility's undated Characteristics Roster showed that the facility admitted Resident 4 in [redacted] 2023 with the diagnosis of [redacted] and [redacted]

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 _____ 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 _____

WAC 388-78A-2210 Medication services.

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This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to administer oral and topical medications as prescribed for 1 of 1 resident (Resident 4). This failure placed Resident 4 at risk for compromised health.

Findings included…

Review of the facility's policy titled, "Assisting Resident with Medication Protocol", dated 12/04/2017, showed all topical medications were administered according to the facility's procedures and State regulations.

Review of the facility's policy titled, "Administration of Topical medications", dated 03/20/2015, showed that staff were expected to check the Medication Administration Record for medication instructions.

Review of the facility's undated Characteristics Roster showed that the facility admitted Resident 4 in [redacted] 2023 with the diagnosis of [redacted] ([redacted]) and [redacted] ([redacted]) [redacted] ([redacted]

[redacted]). The roster showed that Resident 4 resided in the secured memory care unit.

Review of Resident 4's "Individual Service Plan" (ISP), dated 04/14/2025, showed that Resident 4 required "trained medication staff" to administer oral medications and medicated topical medications.

ORAL MEDICATION
Review of Resident 4's February 2025, March 2025, and April 2025 electronic Medication Administration Record (eMAR) showed a routine order for Metoprolol (medication used to treat high blood pressure), 25 milligrams (mg) administered by mouth twice a day. The order showed to hold the Metoprolol if Resident 4's Systolic blood pressure [(SBP) the top number in a blood pressure reading that represents the pressure in your arteries when your heart beats and pumps blood] was less than 110 and to hold if the pulse rate (PR) was below 60 beats a minute.

Review of the February 2025 eMAR showed that Resident 4's SBP on 02/01/2025 was 108, PR on 02/04/2025 was 59, PR on 02/10/2025 was 59, and PR on 02/21/2025 was 54. The February 2025 eMAR showed that Resident 4's Metoprolol was administered on each of these dates and not held as ordered.

Review of Resident 4's March 2025 eMAR showed that on 03/03/2025, Resident 4's SBP at 8:00 AM was 88 and at 7:00 PM, it was 101. On 03/04/2025, the SBP was 102. On 03/07/2025, the PR was 58. On 03/15/2025 at 8:00 AM, the PR was 53 and at 7:00 PM, the PR was 56. On 03/16/2025 at 8:00 AM, the SBP was 108 and at 7:00 PM, the PR was 58. On 03/17/2025, at 7:00 PM, the SBP was 101 and the PR was 56. On 03/23/2025, the PR was 53. On 03/24/2025, the PR was 59. On 03/27/2025, the PR was 58. Review of the March 2025 eMAR showed that Resident 4's Metoprolol was administered and not held as ordered.

Review of Resident 4's April 2025 eMAR showed on 04/08/2025, the PR was 50. On 04/13/2025, the PR was 59. On 04/19/2025 at 8:00 AM, the PR was 51 and at 7:00 PM, the PR was 56. On 04/20/2025 at 8:00 AM, the PR was 56 and at 7:00 PM, the PR was 58. On 04/23/2025, the PR was 52. On 04/26/2025, the PR was 57. On 04/27/2025, the PR was 45. On 04/28/2025, the PR was 52. Review of the April 2025 eMAR showed that Resident 4's Metoprolol was administered and not held as ordered.

During an interview on 04/29/2025 at 1:47 PM, Staff I, Licensed Practical Nurse, Health Services Director, was unaware the staff failed to hold the medication as ordered.

TOPICAL MEDICATION
Review of Resident 4's February 2025, March 2025, and April 2025 electronic Medication Administration Record (eMAR) showed a routine order for Diclofenac gel 1% (anti-inflammatory medication) four grams to be applied topically to both of Resident 4's knees, three times daily for pain.

[redacted]). [redacted]. The roster showed that Resident 4 resided in the secured memory care unit.

Review of Resident 4's "Individual Service Plan" (ISP), dated 04/14/2025, showed that Resident 4 required "trained medication staff" to administer oral medications and medicated topical medications.

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Observation on 04/30/2025 at 7:38 AM, showed Staff F, Medication Care Manager, (unlicensed staff who dispense and administer medications) removed a tube of Diclofenac gel and squeezed out an unknown quantity into their gloved hand. Observation showed Staff F applied the gel to both of Resident 4's knees. Observation showed that Staff F did not measure the amount of Diclofenac to be applied, as ordered.

