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

Senior Development Resources LLC
COVENTRY HOUSE
430 N 2nd Ave
Othello, WA 99344

RE: COVENTRY HOUSE License # 2334

Dear Administrator:

This letter addresses Compliance Determination(s) 38611 (Completion Date 03/20/2024) and 37458 (Completion Date 02/27/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/20/2024 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-2210-1-b, WAC 388-78A-2210-2, WAC 388-78A-2210-2-a, WAC 388-78A-2210-2-b

The Department staff who did the on-site verification:
Joy Pipgras, LTC Surveyor

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 #: 2334	Compliance Determination # 37458
Plan of Correction	COVENTRY HOUSE	Completion Date
Page 1 of 5	Licensee: Senior Development Resources LLC	02/27/2024

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 follow-up on 02/26/2024 and 02/27/2024 of:
COVENTRY HOUSE
430 N 2nd Ave
Othello, WA 99344

This document references the following SOD dated: 02/27/2024

The following sample was selected for review during the unannounced on-site visit: 5 of 39 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

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.

S.M

Residential Care Services

03/07/2024

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 #: 2334	Compliance Determination # 37458
Plan of Correction	COVENTRY HOUSE	Completion Date
Page 2 of 5	Licensee: Senior Development Resources LLC	02/27/2024

Monica Flores 3.14.24

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.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide medications as prescribed for 3 of 4 sampled residents (Residents 1, 2 and 3). This failure resulted in medication errors and placed residents at risk of health complications due to medications errors.

Findings included...

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

<Resident 1>

Review of Resident 1's negotiated service plan, dated 10/24/2023, showed the resident was diagnosed with [redacted] and received medication assistance with all medications.

Review of Resident 1's February 2024 medication administration records (MARs) showed Resident 1 was prescribed metoprolol (medication for high BP) twice daily with a note that instructed the medication be held if the systolic BP (top number) was lower than 100 or if the heart rate was less than 60 .

Review of Resident 1's physician's order, dated 06/20/2023, showed no order to hold the metoprolol within certain parameters.

Review of Resident 1's February 2024 showed the metoprolol was held in the morning with a note stating, "held per Dr/RN orders," on the following dates:

02/09/2024, BP 94/63
02/13/2024, BP 97/68
02/16/2024, BP 84/44
02/25/2024, BP 92/55

Review of Resident 1's February 2024 showed the Metoprolol was held in the evening with a note stating, "held per Dr/RN orders," on the following dates:

02/24/2025, BP 96/55

<Resident 2>

Review of Resident 2's negotiated service plan, dated 07/12/2023, showed the resident was diagnosed with [redacted] and received medication assistance with all medications.

Review of Resident 2's February 2024 MARs showed Resident 2 was prescribed carvedilol (medication for high BP) twice daily with a physician's order note that instructed the medication be held if the systolic BP was below 90.

Review of Resident 2's physician's orders, dated 02/02/2024, showed instructions to hold the carvedilol if the systolic BP was below 90.

Review of Resident 2's February 2024 MARs showed the carvedilol was held in the morning with a note stating, "held per Dr/RN orders," on the following date:

02/05/2024, BP 121/38

Review of Resident 2's February 2024 MARs showed the carvedilol was not held in the morning on the following dates:

02/08/2024, BP 86/42
02/11/2024, BP 89/50

Statement of Deficiencies	License #: 2334	Compliance Determination # 37458
Plan of Correction	COVENTRY HOUSE	Completion Date
Page 4 of 5	Licensee: Senior Development Resources LLC	02/27/2024

<Resident 3>

Review of Resident 3's negotiated service plan, dated 08/21/2023, showed the resident was diagnosed with [redacted] and received medication assistance with all medications.

Review of Resident 3's February 2024 MARs showed Resident 3 was prescribed metoprolol twice daily with an physician's order note that instructed the medication be held if the systolic BP was below 90.

Review of Resident 3's physician's orders, dated 01/10/2024, showed instructions to hold the metoprolol if the systolic BP was less than 90.

Review of Resident 3's February 2024 MARs showed the metoprolol was held in the morning with a note stating, "held per Dr/RN orders" on the following date:

02/09/2024 with a BP 109/40

Review of Resident 3's February 2024 MARs showed the metoprolol was not held in the evening on the following date:

02/12/2024, BP 81/45

Review of Resident 3's February 2024 MARs showed the metoprolol was not held in the morning on the following date:

02/20/2024, BP 85/48

Review of Resident 2's February 2024 MARs showed the metoprolol was held in the evening with a note stating, "held per Dr/RN orders" on the following date:

02/25/2024, BP 118/97

In an interview on 02/27/2024 at 10:40 AM, Staff B, Medication Tech, was unable to identify the difference between the systolic number and the pulse number when interpreting the order, or when the medication should be given or held.

