



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

REDM LLC
FAIRWINDS REDMOND
9988 AVONDALE ROAD NE
REDMOND, WA 98052

RE: FAIRWINDS REDMOND License # 1814

Dear Administrator:

This letter addresses Compliance Determination(s) 26883 (Completion Date 07/19/2023) and 19208 (Completion Date 02/09/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/19/2023 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-2482-3-a, WAC 388-78A-2482-3-b, WAC 388-78A-2482-3, WAC 388-78A-2482-2, WAC 388-78A-2482-1, WAC 388-78A-2482, WAC 388-78A-2450-3-d-i-A, WAC 388-78A-2450-3-d-ii, WAC 388-78A-3040-7-a-iv

The Department staff who did the on-site verification:

Thomas Forkgen, ALF Licenser

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

Sincerely,

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



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 #: 1814	Compliance Determination # 19208
Plan of Correction	FAIRWINDS REDMOND	Completion Date
Page 1 of 7	Licensee: REDM LLC	02/09/2023

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 01/31/2023, 01/31/2023, and 01/31/2023 of:
FAIRWINDS REDMOND
9988 AVONDALE ROAD NE
REDMOND, WA 98052

This document references the following SOD dated: 02/09/2023

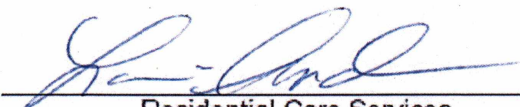
The following sample was selected for review during the unannounced on-site visit: 8 of 28 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licenser
Kathy Young, Licenser

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

02-16-2023
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.



C. J. C. J.
Administrator (or Representative)

2.27.23
Date

WAC 388-78A-2482 Tuberculosis No testing. The assisted living facility is not required to have a staff person tested for tuberculosis if the staff person has:

- (1) A documented history of a previous positive skin test, with ten or more millimeters induration;
- (2) A documented history of a previous positive blood test; or
- (3) Documented evidence of:
 - (a) Adequate therapy for active disease; or
 - (b) Completion of treatment for latent tuberculosis infection preventive therapy.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that 1 of 1 staff (Staff F) had the required documentation for no Tuberculosis (TB) testing. This failure placed residents at risk of contracting an infectious illness.

Findings included...

Record review of the undated facility's document titled, "Employee Staff" showed the facility hired Staff F as a Resident Assistant II on 05/11/2018.

Record review of the facility's document titled, "Job Description Resident Assistant II", dated March 2021, showed "This is a broad-scoped caregiver position... has responsibility for direct resident care... bathing, dressing, grooming, toileting... administer medications and provide 'nursing tasks'."

Record review of the facility's copy of Staff F's untitled medical clinic records, dated 10/06/2014 and 08/13/2022, showed Staff F had two negative chest x-rays. Review of Staff F's facility personnel records showed no documentation that Staff F had a history of a positive skin test of 10 millimeters (mm) induration (measurement) or a previous positive blood test. Further review of Staff F's personnel records showed no documentation Staff F received any adequate therapy for active disease or completed the treatment for latent tuberculosis infection preventive therapy.

Record review of the facility's untitled care staff schedule dated 01/03/2023 – 01/31/2023, showed Staff F worked 21 shifts.



Record review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 11/15/2022 for Staff F. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 01/03/2023.

Observation on 01/31/2023 showed Staff F was off work this day. Previous observations on 10/25/2022 at 11:00 AM and on 10/26/2022 at 1:03 PM and 1:38 PM, showed Staff F had direct contact with residents while they provided care and services.

During an interview on 01/31/2023 at 10:40 AM, Staff X, Resident Care Coordinator, stated that since the completion of the full inspection on 11/15/2022, the facility received no additional TB records for Staff F.

During an interview on 02/02/2023 at 10:39 AM, Staff H, General Manager, stated that Staff B, Wellness Director, informed Staff H that they corrected the issue. Staff H further stated that he instructed Staff B to provide the Department with the plan of correction. As of 02/06/2023, Staff H had not provided any plan of correction to the Department Licensors.

During an interview on 02/06/2023 at 1:36 PM, Staff H stated that the plan of correction showed the facility would review all staffs' TB documentation. The plan of correction also required that any staff without proper documentation were removed from the schedule until the required documentation was provided. Staff H then confirmed that to this date, Staff F still had not provided the required TB documentation. Staff H also confirmed that Staff F continued to be scheduled for work.

This is an uncorrected deficiency previously cited on 11/15/2022.

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 REDMOND is or will be in compliance with this law and / or regulation on (Date) 5-1-23.

