



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) 43623 (Completion Date 07/03/2024) and 40089 (Completion Date 05/01/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/03/2024 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-2466-1, WAC 388-78A-2466-1-a, WAC 388-78A-2466-1-b, WAC 388-78A-2466-2, WAC 388-78A-2466, WAC 388-78A-3000-1-a, WAC 388-78A-2140-1-a, WAC 388-78A-2140-1-a-i, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2474-2-a, WAC 388-78A-2474-2-d, WAC 388-78A-2474-2-e, WAC 388-78A-2474-1, WAC 388-78A-2474-3, WAC 388-78A-2474-4, WAC 388-78A-2474-2-b, WAC 388-78A-2480-1, WAC 388-78A-24681, WAC 388-78A-24681-1, WAC 388-78A-24681-2, WAC 388-78A-2468-1, WAC 388-78A-2484, WAC 388-78A-2484-1, WAC 388-78A-2484-2, WAC 388-78A-2320-2-b, WAC 388-78A-2320-2-a, WAC 388-78A-2690-6-c, WAC 388-78A-2690-7-a, WAC 388-78A-2690-7-b, WAC 388-78A-2690-7, WAC 388-78A-2100-2-b-i, WAC 388-78A-2100-2-b-ii

The Department staff who did the on-site verification:
Thomas Forkgen, ALF Licensors

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

Sincerely,

Laurie Anderson

FAIRWINDS REDMOND # 1814

07/03/2024

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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 # 40089
Plan of Correction	FAIRWINDS REDMOND	Completion Date
Page 1 of 22	Licensee: REDM LLC	05/01/2024

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 04/22/2024, 04/22/2024, 04/24/2024 and 04/24/2024 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 30 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licenser
Michelle Yip, ALF 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.

Laurie Anderson

Residential Care Services

05/07/2024

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.



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DEPARTMENT OF SOCIAL AND HEALTH SERVICES
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Date

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 Administrator (or Representative)

5-15-24 KH
 6/28/2024
 Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

(2) A national fingerprint background check is valid for an indefinite period of time. The assisted living facility must ensure there is a valid national fingerprint background check completed for all administrators and caregivers hired after January 7, 2012. To be considered valid, the national fingerprint background check must be initiated and completed through the department's background check central unit after January 7, 2012.

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility failed to complete a Washington state name and date of birth background inquiry (BGI) every two years for 2 of 2 sampled staff (Staff C and Staff E). This failure placed all residents at risk of potential abuse, neglect, or exploitation from caregivers and staff persons with unknown backgrounds.

Findings included...

STAFF C

Review of the facility's Employee Roster showed the facility hired Staff C, Cook, on 04/11/2022. Review of Staff C's employee records showed that Staff C's previous Washington state name and date of birth BGI expired on 04/11/2024. The records showed on 04/18/2024, the facility completed a BGI, seven days after the previous BGI expired.

STAFF E

Review of the facility's Employee Roster showed the facility hired Staff E, Health and Wellness Coordinator, on 09/12/2016. Review of Staff E's employee records showed that Staff E's previous Washington state name and date of birth BGI expired on 10/01/2022. The records showed on 10/17/2022, the facility completed a BGI, 16 days after the previous BGI expired.

Administrator (or Representative)

Date

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During an interview on 04/22/2024 at 3:15 PM, Staff P, Business Office Manager, stated that they were responsible for the completion of the staff background checks for all employees. Staff P stated that they were aware the facility was required to maintain a valid Washington state name date of birth BGI for all staff. Staff P stated that they did not know why the facility did not complete the staff BGIs on time.

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) 6-15-24.

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


 Administrator (or Representative)

5-15-24
6/18/2024 KH
 Date

WAC 388-78A-3000 Ventilation. The assisted living facility must meet the ventilation requirements of the mechanical code as adopted and amended by the Washington state building council; and

(1) Ventilate rooms to:

(a) Prevent excessive odors or moisture; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure the exhaust air vents in 4 of 4 sampled rooms (two common public bathrooms on the second floor, the west resident laundry room on the second floor, and commercial laundry room in the basement) provided proper air flow and ventilation to the outside of the facility. This failure placed the residents at risk of a diminished quality of life and potential respiratory illnesses from poor air circulation in the building.

Findings included...

NOTE: WAC 388-78A-3030 Toilet rooms and bathrooms stated (2) The assisted living facility must provide each toilet room and bathroom with: (e) Provide mechanical ventilation to the outside. WAC 388-78A-3040 Laundry stated (5) The assisted living facility must ventilate laundry rooms and areas to the outside of the assisted living facility, including areas or rooms where soiled laundry is held for processing by off-site commercial laundry services. WAC 388-78A-3080 Maintenance and housekeeping stated (2) The assisted living facility must provide housekeeping supply room(s): (c) Equipped with: (iv) Mechanical ventilation to the outside of the assisted living facility.

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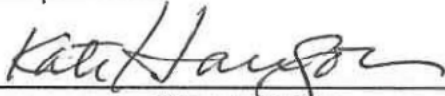
Observations during the environmental tour on 04/22/2024, between 10:00 AM and 11:15 AM, showed non-functioning ventilation systems in the second-floor women's restroom, the second-floor men's restroom, the second floor west resident laundry room, and the basement commercial laundry room. Observations showed the vent covers in the four rooms were covered with dust.

During an interview on 04/22/2024 at the time of the observations, Staff O, Plant Operations Supervisor, stated that the four exhaust air vents observed did not properly function to provide adequate ventilation. Staff O stated that they did not know why the vents did not function.

Plan/Attestation Statement

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


Administrator (or Representative)

5-15-24
6/28/2024 KH
Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

- (1) The care and services necessary to meet the resident's needs, including:
 - (a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:
 - (i) The resident's preadmission assessment;
 - (ii) The resident's full assessments;
 - (iii) On-going assessments of the resident;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to update the Negotiated Service Agreement (NSA) for 5 of 7 sampled residents (Resident 2, Resident 3, Resident 4, Resident 5, and Resident 7). This failure placed Resident 2, Resident 3, Resident 4, Resident 5, and Resident 7 at risk for unmet care needs and potential for worsening of medically diagnosed conditions.

Observations during the environmental tour on 04/22/2024, between 10:00 AM and 11:15 AM, showed non-functioning ventilation systems in the second-floor women's restroom, the second-floor men's restroom, the second floor west resident laundry room, and the basement commercial laundry room. Observations showed the vent covers in the four rooms were covered with dust.

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Statement of Deficiencies

License # 1814

Compliance Determination # 43089

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05/01/2024

Findings included...

RESIDENT 2

Observation in Resident 2's apartment on 04/22/2024 at 4:11 PM showed Resident 2 laid in a hospital bed. There were two half-length bed siderails attached at the head of the bed, one siderail on each side. Observation showed an air pump hung on the footboard of the bed, connected to an overlay alternating pressure relieving mattress. Observation showed Resident 2 used oxygen via a nasal cannula (a tube that delivers oxygen through the nose) connected to an oxygen concentrator (a medical device that extracts oxygen from air).

Review of Resident 2's records showed that the facility admitted Resident 2 in [REDACTED] 2024. Review of Resident 2's "Assessment/Evaluation and Service Planning" showed that on 04/01/2024, Staff A, Health and Wellness Manager, completed a change of condition assessment.

Review of Resident 2's Negotiated Service Agreement (NSA), dated 04/01/2024, did not show Resident 2 used a hospital bed with siderails. The NSA did not show Resident 2 used an alternating pressure relieving mattress. The NSA did not show Resident 2 received oxygen. The NSA did not provide staff any safety instructions for the use of bed rails. The NSA did not provide staff with any instructions about how the alternating pressure relieving mattress functioned. The NSA did not provide staff with any guidelines about Resident 2's use of oxygen.

During an interview on 04/23/2024 at 1:41 PM, Staff A stated that the hospice care agency brought in the hospital bed, bedrails, and overlaying pressure relieving mattress. Staff A stated that they "had no idea" Resident 2 used the medical devices. Staff A stated that they did not document on Resident 2's NSA the use of the hospital bed, the siderails, the overlay pressure relieving mattress, or the use of oxygen.

Resident 3

Review of Resident 3's records showed that the facility admitted Resident 3 in [REDACTED] 2021 with medical diagnoses of [REDACTED] ([REDACTED]) and [REDACTED] ([REDACTED]).

Review of Resident 3's current medication orders showed that Resident 3 was prescribed insulin (a medication used to regulate blood sugar levels).

