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) 63641 (Completion Date 08/05/2025) and 61019 (Completion Date 06/12/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/05/2025 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-2880-1, WAC 388-78A-2880-1-a, WAC 388-78A-2880-1-b, WAC 388-78A-2880-1-c, WAC 388-78A-2880-1-d, WAC 388-78A-2880-2, WAC 388-78A-2880-3, WAC 388-78A-2880, WAC 388-78A-2485-1, WAC 388-78A-2485-2, WAC 388-78A-2485-3, WAC 388-78A-2485

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

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 follow-up on 06/12/2025 of:

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

This document references the following SOD dated: 06/12/2025

The following sample was selected for review during the unannounced on-site visit: 2 of 61 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Michelle Yip, ALF Licensor
Kathy Young, 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

Statement of Deficiencies	License #: 2492	Compliance Determination # 61019
Plan of Correction	Aegis Lodge of Kirkland	Completion Date
Page 2 of 5	Licensee: 116 Ave Kirkland LLC	06/12/2025

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

06/26/2025
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)

7/7/2025
Date

WAC 388-78A-2880 Changing use of rooms. Prior to using a room for a purpose other than what was approved by construction review services, the assisted living facility must:

(1) Notify construction review services:

(a) In writing;

(b) Thirty days or more before the intended change in use;

(c) Describe the current and proposed use of the room; and

(d) Provide all additional documentation as requested by construction review services;

(2) Obtain the written approval of construction review services for the new use of the room; and

(3) Ensure the facility functional program and room list are updated to reflect the change.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to obtain approval from the Washington State Department of Health, Construction Review Services (CRS) when there were changes to 18 of 142 assisted living apartments (apartments 202, 204, 203, 205, 231, 233, 235, 237, 305, 307, 310, 312, 311, 313, 315, 317, 331, and 333). This failure placed eight residents who currently reside in some of these apartments, and potentially any future residents, at risk for harm when apartments were altered without CRS approval for use and occupancy.

Findings included...

Review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed

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

06/26/2025
Date

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Administrator (or Representative)

Date

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Findings included...

Review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed

the Assisted Living Facility (ALF) received a citation for this regulation on 04/30/2025. The ALF signed an attestation statement that stated the facility would have the deficiency corrected by 06/02/2025.

Observation on 04/18/2025 at 9:50 AM showed the facility converted studio apartment 322 to the Health Services Director's office. Observation showed the facility connected apartments 310 and 312 with a door between to convert the apartment into one unit. The facility connected apartments 231 and 233 with a door between to convert the apartment into one unit. The facility connected apartments 235 and 237 with a door between to convert the apartment into one unit.

Review of the facility's internal email series titled, "Plan of Correction from State Visit in May 2025", dated June 4 and June 5, 2025, showed the facility converted 20 studio apartments into one-bedroom apartments. The email showed that Apartment 202 was joined with Apartment 204, with two residents in this converted apartment; Apartment 203 was joined with Apartment 205 with two residents in this converted apartment; Apartment 231 was joined with Apartment 233; Apartment 235 was joined with Apartment 237; Apartment 305 was joined with Apartment 307 with two residents in this new apartment; Apartment 311 was joined with Apartment 313; Apartment 310 was joined with Apartment 312 with one resident in this converted apartment; Apartment 315 was joined with Apartment 317; Apartment 327 was joined with Apartment 329; and Apartment 331 was joined with Apartment 333.

During an interview on 04/18/2025 at 10:14 AM, Staff G, Field Maintenance Specialist, stated the studio apartment conversions with a connecting door were completed many years ago. Staff G stated that they were unaware if the facility obtained CRS approval.

During an interview on 04/30/2025 at 8:45 AM, Collateral Contact 1 (CC1, a representative from CRS) stated that all the apartment conversions were completed without CRS approval, except for the conversion of 327 and 329 units. CC1 stated that the conversion of 327 and 329 was approved.

During an interview on 06/12/2025 at 1:14 PM, Staff A, General Manager, stated that the facility's Corporate Construction Manager came to the facility and reviewed the converted apartments. Staff A stated that the facility had not applied to CRS for approval of the converted apartments.

