STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

VALLEY HOUSE INC
VALLEY HOUSE
PO Box 2167
Spokane, WA 99210

RE: VALLEY HOUSE License # 2151

Dear Administrator:

This letter addresses Compliance Determination(s) 46427 (Completion Date 08/29/2024) and 43641 (Completion Date 07/03/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/29/2024 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-2730-1-c, WAC 388-78A-2730-1-b, WAC 388-78A-2730-1-a, WAC 388-78A-2730-1, WAC 388-78A-2100-2-a, WAC 388-78A-2210-1-b, WAC 388-78A-3090-1-b, WAC 388-78A-3090-1-a

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

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

Sincerely,

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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License # 2151	Compliance Determination # 43541
Plan of Correction	VALLEY HOUSE	Completion Date
Page 1 of 7	Licensee: VALLEY HOUSE INC	07/03/2024

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 07/01/2024, 07/02/2024 and 07/03/2024 of:
VALLEY HOUSE
401 S Eastern Rd
Spokane Valley, WA 99212

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

The department staff that inspected the Assisted Living Facility:

Brian Zbylski, ALF Licensor
Joy Pipgras, LTC Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Residential Care Services — Date: 07/10/2024

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.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for the unannounced on-site full inspection on 07/01/2024, 07/02/2024 and 07/03/2024 of:

VALLEY HOUSE
401 S Eastern Rd
Spokane Valley, WA 99212

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

The department staff that inspected the Assisted Living Facility:

Brian Zbylski, ALF Licensor
Joy Pipgras, LTC Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Residential Care Services _____ 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.

Statement of Deficiencies	License #: 2151	Compliance Determination # 43641
Plan of Correction	VALLEY HOUSE	Completion Date
Page 2 of 7	Licensee: VALLEY HOUSE INC	07/03/2024

Administrator (or Representative)

7/15/2024
Date

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

(1) The assisted living facility licensee is responsible for:

(a) The operation of the assisted living facility;

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

(c) The care and services provided to the assisted living facility residents.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to develop and implement a respiratory protection program as required and failed to ensure staff were fit tested for 5 of 5 sampled staff (Staff A, B, C, D, and E). This failure placed residents at risk for respiratory infection.

Findings included...

Per Chapter 296-842 WAC, Respirators, the facility must implement a program/policy, conduct fit testing (test completed by specially trained personnel to ensure N95 masks seal effectively reducing chance of exposure to respiratory viruses), and provide effective training before employees are assigned duties that may require the use of respirators.

Per WAC 296-842-15005, facilities must conduct fit testing before employees are assigned duties that may require the use of respirators.

Review of a Department of Social and Health Services provider letter, dated 09/14/2023, showed that employers in long term care settings were responsible to "follow regulations pertaining to respiratory protection" including respirator fit testing for long term care workers.

Review of Staff A's, Caregiver, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

Review of Staff B's, Caregiver, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

Review of Staff C's, Cook, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

Review of Staff D's, Caregiver, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

Administrator (or Representative) Date

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

(1) The assisted living facility licensee is responsible for:

(a) The operation of the assisted living facility;

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

(c) The care and services provided to the assisted living facility residents.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to develop and implement a respiratory protection program as required and failed to ensure staff were fit tested for 5 of 5 sampled staff (Staff A, B, C, D, and E). This failure placed residents at risk for respiratory infection.

Findings Included...

Per Chapter 296-842 WAC, Respirators, the facility must implement a program/policy, conduct fit testing (test completed by specially trained personnel to ensure N95 masks seal effectively reducing chance of exposure to respiratory viruses), and provide effective training before employees are assigned duties that may require the use of respirators.

Per WAC 296-842-15005, facilities must conduct fit testing before employees are assigned duties that may require the use of respirators.

Review of a Department of Social and Health Services provider letter, dated 09/14/2023, showed that employers in long term care settings were responsible to “follow regulations pertaining to respiratory protection” including respirator fit testing for long term care workers.

