STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

14900 1st Ave Shoreline LLC
Aegis Living Shoreline
14900 1ST AVENUE NE
SHORELINE, WA 98155

RE: Aegis Living Shoreline License # 2592

Dear Administrator:

This letter addresses Compliance Determination(s) 39550 (Completion Date 04/11/2024) and 36556 (Completion Date 02/08/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/11/2024 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-2481, WAC 388-78A-2481-1, WAC 388-78A-2481-1-a, WAC 388-78A-2481-1-b, WAC 388-78A-2481-2, WAC 388-78A-2210-1, WAC 388-78A-2210-1-a, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2-a

The Department staff who did the on-site verification:
Sunny Kent, Licensor
Scottie Sindora, ALF Licensor

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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies	License #: 2592	Compliance Determination # 36556
Plan of Correction	Aegis Living Shoreline	Completion Date
Page 1 of 5	Licensee: 14900 1st Ave Shoreline LLC	02/08/2024

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 the unannounced on-site full inspection on 02/05/2024 and 02/07/2024 of:
Aegis Living Shoreline
14900 1ST AVENUE NE
SHORELINE, WA 98155

The following sample was selected for review during the unannounced on-site visit: 9 of 99 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Sunny Kent, Licensor
Scottie Sindora, ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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.

Jamie Singer — Residential Care Services
2/14/2024 — 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.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

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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.

Residential Care Services _____ 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)

2/22/2024
Date

WAC 388-78A-2481 Tuberculosis Testing method Required. The assisted living facility must ensure that all tuberculosis testing is done through either:

(1) Intradermal (Mantoux) administration with test results read:

(a) Within forty-eight to seventy-two hours of the test; and

(b) By a trained professional; or

(2) A blood test for tuberculosis called interferon-gamma release assay (IGRA).

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure an approved testing method was used to screen 1 of 5 sample staff (Staff A) for Tuberculosis (TB) within three days of hire. This failure placed 99 residents at risk for infection and increased health issues.

Findings included...

Record review of Staff A's (Caregiver) personnel file showed the ALF hired him on 10/30/2023 as a full-time caregiver. Record review of Staff C's TB record, undated, showed the Staff C received a chest X-ray on 8/22/2023. There was no indication Staff C had been screened for TB since that time.

In an interview, on 01/23/2024 at 08:15 AM, Staff H (Business Office Manager) stated that she thought a chest x-ray was good for five years.

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 Shoreline is or will be in compliance with this law and / or regulation on (Date) 3/24/2024

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

Administrator (or Representative) Date

WAC 388-78A-2481 Tuberculosis Testing method Required. The assisted living facility must ensure that all tuberculosis testing is done through either:

(1) Intradermal (Mantoux) administration with test results read:

(a) Within forty-eight to seventy-two hours of the test; and

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(2) A blood test for tuberculosis called interferon-gamma release assay (IGRA).

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure an approved testing method was used to screen 1 of 5 sample staff (Staff A) for Tuberculosis (TB) within three days of hire. This failure placed 99 residents at risk for infection and increased health issues.

Findings included…

Record review of Staff A's (Caregiver) personnel file showed the ALF hired him on 10/30/2023 as a full-time caregiver. Record review of Staff C's TB record, undated, showed the Staff C received a chest X-ray on 8/22/2023. There was no indication Staff C had been screened for TB since that time.

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

Administrator (or ~~Representative~~) 2/22/2024 Date

WAC 388-78A-2210 Medication services.

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

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(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 Assisted Living Facility (ALF) failed to ensure medications services were implemented when 1 of 9 sample residents (Resident 5) missed 18 doses of a prescribed daily medication, and 1 of 9 sampled residents (Resident 9) who regularly refused two medications, continued documenting the medications as refused without contacting the resident's primary care physician (PCP) for a discontinue order or advice from the PCP. This placed the residents at risk of harm from missed medications.

Findings included...

Record Review of the ALF's "Resident Refusal of Medication Policy", revised 04/21/2021, shows that if and when a resident refuses medication, staff must notify the prescriber in a manner and time frame as requested by the prescriber.

Record review showed the ALF's policy, "Limited Supply Ordering Back-up Medications Process", revised on 03/27/2015, described a system to help eliminate situations where residents went without their prescribed medications. The Medication Care Manager (MCM) was responsible for obtaining medications from both the ALF's preferred pharmacy, and any non-preferred pharmacy.

RESIDENT 5

Record review of a Face Sheet, dated 02/05/2024, showed the ALF admitted Resident 5 on [redacted]/2023 with diagnoses including [redacted] ([redacted]

Administrator (or Representative) Date

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(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

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(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 Assisted Living Facility (ALF) failed to ensure medications services were implemented when 1 of 9 sample residents (Resident 5) missed 18 doses of a prescribed daily medication, and 1 of 9 sampled residents (Resident 9) who regularly refused two medications, continued documenting the medications as refused without contacting the resident's primary care physician (PCP) for a discontinue order or advice from the PCP. This placed the residents at risk of harm from missed medications.

Findings included…

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Record review showed the ALF's policy, "Limited Supply Ordering Back-up Medications Process", revised on 03/27/2015, described a system to help eliminate situations where residents went without their prescribed medications. The Medication Care Manager (MCM) was responsible for obtaining medications from both the ALF's preferred pharmacy, and any non-preferred pharmacy.

RESIDENT 5

Record review of a Face Sheet, dated 02/05/2024, showed the ALF admitted Resident 5 on [redacted]/2023 with diagnoses including [redacted] ([redacted]

[redacted]).