This is an uncorrected deficiency previously cited on 04/30/2025 for Washington Administrative Code (WAC) 388-78A-2880, subsections (1)(a)(b)(c) and (2).

Statement of Deficiencies	License #: 2492	Compliance Determination # 61019
Plan of Correction	Aegis Lodge of Kirkland	Completion Date
Page 4 of 5	Licensee: 116 Ave Kirkland LLC	06/12/2025

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)___ 7/27/2025

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

Administrator (or Representative) — Date: 7/7/25

WAC 388-78A-2485 Tuberculosis Positive test result. When there is a positive result to tuberculosis skin or blood testing the assisted living facility must:

(1) Ensure that the staff person has a chest X-ray within seven days;

(2) Ensure each resident or staff person with a positive test result is evaluated for signs and symptoms of tuberculosis; and

(3) Follow the recommendation of the resident or staff person's health care provider.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 2 of 3 sampled staff (Staff Y and Staff Z) completed a chest X-ray within seven days, was evaluated for signs and symptoms of TB, and followed the health care provider's recommendation, following a positive result to a Tuberculosis (TB) skin test. This failure placed all 61 residents at risk of exposure to tuberculosis, an infectious disease.

Findings included...

Review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 04/30/2025. The ALF signed an attestation statement that stated the facility would have the deficiency corrected by 06/02/2025.

Review of the facility's document titled "TB Requirements by State – Employees & Residents", dated 07/08/2024, showed that the facility followed the state regulations for staff persons with a positive TB test result.

STAFF Y
Review of the facility's Employee Roster showed the facility hired Staff Y, Care Manager,

Plan/Attestation Statement

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Administrator (or Representative) Date

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Findings included...

Review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 04/30/2025. The ALF signed an attestation statement that stated the facility would have the deficiency corrected by 06/02/2025.

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STAFF Y
Review of the facility's Employee Roster showed the facility hired Staff Y, Care Manager,

on 05/19/2025. Review of Staff Y's employee records showed that on 05/21/2025, Staff Y completed a one-step TB skin test, with a positive result. The records showed that on 06/05/2025, Staff Y completed a chest x-ray with a result of no active TB, 15 days following the positive TB skin test result. There was no documentation that showed Staff Y was evaluated for TB signs and symptoms. There was no documentation that showed Staff Y followed up with their health care provider.

STAFF Z
Review of the facility's Employee Roster showed the facility hired Staff Z, Care Manager, on 05/19/2025. Review of Staff Z's employee records showed that Staff Z had an undated history of positive TB from a Gold Test (a blood test for TB). The records showed that on 03/21/2025, Staff Z completed a chest X-ray with a result of no active TB. As of 06/12/2025, there was no documentation that showed Staff Z was evaluated for TB signs and symptoms. There was no documentation that showed Staff Z followed up with their health care provider.

During an interview on 06/12/2025 at 2:00 PM, Staff A, General Manager, stated that they did not find any additional TB documents for the two sampled staff. Staff A stated that they were aware Staff Y and Staff Z's TB testing did not meet the regulation guidelines.

This is an uncorrected deficiency previously cited on 04/30/2025, subsections (1), (2) and (3).

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 [illegible] and is or will be in compliance with this law and / or regulation on (Date)___ 7/27/2025

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

AL OTIENO

Administrator (or Representative) Date 7/7/2025

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STAFF Z
Review of the facility's Employee Roster showed the facility hired Staff Z, Care Manager, on 05/19/2025. Review of Staff Z's employee records showed that Staff Z had an undated history of positive TB from a Gold Test (a blood test for TB). The records showed that on 03/21/2025, Staff Z completed a chest X-ray with a result of no active TB. As of 06/12/2025, there was no documentation that showed Staff Z was evaluated for TB signs and symptoms. There was no documentation that showed Staff Z followed up with their health care provider.

