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

03/18/2025

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) 56428 (Completion Date 03/18/2025) and 52601 (Completion Date 01/16/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/18/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(a) Maintain the premises free of hazards;

The Department staff who did the On Site verification:
Thomas Forkgen, ALF Licensor

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

Sincerely,

Laurie Anderson

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Redmond Heights Senior Living
Provider Type: Assisted Living Facility
License/Cert.#: 2628
Intake ID: 160355
Compliance Determination #: 52601
Region/Unit #: RCS Region 2 / Unit D
Investigator: Thomas Forkgen
Investigation Date(s): 12/23/2024 through 01/16/2025
Complainant Contact Date(s):

Allegation(s):
Multiple complaints of a resident smoking inside apartment.

Investigation Methods:

Sample:	Total residents: 57 Resident sample size: 7 Closed records sample size: 0
Observations:	Observed Alleged Victims in their apartments next to and across form Alleged Perpetrator's apartment. Observed Alleged Perpetrator's apartment.
Interviews:	Interviewed Administrative staff, facility staff, Alleged Victims (1), AP1, Alleged Victim (2), AP2, and Alleged Victim (3) AP3. Interviewed Alleged Perpetrator (AP) .
Record Reviews:	Reviewed Medical records for AV1, AV2, AV3 and AP. Reviewed facility's policy on smoking, Characteristics Roster, Staff Roster, Disclosure of Services, and Abuse and neglect policy. See shared drive.

Investigation Summary:
Failed practice substantiated. Facility failed to monitor the Alleged Perpetrator's smoking and failed to implement Alleged Perpetrator's Service Plan. Complaint was investigated during the full inspection. See full inspection for additional citation issued under WAC 2160.

Conclusion / Action:

- [x] 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 # 528G1
Plan of Correction	Redmond Heights Senior Living	Completion Date
Page 1 of 5	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 an unannounced on-site complaint investigation on 12/23/2024, 01/06/2025 and 12/23/2024 of:

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

This document references the following complaint number(s): 160355

The following sample was selected for review during the unannounced on-site visit: 7 of 57 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Thomas Forkgen, ALF Licensor

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

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

01-22-2025
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.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 12/23/2024, 01/06/2025 and 12/23/2024 of:

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

This document references the following complaint number(s): 160355

The following sample was selected for review during the unannounced on-site visit: 7 of 57 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Thomas Forkgen, ALF Licensor

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

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

Residential Care Services

Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) 01/22/25 Date

WAC 388-76A-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(a) Maintain the premises free of hazards;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure 1 of 1 sampled Resident (Resident 8) did not smoke in their apartment. This failure placed all 67 residents safety and health at risk from potential fire, smoke inhalation, and compromised health.

Finding included...

Review of the facility's undated Disclosure of Services showed that the facility maintained a smoke free community. The Disclosure of Services showed that smoking was permitted in a designated outside area.

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 off 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 smoked. 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 resident 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. For egregious safety risks, eviction may occur sooner than 30 days.

Observation on 12/17/2024, 12/18/2024, 12/19/2024, 12/20/2024, 12/23/2024, and 01/06/2024, showed a smoking area, covered with a canopy with chairs, outside in the parking lot, across from the main entrance, a next to the garbage collection station. During the full inspection visit, multiple unidentified residents were observed smoking in the designated area.

Administrator (or Representative) Date

WAC 388-78A-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(a) Maintain the premises free of hazards;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure 1 of 1 sampled Resident (Resident 8) did not smoke in their apartment. This failure placed all 57 residents safety and health at risk from potential fire, smoke inhalation, and compromised health.

Finding included…

Review of the facility's undated Disclosure of Services showed that the facility maintained a smoke free community. The Disclosure of Services showed that smoking was permitted in a designated outside area.

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 off 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 smoked. 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 resident 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. For egregious safety risks, eviction may occur sooner than 30 days.

Observation on 12/17/2024, 12/18/2024, 12/19/2024, 12/20/2024, 12/23/2024, and 01/06/2024, showed a smoking area, covered with a canopy with chairs, outside in the parking lot, across from the main entrance, a next to the garbage collection station. During the full inspection visit, multiple unidentified residents were observed smoking in the designated area.

