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

Totem Lake Blvd Kirkland LLC
Aegis Living Kirkland
13000 Totem Lake Blvd NE
Kirkland, WA 98034

RE: Aegis Living Kirkland License # 2596

Dear Administrator:

This letter addresses Compliance Determination(s) 31353 (Completion Date 10/24/2023) and 26922 (Completion Date 08/01/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/24/2023 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-2600-2-k, WAC 388-78A-2483-1, WAC 388-78A-2483-2, WAC 388-78A-2483, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2484, WAC 388-78A-2484-1, WAC 388-78A-2484-2

The Department staff who did the on-site verification:
Thomas Forkgen, ALF Licensor
Jane Hermano, NCI
Michelle Yip, 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

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

| Statement of Deficiencies | License #: 2596 | Compliance Determination # 26922 |
|---|---|---|
| Plan of Correction | Aegis Living Kirkland | Completion Date |
| Page 1 of 10 | Licensee: Totem Lake Blvd Kirkland LLC | 08/01/2023 |

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 07/20/2023, 07/20/2023, 07/24/2023 and 07/24/2023 of:
Aegis Living Kirkland
13000 Totem Lake Blvd NE
Kirkland, WA 98034

The following sample was selected for review during the unannounced on-site visit: 7 of 42 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility.

Thomas Forkgen, ALF Licensor
Jane Hermano, NCI
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
08/04/2023 — 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.

STATE OF WASHINGTON

# DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

***20425 72nd Avenue S, Suite 400, Kent, WA 98032***



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Aegis Living Kirkland
13000 Totem Lake Blvd NE
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From:
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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.

Peter J B
Administrator (or Representative)

8/9/2023
Date

**WAC 388-78A-2600 Policies and procedures.**

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(k) To prevent and limit the spread of infections consistent with WAC 388-78A-2810 ;

**This requirement was not met as evidenced by:**

Based on interview and record review, the facility failed to implement their policy on the required Respiratory Protection Program for 36 of 54 staff who have direct contact with residents (Staff B, Medication Care Manager; Staff C, Medication Care Manager; Staff E, Wellness Nurse; Staff G, Housekeeper; Staff H, Life Enrichment Assistant; Staff I, Care Manager; Staff J, Medication Care Manager; Staff K, Care Manager; Staff L, Care Manager; Staff M, Lead Housekeeper; Staff N, Lead Cook; Staff O, Care Manager; Staff P, Lead Host/Hostess; Staff Q, Host/Hostess; Staff R, Lead Medication Care Manager; Staff S, Care Manager; Staff T, Care Manager; Staff U, Care Manager; Staff V, Life Enrichment Director; Staff W, Lead Medication Care Manager; Staff X, Host/Hostess; Staff Y, Care Manager; Staff Z, Lead Medication Care Manager; Staff AA, Medication Care Manager; Staff BB, Associate Care Director; Staff CC, Lead Cook; Staff DD, Care Manager; Staff EE, Host/Hostess; Staff FF, Culinary Service Director; Staff GG, Wellness Nurse; Staff HH, Medication Care Manager; Staff II, Life Enrichment Assistant; Staff JJ, Lead Cook; Staff KK, Care Manager; Staff LL, Lead Medication Care Manager; and Staff MM, Life Enrichment Assistant). This failure placed all residents at risk of contracting and spreading a potentially life-threatening virus.

Findings included...

Review of the Washington State Department of Health (DOH) undated publication titled "Respiratory Protection Program for Long-Term Care Facilities" (https://doh.wa.gov/public-health-healthcare-providers/healthcare-professions-and-facilities/healthcare-associated-infections/respiratory-protection-program), showed specific guidance around respiratory protection program that included medical evaluation and fit testing for respirator use. The document showed that facilities were required to identify which employees would be exposed to a respiratory hazard and to fit test those employees for an appropriate respirator. Facilities were required to provide initial and annual fit tests and to provide fit-tested respirators to their employees.