During an interview on 06/12/2025 at 2:00 PM, Staff A, General Manager, stated that they did not find any additional TB documents for the two sampled staff. Staff A stated that they were aware Staff Y and Staff Z's TB testing did not meet the regulation guidelines.

This is an uncorrected deficiency previously cited on 04/30/2025, subsections (1), (2) and (3).

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Administrator (or Representative) Date

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 04/16/2025 and 04/22/2025 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: 9 of 63 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

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

05/05/2025 — 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.

AL OTIENO — Administrator (or Representative)

05/15/2025 — Date

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(c) Ensure all menus:

(i) Are written at least one week in advance and delivered to residents' rooms or posted where residents can see them, except as specified in (f) of this subsection;

(iii) Include all food and snacks served that contribute to nutritional requirements;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to post or provide for resident review, at least one week of menus, with all meals and snacks, in 1 of 1 memory care unit (Life's Neighborhood). These failures placed all 14 memory care residents at risk of a diminished quality of life.

Findings included...

Observation on 04/18/2025 at 11:10 AM showed no menus were posted for view within Life's Neighborhood. Observation on 04/21/2025 at 8:49 AM, showed only the menu for Saturday, 04/19/2025 was posted on the counter adjacent to the unit's kitchen. No other menus were posted anywhere within the unit.

During an interview on 04/18/2025 at 11:13 AM, Staff I, Medication Care Manager, stated that the facility usually displayed a daily menu but not a weekly menu in Life's Neighborhood.

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

05/05/2025 — Date

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Administrator (or Representative)

Date

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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) 06/02/2025

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

AR OTIENO — Administrator (or Representative)

05/15/2025 — Date

WAC 388-78A-2880 Changing use of rooms. Prior to using a room for a purpose other than what was approved by construction review services, the assisted living facility must:

(1) Notify construction review services:

(a) In writing;

(b) Thirty days or more before the intended change in use;

(c) Describe the current and proposed use of the room; and

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(2) Obtain the written approval of construction review services for the new use of the room; and

(3) Ensure the facility functional program and room list are updated to reflect the change.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to obtain approval from the Washington State Department of Health, Construction Review Services (CRS) when there were changes to 7 of 142 assisted living apartments (231, 233, 235, 237, 310, 312, and 322). This failure placed four residents who currently reside in these apartments, and potential of future residents, at risk for harm when apartments were altered without CRS approval for use and occupancy.

Findings included...

Observation on 04/18/2025 at 9:50 AM showed the facility converted studio apartment 322 to the Health Services Director's office. Observation showed the facility connected apartments 310 and 312 with a door between to convert the apartment into one unit. The facility connected apartments 231 and 233 with a door between to convert the apartment into one unit. The facility connected apartments 235 and 237 with a door between to convert the apartment into one unit.

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During an interview on 04/18/2025 at 10:14 AM, Staff G, Field Maintenance Specialist, stated the studio apartment conversions with connecting door were completed many years ago. Staff G stated that they were unaware if the facility obtained CRS approval.

During an interview on 04/30/2025 at 8:45 AM, a representative from CRS stated that all of the apartment changes were completed without CRS approval.

Plan/Attestation Statement

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

AL OTIENO — Administrator (or Representative)

05/15/2025 — Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

(2) The assisted living facility must provide housekeeping supply room(s):

(c) Equipped with:

(iv) Mechanical ventilation to the outside of the assisted living facility.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure it maintained the air exchange vents in 5 of 10 rooms (third-floor men's bathroom, second-floor men's bathroom, second-floor women's bathroom, main kitchen chemical room with mop sink, and the Life's Neighborhood janitor's supply room with mop sink). The facility failed to ensure oxygen tanks were stored safely and securely in 1 of 1 oxygen storage location (Life's Neighborhood). The facility failed to ensure it kept 1 of 1 exterior path (Path 1) free of trip hazards. The facility failed to secure 3 of 3 areas (the third-floor housekeeping laundry room, the boiler room, and the roof access door) for

During an interview on 04/18/2025 at 10:14 AM, Staff G, Field Maintenance Specialist, stated the studio apartment conversions with connecting door were completed many years ago. Staff G stated that they were unaware if the facility obtained CRS approval.

