



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

05/08/2025

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

RE: Redmond Heights Senior Living # 2628

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 59268 (Completion Date 05/08/2025) and 56422 (Completion Date 03/24/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/08/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

WAC 388-112A-0400 What is specialty training and who is required to take it?

(4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows:

(c) Mental health specialty training as described in WAC 388-112A-0450 .

WAC 388-78A-2500 Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, and:

- (1) Who has received the diagnosis or treatment within the previous two years; and
- (2) Whose diagnosis was made by, or treatment provided by, one of the following:
 - (a) A licensed physician;

- (b) A mental health professional;
- (c) A psychiatric advanced registered nurse practitioner; or
- (d) A licensed psychologist.

WAC 388-112A-0400 What is specialty training and who is required to take it?

(4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows:

- (b) Dementia specialty training as described in WAC 388-112A-0440 ; and

WAC 388-78A-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

WAC 388-112A-0600 What is continuing education and what topics may be covered in continuing education?

(1) Continuing education is annual training designed to promote professional development and increase a long-term care worker's knowledge, expertise, and skills. DSHS must approve continuing education curricula and instructors.

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:

- (i) A certified home care aide;
- (iii) A certified nursing assistant;

(b) A long-term care worker, who is a certified home care aide must comply with continuing education requirements under chapter 246-980 WAC.

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:

- (e) Continuing education.

The Department staff who did the On Site verification:

Thomas Forkgen, ALF Licenser
Michelle Yip, ALF Licenser

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

Statement of Deficiencies	License # 2628	Compliance Determination #56422
Plan of Correction	Redmond Heights Senior Living	Completion Date
Page 1 of 7	Licensee: Bear Creek Senior Living, Inc	03/24/2025

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 03/17/2025 and 03/18/2025 of:

Redmond Heights Senior Living
7950 Willows Rd NE
Redmond, WA 98052

This document references the following SOD dated: 03/24/2025

The following sample was selected for review during the unannounced on-site visit: 9 of 68 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licenser
Michelle Yip, ALF Licenser

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

This document was prepared by Residential Care Services for the Locator website.

Statement of Deficiencies	License # 2623	Compliance Determination # 55422
Plan of Correction	Redmond Heights Senior Living	Completion Date
Page 2 of 7	Licenses: Bear Creek Senior Living, Inc.	03/24/2025

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

04/03/2025

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.

J. D. H. W.

Administrator (or Representative)

04/03/2025

Date

WAC 388-112A-0400 What is specialty training and who is required to take it?

(4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows:

(c) Mental health specialty training as described in WAC 388-112A-0450.

WAC 388-78A-2500 Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, and:

- (1) Who has received the diagnosis or treatment within the previous two years; and
- (2) Whose diagnosis was made by, or treatment provided by, one of the following:
 - (a) A licensed physician;
 - (b) A mental health professional;
 - (c) A psychiatric advanced registered nurse practitioner; or
 - (d) A licensed psychologist.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 3 sampled Staff (Staff O and Staff GG) completed the specialized training for mental health, as required.

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

04/03/20354

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 388-112A-0400 What is specialty training and who is required to take it?

(4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows:

(c) Mental health specialty training as described in WAC 388-112A-0450 .

WAC 388-78A-2500 Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, and:

- (1) Who has received the diagnosis or treatment within the previous two years; and
- (2) Whose diagnosis was made by, or treatment provided by, one of the following:
 - (a) A licensed physician;
 - (b) A mental health professional;
 - (c) A psychiatric advanced registered nurse practitioner; or
 - (d) A licensed psychologist.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 3 sampled Staff (Staff O and Staff GG) completed the specialized training for mental health, as required.

This failure placed all 68 residents at risk for decreased quality of care provided by caregivers with incomplete training.

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 01/16/2025 for Specialized Training for Mental Health. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 02/28/2025.

Review of the facility's Resident Characteristic Roster identified two residents with behavioral/psychosocial issues. Three other sampled residents showed a diagnosis of [REDACTED] and [REDACTED].

STAFF O

Review of the facility's employee roster showed that the facility hired Staff O, Caregiver, on 10/14/2024. Review of Staff O's employee record showed that as of 03/28/2025, 155 days after hire, there was no documentation that showed Staff O completed the Washington state Department of Social and Health Services (DSHS) approved specialized training for mental health.

STAFF HH

Review of the facility's employee roster showed that the facility hired Staff HH, Medication Technician (unlicensed staff who dispenses medications), on 09/11/2024. Review of Staff HH's employee record showed that as of 03/18/2025, 188 days after hire, there was no documentation that showed Staff HH completed the Washington state Department of Social and Health Services (DSHS) approved specialized training for mental health.

During an interview on 03/18/2025 at 3:00 PM, Staff GG, Administrator of Record, stated that Staff O and Staff HH did not complete the specialty training for mental health.

During an interview on 03/18/2025 at 2:49 PM, Staff Q, Executive Director, stated there were no documents that showed Staff O and Staff HH completed the specialty training for mental health.

This is an uncorrected deficiency previously cited on 01/16/2025, WAC 388-78A subsections (1) and (2)(a)(b)(c)(d) and WAC 388-112A-0400 subsection (4)(c).

Statement of Deficiencies	License # 2625	Compliance Determination # 35422
Plan of Correction	Redmond Heights Senior Living	Completion Date
Page 4 of 7	Licensor: Bear Creek Senior Living, Inc.	03/24/2025

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, Redmond Heights Senior Living is or will be in compliance with this law and / or regulation on (Date) 05/01/25

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

J. O'Hara
Administrator (or Representative)

04/03/25
Date

WAC 388-112A-0400 What is specialty training and who is required to take it?

(4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows:

(6) Dementia specialty training as described in WAC 388-112A-0440; and

WAC 388-78A-2610 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 3 sampled staff (Staff G) received Specialty Training for Dementia within 120 days of hire. This failure placed all 68 residents at risk for receiving care from unqualified staff.

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 01/16/2025 for Specialized Training for Dementia. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 02/28/2025.

Review of the facility's characteristics roster identified 8 residents with behavior/psychosocial issues, dementia, Alzheimer's, and cognitive impairment.

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)_____.

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

Administrator (or Representative)

Date

WAC 388-112A-0400 What is specialty training and who is required to take it?

(4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows:

(b) Dementia specialty training as described in WAC 388-112A-0440 ; and

WAC 388-78A-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 3 sampled staff (Staff O) received Specialty Training for Dementia within 120 days of hire. This failure placed all 68 residents at risk for receiving care from unqualified staff.

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 01/16/2025 for Specialized Training for Dementia. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 02/28/2025.

Review of the facility's characteristics roster identified 6 residents with behavior/psychosocial issues, dementia, Alzheimer's, and cognitive impairment.

Statement of Deficiencies	License # 2626	Compliance Determination # 55422
Plan of Correction	Redmond Heights Senior Living	Completion Date
Page 5 of 7	Licensed: Bear Creek Senior Living, Inc.	03/24/2025

Observations on 03/17/2025 between 10:00 AM and 3:00 PM and on 03/18/2025 between 9:30 AM and 3:25 PM, showed seven residents resided in the secured memory care unit, all who were diagnosed with [REDACTED] or [REDACTED].

STAFF Q

Review of the facility's employee roster showed that the facility hired Staff Q, Caregiver, on 10/14/2024. Review of Staff Q's employee record showed that as of 03/26/2025, 155 days after date of hire, there was no documentation that Staff Q completed the Washington State Department of Social and Health Services (DSHS) approved specialized training for dementia.

During an interview on 03/18/2025 at 2:49 PM, Staff Q, Executive Director, stated there were no documents that showed Staff Q completed the specialty training for Dementia.

During an interview on 03/18/2025 at 3:00 PM, Staff QG, Administrator of Record, stated that Staff Q did not complete the specialty training for Dementia.

This is an uncorrected deficiency previously cited on 01/16/2025, for WAC 388-78A-2510 and WAC 388-112A-0600 subsection (4)(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, Redmond Heights Senior Living is or will be in compliance with this law and / or regulation on (Date) 03/26/25

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

J. D. [Signature] RN
Administrator (or Representative)

04/03/25
Date

WAC 388-112A-0600 What is continuing education and what topics may be covered in continuing education?

(1) Continuing education is annual training designed to promote professional development and increase a long-term care worker's knowledge, expertise, and skills. DSHS must approve continuing education curricula and instructors.

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

Observations on 03/17/2025 between 10:00 AM and 3:00 PM and on 03/18/2025 between 9:30 AM and 3:25 PM, showed seven residents resided in the secured memory care unit, all who were diagnosed with [REDACTED] or [REDACTED].

STAFF O

Review of the facility's employee roster showed that the facility hired Staff O, Caregiver, on 10/14/2024. Review of Staff O's employee record showed that as of 03/28/2025, 155 days after date of hire, there was no documentation that Staff O completed the Washington state Department of Social and Health Services (DSHS) approved specialized training for dementia.

During an interview on 03/18/2025 at 2:49 PM, Staff Q, Executive Director, stated there were no documents that showed Staff O completed the specialty training for Dementia.

During an interview on 03/18/2025 at 3:00 PM, Staff GG, Administrator of Record, stated that Staff O did not complete the specialty training for Dementia.

This is an uncorrected deficiency previously cited on 01/16/2025, for WAC 388-78A-2510 and WAC 388-112A-0400 subsection (4)(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, Redmond Heights Senior Living is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

Date

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(1) Continuing education is annual training designed to promote professional development and increase a long-term care worker's knowledge, expertise, and skills. DSHS must approve continuing education curricula and instructors.

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(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:

(i) A certified home care aide;

(iii) A certified nursing assistant;

(b) A long-term care worker, who is a certified home care aide must comply with continuing education requirements under chapter 246-980 WAC.

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:

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to ensure 2 of 2 sampled care staff (Staff E and Staff F) completed all trainings, as required. This failure placed all 68 residents at risk for decreased quality of care provided by caregivers with incomplete training.

Findings included...

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that on 01/16/2025, the Assisted Living Facility (ALF) received a citation for this regulation. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 02/28/2025.

Review of the facility's Employee List showed that the facility hired Staff E, Caregiver, on 04/01/2022 and Staff F, Medication Technician, on 04/01/2022. Review of the facility's Care Staff Schedule showed that Staff E and Staff F worked in February 2025 and March 2025.

STAFF E

Review of Staff E's employee records showed that between their December 2023 and December 2024 birthdays, Staff E completed a total of 0.25 Continuing Education (CE) hours of the Washington state Department of Social and Health Services (DSHS) approved CE. Staff E was short by 11.75 hours from the required 12 CE hours. There was no document that showed Staff E completed the required 12 CE hours.

STAFF F

Review of Staff F's employee records showed that between their September 2023 and September 2024 birthdays, Staff F completed a total of five CE hours of the Washington

Statement of Deficiencies	License # 2628	Compliance Determination # 56422
Plan of Correction	Redmond Heights Senior Living	Completion Date
Page 7 of 7	Licensor: Bear Creek Senior Living, Inc	03/24/2025

state DSHS approved CE. Staff F was short by seven hours from the required 12 CE hours. There was no document that showed Staff F completed the required 12 CE hours.

During an interview on 03/18/2025 at 3:00 PM, Staff GG, Administrator, stated they were unable to find any CE documentation for Staff E and Staff F. Staff GG stated that they were unsure if Staff E and Staff F completed the required 12 hours of the required CE training from their 2023 birthday to their 2024 birthday.

This is an uncorrected deficiency previously cited on 01/16/2025, subsections (2)(e).

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) 05/01/25

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

J. D. Hume
Administrator (or Representative)

04/03/25
Date

state DSHS approved CE. Staff F was short by seven hours from the required 12 CE hours. There was no document that showed Staff F completed the required 12 CE hours.

During an interview on 03/18/2025 at 3:00 PM, Staff GG, Administrator, stated they were unable to find any CE documentation for Staff E and Staff F. Staff GG stated that they were unsure if Staff E and Staff F completed the required 12 hours of the required CE training from their 2023 birthday to their 2024 birthday.

This is an uncorrected deficiency previously cited on 01/16/2025, subsections (2)(e).

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)_____.

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

Administrator (or Representative)

Date



Residential Care Services Investigation Summary Report

Provider/Facility: Redmond Heights Senior Living
License/Cert.#: 2628
Compliance Determination #: 51877
Investigator: Thomas Forkgen
Investigation Date(s): 12/17/2024 through 01/16/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility
Intake ID: 160012
Region/Unit #: RCS Region 2 / Unit D

Allegation(s):

Resident injuries with unknown origin

Investigation Methods:

Sample:	Total residents: 58 Resident sample size: 7 Closed records sample size: 0
Observations:	Identified resident Staff to resident interactions Resident rooms
Interviews:	Identified resident Identified staff Caregivers Nursing staff Family members Administrator
Record Reviews:	Characteristic Roster Staff Roster and schedule Facility policies Resident records

Investigation Summary:

Observation showed a dark purple bruise on the Named Resident (NR)'s breast and abdomen and a one-inch by one-and-a-half inch wound on the NR's right elbow. NR interview showed NR did not remember what happened that caused the injuries. Record review showed NR received memory care, used blood thinner medication, and had a history of frequent falls. There was no documentation that the facility staff monitored and documented NR's injuries. There was no documentation that showed NR experienced a significant change in condition which increased their need for staff assistance with person care. There was no documentation of any incidents that caused the injuries. There was no documentation of wound management for the right elbow. Interview showed several care staff and nurses were unaware of NR's injuries. Interview showed the Named Staff (NS) noticed NR's

injuries a few days before the Department's observation. NS stated that they did not notify the nurse and did not report the resident's injury to the Department. Failed practices were identified. Refer to the full licensing inspection (CD ID: 51877).

Conclusion / Action:

- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A



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 #51877
Plan of Correction	Redmond Heights Senior Living	Completion Date
Page 1 of 47	Licensee: Bear Creek Senior Living, Inc	01/16/2025

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 and complaint investigation on 12/17/2024, 01/06/2025, 12/17/2024, 12/23/2024 and 12/23/2024 of:

Redmond Heights Senior Living
7950 Willows Rd NE
Redmond, WA 98052

This document references the following complaint numbers: 160012.

The following sample was selected for review during the unannounced on-site visit: 7 of 58 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licenser
Michelle Yip, ALF Licenser

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

01/24/2025

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.

This document was prepared by Residential Care Services for the Locator website.

J. M. H. R. N.

Administrator (or Representative)

01/31/25

Date

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

- (1) The care and services necessary to meet the resident's needs, including:
 - (a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:
 - (i) The resident's preadmission assessment;
 - (ii) The resident's full assessments;
 - (iii) On-going assessments of the resident;
 - (b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;
 - (c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;
 - (d) The plan to provide necessary health support services, if provided by the assisted living facility;
 - (e) The resident's preferences for how services will be provided, supported and accommodated by the assisted living facility.
- (2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:
 - (a) Exclusively for the individual resident; or
 - (b) Based on standard policies and procedures in the assisted living facility provided that they are consistent with the reasonable accommodation requirements of state and federal law.
- (3) The times services will be delivered, including frequency and approximate time of day, as appropriate;
- (5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Administrator (or Representative)

Date

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

- (1) The care and services necessary to meet the resident's needs, including:
 - (a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:
 - (i) The resident's preadmission assessment;
 - (ii) The resident's full assessments;
 - (iii) On-going assessments of the resident;
 - (b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;
 - (c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;
 - (d) The plan to provide necessary health support services, if provided by the assisted living facility;
 - (e) The resident's preferences for how services will be provided, supported and accommodated by the assisted living facility.
- (2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:
 - (a) Exclusively for the individual resident; or
 - (b) Based on standard policies and procedures in the assisted living facility provided that they are consistent with the reasonable accommodation requirements of state and federal law.
- (3) The times services will be delivered, including frequency and approximate time of day, as appropriate;
- (5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to update the Negotiated Service Agreement (NSA) for 7 of 9 sampled residents (Resident 1, Resident 3, Resident 4, Resident 5, Resident 6, Resident 19, and Resident 20). This failure placed Resident 1, Resident 2, Resident 4, Resident 5, Resident 6, Resident 19, and Resident 20 at risk for unmet care needs and potential for worsening of medically diagnosed conditions.