Record review of the facility's document titled, "Respiratory Protection Program" (RPP), dated 10/18/2021, showed the RPP Program Administrator's responsibilities included identifying situations that required mandatory use of respirators, ensuring the conduct of fit testing for staff upon hire and annually thereafter, and maintaining records required by the program. The RPP document showed that the Fit Testing Trainer/Designee was

Administrator (or Representative) Date

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Findings included…

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Record review of the facility's document titled, "Respiratory Protection Program" (RPP), dated 10/18/2021, showed the RPP Program Administrator's responsibilities included identifying situations that required mandatory use of respirators, ensuring the conduct of fit testing for staff upon hire and annually thereafter, and maintaining records required by the program. The RPP document showed that the Fit Testing Trainer/Designee was

responsible for ensuring that employees (including new hires) under their supervision, who were required to wear tight-fitting respirators, received appropriate training, annual medical evaluation, and were fit tested if duties involved the use of a respirator or when there were changes in the employee's physical condition that could affect respirator fit. Further review of 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 airborne transmittable diseases. The document identified Health Services Director, Wellness Nurse, Associate Care Directors, Care Directors, Care managers/Medication Care Managers, housekeepers, maintenance staff, life enrichment staff, and culinary staff as employees who may be required to wear filtering facepiece respirators. The document also showed that the Program Administrator would ensure fit tests were conducted in accordance with any appropriate and Occupational Safety and Health Administration (OSHA)-approved protocol of the Respiratory Protection Standard.

Review of the undated facility's "Employee Roster" showed that the facility hired 54 staff responsible for providing care and services to the residents. The document showed the facility hired: Staff B on 01/09/2023; Staff C on 06/16/2021; Staff E on 01/31/2023; Staff G on 07/11/2023; Staff H on 05/18/2023; Staff I on 04/12/2023; Staff J on 05/08/2023; Staff K on 10/27/2022; Staff L on 02/27/2023; Staff M on 05/14/2018; Staff N on 01/06/2023; Staff O on 02/14/2022; Staff P on 11/22/2019; Staff Q on 07/18/2023; Staff R on 07/22/2021; Staff S on 05/25/2022; Staff T on 01/25/2023; Staff U on 07/17/2023; Staff V on 08/10/2020; Staff W on 02/14/2018; Staff X on 03/23/2023; Staff Y on 03/30/2022; Staff Z on 11/06/2017; Staff AA on 08/20/2021; Staff BB on 04/07/2022; Staff CC on 10/12/2021; Staff DD on 09/23/2022; Staff EE on 04/24/2023; Staff FF on 12/05/2018; Staff GG on 05/21/2017; Staff HH on 04/26/2022; Staff II on 09/01/2021; Staff JJ on 12/19/2022; Staff KK on 07/07/2022; Staff LL on 09/15/2000; and Staff MM on 11/18/2022.

Review of the facility's RPP documentation showed that the facility maintained the medical evaluation and fit test results for staff who completed their medical evaluation and were fit tested for respirator use. Further review of the documentation showed there were no fit test records for Staff B, Staff C, Staff E, Staff G, Staff H, Staff I, Staff J, Staff K, Staff L, Staff M, Staff N, Staff O, Staff P, Staff Q, Staff R, Staff S, Staff T, Staff U, Staff V, Staff W, Staff X, Staff Y, Staff CC, Staff DD, Staff EE, Staff FF, Staff HH, Staff II, Staff JJ, Staff KK, Staff LL, and Staff MM. Additionally, the documentation showed that Staff Z and Staff AA both completed a medical evaluation for medical clearance in April 2022. There was no documentation that Staff Z and Staff AA further completed a respirator fit test. The document showed that Staff BB and GG completed their initial medical evaluation and fit test in Apnl 2022. There was no documentation that Staff BB and Staff GG completed their annual medical evaluation and fit test in April 2023.

During an interview on 07/24/2023 at 10:30 AM, Staff D, General Manager, stated that the facility assigned them as the RPP Program Administrator. Staff D stated that the facility followed the DOH guidance on RPP, and the facility required all employees to complete a medical evaluation and a fit test upon hire and then annually. Staff D reported that initially, during the pandemic, the facility contracted with an external agency to conduct fit tests for their staff. Staff D reported that due to a backlog of requests, the contracted agency no longer provided fit tests to them. Staff D reported that as a result, the facility had not completed fit testing for all the staff. Staff D stated that the facility planned to develop an

responsible for ensuring that employees (including new hires) under their supervision, who were required to wear tight-fitting respirators, received appropriate training, annual medical evaluation, and were fit tested if duties involved the use of a respirator or when there were changes in the employee's physical condition that could affect respirator fit. Further review of 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 airborne transmittable diseases. The document identified Health Services Director, Wellness Nurse, Associate Care Directors, Care Directors, Care managers/Medication Care Managers, housekeepers, maintenance staff, life enrichment staff, and culinary staff as employees who may be required to wear filtering facepiece respirators. The document also showed that the Program Administrator would ensure fit tests were conducted in accordance with any appropriate and Occupational Safety and Health Administration (OSHA)-approved protocol of the Respiratory Protection Standard.

