



STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
AGING AND LONG-TERM SUPPORT ADMINISTRATION  
**800 NE 135th Ave Ste 220, Vancouver, WA 98684**

Touchmark At Fairway Village, LLC  
Touchmark at Fairway Village  
2911 SE Village Loop  
Vancouver, WA 98683

RE: Touchmark at Fairway Village # 1189

Dear Administrator:

This document references Compliance Determination 19374 (02/14/2023), which included complaint number(s) 65926.

The Department completed a complaint investigation of your Assisted Living Facility on 02/14/2023 and found that your facility does not meet the Assisted Living Facility requirements.

The department staff who did the inspection and provided consultation:

Jacob Ubl, ALF NCI CI

**Consultation:**

**WAC 388-78A-2640 Reporting significant change in a resident's condition.**

- (1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:
  - (a) There is a significant change in the resident's condition;

The facility failed to notify residents representative of residents significant change in condition and other reportable incidents.

**You Must:**

Touchmark at Fairway Village # 1189

02/14/2023

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- Begin the process of correcting the deficiency or deficiencies immediately; and
- Complete correction as soon as possible.

**You Are Not:**

- Required to submit a plan-of-correction for the deficiency or deficiencies found.

**The Department May:**

- Inspect the facility to determine if you have corrected all deficiencies.

**You May:**

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

**In Addition, You May:**

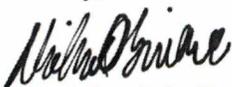
- Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  - o What specific deficiency or deficiencies you disagree with;
  - o Why you disagree with each deficiency; and
  - o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  - o 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 (360)450-1218.

Sincerely,



Michael Burdick, Field Manager  
Region 3, Unit I  
Residential Care Services



## Residential Care Services Investigation Summary Report

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**Provider/Facility:** Touchmark at Fairway Village  
**License/Cert.#:** 1189  
**Compliance Determination #:** 19374  
**Investigator:** Jacob Ubl  
**Investigation Date(s):** 02/02/2023 through 02/14/2023  
**Complainant Contact Date(s):**

**Provider Type:** Assisted Living Facility  
**Intake ID:** 65926  
**Region/Unit #:** RCS Region 3 / Unit I

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### Allegation(s):

1. Resident/Patient/Client Rights: Allegation that resident representative was not notified after resident change in condition and incidences.
  2. Quality of Care/Treatment: Allegation that the facility was calling emergency medical services and not home hospice when resident had a change in condition.
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### Investigation Methods:

**Sample:** Total residents: 104  
Resident sample size: 3  
Closed records sample size: 0

**Observations:** Residents  
Resident rooms  
Staff to resident interactions  
Resident to resident interactions

**Interviews:** Residents  
staff  
Family members  
Hospice staff  
Social services staff

**Record Reviews:** Medical records  
Incident investigation  
Facility policies

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### Investigation Summary:

1. Resident/Patient/Client Rights: The facility failed to notify resident representative of resident change in condition and incidences. The facility received a consultation regarding the failure.
2. Quality of Care/Treatment: Staff and resident interviews did not show concerns. Records reviewed did not show concerns. Observations at facility did not show concerns. The facility had documentation and staff interviews to show that home Hospice was notified. Facility staff called emergency medical services for support after

resident falls and resident was not transferred to the hospital.

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**Conclusion / Action:**

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