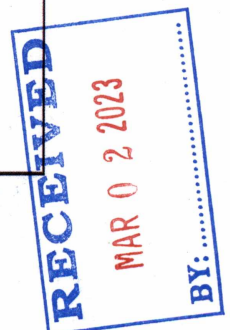
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

C. J. C.
Administrator (or Representative)

2-27-23
Date

WAC 388-78A-2450 Staff.

(3) The assisted living facility must:



(d) Maintain the following documentation on the assisted living facility premises, during employment, and at least two years following termination of employment:

(i) Staff orientation and training or certification pertinent to duties, including, but not limited to:

(A) Training required by chapter 388-112A WAC;

(ii) Disclosure statements and background checks as required in WAC 388-78A-2461 through 388-78A-2471 ; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to maintain on the assisted living facility premises, the personnel records for 1 of 1 Executive Director staff (Staff A). This failure placed all residents at risk for potential abuse or neglect during interactions with a staff member with unverified qualifications.

Findings included...

Review of the Department's Facilities Management System (FMS) showed the facility hired Staff A as the Executive Director on 07/27/2021. Further review of FMS showed that another facility under the same company hired Staff A as the Executive Director on 03/01/2018, and Staff A worked concurrently at both facilities.

Review of the facility's undated "Disclosure of Services" showed the facility accepted residents with dementia. The disclosure also showed that assisted living facilities that chose to serve residents with dementia must provide staff with specialized training in this area.

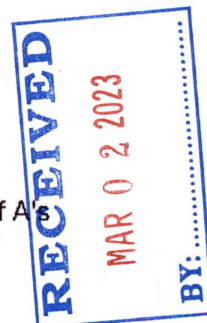
Review of WAC

388-112A-0400 (3)(b) showed the training required for assisted living facility administrators. The requirements included dementia specialty training for facilities that provided services to residents with dementia.

Record review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 11/15/2022 for Staff A. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 01/03/2023.

Observation on 01/31/2023 showed Staff A was off work on this day. Previous observation on 10/25/2022 showed Staff A worked in the facility.

During an interview on 01/31/2023 at 10:45 AM, Staff H, General Manager, confirmed that Staff A's personnel file was not in the facility as Staff A also worked as the Executive Director at another facility under same company as this facility. Staff H stated that Staff A's



record would be provided from the other facility later in the day on 01/31/2023.

Record review of Staff A's personnel documents provided by the other facility showed in a document titled, "IdentiGO", dated 09/25/2019, Staff A completed a fingerprint background check. Further review of the document showed the fingerprints were completed by the Washington State Patrol (WSP). The WSP document titled, "Fingerprint Based Criminal History Background Check", dated 10/01/2019, showed Staff A's fingerprints were run through the Washington State Criminal History Repository. There was no documentation provided that showed Staff A completed the required Department of Social and Health Services national fingerprint background check. Further review of Staff A's personnel records showed no documentation that Staff A completed the required Dementia Specialty Training.

During an interview on 01/31/2023 at 11:42 AM, Staff H stated that Staff A was unavailable for an interview. Staff H further stated that they did not know why Staff A's documents were still unavailable.

During an interview on 02/06/2023 at 8:47 AM, a representative of the DSHS Background Check Central Unit confirmed that Staff A completed a national background check at the same time the Washington State Patrol fingerprint background check was completed.

This is an uncorrected deficiency previously cited on 11/15/2022.

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 REDMOND is or will be in compliance with this law and / or regulation on (Date) 5.1.23.

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



Administrator (or Representative)

2.27.23

Date

WAC 388-78A-3040 Laundry.

(7) The assisted living facility must provide a laundry area or develop and implement policy and procedure to ensure residents have access to an area where residents' may do their personal laundry that is:

(a) Equipped with:

(iv) Mechanical ventilation to the outside of the assisted living facility.



This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that 2 of 6 resident laundry room air exchange vents (ventilation system that exchanges air inside a building with fresh air from outside and gets installed in tightly built buildings with only minimal ventilation) were properly functioning. This failure placed all 28 residents at risk of diminished health and airborne illnesses from breathing poor air quality due to improper ventilation.

Findings included...

Review of the Centers for Disease Control and Prevention's (CDC) website on 11/04/2022, showed that proper building ventilation "reduce the spread of disease and lower the risk of exposure... Protective ventilation practices and interventions can reduce the airborne concentrations and reduce the overall viral dose to occupants."

Record review of the facility's undated document titled, "Resident Characteristic Roster" showed the facility provided care and services to 28 residents.