In an interview on 02/27/2024 at 9:50 AM, Staff A, Administrator, stated that the medications had been given in error.

Statement of Deficiencies	License #: 2334	Compliance Determination # 37458
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Page 5 of 5	Licensee: Senior Development Resources LLC	02/27/2024

This is an uncorrected deficiency previous cited on 01/17/2024 for subsections (1) (b) (2).

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, COVENTRY HOUSE is or will be in compliance with this law and / or regulation on (Date) 3/11/24 .

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

Monica flores — Administrator (or Representative)

3.14.24 — Date

WAC SPECIFIED	CORRECTION	COMPLETION DATES
WAC 388-78A-2210 Medication services 1b, 2a, 2b	MAR audits will be done daily by licensed Nurses and supervisors. Administrator will be involved in making sure mar audits are done daily. All care staff and supervisors who dispence medications will be trained on manual blood pressure by the RN training for care staff has started 3/11/24 and will be an ongoing training. This competency will be evaluated weekly until May 13, 2024 and than will be evaluated monthly moving foward, RN to evaluate. A record of evaluation date and outcome will be kept by RN. A training for all care staff who dispense medications regarding the definition of parameters, the need for parameters for different medication, how to read parameters to make a competent medication decision (to give or hold) within the parameter guidelines will be given by the RN. Competency will be evaluated by the RN upon completion of initial training and every 30 days therafter. Daily audits will determine if all parameters are being observed for all medications that require parameters. Those staff who dispense medications will also be trained on the protocol observed if a medication is missed or is given inappropriately. Staff who are found to not follow the parameters will be pulled from the cart for retraining. Staff requiring retraining for three seperate incidences will be removed from the cart.	3/11/2024

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 #: 2334	Compliance Determination # 35489
Plan of Correction	COVENTRY HOUSE	Completion Date
Page 1 of 20	Licensee: Senior Development Resources LLC	01/17/2024

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 01/09/2024, 01/10/2024, 01/11/2024 and 01/12/2024 of:
COVENTRY HOUSE
430 N 2nd Ave
Othello, WA 99344

The following sample was selected for review during the unannounced on-site visit: 7 of 40 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Carla Rose, NCI Community Licensor
Joy Pipgras, LTC Surveyor
Mark Sedhom, Assisted Living Facility Licensor

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.

S M — 01/24/2024

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 #: 2334	Compliance Determination # 35489
Plan of Correction	COVENTRY HOUSE	Completion Date
Page 2 of 20	Licensee: Senior Development Resources LLC	01/17/2024

Monica Flores
Administrator (or Representative)

2/2/24
Date

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to implement a system to manage COVID-19 infections to limit exposure to residents for 21 of 40 residents (Residents 2, 3, 4, 5, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, and 24). This failed practice placed residents at risk of exposure to COVID-19.

Findings included...

Review of the facility's undated COVID-19 (communicable disease caused by SARS-Co V-2) outbreak plan, showed that staff caring for residents with COVID-19 were to wear a N95 mask (mask designed to have a close facial fit that filters small airborne particles), goggles or facemask, gloves and gown. Further review of the plan showed that "all staff will have been properly trained on infection prevention measures, including the use of and steps to properly put on and remove recommended personal protective equipment (PPE) prior to being assigned".

Observation during the environmental tour on 01/09/2024 at 11:40 AM showed the PPE isolation cart was not stocked with N95 masks. Further observation showed a face shield hung between the wall and handrail.

In an interview on 01/09/2023 at 10:35 AM, Staff A, Administrator, stated that Resident 7 was in isolation because they were positive for COVID-19.

Observation on 01/09/2024 at 11:43 AM showed Staff B, Caregiver, exited Resident 7's room wearing a surgical mask. In an interview at that time, Staff B stated they did not have an N95 mask and had not been fit tested for N95 mask use.

Observation on 01/09/2024 at 12:50 PM Staff G, Activities, exited Resident 7's room wearing a contaminated surgical mask and gown. Staff G then removed the contaminated disposable gown and placed it on top of the PPE cart containing clean (uncontaminated) PPE. Staff G did not dispose of the gown into the designated trash can.

