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

Bear Creek Senior Living, Inc
Redmond Heights Senior Living
7950 Willows Rd NE
Redmond, WA 98052

RE: Redmond Heights Senior Living License # 2628

Dear Administrator:

This letter addresses Compliance Determination(s) 33054 (Completion Date 11/28/2023) and 28674 (Completion Date 08/30/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/28/2023 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-2300-1-c-vi, WAC 388-78A-2300-2-a-i, WAC 388-78A-2300-2-a-ii, WAC 388-78A-3090-1-a, WAC 388-78A-3090-1-b, WAC 388-78A-3090-1-c, WAC 388-78A-2170-1, WAC 388-78A-2930-1-a-i, WAC 388-78A-2930-1-a-ii, WAC 388-78A-2930-1-a-iii, WAC 388-78A-2930-1-a, WAC 388-78A-2180, WAC 388-78A-2180-1, WAC 388-78A-2180-1-a, WAC 388-78A-2180-1-b, WAC 388-78A-2180-2

The Department staff who did the on-site verification:

Steven Garrett, LTC Licensor
Claudia Machado, Community Complaint Investigator
Angelica Rios, ALF Licensor

If you have any questions, please contact me at (253)234-6020.

Sincerely,

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 #: 2628	Compliance Determination # 28674
Plan of Correction	Redmond Heights Senior Living	Completion Date
Page 1 of 11	Licensee: Bear Creek Senior Living, Inc	08/30/2023

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 an unannounced on-site follow-up on 08/15/2023 and 08/17/2023 of:
Redmond Heights Senior Living
7950 Willows Rd NE
Redmond, WA 98052

This document references the following SOD dated: 08/30/2023

The following sample was selected for review during the unannounced on-site visit: 6 of 26 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Steven Garrett, LTC Licensor
Claudia Machado, Community Complaint Investigator
Angelica Rios, ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Laurie Anderson
Residential Care Services

09/12/2023
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.

Administrator (or Representative) Date

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(c) Ensure all menus:

(vi) Are not repeated for at least three weeks, except that breakfast menus in assisted living facilities that provide a variety of daily choices of hot and cold foods are not required to have a minimum three-week cycle.

(2) The assisted living facility must plan in writing, prepare on-site or provide through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC, and serve to each resident as ordered:

(a) Prescribed general low sodium, general diabetic, and mechanical soft food diets according to a diet manual. The assisted living facility must ensure the diet manual is:

(i) Available to and used by staff persons responsible for food preparation;

(ii) Approved by a dietitian; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure menu items were not repeated within a three-week timeframe. The facility also failed to maintain a licensed dietician approved dietary manual, as required. These failures placed residents at risk of receiving food services without meeting the most current nutritional standards and a decreased quality of life.

Findings included...

Record review of the Department of Social and Health Services (DSHS)'s, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 06/15/2023. The ALF signed an attestation statement that stated the facility would have a system in place and deficiency corrected by 07/30/2023.

Review of the facility's menus from 08/05/2023 through 08/18/2023 showed the facility served egg salad sandwiches twice for dinner. Further review showed that between 07/30/2023 and 08/15/2023, Cobb Salad was served for dinner two times.

During an interview on 08/16/2023 at 11:00 AM, Staff J, Dietary Supervisor, stated that the facility did not have a dietary manual. Staff J stated that they were in the process of training

for an online dietary manual application through their food vendor (US Foods).

During an interview on 08/17/2023 at 11:20 AM, Staff A, Administrator, stated that they were unaware the new online dietary manual application was not being used by dietary staff for food preparation.

This is an uncorrected deficiency previously cited on 06/15/2023.

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, Redmond Heights Senior Living is or will be in compliance with this law and / or regulation on (Date) 10/12/23 .

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

Administrator (or Representative) — Date: 9/20/23

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

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

This requirement was not met as evidenced by:

Based on observation, record review, and interview the facility failed to provide an safe and well-maintained environment. This failure placed all residents at risk of injury and a diminished quality of life.

Findings included...

Record review of the Department of Social and Health Services (DSHS)'s, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 06/15/2023. The ALF signed an attestation statement that stated the facility would have a system in place and deficiency corrected by 07/30/2023.

KITCHEN/DINING ROOM

Observation of Kitchen and dining room area on 08/16/2023 at 11:01 AM, showed two box-type area cooling fans. One fan was on a chair in the dining room next to the coffee station facing the food serving line. The second fan sat on a chair, facing the Dietary Supervisor's office. Both fans were observed turned on to circulate the air. Each fan showed visible dust and grime on the fan blades, as well as on the screens.

During an interview on 08/16/2023 at 11:00 AM, Staff J, Dietary Supervisor, stated that the kitchen staff were not responsible for cleaning the fans. Staff J stated that the housekeeping staff cleaned the fans. Staff J was unaware of the housekeeper's cleaning schedule.

Record review of the facility's cleaning document log, dated 2023, showed the fans were cleaned by maintenance staff monthly. Further review of the Augus 2023 document showed staff initialed the fans were cleaned. The log did not show the day in August 2023 when the fans were cleaned.

EXTERIOR OF BUILDING/MEMORY CARE UNIT SECURED OUTDOOR SPACE
Observation of the secured outdoor space in the facility's memory care unit on 08/16/2023 at 10:12 AM, showed an outdoor walkway covered with yard debris, which included leaves. The walkway was uneven with an abrupt edge drop-off to the ground. The uneven surface covered in leaves posed a trip hazard and made it unsafe to navigate the pathway safely.