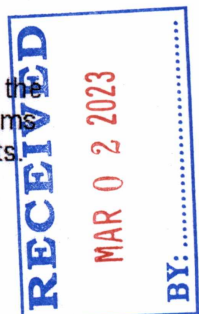
Record review of a heating, ventilation, and air conditioning (HVAC) service company invoice, dated 11/07/2022, showed the facility received two service calls related to the nonfunctional ventilation of the third floor north and second floor west resident laundry rooms. One service call was on an unspecified date and the second call was on 11/02/2023 with the issue unresolved.

Record review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 11/15/2022. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 01/03/2023.

Observation on 01/31/2023 at 10:22 AM, showed the second floor west Resident Laundry Room contained no windows or other means of ventilation other than the air exchange vent. Observation of the mechanical air exchange vent showed that it did not pull air to ventilate the room.

Observation on 01/31/2023 at 10:38 AM, showed the third floor north Resident Laundry Room contained no windows or other means of ventilation other than the air exchange vent. Observation of the mechanical air exchange vent showed that it did not pull air to ventilate the room.

During an interview on 01/31/2023 at 10:20 AM, Staff L, Plant Operations Supervisor, stated that the facility was unable to repair the two nonfunctional air exchange vents for the resident laundry rooms prior to the reinspection. Staff L stated that the delay was related to unavailable replacement parts. Staff L stated that the original fan motors



operated at 277 volts. Staff L further stated that the HVAC company was unable to work out the solution to reduce the voltage of the motors which left the facility waiting to have the repairs completed. Staff L stated that he knew the facility could ask the Department for an extension to the original date for the plan of correction (POC). Staff L stated that the facility failed to request an extension.

During an interview on 01/31/2023 at 10:48 AM, Staff H, General Manager, stated that he was aware of the delay in repairing the air exchange vents. Staff H stated that he needed to check with the HVAC company for an estimated repair time. Staff H further stated that he was aware of his responsibility to call the Department when an extension to the original POC date was needed. Staff L stated that he failed to make the request.

This is an uncorrected deficiency previously cited on 11/15/2022.

Plan/Attestation Statement

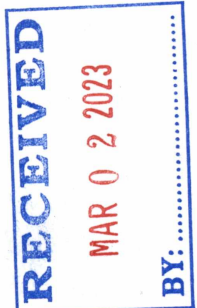
I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, FAIRWINDS REDMOND is or will be in compliance with this law and / or regulation on (Date) 5.1.23.

IN CONSTRUCTION REVIEW

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

Cory Carey
Administrator (or Representative)

2.27.23
Date





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 #: 1814	Compliance Determination #15388
Plan of Correction	FAIRWINDS REDMOND	Completion Date
Page 1 of 17	Licensee: REDM LLC	11/15/2022

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 10/25/2022, 10/25/2022, 10/26/2022 and 10/28/2022 of:

FAIRWINDS REDMOND
9988 AVONDALE ROAD NE
REDMOND, WA 98052

The following sample was selected for review during the unannounced on-site visit: 5 of 25 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licenser
Kathy Young, Licenser

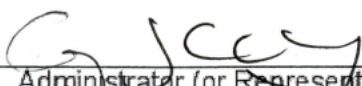
From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2, Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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

11-22-2022
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)12.1.22

Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to monitor that a medical device for 1 of 3 sampled residents (Resident 2) was securely and safely installed for use. This failure placed Resident 2 at risk for entrapment and injury.

Findings included...

BED ENABLER

Note: On 05/15/2013, a "Dear Assisted Living Facility Administrator" letter was issued to Assisted Living Facility Providers related to the safety risks associated with the use of all medical devices to include, i.e. "some examples of medical devices with known safety risks when used include transfer poles, Posey or lap belts, and side bed rails. Potential risks of medical devices may include strangling, suffocating, bodily injury, skin bruising, cuts, scrapes, agitation, feeling isolated or unnecessarily restricted."

Review of an undated facility document titled "Resident Characteristics Roster" showed that the facility admitted Resident 2 in [REDACTED] 2022. Resident 2's Physician Order, dated 06/08/2022, showed a bed mobility bar was ordered on 06/14/2022 to aid in bed mobility independence.

Review of a Bed Rail assessment dated 6/14/2022 and an evaluation done on 09/22/2022 showed that Resident 2 requested the bed rail to allow for independence with bed mobility.

Review of Resident 2's Negotiated Service Agreement, dated 10/14/2022, showed that the care staff were to ensure that the bed rail was correctly installed and secured under the mattress.

Observation on 10/26/2022 at 1:38 PM, showed Resident 2 had a bed rail attached to the

left side, at the head of the bed. The bedrail was 16 inches long and 18-20 inches high. The position of the bedrail allowed for a gap greater than 6 inches wide. The gap was large enough to allow Resident 2's head or an extremity to be entrapped. To use the bedrail with the bed, the bedrail supports slid between the box spring and mattress. The bedrail was not fastened to the bed frame. With minimal effort, the bedrail slid out from under the mattress and away from the bed which created a hazard.