Review of Staff A’s, Caregiver, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

Review of Staff B’s, Caregiver, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

Review of Staff C’s, Cook, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

Review of Staff D’s, Caregiver, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

Statement of Deficiencies	License # 2151	Compliance Determination # 43641
Plan of Correction	VALLEY HOUSE	Completion Date
Page 3 of 7	Licensee: VALLEY HOUSE INC	07/03/2024

Review of Staff E's, Caregiver/Cook, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

In an interview on 07/01/2024 at 12:15 PM, Staff F, Manager, stated that the facility had not completed respirator fit testing for staff.

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, VALLEY HOUSE is or will be in compliance with this law and / or regulation on (Date) 8/12/24

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

Administrator (or Representative) — Date 7/15/24

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete an annual care assessment for 1 of 5 sampled residents (Resident 2). This failure placed the resident at risk of unmet care needs.

Findings included...

In an interview on 07/02/2024 at 9:01 AM, Resident 2 stated that they received meal, medication, and laundry services from the facility staff.

Review of Resident 2's Valley House Care Plan/Assessment showed it was dated and signed by Resident 2 and Staff F, Manager, on 09/10/2022.

In an interview on 07/02/2024 at 9:45 AM, Staff F stated that they were aware that Resident 2 was due to have an assessment completed in 2023.

In an interview on 07/02/2024 at 11:55 AM, Staff F stated that they made a mistake and did not complete the annual assessment for Resident 2 as required.

Review of Staff E's, Caregiver/Cook, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

In an interview on 07/01/2024 at 12:15 PM, Staff F, Manager, stated that the facility had not completed respirator fit testing for staff.

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, VALLEY HOUSE 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:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete an annual care assessment for 1 of 5 sampled residents (Resident 2). This failure placed the resident at risk of unmet care needs.

Findings included…

In an interview on 07/02/2024 at 9:01 AM, Resident 2 stated that they received meal, medication, and laundry services from the facility staff.

Review of Resident 2's Valley House Care Plan/Assessment showed it was dated and signed by Resident 2 and Staff F, Manager, on 09/10/2022.

In an interview on 07/02/2024 at 9:45 AM, Staff F stated that they were aware that Resident 2 was due to have an assessment completed in 2023.

In an interview on 07/02/2024 at 11:55 AM, Staff F stated that they made a mistake and did not complete the annual assessment for Resident 2 as required.

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, VALLEY HOUSE is or will be in compliance with this law and / or regulation on (Date) 8/12/24.

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

Administrator (or Representative) — Date 7/15/24

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide medications as prescribed for 2 of 5 residents (Residents 3 and 4). This failure resulted in medication errors and placed residents at risk of health complications.

Findings included...

Review of the facility's undated policy titled, "Medication Service," stated, "the facility will assure medications are taken in accordance with health care practitioner's instructions".

Review of the facility's undated Medication Assistance Protocol showed that staff were to ensure medications in a resident's blister pack were listed on the medication record and that staff were to initial the medication sheet for medications given.

<Resident 3>

Review of Resident 3's Valley House Care Plan/Assessment, dated 01/05/2024, showed the resident was diagnosed with a [redacted] and received staff medication assistance with all medications.

Review of Resident 3's undated medical chart showed a physician's order for Thera-Tabs M (multi-vitamin) to begin on 04/26/2023.

Review of Resident 3's April 2024, May 2024, and June 2024 medication administration records (MARs) showed the resident was prescribed Thera-tabs M once daily for a vitamin deficiency. Further review showed that the resident did not receive the Thera-tabs M with

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, VALLEY HOUSE 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-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide medications as prescribed for 2 of 5 residents (Residents 3 and 4). This failure resulted in medication errors and placed residents at risk of health complications.

Findings included…

Review of the facility's undated policy titled, "Medication Service," stated, "the facility will assure medications are taken in accordance with health care practitioner's instructions".

Review of the facility's undated Medication Assistance Protocol showed that staff were to ensure medications in a resident's blister pack were listed on the medication record and that staff were to initial the medication sheet for medications given.

<Resident 3>

Review of Resident 3's Valley House Care Plan/Assessment, dated 01/05/2024, showed the resident was diagnosed with a [redacted], and received staff medication assistance with all medications.

Review of Resident 3's undated medical chart showed a physician's order for Thera-Tabs M (multi-vitamin) to begin on 04/26/2023.