Findings included...

RESIDENT 1

Review of the facility's Assisted Living Residents Admission Record showed that the facility admitted Resident 1 in [REDACTED] 2024 with a diagnosis of [REDACTED]

Review of Resident 1's October 2024 and December 2024 electronic Medication Administration Records (eMAR) showed Resident 1 received Eliquis (blood thinner), five milligrams (mg) twice a day as an anticoagulant.

Review of Resident 1's Service Plan, dated 07/31/2024, did not identify that Resident 1 received blood thinning medication. There was no documentation that provided care staff with guidance about the possible side effects from the medication, such as increased risk for bruising and easy bleeding. There were no instructions for staff about what actions were needed if Resident 1 experienced any side effects.

RESIDENT 3

Review of the facility's Assisted Living Residents Admission Record showed that the facility admitted Resident 2 in [REDACTED] 2024 with a diagnosis of [REDACTED] and [REDACTED]

Review of Resident 3's October 2024, November 2024, and December 2024 eMARs showed Resident 3 received aspirin, 81 milligrams once a day, for cerebral vascular accident (interruption of blood flow to the brain) to prevent a stroke.

Review of Resident 3's Service Plan, dated 05/07/2024, did not identify that Resident 3 received the medication with blood thinning properties. There was no documentation that provided care staff with guidance about the possible side effects from the medication, such as increased risk for bruising and easy bleeding. There were no instructions for staff about what actions were needed if Resident 3 experienced any side effects.

RESIDENT 4

Review of the facility's Assisted Living Residents Admission Record showed that the facility admitted Resident 4 in [REDACTED] of 2024 with the diagnoses of [REDACTED]

[REDACTED] The admission record showed a diagnosis of [REDACTED]

[REDACTED] and [REDACTED]

Observation of Resident 4's apartment on 12/19/2024 at 1:33 PM, showed Resident 4 sat on a Roho cushion (an air-filled cushion designed to reduce pressure on the body and prevent skin breakdown while seated), in an electric wheelchair that Resident 4 operated independently. Observation showed a transfer pole next to Resident 4's non-functional electric hospital bed. Observation showed Resident 4 communicated with hand gestures, facial expressions, and a communication board. During an interview at this time, Resident 4 communicated that they used the transfer pole to pull themselves up and move to and from the electrical wheelchair and the bed.

Review of Resident 4's Service Plan, dated 05/10/2024 and revised on 12/17/2024, showed Resident 4 was non-ambulatory and required assistance with transfers to a power wheelchair. The service plan did not show Resident 4 used an electric hospital bed, a transfer pole, and a Roho cushion. There was no guidance provided for the staff on how to assist Resident 4 with the transfer pole. There was no explanation about Resident 4's ability to pull themselves up with the transfer pole and transfer onto the bed. The service plan provided no guidance on the proper inflation of the Roho cushion. The service plan showed that Resident 4 needed extra staff time to communicate and an "alternative communication method needed with speech aphasia." The service plan did not show that Resident 4 used a communication board to spell out words. The service plan did not show Resident 4 was an insulin dependent diabetic (insulin medication used to control the blood sugar levels). There was no documentation that explained the possible side effects of insulin usage, such as hypoglycemia (low blood sugar levels). There were no instructions for staff about what actions were needed if Resident 4 showed any side effects.

RESIDENT 5

Observation of Resident 5's apartment on 12/19/2024 at 12:50 PM, showed a quarter-length bedrail attached to the right side of the bed, at head of the bed. Observation showed less than a two-inches gap between the bedrail and the mattress. The bedrail was not correctly secured to the bed and was slightly wobbly when used. Observation showed Resident 5 used the bedrail to position themselves in bed and to get in and out of the bed. Observation showed Resident 5's right elbow was covered with a two-inch by 4-inch adhesive dressing. Observation showed the adhesive dressing was soiled with yellowish drainage visible on the dressing and one edge of the dressing was loosened.

Observation on 12/20/2024 at 10:40 AM showed Resident 5 with a wound on their right elbow. The wound measured one-inch by one-and-a-half inch with loss of skin in this area. The tissues in the wound bed were light yellowish in color. There was no bleeding and no discharge from the wound.

During an interview on 12/20/2024 at 7:37 AM, Staff H, Caregiver, Medication Technician, stated that they were unaware of Resident 5's wound on the right elbow.

Staff H stated that they were unsure who was responsible to change Resident 5's dressing.

Review of Resident 5's records showed that the facility admitted Resident 5 in [REDACTED] 2024. The records showed that on 10/25/2024, the facility completed an assessment for Resident 5. The assessment showed Resident 5 required assistance with mobility, transfers, and bathing. The records showed the facility assessed Resident 5 for the use of the bedrail. The assessment showed Resident 5's skin was intact in October 2024. Review of the Progress Notes, between 10/01/2024 and 12/18/2024, showed on 10/25/2024, Resident 5 was admitted to the memory care unit. The records showed no documentation of Resident 5's wound on the right elbow and no documentation of any wound management.

Review of Resident 5's October 2024, November 2024, and December 2024 Medication Administration Records (MARs) showed that the facility provided medication assistance to Resident 5. The MARs showed Resident 5 received Clopidogrel Bisulfate (a medication with blood thinning property), 75 milligrams (MG), one tablet by mouth, one time a day, for blood clot prevention.

Review of the Resident 5's Service Plan, undated, showed no documentation that Resident 5 used the bedrail for mobility and transfers. There was no documentation that showed who was responsible to monitor and maintain the safety of the bedrail. The plan did not identify Resident 5's wound on the right elbow. There was no documentation that showed who was responsible to provide wound management and dressing change to the wound. The plan did not identify that Resident 5 received the blood thinning medication. There was no documentation that provided care staff with guidance about the possible side effects from the medication, such as increased risk for bruising and easy bleeding. There were no instructions for staff about what actions were needed if Resident 5 experienced any side effects.

RESIDENT 6

Observation of Resident 6's apartment on 12/20/2024 at 9:27 AM, showed Resident 6 laid in a hospital bed. Observation showed a Medtronic device (a medical device that is used to remotely monitor heart rhythm) was on the bedside console next to the bed. Observation showed Resident 6 used a nasal cannula (a tube that delivers oxygen) to receive continuous oxygen. Observation showed the nasal cannula was connected to an oxygen concentrator (a device that generates oxygen), which sat on the floor, next to the bed. Observation showed the oxygen concentrator was set to deliver oxygen at two liters per minute. During an interview at this time, Resident 6 stated that the Medtronic machine was used to monitor their heart. Resident 6 stated that when they were discharged from the hospital in [REDACTED] 2024, they used the oxygen concentrator to receive continuous oxygen.

Review of Resident 6's records showed that the facility admitted Resident 6 in [REDACTED] 2024. The records showed that on 11/08/2024, the facility completed Resident 6's assessment. The assessment showed Resident 6's medical diagnoses included presence of [REDACTED]

[REDACTED] and [REDACTED]
[REDACTED] The assessment showed Resident 6 had an implanted cardiac pacemaker with a serial number. The assessment showed that Resident 6 required continuous oxygen at a flow rate of two liters per minute.

Review of Resident 6's undated Service Plan showed no documentation that Resident 6 had an implanted cardiac pacemaker and used the Medtronic device. The plan showed no documentation of Resident 6's use of continuous oxygen. The plan showed no contact information for Resident 6's cardiologist office and oxygen company. The plan did not provide any information for staff about the location of the remote Medtronic device. The plan did not identify the physician's order of the oxygen therapy that included the oxygen flow rate and delivery method. The plan did not provide instructions for the care staff on their responsibilities in operating the oxygen concentrator and what to do if the oxygen concentrator did not operate. There were no instructions for the care staff to monitor Resident 6 for any signs and symptoms associated with shortness of breath or heart issues. There were no instructions for care staff about what actions were needed if Resident 6 experienced any signs or symptoms of distress.

During an interview on 12/23/2024 at 3:00 PM, Staff L, Registered Nurse, Wellness Director, stated that they did not update the service plans for Resident 4, Resident 5, and Resident 6.

RESIDENT 19

Review of Resident 19's Admission Record showed that they were admitted by the facility in [REDACTED] 2023 with a diagnosis of [REDACTED]

Review of Resident 19's December 2024 eMAR showed Resident 19 received medications for dementia.

Review of Resident 19's Service Plan, dated 10/25/2024, showed Resident 19 was not allowed to leave the facility without an escort due to forgetfulness and disorientation. The service plan showed that Resident 19 was unable to remember how to get back to the facility. The service plan showed Resident 19 was verbally aggressive, demanding, uncooperative, and disruptive. There was no documentation that showed Resident 19 received medication for dementia. There was no documentation that provided care staff with guidance and interventions on how manage Resident 19's behaviors.

During an interview on 12/20/2024 at 2:45 PM, Staff A, Administrator, stated confirmation that Resident 19's behaviors were disruptive. Staff A stated that Resident 19 suffered from dementia and showed no recollection of their behaviors the next day. Staff A stated that Resident 19 did not intend harm towards anyone and was considered harmless since they "did not inflict physical harm on anyone". Staff A stated that they did not view the situation as a problem towards other residents.

During an interview on 12/23/2024 at 7:47 AM, Staff F, Medication Technician, (unlicensed staff who dispensed medications) stated that Resident 19 had dementia and became very belligerent and verbally abusive. Staff F stated that Resident 19's behaviors occurred two to three times a week.

RESIDENT 20

Review of Resident 20's Admission Record showed the facility admitted Resident 20 in [REDACTED] 2024 with a diagnosis of [REDACTED] and [REDACTED].

During an interview on 12/19/2024 at 2:04 PM, Staff N, Medication Technician, stated that Resident 20 drank alcohol every day. Staff N stated that when Resident 20 was intoxicated, they called for staff assistance every 30 minutes. Staff N stated that they would leave Resident 20 alone to allow them to sleep of the intoxication.

During an interview on 12/20/2024 at 1:22 PM, Resident 20 denied having a problem with alcohol. Resident 20 stated that they recently returned from a rehabilitation center and no longer consumed alcohol. Resident 20 denied disruptive behavior towards others. Resident 20 stated they called 911 a few times. Resident 20 stated they were tired of the conversation and abruptly terminated the interview.

During an interview on 12/23/2024 at 7:47 AM, Staff F, Medication Aide, stated that over the weekend since Resident 20's returned from the rehabilitation center, staff found Resident 20 was intoxicated. Staff F stated that Resident 20's electric wheelchair was stuck between the entryway and door of their apartment. Staff F stated that they switched the automatic mode on the wheelchair to manual to get the wheelchair unstuck. Staff F stated that they smelled a strong odor of alcohol on Resident 20's breath and observed an empty bottle of alcohol on the floor of Resident 20's apartment.

During an interview on 12/23/2024 at 1:15 PM, Staff DD, Medication Technician, stated that when Resident 20 was intoxicated, the staff did not know who to managed Resident 20's behaviors so they called 911 for assistance. Staff DD stated that at times, Resident 20 called 911 when they were intoxicated and requested to be taken to the hospital. Staff DD stated that 911 responded and refused to transport Resident 20 to the hospital when the problem was intoxication. Staff DD stated that the fire department stated that it was not an appropriate utilization of Emergency Medical Services resources to be called to deal with an intoxicated resident.

During an interview on 12/23/2024 at 4:00 PM, Staff A stated that the fire department met with the facility to discuss Resident 20's intoxication and the frequent 911 calls. Staff A stated that Resident 20 was recently in a rehabilitation center and no longer drank alcohol. Staff A stated that Resident 20 was in the rehabilitation center related to a fall, not for alcohol consumption. Staff A did not provide any information on how the facility planned to manage Resident 20's behavior.

Review of Resident 20's Progress Notes, dated 12/05/2024, showed Resident 20 called out for help and was found on the floor face down, bleeding around the nose. The progress note showed 911 was called. The progress note showed Resident 19 was highly intoxicated and unable to take their medication. The notes showed Resident 19 was transferred to hospital after sustaining the fall.

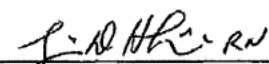
Review of Resident 20's Service Plan, dated 05/02/2024, showed that Resident 20 did not require assistance with wellness and safety. The plan showed no instructions for care staff on how to manage Resident 20's alcoholism and disruptive behavior. There were no instructions for care staff on how to manage Resident 20 when they were intoxicated.

During an interview on 01/06/2024 at 10:00 AM, Staff A stated that the facility contacted Resident 20's family about Resident 20's excessive alcohol consumption and intoxication, and the behaviors that resulted. Staff A stated that the family told the facility that they have dealt with Resident 20's alcoholism for over 40 years and were no longer able to be supportive. Staff A stated that Resident 20's family told them to take whatever action the facility deemed necessary.

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) 2/28/25.

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



Administrator (or Representative)

01/31/25

Date

WAC 358-78A-24681 Background checks Employment Provisional hire Pending results of national fingerprint background check. The assisted living facility may provisionally employ a caregiver and an administrator hired after January 7, 2012 for one hundred and twenty-days and allow the caregiver or administrator to have unsupervised access to residents when:

- (1) The caregiver or administrator is not disqualified based on the results of the Washington state name and date of birth background check; and
- (2) The results of the national fingerprint background check are pending.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 5 of 8 sampled staff (Staff A, Staff B, Staff C, Staff D, and Staff W) completed a national fingerprint background check within 120 days of hire. The facility failed to ensure 4 of 8

Review of Resident 20's Progress Notes, dated 12/05/2024, showed Resident 20 called out for help and was found on the floor face down, bleeding around the nose. The progress note showed 911 was called. The progress note showed Resident 19 was highly intoxicated and unable to take their medication. The notes showed Resident 19 was transferred to hospital after sustaining the fall.

Review of Resident 20's Service Plan, dated 05/02/2024, showed that Resident 20 did not require assistance with wellness and safety. The plan showed no instructions for care staff on how to manage Resident 20's alcoholism and disruptive behavior. There were no instructions for care staff on how to manage Resident 20 when they were intoxicated.

During an interview on 01/06/2024 at 10:00 AM, Staff A stated that the facility contacted Resident 20's family about Resident 20's excessive alcohol consumption and intoxication, and the behaviors that resulted. Staff A stated that the family told the facility that they have dealt with Resident 20's alcoholism for over 40 years and were no longer able to be supportive. Staff A stated that Resident 20's family told them to take whatever action the facility deemed necessary.

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)_____.

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

Administrator (or Representative)

Date

WAC 388-78A-24681 Background checks Employment Provisional hire Pending results of national fingerprint background check. The assisted living facility may provisionally employ a caregiver and an administrator hired after January 7, 2012 for one hundred and twenty-days and allow the caregiver or administrator to have unsupervised access to residents when:

- (1) The caregiver or administrator is not disqualified based on the results of the Washington state name and date of birth background check; and
- (2) The results of the national fingerprint background check are pending.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 5 of 8 sampled staff (Staff A, Staff B, Staff C, Staff D, and Staff W) completed a national fingerprint background check within 120 days of hire. The facility failed to ensure 4 of 8

sampled staff (Staff A, Staff B, Staff D, and Staff W) did not have unsupervised access to residents while the national fingerprint background check results were pending. These failures placed all 58 residents at risk of abuse or neglect from staff with unknown backgrounds.

Findings included...

STAFF A

Observations between 12/18/2024 and 12/23/2024 showed Staff A, Administrator/Director of Nursing, was present in the facility. Observation showed Staff A interacted with residents throughout the day, with no supervision.

Review of the facility's employee List showed that the facility hired Staff A, Administrator/Director of Nursing, on 08/12/2024. Review of Staff A's employee records showed that on 08/13/2024, the facility completed the Washington state name and date of birth background inquiry (BGI). The BGI results showed a Character, Competence, and Suitability (CCS) review was required. The records showed a CCS was completed. The records showed Staff A's Department of Social and Health Services (DSHS) Fingerprint Appointment was scheduled for 12/19/2024, 129 days after they were hired. There was no documentation that showed the facility received the results of Staff A's national fingerprint background check.

