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) 61268 (Completion Date 06/18/2025) and 58362 (Completion Date 04/24/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/18/2025 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-2130-3-a, WAC 388-78A-2130-3-b, WAC 388-78A-2130-3, WAC 388-78A-2305-1, WAC 246-215-02410-1, WAC 246-215-02310-5

The Department staff who did the on-site verification:
Michelle Yip, ALF Licensor
Thomas Forkgen, ALF 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 04/22/2025 of:
Aegis Living Kirkland
13000 Totem Lake Blvd NE
Kirkland, WA 98034

This document references the following SOD dated: 04/24/2025

The following sample was selected for review during the unannounced on-site visit: 5 of 37 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Michelle Yip, ALF Licensor
Thomas Forkgen, 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

Statement of Deficiencies	License # 2586	Compliance Determination # 58362
Plan of Correction	Aegis Living Kirkland	Completion Date
Page 2 of 7	Licensee: Totem Lake Blvd Kirkland LLC	04/24/2025

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

05/06/2025
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

Angela F Marks
Administrator (or Representative)

5/14/2025
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 the service plans for 2 of 5 sampled residents (Resident 5 and Resident 6). This failure placed Resident 5 and Resident 6 at risk for unmet care needs and a diminished quality of life.

Findings included...

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that on 02/25/2025, the Assisted Living Facility (ALF) received a citation for this regulation. The ALF signed an attestation statement that stated the facility would have the deficiency corrected by 04/11/2025.

RESIDENT 5
Observation on 04/22/2025 at 1:31 PM showed Resident 5 sat in their wheelchair 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).

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) _____ 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 the service plans for 2 of 5 sampled residents (Resident 5 and Resident 6). This failure placed Resident 5 and Resident 6 at risk for unmet care needs and a diminished quality of life.

Findings included…

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that on 02/25/2025, the Assisted Living Facility (ALF) received a citation for this regulation. The ALF signed an attestation statement that stated the facility would have the deficiency corrected by 04/11/2025.

RESIDENT 5
Observation on 04/22/2025 at 1:31 PM showed Resident 5 sat in their wheelchair 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).

Review of Resident 5's records showed that the facility admitted Resident 5 in [redacted] 2021 with a medical diagnosis of [redacted]. The records showed that on 12/03/2024, the facility completed Resident 5's assessment. The records showed Resident 5 had a pressure injury (skin breakdown) on their coccyx (tailbone) in December 2024.

Review of Resident 5's Individualized Service Plan (ISP), dated 04/22/2025, showed that Resident 5 used a wheelchair. The ISP did not show Resident 5 used a Roho cushion in the wheelchair. There was no documentation that instructed care staff how to assess and adjust the Roho cushion for proper inflation.

During an interview on 04/22/2025 at 1:35 PM, Staff W, Care Manager, stated that the care staff were responsible to assess the Roho cushion, ensure the Roho cushion was properly inflated, and inflate the Roho cushion when it was deflated. Staff W stated that they were unsure how to measure the Roho cushion for proper inflation. Staff W stated that they were unaware of the Roho cushion instructions.

During an interview on 04/22/2025 at 1:40 PM, Staff S, Care Manager, stated that they did not receive the in-service training for the Roho cushion. Staff S stated that they did not know how to assess and inflate a Roho cushion. Staff S stated that they were unaware of where the instructions for the cushion were kept.

During an interview on 04/22/2025 at 1:51 PM, Staff A, Administrator/Health Service Director, stated that they did not update Resident 5's service plan for the Roho cushion.

RESIDENT 6
Review of Resident 6's records showed that the facility admitted Resident 6 in [redacted] 2023 with a medical diagnosis of [redacted], and [redacted]

Review of Resident 6's "Physical Therapy Visit Note", dated 11/12/2024, showed the physical therapist's (PT) recommended placement of the Roho cushion on top of the gel cushion since the gel cushion was too hard. The note showed that the Roho cushion was "defective" and needed to be reevaluated by the manufacturing company.

Review of Resident 6's ISP, dated 04/22/2025, showed that Resident 6 primarily utilized a wheelchair. The ISP did not show Resident 6 used a Roho cushion in the wheelchair. There was no documentation that instructed care staff how to assess and adjust the air in the Roho cushion to ensure proper inflation.

