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

116 Ave Kirkland LLC
Aegis Lodge of Kirkland
12629 116TH AVE NE
KIRKLAND, WA 98034

RE: Aegis Lodge of Kirkland License # 2492

Dear Administrator:

This letter addresses Compliance Determination(s) 36136 (Completion Date 01/31/2024) and 32545 (Completion Date 11/27/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/31/2024 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-2610-1, WAC 388-78A-2610-2-d, WAC 388-78A-2484-2, WAC 388-78A-2484-1, WAC 388-78A-2484

The Department staff who did the on-site verification:
Steven Garrett, LTC Licensor
Claudia Machado, Community Complaint Investigator

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

Sincerely,

Laurie Anderson

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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
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Plan of Correction	Aegis Lodge of Kirkland	Completion Date
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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 11/14/2023 and 11/17/2023 of:

Aegis Lodge of Kirkland
12629 116TH AVE NE
KIRKLAND, WA 98034

The following sample was selected for review during the unannounced on-site visit: 11 of 64 current residents and O former residents.

The department staff that inspected the Assisted Living Facility:

Steven Garrett, LTC Licensor
Claudia Machado, Community Complaint Investigator

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

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 — **11/30/2023**

Residential Care Services — Date

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

Statement of Deficiencies	License #: 2492	Compliance Determination # 32545
Plan of Correction	Aegis Lodge of Kirkland	Completion Date
Page2 of6	Licensee: 116Ave Kirkland LLC	11/27/2023

Administrator (or Representative) 12/1/23 Date

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(d) Provide all resident care and services according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement infection control policies and requirements to protect 64 of 64 residents (Resident 1 through Resident 64) in the facility from an infectious illness. This failure placed all 64 residents at risk of contracting and spreading a potentially life-threatening infectious disease.

Findings included...

The Centers for Disease Control and Prevention (CDC), the national public health agency for the United States. developed guidelines for infection prevention and control practices in healthcare settings including assisted living facilities. The Washington State Governor's Office, the Washington State Department of Social and Health Services (DSHS), the Washington State Department of Health (DOH), and the Washington State Department of Labor and Industries {L&I), established the current infection control standards to prevent and control the spread of respiratory infections, such as coronavirus disease 2019 (COVID-19), in healthcare settings.

Review of the CDC website "Transmission-Based Precautions" at (https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html),showed that the CDC recommended the use of personal protective equipment (PPE) to prevent infection transmission including a fit-tested National Institute for Occupational Safety and Health (NIOSH)-approved N95 or higher-level respirator for healthcare personnel.

Review of the DOH publication, "Interim Recommendations for SARS-CoV-2 Infection Prevention and Control in Healthcare Settings" dated October 31, 2022, $howed specific guidelines for a Respiratory Protection Program (RPP) that included medical evaluation and fit testing for respirator use. The publication showed that facilities were required to provide initial and annual fit tests for any employee identified as potentially being exposed to respiratory hazard_ The publication showed that facilities were required to provide each

employee with the properly fit-tested respirator identified during the fit-test process.

Review of the DSHS Dear Provider Letter, "Provider Responsibilities for Provision of Personal Protective EqL.1ipment (PPE), Respiratory Protection Program (RPP), and changes to Department of Health RPP Resources" dated 09/14/2023, showed the guidelines for long-term care facilities (LTCF) and employer responsibilities for respiratory protection and RPP. The letter showed that LTCF setting providers were required to supply PPE to staff who provided care to residents with known or suspected communicable disease. The letter also showed that employers were responsible to identify respiratory hazards in the workplace, provide appropriate PPE and follow regulations pertaining to respiratory protection.