Observation of the facility grounds on 08/16/2023 at 10:13 AM, showed a large, grassy area at the back of the building. The grassy lawn areas were overgrown with tall, dried grass, weeds, and brush. Further observation showed two benches, both in disrepair with peeling paint and rotted wood framing. The area was surrounded with a chain-link fence that ran the length of the back property line. Further observation showed the chain-link fence damaged in two places by fallen tree limbs. A concrete sidewalk followed the chain-link fence through the grassy area. At the start of the walkway to the north, a posted sign read "Restricted Area Do Not Enter". Further observation showed the walkway obstructed with yard debris, which included dry leaves, tree branches and overgrown brush. The concrete walkway was broken and uneven in several places. Next to the walkway was a wooden barrier with several exposed rusty nails and screws. The yard debris and uneven and broken concrete of the walkway all posed a trip and fall hazard. At the start of the sidewalk to the south, a sandwich-style sign board read "No wheelchair access on path, restricted area, do not enter, sidewalk closed ahead". Further observation on the south side of the building showed four large black plastic yard trash bags, tied and appearing full, sat next to the walkway.

On 08/16/2023 at 10:44 AM, observation of the sunroom next to the dining room, at the back of the building, showed two doors, one to the north and one to the south, that provided access to the large grassy area outside. The access doors were open with screens that covered the opening. The south end of the sunroom exited to a covered patio area adjacent to the grassy area. Observation of the canopy that covered the patio showed visible dirt, grime, and mold.

During an interview on 08/17/2023 at 10:40 AM, Staff A, Administrator, stated that they were aware the exterior area behind the building was in disrepair. Staff A further stated that the sidewalk along the chain-link fence behind the building was not walkable for residents. Staff A stated that the facility contacted a landscaping vendor to provide maintenance and cleanup of the grassy yard area behind the building. Staff A was unaware of when the landscaping vendor would start the cleanup.

This is an uncorrected deficiency previously cited on 06/15/2023.

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, Redmond Heights Senior Living is or will be in compliance with this law and / or regulation on (Date) 10/12/23 .

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

Administrator (or Representative) — Date: 9/20/23

WAC 388-78A-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed ensure 4 of 4 residents (Resident 2, Resident 4, Resident 8, and Resident 11) side bed rails, attached to the residents' beds, were free of entrapment hazards. This failure placed Resident 2, Resident 4, Resident 8, and Resident 11 at risk of harm or death from unsafe medical equipment.

Finding included...

Record review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 06/15/2023. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 07/30/2023.

Resident 2
Review of Resident 2's (R2) Negotiated Service Agreement (NSA), dated 05/02/2023,

showed that Resident 2 had diagnoses of [redacted] and [redacted].

Review of R2's assessment, dated 05/02/2023, showed that R2 needed frequent re-orientation to place, time, and person. The assessment also showed that R2 had poor self-safety awareness. The assessment showed that R2 had weakness of the lower extremities and required one person assistance with all transfers. The assessment documented that R2 used a side bed rail to aid in independent positioning while in bed.

On 08/15/2023 at 10:20 AM, observation of R2's room showed there was a quarter side bed rail attached at the top of R2's bed, on the right side. Observation showed the bed was in the raised position. The left side of the bed was placed against the wall. The right-side bed rail had a wide gap between the bars, approximately 6.5 inches by 8 inches. The side rails were not covered to protect the resident's limbs from possible entrapment.

Resident 4
Review of Resident 4's (R4) NSA, dated 04/19/2023, showed that R4 had diagnoses of [redacted] and [redacted].

Review of R4's assessment, dated 04/22/2023, showed that R4 needed frequent re-orientation to place, time, and person. The assessment also showed that R4 had poor self-safety awareness. The assessment showed that R4 had intermittent weakness of the lower extremities. The assessment showed that R4 required one or two-person assistance with all transfers. The assessment documented that R4 used a bed rail to aid in positioning while in bed.

On 08/15/2023 at 10:40 AM, observation of R4's room showed full length side rails attached along both the right and left side of R4's bed. Observation showed the bed was in the raised position. The left side of the bed was placed against the wall. Both side rails had a wide gap between the bars of the side rail, approximately 6.5 inches wide and extending the full length of the side rail, approximately 50 inches. The side rails were not covered to protect the resident's limbs from possible entrapment.

During an interview on 08/16/2023 at 1:33 PM, Staff K, Wellness Director, stated that R4 was unable to independently put the side rail down. Staff K also stated that R4 was unable to call for staff assistance.

Resident 8
Review of Resident 8's (R8) NSA, dated 05/16/2023, showed that R8 had diagnoses of [redacted], and [redacted].

Review of R8's assessment, dated 05/16/2023, showed that R8 needed frequent re-orientation to place, time, and person. The assessment also showed that R8 was unable to verbalize personal care needs. The assessment also showed R8 had poor self-safety

awareness. The assessment showed that resident had weakness of the lower extremities and required one-person assistance with all transfers. The assessment documented that when R8 received personal care while in bed, R8 used a bed rail to aid in positioning.

On 08/15/2023 at 10:50 AM, observation of R8's room showed half side rails attached at the top of R8's bed, on the right side. Observation showed the bed was in the raised position. The left side of the bed was placed against the wall. The right-side bed rail had a wide gap between the bars, approximately 6.5 inches by 8 inches. The side rails were not covered to protect the resident's limbs from possible entrapment.

During an interview on 08/16/2023 at 1:30 PM, Staff K stated that R8 was unable to independently put the side rail down. Staff K also stated that R8 was unable to call for staff assistance.

Resident 11
Review of Resident 11's (R11) NSA, dated 07/23/2023, showed that R11 had diagnoses of [redacted], and [redacted].

Review of R11's assessment, dated 07/22/2023, showed that R11 needed frequent re-orientation to place, time, and person. The assessment also showed that R11 had poor self-safety awareness. The assessment showed that resident was resistant to care, combative, and verbally aggressive. The assessment showed that R11 required one or two-person assistance with all transfers.

