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) 50074 (Completion Date 11/18/2024) and 46214 (Completion Date 09/09/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/18/2024 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-2060-4, WAC 388-78A-2060-6

The Department staff who did the on-site verification:
Amy Wright, NCI Complain Investigator

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

Sincerely,

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 #: 46214
Intake ID: 142627
Investigator: Amy Wright
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 08/26/2024 through 09/09/2024
Complainant Contact Date(s): 08/26/2024

Allegation(s):
Neglect of catheter resulting in kidney failure.

Investigation Methods:

Sample:
Total residents: 25
Resident sample size: 2
Closed records sample size: 1

Observations:
Residents
Resident care equipment
Resident rooms
Staff to resident interactions

Interviews:
Medication Technician
Reporter
Resident
Alleged Victim's Representative
Resident Representative
Manager

Record Reviews:
-Disclosure of Services
-Characteristic roster
-Staff roster
-Resident face sheets
-Resident care plan/assessment
-Progress notes
-Admission Agreement

Investigation Summary:
The facility readmitted the Alleged Victim after hospitalization for urinary retention. The facility's preadmission assessment failed to identify that the resident had a urinary catheter. No catheter care was provided for five days, resulting in another hospitalization for acute kidney failure. Failed practice was identified and cited under WAC 388-78A-2060 Preadmission assessment (4)(6).

Conclusion / Action:

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

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Statement of Deficiencies	License # 2151	Compliance Determination # 45214
Plan of Correction	VALLEY HOUSE	Completion Date
Page 1 of 4	Licensee: VALLEY HOUSE INC	09/09/2024

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 an unannounced on-site complaint investigation on 08/25/2024, 08/26/2024 and 08/26/2024 of:

VALLEY HOUSE
401 S Eastern Rd
Spokane Valley, WA 99212

This document references the following complaint number(s): 142827

The following sample was selected for review during the unannounced on-site visit: 2 of 25 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Amy Wright, NCI Complain Investigator

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: 09/18/2024

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.

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Residential Care Services _____ Date _____

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Statement of Deficiencies	License # 2151	Compliance Determination # 46214
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Administrator (or Representative)

09/30/2024
Date

WAC 388-78A-2060 Preadmission assessment. The assisted living facility must conduct a preadmission assessment for each prospective resident that includes the following information, unless unavailable despite the best efforts of the assisted living facility:

(4) Significant known behaviors or symptoms that may cause concern or require special care,

(8) Level of personal care needs,

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to fully assess a resident, prior to admission, to determine the level of care needed to manage the resident's known urinary retention for 1 of 1 resident (Resident 1). This failure resulted in severe discomfort and health complications which required a nine-day hospitalization for Resident 1 and placed new residents at risk of unmet needs, health complications, and decreased quality of life.

Findings included...

Review of a face sheet for Resident 1, dated [redacted]/2020, showed that they admitted to the assisted living facility on that day.

In an interview on 08/26/2024 at 11:00 AM, Collateral Contact 1 (CC1), Hospital Social Worker, stated that Resident 1 arrived at the emergency room for urinary retention on [redacted]/2024. CC1 stated that Resident 1 remained at the hospital for six days before being discharged to a skilled nursing facility with a urinary catheter (tube inserted into the bladder that allows urine to drain). CC1 stated that Resident 1 returned to the hospital from their assisted living facility on [redacted]/2024 with abdominal distention (swollen), purulent drainage (fluid from a wound that indicates a sign of infection) from their catheter site, and severe pain. CC1 stated that the assisted living facility did not know Resident 1 had a urinary catheter. CC1 stated that Resident 1 remained at the hospital for nine days with a urinary tract infection, sepsis (a very serious condition that occurs as a result of a complication with an infection), and kidney failure. CC1 stated that Resident 1 was really sick and could have died as a result of the neglected catheter.

Review of a progress note for Resident 1, dated 07/29/2024 at 11:30 AM, showed that Resident 1 was at their "baseline," and that their discharge from the skilled nursing facility, back to the assisted living facility, was scheduled for [redacted]/2024.

Administrator (or Representative) Date

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Based on interview and record review, the facility failed to fully assess a resident, prior to admission, to determine the level of care needed to manage the resident's known urinary retention for 1 of 1 resident (Resident 1). This failure resulted in severe discomfort and health complications which required a nine-day hospitalization for Resident 1 and placed new residents at risk of unmet needs, health complications, and decreased quality of life.

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Review of a progress note for Resident 1, dated [redacted]/2024, showed that Resident 1 readmitted to the assisted living facility that day. The note showed that no changes were made to the resident's previous plan of care.

Review of Resident 1's care plan/assessment, last updated on [redacted]2024, showed that Resident 1 was continent of bladder and did not require urinary equipment or supplies. The care plan did not indicate that Resident 1 had a urinary catheter. Review of the care plan/assessment showed that on [redacted]2024, Staff B, Manager, reviewed the care plan/assessment and felt it remained appropriate at the time of the resident's readmittance to the facility.

Review of a progress note for Resident 1, dated [redacted]/2024 at 2:00 AM, showed that Resident 1 was found to have had a catheter coiled up and stuffed in their pants that the facility did not know the resident had.

In an interview on 08/26/2024 at 11:12 AM, Staff A, Medication Technician, stated they did not know if Resident 1 had a urinary catheter or not. Staff A stated the facility did not deal with urinary catheters. Staff A stated that they assumed "body checks" were done when residents admitted to the facility.

In an interview on 09/03/2024 at 2:03 PM, Staff B stated that when the skilled nursing facility discharged Resident 1 back to the assisted living facility on [redacted]/2024, Staff B thought Resident 1 was at baseline. Staff B stated they reviewed Resident 1's basic information, though they were unable to go see Resident 1 in person. Staff B stated they were operating under the information that was given to them by the skilled nursing facility, who did not tell Staff B that Resident 1 had a catheter. Staff B stated that when they sent Resident 1 back to the hospital on [redacted]/2024, the resident was feeling "punky," and a caregiver noticed Resident 1's catheter sticking out of their pants. Staff B stated that Resident 1 was quite sick. Staff B stated that the facility did not really do skin or body checks when residents were admitted to the facility.

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) 10/10/2024

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

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In an interview on 08/26/2024 at 11:12 AM, Staff A, Medication Technician, stated they did not know if Resident 1 had a urinary catheter or not. Staff A stated the facility did not deal with urinary catheters. Staff A stated that they assumed "body checks" were done when residents admitted to the facility.

In an interview on 09/09/2024 at 2:03 PM, Staff B stated that when the skilled nursing facility discharged Resident 1 back to the assisted living facility on [redacted]/2024, Staff B thought Resident 1 was at baseline. Staff B stated they reviewed Resident 1's basic information, though they were unable to go see Resident 1 in person. Staff B stated they were operating under the information that was given to them by the skilled nursing facility, who did not tell Staff B that Resident 1 had a catheter. Staff B stated that when they sent Resident 1 back to the hospital on [redacted]/2024, the resident was feeling "punky," and a caregiver noticed Resident 1's catheter sticking out of their pants. Staff B stated that Resident 1 was quite sick. Staff B stated that the facility did not really do skin or body checks when residents were admitted to the facility.

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