Observation on 04/22/2025 at 1:30 PM showed Resident 6 sat in a wheelchair on a Roho cushion in their apartment. During an interview at this time, Resident 6 stated that in

November 2024, their physical therapist (PT) told them that the center cells of the Roho cushion collapsed and needed to be repaired. Resident 6 stated that the PT contacted the company to have the Roho cushion repaired as it was still under warranty. Resident 6 stated that the Roho cushion company was to contact them directly. Resident 6 stated that they had not received a call from the company

During an interview on 04/22/2025 at 1:34 PM, Staff A stated that after the Department's full inspection in February, they assessed Resident 6. Staff A stated that their assessment showed Resident 6 did not use a Roho cushion which was why it was not documented in Resident 6's ISP.

Observation on 04/22/2025 at 1:39 PM showed Resident 6 seated in a wheelchair on a Roho cushion. Observation showed a gel cushion was placed between the Roho cushion and the wheelchair seat. During an interview at this time, Resident 6 stated that the additional gel cushion was used to support the center of the collapsed Roho cushion. Resident 6 stated that they used the Roho cushion, as advised by PT in November 2024.

During an interview on 04/22/2025 at 1:43 PM, Staff A stated that they were unaware Resident 6's Roho cushion was damaged and needed to be repaired or replaced. Staff A stated that they were unaware of the PT's evaluation and recommendation for Resident 6's Roho cushion to be evaluated. Staff A stated that they did not know that Resident 6 still used the Roho cushion. Staff A stated that they since they were unaware that Resident 6 used a Roho cushion, Staff A did not update Resident 6's service plan to include the cushion.

This is an uncorrected deficiency previously cited on 02/25/2025, subsections (3)(a)(b).

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) JUNE 16th 2025

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

Angela F Marks 5/14/2025

Administrator (or Representative) Date

WAC 246-215-02310 Hands and arms When to wash (FDA Food Code 2-301.14). foodemployees shall clean their hands and exposed portions of their arms as specified under WAC 246-215-02305 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and:

November 2024, their physical therapist (PT) told them that the center cells of the Roho cushion collapsed and needed to be repaired. Resident 6 stated that the PT contacted the company to have the Roho cushion repaired as it was still under warranty. Resident 6 stated that the Roho cushion company was to contact them directly. Resident 6 stated that they had not received a call from the company.

During an interview on 04/22/2025 at 1:34 PM, Staff A stated that after the Department's full inspection in February, they assessed Resident 6. Staff A stated that their assessment showed Resident 6 did not use a Roho cushion which was why it was not documented in Resident 6's ISP.

Observation on 04/22/2025 at 1:39 PM showed Resident 6 seated in a wheelchair on a Roho cushion. Observation showed a gel cushion was placed between the Roho cushion and the wheelchair seat. During an interview at this time, Resident 6 stated that the additional gel cushion was used to support the center of the collapsed Roho cushion. Resident 6 stated that they used the Roho cushion, as advised by PT in November 2024.

During an interview on 04/22/2025 at 1:43 PM, Staff A stated that they were unaware Resident 6's Roho cushion was damaged and needed to be repaired or replaced. Staff A stated that they were unaware of the PT's evaluation and recommendation for Resident 6's Roho cushion to be evaluated. Staff A stated that they did not know that Resident 6 still used the Roho cushion. Staff A stated that they since they were unaware that Resident 6 used a Roho cushion, Staff A did not update Resident 6's service plan to include the cushion.

This is an uncorrected deficiency previously cited on 02/25/2025, subsections (3)(a)(b).

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

WAC 246-215-02310 Hands and arms When to wash (FDA Food Code 2-301.14). foodemployees shall clean their hands and exposed portions of their arms as specified under WAC 246-215-02305 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and:

(5) After handling soiled equipment or utensils;

WAC 246-215-02410 Hair restraints Effectiveness (FDA Food Code 2-402.11).

(1) Except as provided in subsection (2) of this section, food employees shall wear short hair or use hair restraints such as hats, hair coverings or nets, rubber bands, or hair clips to keep their hair off the face and behind their shoulders, and clothing that covers body hair to protect exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.

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;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to follow required sanitation procedures for 1 of 2 kitchens (main facility kitchen). This failure placed all 37 residents at risk of consuming contaminated food and contracting food borne illnesses.

Findings included…

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that on 02/25/2025, the Assisted Living Facility (ALF) received a citation for this regulation. The ALF signed an attestation statement that stated the facility would have the deficiency corrected by 04/11/2025.

Review of the facility's policy titled, "Culinary Staff Hygiene and Illness", dated 05/06/2024, showed that all culinary employees shall have their hair restrained per their state's regulation

Review of the facility's "Hand Hygiene Protocol", dated 05/19/2022, showed that employees were expected to wash their hands after handling dirty dishes.