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in-house fit test process to train their staff to be the testers. Staff D further stated that the facility had not implemented the in-house fit test process.

**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 is or will be in compliance with this law and / or regulation on (Date) 9/15/2023

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

Administrator (or Representative) — Date: 8/9/2023

**WAC 388-78A-2483 Tuberculosis One test. The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:**

(1) A documented history of a negative result from a previous two step skin test done no more than one to three weeks apart; or

(2) A documented negative result from one skin or blood test in the previous twelve months.

**This requirement was not met as evidenced by:**

Based on observation, interview, and record review, the facility failed to administer a one-step Tuberculosis (TB) skin test to 2 of 3 sampled staff (Staff A, Health Services Director [HSD] and Staff C, Medication Technician/Care Manager) who had a previously documented negative TB test result. This failure placed all residents at risk of exposure to TB, an infectious disease.

Findings included...

Review of the facility's personnel records showed that the facility hired Staff A on 08/06/2022 and Staff C on 06/16/2021. Review of the records showed that Staff A and Staff C previously completed a two-step TB skin test, both with negative results. Further review of the records showed no documentation that the facility administered a one-step TB test for Staff A and Staff C when hired.

Observations on 07/21/2023 and 07/24/2023, at 10:00 AM and 08:45 AM showed Staff A and Staff C worked in the facility. Observations showed Staff A and Staff C interacted with the residents.

in-house fit test process to train their staff to be the testers. Staff D further stated that the facility had not implemented the in-house fit test process.

**Plan/Attestation Statement**

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Administrator (or Representative) Date

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Based on observation, interview, and record review, the facility failed to administer a one-step Tuberculosis (TB) skin test to 2 of 3 sampled staff (Staff A, Health Services Director [HSD] and Staff C, Medication Technician/Care Manager) who had a previously documented negative TB test result. This failure placed all residents at risk of exposure to TB, an infectious disease.

Findings included...

Review of the facility's personnel records showed that the facility hired Staff A on 08/06/2022 and Staff C on 06/16/2021. Review of the records showed that Staff A and Staff C previously completed a two-step TB skin test, both with negative results. Further review of the records showed no documentation that the facility administered a one-step TB test for Staff A and Staff C when hired.

Observations on 07/21/2023 and 07/24/2023, at 10:00 AM and 08:45 AM showed Staff A and Staff C worked in the facility. Observations showed Staff A and Staff C interacted with the residents.

During an interview on 07/21/2023 at 11:45 AM, Staff A, stated that when the facility reviewed the personnel records for staff, the records showed Staff A and Staff C previously completed a TB test with negative results. Staff A stated that they were unaware the regulation required another one-step TB skin test, within 3 days of hire, for Staff A and Staff C.

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

Peter J K — Administrator (or Representative)

8/9/2023 — Date

**WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:**

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

**This requirement was not met as evidenced by:**

Based on observation, interview and record review, the facility failed to document in 6 of 7 sampled residents (Resident 1, Resident 2, Resident 4, Resident 5, Resident 6 and Resident 7) Negotiated Service Agreements (NSA), the care needs for medical equipment and interventions for physician ordered medical treatments. This failure placed the residents at risk for unmet care needs and worsening of medically diagnosed conditions.

Findings included...

RESIDENT 1
Observation on 07/21/2023 at 1:20 PM, showed Resident 1 used an electric hospital bed. Observation showed an overlay alternating pressure relieving air mattress (A mattresses designed with rows of air cells, which can be inflated or deflated to alternate the pressure within the lying surface of the mattress. A pump automatically inflates or deflates the cells automatically) on top of the regular bed mattress. An air pump was attached to the foot of the bed. The air pump was turned off and the air mattress was deflated. Observation on

During an interview on 07/21/2023 at 11:45 AM, Staff A, stated that when the facility reviewed the personnel records for staff, the records showed Staff A and Staff C previously completed a TB test with negative results. Staff A stated that they were unaware the regulation required another one-step TB skin test, within 3 days of hire, for Staff A and Staff C.

