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

03/24/2025

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 letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 56429 (Completion Date 03/24/2025) and 52607 (Completion Date 01/13/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/24/2025 and found no deficiencies.

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

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

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
License/Cert.#: 2628
Compliance Determination #: 52607
Investigator: Thomas Forkgen
Investigation Date(s): 12/20/2024 through 01/13/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 159952
Region/Unit #: RCS Region 2 / Unit D

Allegation(s):
Resident to resident verbal abuse. Facility failed to recognize the verbal abuse and take measures to stop the verbal abuse.

Investigation Methods:

Sample:	Total residents: 57 Resident sample size: 8 Closed records sample size: 0
Observations:	Observed Alleged Victim, and both Alleged perpetrators in their environment. Observed resident to resident interactions and staff to resident interactions.
Interviews:	Administrative staff, care staff, Alleged Victim, and Alleged perpetrator 1 and Alleged perpetrator 2.
Record Reviews:	Reviewed medical records for Alleged Victim, Alleged perpetrator 1 and Alleged perpetrator 2. Reviewed facility's incident reports, Disclosure of services, Abuse and neglect policy, and resident handbook.

Investigation Summary:
Investigation occurred during the full inspection based on Alleged Victims complaint. Failed practice established. The facility failed to follow it's own policies and failed to ensure Alleged Victims Resident rights to be free of harassment and intimidation were enforced. The facility failed to meet the emotional and psychological needs of Alleged Victim.

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 # 52607
Plan of Correction	Redmond Heights Senior Living	Completion Date
Page 1 of 4	Licensee: Bear Creek Senior Living, Inc	01/13/2025

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 12/20/2024, 01/06/2025 and 12/20/2024 of:

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

This document references the following complaint number(s): 159952

The following sample was selected for review during the unannounced on-site visit: 8 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

01/16/2025 — Date

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

Administrator (or Representative) 01/24/25 Date

RCW 70.129.140 Quality of life -- Rights.

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WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to protect 1 of 1 sampled resident from verbal abuse and neglected their dignity and right to be respected. This failure placed Resident 1 at risk for diminished quality of life from a lack of dignity and respect, and an increase of emotional and psychological harm.

Finding included...

Review of the facility's abuse and neglect policy, dated February 2017, showed that abuse was defined as the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. The policy showed that mental abuse was defined as willful verbal or nonverbal action that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult. Mental abuse may include ridiculing, yelling, swearing or laughing at. The policy showed that verbal abuse was defined as yelling, swearing, using foul language, ridiculing and screaming. The policy showed that the facility thoroughly investigated any, and all reports of abuse and neglect.

Review of the facility's undated Resident Handbook and House Rules showed that residents have the right to be treated in a manner that respected individual identity, human dignity, and fostered constructive self-esteem. The handbook showed residents have the right to be free of all forms of intimidation, exploitation, assault, abuse, and neglect. The handbook showed that residents must not be disruptive and must not be physically or verbally abusive to other residents.

RESIDENT 18
Review of the facility Admission Record showed the facility admitted Resident 18 in [redacted] 2024 with the diagnosis of [redacted]

Administrator (or Representative) Date

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to protect 1 of 1 sampled resident from verbal abuse and neglected their dignity and right to be respected. This failure placed Resident 1 at risk for diminished quality of life from a lack of dignity and respect, and an increase of emotional and psychological harm.

Finding included...

Review of the facility's abuse and neglect policy, dated February 2017, showed that abuse was defined as the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. The policy showed that mental abuse was defined as willful verbal or nonverbal action that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult. Mental abuse may include ridiculing, yelling, swearing or laughing at. The policy showed that verbal abuse was defined as yelling, swearing, using foul language, ridiculing and screaming. The policy showed that the facility thoroughly investigated any, and all reports of abuse and neglect.

Review of the facility's undated Resident Handbook and House Rules showed that residents have the right to be treated in a manner that respected individual identity, human dignity, and fostered constructive self-esteem. The handbook showed residents have the right to be free of all forms of intimidation, exploitation, assault, abuse, and neglect. The handbook showed that residents must not be disruptive and must not be physically or verbally abusive to other residents.

RESIDENT 18
Review of the facility Admission Record showed the facility admitted Resident 18 in [redacted] 2024 with the diagnosis of [redacted]

[redacted] and [redacted].