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resident safety. These failures placed all 63 residents at risk of illness, possible falls and injury, and a diminished quality of life.

Findings included...

Review of the undated facility document titled, "Facility Inspection" showed maintenance task sheets that instructed the building be thoroughly checked for properly functioning air vents free of debris; no cracks, missing concrete, or trip hazards in the outdoor spaces; and safety of the oxygen storage area.

VENTILATION
Observation on 03/18/2025 at 10:12 AM during the environmental tour, showed the air exchange vents in the third-floor men's bathroom, the main kitchen chemical room with mop sink, the second-floor women's bathroom, the second-floor men's bathroom, and Life's Neighborhood (memory care unit) janitor's supply room with mop sink were not functioning. Observations on 03/18/2025 at 10:45 AM, showed the second-floor women's bathroom and second-floor men's bathroom vents were covered with thick dust that fell when the vents were checked.

During an interview on 03/18/2025 at 10:12 AM, Staff G, Corporate Field Maintenance Specialist, stated that the inspection and cleaning of the vents were missed. Staff G stated that the responsibility was scheduled on the monthly and weekly task sheets for the Maintenance Assistant position, which was vacant at this time. Staff G stated that the vent in the main kitchen chemical room was wired incorrectly and pulled air in the wrong direction.

OXYGEN STORAGE
Review of the facility's document titled, "Oxygen Safety and Assistance Policy", dated 03/08/2015, showed the facility allowed oxygen use by residents when physician prescribed.

Review of the Resident Characteristic Roster showed four residents received oxygen therapy.

Observation on 03/18/2025 at 11:17 AM, showed that when the door to the Mechanical Room in Life's Neighborhood was opened, the sound of metal hitting metal was heard. Observation showed that behind the door were numerous oxygen tanks of varying sizes, stored in the path of the door when it was opened.

During an interview at the time, Staff G stated that it was the facility's expectation that the oxygen tanks were stored safely.

EXTERIOR PATHWAY

Observation on 04/18/2025 at 11:38 AM, showed there were two raised slabs of concrete along the walking path. The raised slabs created an uneven path. Observation showed that on the path, there were two loose concrete pieces that measured about four inches by two inches by half inch. Observation showed there were other concrete pieces still between the slabs that rose above the path.

During an interview at the time, Staff G stated that they were unaware the path contained an area with raised and broken slabs of concrete.

UNSAFE ACCESS
Observation during the facility tour on 04/16/2025 at 1:00 PM, showed a third-floor housekeepers' laundry room with a commercial washer and dryer. The laundry room access door, located along a main residents' hallway, did not have a lock. The laundry room allowed access to a second interior boiler room which housed four hot water tanks. Observation of the boiler room showed an iron ladder anchored to one wall that allowed access to the roof. Observation showed the roof hatch was not locked or secured. The door to the boiler room and roof access did not have a lock on the door which allowed for possible resident access.

During an interview on 04/16/2025 at 1:00 PM, Staff J, Marketing Director, stated that the third-floor laundry room was strictly for housekeepers' use. Staff J stated that residents were not allowed access to the laundry room and to the adjacent boiler room. Staff J stated that they were unaware there was no lock on the laundry room door.

Plan/Attestation Statement

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

AL OTIENO

Administrator (or Representative)

05/15/2025

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.

Observation on 04/18/2025 at 11:38 AM, showed there were two raised slabs of concrete along the walking path. The raised slabs created an uneven path. Observation showed that on the path, there were two loose concrete pieces that measured about four inches by two inches by half inch. Observation showed there were other concrete pieces still between the slabs that rose above the path.

During an interview at the time, Staff G stated that they were unaware the path contained an area with raised and broken slabs of concrete.

UNSAFE ACCESS
Observation during the facility tour on 04/16/2025 at 1:00 PM, showed a third-floor housekeepers' laundry room with a commercial washer and dryer. The laundry room access door, located along a main residents' hallway, did not have a lock. The laundry room allowed access to a second interior boiler room which housed four hot water tanks. Observation of the boiler room showed an iron ladder anchored to one wall that allowed access to the roof. Observation showed the roof hatch was not locked or secured. The door to the boiler room and roof access did not have a lock on the door which allowed for possible resident access.

