

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 107201156

Report Date: 03/25/2022

Date Signed: 03/25/2022 12:32:09 PM

Document Has Been Signed on 03/25/2022 12:32 PM - It Cannot Be Edited

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 1314 E SHAW AVE FRESNO, CA 93710
FACILITY EVALUATION REPORT	

FACILITY NAME:	FAIRWINDS - WOODWARD PARK	FACILITY NUMBER:	107201156
ADMINISTRATOR:	EDWARDS, DEANNE	FACILITY TYPE:	740
ADDRESS:	9525 N FT WASHINGTON RD	TELEPHONE:	(559) 434-6444
CITY:	FRESNO	STATE:	CA
CAPACITY:	270	CENSUS:	184
TYPE OF VISIT:	Required - 1 Year	DATE:	03/25/2022
MET WITH:	Desiree Valero, Administrator	UNANNOUNCED TIME BEGAN:	09:14 AM
		TIME	12:35 PM
		COMPLETED:	

NARRATIVE	
1	On 3/25/22, Licensing Program Analyst, M. Medina arrived at the facility unannounced to conduct the required Infection Control Inspection. LPA observed a central entry point with a supply of hand sanitizer located upon entry. A sign in policy that includes documented routine symptom screening for visitors is currently being implemented to follow current visitation guidelines. All staff are screened upon arrival for shift. Mitigation plan was received and approved by Department on 2/23/2021.
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7	LPA toured the facility inside and out. Staff were all observed wearing face coverings. Facility has designated visitation areas. LPAs observed a 30 day supply of PPE and resident medications. Several residents rooms in Assisted Living apartments toured and observed to have adequate soap and paper products available.
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12	Administrator to submit LIC 500, LIC 610E and resident roster to Fresno CCL office no later than 4/1/2022.
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15	Through LPA's observation of documentation and interview with Administrator, the required infection control practices are found to be in compliance. No deficiencies were observed. Exit interview was conducted and report signed. Administrator was informed that as a COVID-19 precautionary measure, this report will be emailed.
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NAME OF LICENSING PROGRAM MANAGER: Melinda Hoffmann

NAME OF LICENSING PROGRAM ANALYST: Melinda Medina

LICENSING PROGRAM ANALYST SIGNATURE:**DATE:** 03/25/2022

I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.

FACILITY REPRESENTATIVE SIGNATURE:**DATE:** 03/25/2022

This report must be available at Child Care and Group Home facilities for public review for 3 years.