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Observation on 07/21/2023 at 1:20 PM, showed Resident 1 used an electric hospital bed. Observation showed an overlay alternating pressure relieving air mattress (A mattresses designed with rows of air cells, which can be inflated or deflated to alternate the pressure within the lying surface of the mattress. A pump automatically inflates or deflates the cells automatically) on top of the regular bed mattress. An air pump was attached to the foot of the bed. The air pump was turned off and the air mattress was deflated. Observation on

07/22/2023 at 7:30 AM, showed the air mattress was still deflated and the air pump was turned off.

Review of Resident 1's "Individualized Service Plan" (ISP), dated 06/09/2023, showed Resident 1 received Hospice Services (end of life care). The individualized service plan showed that Resident 1 used a hospital bed and caregiver instructions were provided for its use. There was no documentation in the individualized service plan that showed Resident 1 used an alternating pressure relieving air mattress. There was no documentation of caregiver instructions about when and how the air mattress was used.

RESIDENT 2
Review of Resident 2's May 2023, June 2023, and July 2023 electronic Medication Administration Record (eMAR) showed a physician's order that showed Resident 2 received Aspirin Low tablet, 81 milligrams (mg) by mouth daily. Further review showed a physician's order that prescribed Eliquis (blood thinner), two and one-half mgs, one tablet by mouth, twice daily for "anticoagulation (blood thinner)."

Review of Resident 2's "Individualized Service Plan", dated 03/13/2023, showed a diagnosis of [redacted] and [redacted] Further review of Resident 2's service plan dated 03/13/2023, showed no documentation that Resident 2 received Aspirin or Eliquis. Further review of the service plan showed no guidance provided for the care staff about the possible side effects from the use of Aspirin and Eliquis, such as increased risk of bleeding. The service plan showed no instructions for staff about what actions were needed if Resident 2 showed signs of any side effects. The plan provided no instructions for staff about when to report any signs and symptoms of side effects to the Licensed Nurse.

RESIDENT 4
Review of Resident 4's May 2023, June 2023, and July 2023, eMARs showed a physician's order that Resident 4 received 81 mg of Aspirin, one tablet by mouth, once a day for "blood thinner." Review of the eMARs showed a diagnosis of [redacted] and [redacted].

Review of Resident 4's "Individualized Service Plan", dated 06/12/2023, showed no guidance for the care staff about the possible side effects from the use of aspirin, such as an increased risk of bleeding. The service plan showed no instructions for staff about what actions were needed if Resident 4 showed signs of any side effects. The plan provided no instructions for staff about when to report any signs and symptoms of side effects to the Licensed Nurse.

RESIDENT 5
Review of Resident 5's May 2023, June 2023, and July 2023 eMARs showed a physician's order that Resident 5 received 81 mg of enteric coated Aspirin (EC, a coating around the tablet to prevent from dissolving in the stomach and protect stomach lining from

07/22/2023 at 7:30 AM, showed the air mattress was still deflated and the air pump was turned off.

Review of Resident 1's "Individualized Service Plan" (ISP), dated 06/09/2023, showed Resident 1 received Hospice Services (end of life care). The individualized service plan showed that Resident 1 used a hospital bed and caregiver instructions were provided for its use. There was no documentation in the individualized service plan that showed Resident 1 used an alternating pressure relieving air mattress. There was no documentation of caregiver instructions about when and how the air mattress was used.

RESIDENT 2
Review of Resident 2's May 2023, June 2023, and July 2023 electronic Medication Administration Record (eMAR) showed a physician's order that showed Resident 2 received Aspirin Low tablet, 81 milligrams (mg) by mouth daily. Further review showed a physician's order that prescribed Eliquis (blood thinner), two and one-half mgs, one tablet by mouth, twice daily for "anticoagulation (blood thinner)."

Review of Resident 2's "Individualized Service Plan", dated 03/13/2023, showed a diagnosis of [redacted] ([redacted]) and [redacted] ([redacted]). Further review of Resident 2's service plan dated 03/13/2023, showed no documentation that Resident 2 received Aspirin or Eliquis. Further review of the service plan showed no guidance provided for the care staff about the possible side effects from the use of Aspirin and Eliquis, such as increased risk of bleeding. The service plan showed no instructions for staff about what actions were needed if Resident 2 showed signs of any side effects. The plan provided no instructions for staff about when to report any signs and symptoms of side effects to the Licensed Nurse.

RESIDENT 4
Review of Resident 4's May 2023, June 2023, and July 2023, eMARs showed a physician's order that Resident 4 received 81 mg of Aspirin, one tablet by mouth, once a day for "blood thinner." Review of the eMARs showed a diagnosis of [redacted] ([redacted]) and [redacted] ([redacted]).