On 08/15/2023 at 10:50 AM, observation of R11's room showed half side rails attached along both the right and left side of R11's bed. Observation showed the bed was in the raised position. The headboard of the bed was placed against the wall. Both side rails had a wide gap between the bars of the side rail, approximately 6.5 inches by 18 inches. There was also a four-inch gap between the edge of the mattress and the left side rail. The left side rail was not attached firmly to the bed frame. The side rails were not covered to protect the resident's limbs from possible entrapment.

During an interview on 08/16/2023 at 1:36 PM, Staff K stated that R11 was unable to independently put the side rail down. Staff K also stated that R11 was unable to call for staff assistance.

During an interview on 08/16/2023 at 1:45 PM, Staff K stated that when new resident beds were delivered to the facility, it was the responsibility of maintenance to check the side rails. Staff K stated that they were unaware that the uncovered side bed rails created a potential entrapment risk. Staff K also stated that they were unaware that side bed rail covers were available for residents that used side bed rails.

This is an uncorrected deficiency previously cited on 06/15/2023.

Statement of Deficiencies	License #: 2628	Compliance Determination # 28674
Plan of Correction	Redmond Heights Senior Living	Completion Date
Page 8 of 11	Licensee: Bear Creek Senior Living, Inc	08/30/2023

DSHS/ALTSA Residential Care Services

SEP 22 2023

Received

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, Redmond Heights Senior Living is or will be in compliance with this law and / or regulation on (Date) 10/12/23 .

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

Administrator (or Representative) 9/20/23 Date

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

(i) Bathrooms and toilet rooms;

(ii) Resident living rooms and resident sleeping rooms; and

(iii) Corridors, as well as common and outdoor areas accessible to residents.

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to provide memory care residents with the means to summon on-duty staff assistance. This failure placed 8 of 8 sampled residents (Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, and Resident 11) at risk of unmet care needs.

Findings included...

Record review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 06/15/2023. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 07/30/2023.

During the facility entrance on 08/15/2023 at 10:05 AM, observations showed no communication system available for the residents in the memory care unit. Observations of the common areas, hallways, bathrooms, and resident rooms provided no system, such as call bells, to summon staff for assistance.

During an interview on 08/17/2023 at 1:10 PM, Staff A, Executive Director, stated that the facility had no communication system in the common areas of the memory care unit or the assisted living. Staff A stated that the facility only provided all the assisted living residents with pendants to call for staff help when needed.

During an interview on 08/17/2023 at 2:10 PM, Staff Q, care staff, stated that the residents in Memory Care do not really have a way to get staff attention. Staff Q stated that at night, staff leave the residents' room doors cracked open. Staff Q stated that as night staff walked by, staff checked on the residents, or the residents yelled out.

During an interview on 08/16/2023 at 11:50 AM, Staff K, Wellness Director, stated that the residents yelled out for staff to respond. Staff K then stated that the residents really had no other way to get staff's attention. Staff K stated that residents in the Memory Care unit "wouldn't know how or when to call for assistance anyway".

This is an uncorrected deficiency previously cited on 06/15/2023.

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, Redmond Heights Senior Living is or will be in compliance with this law and / or regulation on (Date) 10/12/23

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

Administrator (or Representative) — Date: 9/20/23

WAC 388-78A-2180 Activities. The assisted living facility must:

(1) Provide space and staff support necessary for:

(a) Each resident to engage in independent or self-directed activities that are appropriate to the setting, consistent with the resident's assessed interests, functional abilities, preferences, and negotiated service agreement; and

(b) Group activities at least three times per week that may be planned and facilitated by caregivers consistent with the collective interests of a group of residents.

(2) Make available routine supplies and equipment necessary for activities described in subsection (1) of this section.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide group activities for 8 of 8 residents (Resident 2, Resident 3, Resident 4, Resident 5, Resident 8, Resident 9, Resident 10, and Resident 11). This failure placed residents at risk for a decreased quality of life.

Record review of the Department of Social and Health Services (DSHS)'s, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 06/15/2023. The ALF signed an attestation statement that stated the facility would have a system in place and deficiency corrected by 07/30/2023.

Review of the facility's August 2023 activity calendar for the memory care unit showed several activities scheduled for the month. The calendar showed "Watercolor Painting" scheduled for 1:00 PM on 08/16/2023; "Story Time" scheduled for 10:00 AM on 08/17/2023; and "Wacky Ball" scheduled for 1:00 PM on 08/17/2023. Further review of the August 2023 memory care activity calendar showed an "Outside Trail Walking Club-Caregiver Lead" scheduled for every Saturday at 3:30 PM.

Observation on 08/16/2023 at 1:04 PM in the memory care unit showed three residents were seated in their wheelchairs in the common area of the unit. The wheelchairs were arranged in front of the community television. Observation showed no watercolor painting occurred as listed on the activity calendar. Further observation showed no other type of individual, or group activities occurred.

Observation on 08/17/2023 at 10:09 AM in the memory care unit showed four residents were seated in their wheelchairs in the common area of the unit. The wheelchairs were arranged in front of the community television. Observation showed no story time occurred as listed on the activity calendar. Observation showed no other type of individual, or group activities occurred.

Observation on 08/17/2023 at 1:08 PM in the memory care unit showed three residents seated in their wheelchairs in front of the community television. Observation showed no wacky ball occurred as listed on the activity calendar. Further observation showed no other type of individual, or group activities occurred.

During interview on 08/17/2023 at 11:30 AM, Anonymous Staff Q, Caregiver, stated that they had not seen the August 2023 activity calendar for the memory care unit. Anonymous Staff Q stated that the walking club activity shown on the calendar did not occur. Staff Q stated that it was due to lack of available staff. Staff Q stated that only one staff was scheduled in the memory care unit, per shift. Anonymous Staff Q further stated that the walking club required several staff members to take residents outside because of the multiple wheelchairs and resident escort needs. Anonymous Staff Q further stated that they were unaware of any other scheduled caregiver lead activities.

This is an uncorrected deficiency previously cited on 06/15/2023.

