STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

BFG Kennewick Master Tenant LLC
Ciel Senior Living of the Tri-Cities Memory Care
575 N Young St
Kennewick, WA 99336

RE: Ciel Senior Living of the Tri-Cities Memory Care License # 2448

Dear Administrator:

This letter addresses Compliance Determination(s) 78981 (Completion Date 06/26/2026) and 75473 (Completion Date 04/21/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/26/2026 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2630-1, WAC 388-78A-2630-1-a, WAC 388-78A-2630-1-b, WAC 388-78A-2600-2-a

The Department staff who did the on-site verification:
Melissa Milanez, Community Complaint Investigator

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, ALF Field Manager
Region 1, Unit G
Residential Care Services

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Ciel Senior Living of the Tri-Cities Memory Care
Provider Type: Assisted Living Facility
License/Cert.#: 2448
Intake ID: 219283
Compliance Determination #: 75473
Region/Unit #: RCS Region 1 / Unit G
Investigator: Melissa Milanez
Investigation Date(s): 04/07/2026 through 04/21/2026
Complainant Contact Date(s):

Allegation(s):
The facility received allegations of sexual abuse.

Investigation Methods:

Sample:	Total residents: 47 Resident sample size: 2 Closed records sample size:
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Residents Family members
Record Reviews:	Characteristic roster Incident investigation State reporting log Facility policies Personnel files Staff training records Staff patterns

Investigation Summary:
The facility staff did not immediately report the allegations of sexual abuse to the department and to their local law enforcement in a timely manner. Interviews with staff showed that they were aware of the alleged sexual abuse, and did not report the allegation to management, the Department, or Local Law Enforcement (LLE) for fear of losing their jobs. Interview showed the responsible party did not receive notification of the allegation for several days. Failed practice identified. WAC 388-78A-2630(1)(a)(b) and WAC 388-78A-2600 (2)(a) Reference Statement of

Deficiencies (SOD) 04/21/2026.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Ciel Senior Living of the Tri-Cities Memory Care
Provider Type: Assisted Living Facility
License/Cert.#: 2448
Intake ID: 219471
Compliance Determination #: 75473
Region/Unit #: RCS Region 1 / Unit G
Investigator: Melissa Milanez
Investigation Date(s): 04/07/2026 through 04/21/2026
Complainant Contact Date(s): 04/21/2026

Allegation(s):
The facility did not notify the police or family members immediately after becoming aware of allegations of sexual abuse.

Investigation Methods:

Sample:	Total residents: 47 Resident sample size: 2 Closed records sample size:
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Residents Family members Business office manager Human resources
Record Reviews:	Incident investigation Facility policies Personnel files Staff training records Staff patterns State reporting log

Investigation Summary:
The facility staff did not immediately report the allegations of sexual abuse to their local law enforcement. The Administrator stated they had planned to notify the police after completion of their investigation. Failed practice identified. WAC 388-78A-2630(1)(a)(b).

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
HOME AND COMMUNITY LIVING ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

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 04/07/2026 of:

Ciel Senior Living of the Tri-Cities Memory Care
575 N Young St
Kennewick, WA 99336

This document references the following complaint number(s): 219283, 219471

The following sample was selected for review during the unannounced on-site visit: 2 of 47 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Melissa Milanez, Community Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

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

Statement of Deficiencies	License #: 2448	Compliance Determination #75473
Plan of Correction	Ciel Senior Living of the Tri-Cities Memory Care	Completion Date
Page 2 of 9	Licensee: BFG Kennewick Master Tenant LLC	04/21/2026

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.

Laura Williams-Davis — Residential Care Services

05/05/2026 — 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)

5/12/26 — 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

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) staff failed to report to the Department's Complaint Resolution Unit (CRU) hotline and failed to report to local law enforcement (LLE) when staff had reasonable cause to believe suspected sexual abuse by a staff member had occurred for 2 of 2 Residents (Residents 1 & 2). This failed practice resulted in no notification to the LLE and placed the residents at risk of abuse.