Review of Resident 4's "Individualized Service Plan", dated 06/12/2023, showed no guidance for the care staff about the possible side effects from the use of aspirin, such as an increased risk of bleeding. The service plan showed no instructions for staff about what actions were needed if Resident 4 showed signs of any side effects. The plan provided no instructions for staff about when to report any signs and symptoms of side effects to the Licensed Nurse.

RESIDENT 5
Review of Resident 5's May 2023, June 2023, and July 2023 eMARs showed a physician's order that Resident 5 received 81 mg of enteric coated Aspirin (EC, a coating around the tablet to prevent from dissolving in the stomach and protect stomach lining from

irritation), one by mouth, once a day. Review of the eMARs showed Resident 5 was diagnosed with [redacted].

Review of Resident 5's Individualized Service Plan, dated 06/13/2023, showed no guidance for the care staff about the possible side effects from the use of Aspirin, such as an increased risk of bleeding. The service plan showed no instructions for staff about what actions were needed if Resident 5 showed signs of any side effects. The plan provided no instructions for staff about when to report any signs and symptoms of side effects to the Licensed Nurse.

RESIDENT 6
Review of Resident 6's May 2023, June 2023, and July 2023 eMARs showed a physician's order that Resident 6 received 81 mg of chewable Aspirin daily, one tablet by mouth, once per day. The eMARs also showed Resident 6 received an alternated dose of Warfarin (blood thinner), once a day. Review of the eMARs showed Resident 6 was diagnosed with [redacted].

Review of Resident 6's Assessment and Service Plan, dated 06/23/2023, showed no documentation that Resident 6 received Aspirin. Further review of the service plan showed no guidance for the care staff about the possible side effects from the combined use of Aspirin and Warfarin, such as an increased risk of bleeding. The service plan showed no instructions for staff about what actions were needed if Resident 6 showed signs of any side effects. The plan provided no instructions for staff about when to report any signs and symptoms of side effects to the Licensed Nurse.

RESIDENT 7
Review of Resident 7's May 2023, June 2023, and July 2023 eMARs showed a physician's order that Resident 7 received 81 mg of Aspirin EC daily, one tablet by mouth, once per day. Review of the eMARs showed Resident 7 was diagnosed with [redacted].

Review of Resident 7's Individualized Service Plan, dated 05/23/2023, showed no guidance for the care staff about the possible side effects from the use of Aspirin, such as an increased risk of bleeding. The service plan showed no instructions for care staff about what actions were needed if Resident 7 showed signs of any side effects. The plan provided no instructions for staff about when to report any signs and symptoms of side effects to the Licensed Nurse.

During an interview on 07/24/2023 at 12:04 PM, Staff A, Licensed Practical Nurse, Health Services Director, confirmed that Resident's 2, Resident 4, Resident 5, Resident 6, and Resident 7's Individualized Service Plan did not document any safety plan associated with the use of a blood thinner medication. Staff A also confirmed the resident service plans provided no instructions to staff about the adverse effects of blood thinner medication. Staff A stated they were unaware of the regulatory requirement to document interventions

irritation), one by mouth, once a day. Review of the eMARs showed Resident 5 was diagnosed with [redacted]).

Review of Resident 5's Individualized Service Plan, dated 06/13/2023, showed no guidance for the care staff about the possible side effects from the use of Aspirin, such as an increased risk of bleeding. The service plan showed no instructions for staff about what actions were needed if Resident 5 showed signs of any side effects. The plan provided no instructions for staff about when to report any signs and symptoms of side effects to the Licensed Nurse.

RESIDENT 6
Review of Resident 6's May 2023, June 2023, and July 2023 eMARs showed a physician's order that Resident 6 received 81 mg of chewable Aspirin daily, one tablet by mouth, once per day. The eMARs also showed Resident 6 received an alternated dose of Warfarin (blood thinner), once a day. Review of the eMARs showed Resident 6 was diagnosed with [redacted]).

Review of Resident 6's Assessment and Service Plan, dated 06/23/2023, showed no documentation that Resident 6 received Aspirin. Further review of the service plan showed no guidance for the care staff about the possible side effects from the combined use of Aspirin and Warfarin, such as an increased risk of bleeding. The service plan showed no instructions for staff about what actions were needed if Resident 6 showed signs of any side effects. The plan provided no instructions for staff about when to report any signs and symptoms of side effects to the Licensed Nurse.