Statement of Deficiencies	License #: 2628	Compliance Designation # 28674
Plan of Correction	Redmond Heights Senior Living	Completion Date
Page of 11	Licensee: Bear Creek Senior Living, Inc	09/30/2023

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, Redmond Heights Senior Living is or will be in compliance with this law and / or regulation on (Date) 10/14/23 .

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

Administrator (or Representative) 9/24/23 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

Statement of Deficiencies	License #: 2628	Compliance Determination # 24384
Plan of Correction	Redmond Heights Senior Living	Completion Date
Page 1 of 17	Licensee: Bear Creek Senior Living, Inc	06/15/2023

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 05/22/2023 and 05/25/2023 of:
Redmond Heights Senior Living
7950 Willows Rd NE
Redmond, WA 98052

The following sample was selected for review during the unannounced on-site visit: 7 of 26 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Steven Garrett, LTC Licensor
Claudia Machado, Community Complaint Investigator
Angelica Rios, 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

06/29/2023 — 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.

JUL 07 2023
Received

Administrator (or Representative) 7/06/23 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 ensure 4 of 6 staff (Staff C, Med Tech/caregiver; Staff D, CNA – certified nursing assistant; Staff E, Caregiver; and Staff F, Med Tech/caregiver) was tested for tuberculosis (TB) within three days of employment. This failure placed all residents at risk of exposure to Tuberculosis, an infectious disease.

Findings Included...

Review of the facility's personnel staff records showed that the facility hired Staff C, MedTech/caregiver, on 01/16/2023. Review of Staff C's personnel records showed no documentation that Staff C was screened for tuberculosis within three days of hire. Review of the facilities staff schedule showed that Staff C worked in the facility and was allowed direct access to residents.

During an interview on 05/25/2023 at 2:00 PM, Staff B, Director of Nursing Services, confirmed that when Staff C was hired on 01/16/2023 at the facility, Staff C had not been screened for tuberculosis.

Review of the facility's personnel staff records showed that the facility hired Staff D, CNA – certified nursing assistant, on 08/10/2018. Review of Staff D's personnel records showed no documentation that Staff D was screened for tuberculosis within three days of hire. Review of the facilities staff schedule showed that Staff D worked in the facility and was allowed direct access to residents.

During an interview on 05/25/2023 at 2:00 PM, Staff B, Director of Nursing Services, confirmed that when Staff E was hired on 08/10/2018 at the facility, Staff D had not been screened for tuberculosis.

Review of the facility's personnel staff records showed that the facility hired Staff E,

Caregiver, on 07/17/2018. Review of Staff E's personnel records showed no documentation that Staff E was screened for tuberculosis within three days of hire. Review of the facilities staff schedule showed that Staff E worked in the facility and was allowed direct access to residents.

During an interview on 05/25/2023 at 2:00 PM, Staff B, Director of Nursing Services, confirmed that when Staff E was hired on 07/17/2018 at the facility, Staff E had not been screened for tuberculosis.

Review of the facility's personnel staff records showed that the facility hired Staff F, MedTech/caregiver, on 06/24/2019. Review of Staff F's personnel records showed no documentation that Staff F was screened for tuberculosis within three days of hire. Review of the facilities staff schedule showed that Staff F worked in the facility and was allowed direct access to residents.

During an interview on 05/25/2023 at 2:00 PM, Staff B, Director of Nursing Services, confirmed that when Staff F was hired on 06/24/2019 at the facility, Staff F had not been screened for tuberculosis.

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, Redmond Heights Senior Living is or will be in compliance with this law and / or regulation on (Date) 7/30/23 .

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

Administrator (or Representative) 07/07/23 Date

DSHS/ALTSA
Residential Care Services
JUL 07 2023
Received

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(c) Ensure all menus:

(vi) Are not repeated for at least three weeks, except that breakfast menus in assisted living facilities that provide a variety of daily choices of hot and cold foods are not required to have a minimum three-week cycle.

(2) The assisted living facility must plan in writing, prepare on-site or provide through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC, and serve to each resident as ordered:

(a) Prescribed general low sodium, general diabetic, and mechanical soft food diets according to a diet manual. The assisted living facility must ensure the diet manual is:

(i) Available to and used by staff persons responsible for food preparation;

(ii) Approved by a dietitian; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure menu items were not repeated within a three-week timeframe. The facility also failed to maintain a licensed dietician approved dietary manual, as required. These failures placed residents at risk of receiving food services without meeting the most current nutritional standards and a decreased quality of life.

Findings included...

Review of the facility's menus from 04/24/2023 through 05/13/2023 showed the facility served french fries/house made chips a total of 11 times for dinner. Further review showed that between 04/28/2023 and 05/12/2023, fish and chips were served for dinner two times. Review also showed that between 05/04/2023 and 05/20/2023, roasted potatoes were served for lunch a total of five times.

During an interview on 05/23/2023 at 11:30 AM, Staff J, Dietary Supervisor, stated that the facility did not have any dietary manual. Staff J stated that they did not use any dietary manual when menus were written. Staff J further stated that the facility's menus were not reviewed and approved by a licensed dietician.

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, Redmond Heights Senior Living is or will be in compliance with this law and / or regulation on (Date) 7/30/23 .

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

Administrator (or Representative) — Date: 7/04/23

WAC 388-78A-2570 Notification of change in administrator. The licensee must notify the department in writing within ten calendar days of the effective date of a change in the assisted living facility administrator. The notice must include the full name of the new administrator and the effective date of the change.

This requirement was not met as evidenced by:

DSHS/ALTSA
Residential Care Services
JUL 07 2023
received

Based on interview and record review, the facility failed to notify the department of a change in administrator within 10 calendar days of the effective date of change, as required. This failure placed all residents at risk of receiving care from an unqualified staff member.

Findings included...

Review of the facility's undated Disclosure of Services document identified Staff A as the Administrator. The document further stated Staff A was the person to contact for more information related to the facility.