During an interview on 04/30/2025 at 7:40 AM, Staff F stated that "I always do it that way" Staff F stated that the eMAR showed an order for Resident 4 to receive 16 grams of Diclofenac gel. Staff F stated that they were unclear about the amount of Diclofenac to be administered. Staff F stated that there was no measurement device to measure the Diclofenac gel.

During an interview on 04/30/2025 at 2:00 PM, Staff I stated that they were unaware there was no measuring device for the Medication Care Managers to use for the proper application of the Diclofenac gel.

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 SENIOR INN OF REDMOND is or will be in compliance with this law and / or regulation on (Date) 6/20/25.

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

Administrator (or Representative) — Date: 5/13/25

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120:

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to update the service plan for 2 of 7 sampled residents (Resident 4 and Resident 6). This failure

Observation on 04/30/2025 at 7:38 AM, showed Staff F, Medication Care Manager, (unlicensed staff who dispense and administer medications) removed a tube of Diclofenac gel and squeezed out an unknown quantity into their gloved hand. Observation showed Staff F applied the gel to both of Resident 4's knees. Observation showed that Staff F did not measure the amount of Diclofenac to be applied, as ordered.

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

_____ _____

Administrator (or Representative) Date

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(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to update the service plan for 2 of 7 sampled residents (Resident 4 and Resident 6). This failure

placed Resident 4 and Resident 6 at risk for unmet care needs and a diminished quality of life.

Findings included...

RESIDENT 4

Review of the facility's undated Characteristics Roster showed that the facility admitted Resident 4 in [redacted] 2023 with the diagnosis of [redacted].
The Characteristics Roster showed that Resident 4 resided in the secured memory care unit.

Observations in Resident 4's apartment on 04/30/2025 at 7:38 AM, showed Resident 4 seated in a tilt-in-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). Observation showed Resident 4's left arm was placed on an arm rest. Observation showed a wrist brace on Resident 4's nightstand.

During an interview on 04/30/2025 at 7:45 AM, Staff H, Associate Care Director, stated that Resident 4 had a stroke that affected their left side so staff placed the left arm on the wheelchair arm rest. Staff H stated that during the night, Resident 4 wore a brace on their left wrist. Staff H stated that the evening shift caregiver placed the brace on Resident 4's left wrist at night when they put Resident 4 to bed. Staff H stated that when the dayshift caregiver assisted Resident 4 to get up in the morning, the caregiver removed the brace. Staff H stated that the information and instructions about the tilt-in-space wheelchair and the left hand/wrist brace would be documented in Resident 4's Individual Service Plan (ISP).

Review of a "Home Health Care Visit Communication Form" dated 11/13/2024, showed an Occupational Therapy Note that documented Resident 4 was to wear a night splint on the left hand.

Review of Resident 4's ISP dated 04/14/2025, showed no information that Resident 4 used a tilt-in-space wheelchair. There were no caregiver instructions about when and how often the wheelchair needed adjustment to redistribute Resident's 4's body weight to prevent pressure wounds (localized injury to the skin and underlying tissue caused by prolonged pressure). There was no information that showed Resident 4 wore a brace on their left wrist at bedtime.

During an interview on 04/30/2025 at 1:05 PM, Staff I, Health Services Director and Staff J, Regional Corporate Nurse, both stated that they were unable to locate any

placed Resident 4 and Resident 6 at risk for unmet care needs and a diminished quality of life.

Findings included…

RESIDENT 4

Review of the facility's undated Characteristics Roster showed that the facility admitted Resident 4 in [redacted] 2023 with the diagnosis of [redacted]. The Characteristics Roster showed that Resident 4 resided in the secured memory care unit.

Observations in Resident 4's apartment on 04/30/2025 at 7:38 AM, showed Resident 4 seated in a tilt-in-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). Observation showed Resident 4's left arm was placed on an arm rest. Observation showed a wrist brace on Resident 4's nightstand.

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Review of Resident 4's ISP dated 04/14/2025, showed no information that Resident 4 used a tilt-in-space wheelchair. There were no caregiver instructions about when and how often the wheelchair needed adjustment to redistribute Resident's 4's body weight to prevent pressure wounds (localized injury to the skin and underlying tissue caused by prolonged pressure). There was no information that showed Resident 4 wore a brace on their left wrist at bedtime.