During an interview on 10/27/2022 at 9:30 AM, Staff B, Registered Nurse, Health and Wellness Director, stated that staff checked the bed rail every day to ensure it was safe and attached to the bed.

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 7 of 22 staff (Staff F, Staff M, Staff Q, Staff R, Staff S, Staff T and Staff V) wore proper eye protection during all resident encounters. This failure placed all 25 residents at risk of contracting and spreading a potentially life-threatening disease.

Findings included...

The Centers for Disease Control and Prevention (CDC) developed guidelines for agency wide response to the COVID-19 pandemic. The Washington State Governor's Office, the Washington State Department of Social and Health Services (DSHS), the Washington State Department of Labor and Industries (L&I), and the Washington State Department of Health (DOH) established the current standards of infection control to prevent and control the spread of COVID-19 in the community.

Review of a Provider letter dated 10/14/2022 showed that the statewide face coverings and eye protection will still be required in long-term care facilities, according to Center for Disease Control guidance. The current guidance says that staff in facilities located in counties with substantial or high transmission should wear eye protection when residents are present.

Review of The Department of Social and Health Services, Infection Control Preventionist for Residential Services, information dated 10/28/2022 showed that the Department of Health defined an encounter as "in-person, interactions between staff and residents and there is less than 6 feet between the staff and resident for any period of time. These may involve medical procedures, caregiving activities/activities of daily living, medication administration, transportation, etc".

Review of the facility's undated document titled "Assisted Living Facility Resident Characteristic Roster" showed the facility provided care and services to 25 Residents.

PERSONAL PROTECTIVE EQUIPMENT

Observation on 10/25/2022 at 11:00 AM, showed Staff Q, Prime Fit Personal Trainer, facilitated an activity on the first floor. Unidentified residents were observed playing cornhole. Staff Q did not wear eye protection when they interacted with the residents.

Observation on 10/25/2022 at 12:05 PM, and 10/26/2022 at 1:38 PM, showed that Staff F, Medication Technician, Caregiver, provided care to an unidentified resident in their apartment. Observations also showed Staff F communicated with Resident 2, a hearing-impaired resident, by speaking directly into Resident 2's ear. Both observations showed that Staff F did not wear eye protection.

Observation on 10/25/2022 at 12:45 PM, showed that Staff R, Dining Server, wore a mask when serving residents in the dining room. Observation showed Staff R did not wear any eye protection.

Observation on 10/27/2022 between 12:30 PM and 1:00 PM, showed five staff, Staff M, Staff R, Staff S, Staff T, and Staff V (all Restaurant Servers) served food to residents in the facility's main dining room. Further observation showed that none of the five servers wore eye protection.

During an interview on 10/27/2022 at 1:18 PM, Staff U, Resident Assistant, stated that they wore eye protection only when they provided direct care to residents. Staff U showed a pair of goggles they used when they provided direct resident care. Staff U stated that they were unaware they needed to wear eye protection for all resident encounters.

During an interview on 10/27/2022 at 1:38 PM, Staff L, Chef, stated that they were unaware dining room servers were required to wear eye protection when they served food to the residents.

During the exit conference on 10/28/2022 at 3:45 PM, Staff B, Registered Nurse, Wellness Director, stated that the Resident Assistants wore eye protection when they provided direct care to residents. Staff B stated that each Resident Assistant carried a pair of goggles with them. Staff B stated that the facility staff were not required to wear eye protection when they encountered residents in the hallway or other locations. Staff H, General Manager, stated that they thought Restaurant Servers and other staff were not required to wear eye protection when they served food or encountered residents unless they provided direct care.

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 REDMOND is or will be in compliance with this law and / or regulation on (Date) 1.3.2023.

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

Cg LLC
Administrator (or Representative)

12.1.22

Date

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to implement a new medication order or obtain clarification of the new order for 1 of 1 sampled Resident (Resident 4). This failure placed Resident 4 at risk for not receiving pain relieving medication as prescribed.

Finding included...

Review of the facility's document titled "Medication Services Policy", revised March 2022, showed that a medication error occurs when "any situation where the exact orders from the physician were not followed". The policy showed that when the facility accept responsibility for a resident's medications, the facility will obtain the medications in a correct and timely manner.

Review of Resident 4's "Emergency Data Summary" showed the facility admitted Resident 4 in [REDACTED] 2022. Resident 4 admitted with multiple diagnoses which included [REDACTED], [REDACTED], and [REDACTED] and [REDACTED].

