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 of Queen Anne at Rodgers Park
2900 3rd Ave W
Seattle, WA 98119

RE: Aegis of Queen Anne at Rodgers Park # 2381

Dear Administrator:

This document references Compliance Determination 45289 (08/14/2024), which included complaint number(s) 140421.
The Department completed a complaint investigation of your Assisted Living Facility on 08/14/2024 and found that your facility does not meet the Assisted Living Facility requirements.

The department staff who did the inspection and provided consultation:

Cathy Prentice, Complaint Investigator

Consultation:

WAC 388-78A-2410 Content of resident records. The assisted living facility must organize and maintain resident records in a format that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

(7) Any orders for medications, treatments, and modified or therapeutic diets, including any directions for addressing a resident's refusal of medications, treatments, and prescribed diets.

(8) Medical and nursing services provided by the assisted living facility for a resident, including:

(a) A record of providing medication assistance and medication administration, which

contains:

(i) The medication name, dose, and route of administration;

(9) Documentation consistent with WAC 388-78A-2120 Monitoring resident well-being.

(10) Staff interventions or responses to subsection (9) of this section, including any modifications made to the resident's negotiated service agreement.

The Assisted Living Facility (ALF) failed to document their repeated attempts to refill multiple medications in the record for a resident whose medication had run out. This placed residents at risk when the ALF could not show documentation of ensuring medications were refilled.

You Must:
- Begin the process of correcting the deficiency or deficiencies immediately; and
- Complete correction as soon as possible.

You Are Not:
- Required to submit a plan-of-correction for the deficiency or deficiencies found.

The Department May:
- Inspect the facility to determine if you have corrected all deficiencies.

You May:
- Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:
- Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  - o What specific deficiency or deficiencies you disagree with;
  - o Why you disagree with each deficiency; and
  - o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  - o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

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 of Queen Anne at Rodgers Park
Provider Type: Assisted Living Facility
License/Cert.#: 2381
Intake ID: 140421
Compliance Determination #: 45289
Region/Unit #: RCS Region 2 / Unit J
Investigator: Cathy Prentice
Investigation Date(s): 08/07/2024 through 08/14/2024
Complainant Contact Date(s): 07/31/2024, 08/14/2024

Allegation(s):

1. The named resident missed medications three times including for seizures and behaviors and missed a fourth medication 07/21/2024-07/27/2024 due to medication unavailability. 2. Legal rep was not notified of the missed medications as noted in the care plan. 3. There were no attempts to contact the MD for refills of the medications. 4. There is a Covid outbreak in the memory care unit: 8 residents.

Investigation Methods:

Sample:	Total residents: 103 Resident sample size: 2 Closed records sample size: 1
Observations:	Named resident; delivery of care and services; staff interactions with residents; residents' appearance; environment; Infection Control practices.
Interviews:	Named resident not in facility, other residents, staff, administration, collateral contacts.
Record Reviews:	Resident care records, Assessment, Negotiated Service Agreement (NSA), grievances, facility policies, other pertinent records. Infection Control (IC) investigation: Respiratory Protection Program (RPP), and facility policies, resident records.

Investigation Summary:

According to observation, interview and record review, the facility completed an Assessment and Negotiated Service Agreement as required. 1. The named resident missed a blood pressure medication once in June 2024, missed seizure medication once in June 2024, missed a patch medication for dementia nine times in July 2024, missed an eyelid pad a total of five times during May and June 2024 all due to medication unavailability. The missed medication for behavior on 05/19/2024, 05/28/2024 and 07/06/2024 was due to refusal of the medication. Interview and record review showed the facility made multiple attempts to contact the physician for refills without response. A consult was given to the facility for records under WAC 388-78A-2410. 2. Review of the care plan did not show an agreement to notify

the legal rep when medications were unavailable or needed refills. The named resident used the facility pharmacy for obtaining medications. No failed practice identified. 3. The facility documented one fax to the MD requesting medication refill on 07/29/2024 and two progress notes dated 07/27/2024 and 07/30/2024. These communications were after the patch medication ran out on 07/22/2024. The facility stated, and one progress noted on 07/27/2024, multiple attempts to communicate with the MD for medication refills however the facility did not document the repeated attempts to contact the physician for medication refills per facility policy in the record. The facility policy noted attempts to contact the MD for low supply medications and needed refills should be done when 7 days, 5 days, 3 days and 1 day of the medication is left. The facility was unable to provide documentation of these attempts to refill the missed medications. A consult was given to the facility for records under WAC 388-78A-2410. 4. There were a total of 12 residents in the Memory Care Unit Covid positive. The facility had Infection Control systems and policies for delivery of care and services in place as required. There was no failed practice identified for infection control. No failed practice identified.

Conclusion / Action:

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