During an interview on 04/30/2025 at 1:05 PM, Staff I, Health Services Director and Staff J, Regional Corporate Nurse, both stated that they were unable to locate any

information in Resident 4's ISP about the tilt-in-space wheelchair and the left wrist/hand brace. Staff I and Staff J stated that they were unaware there was no information in Resident 4's ISP about the tilt-in-space wheelchair and left wrist/hand brace with instructions on the use of each medical device.

RESIDENT 6
Review of the facility's undated Characteristics Roster showed that the facility admitted Resident 6 in [redacted] 2024 with the diagnosis of [redacted].

Observation of Resident 6's apartment on 04/30/2025 at 11:50 AM, showed Resident 6 seated in a recliner with a walker in front of them. Observation showed a quarter length bed rail attached on one side of at the head of a hospital bed. The other side of the bed was pushed up against the wall. The quarter length rail was secured to the bed and covered with a mesh netting material.

Review of Resident 6's medical records showed a side rail/enabler assessment, dated [redacted] 2024, was signed on 12/10/2024 by Resident 6's representative and Staff I.

Review of Resident 6's ISP, dated 04/29/2025, showed no documentation that Resident 6 used the quarter length bedrail.

During an interview on 04/30/2025 at 11:50 AM, Resident 6 stated that they used the quarter length bed rail for bed mobility and to get in and out of bed.

During an interview on 04/30/2025 at 1:06 PM, Staff I and Staff K, Resident Director, stated that they were unsure why the quarter length bedrail was not documented on Resident 6's ISP.

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 SENIOR INN OF REDMOND is or will be in compliance with this law and / or regulation on (Date) 6/20/25.

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

Administrator (or Representative) — Date: 5/13/25

information in Resident 4's ISP about the tilt-in-space wheelchair and the left wrist/hand brace. Staff I and Staff J stated that they were unaware there was no information in Resident 4's ISP about the tilt-in-space wheelchair and left wrist/hand brace with instructions on the use of each medical device.

RESIDENT 6
Review of the facility's undated Characteristics Roster showed that the facility admitted Resident 6 in [redacted] 2024 with the diagnosis of [redacted].

Observation of Resident 6's apartment on 04/30/2025 at 11:50 AM, showed Resident 6 seated in a recliner with a walker in front of them. Observation showed a quarter length bed rail attached on one side of at the head of a hospital bed. The other side of the bed was pushed up against the wall. The quarter length rail was secured to the bed and covered with a mesh netting material.

Review of Resident 6's medical records showed a side rail/enabler assessment, dated [redacted]/2024, was signed on 12/10/2024 by Resident 6's representative and Staff I.

Review of Resident 6's ISP, dated 04/28/2025, showed no documentation that Resident 6 used the quarter length bedrail.

During an interview on 04/30/2025 at 11:50 AM, Resident 6 stated that they used the quarter length bed rail for bed mobility and to get in and out of bed.

During an interview on 04/30/2025 at 1:05 PM, Staff I and Staff K, Resident Director, stated that they were unsure why the quarter length bedrail was not documented on Resident 6's ISP.

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 SENIOR INN OF REDMOND is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(3) Evaluate, in order to determine if there is a need for further action.

(a) The changes identified in the resident per subsection (2) of this section, and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to monitor 1 of 1 sampled resident's (Resident 3) blood sugar levels, identify changes of conditions, and take appropriate action to resident's change of condition. This failure placed Resident 3 at risk of medical complications and unmet care needs.

Findings included...

Review of Resident 3's records showed that the facility admitted Resident 3 in [redacted] 2024. The records showed Resident 3's medical diagnoses included [redacted]. The records showed that on 01/30/2025, the facility completed Resident 3's assessment. The records showed that Resident 3 required assistance with blood glucose monitoring and insulin administration.

Review of the February 2025, March 2025, and April 2025 Medication Administration Records (MARs) showed a medical order to 'take and record blood sugar values four times a day, notify nurse if under 70 or over 400'. The MARs showed that Resident 3's blood glucose levels were below 70 eight times in February 2025 and five times in April 2025. There was no documentation that showed the medication care managers (MCMs) notified the nurse of the low blood glucose levels in accordance with the medical order.

Review of Resident 3's February 2025, March 2025 and April 2025 progress notes showed no documentation that the nurse was notified of any low blood glucose levels. There was no documentation that showed the nurse assessed the resident and provided any treatments in responses to the low blood glucose levels.

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to monitor 1 of 1 sampled resident's (Resident 3) blood sugar levels, identify changes of conditions, and take appropriate action to resident's change of condition. This failure placed Resident 3 at risk of medical complications and unmet care needs.