RESIDENT 7
Review of Resident 7's May 2023, June 2023, and July 2023 eMARs showed a physician's order that Resident 7 received 81 mg of Aspirin EC daily, one tablet by mouth, once per day. Review of the eMARs showed Resident 7 was diagnosed with [redacted]).

Review of Resident 7's Individualized Service Plan, dated 05/23/2023, showed no guidance for the care staff about the possible side effects from the use of Aspirin, such as an increased risk of bleeding. The service plan showed no instructions for care staff about what actions were needed if Resident 7 showed signs of any side effects. The plan provided no instructions for staff about when to report any signs and symptoms of side effects to the Licensed Nurse.

During an interview on 07/24/2023 at 12:04 PM, Staff A, Licensed Practical Nurse, Health Services Director, confirmed that Resident's 2, Resident 4, Resident 5, Resident 6, and Resident 7's Individualized Service Plan did not document any safety plan associated with the use of a blood thinner medication. Staff A also confirmed the resident service plans provided no instructions to staff about the adverse effects of blood thinner medication. Staff A stated they were unaware of the regulatory requirement to document interventions

in the service plan.

**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 is or will be in compliance with this law and / or regulation on (Date) 9/15/2023 .

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

Peter J Hans — Administrator (or Representative)

8/9/2023 — 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 observation, interview, and record review the facility failed to do an initial Tuberculosis (TB) skin test within three days of hire for 2 of 7 sampled staff (Staff F, Associated Care Director and Staff G, Housekeeper). The facility also failed to do a second step TB test for 1 of 3 focused sampled staff (Staff I, Care Manager) after completion of the first step. This failure placed all the residents at risk of exposure to Tuberculosis, a communicable disease.

Findings included...

Review of a Department of Social and Health Services (DSHS) "Dear Administrator/Provider" letter, amended 05/26/2022, showed that Washington state experienced a significant increase in the number of TB cases. The previous suspension of the tuberculosis testing requirements expired on 07/01/2022. The letter stated that to reduce the risk of illness to the vulnerable people served, TB testing was reinstated on 07/01/2022. In addition, the letter stated that Residential Care Services encouraged facilities and providers to immediately begin staff TB testing. This would allow facilities time to meet the TB testing requirements on 07/01/2022.

Review of the facility's document "Tuberculosis Process and Check-off for Skills Policy", dated 01/30/2019, showed that a first skin test was to be done within three days of hire.

in the service plan.

**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 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

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**This requirement was not met as evidenced by:**

Based on observation, interview, and record review the facility failed to do an initial Tuberculosis (TB) skin test within three days of hire for 2 of 7 sampled staff (Staff F, Associated Care Director and Staff G, Housekeeper). The facility also failed to do a second step TB test for 1 of 3 focused sampled staff (Staff I, Care Manager) after completion of the first step. This failure placed all the residents at risk of exposure to Tuberculosis, a communicable disease.

Findings included...

Review of a Department of Social and Health Services (DSHS) "Dear Administrator/Provider" letter, amended 05/26/2022, showed that Washington state experienced a significant increase in the number of TB cases. The previous suspension of the tuberculosis testing requirements expired on 07/01/2022. The letter stated that to reduce the risk of illness to the vulnerable people served, TB testing was reinstated on 07/01/2022. In addition, the letter stated that Residential Care Services encouraged facilities and providers to immediately begin staff TB testing. This would allow facilities time to meet the TB testing requirements on 07/01/2022.

Review of the facility's document "Tuberculosis Process and Check-off for Skills Policy", dated 01/30/2019, showed that a first skin test was to be done within three days of hire

and the "1st skin test must be read". The policy also showed a second skin test was to be done within 14-21 days of the first skin test. Further review showed that if the employee had a documented negative result from a blood test in the previous 12 months, only a one-step TB test was required.

Review of the facility's undated "Employee Community List" showed the facility hired Staff F, on 06/23/2021, Staff G on 07/11/2023, and Staff I on 04/12/2023.

STAFF F
Review of Staff F's personnel records showed a documented one-step TB skin test administered on 08/15/2022, 45 days after the Tuberculosis Testing requirement was reinstated on 07/01/2022. The one-step results showed a negative outcome when read on 08/22/2022. Further review showed a second-step TB skin test was administered on 09/06/2022, with a negative outcome when read on 09/07/2022.

During an interview on 07/24/2023 at 1:00 PM, Staff A, [Licensed Practical Nurse (Health Services Director)], and Staff D, General Manager, acknowledged Staff F's TB tests were administered late.