STAFF I
Observation on 04/22/2025 at 12:20 PM, showed Staff I, Server, placed soiled trays on the stainless-steel counter of the clean side of the commercial dishwasher, removed the soiled utensils and placed them on the dirty side. Observation showed Staff I removed the soiled trays, placed them on top of a garbage can located at one end of the dirty side of the commercial dishwasher, and disposed of the paper products. Observation showed Staff I placed the soiled trays on the stainless-steel food service counter, removed two soiled plastic baskets that were used to serve pizza, and placed them on top of a stack of clean baskets on the food service line to be used to serve food for the next food order. Observation showed staff I removed the dirty trays and set them on the dirty side of the dishwasher. Observation showed Staff I went into the main dining room and returned to the kitchen with more soiled dishes. Observation showed Staff I disposed of the paper products into the garbage can and placed the soiled trays on the

dirty side of the commercial dishwasher. Observation showed Staff I removed the soiled baskets and returned them directly to the service line on top of the stack of baskets to be used to serve food. Observation showed the baskets were not washed or sanitized between each use.

Staff U
Observation on 04/22/2025 at 12:20 PM, showed Staff U, Life Enrichment Director, entered the kitchen to wash dishes. Observation showed Staff U put on an apron, washed their hands, and proceeded to rinse dirty dishes to remove food debris. Observation showed Staff U placed the dishes in a dish rack, pushed the rack into the dishwasher, and started the wash cycle. Observation showed Staff U removed the clean dishes from the dishwasher on the clean side and repeated the process with the next load of dirty dishes. Observation showed that during the dishwashing process, U's hair fell forward from behind their shoulders which interfered with Staff U's ability to rinse the dirty dishes. Observation showed Staff U pulled their hair back and placed the hair into a ponytail. Observation showed Staff U went from the dirty side of the dishwasher directly to the clean side of the dishwasher, removed the clean dishes, and put them away, without washing their hands in between dirty and clean dishes. During an interview at this time, Staff U stated that they possessed a valid food service worker card.

During an interview on 04/22/2025 at 12:40 PM, Staff O stated that Staff I handled the soiled dishes incorrectly which allowed for potential cross contamination. Staff O stated that staff were expected to follow the process for cleaning dirty dishes: rinse the debris from the dirty dishes, place the dishes in a dishwasher rack, and then push the rack into the dishwasher. Staff O stated that after the dishwasher cycle was completed, the clean dishes were removed from the clean side. Staff O stated that the expectation was that staff who washed dishes needed to wash their hands, or if wearing gloves, change gloves, before putting away the clean dishes.

This is an uncorrected deficiency previously cited on 02/25/2025, Washington Administrative Code (WAC) 388-78A-2305 subsection (1), WAC 246-215-02310 subsection (5), and WAC 246-215-02410 subsection (1).

Statement of Deficiencies	License # 2596	Compliance Determination # 58362
Plan of Correction	Aegis Living Kirkland	Completion Date
Page 7 of 7	Licensee: Totem Lake Blvd Kirkland LLC	04/24/2025

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 Living Kirkland is or will be in compliance with this law and / or regulation on (Date) June 16th 2025

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

Administrator (or Representative) 5/14/2025 Date

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

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 02/18/2025 and 02/20/2025 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 32 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF 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

Statement of Deficiencies	License #: 2596	Compliance Determination #:54920
Plan of Correction	Aegis Living Kirkland	Completion Date
Page 2 of 15	Licensee: Totem Lake Blvd Kirkland LLC	02/25/2025

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

02/27/2025
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)

3/7/2025
Date

WAC 388-112A-0611 Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?

(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described below.

(a) The following long-term care workers must complete twelve hours of continuing education by their birthday each year:

(iii) A certified nursing assistant;

(2) A long-term care worker who does not complete continuing education as required under this chapter must not provide care until the required continuing education is completed.

WAC 388-112A-0720 What are the CPR and first-aid training requirements?

(2) Assisted living facilities.

(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire.

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

This requirement was not met as evidenced by:

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) | Date

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(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 9 sampled care staff (Staff C, Staff E, and Staff H) completed all trainings, as required. This failure placed all 32 residents at risk for decreased quality of care provided by caregivers with incomplete training.

Findings included…

Review of the facility's Employee Roster showed that the facility hired Staff C, Care Manager, on 09/03/2024; Staff E, Medication Care Manager, on 05/09/2022; and Staff H, Lead Medication Care Manager, on 06/16/2021.

FIRST AID
STAFF C
Review of Staff C's employee records showed no documentation that Staff C obtained and maintained a valid first aid card, 168 days after hire.

During an interview on 02/19/2024 at 1:00 PM, Staff O, Business Office Manager, stated that Staff C did not complete first aid training. Staff O stated that Staff C was informed they needed to complete the first aid training.