During interviews on 12/23/2024 at 10:22 AM and at 1:11 PM, 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 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 stated that they complained to the staff and their concerns were ignored. 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 interviews on 12/23/2024 at 10:23 AM and at 1:20 PM, Resident 11 stated that they live next door to Resident 8. Resident 11 stated that Resident 8 frequently smoked cigarettes in their apartment and the smoke entered Resident 11's room. Resident 11 stated that the cigarette smoke was strong and bothered them. Resident 11 stated they were a former smoker, and they were able to identify the smell of cigarette smoke. Resident 11 stated that they like to open their window for fresh air. Resident 11 stated that they were forced to close the window whenever Resident 8 smoked cigarettes in their apartment, as the cigarette smoke entered Resident 11's apartment through the window. Resident 11 stated that they notified staff about Resident 8's cigarette smoking in the apartment. 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 and risk the safety of all the residents.

RESIDENT 8
Review of Resident 8's Negotiated Service Plan, dated 09/16/2024, showed the facility admitted Resident 8 in [redacted] of 2024.

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 sat on a chair in front of the window. The fan blew the air through the window and 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. The apartment smelled of a strong, distinct cigarette smoke. A cigarette lighter was observed on the floor next to the window.

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

Observation of Resident 8's apartment on 12/23/2024 at 11:00 AM, Staff BB, Maintenance Supervisor, observed the cigarette ashes on the windowsill, floor, the fan and cigarette lighter. During an interview at this time, Staff BB stated that Resident 8 was not allowed to smoke in the apartment. Staff BB stated that it was obvious that Resident 8 smoked in the apartment.

Statement of Deficiencies	License #: 2628	Compliance Determination # 52501
Plan of Correction	Redmond Heights Senior Living	Completion Date
Page 4 of 6	Licensee: Bear Creek Senior Living, Inc	01/16/2025

Observation on 12/23/2024 at 11:15 AM, 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 were 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 that Resident 8 did not have a cigarette lighter and would need to request a lighter from the staff. Staff A stated they were unaware Resident 8 possessed a cigarette lighter. Staff A stated that when Staff BB informed them of the smoking paraphernalia and debris found in Resident 8's room, they realized a plan needed to be developed to ensure Resident 8 did not smoke in the apartment.

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

Observation on 12/23/2024 at 5:00 PM, showed Resident 8 smoked a cigarette as they sat in their wheelchair in front of several windows under the entrance breezeway canopy, not the designated smoking area. Observation showed the designated smoking area across the parking lot away from the entrance was equipped with a canopy to provide cover from the rain. Observation showed several other residents were smoking in the designated area.

Observation of Resident 8's apartment on 01/08/2025 at 10:32 AM, showed unused tobacco was strewn on the floor in front of Resident 8's desk. Observation showed several rolled cigarettes in a container on top of the desk. Observation showed the window was closed and there were brown stains on the windowsill.

During an interview on 01/08/2025 at 10:32 AM, Staff A stated that Resident 8 smoked outside only. Staff A denied Resident 8 smoked in their apartment

Plan/Attestation Statement

- Reiteration of smoking policy for both resident and staff and in-service for re-direction and correction.

- Also attached is Fire Marshall evaluation

Observation on 12/23/2024 at 11:15 AM, 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 were 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 that Resident 8 did not have a cigarette lighter and would need to request a lighter from the staff. Staff A stated they were unaware Resident 8 possessed a cigarette lighter. Staff A stated that when Staff BB informed them of the smoking paraphernalia and debris found in Resident 8's room, they realized a plan needed to be developed to ensure Resident 8 did not smoke in the apartment.

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

Observation on 12/23/2024 at 5:00 PM, showed Resident 8 smoked a cigarette as they sat in their wheelchair in front of several windows under the entrance breezeway canopy, not the designated smoking area. Observation showed the designated smoking area across the parking lot away from the entrance was equipped with a canopy to provide cover from the rain. Observation showed several other residents were smoking in the designated area.

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

Plan/Attestation Statement

Statement of Deficiencies	License #: 2628	Compliance Determination # 52601
Plan of Correction	Redmond Heights Senior Living	Completion Date
Page 6 of 6	Licensee: Bear Creek Senior Living, Inc	01/16/2026

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) 2/24/25 .

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

[signature]
Administrator (or Representative)

01/22/25
Date

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