STAFF G
Review of Staff G's personnel records showed a documented one-step TB skin test administered on 07/07/2023. There was no documentation to show if the test results were read.

Observation on 07/20/2023 at 12:15 PM, showed Staff G worked on the first floor. Observation showed Staff G with a housekeeping cleaning cart outside of a public restroom, across from the main dining room. During an interview at this same time, Staff G confirmed a TB skin test was administered to their right forearm. Staff G extended their right forearm to show the injection site of the TB skin test. Observation showed there was an area the size of a needle stick with no redness or induration. Staff G stated that no one read the results of the TB skin test.

STAFF I
Review of Staff I's personnel records showed documentation Staff I completed a QuantiFERON blood test (A blood test detects TB) on 03/25/2022, over 12 months prior to hire. There was no documentation of the blood test results. Further review of Staff I's records showed that on 05/08/2023, a one-step TB skin test was administered, 25 days after date of employment. The one-step results showed a negative outcome when read on 05/10/2023. There was no documentation that showed Staff I was administered a second-step TB skin test.

During an interview on 07/24/2023 at 12:30 PM, Staff A stated that they understood that if Staff I had the QuantiFERON blood test, then the facility was only required to administer a one-step TB test with three days after hire. Staff A stated they failed to notice the blood test was past the allowed 12-month period to be valid.

and the "1st skin test must be read". The policy also showed a second skin test was to be done within 14-21 days of the first skin test. Further review showed that if the employee had a documented negative result from a blood test in the previous 12 months, only a one-step TB test was required.

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Review of Staff F's personnel records showed a documented one-step TB skin test administered on 08/15/2022, 45 days after the Tuberculosis Testing requirement was reinstated on 07/01/2022. The one-step results showed a negative outcome when read on 08/22/2022. Further review showed a second-step TB skin test was administered on 09/05/2022, with a negative outcome when read on 09/07/2022.

During an interview on 07/24/2023 at 1:00 PM, Staff A, [Licensed Practical Nurse (Health Services Director)], and Staff D, General Manager, acknowledged Staff F's TB tests were administered late.

STAFF G
Review of Staff G's personnel records showed a documented one-step TB skin test administered on 07/07/2023. There was no documentation to show if the test results were read.

Observation on 07/20/2023 at 12:15 PM, showed Staff G worked on the first floor. Observation showed Staff G with a housekeeping cleaning cart outside of a public restroom, across from the main dining room. During an interview at this same time, Staff G confirmed a TB skin test was administered to their right forearm. Staff G extended their right forearm to show the injection site of the TB skin test. Observation showed there was an area the size of a needle stick with no redness or induration. Staff G stated that no one read the results of the TB skin test.

STAFF I
Review of Staff I's personnel records showed documentation Staff I completed a QuantiFERON blood test (A blood test detects TB) on 03/25/2022, over 12 months prior to hire. There was no documentation of the blood test results. Further review of Staff I's records showed that on 05/08/2023, a one-step TB skin test was administered, 25 days after date of employment. The one-step results showed a negative outcome when read on 05/10/2023. There was no documentation that showed Staff I was administered a second-step TB skin test.

During an interview on 07/24/2023 at 12:30 PM, Staff A stated that they understood that if Staff I had the QuantiFERON blood test, then the facility was only required to administer a one-step TB test with three days after hire. Staff A stated they failed to notice the blood test was past the allowed 12-month period to be valid.

| Statement of Deficiencies | License #: 2596 | Compliance Determination # 26922 |
|---|---|---|
| Plan of Correction | Aegis Living Kirkland | Completion Date |
| Page of 18 | Licensee: Totem Lake Blvd Kirkland LLC | 08/01/2023 |

**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 is or will be in compliance with this law and / or regulation on (Date) 9/15/2023

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

Administrator (or Representative) — Date: 8/9/2023

**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***

08/04/2023

Totem Lake Blvd Kirkland LLC
Aegis Living Kirkland
13000 Totem Lake Blvd NE
Kirkland, WA 98034

RE: Aegis Living Kirkland # 2596

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 08/01/2023 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

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

08/04/2023

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  - 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-3010 Resident units. The assisted living facility resident units must have the following:**

(8) Miscellaneous. Each sleeping room must have:

(e) A lockable drawer, cupboard or other secure space measuring a least one-half cubic foot with a minimum dimension of four inches;

The facility failed to provide a lockable space in the resident's apartment for 2 of 7 sampled Residents (Resident 6 and Resident 7). Observation showed no lockable secure space in the two Residents' apartments. Facility interview stated that there was a lockable cabinet built in each apartment bathroom. Facility interview stated that they were unaware no lockable cabinet in the two apartments, and they did not know when and why the door lock was removed from the cabinets. On 07/24/2023, during the full inspection, the facility corrected the issue when they replaced the cabinet door with a lockable door and provided the residents a key of the cabinet.