CONTINUING EDUCATION (CE)
STAFF E
Review of Staff E's employee records showed that Staff E's Nursing Assistant Certification was first issued on 09/11/2021 and was in active status. There was no documentation that showed Staff E completed any CE training between their December 2023 and December 2024 birthdays, as required.

STAFF H
Observation on 02/20/2025 between 8:00 AM and 2:00 PM showed Staff H provided care to residents in the facility.

Review of Staff H's employee records showed that Staff H's Nursing Assistant Certification was first issued on 01/19/2023 and was in active status. There was no documentation that showed Staff H completed any CE trainings between their August 2023 and August 2024 birthdays, as required.

During an interview on 02/20/2025 at 11:40 AM, Staff O stated that they were unsure if Staff E and Staff H completed any CE between their 2023 and 2024 birthdays, as required. Staff O stated that they were unable to find any documentation that showed Staff E and Staff H completed the Department of Social and Health Services (DSHS) approved CE certification from their 2023 birthday to their 2024 birthday.

Statement of Deficiencies	License #: 2596	Compliance Determination #:54920
Plan of Correction	Aegis Living Kirkland	Completion Date
Page 4 of 15	Licensee: Totem Lake Blvd Kirkland LLC	02/25/2025

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 Living Kirkland is or will be in compliance with this law and / or regulation on (Date) ~~4/13/2025~~ 4/11/2025 AM

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

Angelat Marks — 3/7/2025

Administrator (or Representative) — Date

WAC 388-78A-2468 Background checks Employment Conditional hire Pending results of Washington state name and date of birth background check. The assisted living facility may conditionally hire an administrator, caregiver, or staff person directly or by contract, pending the result of the Washington state name and date of birth background check, provided that the assisted living facility:

(1) Submits the background authorization form for the person to the department no later than one business day after he or she starts working.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to submit the Washington state name and date of birth background inquiry (BGI) for 1 of 1 sampled contracted staff (Staff P), within one business day after their start date. This failure placed all 32 residents as risk for abuse and neglect from caregivers and staff persons with unknown background.

Findings included...

Review of the facility's personnel records showed that the facility hired Staff P, Agency Caregiver, on 02/07/2025. The records showed that the facility completed the Washington state name and date of birth BGI on 02/19/2025, during the licensing inspection, 12 days after hire.

During an interview on 02/20/2025 at 11:40 AM, Staff O, Business Office Manager, stated that the facility hired Staff P from a contracted healthcare agency. Staff O stated that Staff P provided one-on-one care to the resident between 02/07/2025 and 02/12/2025. Staff O stated that they were unfamiliar with the background check requirements under the Washington Administrative Codes.

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

WAC 388-78A-2468 Background checks Employment Conditional hire Pending results of Washington state name and date of birth background check. The assisted living facility may conditionally hire an administrator, caregiver, or staff person directly or by contract, pending the result of the Washington state name and date of birth background check, provided that the assisted living facility:

(1) Submits the background authorization form for the person to the department no later than one business day after he or she starts working;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to submit the Washington state name and date of birth background inquiry (BGI) for 1 of 1 sampled contracted staff (Staff P), within one business day after their start date. This failure placed all 32 residents as risk for abuse and neglect from caregivers and staff persons with unknown background.

Findings included…

Review of the facility's personnel records showed that the facility hired Staff P, Agency Caregiver, on 02/07/2025. The records showed that the facility completed the Washington state name and date of birth BGI on 02/19/2025, during the licensing inspection, 12 days after hire.

During an interview on 02/20/2025 at 11:40 AM, Staff O, Business Office Manager, stated that the facility hired Staff P from a contracted healthcare agency. Staff O stated that Staff P provided one-on-one care to the resident between 02/07/2025 and 02/12/2025. Staff O stated that they were unfamiliar with the background check requirements under the Washington Administrative Codes.

Statement of Deficiencies	License #: 2596	Compliance Determination #:54920
Plan of Correction	Aegis Living Kirkland	Completion Date
Page 5 of 15	Licensee: Totem Lake Blvd Kirkland LLC	02/25/2025

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: 3/7/2025

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

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete 2 of 2 sampled staff (Staff E and Staff H) Washington State name and date of birth background inquiry (BGI) every two years. This failure placed all 32 residents at risk of abuse, neglect, or exploitation from staff persons with unknown backgrounds.

Findings included...

STAFF E
Review of the facility's Employee Roster showed that the facility hired Staff E, Medication Care Manager, on 05/09/2022. Review of Staff E's employee records showed their previous Washington state name and date of birth BGI expired on 04/29/2024. The records showed that the facility submitted and completed a BGI on 06/24/2024, 56 days after the previous BGI expired.