Review of Resident 4's "Negotiated Service Agreement", dated 10/13/2022, showed that the facility provided medication assistance which included ordering, storage, and set-up service "to ensure safe and effective medication assistance and management practices are followed".

Review of Resident 4's August 2022 electronic Medication Administration Record (eMAR) showed an order for Tramadol HCL 50 mg to be given by mouth three times a day. The eMAR showed that the order was initiated on 08/05/2022. The eMAR showed that the order was placed on hold on 08/05/2022 until the order could be clarified with the doctor due to Resident 4's fall risk. Review of the August 2022, September 2022, and documented

through October 31, 2022 eMARs showed that the order remained on hold until clarified with the physician. The August 2022, September 2022, and October 2022 eMARs also showed that Resident 4 had a preexisting order for Tramadol 50 mg to be given one tablet by mouth three times a day, as needed for pain.

Review of the facility's copy of Resident 4's medical records showed a prescription order dated 08/02/2022 for Tramadol (pain relieving medication) 50 milligrams (mg) to be given three times a day routinely. The prescription order showed that Resident 4's primary physician wrote the order and included the primary physician's Drug Enforcement Agency number. Further review of Resident 4's medical records showed that on 08/02/2022 a fax was sent to Resident 4's primary physician which expressed concerns regarding the new routine Tramadol order. The fax showed that Staff B requested the Tramadol order remain as needed and not changed to routine. There was no additional documentation that showed any clarification from the physician for the routine Tramadol order dated 08/02/2022 was received.

Additional review of Resident 4's medical records showed that on 10/26/2022, another fax was sent to Resident 4's primary physician that requested the routine Tramadol order dated 08/02/2022 be discontinued. The fax showed that a copy of Resident 4's medication list, printed on 10/27/2022, was attached for the physician's review. There was no additional documentation of any other follow up with Resident 4's physician.

During an interview on 10/27/2022 at 1:00 PM, Staff B, Registered Nurse, Health and Wellness Director, stated that during an Emergency Department (ED) visit on 08/02/2022, the ED physician prescribed Resident 4 Tramadol HCL 50 mg to be given by mouth three times a day. Staff B stated that since Resident 4 was a fall risk, Staff B was concerned that implementation of the Tramadol order placed Resident 4 at a higher risk for falls. Staff B stated that based on this concern, she placed the new Tramadol order on hold. Staff B stated that they called the Emergency Department doctor for clarification regarding the Tramadol order. Staff B stated that they did not receive a response back. Staff B stated that they also sent several faxes to Resident 4's primary care physician requesting clarification of the Tramadol order. Staff B stated that the physician did not respond.

During the exit interview on 10/27/2022 at 3:45 PM, Staff B acknowledged that the facility did not implement the administration of the new medication order or obtain clarification of the order before they placed the medication on hold. Staff B also acknowledged they should have followed-up on the routine Tramadol order sooner.

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 REDMOND is or will be in compliance with this law and / or regulation on (Date) 1.3.2023.

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


Administrator (or Representative)12.1.22
Date**WAC 388-78A-2300 Food and nutrition services.**

(2) The assisted living facility must plan in writing, prepare on-site or provide through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC, and serve to each resident as ordered:

(a) Prescribed general low sodium, general diabetic, and mechanical soft food diets according to a diet manual. The assisted living facility must ensure the diet manual is:

(i) Available to and used by staff persons responsible for food preparation;

(iii) Reviewed and updated as necessary or at least every five years.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to maintain and make available an updated diet manual to be used by 3 of 3 staff (Staff L, Staff N, and Staff O) responsible for food preparation. This failure placed all 25 residents at risk of receiving food services without meeting the most current nutritional standards.

Findings included...

Observation of the commercial kitchen on 10/26/2022 from 9:00 AM to 9:30 AM, showed Staff N, Cook and Staff O, Cook, prepared food. Observations of the kitchen on 10/27/2022 between 12:30 PM to 2:05 PM, showed Staff N, Staff O, and Staff L, Chef, prepared food.

Record review of the facility document titled, "Nutritional Assessment of Resident Menu", dated 08/30/2015, showed the facility's diet manual contained a "3 day [SIC] menu random analysis" for a 2015 menu. The document further showed the portion sizes used by the facility were "analyzed for the average resident", a "lightly active" 88-year-old female. The diet manual also contained recommendations based on the nutritional needs of the resident population.

During an interview on 10/26/2022 at 9:03 AM, Staff O reported no knowledge of a diet manual, its location and did not use one. During an interview on 10/26/2022 at 9:08 AM, Staff N was unable to answer questions related to the diet manual. During an interview on 10/27/2022 at 12:35 PM, Staff L reported no knowledge of a diet manual. Staff L stated that none of the staff used the diet manual.

