STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

SPOKN LLC
FAIRWINDS - SPOKANE
520 EAST HOLLAND AVE
SPOKANE, WA 99218

RE: FAIRWINDS - SPOKANE License # 1455

Dear Administrator:

This letter addresses Compliance Determination(s) 77848 (Completion Date 05/21/2026) and 74580 (Completion Date 03/24/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/21/2026 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-2210-1-b, WAC 388-78A-2210-2-a

The Department staff who did the on-site verification:
Brian Zbylski, ALF Licensor

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Community Field Manager
Region 1, Unit B
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

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 follow-up on 03/19/2026, 03/20/2026 and 03/24/2026 of:
FAIRWINDS - SPOKANE
520 EAST HOLLAND AVE
SPOKANE, WA 99218

This document references the following SOD dated: 03/24/2026

The following sample was selected for review during the unannounced on-site visit: 5 of 68 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Tethra Wales, Assisted Living Facility Licensor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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 — 04/02/2026 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.

Michelle DeFor Fer — Administrator (or Representative) — 4/13/2026 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.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement a safe medication delivery system and to ensure medications were administered as prescribed for 1 of 5 sampled residents (Resident 13). This failure resulted in Resident 13 not receiving two prescribed medications and placed the resident at risk for health complications.

Findings included...

Review of Resident 13's Negotiated Service Agreement, dated 03/20/2026, showed that the resident was diagnosed with [redacted] and [redacted]. Further review showed that the facility was to "ensure safe and effective medication assistance."

Review of Resident 13's March 2026 Medication Administration Record (MAR) showed that the resident had an order for clobetasol cream (a topical medication used to treat skin conditions) to be applied once a day, and an order for estradiol (a topical medication used to prevent urinary tract infections) to be applied three days a week. Further review showed that both medications were labeled "self [administered]" and that no time of day was listed for the medications to be given. Review of the MAR showed no documented staff initials to indicate the medication was administered by facility staff for either medication.

Review of a list of Resident 13's medication orders, dated 02/19/2026, showed an order for clobetasol cream to be applied once a day to treat [genital] dystrophy (skin changes to include itching, thinning, or thickening) and dermatoses (rashes, inflammation, or lesions), and an order for estradiol cream to be applied three days a week for frequent urinary tract infections.

In an interview on 03/20/2026 at 1:39 PM, Staff A, General Manager, stated that the clobetasol cream and estradiol cream were kept in the locked medication drawer in Resident 13's room and could only be opened by facility staff. Staff A further stated that the medication orders did not direct the resident to self-administer the clobetasol and estradiol creams, and that the medications should not have been listed as "self" on the MAR. Staff A further stated that because the medications were designated as "self" in the facility's electronic medication system, the system did not prompt staff to provide the medications to the resident and did not allow staff to document if and when the medications were provided. Staff A stated they were unable to confirm the last time either medication was administered.

In an interview on 03/20/2026 at 1:50 PM, Staff H, Resident Assistant 1, stated that Resident 13's clobetasol and estradiol creams were kept in the locked medication drawer in the resident's room and were inaccessible to the resident. Staff H further stated that the clobetasol and estradiol creams did not show in the electronic medication system that outlined medications to be given and that if Resident 13 had requested either of the medications they would have had to advise the resident that they could not provide it until they spoke with administration. Staff H confirmed that the medications could not be documented if given to the resident because the medications did not appear in their system.

This is an uncorrected deficiency previously cited on 01/27/2026 and a recurring deficiency previously cited on 04/20/2023 for subsection (2).

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 - SPOKANE is or will be in compliance with this law and / or regulation on (Date) 5/8/2026.

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

Michelle DeLuca — 4/13/2026

Administrator (or Representative) — Date

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 1455	Compliance Determination #71966
Plan of Correction	FAIRWINDS - SPOKANE	Completion Date
Page 1 of 13	Licensee: SPOKN LLC	01/27/2026

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 the unannounced on-site full inspection on 01/21/2026, 01/22/2026, 01/23/2026 and 01/26/2026 of:
FAIRWINDS - SPOKANE
520 EAST HOLLAND AVE
SPOKANE, WA 99218

The following sample was selected for review during the unannounced on-site visit: 12 of 70 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Veronica Jackson, Assisted Living Facility Licensor
Carla Rose, NCI Community Licensor
Tethra Wales, Assisted Living Facility Licensor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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.