Review of Resident 3's "Assessment/Evaluation and Service Planning" showed that on 03/01/2024, Staff X, Registered Nurse, completed the assessment for Resident 3. The assessment did not show that Resident 3 used a continuous positive airway pressure (CPAP, a machine that assists a person to breathe during sleep). The assessment showed that Resident 3 self-monitored blood sugar levels and self-administered insulin injections. There was no documentation that identified the possible signs and symptoms related to diabetes mellitus, such as hyperglycemia (high blood sugar levels), increased thirst, or excess urination.

Findings included...

RESIDENT 2

Observation in Resident 2's apartment on 04/22/2024 at 4:11 PM showed Resident 2 laid in a hospital bed. There were two half-length bed siderails attached at the head of the bed, one siderail on each side. Observation showed an air pump hung on the footboard of the bed, connected to an overlay alternating pressure relieving mattress. Observation showed Resident 2 used oxygen via a nasal cannula (a tube that delivers oxygen through the nose) connected to an oxygen concentrator (a medical device that extracts oxygen from air).

Review of Resident 2's records showed that the facility admitted Resident 2 in [REDACTED] 2024. Review of Resident 2's "Assessment/Evaluation and Service Planning" showed that on 04/01/2024, Staff A, Health and Wellness Manager, completed a change of condition assessment.

Review of Resident 2's Negotiated Service Agreement (NSA), dated 04/01/2024, did not show Resident 2 used a hospital bed with siderails. The NSA did not show Resident 2 used an alternating pressure relieving mattress. The NSA did not show Resident 2 received oxygen. The NSA did not provide staff any safety instructions for the use of bed rails. The NSA did not provide staff with any instructions about how the alternating pressure relieving mattress functioned. The NSA did not provide staff with any guidelines about Resident 2's use of oxygen.

During an interview on 04/23/2024 at 1:41 PM, Staff A stated that the hospice care agency brought in the hospital bed, bedrails, and overlaying pressure relieving mattress. Staff A stated that they "had no idea" Resident 2 used the medical devices. Staff A stated that they did not document on Resident 2's NSA the use of the hospital bed, the siderails, the overlay pressure relieving mattress, or the use of oxygen.

Resident 3

Review of Resident 3's records showed that the facility admitted Resident 3 in [REDACTED] 2021 with medical diagnoses of [REDACTED] (a [REDACTED]) and [REDACTED] ([REDACTED]). Review of Resident 3's current medication orders showed that Resident 3 was prescribed insulin (a medication used to regulate blood sugar levels).

Review of Resident 3's "Assessment/Evaluation and Service Planning" showed that on 03/01/2024, Staff X, Registered Nurse, completed the assessment for Resident 3. The assessment did not show that Resident 3 used a continuous positive airway pressure (CPAP, a machine that assists a person to breathe during sleep). The assessment showed that Resident 3 self-monitored blood sugar levels and self-administered insulin injections. There was no documentation that identified the possible signs and symptoms related to diabetes mellitus, such as hyperglycemia (high blood sugar levels), increased thirst, or excess urination.

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Review of Resident 3's NSA, dated 04/22/2024, did not show Resident 3 used a CPAP machine. There was no documentation that instructed about Resident 3's use of the CPAP, which included the requirement to fill the reservoir (a container that holds water to keep the air moist) with distilled water, as needed. Review of the NSA showed no documentation that identified the possible signs and symptoms related to diabetes mellitus. There was no documentation that showed Resident 3 received insulin. There was no documentation that explained the possible side effects of insulin usage, such as hypoglycemia (low blood sugar levels) low blood sugar levels. There were no instructions for staff about what actions were needed for such side effects.

During an interview on 04/23/2024 at 1:43 PM, Resident 3 stated that they used the CPAP machine every night. Resident 3 stated that they requested that the caregivers fill the reservoir of the CPAP machine with distilled water.

During an interview 04/23/2024 at 3:00 PM, Staff W, Resident Assistant II, and Staff Y, Resident Assistant II, both stated that they filled the CPAP reservoir with distilled water, per Resident 3's request.

During an interview on 04/23/2024 at 3:05 PM, Staff A stated that they were unaware Resident 3 used a CPAP machine. Staff A stated that they did not know the caregivers assisted Resident 3 with filling the reservoir. Staff A stated that they did not update Resident 3's service plan to document all of Resident 3's care needs.

RESIDENT 4

Observation on 04/23/2024 at 3:15 PM showed Staff W, Resident Assistant II, carried a handheld tablet device at work. Observation showed the handheld tablet device displayed Resident 4's service plan. Observation of Resident 4's service plan showed no guidance about monitoring the signs and symptoms of diabetes mellitus. There was no guidance about the possible side effects from insulin. There were no instructions for staff about what actions were needed for such side effects. During an interview, Staff W stated that Resident 4 was independent with blood sugar monitoring and insulin administration. Staff W stated that the service plan did not show Resident 4 received insulin. Staff W stated that they were unaware Resident 4's blood sugar levels. Staff W stated that they were unaware they were responsible for monitoring Resident 4's signs and symptoms of diabetes mellitus and side effects of insulin.

Review of Resident 4's records showed that the facility admitted Resident 4 in [REDACTED] 2024 with a medical diagnosis of [REDACTED]. Review of Resident 4's current medication orders showed that Resident 4 was prescribed insulin. The medication orders included regular blood sugar checks.

Review of Resident 4's "Assessment/Evaluation and Service Planning" showed that on 04/09/2024, Staff A completed an assessment for Resident 4. The assessment showed Resident 4 self-monitored their blood sugar levels and self-administered their insulin injections. There was no documentation that identified the possible signs and symptoms related to diabetes mellitus, such as hyperglycemia (high blood sugar levels), increased

Review of Resident 3's NSA, dated 04/22/2024, did not show Resident 3 used a CPAP machine. There was no documentation that instructed about Resident 3's use of the CPAP, which included the requirement to fill the reservoir (a container that holds water to keep the air moist) with distilled water, as needed. Review of the NSA showed no documentation that identified the possible signs and symptoms related to diabetes mellitus. There was no documentation that showed Resident 3 received insulin. There was no documentation that explained the possible side effects of insulin usage, such as hypoglycemia (low blood sugar levels) low blood sugar levels. There were no instructions for staff about what actions were needed for such side effects.

During an interview on 04/23/2024 at 1:43 PM, Resident 3 stated that they used the CPAP machine every night. Resident 3 stated that they requested that the caregivers fill the reservoir of the CPAP machine with distilled water.

During an interview 04/23/2024 at 3:00 PM, Staff W, Resident Assistant II, and Staff Y, Resident Assistant II, both stated that they filled the CPAP reservoir with distilled water, per Resident 3's request.

During an interview on 04/23/2024 at 3:05 PM, Staff A stated that they were unaware Resident 3 used a CPAP machine. Staff A stated that they did not know the caregivers assisted Resident 3 with filling the reservoir. Staff A stated that they did not update Resident 3's service plan to document all of Resident 3's care needs.

RESIDENT 4

Observation on 04/23/2024 at 3:15 PM showed Staff W, Resident Assistant II, carried a handheld tablet device at work. Observation showed the handheld tablet device displayed Resident 4's service plan. Observation of Resident 4's service plan showed no guidance about monitoring the signs and symptoms of diabetes mellitus. There was no guidance about the possible side effects from insulin. There were no instructions for staff about what actions were needed for such side effects. During an interview, Staff W stated that Resident 4 was independent with blood sugar monitoring and insulin administration. Staff W stated that the service plan did not show Resident 4 received insulin. Staff W stated that they were unaware Resident 4's blood sugar levels. Staff W stated that they were unaware they were responsible for monitoring Resident 4's signs and symptoms of diabetes mellitus and side effects of insulin.

Review of Resident 4's records showed that the facility admitted Resident 4 in [REDACTED] 2024 with a medical diagnosis of [REDACTED]. Review of Resident 4's current medication orders showed that Resident 4 was prescribed insulin. The medication orders included regular blood sugar checks.

Review of Resident 4's "Assessment/Evaluation and Service Planning" showed that on 04/09/2024, Staff A completed an assessment for Resident 4. The assessment showed Resident 4 self-monitored their blood sugar levels and self-administered their insulin injections. There was no documentation that identified the possible signs and symptoms related to diabetes mellitus, such as hyperglycemia (high blood sugar levels), increased

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thirst, or excess urination. There was no documentation that explained the possible side effects of insulin usage, such as, low blood sugar levels.

Review of Resident 4's NSA, dated 04/18/2024, showed no documentation that identified the possible signs and symptoms related to diabetes mellitus. There was no documentation that showed Resident 4 received insulin. There was no documentation that explained the possible side effects of insulin usage, such as low blood sugar levels. There were no instructions for staff about what actions were needed for such side effects.

RESIDENT 5

Review of Resident 5's records showed that the facility admitted Resident 5 in [REDACTED] 2021. Review of Resident 5's medication orders showed Resident 5 received 81 milligrams (mg) of Aspirin (a blood thinner medication), one time a day, by mouth.