Staff L attempted to locate the diet manual. When Staff L could not locate the diet manual,

Staff L asked Staff M, Restaurant Manager, for assistance. Staff L and Staff M searched Staff L's office and located a document, titled "Nutritional Assessment of Resident Menu", dated 08/30/2015. The document showed an independent dietician wrote the manual specifically for the facility.

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 REDMOND is or will be in compliance with this law and / or regulation on (Date) 1-3-2023.

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



Administrator (or Representative)

12.1.22

Date

WAC 388-78A-2482 Tuberculosis No testing. The assisted living facility is not required to have a staff person tested for tuberculosis if the staff person has:

- (1) A documented history of a previous positive skin test, with ten or more millimeters induration;
- (2) A documented history of a previous positive blood test; or
- (3) Documented evidence of:
 - (a) Adequate therapy for active disease; or
 - (b) Completion of treatment for latent tuberculosis infection preventive therapy.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that 1 of 1 Resident Assistant I staff (Staff F) hired since the last full inspection had the required documentation for no Tuberculosis (TB) testing. This failure placed residents at risk of contracting an infectious illness.

Findings included...

Record review of the undated facility's document titled, "Employee Staff" showed the facility hired Staff F as a Resident Assistant II on 05/11/2022.

Record review of the facility's document titled, "Job Description Resident Assistant II", dated March 2021, showed, "This is a broad-scoped caregiver position... has responsibility for

direct resident care... bathing, dressing, grooming, toileting... administer medications and provide 'nursing tasks'..."

Record review of the facility's copy of Staff F's untitled medical clinic records, dated 10/06/2014 and 08/13/2022, showed Staff F had two negative chest x-rays. Review of Staff F's facility personnel records showed no documentation that Staff F had a history of a positive skin test of 10 millimeters (mm) induration (measurement) or a previous positive blood test. Further review of Staff F's personnel records showed no documentation Staff F received any adequate therapy for active disease or completed the treatment for latent tuberculosis infection preventive therapy.

Record review of the untitled care staff schedule dated 08/02/2022 – 11/03/2022, showed Staff F worked 61 shifts.

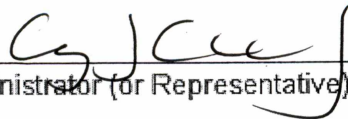
Observations on 10/25/2022 at 11:00 AM and on 10/26/2022 at 1:03 PM and 1:38 PM, showed Staff F had direct contact with residents while they provided care and services.

During an interview on 10/27/2022 at 11:26 PM, Staff J, Business Office Manager, stated that they thought the facility could accept an x-ray for staff who stated that they would be positive for TB if tested.

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 REDMOND is or will be in compliance with this law and / or regulation on (Date) 1.3.2023.

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


Administrator (or Representative)

12.1.22
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;
- (b) Are certified by a veterinarian to be free of diseases transmittable to humans;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 4 of 4 pets (Pet 1, 2, 3, and 4) were certified by a veterinarian to be free of diseases transmittable to humans and had regular examinations and vaccinations. This failure placed the residents at risk of contracting illnesses transmittable by pets.

Findings included...

Observations of the facility during the full inspection between 10/25/2022 and 10/27/2022, showed that dogs and cats resided in the facility.

Record review of the facility document titled, "Pet Policy", dated January 2021, stated, "The Pet Addendum to the Resident Agreement... outline the community's rules and requirements related to resident pets in the community." Record review of the undated facility document titled, "Pet Record Certification" asked for the veterinarian to certify that the named pet was free of diseases transmittable to humans, was current on all immunizations and examinations and that the pet's records to be attached to the certification form. The certification document referenced the regulation.

Record review of the undated facility document titled, "Disclosure of Services" stated, "Pets allowed by the assisted living facility... must have regular veterinary examinations and immunizations, appropriate for the species, and must be free of diseases transmittable to humans. The facility... permits you to have pets under the following conditions... current vaccines and fee required."

Pet 1

Record review of facility copies of Pet 1's records, dated 12/01/2020, showed that Pet 1 was due for two immunizations and an annual exam on 07/24/2021. Further review of Pet 1's records showed no evidence of veterinarian certification that verified Pet 1 was free of diseases transmittable to humans.

Pet 2

Record review of facility copies of Pet 2's records, dated 06/08/2022, showed that Pet 2 was due for a rabies vaccine on 06/03/2022. Further review of Pet 2's records showed no evidence Pet 2 received a current rabies vaccination, other vaccines, or an examination.