J Salquist
Residential Care Services

02/04/2026
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.

Michelle DeLim Ferreira
Administrator (or Representative)

2/13/2026
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.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure medications were safely administered and administered as prescribed for 2 of 9 sampled residents (Resident 3 and 8). This failure resulted in Resident 8 not receiving prescribed medication for 10 months and self-administered medications after being assessed as unsafe to do so, and Resident 3 received medication without vitals checked prior. This failure placed the residents at risk of health complications.

Findings included...

<Resident 8>

Review of Resident 8's Negotiated Service Agreement (NSA) dated 01/23/2026, showed that the resident was diagnosed with [redacted]

[redacted], and [redacted]. Further review showed that the facility had administered all medications to the resident since 10/14/2024 and the facility was to "ensure safe and effective medication assistance."

Review of Resident 8's assessments dated 08/19/2025 and 10/06/2025, showed that Resident 8 was unsafe to manage and self-administer their medications.

Review of an incident report dated 09/25/2025, showed that Resident 8 was disoriented and required further assessment by staff.

Review of the Medication Administration Records (MARs) for November 2025, December 2025, and January 2026, showed Resident 8 had orders for Trazodone (medication for insomnia) to be given at bedtime, Unisom sleep tabs (over the counter [OTC] medication for insomnia) to take at bedtime as needed, and ZzzQuil (OTC medication for insomnia) to take at bedtime as needed. The MARs showed that all three of these medications were "self" administered and were "kept at bedside."

Review of a chain of faxed communications to Resident 8's provider showed the following:

09/25/2025, note sent to the provider "[Resident 8] has been taking ZzzQuil and sleep aids on [their] own... we have no orders for these meds, please advise." The fax showed a response from the provider with a request for the names of the sleep aid medications that Resident 8 had at bedside.

10/03/2025, note sent to the provider with the details of the ZzzQuil and Unisom sleep tabs and a requested an order that the two medications may be kept at bedside.

10/07/2025, the provider responded with orders for the two medications and orders that they may be kept at bedside.

In an interview on 01/23/2026 at 4:00 PM, Staff A, General Manager, was asked about the process when medications were found in a resident's room after they had been assessed as unsafe to self-administer medications. Staff A stated that they notified resident representatives and developed a plan to collect the medications. Staff A further stated that if they had an order for medications to be kept at bedside, they involved family and discussed the next steps.

Review of Resident 8's undated medical records showed no documentation of a discussion with resident or family about the safety of managing bedside medications. In an interview and observation on 01/26/2026 at 10:15 AM, Resident 8 stated they had ZzzQuil and Unisom at bedside. Resident 8 was unable to find the ZzzQuil but did show the department two bottles of Unisom. Resident 8 stated that staff saw the medications and notified Staff E, Health and Wellness Manager. Resident 8 said that Staff E came to

their room and looked at the bottles of the two sleep aides but did not discuss any details about how they took the medications. When asked if Resident 8 took trazodone, Resident 8 stated they were unaware that the doctor had ordered trazodone.

In an interview on 01/26/2026 at 11:05 AM, Staff G, Resident Assistant 2, stated that medications administered by the facility were stored in a locked cabinet in each resident room. Staff G stated that only staff had keys to the cabinets and residents did not have access to them. Staff G confirmed that extra doses and overflow medications were also kept in the locked cabinets.

Observation on 01/26/2026 at 11:10 AM, showed a locked, two drawer cabinet in Resident 8's room that contained the medications that the facility administered to them. Further observation showed the cabinet also contained trazodone. The trazodone was packed in bubble pack cards, with a one-month supply of the medication on each card. The refill dates on each card showed the medication had been filled every month from April 2025 through January 2026, for a total of 10 monthly cards. Observation showed that none of the doses had been removed.

In an interview on 01/26/2026 at 1:25 PM, Staff E confirmed that Resident 8 had ZzzQuil and Unisom at bedside. Staff E stated that they were aware that Resident 8 had an assessment that showed they were unsafe to self-administer all medications. Staff E indicated the provider was not notified of the unsafe self-administration assessment when they requested the order to keep at bedside. When asked about the trazodone, Staff E stated they were unaware that the MAR showed it listed as self-administration. Staff E further stated they were unaware that Resident 8 had an abundance of trazodone and that it had not been administered for several months.