On 05/19/2023, review of Department's Facilities Management System (FMS) database identified Staff H, former administrator, as the current Administrator, since 08/26/2022. There was no documentation in FMS that showed the facility notified the department of any administrator change.

During an interview on 05/22/2023 at 10:50 AM, Staff A stated that they were the current Assisted Living Administrator. Staff A further stated that they were employed as the facility Administrator since 12/16/2022. Staff A stated that they were unaware of any notification sent to the department that identified Staff A as the new Administrator. During an interview at the same time, Staff B, Wellness Director, stated that Staff H has not worked as facility Administrator since December 2022. Staff B further stated that Staff A has been the current facility Administrator since December 2022.

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, Redmond Heights Senior Living is or will be in compliance with this law and / or regulation on (Date) 7/20/23 .

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

Administrator (or Representative) — Date 7/04/23

WAC 388-78A-3000 Ventilation. The assisted living facility must meet the ventilation requirements of the mechanical code as adopted and amended by the Washington state building council; and

(3) Provide intact sixteen mesh screens on operable windows and openings used for ventilation; and

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This requirement was not met as evidenced by:

Based on observation and interview the facility failed to ensure window screens were appropriately placed on 21 operable, exterior windows throughout the facility. This failure placed all residents at potential risk of illness from unnecessary airborne contamination or insect and rodent borne diseases.

Findings included...

Observation during the environmental tour on 05/22/2023 at 1:30 PM with Staff G, Maintenance personnel, and Staff A, Administrator, showed there were screens missing on 21 operable, exterior windows on the first and second floors. Observation showed these screenless windows were for common areas of the facility or for resident rooms.

During an interview on 05/22/2023 at 1:45 PM Staff G stated that there were several windows with missing screens. Staff G stated that all the windows with missing screens needed to be replaced.

During an interview on 05/23/2023 at 3:28 PM, Staff A, Administrator, stated that they were unaware of the missing screens on the windows. Staff A further stated that any window that was openable to the exterior should have screens.

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: 7/04/23

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

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

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to provide an attentive and well-maintained environment. This failure placed all residents at risk of injury and a diminished quality of life.

Findings included...

KITCHEN OBSERVATION
On 05/23/2023 at 11:25 AM, during the food service, observation showed three box-type area cooling fans. One fan was in the dishwashing area, a second fan was in the food preparation area, across from the walk-in refrigerator, and the third fan was in the dining room, under the coffee station/food serving line. The three fans were observed to be turned on to circulate the air. Each fan was observed with visible dust and grime on the fan blades as well as on the screen.

During an interview on 05/23/2023 at 11:27 AM, Staff J, Dietary Supervisor, stated that the fans were not part of the kitchen cleaning schedule. Staff J stated that they did not know when the fans were last cleaned.

MEMORY CARE UNIT SECURED OUTDOOR SPACE
During the environmental tour with Staff G, Maintenance personnel, and Staff A, Administrator, on 05/22/2023 at 1:55 PM, observation showed an outdoor walkway overgrown and covered with plants and yard debris, which included leaves, branches, and grass. The yard debris obstructed the ability to safely navigate the pathway and posed a trip hazard. Observation also showed six park benches all in disrepair with peeling paint and rotted wood framing.

During an interview on 05/23/2023 at 1:55 PM, Staff A stated that the walkways were obstructed with cleanup needed to make them accessible for residents. Staff A further stated that the benches were not useable for residents.

EXTERIOR OF BUILDING
During a tour of the facility grounds on 05/22/2023 at 2:20 PM, observation showed a large, grassy area at the back of the building. The grassy lawn area was overgrown and contained four exterior window screens, a window-mounted air-conditioning unit, four pieces of siding lumber plywood boards, and four rusted metal gardening tools/plant stands. The area was surrounded with a chain-link fence that ran the length of the back property line. Further observation showed the chain-link fence damaged in two places by fallen tree limbs. On the other side of the fence was a steep, brush-covered hillside. A concrete sidewalk followed the fence line through the grass. The sidewalk was uneven in places. The uneven sections of concrete pavement were marked with yellow spray paint. Additional observation showed several places along the sidewalk with yard debris which included leaves, pinecones, and tree branches. There was also a barricade sign, fallen over on the walkway. The yard debris and sign all posed a trip and fall hazard.

Observation outside of the dining/sunroom on the south patio on 05/23/2023 at 11:10 AM, showed several yard treatment chemicals which included: a two and a half pound (lb) bottle of "Sluggo" with a warning label that stated when this product was used, exposure controls/personal protection recommended; a 32 ounce (oz) bottle of "Bioadvanced 3-in-1 insect, disease, mite control" with a warning label that stated harmful if inhaled, swallowed or if absorbed on skin; and a five lb bottle of "Sluggo Plus" with a warning label that stated harmful if inhaled and may cause eye irritation.

During an interview on 05/22/2023 at 2:22 PM, Staff G stated that the facility had no current lawn maintenance provider. Staff G stated that the facility was currently looking for landscaping providers.

During an interview on 05/23/2023 at 3:40 PM, Staff A stated that they were aware of the hazards located in the outdoor areas of the facility. Staff A stated that they locked the doors to the outdoor walkway area in the memory care unit to begin the cleanup and repair process. In addition, they stated that warning signs were posted to close off the walkway outside of the building along the fence border.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 7/04/23

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure hazardous chemicals were stored securely and inaccessible to ambulatory residents with cognitive deficits (defined as difficulty with thinking, learning, remembering and difficulty with decision-making processes). This failure placed 2 of 7 ambulatory residents (Resident 5

and Resident 10) with wandering behaviors at risk for inadvertent ingestion of hazardous chemicals.

Findings included...

Review of the facility's undated document titled "Assisted Living Facility Characteristics Roster," showed the facility provided care and services to seven residents in their secured memory care unit (MCU), a secured area for residents with cognitive deficits.