**WAC 388-78A-3090 Maintenance and housekeeping.**

(1) The assisted living facility must:

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

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

The facility failed to provide a sanitary environment and to keep the equipment in good repair for all residents. Observation showed that a commercial washer, kept in a locked closet in the dining room in the Life's Neighborhood unit, was out of order. Observation showed that there was unclean water remained in the washer tub and there was foul odor come from the washer. Facility interview stated that the washer was found broken a week ago. Facility interview stated that the washer stopped before the drain cycle and that the unclean water stayed in the washer tub. Facility interview stated that they scheduled the repair for 07/24/2023. Additionally, observation showed one exhausted air vent in the second-floor common restroom did not pull air out. Observation showed the kitchen sink faucet of one sampled resident's (Resident 7) apartment leaked water. Facility interview stated that they provided routine monitoring and maintenance service, and they were unaware the faulty exhausted air vent and the dripping faucet. The facility repaired the commercial washer, the exhausted air vent, and the water faucet on 07/24/2023 during the time of the full inspection.

Kent, WA 98032

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
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**Consultation(s):**
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

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(e) A lockable drawer, cupboard or other secure space measuring a least one-half cubic foot with a minimum dimension of four inches;

The facility failed to provide a lockable space in the resident's apartment for 2 of 7 sampled Residents (Resident 5 and Resident 7). Observation showed no lockable secure space in the two Residents' apartments. Facility interview stated that there was a lockable cabinet built in each apartment bathroom. Facility interview stated that they were unaware no lockable cabinet in the two apartments, and they did not know when and why the door lock was removed from the cabinets. On 07/24/2023, during the full inspection, the facility corrected the issue when they replaced the cabinet door with a lockable door and provided the residents a key of the cabinet.

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**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;

The facility failed to post a weekly menu in the facility and to deliver a written menu to residents one week in advance. Observation showed no weekly menu posted in the facility premise. Facility interview stated that they posted only the daily menus in each dining room in the Assisted Living and Life's Neighborhood units. Facility interview stated that they did not send written menus to their residents in advance. The facility posted a monthly menu for July 2023 in the dining rooms and the lobby on 07/21/2023 during the time of the full inspection.

**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;

(iii) Able to be moved to the location where needed; and

The facility failed to ensure the first-aid supply kits were readily available, not locked, clearly marked, and movable to the location where needed. Observation showed that the facility kept one first-aid kit in the passcode-locked medication room in the Assisted Living unit. Observation showed no sign and label of first-aid kits in the facility. Facility interview stated that only several staff members knew the passcode of the medication room, and not all staff and residents were able to access the first-aid kit kept in the medication room. On 07/24/2023, during the full inspection, the facility corrected the issue when they placed five first-aid kits and labels in the common areas in the facility.

**WAC 388-78A-2450 Staff.**

(3) The assisted living facility must:

(d) Maintain the following documentation on the assisted living facility premises, during employment, and at least two years following termination of employment:

(i) Staff orientation and training or certification pertinent to duties, including, but not limited to:

(A) Training required by chapter 388-112A WAC;

Staff C, Medication Technician and Caregiver failed to provide documentation that showed they completed CPR training that included a hands-on demonstration of skills from an

**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;

The facility failed to post a weekly menu in the facility and to deliver a written menu to residents one week in advance. Observation showed no weekly menu posted in the facility premise. Facility interview stated that they posted only the daily menus in each dining room in the Assisted Living and Life's Neighborhood units. Facility interview stated that they did not send written menus to their residents in advance. The facility posted a monthly menu for July 2023 in the dining rooms and the lobby on 07/21/2023 during the time of the full inspection.

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(A) Training required by chapter 388-112A WAC;

Staff C, Medication Technician and Caregiver failed to provide documentation that showed they completed CPR training that included a hands-on demonstration of skills from an

approved provider. The facility General Manager stated that they thought all staff were current with certified CPR training. The General Manager reported that they scheduled Staff C to attend the next CPR training on 07/24/2023.

**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 Box 45600
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

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Sincerely,

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

Enclosure