Review of the facility's document, "Respiratory Protection Program" dated 10i18/2021, showed that the facility General Manager was the Program Administrator responsible for administering the RPP. The Program Administrator responsibilities included ensuring fit testing was conducted upon hire (for those identified staff) and annually thereafter. The document showed that the facility would identify one Fit Testing Trainer/Coordinator who was responsible for ensuring the RPP was implemented. The Fit Testing Trainer/Coordinator responsibilities included ensuring that employees (including new hires) received appropriate training, and annual medical evaluation and fit testing if duties involved use of a respirator. Further review of the document showed the purpose of the RPP was to ensure that all employees who were required to wear respirators when performing their job duties were protected from exposure to these airborne transmissible diseases_ The document showed that respirators were required for those designated staff members who cared for residents who were exposed or who were confirmed positive for COVID-19. The employees who were required to wear respirators may include Associate Care Directors, Care Directors, Care Managers, and Medication Care Managers.

Review of the facility's Employee Roster showed that the facility hired Staff A (General Manager) on 08/16/2023, Staff B (Care Manager 1) on 10/25/2023, Staff C (Medication Care Manager) on 08/02/2023, Staff D (Medication Care Manager) on 09/26/2023, Staff E (Care Manager 1) on 11/21/2022, and Staff F (Medication Care Manager) on 05/20/2015.

Review of the facility's respirator fit testing documentation showed that Staff A Staff B, Staff C, Staff D, and Staff E did not complete the initial fit test or any medical evaluation. Further review of the documentation showed that Staff F was overdue for their medical evaluation_ The documentation showed Staff F was last medically evaluated and fit tested on 10/13/2022_

During an interview on 11/15/2023 at 10:20 AM, Staff A stated that they were the RPP Administrator_ Staff A stated that one of the residents in their memory care unit recently tested positive for COVID-19. Staff A further stated that all care staff were fit-tested for respirators. Staff A stated that they were aware not all care staff required to be fit-tested completed their medical evaluation or fit tests.

Plan/Attestation Statement

Statement of Deficiencies License #: 2492 Compliance Determination # 32545

Plan of Correction Page4 of6 | Aegis Lodge of Kirkland Licensee: 116 Ave Kirkland LLC | Completion Date 11/27/2023

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 Lodge of Kirkland is or will be in compliance with this law and / or regulation on (Date) 1/11/2024

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

Administrator (or Representative) 12/1/23 Date

WAC 388-78A-2484 Tuberculosis Two step skin testing, Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 4 of 6 staff (Staff A. Staff B, Staff C, and Staff D) were screened for Tuberculosis (TB) as required. This failure placed all the residents at risk of exposure to Tuberculosis, an infectious disease.

Findings included...

Note: WAC 388-78A-2480 (1) TL1berculosis-Testing-Required stated the assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

Review of facility's personnel records showed the facility hired Staff A. General Manager, on 08/16/2023; Staff B, Care Manager 1, on 10/23/2023; Staff C, Medication Care Manager, on 07/24/2023; and Staff D, Medication Care Manager, on 09/26/2023.

Review of the facility's staff schedule showed that from 08/16/2023 through 11/17/2023, Staff A worked at the facility providing oversight of staff who provided care and services for residents. Review of Staff A's personnel records showed no documentation that Staff A completed any testing to be screened for TB.

Review of the facility's staff schedule showed that from 10/23/2023 through 11/17/2023, Staff B worked at the facility providing care and services for residents. Review of Staff B's personnel records showed that on 11/02/2023, Staff B completed one-step of the two-

step TB skin test, 10 days after the date of employment. There was no documentation that showed Staff B completed a second test within one to three weeks after the first test.

Review of the facility's staff schedule showed that from 07/24/2023 through 11/17/2023, Staff C worked at the facility providing care and services for residents_ Review of Staff C's personnel records showed that on 08/02/2023, Staff C completed one-step of the two-step TB skin test, nine days after the date of employment. There was no documentation that showed Staff C completed a second test within one to three weeks after the first test.

Review of the facility's staff schedule showed that from 09/26/2023 through 11/17/2023, Staff D worked at the facility providing care and services for residents. Review of Staff O's personnel records showed that Staff D completed a one-step TB skin test on 09/26/2023, as required. The records showed Staff D completed the second skin test 29 days after the first step, eight days past the requirement.