During the environmental tour of the MCU on 05/22/2023 at 2:00 PM, observation showed several unlocked kitchen cabinets. The cabinets contained a variety of cleaning chemicals. The lower storage cabinet next to stovetop contained a 945 milliliters (ml) spray bottle, labeled "Comet Cleaner with Bleach". The manufacturer warning label stated, "If swallowed call physician immediately. Causes eye irritation" The cabinet also contained a 24 ounces (oz) spray bottle containing a blue liquid, labeled "Disinfectant 30-17". The manufacturer warning label stated, "If swallowed call poison control center immediately". The cabinet under the sink contained: a 32 oz bottle, labeled "Spray cleaner with bleach"; two 24 oz spray bottles labeled "Disinfectant 30-17"; and one-gallon pump bottle, labeled "Betco Advanced alcohol gel sanitizer". The warning label stated, " Causes serious eye irritation". The lower right cabinet, next to the dishwasher, contained one pint (pt) of "fruit fresh" dishwasher liquid. The warning label stated, "If swallowed or gets in mouth, drink a glassful of water to dilute and call a poison control center or physician". The lower left cabinet, next to dishwasher, contained a one pound (lb) container of "CaviWipes 2.0". The manufacturer warning label stated, "Avoid contact with eyes, skin and clothing". Further observations showed a 7 oz freestanding air freshener, labeled "Renuzit Citrus Sunburst", sat on table shelf in the common area hallway. The warning label stated, "Danger Poison, Call A Poison Control Center". Further observations showed Resident 5 independently ambulated and walked throughout the common areas of the MCU asking for "something to do".

Observation on 05/23/2023 at 2:00 PM showed Resident 10 independently ambulated and moved about common areas of the MCU, which included the kitchen.

During an interview on 05/22/2023 at 2:05 PM, Staff G, Maintenance, stated that they were unaware the chemicals in the MCU were not properly stored in a secured area.

During an interview on 05/23/2023 at 10 AM, Staff A, Administrator, stated that all the cabinets contained locks for staff to secure hazardous chemicals. Staff A stated that they were unaware the chemicals in the MCU were unsecured.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2628	Compliance Determination # 24384
Plan of Correction	Redmond Heights Senior Living	Completion Date
Page of 17	Licensee: Bear Creek Senior Living, Inc	06/15/2023

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, Redmond Heights Senior Living is or will be in compliance with this law and / or regulation on (Date) 7/30/23 .

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Administrator (or Representative) 7/04/23 Date

WAC 388-78A-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed ensure 2 of 2 residents (Resident 2 and Resident 4) side bed rails, attached to the residents' beds, were free of entrapment hazards. This failure placed Resident 2 and Resident 4 at risk of harm or death from unsafe medical equipment.

Finding included...

Resident 2
Review of Resident 2's (R2) negotiated service agreement (NSA), dated 05/02/2023, showed that Resident 2 had diagnoses of [redacted], and [redacted].

Review of R2's assessment, dated 05/02/2023, showed that R2 needed frequent re-orientation to place, time and person. The assessment also showed that R2 had poor self-safety awareness. The assessment showed that resident had weakness of the lower extremities and required one-person assistance with all transfers. The assessment documented that R2 used a side bed rail to aid in independent positioning while in bed.

On 05/23/2023 at 1:20 PM, observation of R2's room showed there were quarter side bed rails attached at the top of R2's bed, on both the right and left side. Observation showed the bed was in the raised position. The left side of the bed was placed against the wall. Both side bed rails had a wide gap between the bars, approximately 6.5 inches by 8.0 inches. The side rails were not covered to protect the resident's limbs from possible entrapment.

Resident 4
Review of Resident 4's (R4) negotiated service agreement NSA, dated 04/19/2023, showed that R4 had diagnoses of [redacted] and [redacted].

Review of R4's assessment, dated 04/22/2023, showed that R4 needed frequent re-orientation to place, time and person. The assessment also showed that R4 had poor self-safety awareness. The assessment showed that resident had intermittent weakness of the lower extremities and required one-person assistance with all transfers. The assessment documented that R4 used a bed rail to aid in independent positioning while in bed.

On 05/23/2023 at 1:40 PM, observation of R4's room showed full siderails attached along both the right and left side of R4's bed. Observation showed the bed was in the raised position. The left side of the bed was placed against the wall. Both side rails had a wide gap between the bars of the side rail approximately 6.5 inches. The side rails were not covered to protect the resident's limbs from possible entrapment.

During an interview on 05/24/2023 at 1:45 PM, Staff B, said that when R4's bed was delivered, they updated R4's medical device assessment. Staff B stated that when the bed was delivered to the facility, they did not see the full side rail on the bed. Staff B stated that R4 was unable to independently put the side rail down and that R4 was unable to call for staff assistance. Staff B also stated that when new beds were delivered to the facility, it was the responsibility of maintenance to check the siderails. Staff B stated that they were not informed that R4's bed was delivered with side bed rails attached. Staff B stated that they were unaware that the uncovered side bed rails created a potential entrapment risk. Staff B also stated that they were unaware that side bed rail covers were available for residents that used side bed rails.

Plan/Attestation Statement

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Administrator (or Representative) — Date 7/6/23

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:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

(4) The assisted living facility must ensure all persons listed in subsection (2) of this section, obtain the home-care aide certification.

WAC 388-112A-0060 What are the training and certification requirements for volunteers and long-term care workers in assisted living facilities and assisted living facility administrators?

(1) The following chart provides a summary of the training and certification requirements for a volunteer, an administrator or designee, and a long-term care worker in an assisted living facility: Who Status Facility orientation Safety/ orientation training Seventy-hour long-term care worker basic training Specialty training Continuing education (CE) Required credential

(a) Long-term care worker in assisted living facility.