Findings included...

Review of RCW 74.34.035 titled, "Reports—Mandated and permissive—Contents—Confidentiality" when there is reason to suspect that sexual assault has occurred, mandated reporters shall immediately report to the appropriate law enforcement agency and to the department.

RCW 74.34.020 (13) "Mandated reporter" is an employee of the department, law

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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) | Date

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(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) staff failed to report to the Department’s Complaint Resolution Unit (CRU) hotline and failed to report to local law enforcement (LLE) when staff had reasonable cause to believe suspected sexual abuse by a staff member had occurred for 2 of 2 Residents (Residents 1 & 2). This failed practice resulted in no notification to the LLE and placed the residents at risk of abuse.

Findings included…

Review of RCW 74.34.035 titled, “Reports—Mandated and permissive—Contents—Confidentiality” when there is reason to suspect that sexual assault has occurred, mandated reporters shall immediately report to the appropriate law enforcement agency and to the department.

RCW 74.34.020 (13) "Mandated reporter" is an employee of the department; law

enforcement officer; social worker; professional school personnel; individual provider; an employee of a facility; an operator of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science practitioner; or health care provider subject to chapter 18.130 RCW.

Per RCW 74.34.020 (2) Abuse means the intentional, willful, reckless action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult which have the following meanings:

(a) "Sexual abuse" means any form of nonconsensual sexual conduct, including but not limited to unwanted or inappropriate touching, rape, molestation, indecent liberties, sexual coercion, sexually explicit photographing or recording, voyeurism, indecent exposure, and sexual harassment. Sexual abuse also includes any sexual conduct between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under chapter 71A.12 RCW, and a vulnerable adult living in that facility or receiving service from a program authorized under chapter 71A.12 RCW, whether or not it is consensual.

Review of the facility policy titled “Abuse Reporting”, undated, showed that if any alleged or actual incident involving resident abuse, neglect, mistreatment, or misappropriation of resident’s property shall occur, the community shall immediately follow the reporting procedures listed below; notify the appropriate licensing or regulatory agency or Executive Director (ED) for the facility in accordance with specific state regulations, at the direction of the ED or state agency, appropriate law enforcement agency shall be notified. Additionally, the policy stated that all team members are mandatory reporters who will notify the state hotline without fear of retaliation and/or anonymously.

Record review of the assessment showed Resident 1 was admitted to the facility on [redacted]/2022 with diagnosis of [redacted] and had [redacted].

Record review of the assessment showed Resident 2 was admitted to the facility on [redacted]/2023 with diagnosis of [redacted] and had [redacted].

In an interview on 04/07/2026 at 11:21 AM, Staff A, Assistant Administrator, stated they were made aware of the allegations of sexual abuse on 04/05/2026, and had completed an investigation on 04/06/2026. Staff A stated the alleged incidents occurred on 03/31/2026 and 04/01/2026. Staff A stated that based on their investigation, staff reported the allegations to the lead Medication Technician (MT), and the MT failed to

report it to anyone else.

In an interview on 04/07/2026 at 11:25 AM, Staff B, Administrator, stated that they had been made aware of allegations of inappropriate sexual contact on 04/05/2026, involving Staff C, Caregiver, and two residents, Residents 1 & 2. Staff B stated the alleged incidents occurred on 03/31/2026 and 04/01/2026. Staff B stated no one had reported it to CRU and LLE after there was alleged abuse because the caregiver who witnessed the inappropriate sexual contact told them that they were usure if they needed to report it and stated they did not want to create “drama.” Additionally, Staff B stated they had not notified law enforcement themselves, and had planned to notify them on 04/07/2026, after completing the investigation.

Record review of the investigation completed by Staff A, B, and G, dated 04/06/2026 (6 days after the alleged abuse took place), showed that they received a report of alleged abuse on 04/05/2026 at approximately 2:00 PM. The report was that care staff were overheard talking about how Staff C had climbed into bed with a female resident, rubbed their stomach and asked them for a kiss. The resident refused, but Staff C kissed them anyways. That same day, Staff C was suspended pending investigation of sexually inappropriate behaviors with residents.

