STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

RIVERTON RETIREMENT & ASSISTED LIVING COMMUNITY LLC
BONAVENTURE OF THE TRI-CITIES
3425 Boone Rd., SE
SALEM, OR 97317

RE: BONAVENTURE OF THE TRI-CITIES License # 2015

Dear Administrator:

This letter addresses Compliance Determination(s) 29039 (Completion Date 09/07/2023) and 27082 (Completion Date 08/29/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/07/2023 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-2600-1-a, WAC 388-78A-2600-2-d, WAC 388-78A-2600-3

The Department staff who did the on-site verification:
Elaine Lopez, Licensor

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Gwin Kaercher

Gwin Kaercher, Field Manager
Region 1, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: BONAVENTURE OF THE TRI-CITIES
Provider Type: Assisted Living Facility
License/Cert.#: 2015
Intake ID: 89338
Compliance Determination #: 27082
Region/Unit #: RCS Region 1 / Unit G
Investigator: Krista Connelly
Investigation Date(s): 07/24/2023 through 08/29/2023
Complainant Contact Date(s):

Allegation(s):
Identified Resident passed unexpectedly on [redacted]/2023.

Investigation Methods:

Sample:	Total residents: 73 Resident sample size: 5 Closed records sample size: 1
Observations:	Facility front lobby, receptionist desk, access to locked nurses' station, Sampled Resident apartments, (POLST forms accessibility,) and staff-resident supervision.
Interviews:	Sampled Residents, facility Staff and Collateral Contacts not associated with the facility.
Record Reviews:	The Identified Resident's, Sampled Residents' records including face sheets, assessments, physician orders, visits, progress notes, medication/treatment administration records, hospital records and incident investigations.

Investigation Summary:
Observation showed the facility failed to follow their policy on Cardiopulmonary Resuscitation, (CPR,) which resulted in staff providing CPR to the Identified Resident against their wishes. Failed practice identified.

Conclusion / Action:

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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 2015	Compliance Determination # 27082
Plan of Correction	BONAVENTURE OF THE TRI-CITIES	Completion Date
Page 1 of 5	Licensee: RIVERTON RETIREMENT & ASSISTED LIVING COMMUNITY	08/29/2023

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 07/24/2023 and 07/24/2023 of:

BONAVENTURE OF THE TRI-CITIES
1800 BELLERIVE DRIVE
RICHLAND, WA 99352

This document references the following complaint number(s): 89338

The following sample was selected for review during the unannounced on-site visit: 5 of 73 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Krista Connelly, Community Nurse Consultant

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit Z
1200 Alder Street
Union Gap, WA 98903

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.

Michelle Cloaner
Residential Care Services

08/29/2023
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.

Administrator (or Representative)

8/30/23
Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(d) When a resident stops breathing or a resident's heart appears to stop beating, including, but not limited to, any action staff persons must take related to advance directives and emergency care;

(3) The assisted living facility must make the policies and procedures specified in subsection (2) of this section available to staff persons at all times and must inform residents and residents' representatives of their availability and make them available upon request.

This requirement was not met as evidenced by:

Based on observation, Interview and record reviews, the Assisted Living Facility (ALF) failed to ensure their Cardiopulmonary Resuscitation, (CPR) policy was implemented, and the residents' decision on life sustaining measures were made available for staff for 3 of 5 residents, (Resident 1, 2 & 3.) This failure resulted in staff providing end of life treatment, CPR, that the resident did not want and had the potential for affecting all residents end of life wishes.

Findings included...

Record review of the facility's undated policy titled, "CPR Policy," showed all residents must be offered their choice regarding whether cardiopulmonary resuscitation, (CPR) is to be performed in the event of a cardio/pulmonary emergency. In the absence of a signed Advanced Directive, Living Will or a Portable Orders for Life Sustaining Treatment, (POLST,) form, the resident will be treated as "Code." All staff will be familiar with how to determine the code status of the residents.

Procedure:
- Prior to move in residents will be offered the opportunity to choose whether CPR is or is not to be performed in the event of a cardio/pulmonary emergency.
- When the resident makes a choice, a Portable Order on Life Sustaining Treatments, (POLST,) form is completed and sent to the physician to be signed. Once returned from the physician, a copy is made and placed in the chart. A copy of the resident's Advanced

Directive, or Living Will is also placed in the chart.
- The Assisted Living Director will then indicate on the binder of the resident's chart the designated CPR or no CPR status.
- The Office Manager will update a CPR list monthly and with each resident move-in.
- The Assisted Living Director will verify code status when the service plans are reviewed.