STAFF H
Review of the facility's Employee Roster showed that the facility hired Staff H, Lead Medication Care Manager, on 08/16/2021. Review of Staff H's employee records showed their previous Washington state name and date of birth BGI expired on 11/30/2024. The

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.

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Administrator (or Representative) Date

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(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete 2 of 2 sampled staff (Staff E and Staff H) Washington State name and date of birth background inquiry (BGI) every two years. This failure placed all 32 residents at risk of abuse, neglect, or exploitation from staff persons with unknown backgrounds.

Findings included…

STAFF E
Review of the facility's Employee Roster showed that the facility hired Staff E, Medication Care Manager, on 05/09/2022. Review of Staff E's employee records showed their previous Washington state name and date of birth BGI expired on 04/29/2024. The records showed that the facility submitted and completed a BGI on 06/24/2024, 56 days after the previous BGI expired.

STAFF H
Review of the facility's Employee Roster showed that the facility hired Staff H, Lead Medication Care Manager, on 06/16/2021. Review of Staff H's employee records showed their previous Washington state name and date of birth BGI expired on 11/30/2024. The

records showed that the facility submitted and completed a BGI on 12/02/2024, two days after the previous BGI expired.

During an interview on 02/20/2025 at 11:40 AM, Staff O, Business Office Manager (BOM), stated that they started in the Business Office Manager position in June 2024. Staff O stated that the facility missed to complete the BGI for Staff E during the transition between the previous and current BOMs. Staff O stated that they were unable to find additional background check documents for Staff E and Staff H.

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) ~~4/15/2025~~ 4/11/2025 AM

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

Angela Marks — Administrator (or Representative)

3/7/2025 — Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

(c) Initial and on-going assessments of the nursing needs of each resident;

(d) Development of, and necessary amendments to, the nursing component of the negotiated service agreement for each resident;

(e) Implementation of the nursing component of each resident's negotiated service agreement; and

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(a) Chapter 18.79 RCW, Nursing care;

records showed that the facility submitted and completed a BGI on 12/02/2024, two days after the previous BGI expired.

During an interview on 02/20/2025 at 11:40 AM, Staff O, Business Office Manager (BOM), stated that they started in the Business Office Manager position in June 2024. Staff O stated that the facility missed to complete the BGI for Staff E during the transition between the previous and current BOMs. Staff O stated that they were unable to find additional background check documents for Staff E and Staff H.

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-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

(c) Initial and on-going assessments of the nursing needs of each resident;

(d) Development of, and necessary amendments to, the nursing component of the negotiated service agreement for each resident;

(e) Implementation of the nursing component of each resident's negotiated service agreement; and

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(a) Chapter 18.79 RCW, Nursing care;

(b) Chapter 18.88A RCW, Nursing assistants;

(c) Chapter 246-840 WAC, Practical and registered nursing;

(d) Chapter 246-841 WAC, Nursing assistants; and

(e) Chapter 246-888 WAC, Medication assistance.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to implement nurse delegation services for 1 of 1 sampled resident (Resident 5). This failure placed Resident 5 at risk of harm and compromised health from potential medication errors from undelegated staff.

Findings included…

Review of the facility's undated Disclosure of Services showed that the facility provided intermittent nursing services that included medication administration by trained unlicensed staff through nurse delegation.

Review of the facility's document titled, "Nurse Delegation Policy", dated 11/14/2018, showed that the facility was required to determine if a resident needed administration of medication. The policy showed that if the resident was not functionally (physically) able to take medications and cognitively aware they received medications, the medication must be administered by a person authorized to do so.

Observation on 02/20/2025 at 8:30 AM showed Staff W, Care Manager, applied topical medication to Resident 5's tailbone area. Observation on 02/20/2025 at 9:24 AM showed Staff H, Lead Medication Care Manager, administered Resident 5's oral medication. Observation showed Staff H crushed Resident 5's oral medication and mixed it with apple sauce. Observation showed Staff H placed the medication on a spoon and spoon fed Resident 5 the medication.

Review of Resident 5's records showed that the facility admitted Resident 5 in [redacted] 2021 with a medical diagnosis of [redacted]. The records showed Resident 5's medication orders included oral and topical medications and crushed oral medication.

Review of Resident 5's Individual Service Plan, dated 02/18/2025, showed that Resident 5 required medication administration for oral and topical medications by trained medication staff.

Review of the facility's nurse delegation binder showed the facility provided nurse

delegation services to residents. There was no documentation that showed Resident 5 received nurse delegation services. There was no documentation that showed Staff W and Staff H were delegated by the Registered Nurse Delegator to administer Resident 5's medications.