STAFF B

Review of Staff B's employee records showed that the facility hired Staff B, Caregiver, Certified Nursing Assistant, on 03/20/2024. The employee records showed the facility completed the BGI on 03/19/2024. The records showed that 278 days after the facility hired Staff B, there was no documentation that showed Staff B completed a national fingerprint background check.

STAFF D

Review of Staff D's employee records showed that the facility hired Staff D, Medication Technician (unlicensed staff who dispensed medications), on 07/31/2024. The employee record showed the facility completed the BGI on 07/29/2024. The records showed Staff D completed a DSHS national fingerprint check on 12/19/2024, 141 days after they were hired.

STAFF W

Review of Staff W's employee records showed that the facility hired Staff W, Certified Nursing Assistant, on 08/05/2024. The employee records showed the facility completed the BGI on 08/02/2024. The records showed that 136 days after the facility hired Staff W, there was no documentation that showed Staff B completed a national fingerprint background check.

During an interview on 12/19/2024 at 10:45 AM, Staff A stated that the facility hired them to the Wellness Nurse position on 08/12/2024. Staff A stated that they became the

Administrator in September 2024. Staff A stated that they were unable to find their National Fingerprint background check results. Staff A stated that their DSHS fingerprint appointment was scheduled for 12/19/2024.

During an interview on 12/19/2024 at 2:00 PM, Staff Q, Business Office Manager, stated that the previous business office manager did not ensure staff background checks and national fingerprint checks were completed on time.

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) <u>2/28/25</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
<u>J. D. H. R. R. N.</u> Administrator (or Representative)	<u>01/31/25</u> Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility failed to assess 2 of 7 sampled residents (Resident 4 and Resident 6) for their ability to safely use a medical device. This failure placed Resident 4 and Resident 6 at risk for unmet care needs and possible injury.

Findings included ...

RESIDENT 4

Review of the facility's Residents Characteristic Roster showed that the facility admitted

Administrator in September 2024. Staff A stated that they were unable to find their National Fingerprint background check results. Staff A stated that their DSHS fingerprint appointment was scheduled for 12/19/2024.

During an interview on 12/19/2024 at 2:00 PM, Staff Q, Business Office Manager, stated that the previous business office manager did not ensure staff background checks and national fingerprint checks were completed on time.

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)_____.

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

Administrator (or Representative)

Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility failed to assess 2 of 7 sampled residents (Resident 4 and Resident 6) for their ability to safely use a medical device. This failure placed Resident 4 and Resident 6 at risk for unmet care needs and possible injury.

Findings included ...

RESIDENT 4

Review of the facility's Residents Characteristic Roster showed that the facility admitted

Resident 4 in [REDACTED] of 2024 with diagnoses of [REDACTED]

and [REDACTED]

Observation of Resident 4's apartment on 12/19/2024 at 1:33 PM, showed a transfer pole, secured to the floor and ceiling, next to Resident 4's non-functional electric hospital bed. During an interview at this time, Resident 4 communicated with hand gestures, facial expressions, and a communication board due to diagnosis of [REDACTED]. Resident 4 communicated that they used the transfer pole to pull themselves up and transfer to and from the electrical wheelchair and the bed.

Review of Resident 4's Service Plan, dated 05/10/2024, and revised on 12/17/2024, showed no documentation that Resident 4 used a transfer pole. The Plan showed no information or instructions for staff that showed whether Resident 4 used the transfer pole independently or with staff assistance.

Review of Resident 4's Records showed there was no assessment completed that showed Resident 4 used the transfer pole.

RESIDENT 6

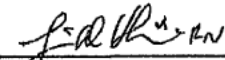
Observation of Resident 6's apartment on 12/20/2024 at 9:27 AM, showed Resident 6 laid in a hospital bed. Observation showed a Continuous Positive Airway Pressure machine (CPAP, a machine that helps a person breathing while asleep) sat on the bedside console to the right side of the bed. Observation showed a facial mask, and a tubing were connected to the CPAP. Observation showed a manual wheelchair, with a Roho cushion (an air-filled cushion designed to reduce pressure on the body while sitting) placed on top of the wheelchair. During an interview at this time, Resident 6 stated that they use the CPAP machine at night, for breathing while asleep. Resident 6 stated that the facility's staff assisted them with putting on and taking off the CPAP facial mask. Resident 6 stated that they independently operated the CPAP. Resident 6 stated that every day, the staff assisted them to sit up in the wheelchair, on the Roho cushion.

Review of Resident 6's records showed that the facility admitted Resident 6 in [REDACTED] 2024. The records showed that the facility completed Resident 6's assessment on 11/08/2024. There was no documentation that showed the facility assessed Resident 6 for use of the CPAP and the Roho cushion.

During an interview on 12/23/2024 at 3:00 PM, Staff L, Registered Nurse, Wellness Director, stated that there were no assessments completed for Resident 4 and Resident 6 to use any medical devices.

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) 02/28/25.

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


Administrator (or Representative)

01/31/25
Date

WAC 388-112A-0400 What is specialty training and who is required to take it?

(4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows:

(c) Mental health specialty training as described in WAC 388-112A-0450 .

WAC 388-78A-2500 Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, and:

- (1) Who has received the diagnosis or treatment within the previous two years; and
- (2) Whose diagnosis was made by, or treatment provided by, one of the following:
 - (a) A licensed physician;
 - (b) A mental health professional;
 - (c) A psychiatric advanced registered nurse practitioner; or
 - (d) A licensed psychologist.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 6 sampled Staff (Staff D) completed the specialized training for mental health illness, as required. This failure placed all 58 residents at risk for decreased quality of care provided by caregivers with incomplete training.

Findings included...

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)_____.

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

Administrator (or Representative)

Date

WAC 388-112A-0400 What is specialty training and who is required to take it?

(4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows:

(c) Mental health specialty training as described in WAC 388-112A-0450 .

WAC 388-78A-2500 Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, and:

- (1) Who has received the diagnosis or treatment within the previous two years; and
- (2) Whose diagnosis was made by, or treatment provided by, one of the following:
 - (a) A licensed physician;
 - (b) A mental health professional;
 - (c) A psychiatric advanced registered nurse practitioner; or
 - (d) A licensed psychologist.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 6 sampled Staff (Staff D) completed the specialized training for mental health illness, as required. This failure placed all 58 residents at risk for decreased quality of care provided by caregivers with incomplete training.

Findings included...

Review of the facility's Resident Characteristic Roster identified four residents with behavioral/psychosocial issues. Three sampled residents showed a diagnosis of [REDACTED] and [REDACTED]

STAFF D

Review of the facility's employee roster showed that the facility hired Staff D, Certified Nursing Assistant, on 07/31/2024. Review of the facility's caregiver schedules showed that Staff D worked in December 2024. Review of Staff D's employee record showed that as of 12/23/2024, 145 days after hire, there was no documentation that showed Staff C completed the Washington state Department of Social and Health Services (DSHS) approved specialized training for mental health.

During an interview on 12/19/2024 at 2:00 PM, Staff Q, Business Office Manager, stated that they were responsible to maintain staff credential and training documents in the employee records. Staff Q stated that they were certain Staff D completed the DSHS specialty training for mental health. Staff Q stated that they requested Staff D provide the facility with documentation of their specialty training for Mental Health. As of 01/09/2025, Staff Q stated that Staff D did not provide any documentation that showed they completed mental health specialty training.

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) 2/28/25

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

J. P. R. R. R. R.

Administrator (or Representative)

01/31/25

Date

WAC 388-112A-0400 What is specialty training and who is required to take it?

(4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows:

(b) Dementia specialty training as described in WAC 388-112A-0440 ; and

WAC 388-78A-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the

Review of the facility's Resident Characteristic Roster identified four residents with behavioral/psychosocial issues. Three sampled residents showed a diagnosis of [REDACTED] and [REDACTED].

STAFF D

Review of the facility's employee roster showed that the facility hired Staff D, Certified Nursing Assistant, on 07/31/2024. Review of the facility's caregiver schedules showed that Staff D worked in December 2024. Review of Staff D's employee record showed that as of 12/23/2024, 145 days after hire, there was no documentation that showed Staff C completed the Washington state Department of Social and Health Services (DSHS) approved specialized training for mental health.

During an interview on 12/19/2024 at 2:00 PM, Staff Q, Business Office Manager, stated that they were responsible to maintain staff credential and training documents in the employee records. Staff Q stated that they were certain Staff D completed the DSHS specialty training for mental health. Staff Q stated that they requested Staff D provide the facility with documentation of their specialty training for Mental Health. As of 01/09/2025, Staff Q stated that Staff D did not provide any documentation that showed they completed mental health specialty training.

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 388-112A-0400 What is specialty training and who is required to take it?

(4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows:

(b) Dementia specialty training as described in WAC 388-112A-0440 ; and

WAC 388-78A-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the

resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 6 sampled staff (Staff D) received Specialty Training for Dementia within 120 days of hire. This failure placed all 58 residents at risk for receiving care from unqualified staff.

Findings included...

Review of the facility's characteristics roster identified 12 residents with behavior/psychosocial issues, dementia, Alzheimer's, and cognitive impairment. The characteristics roster did not identify Resident 19. Review of Resident 19's Admission Record showed a diagnosis of [REDACTED].

During an interview on 12/20/2024 at 2:35 PM, Staff A, Executive Director, stated that Resident 19 suffered from dementia. Staff A stated that Resident 19 was unable to recall any of their offensive behaviors towards others.

STAFF D

Review of the facility's employee roster showed that the facility hired Staff D, Certified Nursing Assistant, on 07/31/2024. Review of the facility's caregiver schedules showed that Staff D worked in December 2024. Review of Staff D's employee record showed that as of 12/23/2024, 145 days after hire, there was no documentation that showed Staff D completed the Washington state Department of Social and Health Services (DSHS) approved specialized training for dementia.

During an interview on 12/19/2024 at 2:00 PM, Staff Q, Business Office Manager, stated that they were responsible to maintain staff credential and training documents in the employee records. Staff Q stated that they were certain Staff D completed DSHS specialty training for mental health and dementia. Staff Q stated that they requested Staff D provide the facility with documentation of their specialty training for Dementia. As of 01/09/2025, Staff Q stated that Staff D did not provide any documentation that showed they completed dementia specialty training.

Plan/Attestation Statement

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[Signature]

01/31/25

resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 6 sampled staff (Staff D) received Specialty Training for Dementia within 120 days of hire. This failure placed all 58 residents at risk for receiving care from unqualified staff.

Findings included...

Review of the facility's characteristics roster identified 12 residents with behavior/psychosocial issues, dementia, Alzheimer's, and cognitive impairment. The characteristics roster did not identify Resident 19. Review of Resident 19's Admission Record showed a diagnosis of [REDACTED].

During an interview on 12/20/2024 at 2:35 PM, Staff A, Executive Director, stated that Resident 19 suffered from dementia. Staff A stated that Resident 19 was unable to recall any of their offensive behaviors towards others.

STAFF D

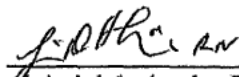
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During an interview on 12/19/2024 at 2:00 PM, Staff Q, Business Office Manager, stated that they were responsible to maintain staff credential and training documents in the employee records. Staff Q stated that they were certain Staff D completed DSHS specialty training for mental health and dementia. Staff Q stated that they requested Staff D provide the facility with documentation of their specialty training for Dementia. As of 01/09/2025, Staff Q stated that Staff D did not provide any documentation that showed they completed dementia specialty training.

Plan/Attestation Statement

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Administrator (or Representative)

01/31/25

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:

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

(b) Provide the resident with personal wireless communication devices, such as pendants or wristbands, when a communication device is not installed in the resident's sleeping room, and when wireless communications are used:

(ii) The facility must have a policy and procedure describing the mitigating measures in the event of system disruption, including for maintenance and loss of power; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide any emergency call devices for residents to summon staff for assistance in 9 of 9 common areas (first floor: resident laundry room, chapel, common bathroom one, common bathroom two, common bathroom three, conference room; second floor: exercise room, library, and common bathroom four) and all hallways in the facility. The facility failed to implement the emergency backup system for the wireless pendant system for 58 of 58 residents (Resident 1 Resident 58) during the power outage. These failures placed all 58 residents at risk of unmet care needs and unattended injury.

Findings included ...

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that as of 07/25/2023, the Assisted Living Facility (ALF) held a DSHS Medicaid Enhanced Adult Residential Care (EARC) contract. The system showed that the facility did not hold any exemptions.

NO EMERGENCY CALL DEVICE IN COMMON AREAS

Review of the facility's Assisted Living Residents Characteristic Roster showed 58 residents resided in the facility. The roster showed 51 residents lived in the assisted living unit. Among the 51 assisted living residents, 39 residents lived in the remodeled apartments. The roster showed seven residents lived in the memory care unit.

Observations during the full inspection, from 12/17/2024 through 12/23/2025, between 9:00 AM and 4:00 PM, showed that the facility had an assisted living unit and a secured memory care unit. Observation showed the facility remodeled 40 apartments

_____ Administrator (or Representative)	_____ Date
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 - (iii) Corridors, as well as common and outdoor areas accessible to residents.
- (b) Provide the resident with personal wireless communication devices, such as pendants or wristbands, when a communication device is not installed in the resident's sleeping room, and when wireless communications are used:
 - (ii) The facility must have a policy and procedure describing the mitigating measures in the event of system disruption, including for maintenance and loss of power; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide any emergency call devices for residents to summon staff for assistance in 9 of 9 common areas (first floor: resident laundry room, chapel, common bathroom one, common bathroom two, common bathroom three, conference room; second floor: exercise room, library, and common bathroom four) and all hallways in the facility. The facility failed to implement the emergency backup system for the wireless pendant system for 58 of 58 residents (Resident 1 Resident 58) during the power outage. These failures placed all 58 residents at risk of unmet care needs and unattended injury.

Findings included ...

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that as of 07/25/2023, the Assisted Living Facility (ALF) held a DSHS Medicaid Enhanced Adult Residential Care (EARC) contract. The system showed that the facility did not hold any exemptions.

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Observations during the full inspection, from 12/17/2024 through 12/23/2025, between 9:00 AM and 4:00 PM, showed that the facility had an assisted living unit and a secured memory care unit. Observation showed the facility remodeled 40 apartments

(Apartments 101 through 121 and 229 through 250) in the assisted living unit. Observation showed that the facility's common areas included a resident laundry room, a chapel, three common bathrooms, a private conference room, and several hallways on the first floor, and a resident exercise room, a library, a common bathroom, and hallways on the second floor. Observation showed there were no emergency call devices installed in any of the common areas or hallways for residents to summon staff assistance. Observation showed that there were no emergency call devices inside the residents' apartments. Observation showed residents used the common areas for day-to-day activities. Observation showed the residents, who resided in the assisted living unit, wore a wireless call pendant. Observation showed the residents, who resided in the memory care unit, did not wear a wireless call pendant.

During an interview on 12/20/2024 at 2:07 PM, Staff BB, Maintenance Supervisor, stated that when a resident activated their pendant, the signal went to the care staffs' pagers. Staff BB stated that the pagers showed the apartment number associated with the resident. Staff BB stated that the pager did not show where the resident was located when the resident activated their call pendant. Staff BB stated that the care staff responded by going to the apartment number assigned to the resident's pendant. Staff BB stated that if the resident was not in their apartment, staff then searched the facility to locate the resident who called for assistance.

During an interview on 12/23/2024 at 9:18 AM, Staff BB stated that there was no emergency call device anywhere in the secured memory care unit. Staff BB stated that due to most residents' poor cognitive status, the facility did not provide memory care residents with a call pendant, except for Resident 12. Staff BB stated that Resident 12's cognitive status was higher so Resident 12 wore a pendant. Staff BB stated that the care staff were required to check on the memory care residents every 15 minutes to ensure their safety.

During an interview on 12/23/2024 at 10:15 AM, Staff F, Medication Aide, stated that when a resident activated their call pendant, their pager showed the apartment number associated with the resident. Staff F stated that they responded by going to the resident's apartment. Staff F stated that if they did not find the resident in their apartment, they went from room to room in the common areas to look for the resident. Staff F stated that without knowing where the resident activated their call pendant, it delayed their response to the resident's call.

FAILED WIRELESS CALL PENDANT SYSTEM

Review of the facility's undated emergency disaster manual showed that during a power outage, the staff would check on all residents every 15 minutes.