Review of Resident 5's "Assessment/Evaluation and Service Planning" showed that on 01/30/2024, Staff A completed an assessment for Resident 5. The assessment showed Resident 5 self-administered their medications. The assessment showed no documentation that Resident 5 received blood thinner medication.

Review of Resident 5's NSA, dated 01/31/2024, showed no documentation that showed Resident 5 received aspirin. There was no documentation that provided care staff with guidance about the possible side effects from aspirin administration, such as increased risk for bruising and easy bleeding. There were no instructions for staff about what actions were needed for such side effects.

RESIDENT 7

Review of Resident 7's records showed that the facility admitted Resident 7 in [REDACTED] 2017. Review of Resident 7's medication orders showed Resident 7 received 81 mg of Aspirin, one time a day, by mouth.

Review of Resident 7's "Assessment/Evaluation and Service Planning" showed that on 12/13/2023, the facility's nurse completed an assessment for Resident 7. The assessment showed Resident 7 received medication assistance for oral medications that included Aspirin.

Review of Resident 7's NSA, dated 01/31/2024, showed no documentation that Resident 7 received aspirin. There was no documentation that provided staff with guidance about the possible side effects from aspirin usage, such as increased risk for bruising and easy bleeding. There were no instructions for staff about what actions were needed for such side effects.

During an interview on 04/23/2024 at 3:15 PM, Staff A stated that caregivers used a handheld tablet at work. Staff A stated that the handheld tablet displayed the service plan for each resident. Staff A stated that caregivers followed the service plan shown on the

thirst, or excess urination. There was no documentation that explained the possible side effects of insulin usage, such as, low blood sugar levels.

Review of Resident 4's NSA, dated 04/18/2024, showed no documentation that identified the possible signs and symptoms related to diabetes mellitus. There was no documentation that showed Resident 4 received insulin. There was no documentation that explained the possible side effects of insulin usage, such as low blood sugar levels. There were no instructions for staff about what actions were needed for such side effects.

RESIDENT 5

Review of Resident 5's records showed that the facility admitted Resident 5 in [REDACTED] 2021. Review of Resident 5's medication orders showed Resident 5 received 81 milligrams (mg) of Aspirin (a blood thinner medication), one time a day, by mouth.

Review of Resident 5's "Assessment/Evaluation and Service Planning" showed that on 01/30/2024, Staff A completed an assessment for Resident 5. The assessment showed Resident 5 self-administered their medications. The assessment showed no documentation that Resident 5 received blood thinner medication.

Review of Resident 5's NSA, dated 01/31/2024, showed no documentation that showed Resident 5 received aspirin. There was no documentation that provided care staff with guidance about the possible side effects from aspirin administration, such as increased risk for bruising and easy bleeding. There were no instructions for staff about what actions were needed for such side effects.

RESIDENT 7

Review of Resident 7's records showed that the facility admitted Resident 7 in [REDACTED] 2017. Review of Resident 7's medication orders showed Resident 7 received 81 mg of Aspirin, one time a day, by mouth.

Review of Resident 7's "Assessment/Evaluation and Service Planning" showed that on 12/13/2023, the facility's nurse completed an assessment for Resident 7. The assessment showed Resident 7 received medication assistance for oral medications that included Aspirin.

Review of Resident 7's NSA, dated 01/31/2024, showed no documentation that Resident 7 received aspirin. There was no documentation that provided staff with guidance about the possible side effects from aspirin usage, such as increased risk for bruising and easy bleeding. There were no instructions for staff about what actions were needed for such side effects.

During an interview on 04/23/2024 at 3:15 PM, Staff A stated that caregivers used a handheld tablet at work. Staff A stated that the handheld tablet displayed the service plan for each resident. Staff A stated that caregivers followed the service plan shown on the

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tablet to provide resident care. Staff A stated that they were aware of Resident 4 had diabetes and self-administered insulin. Staff A stated that they did not update the care plan for Resident 4. Staff A stated that when they completed Resident 5 and Resident 7's recent assessments, they were aware Resident 5 and Resident 7 received blood thinner medications. Staff A stated that they did not update the care plans with the side effects of the use of blood thinner medication.

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) 6-15-24.

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

Kate Hanson
Administrator (or Representative)

5-15-24
6/28/2024 KH
Date

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

- (1) The assisted living facility must ensure staff persons hired before January 7, 2012 meet training requirements in effect on the date hired, including requirements in chapter 388-112A WAC.
- (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:
 - (a) Orientation and safety;
 - (b) Basic;
 - (c) Cardiopulmonary resuscitation and first aid; and
 - (e) Continuing education.
- (3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.
- (4) The assisted living facility must ensure all persons listed in subsection (2) of this section, obtain the home-care aide certification.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to ensure 7 of 7 sampled care staff (Staff A, Staff B, Staff E, Staff G, Staff T, Staff U, and Staff V) completed all required training. This failure placed all residents at risk for decreased quality of care provided by caregivers with incomplete training.

tablet to provide resident care. Staff A stated that they were aware of Resident 4 had diabetes and self-administered insulin. Staff A stated that they did not update the care plan for Resident 4. Staff A stated that when they completed Resident 5 and Resident 7's recent assessments, they were aware Resident 5 and Resident 7 received blood thinner medications. Staff A stated that they did not update the care plans with the side effects of the use of blood thinner medication.

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)_____.

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

Administrator (or Representative)

Date

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

- (1) The assisted living facility must ensure staff persons hired before January 7, 2012 meet training requirements in effect on the date hired, including requirements in chapter 388-112A WAC.
- (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:
 - (a) Orientation and safety;
 - (b) Basic;
 - (d) Cardiopulmonary resuscitation and first aid; and
 - (e) Continuing education.
- (3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.
- (4) The assisted living facility must ensure all persons listed in subsection (2) of this section, obtain the home-care aide certification.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to ensure 7 of 7 sampled care staff (Staff A, Staff B, Staff E, Staff G, Staff T, Staff U, and Staff V) completed all required training. This failure placed all residents at risk for decreased quality of care provided by caregivers with incomplete training.

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Findings included...

Review of the facility's Job Descriptions showed that the facility Health and Wellness Coordinator and Resident Assistants were required to provide personal care services to assisted living residents. The document showed the facility required that staff completed the education and certification trainings in accordance with state regulations.

FIRST-AID STAFF G

Review of the facility's Employee Roster showed that the facility hired Staff G, Resident Assistant II, on 10/27/2023. Review of the care staff schedule showed that Staff G worked in February 2024 and March 2024. Review of the employee records showed that as of 04/22/2024, there was no documentation that showed Staff G maintained a valid first aid card.

During an interview on 04/22/2024 at 3:15 PM, Staff P, Business Office Manager, stated that they maintained the staff first aid cards in their employee records. Staff P stated that there was no first aid card for Staff G in their system. Staff P stated that they were unsure whether if Staff G completed the first aid training, as required.

CONTINUING EDUCATION (CE) STAFF B

Review of the facility's Employee Roster showed the facility hired Staff B, Resident Assistant II, on 07/09/2020. Review of Staff B's employee records showed no Department of Social and Health Services approved CE documentation between their 2022 birthday and their 2023 birthday.

STAFF E

Review of the facility's Employee Roster showed the facility hired Staff E, Health and Wellness Coordinator, on 09/12/2016. Review of Staff E's employee records showed no Department of Social and Health Services approved CE documentation between their 2023 birthday and their 2024 birthday.

STAFF T

Review of the facility's Employee Roster showed the facility hired Staff T, Resident Assistant II, on 05/11/2016. Review of Staff T's employee records showed no Department of Social and Health Services approved CE documentation between their 2023 birthday and their 2024 birthday.

STAFF U

Review of the facility's Employee Roster showed the facility hired Staff U, Resident Assistant II, on 10/26/2016. Review of Staff U's employee records showed between their 2022 birthday and 2023 birthday, Staff U completed a total of two hours of the Washington state Department of Social and Health Services (DSHS) approved CE trainings. Staff U was 10 hours short of the required 12 hours of the CE training.

Findings included...

Review of the facility's Job Descriptions showed that the facility Health and Wellness Coordinator and Resident Assistants were required to provide personal care services to assisted living residents. The document showed the facility required that staff completed the education and certification trainings in accordance with state regulations.

FIRST-AID

STAFF G

Review of the facility's Employee Roster showed that the facility hired Staff G, Resident Assistant II, on 10/27/2023. Review of the care staff schedule showed that Staff G worked in February 2024 and March 2024. Review of the employee records showed that as of 04/22/2024, there was no documentation that showed Staff G maintained a valid first aid card.