During an interview on 04/16/2025 at 1:00 PM, Staff J, Marketing Director, stated that the third-floor laundry room was strictly for housekeepers' use. Staff J stated that residents were not allowed access to the laundry room and to the adjacent boiler room. Staff J stated that they were unaware there was no lock on the laundry room door.

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)_____ .

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

_____ _____
Administrator (or Representative) 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 complete 1 of 3 sampled staff's (Staff B) second skin test for Tuberculosis (TB), as required. This failure placed all 63 residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included...

Review of the facility's document titled "TB Requirements by State – Employees & Residents", dated 07/08/2024, showed that the facility followed the state regulations to complete a TB test within three days of employment. The document showed a staff person, who had no documented history of a negative TB test, required a two-step TB skin test. The document showed that the second TB skin test would be completed in one to three weeks after the first test.

Review of the facility's Employee Roster showed the facility hired Staff B, Medication Care Manager, on 04/24/2024. Review of Staff B's employee records showed on 04/24/2024, Staff B completed one TB skin test with a negative result. There was no documentation that showed Staff B completed a second skin test after the first TB skin test. There was no documentation that showed Staff B met the requirement to complete only one TB test.

During an interview on 04/17/2025 at 2:30 PM, Staff O, Area Business Office Manager, stated that they were unable to find any additional TB documents in Staff B's personnel files.

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) 06/02/2025

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

AC OTIENO — 05/15/2025

Administrator (or Representative) — Date

WAC 388-78A-2485 Tuberculosis Positive test result. When there is a positive result to tuberculosis skin or blood testing the assisted living facility must:

(1) Ensure that the staff person has a chest X-ray within seven days;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete 1 of 3 sampled staff's (Staff B) second skin test for Tuberculosis (TB), as required. This failure placed all 63 residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included...

Review of the facility's document titled "TB Requirements by State – Employees & Residents", dated 07/08/2024, showed that the facility followed the state regulations to complete a TB test within three days of employment. The document showed a staff person, who had no documented history of a negative TB test, required a two-step TB skin test. The document showed that the second TB skin test would be completed in one to three weeks after the first test.

Review of the facility's Employee Roster showed the facility hired Staff B, Medication Care Manager, on 04/24/2024. Review of Staff B's employee records showed on 04/24/2024, Staff B completed one TB skin test with a negative result. There was no documentation that showed Staff B completed a second skin test after the first TB skin test. There was no documentation that showed Staff B met the requirement to complete only one TB test.

During an interview on 04/17/2025 at 2:30 PM, Staff O, Area Business Office Manager, stated that they were unable to find any additional TB documents in Staff B's personnel files.

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2485 Tuberculosis Positive test result. When there is a positive result to tuberculosis skin or blood testing the assisted living facility must:

(1) Ensure that the staff person has a chest X-ray within seven days;

(2) Ensure each resident or staff person with a positive test result is evaluated for signs and symptoms of tuberculosis; and

(3) Follow the recommendation of the resident or staff person's health care provider.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 1 of 1 sampled staff (Staff D) completed a chest X-ray within seven days, was evaluated for signs and symptoms of TB, and followed the health care provider's recommendation, following a positive result to a Tuberculosis (TB) skin test. This failure placed all 63 residents at risk of exposure to tuberculosis, an infectious disease.

Findings included...

Review of the facility's document titled "TB Requirements by State – Employees & Residents", dated 07/08/2024, showed that the facility followed the state regulations for staff persons with a positive TB test result.

Review of the facility's Employee Roster showed the facility hired Staff D, Medication Care Manager, on 08/21/2024. Review of Staff D's employee records showed that on 08/21/2024, Staff D completed one TB skin test, with a positive result. The records showed no documentation that Staff D completed a chest X-ray, within seven days following a positive TB skin test result. There was no documentation that showed Staff E was evaluated for TB signs and symptoms. There was no documentation that showed Staff E followed up with their health care provider.