Pet 3

Record review of facility copies of Pet 3's records, dated 04/15/2022, showed only a rabies certificate. Record review of Pet 2's records showed no evidence Pet 3 was current with an examination and immunizations. Further review of Pet 3's records showed no evidence of veterinarian certification that verified Pet 3 was free of diseases transmittable to humans.

Pet 4

Record review of the facility copies of Pet 4's records, dated 07/23/2021, showed that Pet 4 had an examination and an immunization due on 07/23/2022. Record Further review of Pet 4's records showed no evidence of veterinarian certification that verified Pet 4 was free of diseases transmittable to humans.

During an interview on 10/26/2022 at 11:58 AM, Staff K, Receptionist, identified as the person responsible for maintaining the pet records. Staff K stated that "someone" had told her only the rabies vaccine was required for each pet. Staff K further stated that they did not know of the other requirements that included regular examinations and immunizations appropriate for the species. Staff K also stated that they were unaware a veterinarian certification that verified the pet was free of diseases transmittable to humans was required.

Plan/Attestation Statement

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Administrator (or Representative)

12.1.22

Date

WAC 388-78A-2730 Licensee's responsibilities.

(2) The licensee must:

(b) Maintain and post in a size and format that is easily read, in a conspicuous place on the assisted living facility premises:

(iii) A copy of the report, including the cover letter, and plan of correction of the most recent full inspection conducted by the department.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to keep and place 1 of 1 (2019) copy of the latest full inspection report in a conspicuous location within the facility. This failure placed all residents at risk for being uninformed about facility noncompliance issues that may have significance related to their care and services.

Findings included...

Review of the Department's Facility Management System data base showed the facility's last inspection was completed on 08/26/2019. Observation at the facility on 10/25/2022 at 10:33 AM showed the full inspection report was nowhere to be found.

During an interview on 10/25/2022 at 10:33 AM, Staff L, Plant Operations Supervisor, and Staff K, Receptionist, stated that they were not aware of the requirement to keep the full inspection report in the conspicuous location within the facility. During an interview on 10/25/2022 at 10:33 AM, Staff H, General Manager, added that it was probably in the medical office, and that they would get the report promptly put in a conspicuous location.

During an interview on 10/25/2022 at 10:42 AM, Staff K, Receptionist, stated that the full inspection report was found in the nurse's office. Staff K added that they would put it in a conspicuous location right away.

Further observations on 10/25/2022 at 2:00 PM, 10/26/2022 at 8:39 AM, and 10/27/2022 at 9:50 AM showed the full inspection report still was not in a conspicuous location.

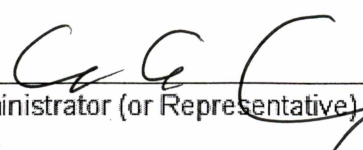
During an interview on 10/27/2022 at 9:50 AM, Staff K acknowledged the full inspection report was behind the reception desk and showed a binder.

Record review of the binder showed it contained an untitled document, dated 08/26/2019. The document was the last full facility inspection report written by representatives of the Department of Social and Health Services. Further review of the binder also showed that it was not ready to be placed in a conspicuous location as it contained an untitled, undated Resident and Staff list marked, "Confidential – Do Not Post."

Plan/Attestation Statement

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Administrator (or Representative)

12.1.22

Date

WAC 388-78A-2450 Staff.

(3) The assisted living facility must:

(d) Maintain the following documentation on the assisted living facility premises, during employment, and at least two years following termination of employment:

(i) Staff orientation and training or certification pertinent to duties, including, but not limited to:

(A) Training required by chapter 388-112A WAC;

(ii) Disclosure statements and background checks as required in WAC 388-78A-2461 through 388-78A-2471 ; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to maintain on the assisted living facility premises records for 1 of 1 Executive Director (Staff A). This failure placed all residents at risk for potential abuse or neglect during interactions with a staff member with unverified qualifications.

Findings included...

Review of the Department's Facilities Management System showed the facility hired Staff A as the Executive Director on 07/27/2021.

Observation on 10/25/2022 showed Staff A was in the facility and participated on 10/25/2022 in the full inspection process.

Review of staff personnel records provided by the facility on 10/25/2022, showed the facility did not have a set of Staff A's records.

During an interview on 10/27/2022 at 9:23 AM, Staff H, General Manager, confirmed that Staff A's personnel file was not in the facility but would be provided.

Record review documentation of Staff A's records provided through 11/11/2022, showed no fingerprint background check results from the Department of Social and Health Services. Further review showed a document titled, "IdentiGO", dated 09/25/2019, was a receipt showing that Staff A obtained fingerprints, a step required in the completion of a fingerprint background check. Record review also showed an email addressed to Staff A, dated 09/24/2022, confirming her appointment for fingerprinting on 09/25/2022.