During an interview on 04/22/2024 at 3:15 PM, Staff P, Business Office Manager, stated that they maintained the staff first aid cards in their employee records. Staff P stated that there was no first aid card for Staff G in their system. Staff P stated that they were unsure whether if Staff G completed the first aid training, as required.

CONTINUING EDUCATION (CE)

STAFF B

Review of the facility's Employee Roster showed the facility hired Staff B, Resident Assistant II, on 07/09/2020. Review of Staff B's employee records showed no Department of Social and Health Services approved CE documentation between their 2022 birthday and their 2023 birthday.

STAFF E

Review of the facility's Employee Roster showed the facility hired Staff E, Health and Wellness Coordinator, on 09/12/2016. Review of Staff E's employee records showed no Department of Social and Health Services approved CE documentation between their 2023 birthday and their 2024 birthday.

STAFF T

Review of the facility's Employee Roster showed the facility hired Staff T, Resident Assistant II, on 05/11/2018. Review of Staff T's employee records showed no Department of Social and Health Services approved CE documentation between their 2023 birthday and their 2024 birthday.

STAFF U

Review of the facility's Employee Roster showed the facility hired Staff U, Resident Assistant II, on 10/26/2018. Review of Staff U's employee records showed between their 2022 birthday and 2023 birthday, Staff U completed a total of two hours of the Washington state Department of Social and Health Services (DSHS) approved CE trainings. Staff U was 10 hours short of the required 12 hours of the CE training.

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STAFF V

Review of the facility's Employee Roster showed the facility hired Staff V, Resident Assistant II, on 02/19/2021. Review of Staff V's employee records showed between their 2022 birthday and 2023 birthday, Staff V completed a total of 7.25 hours of the Washington state DSHS approved CE trainings. Staff V was 4.75 hours short of the required 12 hours of CE training.

During an interview on 04/22/2024 at 3:15 PM, Staff P stated that the facility provided staff the online CE training from a contracted vendor. Staff P stated that the department supervisor kept the access to the staff's online CE records from the contracted vendor. Staff P stated that they did not find Staff B, Staff E, Staff T, Staff U, and Staff V's CE certificates and records in the employees' records.

During an interview on 04/23/2024 at 8:50 AM, Staff E, Health and Wellness Coordinator, stated that they kept track of the CE credits completed by the staff with their contracted vendor. Staff E stated that they were unaware the staff were required to complete the DSHS approved CE courses. Staff E stated that they reviewed the online CE records for the five sampled staff and the records showed Staff B, Staff E, Staff T, Staff U, and Staff V were short of the required 12 CE hours of training.

ORIENTATION AND SAFETY TRAINING AND HOME CARE AIDE (HCA) CREDENTIAL**STAFF A**

Review of the facility staff roster showed the facility hired Staff A, Health and Wellness Manager, on 12/01/2024.

Observation on 04/22/2024, 04/23/2024, and 04/24/2024, between 10:00 AM and 4:00 PM, showed Staff A engaged with residents throughout the day.

Review of Staff A's records showed no documentation that Staff A completed the Department of Social and Health Services Orientation and Safety course. There was documentation that Staff A completed the HCA certification.

During an interview on 04/22/2024 at 3:15 PM, Staff A stated that they completed all the resident assessments which included the preadmission assessments and the resident negotiated service agreement. Staff A stated that so far, they had not provided any hands-on assistance for residents. Staff A stated that they were aware personal care was required as a part of the position. Staff A stated that they kept a pair of scrubs in the office in case they needed to provide hands-on care for a resident. Staff A stated that they did not have any nursing assistant certified (NA-C) credentials or Home Care Aide (HCA) credentials. Staff A stated that they earned a bachelor's degree in human science and were a certified Medical Assistant. Staff A stated that they were not enrolled in any NA-C or HCA course. Staff A stated that they would enroll in a course, if required.

STAFF V

Review of the facility's Employee Roster showed the facility hired Staff V, Resident Assistant II, on 02/18/2021. Review of Staff V's employee records showed between their 2022 birthday and 2023 birthday, Staff V completed a total of 7.25 hours of the Washington state DSHS approved CE trainings. Staff V was 4.75 hours short of the required 12 hours of CE training.

During an interview on 04/22/2024 at 3:15 PM, Staff P stated that the facility provided staff the online CE training from a contracted vendor. Staff P stated that the department supervisor kept the access to the staff's online CE records from the contracted vendor. Staff P stated that they did not find Staff B, Staff E, Staff T, Staff U, and Staff V's CE certificates and records in the employees' records.

During an interview on 04/23/2024 at 8:50 AM, Staff E, Health and Wellness Coordinator, stated that they kept track of the CE credits completed by the staff with their contracted vendor. Staff E stated that they were unaware the staff were required to complete the DSHS approved CE courses. Staff E stated that they reviewed the online CE records for the five sampled staff and the records showed Staff B, Staff E, Staff T, Staff U, and Staff V were short of the required 12 CE hours of training.

ORIENTATION AND SAFETY TRAINING AND HOME CARE AIDE (HCA) CREDENTIAL STAFF A

Review of the facility staff roster showed the facility hired Staff A, Health and Wellness Manager, on 12/01/2024.

Observation on 04/22/2024, 04/23/2024, and 04/24/2024, between 10:00 AM and 4:00 PM, showed Staff A engaged with residents throughout the day.

Review of Staff A's records showed no documentation that Staff A completed the Department of Social and Health Services Orientation and Safety course. There was documentation that Staff A completed the HCA certification.

During an interview on 04/22/2024 at 3:15 PM, Staff A stated that they completed all the resident assessments which included the preadmission assessments and the resident negotiated service agreement. Staff A stated that so far, they had not provided any hands-on assistance for residents. Staff A stated that they were aware personal care was required as a part of the position. Staff A stated that they kept a pair of scrubs in the office in case they needed to provide hands-on care for a resident. Staff A stated that they did not have any nursing assistant certified (NA-C) credentials or Home Care Aide (HCA) credentials. Staff A stated that they earned a bachelor's degree in human science and were a certified Medical Assistant. Staff A stated that they were not enrolled in any NA-C or HCA course. Staff A stated that they would enroll in a course, if required.

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

Kate Hanger
Administrator (or Representative)

5-15-24
6/28/2024 KH
Date

WAC 388-76A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to test 1 of 1 sampled staff (Staff A) for tuberculosis (TB), as required. This failure placed all the residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included ..

Review of the facility's Exposure Control Plan/TB Policy undated showed that staff need to have a one-step TB test within three days of date of hire.

STAFF A

Review of the facility's Employee Roster showed the facility hired Staff A, Health and Wellness Director, on 12/01/2023. Initial review of Staff A's records showed there were no records for any TB test. During the Department's visit, Staff A obtained a copy of their TB QuantIFERON test results from the provider who administered the test. Review of the test results showed that Staff A completed a QuantIFERON blood test for TB on 01/26/2024, 56 days after Staff A's date of employment.

During an interview on 04/22/2024 at 2:30 PM, Staff P, Business Office Manager, stated they were not sure why Staff A's TB test was done so late. Staff P stated they were unaware the facility did not have a copy of Staff A's QuantIFERON test results on file.

Plan/Attestation Statement

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)_____.

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

Administrator (or Representative)

Date

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to test 1 of 1 sampled staff (Staff A) for tuberculosis (TB), as required. This failure placed all the residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included...

Review of the facility's Exposure Control Plan/TB Policy undated showed that staff need to have a one-step TB test within three days of date of hire.

STAFF A

Review of the facility's Employee Roster showed the facility hired Staff A, Health and Wellness Director, on 12/01/2023. Initial review of Staff A's records showed there were no records for any TB test. During the Department's visit, Staff A obtained a copy of their TB QuantiFERON test results from the provider who administered the test. Review of the test results showed that Staff A completed a QuantiFERON blood test for TB on 01/26/2024, 56 days after Staff A's date of employment.

During an interview on 04/22/2024 at 2:30 PM, Staff P, Business Office Manager, stated they were not sure why Staff A's TB test was done so late. Staff P stated they were unaware the facility did not have a copy of Staff A's QuantiFERON test results on file.

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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) 6-15-24.

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

Kate Hanson
Administrator (or Representative)

5-15-24
6/28/2024 *KH*
Date

WAC 388-78A-24581 Background checks Employment Provisional hire Pending results of national fingerprint background check. The assisted living facility may provisionally employ a caregiver and an administrator hired after January 7, 2012 for one hundred and twenty-days and allow the caregiver or administrator to have unsupervised access to residents when:

- (1) The caregiver or administrator is not disqualified based on the results of the Washington state name and date of birth background check; and
- (2) The results of the national fingerprint background check are pending.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to complete a national fingerprint background check for 2 of 2 sampled staff (Staff A and Staff X). This failure placed all 30 residents at risk for potential abuse and neglect from staff with an unknown background.