During an interview on 02/20/2024 at 1:37 PM, Staff Q, Registered Nurse Delegator, stated that they were responsible to assess residents and determine if a resident needed administration of medication. Staff Q stated that Resident 5 was unable to physically take the medications and Resident 5 required delegation for medication assistance. Staff Q stated that they did not delegate any staff to administer Resident 5's medications.

Plan/Attestation Statement

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

Angela Marks — Administrator (or Representative)

3/7/2025 — 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 the service plan for 5 of 8 sampled residents (Resident 1, Resident 2, Resident 5, Resident 6, and Resident 8). This failure placed Resident 1, Resident 2, Resident 5, Resident 6, and Resident 8 at risk for unmet care needs and a diminished quality of life.

Findings included...

delegation services to residents. There was no documentation that showed Resident 5 received nurse delegation services. There was no documentation that showed Staff W and Staff H were delegated by the Registered Nurse Delegator to administer Resident 5's medications.

During an interview on 02/20/2024 at 1:37 PM, Staff Q, Registered Nurse Delegator, stated that they were responsible to assess residents and determine if a resident needed administration of medication. Staff Q stated that Resident 5 was unable to physically take the medications and Resident 5 required delegation for medication assistance. Staff Q stated that they did not delegate any staff to administer Resident 5's medications.

Plan/Attestation Statement

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Administrator (or Representative) Date

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(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 the service plan for 5 of 8 sampled residents (Resident 1, Resident 2, Resident 5, Resident 6, and Resident 8). This failure placed Resident 1, Resident 2, Resident 5, Resident 6, and Resident 8 at risk for unmet care needs and a diminished quality of life.

Findings included…

RESIDENT 1
Review of the facility's Characteristics Roster showed that the facility admitted Resident 1 in [redacted] of 2024.

Review of Resident 1's Face Sheet (information sheet) showed that Resident 1's code status was a full code (cardiopulmonary resuscitation to be initiated) and staff were instructed to perform resuscitation efforts should Resident 1's heart stop.

Review of Resident 1's Individualized Service Plan (ISP), dated 11/14/2024, showed in red font that Resident 1's code status was a full code.

Review of Resident 1's Physicians order for life sustaining treatment (POLST) form dated 08/19/2024, showed Resident 1 was a do not resuscitate (DNR).

RESIDENT 2
Review of the facility's Characteristics Roster showed that the facility admitted Resident 2 in [redacted] of 2024. Review of Resident 2's Face Sheet showed that Resident 2's Code status was a full code.

Review of Resident 2's ISP, dated 10/11/2024, showed that Resident 2's code status was a full code.

Review of Resident 2's POLST form dated 01/31/2025, showed Resident 2's code status was a DNR.

RESIDENT 8
Review of the facility's Characteristics Roster showed that the facility admitted Resident 8 in [redacted] of 2024.

Review of Resident 8's face sheet showed that Resident 8's code status was a full code.

Review of Resident 8's POLST form dated 10/01/2024, showed that Resident 8's code status was a DNR.

During an interview on 02/19/2025 at 2:30 PM, Staff R, Regional Health Services Director, stated that resident ISPs were linked to the resident face sheet. Staff R stated that if the face sheets were incorrect, the ISPs were also incorrect. Staff R stated that Resident 1, Resident 2, and Resident 8 all had a code status of do not resuscitate.

RESIDENT 5
Observation in Resident 5's apartment on 02/20/2025 at 8:30 AM showed Resident 5 sat

in their wheelchair 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). Observation showed two care staff provided Resident 5 with incontinent care, and transfer assistance between the wheelchair and the bed.

Review of Resident 5's records showed that the facility admitted Resident 5 in [redacted] 2021 with a medical diagnosis of [redacted]. The records showed that on 12/03/2024, the facility completed Resident 5's assessment. The records showed Resident 5 had a pressure injury (skin breakdown) on their coccyx (tailbone) in December 2024.

Review of Resident 5's ISP, dated 02/18/2025, showed that Resident 5 used a wheelchair. The ISP did not show Resident 5 used a Roho cushion in the wheelchair. There was no documentation that instructed care staff how to assess and adjust the Roho cushion for proper inflation.

RESIDENT 6
Observation on 02/19/2025 between 11:50 AM and 12:15 PM showed Resident 6 sat in their wheelchair on a Roho cushion.

Review of Resident 6's records showed that the facility admitted Resident 6 in [redacted] 2023. The records showed that on 01/30/2025, the facility completed Resident 6's assessment.