Further review of Staff A's records showed no documentation that Staff A completed the Dementia Specialty Training.

During interviews on 11/07/2022 at 1:16 PM and 11/08/2022 at 10:47 AM, Staff A reported that they could not locate her fingerprint background check results. Staff A stated that she requested a copy of her fingerprint background check results from the Department of Social and Health Services. Staff A also stated that she completed the Dementia Specialty training in 2009 when she completed the Mental Health Specialty training. Staff A stated that they were unable to locate her dementia specialty training certificate.

Plan/Attestation Statement

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Administrator (or Representative)

12.1.22

Date

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105° F and 120° F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to maintain safe water temperatures between 105° and 120° (degrees) Fahrenheit (F) for 11 of 16 sinks in apartments, common restrooms, and resident laundry rooms. This failure placed residents at risk for burn injury.

Findings included...

Observation of sink water temperatures during the environmental tour on 10/25/2022 between 10:28 AM and 1:45 PM showed:

125.3°F	- Third Floor North Resident Laundry
125.0°F	- Second Floor North Resident Laundry
124.1°F	- First Floor West Resident Laundry
121.7°F	- First Floor Common Restroom across from the common living room
121.4°F	- Men's Pool Restroom
122.0 °F	- Women's Pool Restroom

124.8°F	- Apartment 310
123.6°F	- Apartment 212
121.1°F	- Apartment 253
122.4°F	- Apartment 126
120.9°F	- Apartment 131

Further observation on 10/25/2022 at 1:31 PM showed the facility had five boilers set to 130°F and two "mix-it valves" (a system that mixes cold water with hot water to deliver a desired temperature at the tap).

During an interview on 10/25/2022 between 10:28 AM and 1:45 PM, Staff I, Plant Operations Supervisor, acknowledged all the high-water temperatures observed and stated that the problem was related to the north side of the building.

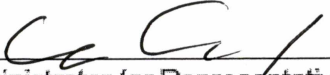
Record review of the facility document titled, "Hot Water Temperature Log", dated 06/03/2022 – 10/18/2022, showed that facility staff recorded no water temperatures above 120°F.

During an interview on 10/25/2022 at 1:31 PM, Staff L explained that the boilers were set at 130°F allowing the mix-it valves to bring the water temperature down to 120°F. Staff L further acknowledged the high-water temperature readings and stated that it did not look like a problem within the boiler room.

Plan/Attestation Statement

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Administrator (or Representative)

12.1.22

Date

WAC 388-78A-3040 Laundry.

(7) The assisted living facility must provide a laundry area or develop and implement policy and procedure to ensure residents have access to an area where residents' may do their personal laundry that is:

(a) Equipped with:

(iv) Mechanical ventilation to the outside of the assisted living facility.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that 2 of 6 resident laundry room air exchange vents (ventilation system that exchanges air inside a building with fresh air from outside and gets installed in tightly built buildings with only minimal ventilation) were properly functioning. This failure placed all 25 residents at risk of diminished health and airborne illnesses from breathing poor air quality due to improper ventilation.

Findings included...

Review of the Centers for Disease Control and Prevention's (CDC) website on 11/04/2022, showed that proper building ventilation "reduce the spread of disease and lower the risk of exposure... Protective ventilation practices and interventions can reduce the airborne concentrations and reduce the overall viral dose to occupants."

Record review of the undated document titled "Resident Characteristic Roster" showed the facility provided care and services to 25 residents.

Observation on 10/25/2022 at 10:47 AM showed the third floor north Resident Laundry Room contained no windows or other means of ventilation other than the air exchange vent. Observation of the mechanical air exchange vent showed that it was covered with dust and did not properly pull air to ventilate the room.

During an interview on 10/25/2022 at 10:47 AM, Staff L, Plant Operations Supervisor, acknowledged that the air exchange vent in the third-floor north laundry room did not work.

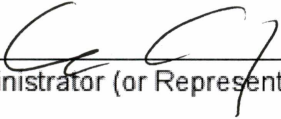
Observation on 10/25/2022 at 11:12 AM showed the second floor west Resident Laundry Room contained no windows or other means of ventilation other than the air exchange vent. Observation of the mechanical air exchange vent showed that it did not properly pull air to ventilate the room.

During an interview on 10/25/2022 at 11:12 AM, Staff L acknowledged that the second floor west laundry room air exchange vent also was not working properly. Staff L added that they were unaware of the regulation. Staff L also stated that there was no system in place to check that the air exchange vents were functioning.

Plan/Attestation Statement

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Administrator (or Representative)

12.1.22

Date