On 07/28/2023 at 1:25 PM, Staff B, Director, stated when the staff found a resident without a pulse, they were directed to begin CPR unless they knew the resident's choice was Do Not Resuscitate, (DNR.) Staff B reported upon admission, each resident was asked about what their decision was, (code status,) in the event of a medical emergency. Staff B stated the code status was recorded on their resident information sheet in their charts. They also stated there was a binder of resident information sheets kept at the front desk for reference if needed.

Resident 1

A review of Resident 1's medical record and face sheet showed Resident 1 was admitted to the facility on [redacted]/2023 and showed the resident had an irregular heartbeat and a history of passing out.

Resident 1's Service Plan, dated [redacted]/2023 showed the resident wanted to be resuscitated, CPR.

Record review of the medical record progress notes showed on 07/13/2023 at 10:30 AM. Staff D, Medication Aide, made a late entry for [redacted]/2023 at 10:00 AM. The late entry showed Resident 1 became unresponsive while staff were assisting them from the bathroom. Staff D documented they instructed staff to call 911 and began CPR until emergency medical services arrived to take over. Staff D documented emergency medical services performed CPR on the resident until their POLST confirmed Resident 1's wishes to be DNR.

During an interview on 07/28/2023 at 12:04 PM, Staff C, Caregiver, reported they were on duty the morning of [redacted]/2023 and responded to a call for all staff to go to room [redacted], Resident 1's room. Staff C stated they entered the room and saw Resident 1 was unresponsive in their chair. They reported Staff D, Medication Aide, requested they help get the resident on the floor for CPR. Staff C stated there was some confusion over the radio to Resident 1's code status, if it was CPR or DNR, and Staff B, ran down to see if there was a POLST in Resident 1's medical record.

During an interview on 07/28/2023 at 1:25 PM, Staff B stated on [redacted]/2023 at 9:30 AM, they responded to a call for all staff to Resident 1's room. Staff B stated they found Resident 1 on the ground while two staff members were performing CPR. Staff B stated there was a

question about Resident's 1 code status and they could not find a POLST in the apartment. Staff B stated they then ran downstairs to see what their medical record said. They reported they could not find a POLST in their medical record.

On 07/28/2023, record review of the binder, kept at the front reception desk showed it included information sheets, (demographic information,) for all residents in the assisted living facility. The binder included a sheet that showed Resident 1's wishes were do not resuscitate, DNR.

On 08/29/2023 at 8:34 AM, Collateral Contact 1 (CC1), Family Representative, stated they were surprised and shocked that the facility started CPR on Resident 1 because Resident 1 was a DNR. CC1 stated the facility told them that they were suppose to have the DNR POLST form on the refrigerator. CC1 stated they never knew this and would have made sure it was on the fridge. In addition, CC1 stated that the nurse at the facility never came to do an assessment on Resident 1 for 12 days after moving to the ALF [redacted], 2023.

Resident 2

A review of Resident 2's medical record and face sheet showed the resident was admitted to the facility on [redacted]/2018 and a Service Plan, dated 07/22/2023 showed the resident did not want to be resuscitated, DNR.

On 07/28/2023, a review of the binder, kept at the front reception desk showed Resident 2's wishes were to be resuscitated, CPR.

Observation on 07/28/2023 at 1:15 PM, showed Resident 2 had a copy of their POLST form taped on the refrigerator in their room. The POLST form showed Resident 2 did not want to be resuscitated, DNR.

Resident 3

A record review of Resident 3's medical record and face sheet showed Resident 3 was admitted to the facility on [redacted]/2021 and a Service Plan dated 05/30/2023, showed the resident wanted to be resuscitated, CPR.

On 07/28/2023, a review of the binder, kept at the front desk showed Resident 3 wanted CPR.

On 07/28/2023, at 1:23 PM, Resident 3 stated they did not want to be resuscitated and they had provided the facility with a signed POLST form reflecting that.

Statement of Deficiencies	License #: 2015	Compliance Determination # 27082
Plan of Correction	BONAVENTURE OF THE TRI-CITIES	Completion Date
Page 5 of 5	Licensee: RIVERTON RETIREMENT & ASSISTED LIVING COMMUNITY	08/29/2023

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, BONAVENTURE OF THE TRI-CITIES is or will be in compliance with this law and / or regulation on (Date) 8/30/23.

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

R. [illegible] — Administrator (or Representative)

8/30/23 — Date