<Resident 3>

Review of Resident 3's NSA dated 01/11/2026, showed that the resident had a history of cerebral infarction (blockage of blood vessels that supply oxygen to the brain) which caused the resident to have right side weakness, and a diagnosis of [redacted]. Further review showed that the facility provided medication administration assistance.

Review of Resident 3's MAR's dated October 2025, November 2025, December 2025 and January 2026 showed an order to give metoprolol (used to treat high blood pressure) daily, to hold the medication if pulse (heart rate) was under 55 and to fax the physician. Further review showed that the medication technicians had administered the medication and the pulse was not monitored or recorded.

In an interview on 01/22/2026 at 4:20 PM, Staff A confirmed that medication technicians did not check Resident 3's pulse when they administered the metoprolol.

This is a recurring deficiency previously cited on 04/20/2023 for 388-78a-2210 (2).

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 - SPOKANE is or will be in compliance with this law and / or regulation on (Date) 3/13/2026

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

Michelle DeSmet — Administrator (or Representative)

2/13/2026 — Date

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

(iii) Corridors, as well as common and outdoor areas accessible to residents.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to provide a communication system in 2 of 2 outdoor patio areas (South and East). This failure placed residents at risk of being unable to communicate with staff in the event of an emergency.

Findings included...

< South Patio>

Observation on 01/21/2026 at 12:56 PM showed a large patio area adjacent to the dining room with no outdoor communication system.

In an interview on 01/21/2026 at 12:56 PM, Staff F, Plant Operations Assistant, identified the space as an outdoor patio residents utilized and confirmed that there was no outdoor communication system. Staff F further stated that the doors to the interior of the building required a key.

During the resident group meeting on 01/22/2026 at 11:00 AM, Resident 10 stated "there is nothing on the [south] patio for help." Resident 10 further stated that residents or visitors needed a cell phone to call for help from the patio.

<East Patio>

Observation on 01/21/2026 at 1:11 PM, showed a large patio area on the east side of the building with no outdoor communication system.

In an interview on 01/21/2026 at 1:11 PM, Staff F identified the space as a second outdoor patio area where residents congregated and confirmed there was no outdoor communication system. Staff F confirmed that the door off the patio area that provided access inside required a key to open.

In an interview on 01/22/2026 at 3:10 PM, Staff A, General Manager, confirmed that there were no communication systems available in the two outdoor patio areas.

In an interview on 01/22/2026 at 4:02 PM, Staff A stated that the key to the exterior doors was optional and that not all residents had an exterior key.

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 - SPOKANE is or will be in compliance with this law and / or regulation on (Date) 3/13/2026.

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

Michelle DeLeon B — Administrator (or Representative)

2/13/2026 — Date

WAC 388-78A-2980 Lighting.

(2) The assisted living facility must maintain electric light fixtures and lighting necessary for the comfort and safety of residents and for the activities of residents and staff.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure adequate lighting was provided to ensure safety for residents' vehicles and personal safety in the resident parking lot for 4 of 6 covered parking areas (Areas 1, 2, 3 and 4) and impacted 2 of 2 residents (Resident 11 and 12). This failure contributed to distress for residents due to concerns about safety about the decreased lights under covered parking.

Findings included...

In an interview on 01/22/2026 at 1:15 PM, Staff F, Plant Operations Assistant, stated that the fence had been cut multiple times by homeless individuals attempting to access the covered parking areas 1, 2, 3, and 4 of the parking lot on the southwest corner.

During the group meeting on 01/22/2026 at 11:00 AM, Resident 11 stated that residents paid an additional monthly fee to park their vehicles in the covered parking spaces. Resident 11 stated they had notified management multiple times about their safety concerns and other residents' concerns about the poorly lit areas of the covered parking.

In an interview on 01/22/2026 at 4:00 PM, Staff A, General Manager, stated that they were aware of resident concerns of inadequate lighting in the parking lot and the concerns were brought to the attention of the Operations Director last year. Staff A stated that they were informed that the Operations Director felt the lighting was adequate and that additional parking lot lights would possibly shine into resident room windows.

