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) 50811 (Completion Date 11/22/2024) and 47620 (Completion Date 10/01/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/22/2024 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-2240

The Department staff who did the on-site verification:
Karri Hernandez, 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

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: Aegis Lodge of Kirkland
Provider Type: Assisted Living Facility

License/Cert.#: 2492
Intake ID: 147655
Compliance Determination #: 47620
Region/Unit #: RCS Region 2 / Unit D
Investigator: Karri Hernandez
Investigation Date(s): 09/24/2024 through 10/01/2024
Complainant Contact Date(s): 09/24/2024

Allegation(s):
Facility failed to provide and administer ordered medications.

Investigation Methods:

Sample:	Total residents: 64 Resident sample size: 2 Closed records sample size:
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Residents Family members
Record Reviews:	Medical records Hospital records Incident investigation Facility policies

Investigation Summary:
Reviewed intake. Interviewed facility staff, residents, collateral contact. Reviewed medical records, facility records, Washington State Administrative Code.

Named Resident (NR) admitted to facility from hospital without all medications present from pharmacy on admit. NR re-admitted to hospital from facility three days later diagnosed with [redacted].

Failed practice found; citation issued 10/08/2024 intake number 47620.

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Conclusion / Action:

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

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Statement of Deficiencies	License #: 2492	Compliance Determination #47620
Plan of Correction	Aegis Lodge of Kirkland	Completion Date
Page 1 of 3	Licensee: 116 Ave Kirkland LLC	10/01/2024

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

The department completed data collection for an unannounced on-site complaint investigation on 09/24/2024, 09/24/2024 and 09/24/2024 of:

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

This document references the following complaint number(s): 147655

The following sample was selected for review during the unannounced on-site visit: 2 of 64 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Karri Hernandez, 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 — Residential Care Services

10/04/2024 — 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.

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Administrator (or Representative) 10/11/24 Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interviews and record review, the facility failed to obtain Resident 1's prescribed medications. This failure placed Resident 1 at risk for potential medical complications related to missed medications.

Findings included...

Review of Resident 1's hospital After Visit Summary (AVS) dated [redacted]/2024, showed Resident 1 was prescribed clonazepam (medication used to treat seizures and panic disorder). The order showed Resident 1 was to receive 0.5 milligrams (mg) two times per day, at 09:00 AM and 03:00 PM, and 1.5 mg one time per day, at 09:00 PM. The AVS showed that on 09/13/2024 at 08:48 AM, Resident 1 received 0.5 mg of clonazepam at the hospital.

Review of Resident 1's progress notes, dated [redacted]/2024, showed that earlier in the day, the facility newly admitted Resident 1 from the hospital.

Review of Resident 1's September 2024 Medication Administration Record (MAR) showed no documentation that Resident 1 received clonazepam on 09/13/2024, 09/14/2024, 09/15/2024, and 09/16/2024. MAR documentation showed "Medication unavailable", "waiting for pharmacy delivery" on all scheduled administrations ordered from 09/13/2024 to 09/16/2024.

Review of Resident 1's progress notes, dated 09/16/2024, showed Emergency Medical Services (EMS) transported Resident 1 to the hospital. The progress notes showed that when Resident 1 admitted to the facility on [redacted]/2024, there was no pharmacy delivery of clonazepam. The progress note showed that on 09/15/2024, the pharmacy attempted to fax the provider twice, with no response. The progress note showed facility staff planned to have Resident 1 meet with [redacted] Provider on 09/16/2024 and obtain the prescription for clonazepam at that time. The progress notes showed the facility staff made no attempt to obtain the prescribed clonazepam by any other means.

Review of Resident 1's hospital record titled "Note from Admission", dated 9-16-2024, showed the hospital admitted Resident 1 for suspected clonazepam withdraw.

During an interview on 09/24/2024 at noon, Collateral Contact 1 (Resident 1's representative) stated that the facility staff informed them that all medications from

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hospital at time of discharge were ordered and delivered to the facility from the pharmacy on [redacted]/2024, prior to Resident 1's readmission to the facility. Collateral Contact stated Resident 1 had taken clonazepam for a very long time before hospitalization. Collateral Contact 1 stated facility staff did not contact them about the missing medications or ask for assistance to obtain the missing medications.

During an interview on 09/24/2024 at 1:00 PM, Staff A, General Manager, stated that Resident 1 admitted to the facility without the clonazepam medication available. Staff A stated that the prescription from the hospital to the pharmacy missed some information. Staff A stated that the pharmacy informed facility staff that the pharmacy requested the original prescriber correct the missing information. Staff A stated that when Resident 1 admitted to facility on a Friday, the facility pharmacy was unable to obtain the prescribed clonazepam over the weekend. Staff A stated that Resident 1 was scheduled to meet with the facility [redacted] provider on Monday afternoon. Staff A stated that the staff decided to wait until this appointment with [redacted] provider to obtain the missing clonazepam order and then order the missing medication. Staff A stated that no other actions were attempted to obtain Resident 1's missing medication.

During an interview on 09/24/2024 at 1:00 PM, Staff B, Regional Registered Nurse, stated that Resident 1 admitted to facility on [redacted]/2024 from the hospital. Staff B stated that the pharmacy verified the medication list from Resident 1's hospital discharge record, dated [redacted]/2024. Staff B stated that the facility required staff verify that all medications sent from the pharmacy matched the MAR whenever a new resident admitted to the facility. Staff B stated that when Resident 1 admitted on [redacted]/2024, the medications sent to facility by the pharmacy did not include the clonazepam. Staff B stated that the facility staff made no other effort to contact resident neurologist, Primary Care Physician (PCP) or hospital provider to correct the prescription error. Staff made no attempt to have the new order issued to another pharmacy. Staff B stated that sometime over the weekend, facility staff contacted Collateral Contact 1 regarding the missing clonazepam. Staff B stated that Collateral Contact 1 deferred all medication questions back to the facility staff. Staff B stated that Collateral Contact 1 told facility staff that it was the facility's responsibility to obtain Resident 1's medications. Staff B stated that facility staff decided to wait for Resident 1 to meet with [redacted] provider on Monday, 09/16/2024, to obtain the order for clonazepam. Staff B stated that if the pharmacy received an incorrect medication order, there was not a lot that the facility could do.

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) NOV 25th 2024
NOV 15th 2024

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

Administrator (or Representative) — Date: 10/11/24

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