During an interview on 12/17/2024 at 10:55 AM, Staff BB stated that during a power outage, the wireless call pendant system was backed up by the generator. Staff BB stated that during the recent power outage that affected the region in November 2024, the facility was without power for three days. Staff BB stated that the generator powered the pendant system for several days. Staff BB stated that staff and residents were informed that the wireless pendant system functioned. Staff BB stated that the

generator did not provide power to the two elevators in the building.

Observation on 12/19/2024 at 11:00 AM, showed a pendant call system module in the roof access room located on the second floor. Observation showed the power cord from the call pendant module box was plugged into an outlet marked emergency power. During an interview at this time, Staff BB stated that the wireless call pendant system needed to be rebooted every time the power went out. Staff BB stated and demonstrated that the power cord needed to be unplugged for 15 seconds and plugged back in to reboot the call system. Staff BB stated that in November 2024, they came into the facility at 9:45 PM the night the power first went out. Staff BB stated that the pendant system functioned at that time during the power outage.

Observation on 12/19/2024 at 1:33 PM, showed Resident 4's apartment was located on the second floor. Observation showed Resident 4 used an electric wheelchair and a communication board to communicate, along with hand gestures and sounds in response to yes and no questions. During an interview at this time, Resident 4 and their representative stated that Resident 4's call pendant did not work during the power outage in November 2024. Resident 4 stated that they were not able to use the elevator during the power outage. Resident 4 communicated that the staff did not check on them often during a power outage, as outlined in the facility Disaster Manual for power outage.

During an interview on 12/19/2024 at 2:10 PM, Staff N, Medication Technician (unlicensed staff who dispensed medications) stated that during the windstorm in November 2024, the power went out for three days. Staff N stated that on the first day of the power outage, Staff BB came into the building and reset the call system to run off the emergency back-up generator. Staff N stated that over the following days during the power outage, the call pendant system did not function.

During an interview on 12/19/2024 at 3:00 PM, Staff A, Administrator/Director of Nursing, and Staff L, Wellness Director, stated that during the windstorm in November 2024, the power went out multiple times over a three-day period. Staff L stated that the power came back on for short periods of time and then went back out. Staff L stated that each time the power went out, an alarm was triggered, and then they silenced the alarm and rebooted the call pendant system by pushing the reset button on the computer call system. Staff L stated that the computer pendant system was on the first floor in the Health and Wellness office, behind the concierge desk. Staff A and Staff L stated that they were unaware the call system in the roof access room on the second floor also needed to be rebooted.

During an interview on 12/20/2024 at 07:30 AM, Staff BB stated that the call system was powered by a power pack control in the nurse's station/office area. Observation at this time showed the nurse's station held a module tower with buttons to turn on, turn off, and to reboot the call system. Staff BB stated that to make the call system work, the system needed to be reset every time the power went out. During a previous interview on 12/19/2024, Staff BB confirmed that they informed the licensor that every time the power goes out and the generator kicks in the call system module box located on the

second floor needed to be reset by unplugging it, wait 15 seconds and then plugged back into the emergency plug which was connected to the generator. During this interview on 12/20/2025, Staff BB changed their statement and stated that the staff only need to reset the call system module in the nurse's station. Staff BB clarified that each time the electricity came back on and then went out, referred to as "brown outs", both the panel on the second floor and the call system power pack in the nurses' office needed to be rebooted. Staff BB confirmed that resetting the call system located in the nurses' office alone would not reboot the system until the panel on the second floor was also rebooted.

During an interview on 12/20/2024 at 9:27 AM, Resident 6 stated that during the power outage, they forgot the date, their oxygen concentrator (a device that generates oxygen) stopped, and they did not receive any oxygen for four hours. Resident 6 stated that they experienced shortness of breath during this time. Resident 6 stated that when they measured their oxygen level on their own, their oxygen level dropped to 84 percent. Resident 6 stated that they called the care staff for help and their call pendant did not work. Resident 6 stated that no staff came to help, so Resident 6 called 911.

Review of an in-service document dated 12/20/2024, showed 13 staff attended the training. The in-service instructions showed staff what to do on the call-system during the power outage. The instructions showed there were three steps required to reboot the call pendant system. First, check the back-up power (UPS/black box) located at the nurse station if it alarmed or was turned-off. Second, if there was a red-light flashing, the UPS was off and, in this case, it needed to be plugged-in to the emergency outlet located at concierge desk. Third, check the power supply on the call-system panel located on the second floor in the roof access room.

During an interview on 12/23/2024 at 3:00 PM, Staff A and Staff L stated that they were unaware the multiple steps required to ensure the pendant system operated during a power outage. Staff A and Staff L stated that they did not reset the wireless call pendant system properly. Staff A and Staff L stated that the residents' pendants did not function during the recent power outage.

Plan/Attestation Statement

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J. D. HARRIS
Administrator (or Representative)

01/31/25
Date

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During an interview on 12/23/2024 at 3:00 PM, Staff A and Staff L stated that they were unaware the multiple steps required to ensure the pendant system operated during a power outage. Staff A and Staff L stated that they did not reset the wireless call pendant system properly. Staff A and Staff L stated that the residents' pendants did not function during the recent power outage.

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Administrator (or Representative)

Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure 1 of 3 sampled medication carts (Cart 1, located in the memory care unit) was locked when left unsupervised by staff. This failure placed the seven memory care residents at risk for harm or illness if the medications were accessed and swallowed.

Findings included...

Observation on 12/17/2024 at 11:35 AM, showed the door to the medication room in the memory care unit on the first floor was unlocked. Observation showed there were no facility staff present in the room. Observation showed one medication cart (Cart 1) inside the medication room. Observation showed Cart 1 was unlocked and a set of keys remained inserted in the lock pad. Observation showed the unlocked cart stored resident medications. The unlocked door to the medication room and the unlocked medication cart provided opportunities for residents to access the medications.

During an interview on 12/17/2024 at 11:40 AM, Staff H, Medication Technician, stated that they were the assigned Medication Technician in the memory care unit. Staff H stated that while they responded to a resident, they left their keys inserted in the medication cart and the door to the medication room unlocked. Staff H stated that the door to the medication room should be kept locked when no facility staff were present in the room. Staff H stated that the medication cart keys, which included the key to the narcotic box, should not be left inserted in the medication cart lock pad.

Plan/Attestation Statement

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J. D. H. H. H.

Administrator (or Representative)

02/31/25

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Date

WAC 246-215-04520 Equipment Warewashing machines, manufacturer's operating instructions (FDA Food Code 4-501.15).

(1) A warewashing machine and its auxiliary components must be operated in accordance with the machine's data plate and other manufacturer's instructions.

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 ensure that 1 of 1 kitchen commercial dishwashers (Dishwasher 1) in the kitchen operated with the hot water sanitization at a minimum of 120 degrees Fahrenheit (F), in accordance with the manufacturer's instructions. This failure placed all 58 residents at risk for foodborne illnesses.

Findings included...

Review of the facility's Dish Washing Machine Temperature Record, dated December 2024, showed the Dishwasher 1's temperatures of the wash cycles were taken and documented at 7:00 AM, noon, and 3:00 PM for each day. There was no documentation of Dishwasher 1's temperature of the rinse cycles. The record showed the recorded temperatures were all at 120 degrees F. The record showed instructions that the water should be changed every two hours during service. The records showed instructions to alert managers if the temperature was in an unacceptable range.

Observation on 12/18/2024 at 11:30 AM showed the manufacturer's instruction label on the Dishwasher 1 that showed the dishwasher operating requirements included "water temperature at 120 degrees F minimum". Observation showed that Dishwasher 1 ran below the required 120 degrees F, in both the wash cycles and rinse cycles in 10 consecutive runs.

Observation on 12/19/2024 at 1:28 PM showed Staff Z, Dietary Aide, washed dishes with Dishwasher 1. Observation showed Dishwasher 1 ran at 115 degrees F, five degrees below the required temperature. During an interview at this time, Staff Z stated that they were instructed to run Dishwasher 1 and drain the water two times before they washed the dishes. Staff Z stated that the dishwasher should be operated between 100 and 110 degrees F. Staff Z stated that they were unaware of the requirement to monitor the dishwasher's temperature when they ran the machine. Staff Z stated that they were unaware the dishwasher did not reach the required water temperature when they washed the dishes.

During an interview on 12/19/2024 at 1:32 PM, Staff AA, Dietary Supervisor, stated that they used the commercial dishwasher (Dishwasher 1) to wash dishes and utensils for all

residents. Staff AA stated that they were required to ensure Dishwasher 1 reached the required temperature at 120 degrees F when they washed dishes. Staff AA stated that they monitored and documented the dishwasher temperatures every day. Staff AA stated that they were unaware staff did not monitor the dishwasher's temperatures, and that the dishwasher did not meet the required temperature.

During an interview on 12/19/2024 at 1:40 PM, Staff BB, Maintenance Supervisor, stated that they were unaware the washer temperatures did not meet the minimum water temperature, as required by the manufacturer. Staff BB stated that on 12/19/2024, they adjusted the water temperature of the boiler that supplied the dishwasher. Staff BB stated that they were required to run the dishwasher and drain the water five to six times before they washed the dishes.

Plan/Attestation Statement

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J. D. H. RN

Administrator (or Representative)

01/31/25

Date

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 Assisted Living Facility failed to complete a Washington State name and date of birth background inquiry (BGI) every two years for 2 of 2 sampled staff (Staff E and Staff F). This failure placed all 58 residents at risk of abuse, neglect, or exploitation from staff with unknown backgrounds.

Findings included...

residents. Staff AA stated that they were required to ensure Dishwasher 1 reached the required temperature at 120 degrees F when they washed dishes. Staff AA stated that they monitored and documented the dishwasher temperatures every day. Staff AA stated that they were unaware staff did not monitor the dishwasher's temperatures, and that the dishwasher did not meet the required temperature.

During an interview on 12/19/2024 at 1:40 PM, Staff BB, Maintenance Supervisor, stated that they were unaware the washer temperatures did not meet the minimum water temperature, as required by the manufacturer. Staff BB stated that on 12/19/2024, they adjusted the water temperature of the boiler that supplied the dishwasher. Staff BB stated that they were required to run the dishwasher and drain the water five to six times before they washed the dishes.

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This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to complete a Washington State name and date of birth background inquiry (BGI) every two years for 2 of 2 sampled staff (Staff E and Staff F). This failure placed all 58 residents at risk of abuse, neglect, or exploitation from staff with unknown backgrounds.

Findings included...

Review of the facility's Employee List showed that the facility hired Staff E, Caregiver, on 04/01/2022 and Staff F, Medication Aide, on 04/01/2022. Review of the facility's Care Staff Schedule showed that Staff E and Staff F worked in December 2024.

STAFF E

Review of Staff E's employee records showed their previous Washington state name and date of birth BGI expired on 11/01/2023. The records showed that the facility completed a BGI on 02/26/2024, 117 days after the previous BGI expired.

STAFF F

Review of Staff F's employee records showed their initial Washington state name and date of birth BGI expired on 02/09/2023. The records showed that the facility completed a BGI on 02/27/2023, 18 days after the initial BGI expired.

During an interview on 12/20/2024 at 2:00 PM, Staff Q, Business Office Manager, stated that they were aware of the requirements for background checks. Staff Q stated that they completed Staff E and Staff F Washington state name and date of birth BGI late.

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) 02/28/25.

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

J. P. H. R. R. R.

Administrator (or Representative)

01/31/25

Date

WAC 388-112A-0600 What is continuing education and what topics may be covered in continuing education?

(1) Continuing education is annual training designed to promote professional development and increase a long-term care worker's knowledge, expertise, and skills. DSHS must approve continuing education curricula and instructors.

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:

(i) A certified home care aide;

Review of the facility's Employee List showed that the facility hired Staff E, Caregiver, on 04/01/2022 and Staff F, Medication Aide, on 04/01/2022. Review of the facility's Care Staff Schedule showed that Staff E and Staff F worked in December 2024.

STAFF E

Review of Staff E's employee records showed their previous Washington state name and date of birth BGI expired on 11/01/2023. The records showed that the facility completed a BGI on 02/26/2024, 117 days after the previous BGI expired.

STAFF F

Review of Staff F's employee records showed their initial Washington state name and date of birth BGI expired on 02/09/2023. The records showed that the facility completed a BGI on 02/27/2023, 18 days after the initial BGI expired.

During an interview on 12/20/2024 at 2:00 PM, Staff Q, Business Office Manager, stated that they were aware of the requirements for background checks. Staff Q stated that they completed Staff E and Staff F Washington state name and date of birth BGI late.

Plan/Attestation Statement

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Date

WAC 388-112A-0600 What is continuing education and what topics may be covered in continuing education?

(1) Continuing education is annual training designed to promote professional development and increase a long-term care worker's knowledge, expertise, and skills. DSHS must approve continuing education curricula and instructors.

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:

(i) A certified home care aide;

(iii) A certified nursing assistant;

(b) A long-term care worker, who is a certified home care aide must comply with continuing education requirements under chapter 246-980 WAC.

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:

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to ensure 2 of 2 sampled care staff (Staff E and Staff F) completed all trainings, as required. This failure placed all 58 residents at risk for decreased quality of care provided by caregivers with incomplete training.

Findings included...

Review of the facility's Employee List showed that the facility hired Staff E, Caregiver, on 04/01/2022 and Staff F, Medication Aide, on 04/01/2022. Review of the facility's Care Staff Schedule showed that Staff E and Staff F worked in December 2024.

STAFF E

Review of Staff E's employee records showed that between their December 2023 and December 2024 birthdays, Staff E completed a total of 0.25 Continuing Education (CE) hours of the Washington state Department of Social and Health Services (DSHS) approved CE. Staff E was short by 11.75 hours from the required 12 CE hours.

STAFF F

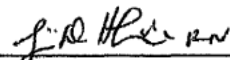
Review of Staff F's employee records showed that between their September 2023 and September 2024 birthdays, Staff F completed a total of five CE hours of the Washington state DSHS approved CE. Staff F was short by seven hours from the required 12 CE hours.

During an interview on 12/20/2024 at 2:00 PM, Staff Q, Business Office Manager, stated they were unaware staff were required to complete the continuing education courses that were approved by the Washington State DSHS. Staff Q stated that Staff E and Staff F did not complete the required 12 hours of the required CE training from their 2023 birthday to their 2024 birthday.

This document was prepared by Residential Care Services for the Locator website.

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Administrator (or Representative)

01/31/25

Date

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(2) Ensure animals living on the assisted living facility premises:

- (a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;
- (b) Are certified by a veterinarian to be free of diseases transmittable to humans;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 2 sampled pets (Pet 2) were up-to-dated with immunizations and received a regular veterinarian examination. The facility failed to ensure 2 of 2 sampled pets (Pet 1 and Pet 2) were certified by a veterinarian to be free of disease transmittable to humans. These failures placed all 58 residents at risk for infectious diseases transmitted by animals.

Findings included...

Review of the facility's "Pet Policy", dated 04/01/2022, showed that the facility permitted pets to live on the premises. The policy showed that the facility followed the Washington Administrative Code (WAC). The policy showed that the facility was required to ensure animals living on the facility premises received regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington State. The policy showed the facility required that the animals be certified by a veterinarian to be free of diseases transmittable to humans.

Review of the facility's pet records showed that two pets (Pet 1, cat, and Pet 2, cat) lived on the premise. The records showed that Pet 1 was current with their rabies vaccination and its last examination was 04/26/2024. There was no documentation that showed Pet 1 was certified by a veterinarian to be free of infectious diseases. The records showed Pet 2's rabies booster expired on 08/13/2024. There was no documentation that showed Pet 2's rabies vaccination was updated. There was no documentation that showed Pet 2 received a regular veterinarian examination. There was no documentation that showed Pet 2 was certified by a veterinarian to be free of

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Date

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(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

(b) Are certified by a veterinarian to be free of diseases transmittable to humans;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 2 sampled pets (Pet 2) were up-to-dated with immunizations and received a regular veterinarian examination. The facility failed to ensure 2 of 2 sampled pets (Pet 1 and Pet 2) were certified by a veterinarian to be free of disease transmittable to humans. These failures placed all 58 residents at risk for infectious diseases transmitted by animals.

