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) 48732 (Completion Date 10/21/2024) and 45849 (Completion Date 08/29/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/21/2024 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-2140-5, WAC 388-78A-2371, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2371-4

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

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: COVENTRY HOUSE
Provider Type: Assisted Living Facility
License/Cert.#: 2334
Compliance Determination #: 45849
Intake ID: 142985
Investigator: Amy Wright
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 08/19/2024 through 08/29/2024
Complainant Contact Date(s): 08/19/2024, 09/03/2024

Allegation(s):

1. Frequent falls.
2. Resident to resident altercation.
3. Facility serving meals late.
4. Improper transfers.

Investigation Methods:

Sample:
Total residents: 41
Resident sample size: 3
Closed records sample size: 0

Observations:
Alleged Victim
Residents
Dining
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions
Medication administration

Interviews:
Alleged Victim's Representatives
Resident Representatives
Administrator

Record Reviews:
*Disclosure of Services
*Characteristic roster
*Staff roster
*Resident face sheets
*Resident care plans
*Food Service Policy & Procedure
*Fall Policy
*Shower documentation
*Progress notes
*Incident report
*Abuse and Misappropriation Policy
*Managing Aggressive and Assaultive Residents Policy

This document was prepared by Residential Care Services for the Locator website.

Investigation Summary:

1. Review of progress notes for the Alleged Victim showed they had multiple falls. The facility was unable to provide documentation of fall investigations. Failed facility practice was identified and cited under WAC 388-78A-2371 Investigations (1)(2)(3)(4).
2. The Alleged Victim exhibited disruptive behaviors in the dining room resulting in a resident-to-resident altercation. The Alleged Victim's care plan failed to identify the resident's disruptive behaviors at mealtime or interventions to be used by staff to prevent the disruptive behaviors. The facility was unable to provide a documented investigation for the altercation. Failed facility practice was identified and cited under WAC 388-78A-2140 Negotiated service agreements contents (5) and WAC 388-78A-2371 Investigations (1)(2)(3)(4).
3. The Alleged Victim exhibited disruptive behaviors in the dining room during mealtime. The facility and the Alleged Victim's Representative had a plan to stagger mealtime service for the Alleged Victim who preferred not to visit with others at meals. The Alleged Victim was observed napping during routine lunch service and the facility was prepared to serve them lunch upon awakening. No failed facility practice.
4. Interview with facility staff showed that the Alleged Victim was being transferred according to their care plan. The Alleged Victim was observed with care planned mobility devices within reach. Interview with a Resident Representative showed they had no concerns about the care their loved one received at the facility. Staff were observed available to assist with resident care needs. No failed facility practice.

Conclusion / Action:

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: COVENTRY HOUSE
Provider Type: Assisted Living Facility
License/Cert.#: 2334
Compliance Determination #: 45849
Intake ID: 142106
Investigator: Amy Wright
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 08/19/2024 through 08/29/2024
Complainant Contact Date(s): 08/16/2024, 09/03/2024

Allegation(s):

1. Resident eating without other residents in dining room.
2. Resident to resident altercations.
3. Inadequate personal care.
4. Repeated falls.

Investigation Methods:

Sample:
Total residents: 41
Resident sample size: 3
Closed records sample size: 0

Observations:
Alleged Victim
Residents
Dining
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions
Medication administration

Interviews:
Alleged Victim's Representatives
Resident Representatives
Administrator

Record Reviews:
*Disclosure of Services
*Characteristic roster
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*Resident face sheets
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*Food Service Policy & Procedure
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*Shower documentation
*Progress notes
*Incident report
*Abuse and Misappropriation Policy
*Managing Aggressive and Assaultive Residents Policy

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Investigation Summary:

1. The Alleged Victim exhibited disruptive behaviors in the dining room during mealtime. The facility and the Alleged Victim's Representative had a plan to stagger mealtime service for the Alleged Victim who preferred not to visit with others at meals. The Alleged Victim was observed napping during routine lunch service and the facility was prepared to serve them lunch upon awakening. No failed facility practice.
2. The Alleged Victim exhibited disruptive behaviors in the dining room resulting in resident-to-resident altercations. The Alleged Victim's care plan failed to identify the resident's disruptive behaviors at mealtime or interventions to be used by staff to prevent the disruptive behaviors. The facility was unable to provide documented investigations for the altercations. Failed facility practice was identified and cited under WAC 388-78A-2140 Negotiated service agreements contents (5) and WAC 388-78A-2371 Investigations (1)(2)(3)(4).
3. Facility documentation showed that the Alleged Victim was offered routine showers. Interview with a Resident Representative showed they had no concerns about their loved one's care at the facility. The Alleged Victim was observed, and no unmet needs were identified. Staff were observed available to assist with resident care needs. No failed facility practice.
4. Review of progress notes for the Alleged Victim showed they had multiple falls. The facility was unable to provide documentation of fall investigations. Failed facility practice was identified and cited under WAC 388-78A-2371 Investigations (1)(2)(3)(4).

Conclusion / Action:

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

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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 # 45849
Plan of Correction	COVENTRY HOUSE	Completion Date
Page 1 of 5	Licensee: Senior Development Resources LLC	08/29/2024

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 08/19/2024, 08/19/2024 and 08/19/2024 of:

COVENTRY HOUSE
430 N 2nd Ave
Othello, WA 99344

This document references the following complaint number(s): 142985, 142106

The following sample was selected for review during the unannounced on-site visit: 3 of 41 current residents and 0 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.

Stephanie Jones
Residential Care Services

09/04/2024
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.