Findings included…

Review of Resident 3's records showed that the facility admitted Resident 3 in [redacted] 2024. The records showed Resident 3's medical diagnoses included [redacted]. The records showed that on 01/30/2025, the facility completed Resident 3's assessment. The records showed that Resident 3 required assistance with blood glucose monitoring and insulin administration.

Review of the February 2025, March 2025, and April 2025 Medication Administration Records (MARs) showed a medical order to "take and record blood sugar values four times a day, notify nurse if under 70 or over 400". The MARs showed that Resident 3's blood glucose levels were below 70 eight times in February 2025 and five times in April 2025. There was no documentation that showed the medication care managers (MCMs) notified the nurse of the low blood glucose levels in accordance with the medical order.

Review of Resident 3's February 2025, March 2025 and April 2025 progress notes showed no documentation that the nurse was notified of any low blood glucose levels. There was no documentation that showed the nurse assessed the resident and provided any treatments in responses to the low blood glucose levels.

Observation on 04/30/2025 at 7:45 AM, showed Resident 3 used a FreeStyle Libre 2 (a continuous glucose monitoring system) to monitor blood glucose levels. During an interview at this time, Resident 3 stated that they had diabetes for 30 years. Resident 3 stated that in the recent years, their blood glucose control was unstable. Resident 3 stated that in the past, they experienced loss of consciousness one time due to low blood glucose level.

Observation on 04/30/2025 at 8:09 AM, showed Staff N, Medication Care Manager/Associate Care Director, checked Resident 3's blood glucose level. The results showed the glucose level was 60. Observation showed Staff N notified the nurse by phone of Resident 3's low blood glucose level. During an interview at this time, Staff N stated that the glucose reading of was lower than Resident 3's normal range. Staff N stated that when they notified Staff I, Licensed Practical Nurse (LPN)/Health Services Director, Staff I gave Staff N a verbal order to withhold the insulin administration and provide Resident 3 with a cup of orange juice. Observation showed Staff N documented the blood glucose level and the actions taken in the MARs.

During an interview on 04/30/2025 at 10:45 AM, Staff I stated that the MCMs were required to follow the medical order and notify the nurse whenever the resident's blood glucose levels were outside the recommended parameters. Staff I stated that the MCMs were required to document in the electronic MARs when they notified the nurse. Staff I stated that they were unaware that Resident 3's blood glucose levels were low several times in February 2025 and April 2025. Staff I stated that the MCMs did not notify them

During an interview on 04/30/2025 at 10:50 AM, Staff O, LPN/Wellness Nurse, stated that they were unaware Resident 3's blood glucose levels were low several times in February 2025 and April 2025. Staff O stated that the MCMs did not notify them.

During an interview on 05/06/2025 at 5:30 PM, Staff D, Medication Care Manager, stated that they were Resident 3's assigned Medication Technician. Staff D stated that they checked Resident 3's blood glucose at night. Staff D stated that they were aware Resident 3's blood glucose levels were low on several days in April 2025. Staff D stated that when Resident 3's blood glucose level was low, they provided the resident with orange juice. Staff D stated that the procedures for blood glucose monitoring in the night shifts were different from the morning and afternoon shifts. Staff D stated that they were unaware who the facility's on call nurse was. Staff D stated that they did not notify the nurse of Resident 3's low blood glucose levels.

Observation on 04/30/2025 at 7:45 AM, showed Resident 3 used a FreeStyle Libre 2 (a continuous glucose monitoring system) to monitor blood glucose levels. During an interview at this time, Resident 3 stated that they had diabetes for 30 years. Resident 3 stated that in the recent years, their blood glucose control was unstable. Resident 3 stated that in the past, they experienced loss of consciousness one time due to low blood glucose level.

Observation on 04/30/2025 at 8:09 AM, showed Staff N, Medication Care Manager/Associate Care Director, checked Resident 3's blood glucose level. The results showed the glucose level was 60. Observation showed Staff N notified the nurse by phone of Resident 3's low blood glucose level. During an interview at this time, Staff N stated that the glucose reading of was lower than Resident 3's normal range. Staff N stated that when they notified Staff I, Licensed Practical Nurse (LPN)/Health Services Director, Staff I gave Staff N a verbal order to withhold the insulin administration and provide Resident 3 with a cup of orange juice. Observation showed Staff N documented the blood glucose level and the actions taken in the MARs.