Findings included...

Review of the facility's "Pet Policy", dated 04/01/2022, showed that the facility permitted pets to live on the premises. The policy showed that the facility followed the Washington Administrative Code (WAC). The policy showed that the facility was required to ensure animals living on the facility premises received regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington State. The policy showed the facility required that the animals be certified by a veterinarian to be free of diseases transmittable to humans.

Review of the facility's pet records showed that two pets (Pet 1, cat, and Pet 2, cat) lived on the premise. The records showed that Pet 1 was current with their rabies vaccination and its last examination was 04/26/2024. There was no documentation that showed Pet 1 was certified by a veterinarian to be free of infectious diseases. The records showed Pet 2's rabies booster expired on 08/13/2024. There was no documentation that showed Pet 2's rabies vaccination was updated. There was no documentation that showed Pet 2 received a regular veterinarian examination. There was no documentation that showed Pet 2 was certified by a veterinarian to be free of

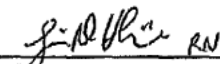
Infectious diseases.

During an interview on 12/20/2024 at 2:00 PM, Staff Q, Business Office Manager, stated that Pet 1 and Pet 2 resided in the assisted living facility. Staff Q stated that they maintained the pet records. Staff Q stated that they were unaware Pet 1's rabies booster expired. Staff Q stated that they were unsure if Pet 1 received any veterinarian examination and rabies vaccination. Staff Q stated that they were unaware if the two pets were certified by a veterinarian to be free of human transmittable diseases.

Plan/Attestation Statement

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Administrator (or Representative)

01/31/25

Date

WAC 388-78A-2665 Resident rights Notice Policy on accepting medicaid as a payment source. The assisted living facility must fully disclose the facility's policy on accepting medicaid payments. The policy must:

- (1) Clearly state the circumstances under which the assisted living facility provides care for medicaid eligible residents and for residents who become eligible for medicaid after admission;
- (2) Be provided both orally and in writing in a language that the resident understands;
- (3) Be provided to prospective residents, before they are admitted to the home;
- (4) Be provided to any current residents who were admitted before this requirement took effect or who did not receive copies prior to admission;
- (5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point; and
- (6) Be signed and dated by the resident and be kept in the resident record after signature.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 2 of 7 sampled residents (Resident 3 and Resident 6) received a copy of the facility's policy regarding Medicaid as a payment source, with a signed and dated acknowledgement by the resident. This failure placed Resident 3 and Resident 6 at risk of being discharged and unable to reside in the facility on Medicaid.

infectious diseases.

During an interview on 12/20/2024 at 2:00 PM, Staff Q, Business Office Manager, stated that Pet 1 and Pet 2 resided in the assisted living facility. Staff Q stated that they maintained the pet records. Staff Q stated that they were unaware Pet 1's rabies booster expired. Staff Q stated that they were unsure if Pet 1 received any veterinarian examination and rabies vaccination. Staff Q stated that they were unaware if the two pets were certified by a veterinarian to be free of human transmittable diseases.

Plan/Attestation Statement

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Date

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- (1) Clearly state the circumstances under which the assisted living facility provides care for medicaid eligible residents and for residents who become eligible for medicaid after admission;
- (2) Be provided both orally and in writing in a language that the resident understands;
- (3) Be provided to prospective residents, before they are admitted to the home;
- (4) Be provided to any current residents who were admitted before this requirement took effect or who did not receive copies prior to admission;
- (5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point; and
- (6) Be signed and dated by the resident and be kept in the resident record after signature.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 2 of 7 sampled residents (Resident 3 and Resident 6) received a copy of the facility's policy regarding Medicaid as a payment source, with a signed and dated acknowledgement by the resident. This failure placed Resident 3 and Resident 6 at risk of being discharged and unable to reside in the facility on Medicaid.

Findings included...

Review of the facility's undated policy titled, "Notice of Policy on Medicaid as Payment Source", showed that the facility did not have a contract with the State of Washington to participate in the Medicaid Program. The document stated a resident would need to relocate to another setting in the event that the resident became eligible for Medicaid assistance and unable to fully pay for the cost of the stay and services.

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that as of 07/25/2023, the Assisted Living Facility (ALF) held a current DSHS Medicaid Enhanced Adult Residential Care (EARC) contract.

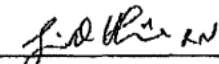
Review of the facility's Characteristic Roster showed that the facility admitted Resident 3 in [REDACTED] 2024 and Resident 6 in [REDACTED] 2024. Review of the facility's records showed no documentation that showed Resident 3 and Resident 6 received and signed the facility's Medicaid policy.

During an interview on 01/07/2024 at 11:31 AM, Staff A, Administrator, Director of Nursing, stated that all the assisted living residents signed the facility's Medicaid notice. Staff A stated that they thought Resident 3 and Resident 6 had signed the Medicaid notice. Staff A stated that they were unable to find Resident 3 and Resident 6's signed Medicaid notice.

Plan/Attestation Statement

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Administrator (or Representative)

01/31/25

Date

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:

(iii) A copy of the report, including the cover letter, and plan of correction of the most recent full inspection conducted by the department.

Findings included...

Review of the facility's undated policy titled, "Notice of Policy on Medicaid as Payment Source", showed that the facility did not have a contract with the State of Washington to participate in the Medicaid Program. The document stated a resident would need to relocate to another setting in the event that the resident became eligible for Medicaid assistance and unable to fully pay for the cost of the stay and services.

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that as of 07/25/2023, the Assisted Living Facility (ALF) held a current DSHS Medicaid Enhanced Adult Residential Care (EARC) contract.

Review of the facility's Characteristic Roster showed that the facility admitted Resident 3 in [REDACTED] 2024 and Resident 6 in [REDACTED] 2024. Review of the facility's records showed no documentation that showed Resident 3 and Resident 6 received and signed the facility's Medicaid policy.

During an interview on 01/07/2024 at 11:31 AM, Staff A, Administrator, Director of Nursing, stated that all the assisted living residents signed the facility's Medicaid notice. Staff A stated that they thought Resident 3 and Resident 6 had signed the Medicaid notice. Staff A stated that they were unable to find Resident 3 and Resident 6's signed Medicaid notice.

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Date

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:

(iii) A copy of the report, including the cover letter, and plan of correction of the most recent full inspection conducted by the department.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility failed to post 1 of 1 Department of Social and Health Services full inspection report (June 2023 report) in a visible location within the facility premises. This failure placed all 58 residents at risk of being uninformed of any facility deficiencies.

Finding Included...

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that DSHS last completed a full inspection at the assisted living facility in June 2023.

Observations on 12/17/2024 between 9:00 AM and 3:00 PM and on 12/18/2024 between 9:00 AM and 10:00 AM, showed there was no copy of the June 2023 inspection report posted anywhere on the assisted living premises. Observation on 12/18/2024 at 10:00 AM showed the DSHS June 2023 full inspection report was kept inside a binder. Observation showed the binder that contained the inspection report was embedded with other binders behind the front desk. The binder was not visible to other people. Observation showed no sign posted at the front desk that informed others that the most recent full inspection report was kept there.

During an interview on 12/18/2024 at 10:00 AM, Staff Y, Resources Nurse/Registered Nurse Delegator, stated that the facility maintained the Department's letters in a binder and kept the binder behind the front desk. Staff Y stated they were aware that the facility was required to post the most recent inspection report in a conspicuous place. Staff Y stated that they did not know why they kept the binder behind the front desk.

During the resident group meeting on 12/18/2024 at 1:00 PM, several anonymous residents stated that they were unable to find the most recent DSHS full inspection anywhere in the facility. The residents stated that they wanted to know when the last full inspection was and what the inspection results were.

Plan/Attestation Statement

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J. D. H. - RN

Administrator (or Representative)

01/31/25

Date

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility failed to post 1 of 1 Department of Social and Health Services full inspection report (June 2023 report) in a visible location within the facility premises. This failure placed all 58 residents at risk of being uninformed of any facility deficiencies.

Finding included...

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that DSHS last completed a full inspection at the assisted living facility in June 2023.

Observations on 12/17/2024 between 9:00 AM and 3:00 PM and on 12/18/2024 between 9:00 AM and 10:00 AM, showed there was no copy of the June 2023 inspection report posted anywhere on the assisted living premises. Observation on 12/18/2024 at 10:00 AM showed the DSHS June 2023 full inspection report was kept inside a binder. Observation showed the binder that contained the inspection report was embedded with other binders behind the front desk. The binder was not visible to other people. Observation showed no sign posted at the front desk that informed others that the most recent full inspection report was kept there.

During an interview on 12/18/2024 at 10:00 AM, Staff Y, Resources Nurse/Registered Nurse Delegator, stated that the facility maintained the Department's letters in a binder and kept the binder behind the front desk. Staff Y stated they were aware that the facility was required to post the most recent inspection report in a conspicuous place. Staff Y stated that they did not know why they kept the binder behind the front desk.

During the resident group meeting on 12/18/2024 at 1:00 PM, several anonymous residents stated that they were unable to find the most recent DSHS full inspection anywhere in the facility. The residents stated that they wanted to know when the last full inspection was and what the inspection results were.

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Date

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

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure the water temperature in 3 of 7 sampled resident apartments (Resident 3, Resident 6, and Resident 7) bathroom and kitchen sinks measured no higher than 120 degrees Fahrenheit (F). This failure placed Resident 3, Resident 6, and Resident 7 at risk of burns from scalding water and diminished quality of life.

Finding included...

RESIDENT 3

Observation on 12/20/2024 at 2:00 PM showed the hot water temperature in Resident 4's bathroom sink measured 133 degrees F, 13 degrees above the highest temperature allowed. Observation showed the hot water temperature in Resident 4's kitchen sink measured 131 degrees F, 11 degrees above the highest temperature allowed.

RESIDENT 6

Observation on 12/20/2024 at 11:22 AM showed the hot water temperature in Resident 6's bathroom measured 138 degrees F, 18 degrees above the highest temperature allowed.

RESIDENT 7

Observation on 12/18/2024 at 2:42 PM showed the hot water temperature in Resident 7's bathroom measured 139 degrees F, 19 degrees above the highest temperature allowed.

During an interview on 12/23/2024 at 3:00 PM, Staff BB, Maintenance Supervisor, stated that they were unaware the water temperature in some residents' rooms measured above the required 120 degrees F. Staff BB stated that the facility's water boiler was in the middle of the building. Staff BB stated that there were variations of water temperatures throughout the facility. Staff BB stated that the water temperatures of apartments closer to the boiler were higher and the water temperature of those apartments farther down the hall from the boiler were lower.

This document was prepared by Residential Care Services for the Locator website.

Plan/Attestation Statement

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J. D. H. and
Administrator (or Representative)

01/31/25
Date

WAC 388-78A-3010 Resident units. The assisted living facility resident units must have the following:

(8) Miscellaneous: Each sleeping room must have:

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility failed to provide lockable storage in 40 of 101 sampled apartments (Apartments 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 229, 230, 231, 232, 233, 234, 236, 237, 238, 239, 240/242, 241, 243, 244/246, 245, 247, 248, 249, and 250). This failure placed all 39 residents who resided in those apartments at risk of financial exploitation from potential theft of personal items not kept in locked storage.

Findings included...

Observation between 12/17/2024 and 01/06/2025 showed that the facility remodeled 40 apartments (Apartments 101 through 121 and 229 through 250). Observation of the 40 remodeled apartments on 01/06/2025 showed there was no lockable storage area, as required. The facility's Characteristic Roster showed 39 residents resided in the remodeled apartments.

Observation of Resident 7's apartment on 12/18/2024 at 2:42 PM showed no lockable storage. During an interview at this time, Resident 7 stated that since they moved into the apartment, they were not provided with any lockable storage. Resident 7 stated that they preferred to have lockable storage to store their personal belongings.

Observation of Resident 3's apartment on 12/20/2024 at 2:00 PM, showed no lockable storage. During an interview at that time, Resident 3 stated that they were not provided with any lockable storage. Resident 3 stated that they would like to have a lockable storage to secure their personal items.

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)_____.

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(8) Miscellaneous: Each sleeping room must have:

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility failed to provide lockable storage in 40 of 101 sampled apartments (Apartments 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 229, 230, 231, 232, 233, 234, 236, 237, 238, 239, 240/242, 241, 243, 244/246, 245, 247, 248, 249, and 250). This failure placed all 39 residents who resided in those apartments at risk of financial exploitation from potential theft of personal items not kept in locked storage.

Findings included...

Observation between 12/17/2024 and 01/06/2025 showed that the facility remodeled 40 apartments (Apartments 101 through 121 and 229 through 250). Observation of the 40 remodeled apartments on 01/06/2025 showed there was no lockable storage area, as required. The facility's Characteristic Roster showed 39 residents resided in the remodeled apartments.

Observation of Resident 7's apartment on 12/18/2024 at 2:42 PM showed no lockable storage. During an interview at this time, Resident 7 stated that since they moved into the apartment, they were not provided with any lockable storage. Resident 7 stated that they preferred to have lockable storage to store their personal belongings.

Observation of Resident 3's apartment on 12/20/2024 at 2:00 PM, showed no lockable storage. During an interview at that time, Resident 3 stated that they were not provided with any lockable storage. Resident 3 stated that they would like to have a lockable storage to secure their personal items.

During an interview on 12/23/2024 at 3:00 PM, Staff A, Administrator, Director of Nursing, stated the facility remodeled the 40 apartments in July 2023. The remodeled apartments were for residents on Medicaid services. Staff A stated that they did not install any lockable storage space in those apartments when the rooms were remodeled.

Plan/Attestation Statement

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J. D. H. R. R. V.

Administrator (or Representative)

01/31/25

Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

- (1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;
- (2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:
 - (a) Departure from the resident's customary range of functioning; or
 - (3) Evaluate, in order to determine if there is a need for further action:
 - (a) The changes identified in the resident per subsection (2) of this section; and
 - (b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.
- (4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to monitor 2 of 2 sampled residents' (Resident 5 and Resident 6) well-being and identify any changes of conditions. This failure placed Resident 5 and Resident 6 at risk of unmet care needs and a decreased quality of life.

Findings included...

During an interview on 12/23/2024 at 3:00 PM, Staff A, Administrator, Director of Nursing, stated the facility remodeled the 40 apartments in July 2023. The remodeled apartments were for residents on Medicaid services. Staff A stated that they did not install any lockable storage space in those apartments when the rooms were remodeled.

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Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

- (1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;
- (2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:
 - (a) Departure from the resident's customary range of functioning; or
 - (3) Evaluate, in order to determine if there is a need for further action:
 - (a) The changes identified in the resident per subsection (2) of this section; and
 - (b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.
- (4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to monitor 2 of 2 sampled residents' (Resident 5 and Resident 6) well-being and identify any changes of conditions. This failure placed Resident 5 and Resident 6 at risk of unmet care needs and a decreased quality of life.

Findings included...

RESIDENT 5

Observation on 12/19/2024 at 12:50 PM, showed a dark purple bruise on Resident 5's skin, on the right breast extending down to the right upper abdomen. Observation showed Resident 5's right elbow was covered with a two-inch by four-inch adhesive dressing. Observation showed the adhesive dressing was soiled with yellowish drainage visible on the dressing and one edge of the dressing was loosened.

Observation on 12/20/2024 at 10:40 AM showed a wound on the Resident 5's right elbow. The wound showed a one-inch by one-and-a-half-inch area of skin loss with light yellowish tissues in the wound bed. There was no bleeding and no discharge from the wound. During an interview at this time, Resident 5 denied any pain and discomfort. Resident 5 stated that they fell several times in the past two weeks, and they were unable to remember what happened that caused the injuries.

Review of Resident 5's records showed that the facility admitted Resident 5 in [REDACTED] 2024. The records showed that on 10/25/2024, the facility completed an assessment for Resident 5. The assessment showed in October 2024, Resident 5's skin was intact. Review of Resident 5's Service Plan, dated 10/25/2024, showed that the facility staff was responsible to monitor skin and to notify the Wellness Director immediately for any skin redness, openings, and abnormality. Review of the Progress Notes, dated between 10/01/2024 and 12/18/2024, showed no documentation the care staff monitored and documented Resident 5's bruise on the body and the wound on the right elbow. There was no documentation that showed the facility's staff provided wound care and dressing change to the right elbow. There was no documentation that showed Resident 5 experienced a significant change in their condition which increased their need for staff assistance with personal care and no documentation of any incidents that caused the injuries.