Review of Resident 6's ISP, dated 02/18/2025, showed that Resident 6 used a wheelchair. The ISP did not show Resident 6 used a Roho cushion in the wheelchair. There was no documentation that instructed care staff how to assess and adjust the Roho cushion for proper inflation.

During an interview on 02/20/2025 at 12:20 PM, Staff R, Regional Health Services Director, stated that there were no care staff instructions for the Roho cushion used by Resident 5 and Resident 6' service plans. Staff R stated that they did not update the ISP for Resident 5 and Resident 6.

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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) ~~4/18/2025~~ 4/11/2025 AM.

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

Administrator (or Representative) — Date: 3/7/2025

WAC 246-215-02310 Hands and arms When to wash (FDA Food Code 2-301.14). foodemployees shall clean their hands and exposed portions of their arms as specified under WAC 246-215-02305 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and:

(5) After handling soiled equipment or utensils;

WAC 246-215-02410 Hair restraints Effectiveness (FDA Food Code 2-402.11).

(1) Except as provided in subsection (2) of this section, food employees shall wear short hair or use hair restraints such as hats, hair coverings or nets, rubber bands, or hair clips to keep their hair off the face and behind their shoulders, and clothing that covers body hair to protect exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.

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;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to follow proper sanitation procedures for 1 of 2 kitchens (Main facility kitchen). This failure placed all 32 residents at risk of consuming contaminated food and contracting food borne illnesses.

Findings included...

Review of the facility's policy titled, "Culinary Staff Hygiene and Illness", dated 05/06/2024, showed that all culinary employees shall have their hair restrained per their state's regulations.

HAIR CONSTRAINT

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)_____ .

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Administrator (or Representative) Date

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(1) Except as provided in subsection (2) of this section, food employees shall wear short hair or use hair restraints such as hats, hair coverings or nets, rubber bands, or hair clips to keep their hair off the face and behind their shoulders, and clothing that covers body hair to protect exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to follow proper sanitation procedures for 1 of 2 kitchens (Main facility kitchen). This failure placed all 32 residents at risk of consuming contaminated food and contracting food borne illnesses.

Findings included…

Review of the facility's policy titled, "Culinary Staff Hygiene and Illness", dated 05/06/2024, showed that all culinary employees shall have their hair restrained per their state's regulations.

HAIR CONSTRAINT

Observation on 02/18/2025 at 12:36 PM and 02/19/2025 between 11:04 AM and 12:30 PM, showed Staff U, Culinary Service Director, prepared food in the facility's main kitchen. Observation showed Staff U's hair was pulled back from the forehead with a head band. Observation showed Staff U's hair dangled over the shoulders. Observation showed Staff U did not keep their hair behind the shoulders and did not protect exposed food. Observation showed that when Staff U leaned forward and used a soup ladle to place soup in a bowl, then placed the bowl on a plate, Staff U's hair fell forward towards the soup.

HANDWASHING
Review of the facility's Hand Hygiene Protocol dated 05/19/2022, showed that employees were expected to wash their hands "after handling dirty dishes".

During an interview on 02/19/2025 between 11:04 AM and 12:30 PM, Staff U stated that there was not a designated dishwasher position. Staff U stated that all the kitchen staff washed dishes.

Observation on 02/19/2025 at 11:38 AM, showed Staff V, Lead Cook, go from dirty dishes to clean dishes without washing their hands. Observation showed Staff V removed food debris from the dirty dishes, placed the dishes in a dish rack, and pushed the rack into the dishwasher. Observation showed Staff V removed the clean dishes from the dishwasher on the clean side and repeated the process with the next load of dirty dishes. Observation showed Staff V went from the dirty side of the dishwasher directly to the clean side of the dishwasher, removed the clean dishes, and put them away without washing their hands in-between dirty and clean.

Observation on 02/20/2025 at 10:20 AM, showed Staff V sprayed off dirty dishes, loaded them into a dish rack, and pushed the rack into the dishwasher. When the dishwasher cycle was completed, Staff V removed the clean dishes from the clean side of the dishwasher. Observation showed that after Staff V handled the dirty dishes, they walked over to the clean dishes and put them away without washing their hands.

During an interview on 02/20/2025 at 10:30 AM, Staff V stated that the process for cleaning dirty dishes was to rinse the debris from the dirty dishes with a sprayer, hard to remove food particles were scrubbed off, dishes were placed in a dishwasher rack which was then pushed into the dishwasher. Staff V stated that after the dishwasher cycle was completed, the clean dishes were removed from the clean side of the dishwasher and allowed to remain in the dishrack to dry before they were put away. Staff V stated that they were supposed to wash their hands in-between dirty dishes and clean dishes. Staff V stated they forgot to wash their hands between the tasks.