Statement of Deficiencies	License #: 2334	Compliance Determination # 35489
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Observation on 01/09/2024 at 12:56 PM showed Staff G entered Resident 7's room and upon exit did not remove the contaminated gloves from their hands. Staff G placed their contaminated face shield on top of isolation cart that contained clean PPE supplies.

In an interview on 01/09/2024 at 12:57 PM, Staff G stated that they did not wear an N95 mask due to personal preference and only sanitized their face shield at the end of their shift.

In an interview on 01/09/2024 at 1:05 PM, Staff C, Registered Nurse (RN), stated that isolation PPE carts should have been stocked with N95 masks. Staff C stated they were not sure why N95 masks were not stocked on the cart. Staff C stated that the proper protocol for PPE removal included sanitizing face shields after each use, and gown disposal. Staff C further stated that the most recent Covid-19 outbreaks were likely caused by staff who had spread the infection to residents.

In an interview on 01/09/2024 at 4:30 PM, Staff A, Administrator, stated that staff needed additional training on N95 use to include when they should be worn, why they were necessary, and proper donning and doffing (specific sequence in which PPE is put on and removed to avoid contamination).

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, COVENTRY HOUSE is or will be in compliance with this law and / or regulation on (Date) 2/23/24 .

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

Monica Flores — Administrator (or Representative)

2/2/24 — Date

WAC 388-78A-2650 Reporting fires and incidents. The assisted living facility must immediately report to the department's aging and disability services administration:

(3) Circumstances which threaten the assisted living facility's ability to ensure continuation of services to residents.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to report COVID-19 outbreaks to the Complaint Resolution Unit department for 21 of 40 residents (Residents 2, 3, 4, 5, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, and 24). This failed practice precluded the department from having immediate knowledge to conduct an investigation.

Statement of Deficiencies	License #: 2334	Compliance Determination # 35489
Plan of Correction	COVENTRY HOUSE	Completion Date
Page 4 of 20	Licensee: Senior Development Resources LLC	01/17/2024

Findings included...

Review of a resident list, dated 01/12/2024, showed the following residents had a positive COVID-19 (communicable disease caused by SARS-Co V-2) test between November 2023 and January 2024: Residents 2, 3, 4, 5, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, and 23.

In an interview on 01/09/2024 at 11:00 AM, Staff A, Administrator, stated they were unaware that COVID-19 outbreaks were required to be reported to the department.

Review of Complaint Resolution Unit department records showed there were no reports of COVID-19 outbreaks in the facility between November 2023 and January 2024.

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, COVENTRY HOUSE is or will be in compliance with this law and / or regulation on (Date) 1/12/24 .

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

Monica Flores
Administrator (or Representative)

2/2/24
Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(a) Nursing services supervision;

(b) Nurse delegation, if provided;

(c) Initial and on-going assessments of the nursing needs of each resident;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure the registered nurse delegator evaluated delegated tasks and assessed the residents and caregivers every 90 days for 5 of 5 residents (Residents 2, 3, 5, 6, and 7) sampled for nurse delegation. This failed practice resulted in residents receiving delegated nursing tasks that may not have been safe or effective.

Findings included...

Per WAC 246-840-930, Criteria for nurse delegation, before delegating a nursing task, the registered nurse delegator:

- Assesses the ability of the nursing assistant (NA) or home care aid (HCA) to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision.

- The registered nurse delegator ensures safe and effective services are provided. Reevaluation of the resident and delegated staff must be documented and occur at least every 90 days.

<Resident 2>

Review of Resident 2's Care Plan (the facility's title negotiated service agreement, NSA), dated 06/16/2023, showed they were diagnosed with [redacted]. Further review showed that Resident 2 received nurse delegated tasks for blood sugar checks (measurement of sugar in the blood) and insulin (injectable medication used to lower blood sugar) administration.

Review of Resident 2's November 2023, December 2023, and January 2024 medication administration records (MARs) showed undelegated caregivers administered insulin injections daily and performed blood sugar checks four times a day.

Review of Resident 2's most recent Nurse Delegation Nursing Visit record, dated 03/22/2022 showed they were delegated for insulin administration and blood sugar checks. The documentation showed that Resident 2's next 90-day delegation visit was scheduled for 06/22/2022. Further review showed that no further nursing visits occurred.

<Resident 3>

Review of Resident 3's NSA, dated 10/09/2023, showed they were diagnosed with [redacted]. Further review showed that Resident 3 received nurse delegated tasks for blood

sugar checks and insulin administration.