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Monica Flores 9/16/24

Statement of Deficiencies | License #: 2334 | Compliance Determination # 45849
Plan of Correction | COVENTRY HOUSE | Completion Date
Page 2 of 5 | Licensee: Senior Development Resources LLC | 08/29/2024

Administrator (or Representative) Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document in the resident's negotiated service agreement, appropriate interventions for known disruptive behaviors for 1 of 1 resident (Resident 1). This failure resulted in physical and verbal aggression towards Resident 1 by other residents and placed residents with disruptive behaviors at increased risk for aggression by others, potential physical and psychosocial harm, and decreased quality of life.

Findings included...

Review of an undated face sheet for Resident 1 showed they admitted to the facility on [redacted]/2023.

Review of a progress note for Resident 1, dated 08/08/2024 at 11:44 AM, showed that Resident 2 was seen pouring water on Resident's 1 head because Resident 1 was yelling out in the dining room. The note showed that Resident 2 was saying, "shut up" to Resident 1. Further review of the note showed that other residents were mimicking Resident 1, laughing, and yelling. The note showed that Resident 1's excessive yelling triggered the other residents.

In an interview on 08/16/2024 at 3:57 PM, Collateral Contact 2 (CC2), Resident Representative, stated that Resident 1's calling out in the dining room caused other residents to yell at Resident 1. CC2 stated that another resident threw water on Resident 1, and they felt that could have been avoided.

In an interview on 08/19/2024 at 11:14 AM, Collateral Contact 1, Resident Representative, stated that Resident 1 screamed out in the dining room and that the behavior was nothing new.

In an interview on 08/29/2024 at 9:31 AM, Staff A, Administrator, stated that Resident 1 often yelled out in the dining room.

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Statement of Deficiencies	License #: 2334	Compliance Determination # 45849
Plan of Correction	COVENTRY HOUSE	Completion Date
Page 3 of 5	Licensee: Senior Development Resources LLC	08/29/2024

Review of a negotiated service agreement (NSA) for Resident 1, dated 05/02/2024, showed that Resident 1 had diagnoses including [redacted] and [redacted]. Further review of the NSA showed that it failed to indicate Resident 1 exhibited disruptive behaviors in the dining room during mealtime. The NSA also failed to identify interventions to be used by staff when Resident 1 exhibited the disruptive behaviors at mealtime.

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) 9/8/24 .

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

Monica Flores
Administrator (or Representative)

9/12/24
Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document investigative actions and findings for 1 of 1 resident (Resident 1) reviewed for falls and abuse. This failure placed Resident 1 at increased risk for additional falls, abuse, and physical and psychosocial harm and placed facility residents at increased risk for physical harm, psychosocial harm, and decreased quality of life.

Findings included...

The facility policy, titled, "Resident Care Policies and Procedures," last revised

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02/06/2002, stated that the Administrator, or their designee, was to investigate circumstances or allegations of abuse of a resident.

Review of a negotiated service agreement (NSA) for Resident 1, dated 05/02/2024, showed that Resident 1 had diagnoses including [redacted].

Review of a progress note for Resident 1, dated 06/09/2024 at 11:39 AM, showed that Resident 1 was found on the floor that day after falling out of their recliner. The facility was unable to provide any other documentation related to this fall.

Review of an incident report, dated 06/13/2024, showed that on that day, a staff member found Resident 1 on the floor. The incident report showed that Resident 1 stated someone threw or pulled them off their chair. The incident report indicated that no "remediation" was needed following Resident 1's fall and abuse allegation. There was no documentation in the incident report indicating Resident 1's fall or abuse allegation were investigated, and there was no documentation to show that Resident 1 was protected following their allegation of abuse. Additionally, there was no documentation showing a possible cause for Resident 1's fall.

In an interview on 08/29/2024 at 9:41 AM, Staff A, Administrator, stated that on 06/09/2024, Resident 1 slipped off of their recliner. Staff A stated that on 06/13/2024, Resident 1 was found on the floor by their chair stating that someone had thrown them. Staff A stated the incidents were mostly just talked about and that they could not recall if they wrote anything down about the incidents.

On 08/20/2024 at 8:12 AM, an email was sent to Staff A, requesting investigations for Resident 1's falls since June 1, 2024. No investigations were received.

Review of facility records showed no documentation of actions taken to investigate Resident 1's allegation of physical abuse.

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) 9/18/24.

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

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Statement of Deficiencies	License #: 2334	Compliance Determination # 45849
Plan of Correction	COVENTRY HOUSE	Completion Date
Page 5 of 5	Licensee: Senior Development Resources LLC	08/29/2024

Monica Floral — 9/12/24

Administrator (or Representative) — Date

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WAC SPECIFIED	CORRECTION	COMPLETION DATES
WAC 388-78A-2140 Negotiated service agreement contents 5	All negotiated service agreements will be reviewed by the Wellness Director and/or Administrator for verification that they are all accurate as to the current care needs of the residents	9/18/2024
	Additional thorough and extensive training will be provided to the registered nurse on accuracy and completion of negotiated service agreements.	10/4/2024
WAC 388-78A-2371 Investigations 1, 2, 3, 4	All supervisors and registered nurse will be retrained by the Wellness Director and/or Administrator on how to properly complete and document a thorough investigation after an incident.	9/18/2024
	All investigations/incident reports will be reviewed/audited by the Wellness Director and/or Administrator from the past 3 months for completion, proper documentation and accuracy.	9/18/2024
	Additional thorough and extensive training will be provided to all supervisors, caregivers and registered nurse on completion and documentation of an investigation. This will include intensive retraining on the recognition, prevention and reporting of potential or witnessed abuse of a resident.	10/4/2024

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