Review of Resident 3's April 2024, May 2024, and June 2024 medication administration records (MARs) showed the resident was prescribed Thera-tabs M once daily for a vitamin deficiency. Further review showed that the resident did not receive the Thera-tabs M with

documentation on the MAR stating, "Med not in blister/needs DR appt for new order" on the following dates: 04/19/2024, 04/25/2024, 05/01/2024, 05/02/2024, 05/06/2024, 05/07/2024, 05/08/2024, 05/09/2024, 05/10/2024, 05/13/2024, 05/15/2024, 05/16/2024, 05/21/2024, and 06/06/2024. Further review showed that the Thera-tabs M were documented as administered on all other dates in the period between 04/19/2024 and 06/05/2024, indicating staff were not following the five rights of medication administration (correct medication, resident, dosage, time and route).

<Resident 4>

Review of Resident 4's Valley House Care Plan/Assessment, dated 06/29/2023, showed the resident was diagnosed with [redacted] and received staff assistance with all medications.

Review of a provider note, dated 06/14/2024, showed Resident 4 experienced an exacerbation (irritation) of COPD and was prescribed azithromycin (medicine to treat infection), guaifenesin (medicine to thin mucus) and prednisone (medicine to treat inflammation).

Review of Resident 4's June 2024 MAR showed azithromycin was to be administered for five days beginning on 06/16/2024. Further review showed the first dose was started on 06/18/2024 and was documented as administered until 06/29/2024 (a total of 10 days).

Review of Resident 4's June 2024 MAR showed guaifenesin was to be administered three times a day for five days for a total of 15 doses. Further review showed the medication was documented as administered 16 times.

Review of Resident 4's June 2024 MAR showed the prednisone was to be administered twice daily for five days beginning 06/16/2024 and ending 06/21/2024. Further review showed the first doses were documented as administered on 06/18/2024 and the last doses were documented as administered on 06/21/2024 (a total four days).

In an interview on 07/02/2024 at 10:17 AM, Staff F, Manager, stated they did not know if Residents 3 and Resident 4 received their medications or if the administration documentation was incorrect.

In an interview on 07/02/2024 at 1:40 PM, Staff D and Staff G, Caregivers, stated that it was sometimes difficult to check the MARs and then the medications to ensure they matched when they administered the medications.

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, VALLEY HOUSE is or will be in compliance with this law and / or regulation on (Date) 8/12/24

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

documentation on the MAR stating, “Med not in blister/needs DR appt for new order” on the following dates: 04/18/2024, 04/25/2024, 05/01/2024, 05/02/2024, 05/06/2024, 05/07/2024, 05/08/2024, 05/09/2024, 05/10/2024, 05/13/2024, 05/15/2024, 05/16/2024, 05/21/2024, and 06/06/2024. Further review showed that the Thera-tabs M were documented as administered on all other dates in the period between 04/19/2024 and 06/05/2024, indicating staff were not following the five rights of medication administration (correct medication, resident, dosage, time and route).

<Resident 4>

Review of Resident 4’s Valley House Care Plan/Assessment, dated 08/28/2023, showed the resident was diagnosed with [redacted] and received staff assistance with all medications.

Review of a provider note, dated 06/14/2024, showed Resident 4 experienced an exacerbation (irritation) of COPD and was prescribed azithromycin (medicine to treat infection), guaifenesin (medicine to thin mucus) and prednisone (medicine to treat inflammation).

Review of Resident 4’s June 2024 MAR showed azithromycin was to be administered for five days beginning on 06/16/2024. Further review showed the first dose was started on 06/18/2024 and was documented as administered until 06/28/2024 (a total of 10 days).

Review of Resident 4’s June 2024 MAR showed guaifenesin was to be administered three times a day for five days for a total of 15 doses. Further review showed the medication was documented as administered 16 times.

Review of Resident 4’s June 2024 MAR showed the prednisone was to be administered twice daily for five days beginning 06/16/2024 and ending 06/21/2024. Further review showed the first doses were documented as administered on 06/18/2024 and the last doses were documented as administered on 06/21/2024 (a total four days).

In an interview on 07/02/2024 at 10:17 AM, Staff F, Manager, stated they did not know if Residents 3 and Resident 4 received their medications or if the administration documentation was incorrect.