During an interview on 04/17/2025, at 2:30 PM, Staff O, Area Business Office Manager, stated that they did not find any additional TB documents for Staff D. Staff O stated that Staff B's TB testing was out of compliance.

Plan/Attestation Statement

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

AL OTIENO — 05/15/2025

Administrator (or Representative) — Date

(2) Ensure each resident or staff person with a positive test result is evaluated for signs and symptoms of tuberculosis; and

(3) Follow the recommendation of the resident or staff person's health care provider.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 1 of 1 sampled staff (Staff D) completed a chest X-ray within seven days, was evaluated for signs and symptoms of TB, and followed the health care provider's recommendation, following a positive result to a Tuberculosis (TB) skin test. This failure placed all 63 residents at risk of exposure to tuberculosis, an infectious disease.

Findings included...

Review of the facility's document titled "TB Requirements by State – Employees & Residents", dated 07/08/2024, showed that the facility followed the state regulations for staff persons with a positive TB test result.

Review of the facility's Employee Roster showed the facility hired Staff D, Medication Care Manager, on 08/21/2024. Review of Staff D's employee records showed that on 08/21/2024, Staff D completed one TB skin test, with a positive result. The records showed no documentation that Staff D completed a chest X-ray, within seven days following a positive TB skin test result. There was no documentation that showed Staff E was evaluated for TB signs and symptoms. There was no documentation that showed Staff E followed up with their health care provider.

During an interview on 04/17/2025, at 2:30 PM, Staff O, Area Business Office Manager, stated that they did not find any additional TB documents for Staff D. Staff O stated that Staff B's TB testing was out of compliance.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

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 2 of 9 sampled residents (Resident 2 and Resident 3) service plans. This failure placed Resident 2 and Resident 3 at risk of unmet care needs and a diminished quality of life.

Findings included...

RESIDENT 2
Review of the facility's undated Characteristics Roster showed that the facility admitted Resident 2 in [redacted] of 2019 with a diagnosis of [redacted] ([redacted]). Resident 2 resided in the secured Life's Neighborhood unit (memory care).

Observation on 04/21/2025 at 8:35 AM, Showed Resident 2 seated on a Roho cushion (a pressure relief cushion that is made of soft, flexible air cells to decrease the amount of pressure on the sitting area) in a tilt-n-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 Staff C, Memory Care Medication Manager/Care Manager, and Staff K, Care Manager 2, transferred Resident 2 with a mechanical lift to a hospital bed. Observation showed an alternating pressure relieving air mattress overlay (a type of medical mattress that uses a series of air cells that inflate and deflate in a cycle to redistribute pressure across the body) laid on top of the hospital bed's regular mattress. Observation showed an air pump that inflated the alternating pressure relieving air mattress hung on the foot board of the hospital bed. Observation showed that Resident 2 was completely dependent on the staff for all aspects of care.

Review of Resident 2's ISP, dated 03/17/2025, showed that Resident 2 required two-person hands-on assistance to dress and undress, transfer with a mechanical lift, receive incontinence (lack of voluntary control over urination and defecation) care, and bathing. The ISP showed that Resident 2 required hands-on assistance with grooming, personal hygiene care, and feeding. There was no documentation in the ISP that showed Resident 2 used an alternating pressure-relieving air mattress, a tilt-in-space wheelchair, or a Roho cushion. There was no documentation that instructed care staff how to adjust the tilt-in-space wheelchair. There were no instructions for staff about

how to evaluate the Roho cushion for proper use and inflation. There were no instructions for staff about how to check that the alternating pressure-relieving air mattress was properly inflated.

During an interview on 04/21/2025 at 8:35 AM, Staff C stated that the Roho cushion required an air pump to inflate the cushion. Staff C stated that air was added to the Roho cushion if it was deflated. Staff C did not know how to properly assess the Roho cushion to determine the proper inflation level. Staff C stated that the tilt-in-space wheelchair, Roho cushion, and alternating pressure-relieving air mattress were provided to Resident 2 within the last month.

