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 Living Kirkland Waterfront
1002 Lake Street S
Kirkland, WA 98033

RE: Aegis Living Kirkland Waterfront License # 2586

Dear Administrator:

This letter addresses Compliance Determination(s) 32687 (Completion Date 11/16/2023) and 29069 (Completion Date 09/26/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/16/2023 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-2210-1-b, WAC 388-78A-2210-2-a

The Department staff who did the on-site verification:
Kailash Sharma, ALF Licensor

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Aegis Living Kirkland Waterfront
License/Cert.#: 2586
Compliance Determination #: 29069
Investigator: Kailash Sharma
Investigation Date(s): 09/06/2023 through 09/26/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 96544
Region/Unit #: RCS Region 2 / Unit D

Allegation(s):
Medication error

Investigation Methods:

Sample:	Total residents: 45 Resident sample size: 1 Closed records sample size: 1
Observations:	General tour of facility, common areas, activities and staff resident interaction.
Interviews:	Executive Director, designee, Health Service Director.
Record Reviews:	Incident report, investigation report, characteristic roster, face sheet, service plan, medication record. medication management policy.

Investigation Summary:
Facility cooperated with investigation, provided needed information and took actions to promote safety. Health Service Director (HSD) stated Named Resident fell around 8:00 PM, staff responded immediately and assisted to bed. Named Resident had low blood pressure so staff called medics. Named Resident sent to hospital. At 11:00 PM, family was informed Named Resident passed away. HSD added while staff assisted Named Resident, staff discovered Named Resident had four Rivastigmine (medication used to treat dementia) patches applied. HSD reported facility policy in place where staff were trained to remove old patch before applying new patch. Facility failed to remove patches as per policy. Citation issued for medication administration error.

Conclusion / Action:

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

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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 complaint investigation on 09/06/2023, 09/06/2023 and 09/06/2023 of:

Aegis Living Kirkland Waterfront
1002 Lake Street S
Kirkland, WA 98033

This document references the following complaint number(s): 96544

The following sample was selected for review during the unannounced on-site visit: 1 of 45 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Kailash Sharma, 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

09/26/2023 — 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.

DAVID WATKINS
Administrator (or Representative)

10/20/23
Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(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 interview, and record review, the facility failed to properly administer medications for 1 of 3 residents (Resident 1). This failure placed Resident 1 at risk of harm and possible overdose.

Findings included...

Review of Resident 1's Individualized Service Plan (ISP), dated 09/01/2023, showed a diagnosis of [redacted] The ISP showed Resident 1 was prescribed medication to treat their dementia. Further review of the ISP showed the facility assisted Resident 1 with medication management.

Review of Resident 1's August 2023 Electronic Medication Administration Record (eMAR) showed Resident 1 received Rivastigmine (medication used to manage and treat dementia), 4.6 milligram, 24 Hour patch. On 08/25/2023, staff administered the first patch to Resident 1. On 08/31/2023, staff administered the last patch. Between 08/25/2023 and 08/31/2023, Resident 1 received a total of seven patches. Further review of the eMAR showed the physician order stated to place a new patch onto the skin of the upper or lower back every 24 hours for 30 days. Place on clean, dry, hairless, healthy, skin, free of skin products like lotions or powders. Do not reuse same site for 14 days. Order stated to apply patch, write the date and time on the patch, and staff who applied the new patch were to initial it.

Review of the facility's policy titled "Administration of Topical Medication", revised 03/20/2015, showed. "always remove the old patch before applying a new patch".

During an interview on 09/06/2023 at 11:45 AM Staff A (Health Service Director) stated that on 09/01/2023, around 8:00 PM Resident 1 fell in the bathroom. The fall was unwitnessed. Staff A stated that after the fall, staff provided care to Resident 1 in their bed. At that time, staff noticed there were four patches of Rivastigmine on Resident 1' s back. Staff A stated that Resident 1 experienced episodes of vomiting and low blood pressure, possible side effects of the medication. Staff A stated that the facility sent Resident 1 to the hospital. Staff A stated that while at the hospital, Resident 1 passed away.

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 Living Kirkland Waterfront is or will be in compliance with this law and / or regulation on (Date) 11/10/2023 .

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

Administrator (or Representative) — Date: 10/20/23