Findings included...

STAFF A

Review of the facility's staff roster showed the facility hired Staff A as the Health and Wellness Manager on 12/01/2024.

Observation on 04/22/2024 at 2:30 PM, 04/23/2024 at 11:00 AM, and 04/24/2024 at 9:30 AM showed Staff A interacted with residents and staff.

Review of Staff A's records showed a Washington State name and date of birth background check was completed on 12/01/2024 with no disqualifying results. The name and date of birth background check did not show any pending interim fingerprint check. There was no documentation that showed a national fingerprint check was completed within 120 days of hire to allow Staff A unsupervised access to residents.

During an interview on 04/22/2024 at 3:15 PM, Staff A stated that they did not know why they were not asked to complete a national fingerprint check. Staff A stated they would have

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)_____.

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

Administrator (or Representative)

Date

WAC 388-78A-24681 Background checks Employment Provisional hire Pending results of national fingerprint background check. The assisted living facility may provisionally employ a caregiver and an administrator hired after January 7, 2012 for one hundred and twenty-days and allow the caregiver or administrator to have unsupervised access to residents when:

(1) The caregiver or administrator is not disqualified based on the results of the Washington state name and date of birth background check; and

(2) The results of the national fingerprint background check are pending.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to complete a national fingerprint background check for 2 of 2 sampled staff (Staff A and Staff X). This failure placed all 30 residents at risk for potential abuse and neglect from staff with an unknown background.

Findings included...

STAFF A

Review of the facility's staff roster showed the facility hired Staff A as the Health and Wellness Manager on 12/01/2024.

Observation on 04/22/2024 at 2:30 PM, 04/23/2024 at 11:00 AM, and 04/24/2024 at 9:30 AM showed Staff A interacted with residents and staff.

Review of Staff A's records showed a Washington State name and date of birth background check was completed on 12/01/2024 with no disqualifying results. The name and date of birth background check did not show any pending interim fingerprint check. There was no documentation that showed a national fingerprint check was completed within 120 days of hire to allow Staff A unsupervised access to residents.

During an interview on 04/22/3:15 PM, Staff A stated that they did not know why they were not asked to complete a national fingerprint check. Staff A stated they would have

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completed one, if asked.

STAFF X

Review of email correspondence from Staff P, Business Office Manager, dated 04/29/2023, showed Staff X, Registered Nurse, from affiliated facility, started to work at the facility in October of 2023.

Review of Resident J's Assessment and Evaluation and Service Planning, dated 03/01/2024, showed it was completed and signed by Staff X.

Review of Staff X's records showed no documentation that Staff X completed a national fingerprint check within 120 days of the date they started to work at the facility.

During an interview on 04/23/2024 at 2:20 PM, Staff P stated that they did not have a copy of Staff X's background check at the facility. Staff P stated that Staff X primarily worked at an affiliated facility in Idaho. Staff P stated that Staff X's background check and fingerprint check was at the Idaho facility.

Review of email correspondence from Staff P, dated 04/24/2024, showed the Business Office Manager from the Idaho Falls, Idaho affiliated facility provided a copy of Staff X's background check. There was no national fingerprint check provided.

Plan/Attestation Statement

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

Kate Hanson
Administrator (or Representative)

5-15-24
6/28/2024 *KH*
Date

WAC 388-78A-2468 Background checks Employment Conditional hire Pending results of Washington state name and date of birth background check. The assisted living facility may conditionally hire an administrator, caregiver, or staff person directly or by contract, pending the result of the Washington state name and date of birth background check, provided that the assisted living facility:

(1) Submits the background authorization form for the person to the department no later than one business day after he or she starts working;

This requirement was not met as evidenced by:

completed one, if asked.

STAFF X

Review of email correspondence from Staff P, Business Office Manager, dated 04/29/2023, showed Staff X, Registered Nurse, from affiliated facility, started to work at the facility in October of 2023.

Review of Resident 3's Assessment and Evaluation and Service Planning, dated 03/01/2024, showed it was completed and signed by Staff X.

Review of Staff X's records showed no documentation that Staff X completed a national fingerprint check within 120 days of the date they started to work at the facility.

During an interview on 04/23/2024 at 2:20 PM, Staff P stated that they did not have a copy of Staff X's background check at the facility. Staff P stated that Staff X primarily worked at an affiliated facility in Idaho. Staff P stated that Staff X's background check and fingerprint check was at the Idaho facility.

Review of email correspondence from Staff P, dated 04/24/2024, showed the Business Office Manager from the Idaho Falls, Idaho affiliated facility provided a copy of Staff X's background check. There was no national fingerprint check provided.

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)_____.

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

Administrator (or Representative)

Date

WAC 388-78A-2468 Background checks Employment Conditional hire Pending results of Washington state name and date of birth background check. The assisted living facility may conditionally hire an administrator, caregiver, or staff person directly or by contract, pending the result of the Washington state name and date of birth background check, provided that the assisted living facility:

(1) Submits the background authorization form for the person to the department no later than one business day after he or she starts working;

This requirement was not met as evidenced by:

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Based on interview and record review, the facility failed to complete a Washington state name and date of birth background inquiry (BGI) for 3 of 3 sampled staff (Staff D, Staff K, and Staff X). This failure placed the 30 Assisted Living residents at risk for potential abuse and/or neglect by a staff with an unknown background check.

Findings included...

STAFF D

Review of the facility's employee roster showed the facility hired Staff D as Resident Assistant II on 03/05/2024.

Review of Staff D's records showed a Washington state name and date of birth background check (BGI) was processed by the Department of Social and Health Services (DSHS) Background Check Central Unit (BCCU) on 03/10/2024, five days after date of hire.

During an interview on 04/22/2024 at 3:15 PM, Staff P, Business Office Manager, stated that they were responsible for the completion of the staff background checks for all employees. Staff P stated that they did not know why Staff D's BGI was not completed on time.

STAFF K

Review of the facility's employee roster showed the facility hired Staff K as Resident Assistant II on 03/04/2024.

During an interview on 04/22/2024 at 3:15 PM, Staff P stated that Staff K's first day they worked for pay was on 03/06/2024.

Review of Staff K's records showed a BGI was processed by DSHS BCCU on 03/10/2024, six days after date of hire and four days after the first day Staff K worked for pay.

STAFF X

During the entrance conference interview on 04/22/2024 at 9:31 AM Staff N, General Manager/Administrator Designee, stated that Staff X, Registered Nurse from an affiliated facility, and Staff Z, Registered Nurse from an affiliated facility, completed all the preadmission assessments for the facility.

During the entrance conference interview on 04/22/2024 between 9:48 AM and 10:00 AM, Staff A, Health and Wellness Manager, stated that prior to their employment, Staff X and Staff Z provided the facility with nurse support during the absence of a Health and Wellness Director. Staff A stated that the two nurses completed preadmission assessments, assessments, and updated service plans as needed. Staff A stated that Staff X and Staff Z fulfilled other duties that required licensed nurse oversight. Staff A stated that the two nurses continued to provide nurse support, as needed.

Based on interview and record review, the facility failed to complete a Washington state name and date of birth background inquiry (BGI) for 3 of 3 sampled staff (Staff D, Staff K, and Staff X). This failure placed the 30 Assisted Living residents at risk for potential abuse and/or neglect by a staff with an unknown background check.

Findings included...

STAFF D

Review of the facility's employee roster showed the facility hired Staff D as Resident Assistant II on 03/05/2024.

Review of Staff D's records showed a Washington state name and date of birth background check (BGI) was processed by the Department of Social and Health Services (DSHS) Background Check Central Unit (BCCU) on 03/10/2024, five days after date of hire.

During an interview on 04/22/2024 at 3:15 PM, Staff P, Business Office Manager, stated that they were responsible for the completion of the staff background checks for all employees. Staff P stated that they did not know why Staff D's BGI was not completed on time.

STAFF K

Review of the facility's employee roster showed the facility hired Staff K as Resident Assistant II on 03/04/2024.

During an interview on 04/22/2024 at 3:15 PM, Staff P stated that Staff K's first day they worked for pay was on 03/06/2024.

Review of Staff K's records showed a BGI was processed by DSHS BCCU on 03/10/2024, six days after date of hire and four days after the first day Staff K worked for pay.

STAFF X

During the entrance conference interview on 04/22/2024 at 9:31 AM Staff N, General Manager/Administrator Designee, stated that Staff X, Registered Nurse from an affiliated facility, and Staff Z, Registered Nurse from an affiliated facility, completed all the preadmission assessments for the facility.