During an interview on 04/30/2025 at 10:45 AM, Staff I stated that the MCMs were required to follow the medical order and notify the nurse whenever the resident's blood glucose levels were outside the recommended parameters. Staff I stated that the MCMs were required to document in the electronic MARs when they notified the nurse. Staff I stated that they were unaware that Resident 3's blood glucose levels were low several times in February 2025 and April 2025. Staff I stated that the MCMs did not notify them.

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Statement of Deficiencies	License #: 1804	Compliance Determination #58612
Plan of Correction	AEGIS SENIOR INN OF REDMOND	Completion Date
Page 9 of 11	Licensee: Aegis Senior Communities LLC	05/07/2026

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 SENIOR INN OF REDMOND is or will be in compliance with this law and / or regulation on (Date) 6/20/25

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

Administrator (or Representative) — Date: 5/13/25

WAC 388-78A-2703 Safety of the built environment. The assisted living facility must provide a safe environment and promote the safety of each resident whenever the resident is on the premises or under the supervision of staff persons consistent with the resident's negotiated service agreement, and must maintain the premises and equipment used in resident care so as to be free of hazards, including:

(4) Providing door hardware to ensure:

(a) Residents cannot lock themselves in, or out of, rooms or areas accessible to them; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that 1 of 1 door (Door 1), that opened to the secured memory care outdoor courtyard, was unlocked to allow residents free access to and from the courtyard. This failure placed all 12 memory care residents at risk of being locked out of the facility and a diminished quality of life.

Findings included...

Observation on 04/28/2024 at 10:00 AM showed a secure outdoor area for the residents in the secured memory care unit. Observation showed one access glass door (Door 1) between the dining room/activity room and the outdoor courtyard. The door was equipped with a push bar that allowed residents to independently enter the outdoor space from inside the facility without staff assistance. Observation showed the door was locked from the outside, which prevented residents from independently re-entering the facility. There was no sign posted anywhere that instructed people how to re-enter the facility from the courtyard.

Observation on 04/28/2025 at 2:30 PM showed Door 1 allowed memory care residents and staff unrestricted access to the secured outdoor area. Observation showed Door 1

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Observation on 04/28/2025 at 2:30 PM showed Door 1 allowed memory care residents and staff unrestricted access to the secured outdoor area. Observation showed Door 1

remained locked from the outside. Observation showed an unidentified staff was outside in the secured courtyard and attempted to re-enter the facility. Observation showed staff were unable to open Door 1 to re-enter the facility without assistance from someone inside opening the door for them. Observation showed the unidentified staff knocked on the glass door that alerted Staff L, Medication Care Manager, in the dining room/activity room. Observation showed Staff L opened the glass door to let the unidentified staff back into the facility.

During an interview on 04/28/2025 at 2:35 PM, Staff L stated that access to the outdoor area in the secured memory care unit was easily available from the dining room/activity room. Staff L stated that access to the courtyard only required the release bar on the door to be pushed. Staff L stated that from the outside, the door was locked. Staff L stated that any resident, visitor, and staff person who were outside in the courtyard required someone inside the facility to open the door for them. Staff L stated that the assigned memory care staff were responsible to pay attention to anyone that attempted to re-enter the building through Door 1. Staff L stated that the memory care residents were not allowed to go out to the courtyard on their own and they must be accompanied by a staff person. Staff L stated that when a resident wanted to go out to the courtyard, the resident needed to ask staff for assistance.

During an interview on 05/01/2025 at 4:40 PM, Collateral Contact 1 (CC 1, Resident 1's family), stated that Resident 1 walked independently and enjoyed walking outdoors. CC 1 stated that they took Resident 1 out for a walk in the secured courtyard. CC 1 stated when they attempted to re-enter the building, they were locked out in the courtyard. CC 1 stated that they waited until someone opened the door to let them back into the building.

Review of an email from Staff M, Executive Director, dated 05/05/2025, showed that the facility did not have a written policy specific to courtyard use. Staff M stated that Door 1 provided the memory care residents with access to the secured outdoor courtyard. The email showed that the area was secured with controlled access. The email showed that in the event of an accidental lockout, residents or staff could ring a bell located near the door for assistance.

During an interview on 05/05/2025 at 1:58 PM, Staff M stated that the memory care residents were not allowed to go out to the courtyard, by themselves, without staff supervision. Staff M stated that residents must be accompanied by a staff member while in the courtyard. Staff M stated that the facility scheduled supervised walks for residents, twice a day. Staff M stated that there was a doorbell near the door in the courtyard. Staff M stated there were no posted signs that instructed people how to re-enter the facility.

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Administrator (or Representative) — Date: 5/13/25

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