During an interview on 12/19/2024 at 1:10 PM, Staff E, Caregiver, stated that they worked in the memory care unit. Staff E stated that they did not know when or how Resident 5 got the wound on the right elbow and the bruise on their body. Staff E stated that they first noticed Resident 5's bruise when they came to work a few days ago. Staff E stated that the other staff did not mention any resident incidence and injury at the change of the shifts. Staff E stated that they did not witness what happened to the resident and how the resident got injured. Staff E stated that they did not notify the nurse and did not report the resident's injury to the Department.

During an interview on 12/20/2024 at 7:37 AM, Staff H, Caregiver, Medication Technician, stated that they were unaware of Resident 5's wound on the right elbow and bruise on the body. Staff H stated that they worked mostly as the Medication Aide and on occasions, filled in as the caregiver. Staff H stated that the assigned caregivers assisted Resident 5 with incontinence care, bathing, and dressing. Staff H stated that the last time they assisted Resident 5 with incontinence care was two weeks ago. Staff H stated that two weeks ago when they provided care to Resident 5, they did not notice any bruises or bodily injuries. Staff H stated that they did not know when or how Resident 5 was injured.

During an interview on 12/20/2024 at 11:00 AM, Staff L, Registered Nurse, Wellness Director, stated that care staff were responsible to monitor residents and notify the nurses about any resident's injuries and change of condition. Staff L stated that they were unaware of Resident 5's injuries. Staff L stated that no staff notified them of Resident 5's injuries.

RESIDENT 6

Observation of Resident 6's apartment on 12/20/2024 at 9:27 AM, showed Resident 6 laid in a hospital bed. Observation showed Resident 6 used a nasal cannula (a tube that delivers oxygen) to receive continuous oxygen. Observation showed the nasal cannula was connected to an oxygen concentrator (a device that generates oxygen), which sat on the floor, next to the bed. Observation showed the oxygen concentrator was set to deliver oxygen at two liters per minute. Observation showed two tall oxygen cylinder canisters were stored in the closet. There was no sign posted at the apartment entrance that instructed others that oxygen was in use inside. During an interview at this time, Resident 6 stated that when they were discharged from the hospital in [REDACTED] 2024, they used the oxygen concentrator for oxygen. Resident 6 stated that in November 2024 when the facility experienced power outage, their oxygen concentrator did not operate, and they did not get any oxygen for four hours. Resident 6 stated that during that time, they experienced shortness of breath. Resident stated that when they measured their oxygen level on their own, their oxygen level dropped to 84 percent. Resident 6 stated that they called the care staff for help and their call pendant did not work. Resident 6 stated no staff came to help, so they called 911. Resident 6 stated that when the emergency medical service (EMS) arrived, the paramedics said that the oxygen concentrator had no power. Resident 6 stated that they observed the paramedics plugged in the oxygen concentrator and the oxygen concentrator operated again. Resident 6 stated that the paramedic checked on them. Resident 6 stated that they did not go to the emergency room.

During an interview on 12/19/2024 at 2:10 PM, Staff N, Medication Technician, stated that the facility experienced a power outage between 11/19/2024 and 11/21/2024. Staff N stated that none of the residents' call pendants functioned during the power outage. Staff N stated that they worked on 11/19/2024 and 11/21/2024. Staff N stated that they were unaware Resident 6's oxygen concentrator did not work. Staff N stated that they were unaware Resident 6 experienced shortness of breath and called for EMS assistance.

During an interview on 12/20/2024 at 11:22 AM, Staff F, Medication Aide, stated that they were unaware Resident 6's oxygen concentrator did not work during the power outage. Staff F stated that they were unaware Resident 6 experienced shortness of breath and called for EMS assistance.

During an interview on 12/23/2024 at 3:00 PM, Staff A, Administrator, Director of Nursing, and Staff L, Wellness Director, stated that they worked in the facility during the facility power outage. Staff A and Staff L stated they were unaware Resident 6's oxygen concentrator did not work. Both stated that they were unaware that Resident 6 experienced shortness of breath and called for EMS assistance. Staff A and Staff L stated that care staff were responsible to monitor the resident and notify the nurses of

any residents change of conditions. Staff A and Staff L stated that no staff notified them Resident 6 called for EMS assistance.

During an interview on 12/24/2024 at 8:34 AM, Collateral Contact 1 (CC 1), Medical Services Officer, Redmond Fire Department, stated their records showed that on 11/21/2024 at 1:22 AM, Resident 6 called 911 for "shortness of breath and the oxygen concentrator was not working". CC 1 stated that their records showed the first responders found the oxygen concentrator was out of power. Their records showed the first responders plugged in the oxygen concentrator, turned it on, and the oxygen concentrator operated again. Their records showed Resident 6's oxygen level improved and Resident 6 was not sent the emergency room.

Review of Resident 6's records showed that the facility admitted Resident 6 in [REDACTED] 2024 with a medical diagnosis of [REDACTED].

The records showed that on 11/08/2024, the facility completed an assessment for Resident 6. The assessment showed Resident 6 required use of continuous oxygen at a flow rate of two liters per minute. Review of Resident 6's undated Service Plan, showed that the care staff were responsible to monitor Resident 6 for signs and symptoms of shortness of breath. There was no documentation in the service plan that showed Resident 6 used oxygen and required care assistance with oxygen therapy. Review of the Progress Notes, dated between 10/01/2024 and 12/18/2024, showed no documentation that the care staff monitored and documented Resident 6's oxygen concentrator was out of power. There was no documentation that showed Resident 6 experienced shortness of breath and decreased oxygen level. There was no documentation that showed Resident 6 called 911 for EMS assistance.

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) 02/28/25.

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

J. R. [Signature]
Administrator (or Representative)

01/31/25
Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

any residents change of conditions. Staff A and Staff L stated that no staff notified them Resident 6 called for EMS assistance.

During an interview on 12/24/2024 at 8:34 AM, Collateral Contact 1 (CC 1), Medical Services Officer, Redmond Fire Department, stated their records showed that on 11/21/2024 at 1:22 AM, Resident 6 called 911 for "shortness of breath and the oxygen concentrator was not working". CC 1 stated that their records showed the first responders found the oxygen concentrator was out of power. Their records showed the first responders plugged in the oxygen concentrator, turned it on, and the oxygen concentrator operated again. Their records showed Resident 6's oxygen level improved and Resident 6 was not sent the emergency room.

Review of Resident 6's records showed that the facility admitted Resident 6 in [REDACTED] 2024 with a medical diagnosis of [REDACTED]. The records showed that on 11/08/2024, the facility completed an assessment for Resident 6. The assessment showed Resident 6 required use of continuous oxygen at a flow rate of two liters per minute. Review of Resident 6's undated Service Plan, showed that the care staff were responsible to monitor Resident 6 for signs and symptoms of shortness of breath. There was no documentation in the service plan that showed Resident 6 used oxygen and required care assistance with oxygen therapy. Review of the Progress Notes, dated between 10/01/2024 and 12/18/2024, showed no documentation that the care staff monitored and documented Resident 6's oxygen concentrator was out of power. There was no documentation that showed Resident 6 experienced shortness of breath and decreased oxygen level. There was no documentation that showed Resident 6 called 911 for EMS assistance.

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)_____.

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

Administrator (or Representative)

Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to report 1 of 1 sampled resident's (Resident 5) injury of unknown origin to the Department of Social and Health Services (DSHS) Complaint Resolution Unit (CRU). This failure placed Resident 5 at risk of additional harm and potential abuse and neglect.

Findings included...

Note: WAC 388-78A-2371 states the assisted living facility must: (1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life; (2) determine the circumstances of the event.

Observation on 12/19/2024 at 12:50 PM showed a dark purple bruise on Resident 5's skin, on the right breast extending down to the right upper abdomen. Observation showed Resident 5's right elbow was covered with a two-inch by four-inch adhesive dressing. Observation showed the adhesive dressing was soiled with yellowish drainage visible on the dressing and one edge of the dressing was loosened.

Observation on 12/20/2024 at 10:40 AM showed a wound on the Resident 5's right elbow. The wound showed a one-inch by one-and-a-half-inch area of skin loss with light yellowish tissues in the wound bed. There was no bleeding and no discharge from the wound. During an interview at this time, Resident 5 denied of any pain and discomfort. Resident 5 stated that they fell several times in the past two weeks, and they were unable to remember what happened that caused the injuries.

Review of Resident 5's records showed that the facility admitted Resident 5 in [REDACTED] 2024. Review of the Progress Notes, dated between 10/01/2024 and 12/18/2024, showed no documentation of any bodily injuries. There was no documentation that showed the care staff monitored and documented Resident 5's bruise on the body and the wound on the right elbow. There was no documentation that showed Resident 5 experienced any significant change in their condition and no documentation of any incidents that caused the injuries. There was no documentation that showed the facility investigated the incident to rule out abuse or neglect. There was no documentation that showed the facility reported the incident to the Department.

During an interview on 12/19/2024 at 1:10 PM, Staff E, Caregiver, stated that they worked as a caregiver in the memory care unit. Staff E stated that they did not know when or how Resident 5 got the wound on the right elbow and the bruise on their body. Staff E stated that they first noticed Resident 5's bruise when they came to work a few days ago. Staff E stated that the other staff did not mention any resident incidence and injury at the change of the shifts. Staff E stated that they did not witness what happened to the resident and how the resident got injured. Staff E stated that they did not notify the nurse. Staff E stated that they did not report the resident injury to the Department.

During an interview on 12/20/2024 at 11:00 AM, Staff L, Registered Nurse, Wellness Director, stated that care staff were responsible to monitor residents and notify the nurses about any resident's injuries and change of condition. Staff L stated that they were unaware of Resident 5's injuries. Staff L stated that no staff notified them of Resident 5's injuries.

During an interview on 12/23/2024 at 3:00 PM, Staff L stated that staff did not know the cause of Resident 5's bruise. Staff L stated that staff thought the resident's injury was already reported, so they did not report to the Department, and "that was a mere misunderstanding". Staff L stated that staff did not understand the mandatory reporting policy and procedure, and staff required training.

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) 2/28/25.

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

J. R. H. H. H.
Administrator (or Representative)

1/31/25
Date

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a one-step test for Tuberculosis (TB) for 1 of 7 sampled staff (Staff D) with a history of a negative blood test. This failure placed all 68 residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included...

ONE-STEP TB TEST

STAFF D

Review of the facility's Employee Roster showed that the facility hired Staff D on 07/31/2024. Review of Staff D's employee records showed documentation of an

During an interview on 12/20/2024 at 11:00 AM, Staff L, Registered Nurse, Wellness Director, stated that care staff were responsible to monitor residents and notify the nurses about any resident's injuries and change of condition. Staff L stated that they were unaware of Resident 5's injuries. Staff L stated that no staff notified them of Resident 5's injuries.

During an interview on 12/23/2024 at 3:00 PM, Staff L stated that staff did not know the cause of Resident 5's bruise. Staff L stated that staff thought the resident's injury was already reported, so they did not report to the Department, and "that was a mere misunderstanding". Staff L stated that staff did not understand the mandatory reporting policy and procedure, and staff required training.

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)_____.

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

Administrator (or Representative)

Date

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a one-step test for Tuberculosis (TB) for 1 of 7 sampled staff (Staff D) with a history of a negative blood test. This failure placed all 58 residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included...

ONE-STEP TB TEST
STAFF D

Review of the facility's Employee Roster showed that the facility hired Staff D on 07/31/2024. Review of Staff D's employee records showed documentation of an

This document was prepared by Residential Care Services for the Locator website.

Interferon Gamma Release Assays [(IGRA) blood test], dated 11/30/2023, with negative results. Review of Staff D's employee record showed no documentation Staff D completed a one-step TB test upon hire, as required.

During an interview on 12/19/2024 at 2:00 PM, Staff Q, Business Office Manager, stated that they thought that since Staff D received an IGRA within 12 months of hire, Staff D was not required to complete any further TB test.

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) 2/28/25.

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

[Signature]
Administrator (or Representative)

1/31/25
Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 7 sampled residents (Resident 4) adjustable electric hospital bed was in good repair and functioned. This failure placed Resident 4 at risk for limited bed mobility with potential for skin breakdown, emotional distress, and a diminished quality of life.

RESIDENT 4

Review of the facility's Assisted Living Residents Characteristic Roster showed that the facility admitted Resident 4 in [REDACTED] of 2024. The roster showed Resident 4's diagnoses included [REDACTED]

and [REDACTED]

Observation of Resident 4's apartment on 12/19/2024 at 1:33 PM, showed a transfer pole positioned next to an adjustable electric hospital bed. Observation showed Resident 4 communicated with hand gestures, facial expressions, and a communication board. During an interview at this time, Resident 4 communicated that the electric hospital bed did not work. Resident 4 communicated that they were unable to reposition

Interferon Gamma Release Assays [(IGRA) blood test], dated 11/30/2023, with negative results. Review of Staff D's employee record showed no documentation Staff D completed a one-step TB test upon hire, as required.

During an interview on 12/19/2024 at 2:00 PM, Staff Q, Business Office Manager, stated that they thought that since Staff D received an IGRA within 12 months of hire, Staff D was not required to complete any further TB test.

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)_____.

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

Administrator (or Representative)

Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 7 sampled residents (Resident 4) adjustable electric hospital bed was in good repair and functioned. This failure placed Resident 4 at risk for limited bed mobility with potential for skin breakdown, emotional distress, and a diminished quality of life.

RESIDENT 4

Review of the facility's Assisted Living Residents Characteristic Roster showed that the facility admitted Resident 4 in _____ of 2024. The roster showed Resident 4's diagnoses included _____

_____ and _____

Observation of Resident 4's apartment on 12/19/2024 at 1:33 PM, showed a transfer pole positioned next to an adjustable electric hospital bed. Observation showed Resident 4 communicated with hand gestures, facial expressions, and a communication board. During an interview at this time, Resident 4 communicated that the electric hospital bed did not work. Resident 4 communicated that they were unable to reposition

themselves in bed because the electric component of the bed did not work. Observation showed the electrical bed was plugged in and when the controls were activated to adjust the bed, the bed did not move.

During the interview on 12/19/2024 at 1:33 PM, Resident 4's representative, Collateral Contact 2 (CC2), stated that the facility provided the electrical hospital bed when Resident 4 initially moved into the facility. CC2 stated that the electric bed never worked. CC2 stated that they notified the facility maintenance and administrative staff of the broken bed and were told it would be fixed. CC2 stated that nothing happened to fix the bed. CC2 stated that they were afraid to make too much of a fuss out of fear Resident 4 would be asked to leave.

Review of Resident 4's Service Plan, dated 05/10/2024 and revised on 12/17/2024, showed Resident 4 was non-ambulatory. There was no documentation in the service plan that showed Resident 4 used an adjustable, electric hospital bed.

Review of Resident 4's Occupational Therapy visit summary, dated 11/22/2024, documented that Resident 4 needed the hospital bed fixed, that the head of bed did not go up. The visit summary documented a note that requested maintenance to fix hospital bed, the head elevation feature did not work.

During an interview on 12/19/2024 between 3:00 PM and 4:00 PM, Staff A, Administrator, stated that they were unaware that Resident 4's electric hospital bed was broken. Staff A stated that the bed would be fixed soon.

Observation on 01/06/2024 in Resident 4's apartment, with Resident 4 and Staff A, between 9:00 AM and 10:00 AM, showed Resident 4's adjustable electric bed was not operable and would not adjust when the electric control was activated.

During an interview on 01/06/2024 between 9:00 AM and 10:00 AM, Resident 4 shook their head when asked if the electric bed worked. Staff A stated that they were not aware Resident 4's electric bed was still broken and did not work.

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) 2/28/25.

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

themselves in bed because the electric component of the bed did not work. Observation showed the electrical bed was plugged in and when the controls were activated to adjust the bed, the bed did not move.