In an interview and observation on 01/23/2026 at 11:00 AM, Resident 11 showed the department licensor areas of concern in the resident parking lot areas that they identified as dark and not well lit at night, where they felt unsafe and other residents had voiced their concerns of feeling unsafe at resident council meetings. Resident 11 stated they had discussed this issue with the facility, and tried to get increased outside lighting for around four years. During the observation, Resident 11 pointed out and stated that all 6 of the covered parking areas were dark at night, that the carports blocked the light from the tall security lights, only shined straight down and did not illuminate large areas. Resident 11 also pointed out a black van across the street by the east entrance and stated that homeless people were living in it for the last four months. Resident 11 named several residents that had various experiences with their cars being vandalized, broken into, and a punctured gas tank (to steal gasoline) that happened in the parking lots. They further stated last summer a resident's daughter (who no longer lives at the facility) was assaulted in an attempted carjacking on facility grounds. When the department asked Resident 11 if the facility had invited them to show them the areas of concern that they reported, the Resident stated that they had not.

In an interview on 01/23/2026 at 11:25 AM, Resident 12 stated that their vehicle's side window was broken when it was parked by the facility's covered parking lot. Resident

12 stated due to this incident, and unsafe lighting they gave up their car.

In an interview on 01/23/2026 at 4:00 PM, Staff A confirmed there was an incident in the summertime where a previous resident's daughter had been assaulted in the facility parking lot in an attempted carjacking and they had filed a police report.

Observation on 01/24/2026 at 6:05 PM, of the larger carport areas running north to south on the southeast side of the parking lot adjacent to Walmart (Carport areas 1, 2, 3, and 4) showed that the carport roofs blocked much of the overhead lighting which created darkened areas close to and in between parked cars. Further observation showed homeless individuals resided on the other side of the fence that bordered the covered parking areas in a black van that Resident 11 had described previously and a large motorhome. There was also a parking lot entrance with no security barrier or gate right next to the property that bordered Walmart which was dark and allowed individuals to trespass without being seen under the covered parking areas.

Review of suspicious activity reports by the company that provided overnight security rounds to the facility showed suspicious activity on:

09/09/2025 at 7:21 AM: "Rav4 parked with windows down."

12/19/2025 at 6:46 AM: "found trash-possibly homeless activity in the back driveway by the east entrance."

12/26/2025 at 12:48 AM: "found one vehicle with no one around idling in parking lot with lights on. Rechecked at 1:47 AM and the car was off and showed pictures taken."

01/23/2026 at 1:39 AM: "small piece of trash on southwest corner behind garage. Smal cardboard box out on the main sidewalk with pictures shown."

In an interview on 01/26/2026 at 11:05 AM Collateral Contact 1, Resident Representative, stated they did not feel safe when coming and going in the parking lot, where they and their spouse (assisted living resident) parked their car. They further stated they had removed broken glass by their car three times that would have caused damage to their tires if not picked up, they observed homeless people frequently in the area walking by the parking area and would feel a lot safer if there was more light in order to improve visibility and decrease the element of surprise. They stated increased visibility provided with more light would allow them some time to reach for their phone to call for help if needed.

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 - SPOKANE s or will be in compliance with this law and / or regulation on (Date) 3/13/2026.

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

Michelle DeLeeB — Administrator (or Representative)

2/13/2026 — Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based upon interview and record review, the facility failed to ensure that a second Tuberculosis skin test was completed for 1 of 6 staff (Staff D). This failure placed residents at risk of exposure to Tuberculosis, a communicable disease.

Findings included...

Review of Staff D's, Resident Assistant 2, personnel file showed that they were hired on 07/16/2025. Further review showed the file did not contain documentation of the second step of their two-step tuberculosis (TB, a communicable respiratory disease) testing.

Review of the facility's schedule dated January 2026 showed that Staff D worked on 01/07/2026, 01/08/2026, 01/11/2026, 01/12/2026, 01/16/2026, 01/19/2026, 01/20/2026, 01/22/2026, 01/22/2026, and 01/23/2026.

In an interview on 01/26/2026 at 2:40 PM, Staff A, General Manager, stated that Staff D had not completed the second step TB test.