DLffing an interview on 11/17/2023 at 2:30 PM, Staff A confirmed that when they were hired, they were not screened for TB_ Staff A stated that they were unaware that TB testing was required for all facility staff within three days of employment. Staff A confirmed that Staff B and Staff C were not screened for tuberculosis within three days of employment and did not complete the second skin test one to three weeks after the first test, as required. Staff A stated that Staff D completed the second TB skin test late and missed the required time frame_

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 Lodge of Kirkland is or will be in compliance with this law and / or regulation on {Date) 1/11/2024

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

Administrator (or Representative) 12/1/23 Date

WAC 388-78A 2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Statement of Deficiencies	License#: 2492	Compliance Determination# 32545
Plan of Correction	Aegis Lodge of Kirkland	Completion Date
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Based on observation, interview, and record review, the facility failed ensure the safety of 1 of i resident (Resident 1), who used a side bed rail attached to the resident's bed. This failure placed Resident 1 at risk of potential harm or death from use of unsafe medical equipment.

Findings included...

On 11/17/2023 at 10:50 AM, observation of Resident 1's room showed a half side rail attached along the right side of Resident 1's bed_ Observation showed the bed was in the lowered position with the headboard against the wall. The left side of the bed was placed against the wall. Observation showed a gap between the bars of the side rail, approximately 6.5 inches by 18 inches. There was also a four-inch gap between the edge of the mattress and the side rail. The side rail was not covered to protect the resident's head and limbs froin possible entrapment.

Review of Resident 1's assessment. dated 10/12/2023, showed a diagnosis of [redacted] which required frequent re-orientation to place, time, and person. The assessment showed that Resident 1 had poor self-safety awareness_ The assessment showed that Resident 1 was resistant to care, combatfve, and verbally aggressive. The assessment showed that Resident 1 was a moderate to high fall-risk and required one- person assistance with all care_

Review of Resident 1's November 2023 medication and treatment administration record showed that facility staff documented the completion of the side rail safety check on 11/17/2023.

During an interview on 11/17/2023 at 11:36 AM, Staff G, Care Director, stated that stated that they were unaware the side rail needed a cover. Staff G stated that they would locate a cover for the side rail. Staff G stated that they were unaware of the gap between the mattress and side rail. Staff G stated they would notify maintenance of the gap between the mattress and the side rail. Staff G stated that Resident 1 was unable to independently put the side rail down. Staff G stated that R1 was unable to call for staff assistance. Staff G stated that safety checks on side rails were done by care staff daily; 3 times a day, one time per shift. Staff G stated that care staff documented side rail safety checks on Resident 1's medication/treatment administration record_

During an interview on 11/17/2023 at 3:00 PM, Staff A, General Manager, stated that it was the responsibility of facility care staff to check the side rails used by any residents for safety. Staff A stated that they were aware that the uncovered side bed rails created a potential entrapment risk.

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 Lodge of Kirkland is or will be in compliance with this law and / or regulation on {Date) 1/11/2024

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

Administrator (or Representative) 12/1/23 Date

STATE OF W,<\SHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenues, Suite 400, Kent, WA 98032

11/30/2023

116 Ave Kirkland LLC
Aegis Lodge of Kirkland
12629 116TH AVE NE
KIRKLAND, WA 98034

RE: Aegis Lodge of Kirkland # 2492

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 11/27/2023 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:
• Wrote the enclosed report; and
• May take licensing enforcement action based on many deficiency listed on the enclosed report; and
• May inspect your program to determine if you have corrected all deficiencies; and
• Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:
• Begin the process of correcting the deficiency or deficiencies immediately;
• Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

• Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  o Sign and date the enclosed report;
  o For each deficiency, indicate the date you have or will correct each deficiency;
  o Mail the Plan/Attestation Statement and report with original signatures to:

Laurie Anderson, Field Manager
Residential Care Services
Region 2, Unit D
20425 72nd Avenue S, Suite 400

Kent, WA 98032

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s}:
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388 78A 2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(e) Make sure first-aid supplies are:

(i) Readily available and not locked;

(ii) Clearly marked;

The location of first aid kits throughout the facility were not identified. The kits were not readily available. During the inspection, the facility staff placed several first aid kits throughout the facility with identifier signs posted with each kit

You Are Not:
• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

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 Box45600
Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

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

Enclosure