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Plan/Attestation Statement

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

Angela F Marks — Administrator (or Representative)

3/7/2025 — 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.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete 3 of 14 sampled staff (Staff D, Staff G, and Staff K) one-step skin test for Tuberculosis (TB), within three days of hire, as required. The facility failed to complete 1 of 14 sampled staff's (Staff C) second TB test, one to three weeks after the first TB test. The facility failed to obtain 2 of 3 sampled staff (Staff J and Staff M) documentation of their chest-X-ray results. These failures placed all 32 residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding includes...

Review of the facility's TB policy, dated 07/08/2024, showed that the facility followed the Washington Administrative Code (WAC) for TB screening and testing requirements. The policy showed the facility required all employees be screened and tested for TB within three days of employment and a second test done within one to three weeks after the first TB test. The policy showed that when there is a positive TB test result or blood test the facility "must" ensure that each staff member with a positive test result was evaluated for signs and symptoms of tuberculosis and followed the recommendation of the staff member's care provider.

ONE-STEP TB TEST

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

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(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 3 of 14 sampled staff (Staff D, Staff G, and Staff K) one-step skin test for Tuberculosis (TB), within three days of hire, as required. The facility failed to complete 1 of 14 sampled staff's (Staff C) second TB test, one to three weeks after the first TB test. The facility failed to obtain 2 of 3 sampled staff (Staff J and Staff M) documentation of their chest-X-ray results. These failures placed all 32 residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included…

Review of the facility's TB policy, dated 07/08/2024, showed that the facility followed the Washington Administrative Code (WAC) for TB screening and testing requirements. The policy showed the facility required all employees be screened and tested for TB within three days of employment and a second test done within one to three weeks after the first TB test. The policy showed that when there is a positive TB test result or blood test the facility "must" ensure that each staff member with a positive test result was evaluated for signs and symptoms of tuberculosis and followed the recommendation of the staff member's care provider.

ONE-STEP TB TEST

STAFF D
Review of the facility's Employee Roster showed that the facility hired Staff D, Care Manager, on 07/29/2024. Review of Staff D's employee records showed documentation of a negative interferon gamma release assays [(IGRA) blood test] test done on 09/18/2024, 51 days after hire.

STAFF G
Review of the facility's Employee Roster showed that the facility hired Staff G, Concierge, on 01/24/2025. Review of Staff G's employee records showed documentation of a negative one-step TB test done on 02/07/2025, 14 days after hire.

STAFF K
Review of the facility's Employee Roster showed that the facility hired Staff K, Care Manager, on 02/03/2025. Review of Staff K's employee records showed documentation of a one-step TB test dated 02/18/2025 with results pending, 15 days after hire.

SECOND STEP-TB TEST

STAFF C
Review of the facility's Employee Roster showed that the facility hired Staff C, Care Manger, on 09/03/2024. Review of Staff C's employee records showed documentation of a negative one-step TB test done on 09/03/2025 and second-step TB test done on 09/19/2024. Review of the second-step TB test showed that it was not read and there were no results documented.

CHEST X-RAY

STAFF J
Review of the facility's Employee Roster showed that the facility hired Staff J, Assistant Care Director, on 11/26/2024. Review of Staff J's employee records showed documentation of a chest X-Ray, dated 12/09/2024, 13 days after hire. Review of the chest X-Ray results showed "no status required". The chest X-ray report did not show it was done to rule out TB. The chest X-ray did not provide results as to whether TB was ruled out.

Staff M
Review of the facility's Employee Roster showed that the facility hired Staff M, Care Manager, on 01/24/2025. Review of Staff M's employee records showed documentation of a positive one-step TB test done on 02/03/2025, 10 days after hire. The one-step TB test was read on 02/06/2025 and showed a positive result of 12 millimeters (mm). Review of a chest x-ray dated 02/11/2025, showed the results status as "no status required". The chest X-ray report did not show it was done to rule out TB. The chest X-ray did not provide results as to whether TB was ruled out.

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During an interview on 02/20/2025 at 11:30 AM, Staff O, Business Office Manager, stated that they did not realize the chest X-ray report failed to provide the results of the chest X-ray and to show it was to rule out active TB. Staff O stated that they were aware several TB tests were not done within the required time frame.

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: 3/7/2025

During an interview on 02/20/2025 at 11:30 AM, Staff O, Business Office Manager, stated that they did not realize the chest X-ray report failed to provide the results of the chest X-ray and to show it was to rule out active TB. Staff O stated that they were aware several TB tests were not done within the required time frame.

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