During the entrance conference interview on 04/22/2024 between 9:45 AM and 10:00 AM, Staff A, Health and Wellness Manager, stated that prior to their employment, Staff X and Staff Z provided the facility with nurse support during the absence of a Health and Wellness Director. Staff A stated that the two nurses completed preadmission assessments, assessments, and updated service plans as needed. Staff A stated that Staff X and Staff Z fulfilled other duties that required licensed nurse oversight. Staff A stated that the two nurses continued to provide nurse support, as needed.

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Review of email correspondence from Staff P dated 04/28/2023 showed Staff X started to work at the facility in October of 2023.

Review of Staff X's records showed a background check dated 07/15/2024 was completed through the state of Idaho Department of Health and Welfare. There were no records that showed Staff X completed a Washington state name and date of birth background check through DSHS' BCCU.

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) <u>6-15-24</u>	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
<u>Kate Hanson</u> Administrator (or Representative)	<u>5-15-24</u> <u>6/28/2024</u> KH 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:

- (1) An initial skin test within three days of employment; and
- (2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to test 1 of 7 sampled staff (Staff D) for tuberculosis (TB) within three days of hire, as required. This failure placed all the residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included...

Review of the facility's undated policy titled, "Exposure Control Plan/TB Policy" showed that staff needed to have a one-step TB test within three days of hire. The policy showed that staff must have a two-step test initiated within three days of being hired no less than one and no than three weeks apart.

STAFF D

Review of email correspondence from Staff P dated 04/29/2023 showed Staff X started to work at the facility in October of 2023.

Review of Staff X's records showed a background check dated 07/15/2024 was completed through the state of Idaho Department of Health and Welfare. There were no records that showed Staff X completed a Washington state name and date of birth background check through DSHS' BCCU.

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)_____.

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

Administrator (or Representative)

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:

- (1) An initial skin test within three days of employment; and
- (2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to test 1 of 7 sampled staff (Staff D) for tuberculosis (TB) within three days of hire, as required. This failure placed all the residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included...

Review of the facility's undated policy titled, "Exposure Control Plan/TB Policy" showed that staff needed to have a one-step TB test within three days of hire. The policy showed that staff must have a two-step test initiated within three days of being hired no less than one and no than three weeks apart.

STAFF D

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Review of the facility's Employee Roster showed that the facility hired Staff D, Resident Assistant II, on 03/05/2024. Review of Staff D's employee records showed that Staff D was administered an initial one-step TB test on 03/12/2024, seven days after hired, and the test was completed on 03/14/2024. There were no records to show the second step of the TB test was administered and completed one to three weeks after the first step.

During an interview on 04/22/2024 at 3:15 PM, Staff P, Business Office Manager, stated that they did not know why the second step of the TB test was not administered to Staff D.

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) 6-15-24.

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

Kate Harrison
Administrator (or Representative)

5-15-24
6/08/2024
Date

WAC 388-78A-2320 Intermittent nursing services systems.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

- (a) Nursing services supervision;
- (b) Nurse delegation, if provided;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to assess and implement nurse delegation services for 1 of 1 sampled resident (Resident 2). This failure placed Resident 2 at risk for medication errors when unqualified staff and staff who lacked instruction provided care.

Findings included...

Review of the facility's Disclosure of Services showed the facility did not use nursing assistants to administer drops, oral, and topical medications under delegation of a Registered Nurse.

Review of the facility's Employee Roster showed that the facility hired Staff D, Resident Assistant II, on 03/05/2024. Review of Staff D's employee records showed that Staff D was administered an initial one-step TB test on 03/12/2024, seven days after hired, and the test was completed on 03/14/2024. There were no records to show the second step of the TB test was administered and completed one to three weeks after the first step.

During an interview on 04/22/2024 at 3:15 PM, Staff P, Business Office Manager, stated that they did not know why the second step of the TB test was not administered to Staff D.

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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)_____.

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

Administrator (or Representative)

Date

WAC 388-78A-2320 Intermittent nursing services systems.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

- (a) Nursing services supervision;
- (b) Nurse delegation, if provided;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to assess and implement nurse delegation services for 1 of 1 sampled resident (Resident 2). This failure placed Resident 2 at risk for medication errors when unqualified staff and staff who lacked instruction provided care.

Findings included...

Review of the facility's Disclosure of Services showed the facility did not use nursing assistants to administer drops, oral, and topical medications under delegation of a Registered Nurse.

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During the entrance conference interview on 04/22/2024 at 9:10 AM, Staff N, General Manager, Administrator Designee, stated that the facility did not provide nurse delegation services. During the interview at 9:40 AM, Staff A, Health and Wellness Manager, stated that there were no current residents who required nurse delegation.

RESIDENT 2

Review of Resident 2's records showed that the facility admitted Resident 2 in [REDACTED] 2024 with a medical diagnosis of [REDACTED], [REDACTED], and [REDACTED]. Review of Resident 2's records showed that Resident 2 received Hospice Care services (end of life services).

Observation on 04/22/2024 at 4:11 PM, showed Resident 2 laid in a hospital bed. Observation showed an oxygen concentrator on the floor of Resident 2's apartment. Resident 2 used a nasal cannula (device that delivers oxygen via a tube through the nose) to receive supplemental oxygen. Observation showed Resident 2 moved in bed with the assistance of a private caregiver. Observation showed a bandage adhered to Resident 2's right leg. During an interview at this time, Resident 2 stated that the caregivers gave them their medications and applied a pain patch to their body. Collateral Contact 1 (CC1), private caregiver, stated that Resident 2 was able to swallow fluids through a straw while the private caregiver held the cup. CC1 stated that Resident 2 was too weak to hold the cup.

Review of Resident 2's Assessment/Evaluation and Service Planning, dated 04/01/2024, showed Resident 2 received oral medication assistance for set-up three times daily. The assessment showed that Resident 2 did not require assistance with inhalers. There was no documentation in the assessment that showed Resident 2 had a wound to the right leg or a wound to the coccyx (tailbone). There was no documentation that showed Resident 2 received delegation services.

Review of Resident 2's Negotiated Service Agreement (NSA), dated 04/01/2024, showed that the facility Medication Technicians (unlicensed staff who dispense medications) were responsible to set-up services to ensure safe and effective medication assistance and management practices were followed. There was no documentation in the NSA that showed Resident 2 had a wound to the right leg or a wound to the coccyx. There was no documentation in that showed Resident 2 received nurse delegation services for administration of medications and wound care.

Review of Resident 2's April 2024 electronic medication administration records (eMARs) showed Resident 2 received prescription medications which included an inhaler. The April 2024 eMAR showed an order for liquid morphine (pain medication), 20 milligrams (mgs) per 1 milliliter (ml), .25 ml (7.5mg), given three times a day; Fentanyl (pain medication), 12 micrograms (MC) patch, applied to the skin topically every three days; Haldol (antipsychotic medication for anxiety), 2mg/ml, .5ml (1mg), given by mouth at bedtime; iodine solution applied topically three days a week to eschar tissue (dead tissue that forms over healthy tissue) on both great toes and right heel, as needed. The eMAR showed an order for oxygen two to four liters by mouth per minute, continuously via a nasal cannula or mask as

During the entrance conference interview on 04/22/2024 at 9:10 AM, Staff N, General Manager, Administrator Designee, stated that the facility did not provide nurse delegation services. During the interview at 9:40 AM, Staff A, Health and Wellness Manager, stated that there were no current residents who required nurse delegation.

RESIDENT 2

Review of Resident 2's records showed that the facility admitted Resident 2 in [REDACTED] 2024 with a medical diagnosis of [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. Review of Resident 2's records showed that Resident 2 received Hospice Care services (end of life services).

Observation on 04/22/2024 at 4:11 PM, showed Resident 2 laid in a hospital bed. Observation showed an oxygen concentrator on the floor of Resident 2's apartment. Resident 2 used a nasal cannula (device that delivers oxygen via a tube through the nose) to receive supplemental oxygen. Observation showed Resident 2 moved in bed with the assistance of a private caregiver. Observation showed a bandage adhered to Resident 2's right leg. During an interview at this time, Resident 2 stated that the caregivers gave them their medications and applied a pain patch to their body. Collateral Contact 1 (CC1), private caregiver, stated that Resident 2 was able to swallow fluids through a straw while the private caregiver held the cup. CC1 stated that Resident 2 was too weak to hold the cup.

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needed for shortness of breath. Review of the April 2024 eMAR showed that the Medication Technicians applied the Fentanyl patch to Resident 2's body three times. The eMAR showed that staff administered morphine 47 times and Haldol once.