Review of Resident 3's November 2023, December 2023, and January 2024 MARs showed undelegated caregivers administered insulin injections and performed blood sugar checks three times a day.

Review of Resident 3's undated facility chart showed no 90-day documentation of a resident or caregiver assessment.

<Resident 5>

Review of Resident 5's NSA, dated 08/21/2023, showed they were diagnosed with [redacted]. Further review showed that Resident 5 received nurse delegated tasks for blood sugar checks and insulin administration.

Review of Resident 5's November 2023, December 2023, and January 2024 MARs showed undelegated caregivers administered insulin injections and performed blood sugar checks three times a day.

Review of Resident 5's undated facility chart showed no 90-day documentation of a resident or caregiver assessment.

<Resident 6>

Review of Resident 6's NSA, dated 01/10/2024, showed they were diagnosed with [redacted]. Further review showed that Resident 6 received nurse delegated tasks for blood sugar checks and insulin administration.

Review of Resident 6's November 2023, December 2023, and January 2024 MARs showed undelegated caregivers administered insulin injections daily and performed blood sugar checks three times a day.

Review of Resident 6's undated facility chart showed no 90-day documentation of a resident or caregiver assessment.

<Resident 7>

Review of Resident 7's NSA, dated 07/12/2023, showed they were diagnosed with [redacted]. Further review showed that Resident 7 received nurse delegated tasks for blood sugar checks and insulin administration.

Review of Resident 7's November 2023, December 2023, and January 2024 MARs showed undelegated caregivers administered insulin injections daily and performed blood sugar checks four times a day.

Review of Resident 7's undated facility chart showed no 90-day documentation of a resident or caregiver assessment.

In an interview on 01/11/2024 at 11:24 AM Staff A, Administrator, confirmed the last 90-day delegation nursing visit for Resident 2 occurred on 03/22/2022 file. Staff A confirmed that Resident 3, Resident 5, Resident 6, and Resident 7 had no documentation of delegation for their insulin injections or blood sugar checks. Staff A further stated that unlicensed staff had performed the insulin administration and blood sugar checks for all the residents.

In an interview on 01/12/2024 at 10:19 AM, Staff F, RN/Registered Nurse Delegator, confirmed the nurse delegation assessments and documentation were outdated for Resident 2 and had not been initiated for Resident 3, Resident 5, Resident 6, and Resident 7.

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, COVENTRY HOUSE is or will be in compliance with this law and / or regulation on (Date) 1|12|24 .

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

Monica Flores
Administrator (or Representative)

2|2|24
Date

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that respirator fit testing was performed by a qualified test administrator for 4 of 6 sampled staff (Staff A, C, D, and

E). This failed practice placed residents and staff at risk of exposure to respiratory illness.

Findings included...

Review of the Washington Department of Health's Respiratory Protection Program guidelines showed the following guidelines to become a qualified fit test administrator:

-Pre-training policy review
-Virtual training
-Hands on training
-Post training evaluation

In an interview on 01/12/2024 at 3:45 PM, Staff A, Administrator, stated that they and Staff F, RN, were trained to perform fit testing. Staff A confirmed that Staff H had not completed fit test administrator training.

Review of Staff A's fit testing record, dated 05/18/2023, showed they were fit tested by Staff H, Activities.

Review of Staff C's, RN, fit testing record, dated 03/01/2023, showed they were fit tested by Staff H.

Review of Staff D's, Activities/Caregiver, fit testing record, dated 05/01/2023, showed they were fit tested by Staff H.

Review of Staff E's, Supervisor, fit testing record, dated 08/10/2023, showed they were fit tested by Staff H.

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, COVENTRY HOUSE is or will be in compliance with this law and / or regulation on (Date) 2/10/24 .

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

Monica Flores
Administrator (or Representative)

2/2/24
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.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

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 7 sampled residents (Residents 5 and 7). This failed practice placed residents at risk of health complications due to medication errors.

Findings included...

The facility's undated "Medication Service Policy stated," "the facility will assure medications are taken in accordance with health care practitioner's instructions."

<Resident 5>

Review of Resident 5's Care Plan (the facility's titled negotiated service agreement, NSA), dated 08/21/2023, showed the facility provided assistance with medications. Further review showed Resident 5 was diagnosed with [redacted], and [redacted].

Review of Resident 5's November 2023, December 2023 and January 2024 medication administration records (MARs) showed the resident was prescribed carvedilol (medication used to treat heart failure and high BP) two times a day. Further review showed the doctor had not prescribed any parameters to hold the medication.

