STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

03/03/2026

BRITTANY PARK LLC
FAIRWINDS BRITTANY PARK
17143 133RD AVE NE
WOODINVILLE, WA 98072

RE: FAIRWINDS BRITTANY PARK # 1172

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 73759 (Completion Date 03/03/2026) and 71327 (Completion Date 01/20/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/03/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

The Department staff who did the On Site verification:
Jodi Condyles, Nursing Consultant Institutional
Steven Kindle, Nursing Consultant Institutional

If you have any questions, please contact me at (206)305-3489.

Sincerely,

Jim Sherman

James Sherman, Field Manager

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Region 2, Unit D
Residential Care Services

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Residential Care Services
Investigation Summary Report

Provider/Facility: FAIRWINDS BRITTANY PARK
Provider Type: Assisted Living Facility
License/Cert.#: 1172
Intake ID: 205279
Compliance Determination #: 71327
Region/Unit #: RCS Region 2 / Unit D
Investigator: Wesler Dumecquias
Investigation Date(s): 01/13/2026 through 01/20/2026
Complainant Contact Date(s):

Allegation(s):
The Named Resident (NR) had missing medications.

Investigation Methods:

Sample:
Total residents: 38
Resident sample size: 3
Closed records sample size: 0

Observations:
Identified resident
Residents
Resident rooms
Medication safe box
Medication room

Interviews:
Identified resident
Identified staff
Nursing staff
Residents
Administrator

Record Reviews:
Facility policies
Incident investigation
State reporting log
Personnel files- background checks
eMAR
Incident report
Care plans
Witness/staff statements
Narcotic medication log books
Progress notes
PCP fax

Investigation Summary:
The facility investigated the incident but was unable to determine how seven tablets of narcotic medications of the NR went missing. The facility had a single narcotic safe box where the narcotic medications were stored. All MTs had access to the

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secure box. The facility had two MTs for the morning (AM) shift, two for the evening (PM) shift and one for the night shift (NOC). Out of the four MTs for the AM and PM shifts, and three for the PM and NOC shifts, only two MT each were responsible for the counting of the narcotic medications and sign the narcotic log book. One MT removed the unsealed bottle of the NR's narcotic medication, brought to the NR's room but eventually returned it because the NR refused without an accounting after removing and before taking it out to the NRs room, and without an accounting after returning the narcotic in the safe box. The MT stated they did not count because they relied on the quantity recorded in the narcotic logbook. At the end of the shift and during narcotic count, the MTs determined there were seven missing narcotic medications. Interview showed the outer door of the safe box containing the key to the narcotic drawer was open and unlocked. Failed practice was identified. A citation was issued for non compliance with WAC 388-78A-2210 (10 (b). Medication services.

Conclusion / Action:

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

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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 #: 1172	Compliance Determination # 71327
Plan of Correction	FAIRWINDS BRITTANY PARK	Completion Date
Page 1 of 5	Licensee: BRITTANY PARK LLC	01/20/2026

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 01/13/2026 of:

FAIRWINDS BRITTANY PARK
17143 133RD AVE NE
WOODINVILLE, WA 98072

This document references the following complaint number(s): 205279

The following sample was selected for review during the unannounced on-site visit: 3 of 38 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Wesler Dumecquias, Community Complaint Investigator

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

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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.

Jim Sherman
Residential Care Services

01-22-2026
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)

1/22/26
Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to implement a system that promoted a safe medication service for 1 of 1 residents (Resident 1). The facility failed to ensure that Resident 1's narcotic (a controlled substance used to treat moderate to severe pain) medication was fully accounted for, fully secured or locked. This failure resulted in the loss of seven narcotic tablets for Resident 1.

Findings included...

Review of Resident 1's face sheet showed they were admitted to the facility on [redacted]/2024 with multiple diagnoses including [redacted].

Review of the Medication Administration Record dated December 2025 showed Resident 1 was prescribed a narcotic, Oxycodone Hydrochloride (HCL) Immediate Release 10 Milligrams (MG) tablet to be given one tablet by mouth as needed for pain.

Review of an incident report dated 12/12/2025 showed Staff H, Medication Technician/Caregiver, and Staff I, Medication Technician/Caregiver, during an evening

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and night shift change narcotics medication count at 10:00 PM discovered seven tablets of Resident 1's narcotics medication were missing from the original container.

Review of the facility's narcotics medication logbook dated from 11/21/2025 to 12/15/2025 indicated that 60 tablets of Resident 1's Oxycodone HCL 10 MG were received and recorded. The narcotic medication logbook showed the remaining quantity was 38 tablets during the morning and evening shift change narcotic medication count on 12/12/2025, Later that same day, at the 10:00 PM shift change, the narcotic medication logbook recorded that there were 31 tablets remaining in Resident 1's Oxycodone medication.