In an interview on 07/02/2024 at 1:40 PM, Staff D and Staff G, Caregivers, stated that it was sometimes difficult to check the MARs and then the medications to ensure they matched when they administered the medications.

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, VALLEY HOUSE 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.

Statement of Deficiencies	License # 2151	Compliance Determination # 43641
Plan of Correction	VALLEY HOUSE	Completion Date
Page 6 of 7	Licensee: VALLEY HOUSE INC	07/03/2024

Administrator (or Representative) 7/15/24 Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to provide a safe and sanitary environment in the facility kitchen and second floor resident restroom. This failure placed the residents at risk of harm due to the facility not being safely maintained.

Findings included...

<Kitchen>

Observation of the facility kitchen on 07/01/2024 at 9:55 AM, with Staff C, Cook, showed the wall below the air conditioner and above the coffee pot had dry, peeling paint and exposed dry wall.

In an interview at the time of the kitchen observation, Staff C stated that the wall had been damaged prior to their hire date of 08/01/2023.

In an interview on 07/01/2024 at 4:26 PM, Staff F, Manager, stated they were aware that the wall under the air conditioner was damaged and in need of repair.

<Environmental>

Observations during the facility environmental tour on 07/01/2024 at 11:05 AM with Staff F showed the following:

>The hand railing above the stairwell on the second floor consisted of a cable railing system (cables stretched horizontally between the support posts). All eleven cables were missing, loose, or disconnected.

> A softball sized hole in the outside ply of the hollow door (door consisting of two thin sheets of material with a hollow core space between the sheets) to room 19.

>The paper towel holder in the second-floor public restroom was disconnected from the wall and laying on the floor next to the toilet.

In an interview at that time, Staff F stated that the stairwell railing cables were damaged about one month prior. Staff F further stated that they were not aware that the paper towel

Administrator (or Representative) Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to provide a safe and sanitary environment in the facility kitchen and second floor resident restroom. This failure placed the residents at risk of harm due to the facility not being safely maintained.

Findings included…

<Kitchen>

Observation of the facility kitchen on 07/01/2024 at 9:55 AM, with Staff C, Cook, showed the wall below the air conditioner and above the coffee pot had dry, peeling paint and exposed dry wall.

In an interview at the time of the kitchen observation, Staff C stated that the wall had been damaged prior to their hire date of 08/01/2023.

In an interview on 07/01/2024 at 4:25 PM, Staff F, Manager, stated they were aware that the wall under the air conditioner was damaged and in need of repair.

<Environmental>

Observations during the facility environmental tour on 07/01/2024 at 11:05 AM with Staff F showed the following:

>The hand railing above the stairwell on the second floor consisted of a cable railing system (cables stretched horizontally between the support posts). All eleven cables were missing, loose, or disconnected.

> A softball sized hole in the outside ply of the hollow door (door consisting of two thin sheets of material with a hollow core space between the sheets) to room 19.

>The paper towel holder in the second-floor public restroom was disconnected from the wall and laying on the floor next to the toilet.

In an interview at that time, Staff F stated that the stairwell railing cables were damaged about one month prior. Staff F further stated that they were not aware that the paper towel

Statement of Deficiencies	License # 2151	Compliance Determination # 43641
Plan of Correction	VALLEY HOUSE	Completion Date
Page 7 of 7	Licensee: VALLEY HOUSE INC	07/03/2024

holder had been removed from the restroom wall.

In an interview on 07/02/2024 at 1:15 PM, Resident 5 stated they thought that the stairwell railing cables had been damaged for a few months. Resident 5 further stated that they did not have a private restroom and used the second-floor public restroom.

This is a recurring deficiency previously cited on 04/07/2022.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, VALLEY HOUSE is or will be in compliance with this law and / or regulation on (Date) 8/02/24 .

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

Administrator (or Representative) — Date 7/15/24

holder had been removed from the restroom wall.

In an interview on 07/02/2024 at 1:15 PM, Resident 5 stated they thought that the stairwell railing cables had been damaged for a few months. Resident 5 further stated that they did not have a private restroom and used the second-floor public restroom.

This is a recurring deficiency previously cited on 04/07/2022.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, VALLEY HOUSE 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