During an interview on 04/21/2025 at 8:35 AM, Staff K stated they were not sure how to properly evaluate and inflate the Roho cushion.

RESIDENT 3
Review of the facility's undated Characteristics Roster showed that the facility admitted Resident 3 in [redacted] 2021 with a diagnosis of [redacted] and [redacted] ([redacted]).

During an interview on 04/21/2025 at 10:47 AM, observation showed Resident 3 laid on an alternating pressure relieving air mattress that was on top of the hospital bed's regular mattress. Observation showed an air pump that inflated the alternating pressure relieving air mattress hung on the foot board of the hospital bed.. Resident 3 stated that they were primarily bed bound and seldom got out of bed. Resident 3 stated that the care staff used a mechanical lift to transfer them when they got out of bed. Resident 3 stated that there were two pressure wounds (localized damage to the skin and/or underlying tissue caused by prolonged pressure, often over a bony prominence) on their buttocks. Resident 3 stated that the wounds varied from healed to redness to open. Resident 3 stated that the wounds were currently healed based on what the care staff communicated with them.

Review of Resident 3's ISP, dated 02/03/2025, showed no documentation that Resident 3 used an alternating pressure relieving air mattress. There was no documentation that instructed care staff how to properly evaluate that the alternating pressure relieving air mattress was correctly inflated.

During an interview on 04/22/2025 at 10:00 AM, Staff L, Care Director, stated that Resident 3 did not currently have any open wounds. Staff L stated that Resident 3 had issues with ongoing pressure wounds to the buttocks that open from time to time.

During an interview on 04/22/2025 10:20 AM, Staff L and Staff M, Registered Nurse, Health Services Director, both stated that they were unsure why Resident 2's ISP was not updated to show that Resident 2 used a tilt-in-space wheelchair, Roho cushion, and an alternating pressure-relieving mattress. Staff L and Staff M both stated that they

were unsure why Resident 3's ISP did not show they used an alternating pressure relieving air mattress. Staff L and Staff M both stated that the ISPs for both residents needed to be updated to reflect their care needs.

During an interview with Staff N, RN, Regional Health Services Consultant, stated that they were unsure why the ISP for Resident 2 and Resident 3 were not updated to show the medical equipment each resident currently used.

Plan/Attestation Statement

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

AL OTIENO — Administrator (or Representative)

05/15/2025 — Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 6 of 10 staff (Staff E, Staff F, Staff Q, Staff R, Staff S, and Staff T) completed a Washington State name and date of birth background check (BGI) every two years. This failure placed all 63 residents at risk for potential abuse or neglect by staff with an unknown background check.

Findings included...

Review of the facility's "Background Clearance & Training/Orientation Requirements for Washington" document, dated 08/23/2018, showed that a new Background Authorization form must be submitted every two years thereafter for all staff.

were unsure why Resident 3's ISP did not show they used an alternating pressure relieving air mattress. Staff L and Staff M both stated that the ISPs for both residents needed to be updated to reflect their care needs.

During an interview with Staff N, RN, Regional Health Services Consultant, stated that they were unsure why the ISP for Resident 2 and Resident 3 were not updated to show the medical equipment each resident currently used.

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Based on interview and record review, the facility failed to ensure 6 of 10 staff (Staff E, Staff F, Staff Q, Staff R, Staff S, and Staff T) completed a Washington State name and date of birth background check (BGI) every two years. This failure placed all 63 residents at risk for potential abuse or neglect by staff with an unknown background check.

Findings included...

Review of the facility's "Background Clearance & Training/Orientation Requirements for Washington" document, dated 08/23/2018, showed that a new Background Authorization form must be submitted every two years thereafter for all staff.

Review of the facility's undated employee roster showed the facility hired Staff E, Memory Care (MC) Medication Care Manager on 09/09/2021; Staff F, Care Manager 2, on 01/17/2023; Staff Q, Medication Manager, on 05/20/2015; Staff R, Wellness Nurse, on 03/06/2014; Staff S, Art Therapist, on 08/27/2021; and Staff T, Life Enrichment Assistant, on 06/19/2017.