In an interview on 01/12/2024 at 10:00 AM, Staff I, Supervisor, stated that med techs are to call the registered nurse (RN) if a resident's systolic BP (SBP, top number) is below 90. When asked about holding blood pressure (BP) medications, Staff I stated that they hold the BP medication if there are parameters from the doctor to hold the medication. Staff I further stated that if the order does not contain a parameter, they will call the RN for

direction.

In an interview on 01/12/2024 at 11:30 AM Staff F, RN, stated that when med techs called them about Resident 5's BP, they (the RNs) held the BP medication at their discretion. Staff F confirmed they did not call the doctor to obtain an order to hold Resident 5's BP medication.

Review of Resident 5's November 2023, December 2023 and January 2024 MARs showed the carvedilol was held in the morning on the following dates:

11/04/2023, BP 87/37
11/07/2023, BP 113/25
11/12/2023, BP 97/57
11/16/2023, BP 123/34
11/17/2023, BP 107/39
11/19/2023, BP 111/25
11/22/2023, BP 83/21
11/23/2023, BP 101/32
11/24/2023, BP 154/38
11/29/2023, BP 87/47
12/01/2023, BP 116/30
12/02/2023, BP 101/43
12/03/2023, BP 106/31
12/08/2023, BP 102/38
12/14/2023, BP 108/43
12/19/2023, BP 84/37
12/22/2023, BP 107/51
12/28/2023, BP 162/35
12/29/2023, BP 97/37
12/30/2023, BP 100/40
01/01/2024, BP 89/60
01/04/2024, BP 100/34
01/05/2024, BP 93/53
01/06/2024, BP 119/41
01/09/2024, BP 121/31

Review of Resident 5's November 2023, December 2023 and January 2024 MARs showed the carvedilol was held in the evening on the following dates:

11/07/2023, BP 121/40
11/19/2023, BP 102/42
11/23/2023, BP 116/32
11/24/2023, BP 138/27
12/02/2023, BP 146/37
12/14/2023, BP 126/45
12/22/2023, BP 125/34
12/28/2023, BP 157/46

12/29/2023, BP 101/39
01/01/2024, BP 90/33
01/06/2024, BP 98/31
01/09/2024, BP 98/37
01/10/2024, BP 119/37

<Resident 7>

Review of Resident 7's NSA and annual assessment, both dated 07/12/2023, showed the facility provided assistance with medication administration due to diagnoses of [redacted], and [redacted].

Review of Resident 7's November 2023, December 2023 and January 2024 MARs showed the resident was prescribed amlodipine (medication used to treat high blood pressure) each morning. The MARs showed an order that stated the medication was to be held if the resident's SBP was below 110.

Review of Resident 7's MARs showed documentation that the resident received the amlodipine when the SBP was below 110 on:

11/06/2023, BP 99/59
11/07/2023, BP 73/54
11/08/2023, BP 69/56
11/18/2023, BP 105/57
11/29/2023, BP 108/41
12/02/2023, BP 95/50
12/03/2023, BP 78/62
12/08/2023, BP 99/56
12/17/2023, BP 109/58
12/21/2023, BP 109/59
12/23/2023, BP 109/53
12/27/2023, BP 98/50
01/01/2024 BP 107/57
01/09/2024 BP 105/53

Review of Resident 7's November 2023, December 2023 and January 2024 MARs showed the resident was prescribed metoprolol (medication used to treat high blood pressure) two times a day. The MARs showed an order that stated the medication was to be held if the resident's SBP number was below 110.

Review of Resident 7's MARs showed documentation that the resident received the metoprolol in the morning when the SBP was below 110 on:

11/01/2023, BP 89/68

11/03/2023, BP 109/59
11/04/2023, BP 100/55
11/06/2023, BP 99/59
11/07/2023, BP 73/54
11/08/2023, BP 69/56
11/29/2023, BP 108/41
12/02/2023, BP 95/50
12/03/2023, BP 78/62
12/08/2023, BP 99/56
12/17/2023, BP 109/58
12/21/2023, BP 109/59
12/23/2023, BP 109/53
12/27/2023, BP 98/50
12/30/2023, BP 98/64
01/01/2023, BP 107/57
01/09/2023, BP 105/53

Review of Resident 7's MARs showed documentation that the resident received the metoprolol in the evening when the SBP was below 110 on:

11/06/2023, BP 76/41
11/07/2023, BP 105/60
11/08/2023, BP 96/68
11/24/2023, BP 95/52
11/29/2023, BP 84/53
12/02/2023, BP 102/76
12/03/2023, BP 95/55
12/08/2023, BP 101/38
12/13/2023, BP 105/45
12/17/2023, BP 98/54
12/22/2023, BP 100/83
12/31/2023, BP 108/56
01/01/2023, BP 98/53
01/04,2023, BP 108/56
01/05/2023, BP 109/54

In an interview on 01/10/2023 at 4:40 PM, Staff A, Administrator and Staff C, RN, confirmed the medication errors, and stated staff needed more training.

