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

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

RE: Redmond Heights Senior Living # 2628

Dear Administrator:

This document references Compliance Determination 44169 (08/13/2024), which included complaint number(s) 136786.
The Department completed a complaint investigation of your Assisted Living Facility on 08/13/2024 and found that your facility does not meet the Assisted Living Facility requirements.

The department staff who did the inspection and provided consultation:

Harrison Udoye, Community Complaint Investigator

**Consultation:**

**WAC 388-78A-2650 Reporting fires and incidents. The assisted living facility must immediately report to the department's aging and disability services administration:**

(3) Circumstances which threaten the assisted living facility's ability to ensure continuation of services to residents.

Facility failed to notify the department when food services were disrupted related to plumbing issue in the kitchen which resulted in a change of food services to all 64 residents.
Facility immediately contacted plumbing company to correct the issue. Facility failed to notify the department of the temporary disruption with their food services. No resident meals were missed.
Facility administration re-educated staff on the requirements to

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Facility administration re-educated staff on the requirements to

report to the department any incidents related to the disruption of services to residents.

**You Must:**
- Begin the process of correcting the deficiency or deficiencies immediately; and
- Complete correction as soon as possible.

**You Are Not:**
- Required to submit a plan-of-correction for the deficiency or deficiencies found.

**The Department May:**
- Inspect the facility to determine if you have corrected all deficiencies.

**You May:**
- Contact me for clarification of the deficiency or deficiencies found.

**In Addition, You May:**
- Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  - o What specific deficiency or deficiencies you disagree with;
  - o Why you disagree with each deficiency; and
  - o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  - o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

**If You Have Any Questions:**
- Please contact me at (253)234-6020.

Sincerely,

*Laurie Anderson*

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

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

# Residential Care Services
## Investigation Summary Report

**Provider/Facility:** Redmond Heights Senior Living
**License/Cert.#:** 2628
**Compliance Determination #:** 44169
**Investigator:** Harrison Udoye
**Investigation Date(s):** 07/15/2024 through 08/13/2024
**Complainant Contact Date(s):**

**Provider Type:** Assisted Living Facility

**Intake ID:** 136786
**Region/Unit #:** RCS Region 2 / Unit D

**Allegation(s):**
Food service disruption

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 64<br>Resident sample size: 3<br>Closed records sample size: 0 |
| **Observations:** | Identified resident<br>Residents<br>Activities<br>Dining<br>Resident care equipment<br>Resident rooms<br>Resident to resident interactions<br>Kitchen<br>Food preparation |
| **Interviews:** | Identified resident<br>Nursing staff<br>Residents<br>Family members<br>Housekeeping staff<br>Business office manager<br>Staff development coordinator<br>Kitchen staff |
| **Record Reviews:** | Facility policies<br>Personnel files<br>Staff training records<br>Maintenance logs |

**Investigation Summary:**
Food service disruption for three days in the Assisted Living Facility (ALF).
Interview and record review showed that facility kitchen staff discovered a plumbing issue with the dishwasher on 07/01/2024. Facility management immediately called

in emergency plumbing company to assess and correct the problem. Facility staff notified all Residents and blocked off the area until the issue was completely resolved. Facility erred on the side of caution and served all Residents continental breakfast, sandwiches and a non-heated meals on the first day. Facility returned to regular meal preparation for all other meals during repairs. The plumbing repairs for the dishwasher took two days to complete. Facility failed to notify Residential Care Services( RCS) of the disruption in services for their Residents. Consultation given per WAC 388-78A-2650 (3).

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**Conclusion / Action:**

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A