This is a recurring deficiency previously cited on 04/20/2023 for 388-78a-2484 (2).

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 - SPOKANE is or will be in compliance with this law and / or regulation on (Date) 3/13/2026

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

Michelle DeLaTorre — Administrator (or Representative)

2/13/2026 — Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that specialty training was completed by 2 of 6 sampled staff (Staff C and D), and that the home-care aide certification was maintained and current for 1 of 6 staff (Staff B). This failure placed residents at risk of receiving care from untrained care staff.

Findings included...

<Staff B>

Review of 388-112-0060 (1) showed that long term care workers were required to maintain their credential in good standing.

Review of Staff B's, Resident Assistant 1, personnel file showed that Staff B was hired on 03/27/2025.

Review of the Department of Health on-line Provider Credential Search completed by the department on 01/26/2026 at 2:15 PM, showed that Staff B's Nursing Assistant Certification (NAC) had expired on 01/10/2026.

Review of the facility's schedule dated January 2026, showed that Staff B worked on 01/14/2026, 01/15/2026, 01/16/2026, 01/17/2026, 01/22/2026, and 01/23/2026.

In an interview on 01/26/2026 at 2:40 PM, Staff A, General Manager, confirmed that Staff B's NAC had expired and they had not yet renewed their certification. Staff A further stated that Staff B had provided care to residents after their certification had expired.

<Staff C>

Review of the facility's undated Disclosure of Services stated that they accepted residents with mental health and dementia issues and that they provided staff with specialty training in these areas.

Review of Staff C's, Resident Assistant 2, personnel file showed that Staff C was hired on 11/07/2024. Further review showed no documentation of dementia specialty training.

Review of the facility's Resident Characteristics Roster dated 01/21/2026, showed that the facility had six residents with a diagnosis or symptoms of [redacted].

Review of the facility's schedule dated January 2026 showed that Staff C worked on 01/04/2026, 01/07/2026, 01/08/2026, 01/09/2026, 01/11/2026, 01/15/2026, 01/17/2026, 01/18/2026, 01/22/2026, 01/23/2026, and 01/24/2026.

In an interview on 01/26/2026 at 3:35 PM, Staff A confirmed that Staff C had not completed dementia training.

<Staff D>

Review of Staff D's, Resident Assistant 2, personnel file showed that Staff D was hired on 07/16/2025. Further review showed no documentation of dementia or mental health specialty trainings.

Review of the facility's Resident Characteristics Roster dated 01/21/2026, showed that the facility had six residents with a diagnosis or symptoms of [redacted].

Review of the facility's undated Disclosure of Services stated that they accept residents with mental health and dementia issues and that they provided staff with specialty training in these areas.

Review of Resident 8's Negotiated Service Agreement (NSA), dated 01/23/2026, stated a diagnosis of [redacted].

Review of the facility's schedule dated January 2026 showed that Staff D worked on 01/07/2026, 01/08/2026, 01/11/2026, 01/12/2026, 01/16/2026, 01/19/2026, 01/20/2026, 01/22/2026, 01/22/2026, and 01/23/2026.

In an interview on 01/26/2026 at 4:15 PM, Staff A confirmed that they did not have documentation of Staff D's dementia or mental health training.

In an electronic email communication on 01/27/2026 at 4:32 PM, Staff A stated that Staff D had not completed specialty training for dementia and mental health.

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 - SPOKANE is or will be in compliance with this law and / or regulation on (Date) 3/13/2026

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

Michelle Dexter — 2/13/2026

Administrator (or Representative) — Date

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(2) Ensure animals living on the assisted living facility premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that required vaccinations were current when a pet lived on the premises for 1 of 3 pets (Pet A). This failure placed residents at risk of exposure to diseases transmitted from pets to humans.

Findings included...

Review of Pet A's Certificate of Vaccination, dated 07/19/2024, showed that Pet A's rabies vaccination expired on 07/19/2025.

In an interview on 01/26/2026 at 4:15 PM, Staff A, General Manager, acknowledged that Pet A was not current with required vaccinations.

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 - SPOKANE is or will be in compliance with this law and / or regulation on (Date) 3/13/2026.

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

Michelle DeLemFer — 2/13/2026

Administrator (or Representative) — Date