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, COVENTRY HOUSE is or will be in compliance with this law and / or regulation on (Date) 2/5/24 .

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

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monica flores
Administrator (or Representative) Date 2/2/24

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to perform an initial safety assessment for medical devices for 2 of 6 residents (Residents 7 and 8). This failed practice placed residents at risk of injury from using medical devices they had not been assessed to safely use.

Findings included...

<Resident 7>

Review of Resident 7's Care Plan (the facility's titled negotiated service agreement, NSA) and assessment, both dated 07/12/2023, showed Resident 7 was admitted on [redacted]/2023 and the resident used bedrails (a rail attached to the side of a bed for mobility assistance). Further review showed no documentation of a bedrail safety assessment.

Observation on 01/10/2024 at 2:31 PM, showed Resident 7 had bedrails. In an interview at that time, Resident 7 stated, "I use these to roll on my side."

In an interview on 01/10/2024 at 3:15 PM, Staff C, RN, confirmed that a bedrail safety assessment had not been completed for Resident 7.

<Resident 8>

Review of the facility's Characteristic Roster showed Resident 8 was admitted on [redacted]/2023.

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Observation on 1/12/2024 at 1:00 PM, showed Resident 8 had bedrails.

Review of Resident 8's undated medical file showed no documentation of a bedrail safety assessment.

In an interview on 1/12/2024 at 1:30 PM, Staff A, Administrator, confirmed bedrail safety assessments had not been completed for Resident 7 and Resident 8.

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, COVENTRY HOUSE is or will be in compliance with this law and / or regulation on (Date) 1/12/24 .

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

Monica Flores — Administrator (or Representative)

2/2/24 — 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 observation, interview, and record review, the facility failed to perform an annual safety assessment for a medical devices for 1 of 6 residents (Residents 6). This failed practice placed residents at risk of injury from using medical devices they had not been assessed to safely use.

Review of Resident 6's Care Plan (the facility's titled negotiated service agreement, NSA) showed they were admitted [redacted]/2017. Further review of the NSA showed no documentation of a bedrail safety assessment (a rail attached to the side of a bed for mobility assistance).

Observation on 01/11/2024 at 11:30 AM, showed a bedrail on the left side of Resident 6's bed.

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Review of Resident 6's undated medical chart showed no documentation of an annual bedrail safety assessment.

In an interview on 1/12/2024 at 1:30 PM, Staff A, Administrator, confirmed a bedrail safety assessment had not been completed for Residents 6.

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, COVENTRY HOUSE is or will be in compliance with this law and / or regulation on (Date) 1/16/24 .

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

Monica Flores — Administrator (or Representative)

2/2/24 — Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure medications and insulin needles were secured in a locked compartment. This failed practice placed residents with cognitive impairment at risk of harm.

Findings included...

Review of the facility's Characteristic Roster showed 18 residents were diagnosed with [redacted].

Observation on 01/09/2024 at 12:13 PM showed a medication cart left unattended with keys to the cart hanging on a hook, on the side of the cart.

In an interview on 01/09/2024 at 12:14 PM, Staff E, Supervisor, stated the cart contained

insulin, needles/pens for injections and blood sugars, and sterile dressings for wound care. Staff E further stated that they knew the keys should not have been left unattended.

In an interview on 01/10/2024 at 11:15 AM, Staff A, Administrator stated it was not the facility's practice, staff "know better than to leave keys on the cart", and "it was as good as leaving it unlocked."

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, COVENTRY HOUSE is or will be in compliance with this law and / or regulation on (Date) 1/12/24 .

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

Monica Flores
Administrator (or Representative)

2/2/24
Date

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure hazardous supplies and materials were locked and secured. This failed practice placed residents with cognitive impairment at risk of harm.

Findings included...

Review of the facility Characteristic Roster, dated 01/09/2024, showed 18 residents were diagnosed with [redacted].