Review of Resident 18's Service Plan, dated 09/18/2024, showed Resident 18 was alert and oriented to person, place, and time. The service plan showed Resident 18 independently managed their own medications and all their care needs. The service plan showed that Resident 18 did not require assistance with wellness/safety. There was no documentation in the service plan that provided instructions for staff to support Resident 18 when they were subjected to harassment from other residents.

During an interview on 12/18/2024 at 2:07 PM, Resident 18 stated that shortly after they moved into the facility, they were subjected to frequent harassment at night by other residents. Resident 18 stated that their next-door neighbor, Resident 19, pounded on the walls during the night and called them homophobic slurs which included statements of "burning in hell for their sexual orientation". Resident 18 stated that they spoke with the administrative staff. Resident 18 stated that staffs' response was to share that Resident 19 suffered from dementia and denied any recollection of their behavior towards Resident 18. Resident 18 stated that administration initially offered alternative accommodations, then administration stated they would work to resolve the issues. Resident 18 stated that based on this information from administration, they declined the relocation in hopes the situation would improve. Resident 18 stated that the situation did not improve, and the abuse and harassment continued. Resident 18 stated that their other neighbor, Resident 20, was a known alcoholic who became intoxicated at night and would start yelling for help. Resident 18 stated that Resident 20's yelling interrupted their living environment. Resident 18 stated that between the two neighbors, they got very little sleep. Resident 18 stated that despite reassurances from Staff A, Administrator, and other administrative staff that they were working on the issues, Resident 18 was frustrated that nothing has changed. Resident 18 stated they felt forgotten and ignored.

During an interview on 12/19/2024 between 3:00 PM and 4:00 PM, Staff A, Administrator, stated they were unaware of the emotional abuse endured by Resident 18. Staff A stated that Resident 19 did not physically harm anyone and therefore was not a threat or a safety concern. Staff A stated that there was no plan in place to address Resident 18's emotional needs since Resident 19 did not pose a physical threat.

During an attempted interview on 12/20/2024 at 1:20 PM, Resident 19 declined to be interviewed and stated they were fine.

During an interview on 12/20/2024 at 2:45 PM, Staff A stated that Resident 19's behavior was disruptive and Resident 18's allegations were correct. Staff A stated that Resident 19 suffered from dementia and showed no recollection of their behavior the next day. Staff A stated that Resident 19 did not recall they used homophobic slurs and Resident 19 stated they would never behave in such a manner. 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 has dementia and was very belligerent and verbally abusive especially towards Resident 18. Staff F stated Resident 18 was a "very humble, nice" person. Staff F stated that they have heard Resident 19 call Resident 18 derogatory names. Staff F stated that Resident 19 insisted that Resident 18's TV was too loud when in fact the TV was turned off. Staff F stated that Resident 19's behaviors towards Resident 18 occurred two to three times a week.

During an interview on 01/06/2024 at 9:55 AM, Resident 18 stated that there were no further incidents of verbal attacks from Resident 19 after the Department Licensors addressed the issue with the facility administrative staff. Resident 18 stated "why did it have to take so long before the issue was addressed". Resident 18 stated that the homophobic slurs "hurt" "really hurt".

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) 02/18/24 02/18/25.

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

[signature] 01/18/24

Administrator (or Representative) Date

During an interview on 12/23/2024 at 7:47 AM, Staff F, Medication Technician (unlicensed staff who dispensed medications), stated that Resident 19 has dementia and was very belligerent and verbally abusive especially towards Resident 18. Staff F stated Resident 18 was a "very humble, nice" person. Staff F stated that they have heard Resident 19 call Resident 18 derogatory names. Staff F stated that Resident 19 insisted that Resident 18's TV was too loud when in fact the TV was turned off. Staff F stated that Resident 19's behaviors towards Resident 18 occurred two to three times a week.

During an interview on 01/06/2024 at 9:55 AM, Resident 18 stated that there were no further incidents of verbal attacks from Resident 19 after the Department Licensors addressed the issue with the facility administrative staff. Resident 18 stated "why did it have to take so long before the issue was addressed". Resident 18 stated that the homophobic slurs "hurt" "really hurt".

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