On 01/13/2026 at 1:47 PM Staff B, the Health and Wellness Director, stated that they could not ascertain how the seven pills went missing. Staff B stated that there were two Medication Technicians (MT)/Caregivers for both the morning and evening shifts. Staff B stated that Staff F, MT/caregiver and Staff D, MT/Caregiver were assigned for the morning shift and Staff H, MT/Caregiver and Staff E, MT/Caregiver were assigned for the evening shift on 12/12/2025. Staff B stated that all four MTs had access to the narcotic medications safe box, keys, and medications. Staff B stated that not all outgoing and incoming MTs would participate in the narcotics medication count. Instead, two MTs, one from the outgoing shift and one from the incoming shift, were responsible for counting the narcotics. Staff B stated that the process for their staff in administering narcotic medications involved the MTs opening the safe box when a resident requested a narcotic, retrieving the key from the safe box, and using the key to unlock the narcotic medication drawer inside the safe box. The MT would then remove the narcotic medication, place it in their portable red bag, and deliver it directly to the resident's room. Staff B stated that staff would not count the narcotic medications at the time of removal from the safe box but rather count them after they returned the narcotic medications to the safe box and document the quantity in the narcotic medications' logbook.

Observation on 01/13/2026 at 2:11 PM showed there was a single narcotic safe located in the MT/Nurses station. The safe box featured an outer door equipped with a keypad for code access. When the outer door of the safe was opened, keys were found hanging inside the door. The safe box also included a drawer that could be accessed manually using a key. One of these keys was specifically designated for opening the drawer where all narcotics and controlled medications were stored. Staff indicated that one of the keys was used to unlock the drawer containing narcotics.

On 01/13/2026 at 2:37 PM, Staff D, morning MT/Caregiver stated that they worked on 12/12/2026 with Staff F for the morning shift. Staff D stated that they were assigned to Resident 1 and they administered one Oxycodone tablet to Resident 1 on 12/12/2026. Staff D stated Staff F, MT and Staff H, evening MT counted the narcotic medications at 2:00 PM shift change and the count was correct. Staff D stated that they did not count the narcotic medications with Staff D and H.

On 01/13/2026, at 2:37 PM, Staff D, morning MT/Caregiver, stated that they worked with

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Staff F during the morning shift on 12/12/2025. Staff D stated that they were responsible for Resident 1 and administered one Oxycodone tablet to Resident 1 on that date. Staff D stated that at the 2:00 PM shift change, Staff F, MT, and Staff H, evening MT, counted the narcotic medications, and the count was accurate. Staff D indicated that they did not participate in the count of narcotic medications with Staff D and H.

On 01/13/2026 at 2:58 PM, Staff E stated that they worked with Staff H during the evening shift on 12/12/2025. Staff E stated that they arrived late for their shift at 2:40 PM on 12/12/2025. Staff E stated that their protocol required that the first staff member to arrive for the incoming shift would conduct the count with the outgoing shift. Staff E stated that there were only two Staff responsible for counting the narcotic medications. Staff E stated that they do not conduct a count of the narcotic medications when they removed medication from the safe box, as they typically only count after they administered the medication. Staff E stated that the Staff returning the narcotic medication would count by themselves alone before they return it to the safe box. Staff E stated that they relied on the quantity recorded in the narcotic medication logbook and would not count after they removed it from the safe box, and prior to bringing it to residents' apartments. On 12/12/2025, Staff E stated that, due to a reminder from Staff D, the outgoing shift, regarding Resident 1's potential need for Oxycodone, Staff E retrieved Resident 1's Oxycodone bottle from the safe box, which had been previously opened and unsealed, placed it in their red bag and brought it to Resident 1's apartment. Resident 1 did not require pain medication at that time, and so Staff E returned the Oxycodone bottle to the safe box. Upon returning the bottle to the safe box, Staff E stated that they did not count the tablets in the Oxycodone bottle at that time, as they had not administered any medication to Resident 1.

In an interview on 01/14/2026 at 1:21 PM, Staff F, MT/Caregiver, stated that on 02/12/2025 they conducted a count of the narcotic medication with Staff H. Staff F stated that Staff E did not arrive yet and did not participate in the narcotic medication count. Staff F explained that they counted the narcotic medications with the incoming shift MT, who arrived first. According to Staff F, not all four Medication Technicians (MTs) would conduct the count together. Staff F stated that after they completed the count, they secured the narcotic drawer, locked it and hung the narcotic drawer key in the outer door of the safe box. Staff F stated that they did not lock the outer door of the safe box. Staff F stated that Staff H called them back to retrieve their lunchbox, and upon returning, they observed that the outer door of the safe box remained open, with Staff H still present in the room.

On 01/14/2026 at 1:35 PM, Staff G, a Licensed Nurse (LN), stated that they were the LN on duty that day (12/12/2025). Staff G stated that they observed the outer door of the safe box, which contained the narcotics drawer and the keys, to be open and unlocked .

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Statement of Deficiencies	License #: 1172	Compliance Determination # 71327
Plan of Correction	FAIRWINDS BRITTANY PARK	Completion Date
Page 5 of 5	Licensee: BRITTANY PARK LLC	01/20/2026

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, FAIRWINDS BRITTANY PARK is or will be in compliance with this law and / or regulation on (Date) 3/1/26.

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

Administrator (or Representative) Date 1/22/26

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