(iii) Employed in an assisted living facility and does not meet the criteria in subsection (1)(a) or (b) of this section. Meets the definition of long-term care worker in WAC 388-112A-0010 . Not required. Required. Five hours per WAC 388-112A-0200 (2) and 388-112A-0220 . Required. Seventy-hours per WAC 388-112A-0300 and 388-112A-0340 . Required per WAC 388-112A-0400 . Required. Twelve hours per WAC 388-112A-0611 . Home care aide certification required per WAC 388-112A-0105 within two hundred days of the date of hire as provided in WAC 246-980-050 (unless the department of health issues a provisional certification under WAC 246-980-065).

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 4 of 4 staff (Staff D, certified nursing assistant (CNA), Staff E; caregiver; Staff F, Med Tech/caregiver; and Staff I, receptionist) completed all required training to perform their job duties and responsibilities. This failure placed all the residents at risk of unmet care needs from staff with incomplete training.

Findings included...

Review of facility's undated personnel records showed the facility hired Staff D on 08/18/2018; Staff E on 07/17/2018; Staff F on 06/24/2019; and Staff I on 03/17/2023.

Specialty training
Review of Staff E's undated personnel records showed Staff E worked with residents from 07/17/2018 through 05/25/2023. There was no documentation in Staff E's records that showed Staff E completed specialty training for dementia or mental illness.

Review of Staff F's undated personnel records showed Staff F worked with residents from 06/24/2019 through 05/25/2023. There was no documentation in Staff F's records that showed Staff F completed specialty training for dementia or mental illness.

CPR and first aid
Review of Staff D's undated personnel records showed Staff D completed cardiopulmonary resuscitation (CPR) certification on 04/18/2023. There was no documentation in Staff E's records that showed Staff E completed first aid training.

Review of Staff E's undated personnel records showed Staff E completed cardiopulmonary resuscitation (CPR) certification on 03/11/2023. There was no documentation in Staff E's records that showed Staff E completed first aid training.

Home Care Aide certification
Observations in the Memory Care unit on 05/25/2023 at 1:40 PM, showed Staff I provided direct care to residents in the Memory Care unit. Staff I assisted residents with transfers from furnishings into wheelchairs. Staff I also assisted to feed residents during meals and snacks.

During an interview on 05/25/2023 at 1:55 PM, Staff I stated that they were a certified Home Care Aide (HCA). Staff I stated that there was no documentation of their certification as an HCA on file in the facility.

Review of the Washington State Department of Health website, Provider Credential Search, on 05/25/2023, showed no documentation of Staff I's HCA certification record.

During interview on 05/25/2023 at 2:15 PM, Staff A, Administrator in Training, stated that they were unaware of the incomplete training records. Staff A stated that they were unaware that Staff D and Staff E had not completed first aid training, that Staff E and Staff F had not completed specialty training for dementia and mental illness, and that Staff I was not a certified health care aide.

Plan/Attestation Statement

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Administrator (or Representative) — Date 7/04/23

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance;

from all resident-accessible areas including:

(i) Bathrooms and toilet rooms;

(ii) Resident living rooms and resident sleeping rooms; and

(iii) Corridors, as well as common and outdoor areas accessible to residents.

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to provide memory care residents with the means to summon on-duty staff assistance. This failure placed 7 of 7 sampled residents (Residents 4, 5, 6, 7, 8, 9, and 10) at risk of unmet care needs.

Findings included...

During the facility entrance tour on 05/22/2023 at 1:05 PM, observations showed no communication system available for the residents in the memory care unit. Observations of the common areas, hallways, bathrooms, and resident rooms provided no system, such as call bells, to summon staff for assistance.

During an interview on 05/22/2023 at 1:10 PM, Staff A, Administrator-in-Training, stated that the facility had no communication system in the memory care areas or in the assisted living areas. Staff A stated that the facility provided all the assisted living residents with pendants to call for staff help when needed.

During an interview on 05/23/2023 at 2:40 PM, Staff M, Certified Nursing Assistant (CNA), stated that the residents do not really have a way to get staff attention. Staff M stated that during the day, staff locked all the resident room doors. Staff M stated this allowed the staff to just see the residents. Staff M stated that at night, staff leave the residents' room doors cracked open. Staff M stated that as night staff walked by, staff checked on the residents or the residents yelled out.

During an interview on 05/24/2023 at 1:50 PM, Staff B, Wellness Director, stated that the residents yelled out for staff to respond. Staff B then stated that the residents really had no other way to get staff's attention.

Plan/Attestation Statement

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DSHS/ALTSA
Residential Care Services

JUL 07 2023

Received

Administrator (or Representative) 7/04/23 Date

WAC 388-78A-2180 Activities. The assisted living facility must:

(1) Provide space and staff support necessary for:

(a) Each resident to engage in independent or self-directed activities that are appropriate to the setting, consistent with the resident's assessed interests, functional abilities, preferences, and negotiated service agreement; and

(b) Group activities at least three times per week that may be planned and facilitated by caregivers consistent with the collective interests of a group of residents.

(2) Make available routine supplies and equipment necessary for activities described in subsection (1) of this section.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide group activities for 7 of 7 sampled residents (Residents 4, 5, 6, 7, 8, 9, and 10) with readily accessible activity materials. This failure placed residents at risk for a decreased quality of life and behaviors due to lack of structured activities.

Findings included...

Observation on 05/23/2023, 1:35 PM in the memory care unit showed four residents, seated in wheelchairs. The wheelchairs were arranged in a semi-circle in front of the community television. Each of the four residents appeared to be sleeping. Resident 5 paced up and down the corridor. The television was tuned to a music channel at a low volume that was inaudible to the licensors. Observations like this one occurred each day of the inspection.

Further observations throughout the inspection from 05/22/2023 to 05/25/2023, showed Resident 5 continually paced around the unit and repeatedly stated "I don't know what to do...what do you do with someone like me...there's nothing to do". Observation showed one staff person, not the activity coordinator, was present on the unit.