During an interview on 04/22/2024 at 3:16 PM, Staff A stated that Resident 2 was on Hospice Services. Staff A stated that Resident 2 received liquid morphine via a syringe, Lorazepam (medication for anxiety), crushed in applesauce, and a Fentanyl patch applied every three days for pain management. Staff A stated that the Medication Technicians used a syringe to draw up the morphine and physically "squirted" the morphine into Resident 2's mouth. Staff A stated that the facility staff administered all Resident 2's medications. Staff A stated that the care staff did not assist with Resident 2's oxygen. Staff A stated that the caregivers did not change the bandage on Resident 2's right leg, they only reinforced the bandages that covered the wound when fluid leaked, and when the existing bandage was soiled.

During an interview on 04/23/2024 at 1:41 PM, Staff B, Resident Assistant II/Med Tech, stated that they administered Resident 2's medications. Staff B stated that after the caregivers repositioned Resident 2 in the bed, Resident 2 expressed pain afterwards. Staff B stated that they administered Resident 2 morphine at 8:00 AM and 11:00 AM that morning. Staff B stated that they used a syringe to physically administer Resident 2's morphine. Staff B stated that they squirted the medication into Resident 2's mouth. Staff B stated that the Haldol was also in liquid form and was administered via a syringe on the night of 04/22/2024. Staff B stated that they applied the Fentanyl patch to Resident 2's body as ordered. Staff B stated that Resident 2 was unable to apply the patch themselves. Staff B stated that they assisted Resident 2 with the oxygen when Resident 2 had difficulty breathing. Staff B stated they adjusted the oxygen rate according to Resident 2's comfort to breathe.

Review of Resident 2's progress note, dated 03/24/2024, showed Staff W, Resident Assistant II, documented that Resident 2 had an open sore on their coccyx, the size of pea. Review of Resident 2's progress note dated 04/04/2024 at 1:16 PM, showed Resident 2 started the use of iodine. The progress note was electronically signed by Staff B.

Review of Resident 2's progress note dated 04/07/2024 at 5:51 PM, showed Staff AA, Resident Assistant II, documented that they removed the bandage on Resident 2's right leg and cleaned the wound. Staff AA applied a new bandage to the leg and documented that the wound be checked later, as the bandage may need to be changed again, if the bandage was soiled.

Review of Resident 2's progress notes dated 04/15/2024 at 4:10 PM, showed Staff A documented that they called Staff X, Registered Nurse, and asked if staff were allowed to do a simple dressing change, with an abdominal gauze pad bandage and a waterproof foam dressing. The progress note showed that Staff X stated, "technically that is wound care but given (Resident 2) was on Hospice and has little time left", Staff X thought it was fine.

needed for shortness of breath. Review of the April 2024 eMAR showed that the Medication Technicians applied the Fentanyl patch to Resident 2's body three times. The eMAR showed that staff administered morphine 47 times and Haldol once.

During an interview on 04/22/2024 at 3:15 PM, Staff A stated that Resident 2 was on Hospice Services. Staff A stated that Resident 2 received liquid morphine via a syringe, Lorazepam (medication for anxiety), crushed in applesauce, and a Fentanyl patch applied every three days for pain management. Staff A stated that the Medication Technicians used a syringe to draw up the morphine and physically "squirted" the morphine into Resident 2's mouth. Staff A stated that the facility staff administered all Resident 2's medications. Staff A stated that the care staff did not assist with Resident 2's oxygen. Staff A stated that the caregivers did not change the bandage on Resident 2's right leg, they only reinforced the bandages that covered the wound when fluid leaked, and when the existing bandage was soiled.

During an interview on 04/23/2024 at 1:41 PM, Staff B, Resident Assistant II/Med Tech, stated that they administered Resident 2's medications. Staff B stated that after the caregivers repositioned Resident 2 in the bed, Resident 2 expressed pain afterwards. Staff B stated that they administered Resident 2 morphine at 8:00 AM and 11:00 AM that morning. Staff B stated that they used a syringe to physically administer Resident 2's morphine. Staff B stated that they squirted the medication into Resident 2's mouth. Staff B stated that the Haldol was also in liquid form and was administered via a syringe on the night of 04/22/2024. Staff B stated that they applied the Fentanyl patch to Resident 2's body as ordered. Staff B stated that Resident 2 was unable to apply the patch themselves. Staff B stated that they assisted Resident 2 with the oxygen when Resident 2 had difficulty breathing. Staff B stated they adjusted the oxygen rate according to Resident 2's comfort to breathe.

Review of Resident 2's progress note, dated 03/24/2024, showed Staff W, Resident Assistant II, documented that Resident 2 had an open sore on their coccyx, the size of pea. Review of Resident 2's progress note dated 04/04/2024 at 1:18 PM, showed Resident 2 started the use of iodine. The progress note was electronically signed by Staff B.

Review of Resident 2's progress note dated 04/07/2024 at 5:51 PM, showed Staff AA, Resident Assistant II, documented that they removed the bandage on Resident 2's right leg and cleaned the wound. Staff AA applied a new bandage to the leg and documented that the wound be checked later, as the bandage may need to be changed again, if the bandage was soiled.

Review of Resident 2's progress notes dated 04/15/2024 at 4:10 PM, showed Staff A documented that they called Staff X, Registered Nurse, and asked if staff were allowed to do a simple dressing change, with an abdominal gauze pad bandage and a waterproof foam dressing. The progress note showed that Staff X stated, "technically that is wound care but given (Resident 2) was on Hospice and has little time left", Staff X thought it was fine.

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Review of a progress note dated 04/18/2024 at 8:05 AM showed that Staff Y, Resident Assistant II, documented that they placed the oxygen nasal canula on Resident 2 when Resident 2 stated they were having trouble breathing.

During an interview on 04/23/2024 at 3:00 PM, Staff Y stated that they adjusted the oxygen rate according to Resident 2's comfort level until Resident 2 stated they could breathe better.

Review of a progress note dated 04/19/2024 at 8:54 PM, Staff W documented that they applied a pain patch to Resident 2's right shoulder.

During an interview on 04/23/2024 at 3:00 PM, Staff A stated that the corporate nurse "caught" the order for oxygen which showed the oxygen levels (two to four liters) were to be titrated for comfort. Staff A stated that there were no instructions for the Medication Technicians on when to titrate the oxygen. Staff A stated that the corporate nurse stated that the order required Med Techs to use nursing judgement. Staff A stated that the corporate nurse stated the oxygen order needed to be rewritten. Staff A stated that when they changed the dressing on Resident 2's right leg, that was technically wound care. Staff A stated that wound care needed to be done either by a nurse, the Hospice nurse, or nurse delegation services which the facility did not provide.

Plan/Attestation Statement

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

Kate Harrison

Administrator (or Representative)

5-15-24
6/28/2024

Date

WAC 388-78A-2690 Electronic monitoring equipment Resident requested use.

(6) If the resident requests the assisted living facility to conduct audio or video monitoring of his or her apartment or sleeping area, before any electronic monitoring occurs, the assisted living facility must ensure:

(c) The resident and the assisted living facility have agreed upon a specific duration for the electronic monitoring and the agreement is documented in writing.

(7) The assisted living facility must:

(a) Reevaluate the need for the electronic monitoring with the resident at least quarterly; and

Review of a progress note dated 04/18/2024 at 6:05 AM showed that Staff Y, Resident Assistant II, documented that they placed the oxygen nasal canula on Resident 2 when Resident 2 stated they were having trouble breathing.

During an interview on 04/23/2024 at 3:00 PM, Staff Y stated that they adjusted the oxygen rate according to Resident 2's comfort level until Resident 2 stated they could breathe better.

Review of a progress note dated 04/19/2024 at 9:54 PM, Staff W documented that they applied a pain patch to Resident 2's right shoulder.

During an interview on 04/23/2024 at 3:00 PM, Staff A stated that the corporate nurse "caught" the order for oxygen which showed the oxygen levels (two to four liters) were to be titrated for comfort. Staff A stated that there were no instructions for the Medication Technicians on when to titrate the oxygen. Staff A stated that the corporate nurse stated that the order required Med Techs to use nursing judgement. Staff A stated that the corporate nurse stated the oxygen order needed to be rewritten. Staff A stated that when they changed the dressing on Resident 2's right leg, that was technically wound care. Staff A stated that wound care needed to be done either by a nurse, the Hospice nurse, or nurse delegation services which the facility did not provide.

Plan/Attestation Statement

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Administrator (or Representative)

Date

WAC 388-78A-2690 Electronic monitoring equipment Resident requested use.

(6) If the resident requests the assisted living facility to conduct audio or video monitoring of his or her apartment or sleeping area, before any electronic monitoring occurs, the assisted living facility must ensure:

(c) The resident and the assisted living facility have agreed upon a specific duration for the electronic monitoring and the agreement is documented in writing.