Observations during the environmental tour, on 01/09/2024 beginning at 11:03 AM, showed the following:

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-Two housekeeping carts were unattended and unlocked with side storage doors open. Each contained Lysol, peroxide multi-cleaner and liquid room freshener, with warning labels that stated "keep out of reach of children" and "external use only."

-Room 20 was unlocked and used as a storage room. There were two signs on the door that read, "keep locked at all times." Oxivir wipes and Green Link antiseptic, both containing warning labels, were on a cart by the entrance of the room.

-The salon door had signage that stated , "keep locked at all times." There were unsecured bottles of nail polish remover, Ecolab room spray, Lysol with warning labels, and numerous pairs of hairdressing shears.

-The electrical room door, attached to the dining room, was unlocked with numerous cable wires and electrical equipment.

-The exterior maintenance shop was unlocked and contained Round-up weed killer and a container of gasoline next to an unattended space heater.

- An exterior gate to the area surrounding the pond was unlocked and the pond pump room did not have a working lock. It contained pond maintenance machinery, shovels, a hedge trimmer, a garden hoe, a hand saw, two pruning shears, WD 40, gasoline, and Round-up.

In an interview following the environmental tour ending at 12:05 PM, Staff J, Maintenance, stated that the exterior shop is left open when they are on shift. Staff J confirmed that it should be locked when they are not using it and that the exterior gates, interior and exterior doors, and housekeeping carts should be locked when not in use.

In an interview on 01/09/2024 at 4:31 PM, Staff A, Administrator, stated that they were not aware of the unsecured exterior gates and confirmed that the interior door and housekeeping carts should always be secured.

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, COVENTRY HOUSE is or will be in compliance with this law and / or regulation on (Date) 1/12/24 .

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

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WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

(2) A national fingerprint background check is valid for an indefinite period of time. The assisted living facility must ensure there is a valid national fingerprint background check completed for all administrators and caregivers hired after January 7, 2012. To be considered valid, the national fingerprint background check must be initiated and completed through the department's background check central unit after January 7, 2012.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure Washington state name and date of birth background checks were completed every two years for 2 of 6 sampled staff (Staff A and Staff E) and national fingerprint background checks were completed for 1 of 6 sampled staff (staff E). This failed practice placed residents at risk of receiving care and services from potentially disqualified staff.

Findings included...

<Staff A>

Review of Staff A's, Administrator, undated personnel file showed a hire date of 07/01/2015. Review of Staff A's name and date of birth background check showed it was last completed on 06/23/2021.

In an interview on 01/10/2024 at 9:00 AM, Staff A stated, "I didn't know it had to be done every 2 years."

<Staff E>

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Review of Staff E's, Supervisor, undated personnel file showed they were hired on 07/01/2015. Further review showed Staff E's Washington state name and date of birth background check was last completed on 06/17/2021. The file did not contain a national fingerprint background check for Staff E.

In an interview on 1/10/2024 at 9:00 AM, Staff A stated that Staff E did not have a current Washington state name and date of birth background check. Staff A stated they were unsure if a national fingerprint background check had been submitted for Staff E.

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, COVENTRY HOUSE is or will be in compliance with this law and / or regulation on (Date) 1/12/24.

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

Monica Flores — Administrator (or Representative)

2/2/24 — Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure specialty training for dementia was completed for 2 of 6 sampled staff (Staff B and C). This failed practice placed residents at risk of improper care.

Findings included...

Review of the most recent Disclosure of Services showed the facility accepted residents with a diagnosis of [redacted].

Review of the facility's Characteristic Roster showed 18 residents were diagnosed with [redacted]

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[redacted].

<Staff B>

Review of Staff B's, Caregiver, personnel file showed they were hired on 09/20/2022. Further review showed no documentation of specialty training for dementia.

<Staff C>

Review of Staff C's, Registered Nurse, personnel file showed they were hired on 02/22/2023. Further review showed no documentation of specialty training for dementia.

In an interview on 1/11/2024 at 09:00 AM, Staff A, Administrator, confirmed that Staff B and Staff C did not complete specialty training for dementia.

In an interview on 01/11/2024 at 4:15 PM, Staff C stated they did not complete the specialty training for dementia.

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, COVENTRY HOUSE is or will be in compliance with this law and / or regulation on (Date) 2/14/24 .

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

Monica Flores — Administrator (or Representative)

2/2/24 — Date

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

Senior Development Resources LLC
COVENTRY HOUSE
430 N 2nd Ave
Othello, WA 99344

RE: COVENTRY HOUSE # 2334

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 01/17/2024 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Stephanie Jenks, Field Manager
Residential Care Services
Region 1, Unit B
8517 E Trent Ave, Ste 102

Spokane Valley, WA 99212

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):

In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-3040 Laundry.