STAFF E
Review of Staff E's facility personnel records showed that an initial Washington State BGI was completed on 08/25/2021. This background check expired on 08/25/2023. Staff E completed a new BGI on 03/20/2024, 208 days after the expiration of the initial BGI.

STAFF F
Review of Staff F's facility personnel records showed that an initial Washington State BGI was completed on 01/09/2023. This background check expired on 01/09/2025. Staff F completed a new BGI on 02/24/2025, 46 days after expiration of the initial BGI.

STAFF Q
Review of Staff Q's facility personnel records showed that the facility last completed a Washington State BGI on 03/21/2023. This background check expired on 03/21/2025. Staff Q completed a new BGI on 04/07/2025, 17 days after expiration of the last BGI.

STAFF R
Review of Staff R's facility personnel records showed that the facility last completed a Washington State BGI on 02/23/2022. This background check expired on 02/23/2024. Staff R completed a new BGI on 09/12/2024, 202 days after expiration of the last BGI.

STAFF S
Review of Staff S's facility personnel records showed that an initial Washington State BGI was completed on 12/02/2021, 97 days after date of hire. This background check expired on 12/02/2023. Staff S completed a new BGI on 12/13/2023, 11 days after the expiration of the initial BGI.

STAFF T
Review of Staff T's facility personnel records showed that the facility completed a Washington State BGI on 08/30/2022. This background check expired on 08/30/2024. Staff T completed a new BGI on 09/16/2024, 17 days after the expiration of the last BGI.

During an interview on 04/17/2025 at 2:30 PM, Staff O, Area Business Office Manager, stated that each facility no longer employed individual Business Office Managers. Staff O stated that the company recently transferred most Business Office Manager tasks, which included Human Resources, to an overseas company. Staff O stated that they were unable to provide an explanation for why every two-year BGIs were done late.

Plan/Attestation Statement

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

Az OTIOSO — 05/15/2025

Administrator (or Representative) — Date

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

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

05/05/2025

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 04/30/2025 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 Return the Plan/Attestation Statement and report with signatures to:

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

eFax: (253) 395-5071
Email: rcsregion2email@dshs.wa.gov
Optional method:
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 246-215-02110 Duties Food protection manager certification (FDA Food Code 2-102.20). certified food protection manager responsibilities include training and implementing a program of food protection and education for each person in charge, so each person in charge is able to successfully demonstrate knowledge described in WAC 246-215-02105 , and fulfill the duties as described in WAC 246-215-02115 to maintain active managerial control.

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

The facility did not ensure one culinary services staff completed food safety training and received a food worker card, within 14 days of their date of hire, 03/24/2025. During the full inspection, staff completed the training and obtained the card.

WAC 388-78A-2380 Freedom of movement. An assisted living facility must ensure all of the following conditions are present before moving residents into units or buildings with exits that may restrict a resident's egress:

(3) The assisted living facility must have a system in place to inform and permit visitors, staff persons and appropriate residents how they may exit without sounding the alarm.

The memory care unit exit door and elevator entrance did not provide information for visitors and appropriate residents about how to exit the unit. During the full inspection, the facility added signage at the exit door and elevator that informed visitors, staff, and appropriate residents how they may exit the secured unit.

WAC 388-78A-2730 Licensee's responsibilities.

(2) The licensee must:

(b) Maintain and post in a size and format that is easily read, in a conspicuous place on the assisted living facility premises:

(iii) A copy of the report, including the cover letter, and plan of correction of the most recent full inspection conducted by the department.

The facility failed to post a copy of the last full inspection report in a conspicuous location within the facility that was available to residents and guests. During the inspection, the facility corrected this issue.

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:

- What specific deficiency or deficiencies you disagree with;
- Why you disagree with each deficiency; and
- Whether you want an IDR to occur in-person, by telephone or as a paper review.
- Send your request to:

Email: RCSIDR@dshs.wa.gov; or
Fax: (360) 725-3225

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

Enclosure