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 # 2151

Dear Administrator:

This document references Compliance Determination 30881 (10/17/2023), which included complaint number(s) 101652.
The Department completed a complaint investigation of your Assisted Living Facility on 10/17/2023 and found that your facility does not meet the Assisted Living Facility requirements.

The department staff who did the inspection and provided consultation:

Sylvia Shauvin, Complaint Investigator

Consultation:

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(3) Evaluate, in order to determine if there is a need for further action:

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

The facility did not evaluate a resident's injuries in a timely manner. The resident fell and sustained minor facial injuries. The facility's policy directed staff to call 911 for these types of injuries. 911 was not called until three days later. The resident was evaluated and sent back to the facility without significant injury. The facility administrator and nurse stated that they would provide education to care staff about the need to call the nurse to evaluate injuries and to call 911 when a resident fell and sustained any head/facial injury.

You Must:

- 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 (509)993-7821.

Sincerely,

S. M

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

Residential Care Services
Investigation Summary Report

Provider/Facility: VALLEY HOUSE
Provider Type: Assisted Living Facility
License/Cert.#: 2151
Compliance Determination #: 30881
Intake ID: 101652
Investigator: Sylvia Shauvin
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 10/10/2023 through 10/17/2023
Complainant Contact Date(s): 10/17/2023

Allegation(s):

1. Injury of unknown origin.
2. Failure to investigate injuries.
3. Residents restricted from going outside.
4. Residents searched against their will.
5. Inappropriate resident placement.

Investigation Methods:

Sample:	Total residents: 26 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents/ safety and well-being Any residents' injuries Activities Staff and residents' interactions Named resident
Interviews:	Three residents Named resident Two facility caregivers Manager/Administrator Designee Owner/Administrator
Record Reviews:	Sample residents' Face Sheets, assessments, care plans, and Progress Notes Facility's investigation documents Sample three staff's credentials Admission Agreement and facility rules Disclosure of Services Policy and procedures - Emergency Medical Care and First Aid

Investigation Summary:

1 - Named resident was observed with bruising, swelling, and cut around the eye. Resident and staff interviews showed the resident fell and injuries were possibly related to it. Facility failed to promptly notify the manager and the resident's guardian. The facility did not arrange for evaluation of the injuries in a timely manner. Failed

facility practice was found and a Consultation provided for WAC 388-78A-2120 Monitoring resident's well-being.
2 - Interviews with residents and staff; and review of facility's investigation documents showed the facility investigated named resident's injuries to rule out abuse and neglect. No failed facility practices were found related to allegation.
3 - As observed, residents were able to go outside as they wished. Interviews with residents and staff showed residents were able to voluntarily leave the facility/premises. Review of sample residents' assessments showed the facility assessed residents' ability to independently and safely leave the facility/premises. No failed facility practices were found related to allegation.
4 - Interviews with residents and staff; and review of the facility's Admission Agreement and the facility rules did not support the allegation. No failed facility practices were found related to allegation.
5 - Residents interviewed had no concerns about unmet needs. Reviews of sample residents' assessments and care plans; and Disclosure of Services showed facility informed prospective residents about available care and services; and facility assessed its ability to meet residents' needs. No failed facility practices were found related to allegation.

Conclusion / Action:

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