Record reviews of April 2026 and March 2026 as worked schedule, showed that Staff C worked in the facility’s memory care unit on March 29, March 30, March 31, April 1, and again on April 4 and April 5, 2026.

During an observation on 04/07/2026 at 1:48 PM, Resident 1 was observed seated in the dining room, was unable to reliably communicate needs or report concerns, and had disorganized speech.

In an interview on 04/07/2026 at 11:57 AM, Collateral Contact 1 (CC1), Anonymous, stated that staff had ongoing concerns regarding Staff C and that multiple staff attempted to report concerns to supervisors but felt their concerns were dismissed. CC1 stated that staff had expressed fear of retaliation and job loss, which discouraged reporting. Additionally, CC1 stated that there had previously been a meeting addressing gossip and staff were required to sign a form, which contributed to staff reluctance to report concerns.

In an interview on 04/07/2026 at 2:15 PM, Staff D, Caregiver, stated that they had observed Staff C on 03/31/2026 seated on the couch between two residents with their arms around both residents, rubbing their shoulders, and allowing the residents to rub their legs. Staff D stated that initially they did not report the observation, as they were unsure how to interpret the behavior. Staff D further stated they later had discussed the observation with another caregiver, who reported observing similar interactions. Staff D stated that on a different day, they observed Resident 2 had appeared distressed, was pacing, and attempted to push open the secured doors. Staff D stated the resident expressed fear in being kidnapped and stated to them “that man says he likes me, but I

don't need a man." Staff D asked Resident 2 who they were referring to, and Resident 2 turned around and pointed at Staff C. Staff D stated the lead Medication Technician (MT) instructed them to take care of Resident 2 in place of Staff C. Staff D stated they informed Staff C not to go into that room, however, Staff C continued to attempt to enter the resident's room. When asked why they had not reported the concerns to management, Staff D stated they did not report the concerns due to belief it would be considered "drama" and not be addressed.

In an interview on 04/07/2026 at 2:52 PM, Staff E, Lead Medication Technician, stated that staff had reported to them that Staff C was sitting on the couch and had their arms around Resident 1 & 2, they stated they looked briefly and witnessed this interaction but had not initially perceived it as inappropriate. Staff E further stated that on a separate occasion on 03/31/2026 or 04/01/2026 during their shift they noticed Resident 2 visibly upset and whimpering and stated that a man was harassing them. When asked to identify the man, Resident 2 pointed at Staff C. Staff E then stated that they had mentioned to the female staff members to take over care of Resident 2's room, as Staff C had been assigned to that room. When asked if they had reported the incident, they stated they believed reassigning staff away from the residents' room was sufficient and no additional reporting or action was needed. Additionally, they stated they had thought about it during their two days off and had planned on reporting it to someone on their first day back at work but learned that a report had already been made.

During an observation on 04/07/2026 at 12:21 PM, Resident 2 was observed seated in the dining room, upon finishing lunch, the resident walked back to their room independently. Resident 2 exhibited impaired memory and incoherent responses, and their statements did not consistently make sense.

In an interview on 04/07/2026 at 2:27 PM, Staff F, Caregiver, stated that on 03/31/2026 they observed Staff C sitting on the couch, in a slouched posture, leaning back onto the couch, and having their arms around Residents 1 & 2. They stated that Resident 2 leaned their head on Staff C's shoulder and that the interaction made them feel uncomfortable. Staff F stated that the next day, they observed Resident 2 exhibiting signs of fear, including flushed cheeks, holding their hands up near their face, and stated that someone was trying to kidnap them. Staff F stated that the residents' presentation was not consistent with their typical baseline. Additionally, Staff F stated they entered Resident 1's apartment with Staff C and attempted to get the resident to lay down. Resident 1 was being resistant, but Staff C directed Resident 1 to lay down, the resident laid down, then Staff C laid down next to the resident, rubbed their lower abdomen over their clothing and requested a kiss, stating "give me a peck baby," the resident refused and Staff C leaned in and continued to give the resident a peck between their nose and lips. Staff F stated the incident did not sit well with them, so they notified Staff E; however, no further action was taken. Staff F stated they had not escalated the concern to management, as they believed it would be dismissed as gossip.