On 05/23/2023, review of the memory care unit activity calendar showed nail care as the only scheduled activity for this date. Additional observations on this day showed the scheduled activity of nail care did not happen and there were no other activities completed with the residents. Continued observations throughout each day of the licensing inspection noted that the memory care unit displayed no resident accessible activity materials, such as puzzles, picture books, or sensory items (such as blocks, fabrics, activity boards/stations) and no staff engaged in activities with the residents.

Observation on 05/24/2023 at 3:25 PM, showed Resident 10 seated in a chair by a table. During an interview at this time, Resident 10 stated, "Why did you come here? I guess I'll watch more TV. I am just bored. There really isn't anything else to do here."

Observations throughout the licensing visit, from 05/22/2023 – 05/25/2023, showed activities did not occur as described on the posted activity calendar. Further observations showed that residents were not provided with supplies and equipment to engage in any activity that met their personal interest.

Review of the facility's undated care delivery guide for Resident 4 and Resident 5 showed each resident required assistance to participate in activities.

Review of the facility's May 2023 Memory Care Activity posted calendar showed that the listed Monday through Friday activities were repeated for throughout each weekday. The calendar showed as follows: Mondays: 9:15 AM, Stretch Up; 10:30 AM, Cool down Hydrate; 1:00 PM, Nail Care; and 3:00 PM, Afternoon Snack. Tuesdays: Pre-scheduled Medical Transport; 9:15 AM, Sing along; 1:00 PM, Nail Care; and 3:00 PM, Afternoon Snack. Wednesdays: 9:15 AM, Stretch Up; 10:30 AM, Cool down Hydrate; 1:00 PM, Nail Care; and 3:00 PM, Afternoon Snack. Thursdays: Pre-scheduled Medical Transport; 9:15 AM, Sing along; 1:00 PM, Nail Care; and 3:00 PM, Afternoon Snack. Fridays: 9:15 AM, Stretch Up; 10:30 AM, Cool down Hydrate; 1:00 PM, Nail Care; and 3:00 PM, Afternoon Snack.

During an interview on 05/23/2023 at 1:40 PM, Staff M, certified nursing assistant (CNA), stated that Resident 5 continually walked around the unit, talked to themselves and staff, and sometimes waited for family to come visit.

Staff M stated that when the activity coordinator came to the unit, the coordinator brought activity stuff over with them.

During an interview on 05/24/2023 at 1:50 PM, Staff B, Wellness Director, stated that the facility needed to find a better way to engage residents and offer activities. Staff B stated that the activity coordinator should be in the facility. Staff B stated that the activity coordinator worked in activities, as care staff, and helped the receptionist. Staff B stated the activity coordinator may have worked as care staff on this date. Staff B stated that the staff cover for one another. Staff B stated that the activity coordinator managed activities for the entire facility and created the calendar and schedule.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2628	Compliance Determination # 24384
Plan of Correction	Redmond Heights Senior Living	Completion Date
Page of 17	Licensee: Bear Creek Senior Living, Inc	06/15/2023

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, Redmond Heights Senior Living is or will be in compliance with this law and / or regulation on (Date) 7/30/23 .

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Administrator (or Representative) 7/04/23 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

06/29/2023

Bear Creek Senior Living, Inc
Redmond Heights Senior Living
7950 Willows Rd NE
Redmond, WA 98052

RE: Redmond Heights Senior Living # 2628

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 06/15/2023 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

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-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:

(c) Dementia. While screening a resident for dementia, the assisted living facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(ii) Document the evidence in the resident's record.

(d) Other conditions affecting cognition, such as traumatic brain injury.

(10) Individual's personal identity and lifestyle, to the extent the individual is willing to share the information, and the manner in which they are expressed, including preferences regarding food, community contacts, hobbies, spiritual preferences, or other sources of pleasure and comfort.

The facility did not fully evaluate Memory Care residents and document the personal information needed to complete an accurate assessment that described each residents' care assistance needs and personal preferences. There was no documentation in the residents' assessments to establish a base line of functioning to be used as a guide for care assistance (such as mini-mental status exams that helped to determine residents' current level of cognitive functioning). Documentation of base line conditions assist facility staff to recognize changes in residents' conditions and cognitive functioning. Staff A, Administrator in Training, and Staff B, Wellness Director, stated they would update all assessments, which would include information obtained for development of base line functioning.

WAC 388-78A-2450 Staff.

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

(b) Maintain the assisted living facility free of safety hazards; and

(c) Implement fire and disaster plans.

The facility failed to provide sufficient staff on each shift to meet the needs of the Memory Care residents. Five memory care residents required two caregivers for assistance with mobility, transfers, and personal care (such as toileting and bathing). Memory Care staff reported that when additional staff needed for assistance with resident care, caregivers in the assisted living portion of the building were called over the walkie talkie communication system. Staff A, Administrator, stated that due to staffing shortage, the facility only provided one caregiver per shift in the memory care unit. Staff A stated the facility was actively working to hire more staff.

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;

The location of first aid kits throughout the facility were not identified. The kits were not readily available. During the inspection, the facility staff placed several first aid kits throughout the facility with identifier signs posted with each kit.

WAC 388-78A-2730 Licensee's responsibilities.

(2) The licensee must:

(b) Maintain and post in a size and format that is easily read, in a conspicuous place on the assisted living facility premises:

(i) A current assisted living facility license, including any related conditions on the license;

The facility license posted expired 12/31/2022. During the inspection, facility Administrator removed the expired license. Administrator posted the current facility license.

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

Water temperature in three bathroom sinks, used by residents and visitors, measured below the regulation requirements of 105 degrees Fahrenheit. During the inspection, Facility Maintenance staff replaced sink fixtures where needed and adjusted thermostat on water tank. Water temperature increased to meet the regulatory requirements.

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, Field Manager
Region 2, Unit D
Residential Care Services

Enclosure