During the interview on 12/19/2024 at 1:33 PM, Resident 4's representative, Collateral Contact 2 (CC2), stated that the facility provided the electrical hospital bed when Resident 4 initially moved into the facility. CC2 stated that the electric bed never worked. CC2 stated that they notified the facility maintenance and administrative staff of the broken bed and were told it would be fixed. CC2 stated that nothing happened to fix the bed. CC2 stated that they were afraid to make too much of a fuss out of fear Resident 4 would be asked to leave.

Review of Resident 4's Service Plan, dated 05/10/2024 and revised on 12/17/2024, showed Resident 4 was non-ambulatory. There was no documentation in the service plan that showed Resident 4 used an adjustable, electric hospital bed.

Review of Resident 4's Occupational Therapy visit summary, dated 11/22/2024, documented that Resident 4 needed the hospital bed fixed, that the head of bed did not go up. The visit summary documented a note that requested maintenance to fix hospital bed, the head elevation feature did not work.

During an interview on 12/19/2024 between 3:00 PM and 4:00 PM, Staff A, Administrator, stated that they were unaware that Resident 4's electric hospital bed was broken. Staff A stated that the bed would be fixed soon.

Observation on 01/06/2024 in Resident 4's apartment, with Resident 4 and Staff A, between 9:00 AM and 10:00 AM, showed Resident 4's adjustable electric bed was not operable and would not adjust when the electric control was activated.

During an interview on 01/06/2024 between 9:00 AM and 10:00 AM, Resident 4 shook their head when asked if the electric bed worked. Staff A stated that they were not aware Resident 4's electric bed was still broken and did not work.

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)_____.

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

J. M. Brown
Administrator (or Representative)

01/31/25
Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to implement 3 of 3 sampled residents' (Resident 6, Resident 8, and Resident 12) Negotiated Service Agreements (Service Plan). This failure placed Resident 6, Resident 8, and Resident 12 at risk for not having their needs met.

Findings included...

RESIDENT 6

During an interview on 12/20/2024 at 9:27 AM, Resident 6 stated that they needed a bath. Resident 6 stated that they had not received a shower for weeks. Resident 6 stated that they were unable to independently sit up and take a shower. Resident 6 stated that the facility did not provide them a sponge bath or a bed bath as alternatives for a shower.

Review of Resident 6's record showed that the facility admitted Resident 6 in [REDACTED] 2024. The records showed Resident 6's physician orders included daily weight checks due to Congestive Heart Failure (condition where the heart is unable to pump enough blood to the body's organs). The records showed that on 11/08/2024, the facility completed Resident 6's assessment. The assessment showed Resident 6 required assistance with bathing and showering. Review of Resident 6's undated Service Plan, showed that facility staff were responsible to provide Resident 6 physical assistance with bathing one time per week. Review of the Progress notes between 10/01/2024 and 12/18/2024 showed no documentation that the facility provided Resident 6 with bathing assistance. There was no documentation that showed Resident 6 was offered the bathing assistance and no documentation that Resident 6 refused.

Review of Resident 6's October 2024, November 2024, and December 2024 Medication Administration Records (MARs) showed that the facility staff were responsible to weigh Resident 6 every day. The MARs showed no documentation of Resident 6's body weights on 74 of 79 days in October 2024, November 2024, and December 2024. The MARs showed on 29 of the 79 days, Resident was absent from the facility. The MARs showed on 14 of the 79 days, Resident 6 refused to be weighed. The MARs showed 31

_____ Administrator (or Representative)	_____ Date
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WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to implement 3 of 3 sampled residents' (Resident 6, Resident 8, and Resident 12) Negotiated Service Agreements (Service Plan). This failure placed Resident 6, Resident 8, and Resident 12 at risk for not having their needs met.

Findings included...

RESIDENT 6

During an interview on 12/20/2024 at 9:27 AM, Resident 6 stated that they needed a bath. Resident 6 stated that they had not received a shower for weeks. Resident 6 stated that they were unable to independently sit up and take a shower. Resident 6 stated that the facility did not provide them a sponge bath or a bed bath as alternatives for a shower.

Review of Resident 6's record showed that the facility admitted Resident 6 in [REDACTED] 2024. The records showed Resident 6's physician orders included daily weight checks due to Congestive Heart Failure (condition where the heart is unable to pump enough blood to the body's organs). The records showed that on 11/08/2024, the facility completed Resident 6's assessment. The assessment showed Resident 6 required assistance with bathing and showering. Review of Resident 6's undated Service Plan, showed that facility staff were responsible to provide Resident 6 physical assistance with bathing one time per week. Review of the Progress notes between 10/01/2024 and 12/18/2024 showed no documentation that the facility provided Resident 6 with bathing assistance. There was no documentation that showed Resident 6 was offered the bathing assistance and no documentation that Resident 6 refused.

Review of Resident 6's October 2024, November 2024, and December 2024 Medication Administration Records (MARs) showed that the facility staff were responsible to weigh Resident 6 every day. The MARs showed no documentation of Resident 6's body weights on 74 of 79 days in October 2024, November 2024, and December 2024. The MARs showed on 29 of the 79 days, Resident was absent from the facility. The MARs showed on 14 of the 79 days, Resident 6 refused to be weighed. The MARs showed 31

of the 79 days, the facility did not weigh Resident 6 due to Resident 6 sleeping.

During an interview on 01/09/2025, Staff A, Administrator, Director of Nursing, stated that Resident 6 received weigh daily in October 2024 until the resident was admitted to the hospital for a month. Staff A stated that when they returned to the facility, Resident 6 became bed bounded. Staff A stated that Resident 6 pretty much refused to be weigh. Staff A stated that the MARs documented why Resident 6 was not weighed for each day.

RESIDENT 8

Review of the facility's policy titled, "Smoking Policy", dated 04/01/2022, showed that the facility provided a safe environment for all residents in regards to upholding the rights of resident to smoke if they desire. The policy showed that smoking of any kind was not allowed within the facility. The policy showed that upon admission, a resident would be interviewed to determine if they smoke. A smoking evaluation would be performed by the Wellness Director to determine if the resident was able to smoke safely in the designated smoking area. The policy showed that the results of the evaluation was to be discussed with the resident/responsible party and placed in the resident's record. The policy showed the service plan would be updated. The policy showed that the facility reserved the right to immediately confiscate smoking materials as well as rescind the resident's smoking privileges if failing to take such measures would jeopardize resident safety. The policy showed that a non-compliant resident would receive a thirty-day notice of eviction and for egregious safety risks, eviction may occur sooner than 30 days.

Review of Resident 8's Negotiated Service Plan dated 09/16/2024, showed the facility admitted Resident 8 in [REDACTED] of 2024 and readmitted Resident 8 in [REDACTED] of 2024 after a 30-day absence.

Review of Resident 8's service plan, dated 04/16/2024, showed that Resident 8 went out to the designated smoking area daily to smoke and independently managed their smoking. The service plan showed that staff maintained Resident 8's smoking materials in a designated, secured area. The service plan showed that when Resident 8 wanted to smoke, Resident 8's smoking material was provided to them by the Medication Technician (unlicensed staff who dispense medications).

During an interview on 12/23/2024 at 10:22 AM, Resident 9 stated they lived across from Resident 8's apartment. Resident 9 complained that Resident 8 often smoked in their apartment, rather than go outside to the designated smoking area. Resident 9 stated that the smoke would enter their apartment which they shared with their spouse, Resident 10. Resident 9 stated that the smoke irritated their eyes and the smell bothered them. Resident 9 stated that they complained to the staff and their concerns were ignored.

During an interview on 12/23/2024 at 10:23 AM, Resident 11, stated that they live next door to Resident 8. Resident 11 stated that Resident 8 frequently smoked cigarettes in

their apartment. Resident 11 stated that the cigarette smoke was strong and bothered them.

During an interview on 12/23/2024 at 1:11 PM, Resident 9 and Resident 10 both stated that the cigarette smoke from Resident 8's apartment entered their apartment under the entrance door and caused their eyes to water. Resident 10 stated they have difficulty breathing and the cigarette smoke aggravated their condition. Resident 9 and Resident 10 stated that they were concerned Resident 8's cigarette smoking could cause a fire and jeopardize all the residents and staff safety.

During an interview on 12/23/2024 at 1:20 PM, Resident 11 stated that Resident 8 often smoked in their apartment because the smoke would enter Resident 11's room. Resident 11 stated that they were a former smoker and was able to identify cigarette smoke. Resident 11 stated that they opened their window for fresh air and was forced to close the window whenever Resident 8 smoked cigarettes in their apartment, because the cigarette smoke entered their apartment through the window. Resident 11 stated that they notified staff about Resident 8's cigarette smoking. Resident 11 stated that the staff ignored the issue, and no one has addressed the problem with Resident 8. Resident 11 stated they were concerned that Resident 8 could start a fire, risking the safety of all the residents.

Observation of Resident 8's apartment on 12/23/2024 at 10:54 AM, showed tobacco strewn all over the floor in front of Resident 8's desk. Observation showed Resident 8's window was open, and a fan located on a chair in front of the window, blew air out of the room. Observation showed blackened cigarette ashes covered the white windowsill and the window track of the open window. Ashes and burnt cigarette butts were observed on the windowsill and laminate floor. A cigarette lighter was observed on the floor next to the window. The apartment smelled of strong, distinct cigarette smoke.

During an interview on 12/23/2024 at 10:54 AM, Resident 8 denied smoking in their apartment. Resident 8 stated they rolled their own cigarettes at the desk which was why unused tabaco was strew all over the floor.

Observation of Resident 8's apartment and interview on 12/23/2024 at 11:00 AM, Staff BB, Maintenance Supervisor, stated Resident 8 was not allowed to smoke in the apartment. Staff BB observed the cigarette ashes on the windowsill, floor, and the fan and cigarette lighter. Staff BB stated that it was obvious that Resident 8 smoked in the apartment. At 11:15 AM, observation showed Staff BB immediately directed a facility housekeeper to clean the apartment floor, windowsill, and remove the fan and cigarette lighter.

Observation on 12/23/2024 at 11:24 AM showed Staff A, Executive Director, in Resident 8's apartment, speaking with Staff BB about the cigarette ashes, butts, fan, and cigarette lighter. Observation showed that the cigarette debris was cleaned up and the fan and lighter removed. During an interview at this time, Staff A stated that Resident 8 rolled their own cigarettes and knew not to smoke in their apartment. Staff A stated

that Resident 8 used the outside designated smoking area to smoke. Staff A stated they were unaware Resident 8 possessed a cigarette lighter. Staff A stated that they thought Resident 8 needed to request a cigarette lighter from the staff.

Observation on 12/23/2024 at 5:00 PM, showed Resident 8 sat in a wheelchair, under the entrance breezeway canopy, in front of several windows, smoking. Observation showed the designated smoking area was across the parking lot, away from the entrance. The designated smoking area was equipped with a canopy to provide cover from the rain. Observation showed several other residents smoking in the designated area.

Observation of Resident 8's apartment on 01/06/2025 at 10:32 AM, showed unused tobacco strewn on the floor in front of Resident 's desk. Observation showed several rolled cigarettes in a container on top of the desk. Observation showed the window was closed and brown stained marks were on the windowsill.

During an interview on 01/06/2025 at 10:32 AM, Staff A stated that Resident 8 smoked outside only. Staff A denied Resident 8 smoked in their apartment.

RESIDENT 12

Observation of the memory care unit between 12/17/2024 and 12/23/2024 showed no emergency call device in the corridors and common areas. Observation of Resident 12's room on 12/23/2024 at 10:50 AM, showed no emergency call device in the bathroom, the living room, and the sleeping area. Observation showed Resident 12 did not have a call pendant.

Review of Resident 12's records showed that the facility admitted Resident 12 in [REDACTED] 2024. The records showed that on 09/07/2024, the facility completed Resident 12's assessment. Review of Resident 12's Service Plan, dated 06/01/2024, showed that Resident 12 was at risk of falls and wore an emergency call pendant.

During an interview on 12/23/2024 at 3:00 PM, Staff L, Registered Nurse, Wellness Director, stated that they did not install any emergency call device in the residents' rooms and in the common areas in the memory care unit. Staff L stated that they provided a call pendant to Resident 12. Staff L stated that they were unaware Resident 12 did not have a call pendant.

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) 2/28/25.

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

that Resident 8 used the outside designated smoking area to smoke. Staff A stated they were unaware Resident 8 possessed a cigarette lighter. Staff A stated that they thought Resident 8 needed to request a cigarette lighter from the staff.

Observation on 12/23/2024 at 5:00 PM, showed Resident 8 sat in a wheelchair, under the entrance breezeway canopy, in front of several windows, smoking. Observation showed the designated smoking area was across the parking lot, away from the entrance. The designated smoking area was equipped with a canopy to provide cover from the rain. Observation showed several other residents smoking in the designated area.

Observation of Resident 8's apartment on 01/06/2025 at 10:32 AM, showed unused tobacco strewn on the floor in front of Resident 's desk. Observation showed several rolled cigarettes in a container on top of the desk. Observation showed the window was closed and brown stained marks were on the windowsill.

During an interview on 01/06/2025 at 10:32 AM, Staff A stated that Resident 8 smoked outside only. Staff A denied Resident 8 smoked in their apartment.

RESIDENT 12

Observation of the memory care unit between 12/17/2024 and 12/23/2024 showed no emergency call device in the corridors and common areas. Observation of Resident 12's room on 12/23/2024 at 10:50 AM, showed no emergency call device in the bathroom, the living room, and the sleeping area. Observation showed Resident 12 did not have a call pendant.

Review of Resident 12's records showed that the facility admitted Resident 12 in [REDACTED] 2024. The records showed that on 09/07/2024, the facility completed Resident 12's assessment. Review of Resident 12's Service Plan, dated 06/01/2024, showed that Resident 12 was at risk of falls and wore an emergency call pendant.

During an interview on 12/23/2024 at 3:00 PM, Staff L, Registered Nurse, Wellness Director, stated that they did not install any emergency call device in the residents' rooms and in the common areas in the memory care unit. Staff L stated that they provided a call pendant to Resident 12. Staff L stated that they were unaware Resident 12 did not have a call pendant.

Plan/Attestation Statement

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<u><i>L. R. H. RN</i></u> Administrator (or Representative)	<u>01/31/25</u> Date
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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:

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure all nurse delegation services were followed for 6 of 6 insulin dependent sampled residents (Resident 11, Resident 13, Resident 14, Resident 15, Resident 16, and Resident 17). This failure placed Resident 11, Resident 13, Resident 14, Resident 15, Resident 16, and Resident 17 at risk of harm and compromised health from potential medication errors from unsupervised delegated staff.

Findings included...

NOTE: WAC 246-840-930, Criteria for delegation

(12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes:

(l) Document teaching done and a return demonstration, or other method for verification of competency; and

(m) Supervision shall occur at least every 90 days. With delegation of insulin injections, the supervision occurs at least every two weeks for the first four weeks and may be more frequent.

(19) The registered nurse must supervise and evaluate the performance of the nursing assistant or home care aide with delegated insulin injection authority at least every two weeks for the first four weeks. After the first four weeks the supervision shall occur at least every 90 days.

NURSE DELEGATION DIABETIC MONITORING

Review of the facility's Registered Nurse Delegation binder showed six Department of Social and Health Services (DSHS) "Nurse Delegation: Nursing Visit" forms for Resident 11, Resident 13, Resident 14, Resident 15, Resident 16, and Resident 17. Review of the forms showed that all six residents received nurse delegation services for insulin administration. Review of the nurse delegation binder showed that 11 facility staff (Staff B, Staff C, Staff D, Staff F, Staff H, Staff K, Staff M, Staff R, Staff W, Staff DD, and Staff FF), were delegated by the facility's Registered Nurse Delegator (RND) to administer insulin injections. The Nurse Delegation binder showed no documentation or other forms of verification from Staff Y, Registered Nurse, Resource Nurse, RND, that showed the 11 staff delegated to administer insulin were supervised, and their performance evaluated every two weeks for the first four weeks after the initial delegation, as required per WAC

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure all nurse delegation services were followed for 6 of 6 insulin dependent sampled residents (Resident 11, Resident 13, Resident 14, Resident 15, Resident 16, and Resident 17). This failure placed Resident 11, Resident 13, Resident 14, Resident 15, Resident 16, and Resident 17 at risk of harm and compromised health from potential medication errors from unsupervised delegated staff.