In an interview on 04/07/2026 at 3:44 PM, Staff G, Business Office Manager, stated it is the facility's policy to report allegations of abuse to the CRU, and LLE immediately. Staff

G stated they were made aware of the incident on 04/05/2026 at around 2:00 PM. When asked why staff had not reported their concerns sooner, they stated that staff had recently been warned about gossiping and heard that they felt uncomfortable reporting concerns to their immediate supervisor out of fear of being terminated

In an interview on 04/17/2026 at 2:59 PM, Collateral Contact 2 (CC2), Resident Representative, stated they were informed of the incident on 04/06/2026 (six days later). CC2 stated they reported the incident to LLE that late evening

In an interview on 04/21/2026 at 2:11 PM, Collateral Contact 3 (CC3), Resident Representative stated that facility staff notified them of the alleged incident on 04/06/2026. CC3 stated they were told that the incident took place on 03/31/2026 and 04/01/2026 and had expressed concern regarding the delay in reporting. CC3 further stated the facility did not indicate that law enforcement had been notified until their sister reported it the night of 04/06/2026.

In an interview on 04/07/2026 at 4:09 PM, Staff B stated that they too had concerns that staff failed to report the allegations sooner, stating staff were trained to report abuse immediately. They stated that staff indicated to them that they had not felt comfortable reporting to their immediate supervisor as they didn't want to contribute to "drama." Additionally, Staff B stated that they planned to terminate Staff C and would be providing education to the staff on abuse and neglect reporting requirements

This is a recurring deficiency previously cited on 07/17/2023

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Ciel Senior Living of the Tri-Cities Memory Care is or will be in compliance with this law and / or regulation on (Date) 6/5/26

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

Administrator (or Representative) 5/12/26 Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement, and train staff persons on policies and procedures to address what staff persons must do:

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

G stated they were made aware of the incident on 04/05/2026 at around 2:00 PM. When asked why staff had not reported their concerns sooner, they stated that staff had recently been warned about gossiping and heard that they felt uncomfortable reporting concerns to their immediate supervisor out of fear of being terminated.

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In an interview on 04/21/2026 at 2:11 PM, Collateral Contact 3 (CC3), Resident Representative stated that facility staff notified them of the alleged incident on 04/06/2026. CC3 stated they were told that the incident took place on 03/31/2026 and 04/01/2026 and had expressed concern regarding the delay in reporting. CC3 further stated the facility did not indicate that law enforcement had been notified until their sister reported it the night of 04/06/2026.

In an interview on 04/07/2026 at 4:09 PM, Staff B stated that they too had concerns that staff failed to report the allegations sooner, stating staff were trained to report abuse immediately. They stated that staff indicated to them that they had not felt comfortable reporting to their immediate supervisor as they didn't want to contribute to "drama." Additionally, Staff B stated that they planned to terminate Staff C and would be providing education to the staff on abuse and neglect reporting requirements.

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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 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement, and train staff persons on policies and procedures to address what staff persons must do:

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to follow the facility's policy for identifying, reporting and investigating abuse incidents for 2 of 2 residents (Residents 1&2). This failure resulted in delayed reporting and investigation and placed residents at risk of abuse.

Findings included…

Review of the facility policy titled "Abuse Reporting", undated, showed that if any alleged or actual incident involving resident abuse, neglect, mistreatment, or misappropriation of resident's property shall occur, the community shall immediately follow the reporting procedures listed below; notify the appropriate licensing or regulatory agency or Executive Director (ED) for the facility in accordance with specific state regulations, at the direction of the ED or state agency, appropriate law enforcement agency shall be notified. Additionally, the policy stated that all team members are mandatory reporters who will notify the state hotline without fear of retaliation and/or anonymously.