(3) The assisted living facility must use washing machines that have a continuous supply of hot water with a temperature of 140 F measured at the washing machine intake, that automatically dispenses a chemical sanitizer as specified by the manufacturer, or that employs alternate sanitization methods recommended by the manufacturer.

The facility had two washing machines, both used for facility and resident laundry. Neither washing machine reached a water temperature of 140°F at the intake. Facility staff began the process of obtaining an automatic sanitizing dispenser.

You Are Not:

• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

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,

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

Enclosure

WAC SPECIFIED	CORRECTION	COMPLETION DATES
WAC 388-78A-2610 1.) Infection control	All staff will be required to complete the "All things COVID-19" course on Relias. All staff will then be required to demonstrate appropriate donning and doffing, to include appropriate sanitizing of supplies, with the 2 facility RN's.	2/23/2024
	All staff will be required to complete this training upon hire and annually.	Completed 1/12/2024
	Supervisors will ensure appropriate PPE, including N95's, are stocked at all times when PPE is required to be used.	Completed 1/12/2024
WAC 388-78A-2650 3.) Reporting incidences	Staff A will immediatly report any COVID outbreak to the department's aging and disability services administration.	Completed 1/12/2024
WAC 388-78A-2320 Nurse Delegation. 1a, 1b, 2a, 2b, 2c,	Staff F will ensure all the appropriate nurse delegation tasks, assessments and documentations are completed as required and prior to their due date.	Completed 1/12/2024
	Staff F will keep a running calendar of when assessments are due, and will ensure they are completed.	Completed 1/12/2024
WAC 388-78A-2210 Medication services 1b, 2a, 2b	Staff C contacted the primary care provider of Resident 7. A requested was made to clarify if the PCP would like parameters set for the specific hypertension medications, and if so, what the parameters are to be set at. Orders received.	Completed 1/10/2024
	Staff F contacted the primary care provider of Resident 5. A requested was made to clarify if the PCP would like parameters set for the specific hypertension medications, and if so, what the parameters are to be set at.	2/5/2024

	Staff C and staff F will be running medication exemption and missed med reports daily and auditing them for any concerns.	Completed 1/15/2024
WAC 388-78A-2090 Full Assessment topics 6e	Bed rail safety assessments was completed on Resident 7.	Completed 1/11/2024
	Bed rail safety assessments was completed on Resident 8.	Completed 1/16/2024
	Staff C and staff F will ensure assessments are completed with negotiated service agreements or prior to any medical device use and in admission.	Completed 1/12/2024
WAC 388-78A-2100 Ongoing assessments 2a	Bed rail safety assessments were completed on Resident 6.	Completed 1/16/2024
	Staff C and staff F will ensure ongoing assessments are completed with annual negotiated service agreements or prior to any medical device use.	Completed 1/12/2024
WAC 388-78A-2260 Storing, securing, and accounting for medications 2d	Nursing staff were reeducated on the importance of ensuring all medications and/or medical supplies are secured and locked in their designated areas.	Completed 1/12/2024
	Staff A, C and F will be doing spot checks periodically to ensure this is being completed.	Completed 1/12/2024
WAC 388-78A-3100 Safe storage of supplies and equipment 1, 2	All staff were reeducated on the importance of ensuring all areas and/or rooms that contain hazardous or toxic supplies or equipment are secured at all time.	Completed 1/12/2024
	Staff J was reeducated on the importance of ensuring the maintenance shop, exterior gates surrounding the pond and the pond pump room are secured at all times.	Completed 1/12/2024
WAC 388-78A-2466 Background checks. 1a, 1b, 2	The birth background check was completed for Staff A.	Completed 1/12/2024

	The national fingerprint background check was completed for Staff E.	Completed 1/12/2024	
	Staff A will be running a monthly report of all staff and ensuring that background checks are completed every 2 years.	Completed 1/12/2024	
WAC 388-78A-2474 Training and HCA certification requirements 2c	Staff B and Staff C were scheduled for the required dementia specialty training.		2/14/2024
WAC 388-78A-2730 Licensee's Responsibility 1b	Staff H was to be trained per the Dept of Health's Respiratory Protection Program guidelines to be a qualified fit test administrator.		2/10/2024
	Staff A, C, D, and E will be fit tested for N-95 masks according to DOH Respiratory Protection Program guidelines by Staff F.		2/9/2024