Findings included...

NOTE: WAC 246-840-930, Criteria for delegation

(12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes:

(l) Document teaching done and a return demonstration, or other method for verification of competency; and

(m) Supervision shall occur at least every 90 days. With delegation of insulin injections, the supervision occurs at least every two weeks for the first four weeks and may be more frequent.

(19) The registered nurse must supervise and evaluate the performance of the nursing assistant or home care aide with delegated insulin injection authority at least every two weeks for the first four weeks. After the first four weeks the supervision shall occur at least every 90 days.

NURSE DELEGATION DIABETIC MONITORING

Review of the facility's Registered Nurse Delegation binder showed six Department of Social and Health Services (DSHS) "Nurse Delegation: Nursing Visit" forms for Resident 11, Resident 13, Resident 14, Resident 15, Resident 16, and Resident 17. Review of the forms showed that all six residents received nurse delegation services for insulin administration. Review of the nurse delegation binder showed that 11 facility staff (Staff B, Staff C, Staff D, Staff F, Staff H, Staff K, Staff M, Staff R, Staff W, Staff DD, and Staff FF, were delegated by the facility's Registered Nurse Delegator (RND) to administer insulin injections. The Nurse Delegation binder showed no documentation or other forms of verification from Staff Y, Registered Nurse, Resource Nurse, RND, that showed the 11 staff delegated to administer insulin were supervised, and their performance evaluated every two weeks for the first four weeks after the initial delegation, as required per WAC

246-840-930.

Review of Washington Administrative Code 388-78A-2020 Definitions showed that the definition of documentation as "document means to record, with signature, title, date, and time: information about medication administration, medication assistance or nursing care procedure, and processes that are required by law, rule, or policy".

During an interview on 12/18/2023 at 10:34 AM, Staff Y stated that they used a process to teach insulin delegation administration for new staff. During the process, Staff Y educated and instructed the new staff on insulin administration, demonstrated how to dial the pen and administer the insulin step by step, and observation of the new staff completing a return demonstration. Staff Y stated that a follow-up visit occurred every 90 days to review the delegation process for each staff member and resident. Staff Y stated that they were unaware that after the initial delegation for insulin, a follow-up visit was required to supervise and evaluate the new delegated staff every two weeks for the first four weeks.

Plan/Attestation Statement

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

f. R. H. n. w.

Administrator (or Representative)

01/31/25

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 record review and interview, the facility failed to submit background checks within one business day after hire for 6 of 16 sampled staff (Staff I, Staff J, Staff P, Staff T, Staff U, and Staff V). This failure placed all 58 residents at risk for abuse and neglect from staff with unknown backgrounds.

Findings included...

246-840-930.

Review of Washington Administrative Code 388-78A-2020 Definitions showed that the definition of documentation as "document means to record, with signature, title, date, and time: information about medication administration, medication assistance or nursing care procedure, and processes that are required by law, rule, or policy".

During an interview on 12/18/2023 at 10:34 AM, Staff Y stated that they used a process to teach insulin delegation administration for new staff. During the process, Staff Y educated and instructed the new staff on insulin administration, demonstrated how to dial the pen and administer the insulin step by step, and observation of the new staff completing a return demonstration. Staff Y stated that a follow-up visit occurred every 90 days to review the delegation process for each staff member and resident. Staff Y stated that they were unaware that after the initial delegation for insulin, a follow-up visit was required to supervise and evaluate the new delegated staff every two weeks for the first four weeks.

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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 record review and interview, the facility failed to submit background checks within one business day after hire for 6 of 16 sampled staff (Staff I, Staff J, Staff P, Staff T, Staff U, and Staff V). This failure placed all 58 residents at risk for abuse and neglect from staff with unknown backgrounds.

Findings included...

This document was prepared by Residential Care Services for the Locator website.

STAFF I

Review of the facility's employee roster showed that the facility hired Staff I on 09/01/2024 as a Dietary Aide. Review of Staff I's employee record showed the facility completed a background check on 12/19/2024, 109 days after hire.

STAFF J

Review of the facility's employee roster showed that the facility hired Staff J on 11/26/2024 as a Caregiver. Review of Staff J's employee record showed the facility completed a background check on 12/19/2024, 23 days after date of hire.

STAFF P

Review of the facility's employee roster showed that the facility hired Staff P on 03/08/2024 as a Caregiver. Review of Staff P's employee record showed the facility completed a background check on 03/16/2024, nine days after hire.

STAFF T

Review of the facility's employee roster showed that the facility hired Staff T, Bus Driver/Maintenance, Staff, on 10/03/2024. Review of Staff T's record showed that the facility completed a BGI on 10/21/2024, 17 days after date of hire.

STAFF U

Review of the facility's employee roster showed that the facility hired Staff U, Housekeeper, on 01/03/2024. Review of Staff U's records showed that the facility completed a BGI on 01/23/2024, 20 days after date of hire.

STAFF V

Review of the facility's employee roster showed that the facility hired Staff V, Dietary Aide, on 11/06/2024. Review of Staff V's records showed that the facility completed a BGI on 11/12/2024, six days after date of hire.

During an interview on 12/19/2024 at 2:00 PM, Staff Q, Business Office Manager, stated that the previous business office manager did not ensure background checks were completed within the time frame required. Staff Q stated that they discovered several recently hired staff background checks were missed.

Plan/Attestation Statement

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Review of the facility's employee roster showed that the facility hired Staff I on 09/01/2024 as a Dietary Aide. Review of Staff I's employee record showed the facility completed a background check on 12/19/2024, 109 days after hire.

STAFF J

Review of the facility's employee roster showed that the facility hired Staff J on 11/26/2024 as a Caregiver. Review of Staff J's employee record showed the facility completed a background check on 12/19/2024, 23 days after date of hire.

STAFF P

Review of the facility's employee roster showed that the facility hired Staff P on 03/06/2024 as a Caregiver. Review of Staff P's employee record showed the facility completed a background check on 03/15/2024, nine days after hire.

STAFF T

Review of the facility's employee roster showed that the facility hired Staff T, Bus Driver/Maintenance, Staff, on 10/03/2024. Review of Staff T's record showed that the facility completed a BGI on 10/21/2024, 17 days after date of hire.

STAFF U

Review of the facility's employee roster showed that the facility hired Staff U, Housekeeper, on 01/03/2024. Review of Staff U's records showed that the facility completed a BGI on 01/23/2024, 20 days after date of hire.

STAFF V

Review of the facility's employee roster showed that the facility hired Staff V, Dietary Aide, on 11/06/2024. Review of Staff V's records showed that the facility completed a BGI on 11/12/2024, six days after date of hire.

During an interview on 12/19/2024 at 2:00 PM, Staff Q, Business Office Manager, stated that the previous business office manager did not ensure background checks were completed within the time frame required. Staff Q stated that they discovered several recently hired staff background checks were missed.

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<u><i>J. R. H. nn</i></u>	<u>01/31/25</u>
Administrator (or Representative)	Date

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(e) Ensure all resident care and services are provided only by staff persons who have the training, credentials, experience and other qualifications necessary to provide the care and services;

This requirement was not met as evidenced by:

Based on interview, and record review the facility failed to ensure that 1 of 8 sampled staff (Staff W) was qualified to work with vulnerable adult residents. This failure placed all 58 residents at risk for receiving care from an unqualified staff.

Findings included...

Review of the facility's Assisted Living Certified Nursing Assistant (CNA) job description showed that CNAs provided assigned residents with routine daily nursing care and services in accordance with the resident's assessment and care plan. The job description showed that the education qualifications required the staff to graduate from an accredited CNA program and must possess an active CNA certificate valid in the state of Washington.

Review of the facility Assisted Living Medication Aide (Tech) job description showed the position qualifications required completion of a state approved Caregiver program and possess a Registered Nurse approved, Medication Administration Delegation as required by state regulation.

STAFF W

Review of the facility's Employee Roster showed that the facility hired Staff W, Nursing Assistant Registered, Staffing Coordinator, on 08/05/2024. Review of Registered Nurse Delegation binder showed Staff W was delegated to administer medications, which included Insulin. Review of Staff W's employee record showed that as of 12/23/2024, 140 days after hire, there was no documentation that showed Staff W completed the Home Care Aide certification or the Certified Nursing Assistant program.

During an interview on 12/20/2024 at 10:00 AM, Staff Q, Business Office Manager, stated that they were sure Staff W completed the Nursing Assistant Certified program.

Review of the Washington State Provider Credential Search Website 12/23/2024 and...

_____ Administrator (or Representative)	_____ Date
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WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(e) Ensure all resident care and services are provided only by staff persons who have the training, credentials, experience and other qualifications necessary to provide the care and services;

This requirement was not met as evidenced by:

Based on interview, and record review the facility failed to ensure that 1 of 9 sampled staff (Staff W) was qualified to work with vulnerable adult residents. This failure placed all 58 residents at risk for receiving care from an unqualified staff.

Findings included...

Review of the facility's Assisted Living Certified Nursing Assistant (CNA) job description showed that CNAs provided assigned residents with routine daily nursing care and services in accordance with the resident's assessment and care plan. The job description showed that the education qualifications required the staff to graduate from an accredited CNA program and must possess an active CNA certificate valid in the state of Washington.

Review of the facility Assisted Living Medication Aide (Tech) job description showed the position qualifications required completion of a state approved Caregiver program and possess a Registered Nurse approved, Medication Administration Delegation as required by state regulation.

STAFF W

Review of the facility's Employee Roster showed that the facility hired Staff W, Nursing Assistant Registered, Staffing Coordinator, on 08/05/2024. Review of Registered Nurse Delegation binder showed Staff W was delegated to administer medications, which included insulin. Review of Staff W's employee record showed that as of 12/23/2024, 140 days after hire, there was no documentation that showed Staff W completed the Home Care Aide certification or the Certified Nursing Assistant program.

During an interview on 12/20/2024 at 10:00 AM, Staff Q, Business Office Manager, stated that they were sure Staff W completed the Nursing Assistant Certified program.

Review of the Washington State Provider Credential Search Website 12/23/202 and

01/15/2024 showed an active Nursing Assistant Registered. The Website did not show any Nursing Assistant Certification or Health Care Aide certification.

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) 2/28/25.

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

J. D. [Signature] RN

Administrator (or Representative)

01/31/25

Date

WAC 388-78A-2990 Heating-cooling Temperature. The assisted living facility must:

(5) Equip each resident sleeping room with individual temperature controls located between eighteen and forty-eight inches above the floor capable of maintaining room temperature plus or minus 3 F from setting, within a range of minimum 60 F to maximum 85 F, these individual temperature controls may be modified to prevent resident access only when:

- (a) Appropriate, as documented in resident assessment(s) and their negotiated service plan; and
- (b) The temperature range is maintained at a range of 70 F to 75 F.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to install the heater's temperature control dial between eighteen and forty-eight inches above the floor in 40 of 101 sampled apartments (Apartments 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 229, 230, 231, 232, 233, 234, 236, 237, 238, 239, 240/242, 241, 243, 244/246, 245, 247, 248, 249, and 250). This failure placed 39 residents at risk of a decreased quality of life and increased risk of illness from inability to independently access the thermostat control and adjust the room temperature according to their preference.

Findings included...

Observations between 12/17/2024 and 01/06/2025 showed that prior to the full inspection, the facility remodeled 40 apartments (Apartments 101 through 121 and 229 through 250). Observation of the 40 remodeled apartments on 01/06/2025 between 10:00 AM and 11:00 AM, showed each apartment had a wall heater with an individual thermostat control knob. The heaters were installed on a wall in the sleeping room and in the bathroom of each apartment. Observation showed the thermostat control knob

01/15/2024 showed an active Nursing Assistant Registered. The Website did not show any Nursing Assistant Certification or Health Care Aide certification.

Plan/Attestation Statement

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Administrator (or Representative)

Date

WAC 388-78A-2990 Heating-cooling Temperature. The assisted living facility must:

(5) Equip each resident sleeping room with individual temperature controls located between eighteen and forty-eight inches above the floor capable of maintaining room temperature plus or minus 3 F from setting, within a range of minimum 60 F to maximum 85 F, these individual temperature controls may be modified to prevent resident access only when:

- (a) Appropriate, as documented in resident assessment(s) and their negotiated service plan; and
- (b) The temperature range is maintained at a range of 70 F to 75 F.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to install the heater's temperature control dial between eighteen and forty-eight inches above the floor in 40 of 101 sampled apartments (Apartments 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 229, 230, 231, 232, 233, 234, 236, 237, 238, 239, 240/242, 241, 243, 244/246, 245, 247, 248, 249, and 250). This failure placed 39 residents at risk of a decreased quality of life and increased risk of illness from inability to independently access the thermostat control and adjust the room temperature according to their preference.

Findings included...

Observations between 12/17/2024 and 01/06/2025 showed that prior to the full inspection, the facility remodeled 40 apartments (Apartments 101 through 121 and 229 through 250). Observation of the 40 remodeled apartments on 01/06/2025 between 10:00 AM and 11:00 AM, showed each apartment had a wall heater with an individual thermostat control knob. The heaters were installed on a wall in the sleeping room and in the bathroom of each apartment. Observation showed the thermostat control knob

controlled the volume of air flow into the room that regulated the room temperature. Observation showed the air-flow control knob was located over six feet above the floor in each room. The facility's characteristic roster showed 39 of the 40 rooms were occupied by residents.

Observation of Resident 7's apartment on 12/18/2024 at 2:42 PM, showed a heater unit, with a thermostat air-flow control knob, installed on the wall in the sleeping room. Observation showed the thermostat air-flow control knob was located over six feet above the floor. Observation showed Resident 7 sat in a wheelchair. Observation showed Resident 7's left leg was [REDACTED]. During an interview at this time, Resident 7 stated that the temperature control knob was located high up on the wall. Resident 7 stated that they were unable to access the knob that regulated the temperature in the room. Resident 7 stated that during the cold weather, they felt cold inside the room. Resident 7 stated that when they wanted to adjust the room temperature, they asked the staff for assistance. Resident 7 stated that they preferred to adjust the room temperature on their own.

Plan/Attestation Statement

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J. D. Wilson
Administrator (or Representative)

01/31/25
Date

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Observation of Resident 7's apartment on 12/18/2024 at 2:42 PM, showed a heater unit, with a thermostat air-flow control knob, installed on the wall in the sleeping room. Observation showed the thermostat air-flow control knob was located over six feet above the floor. Observation showed Resident 7 sat in a wheelchair. Observation showed Resident 7's left leg was [REDACTED]. During an interview at this time, Resident 7 stated that the temperature control knob was located high up on the wall. Resident 7 stated that they were unable to access the knob that regulated the temperature in the room. Resident 7 stated that during the cold weather, they felt cold inside the room. Resident 7 stated that when they wanted to adjust the room temperature, they asked the staff for assistance. Resident 7 stated that they preferred to adjust the room temperature on their own.

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Administrator (or Representative)

Date



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

01/24/2025

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

RE: Redmond Heights Senior Living # 2628

Dear Administrator:

This document references the following complaint numbers 160012.

The Department completed a full inspection and complaint investigation of your Assisted Living Facility on 01/16/2025 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

This document was prepared by Residential Care Services for the Locator website.

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-2970 Garbage and refuse disposal. The assisted living facility must:

(1) Provide an adequate number of garbage containers to store refuse generated by the assisted living facility:

(c) Cleaned and maintained to prevent:

(i) Entrance of insects, rodents, birds, or other pests;

(ii) Odors; and

(iii) Other nuisances.

The Assisted Living Facility failed to ensure the garbage refuse area was kept clean and well maintained. During the full inspection, the facility cleaned up the garbage refuse area.

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

Redmond Heights Senior Living #2628

01/16/2025

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Residential Care Services

PO Box 45600

Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

Laurie Anderson, Field Manager

Region 2, Unit D

Residential Care Services

Enclosure

This document was prepared by Residential Care Services for the Locator website.