Review of an electronic Medication Administration Record (eMAR) for 11/05/2023 through 12/04/2023 showed Resident 5's PCP prescribed a statin (a class of medications used to treat hyperlipidemia/high cholesterol by working in the liver to prevent the formation of cholesterol). The statin was scheduled for administration at 8:00 PM every night. Further review of the eMAR showed Resident 5 missed 18 doses of the statin beginning on 11/05/2023 and ending on 11/22/2023. The medication was eventually filled and daily administration began on 11/23/2023.

The 18 missed doses of medication were documented as, "Medication did not come with resident at admission".

During an interview, on 02/07/2024 at 9:45 AM, Staff I (Registered Nurse, Health Services Director) stated that Resident 5 supplied their own medications when admitted to the ALF. Resident 5 requested that the ALF use only medications from their personal supply before ordering more from the pharmacy. The statin was not included in the medications supplied by Resident 5 upon admission.

RESIDENT 9

Record review of a Face Sheet, dated 02/07/2024, showed the ALF admitted Resident 9 on [redacted]/2023 with diagnoses including [redacted] and [redacted], [redacted], and [redacted].

RESIDENT 9-STATIN

Review of eMARs, dated 11/05/2023 through 02/05/2024, showed Resident 9's PCP prescribed a sodium chloride (salt) nebulizer (a device that turns liquid medicine into a mist which is then inhaled through a mouthpiece or a mask) treatment. The PCP scheduled the treatment for 8:00 AM and 5:00 PM.

The eMAR for 11/05/2023 through 12/04/2023 showed Resident 9 refused the medication twice daily for 30 days. The eMAR for 12/05/2023 through 01/04/2024 showed Resident 9 refused the medication twice daily for 27 days. The eMAR for 01/05/2024 through 01/05/2024 showed Resident 5 refused the medication twice daily for 28 days. Reasons for not administering the medication documented on the eMARs included, "Order requires Nursing intervention: resident no longer uses the nebulizer", "Resident refused", "Resident refused: asked for the med to be discontinued", and "Provider order: Resident wants to discontinue".

RESIDENT 9-GAS MEDICATION

[redacted]).

Review of an electronic Medication Administration Record (eMAR) for 11/05/2023 through 12/04/2023 showed Resident 5's PCP prescribed a statin (a class of medications used to treat hyperlipidemia/high cholesterol by working in the liver to prevent the formation of cholesterol). The statin was scheduled for administration at 8:00 PM every night. Further review of the eMAR showed Resident 5 missed 18 doses of the statin beginning on 11/05/2023 and ending on 11/22/2023. The medication was eventually filled and daily administration began on 11/23/2023.

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RESIDENT 9

Record review of a Face Sheet, dated 02/07/2024, showed the ALF admitted Resident 9 on [redacted]/2023 with diagnoses including [redacted] and [redacted], [redacted], and [redacted].

RESIDENT 9-STATIN

Review of eMARs, dated 11/05/2023 through 02/05/2024, showed Resident 9's PCP prescribed a sodium chloride (salt) nebulizer (a device that turns liquid medicine into a mist which is then inhaled through a mouthpiece or a mask) treatment. The PCP scheduled the treatment for 8:00 AM and 5:00 PM.

The eMAR for 11/05/2023 through 12/04/2023 showed Resident 9 refused the medication twice daily for 30 days. The eMAR for 12/05/2023 through 01/04/2024 showed Resident 9 refused the medication twice daily for 27 days. The eMAR for 01/05/2024 through 01/05/2024 showed Resident 5 refused the medication twice daily for 28 days. Reasons for not administering the medication documented on the eMARs included, "Order requires Nursing intervention: resident no longer uses the nebulizer", "Resident refused", "Resident refused: asked for the med to be discontinued", and "Provider order: Resident wants to discontinue".

RESIDENT 9-GAS MEDICATION

Further review of the eMARs showed Resident 9's PCP prescribed a medication to treat flatulence. The PCP scheduled the medication for administration after meals at 9:00 AM, 12:00 PM, and 5:00 PM. Resident 9 refused the medication on 12/09/2023. Between 01/05/2024 and 02/04/2024, Resident 9 refused the medication 31 times. Reasons for refusal included, "Resident refused: declined taking medication since she was getting ready to leave", "Resident refused: communicated that she did not need this med", "Resident refused: did not want to take this med today" and, "preferred not to take this med today"; Resident refused: did not need", "Resident refused: Resident said these medications are not helping", "Resident refused: did not want", and, "Resident refused".

During an interview on 02/07/2024 at 1:35 PM, Staff I (Registered Nurse, Health Services Director) stated that if a resident continues to refuse a medication, the ALF sends a request to the PCP for orders to discontinue the medication. For the statin, Staff I reviewed records and stated that the request to discontinue was initiated in November and was "on hold", waiting for Provider response, as of 02/06/2024. Staff I also stated that Resident 9's pharmacy, a component of their managed care health system, was often slow and/or unresponsive to the ALF's requests for orders or other information.

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 Shoreline is or will be in compliance with this law and / or regulation on (Date) 03/24/2024

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

Administrator (or Representative) 2/22/2024 Date

Further review of the eMARs showed Resident 9's PCP prescribed a medication to treat flatulence. The PCP scheduled the medication for administration after meals at 9:00 AM, 12:00 PM, and 5:00 PM. Resident 9 refused the medication on 12/09/2023. Between 01/05/2024 and 02/04/2024, Resident 9 refused the medication 31 times. Reasons for refusal included, "Resident refused: declined taking medication since she was getting ready to leave", "Resident refused: communicated that she did not need this med", "Resident refused: did not want to take this med today" and, "preferred not to take this med today"; Resident refused: did not need", "Resident refused: Resident said these medications are not helping", "Resident refused: did not want", and, "Resident refused".

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Administrator (or Representative) Date