Record review of Resident 1's assessment, dated 02/03/2026, showed they were admitted to the facility on [redacted]/2022, with a diagnosis of [redacted] and had [redacted].

Record review of Resident 2's assessment, dated 03/20/2026, showed they were admitted to the facility on [redacted]/2023, with diagnosis of [redacted] and had [redacted].

Record review of the Facility Internal Investigation completed by Staff A, B, and G, dated 04/06/2026, showed that they received a report of alleged sexual abuse on 04/05/2026 (6 days after the alleged abuse took place) at approximately 2:00 PM. The report was that care staff were overheard talking about how Staff C had climbed in bed with a female resident, rubbed their stomach and asked them for a kiss. The resident had refused, but Staff C kissed them anyways. Staff C was suspended on 04/05/2026 pending investigation of sexually inappropriate behaviors with residents.

Record reviews of April 2026 and March 2026 as worked schedule, showed that Staff C worked in the facility's memory care unit on March 29, March 30, March 31, April 1, and again on April 4, 2026.

Record review of an employee's written statement included in the facility's internal investigation, dated 04/05/2026, showed that they overheard staff talking about instances of sexual abuse regarding Staff C and several residents and how the staff had

not been able to sleep because of what had been going on. The statement showed that the staff were not able to talk to their immediate supervisor, because they kept telling staff they were “bias.” Further review of the staff’s statement showed that staff did not know what to do and another staff member suggested calling the number on their badge (CRU complain number) if they could not talk to management about it.

In an interview on 04/07/2026 at 11:21 AM, Staff A, Assistant Administrator, stated they were made aware of the allegations of sexual abuse on 04/05/2026, and had completed an investigation on 04/06/2026. Staff A stated the alleged incidents occurred on 03/31/2026 and 04/01/2026. Staff A stated that based on their investigation, staff reported the allegations to the lead Medication Technician (MT), and the MT failed to report it to anyone else.

In an interview on 04/07/2026 at 11:25 AM, Staff B, Administrator, stated that they had been made aware of allegations of inappropriate sexual contact on 04/05/2026, involving Staff C, Caregiver, and two residents, Residents 1 & 2. Staff B stated no one had reported it to CRU and LLE after there was alleged abuse was because the caregiver who witnessed the inappropriate sexual contact told them that they were unsure if they needed to report it and stated they did not want to create “drama.” Additionally, Staff B stated they had not notified law enforcement themselves, and had planned to notify them on 04/07/2026, after completing the investigation.

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In an interview on 04/07/2026 at 2:15 PM, Staff D, Caregiver, stated that they had observed inappropriate behaviors involving Staff C and two residents on 03/31/2026 but had not reported it to upper management. When asked why they had not reported the concerns to management, Staff D stated they did not report the concerns due to belief it would be considered “drama” and not be addressed.

In an interview on 04/07/2026 at 2:15 PM, Staff F, Caregiver, stated that they had observed inappropriate behaviors involving Staff C and two residents on 03/31/2026 and 04/01/2026. Staff F stated the incidents did not sit well with them, so they notified Staff E, Lead Medication Technician; however, no further action was taken. Staff F stated they had not escalated the concern to management, as they believed it would be dismissed as gossip.

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the facility's policy to report allegations of abuse to the CRU, and LLE immediately. When asked as to why staff had not reported their concerns sooner, they stated that staff had recently been warned about gossiping and heard that they felt uncomfortable reporting concerns to their immediate supervisor out of fear of being terminated.

In an interview on 04/07/2026 at 4:09 PM, Staff B stated that they too had concerns that staff failed to report the allegations sooner, stating staff were trained to report abuse immediately.

This is a recurring deficiency previously cited on 07/17/2023

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Ciel Senior Living of the Tri-Cities Memory Care is or will be in compliance with this law and / or regulation on (Date) 6/5/26

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

Administrator (or Representative) — Date: 5/12/26

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Administrator (or Representative) Date