(7) The assisted living facility must:

(a) Reevaluate the need for the electronic monitoring with the resident at least quarterly; and

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(b) Have each reevaluation in writing, signed and dated by the resident.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to document in writing an initial agreement and quarterly reevaluations of electronic surveillance for 1 of 1 sampled resident (Resident 3). This failure placed Resident 3 at risk for potential violation of their rights.

Findings included...

Review of the facility's policy titled, "Electronic Monitoring Policy" dated August 2023, showed that the use of electronic devices that have monitoring capabilities would comply with applicable state, federal, and other jurisdictional laws. The document showed that resident conducted electronic monitoring may be permitted if the facility was notified in advance to ensure the rights of the resident were properly protected and necessary consents were obtained.

Resident 3

Review of Resident 3's records showed that the facility admitted Resident 3 in [REDACTED] 2021. The records showed no documentation of any video surveillance agreement, no quarterly evaluations, and no resident or resident representatives signed consent.

Review of Resident 3's Assessment/Evaluation and Service Planning, dated 03/01/2024, and the Negotiated Service Agreement, dated 03/01/2024, showed no documentation that Resident 3 used video surveillance in their apartment.

Observation on 04/23/2024 at 1:48 PM, showed a video camera sat on a credenza, pointed in the direction of a recliner where Resident 3 was seated.

During an interview on 04/23/2024 at 1:45 PM, Resident 3 stated that they were aware of the video camera. Resident 3 stated that their family installed the camera. Resident 3 stated that they were fine with the video camera and wanted the video camera to remain in the apartment.

During an interview on 04/23/2024 at 3:00 PM, Staff A, Health and Wellness Manager, stated that Resident 3 and their family installed the video camera in Resident 3's apartment. Staff A stated that there was no documented agreement between the facility, Resident 3 and their family regarding the use of the video camera. Staff A stated that since the family and Resident 3 wanted the video camera installed, the facility did not complete a quarterly re-evaluate for the use of the video camera.

(b) Have each reevaluation in writing, signed and dated by the resident.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to document in writing an initial agreement and quarterly reevaluations of electronic surveillance for 1 of 1 sampled resident (Resident 3). This failure placed Resident 3 at risk for potential violation of their rights.

Findings included...

Review of the facility's policy titled, "Electronic Monitoring Policy" dated August 2023, showed that the use of electronic devices that have monitoring capabilities would comply with applicable state, federal, and other jurisdictional laws. The document showed that resident conducted electronic monitoring may be permitted if the facility was notified in advance to ensure the rights of the resident were properly protected and necessary consents were obtained.

Resident 3

Review of Resident 3's records showed that the facility admitted Resident 3 in [REDACTED] 2021. The records showed no documentation of any video surveillance agreement, no quarterly evaluations, and no resident or resident representatives signed consent.

Review of Resident 3's Assessment/Evaluation and Service Planning, dated 03/01/2024, and the Negotiated Service Agreement, dated 03/01/2024, showed no documentation that Resident 3 used video surveillance in their apartment.

Observation on 04/23/2024 at 1:46 PM, showed a video camera sat on a credenza, pointed in the direction of a recliner where Resident 3 was seated.

During an interview on 04/23/2024 at 1:46 PM, Resident 3 stated that they were aware of the video camera. Resident 3 stated that their family installed the camera. Resident 3 stated that they were fine with the video camera and wanted the video camera to remain in the apartment.

During an interview on 04/23/2024 at 3:00 PM, Staff A, Health and Wellness Manager, stated that Resident 3 and their family installed the video camera in Resident 3's apartment. Staff A stated that there was no documented agreement between the facility, Resident 3 and their family regarding the use of the video camera. Staff A stated that since the family and Resident 3 wanted the video camera installed, the facility did not complete a quarterly re-evaluate for the use of the video camera.

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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) 6-15-24.

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

Kate Hanson
 Administrator (or Representative)

5-15-24 KAH
6/28/2024
 Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues.

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to assess a medical device for 1 of 1 sampled resident (Resident 2). This failure placed Resident 2 at risk for compromised health and potential injury.

Findings included...

BED SIDERAIL

Note: On 05/15/2013, the Department of Social and Health Services issued a letter titled, "Dear Assisted Living Facility Administrator". The letter informed facilities of the safety risks associated with the use of all medical devices. The letter stated "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 Resident 2's records showed that the facility admitted Resident 2 in [REDACTED] 2024 with a medical diagnosis of [REDACTED], [REDACTED], and [REDACTED]. Review of R2's records showed that R2 received Hospice Care services (end of life services).

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)_____.

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

Administrator (or Representative)

Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to assess a medical device for 1 of 1 sampled resident (Resident 2). This failure placed Resident 2 at risk for compromised health and potential injury.

Findings included...

BED SIDERAIL

Note: On 05/15/2013, the Department of Social and Health Services issued a letter titled, "Dear Assisted Living Facility Administrator". The letter informed facilities of the safety risks associated with the use of all medical devices. The letter stated "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 Resident 2's records showed that the facility admitted Resident 2 in [REDACTED] 2024 with a medical diagnosis of [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. Review of R2's records showed that R2 received Hospice Care services (end of life services).

Statement of Deficiencies	License #: 1814	Compliance Determination # 48089
Plan of Correction	FAIRWINDS REDMOND	Completion Date
Page of 22	Licensee: REDM LLC	05/01/2024

Observation on 04/22/2024 at 4:11 PM, showed Resident 2 laid in a hospital bed with two half bed siderails attached at the head of the bed, one rail on each side. Observation showed Resident 2 used the bed rails to assist with bed mobility. Observation showed Resident 2 grabbed the half rail with their left hand to move within the bed.

Review of Resident 2's records showed no assessment for the bed siderails to determine if the bed siderails were safe, secured, and did not have restraint like qualities. The records showed no documentation that Resident 2 requested or wanted the bed siderails. There was no documentation that showed the bed siderails were installed securely and safely. There was no documentation that explained the reason for the bed siderails.

During an interview on 04/22/2024 at 3:15 PM, Staff A, Health and Wellness Manager, stated that they completed all the preadmission assessments, initial assessments, and the ongoing assessments.

During an interview on 04/23/2024 at 1:41 PM, Staff A stated that there was no assessment for Resident 2's bed siderails. Staff A stated that on 04/14/2024, Hospice delivered the hospital bed and attached the bed siderails. Staff A stated that they thought Hospice performed the assessment. Staff A stated that they were unaware the facility was responsible for the assessment of the bed siderails.

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) 6-15-24.

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

Kate Hanson
Administrator (or Representative)

5-15-24
6/28/2024 KTH
Date

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During an interview on 04/22/2024 at 3:15 PM, Staff A, Health and Wellness Manager, stated that they completed all the preadmission assessments, initial assessments, and the ongoing assessments.

During an interview on 04/23/2024 at 1:41 PM, Staff A stated that there was no assessment for Resident 2's bed siderails. Staff A stated that on 04/14/2024, Hospice delivered the hospital bed and attached the bed siderails. Staff A stated that they thought Hospice performed the assessment. Staff A stated that they were unaware the facility was responsible for the assessment of the bed siderails.

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

Administrator (or Representative)

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

05/07/2024

REDM LLC
FAIRWINDS REDMOND
9956 AVONDALE ROAD NE
REDMOND, WA 98052

RE: FAIRWINDS REDMOND # 1814

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 05/01/2024 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);
- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
 - o Sign and date the enclosed report;
 - o For each deficiency, indicate the date you have or will correct each deficiency;
 - o Mail the Plan/Attestation Statement and report with original signatures to:

Laurie Anderson, Field Manager
Residential Care Services
Region 2, Unit D
20425 72nd Avenue S, Suite 400



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
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Residential Care Services
Region 2, Unit D
20425 72nd Avenue S, Suite 400

FAIRWINDS REDMOND # 1814

05/31/2024

Page 2 of 3

Kent, WA 98032

- Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
- Have your plan approved by the Department.

Consultation(s):

In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

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:
 - (i) A current assisted living facility license, including any related conditions on the license;

The assisted living facility (ALF) failed to post the current ALF license. During the full inspection, facility staff posted the current license on the wall behind the front desk.

You Are Not:

- Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

- Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

- Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
 - o What specific deficiency or deficiencies you disagree with;
 - o Why you disagree with each deficiency; and
 - o Whether you want an IDR to occur in-person, by telephone or as a paper review.
- Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (253)234-6020.

Kent, WA 98032

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FAIRWINDS REDMOND #1814

05/31/2024

Page 3 of 3

Sincerely,

Laurie Anderson

Laurie Anderson, Field Manager

Region 2, Unit D

Residential Care Services

Enclosure

FAIRWINDS REDMOND # 1814

05/01/2024

Page 3 of 3

Sincerely,

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

Enclosure