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

05/16/2025

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

RE: BONAVENTURE OF THE TRI-CITIES # 2015

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 58903 (Completion Date 05/16/2025) and 55536 (Completion Date 04/03/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/16/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

The Department staff who did the On Site verification:
Krista Connelly, Community Nurse Consultant

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

Sincerely,

Laura Williams-Davis, ALF Field Manager

Region 1, Unit G
Residential Care Services

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

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 02/04/2025 and 02/07/2025 of:
BONAVENTURE OF THE TRI-CITIES
1800 BELLERIVE DRIVE
RICHLAND, WA 99352

This document references the following SOD dated: 04/03/2025

The following sample was selected for review during the unannounced on-site visit: 3 of 79 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Krista Connelly, Community Nurse Consultant

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
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.

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.

Administrator (or Representative)

Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) staff failed to report an injury of unknown origin to the Washington Department of Social and Health Services (Department) hotline for 1 of 1 resident (Resident 1). This failure placed residents at risk for not having the departments oversight when there was a reasonable belief that abuse or neglect occurred.

Findings included…

Review of the facility's undated policy titled, "Abuse, Neglect or Exploitation Policy," showed that all staff members are mandated reporters and have the responsibility to immediately report when they have witnessed or have reason to believe that an incident is the result of abuse, exploitation or neglect to the Department's hotline.

Record review of Resident 1's medical record included a service plan dated 10/28/2024, that showed Resident 1 had dementia (when a person's ability to remember, think and perform activities of daily living are impaired.) The service plan showed Resident 1 was not able to use the call system to communicate their needs to the staff, was able to walk using a walker independently in their apartment and was a low fall risk.

Resident 1's medical record included a Resident Occurrence Report dated 01/16/2025 at 12:00 AM, written by Staff B, Medication Aide. The report showed Staff A, Assistant Executive Director, was notified of the bruising on Resident 1's upper left thigh 01/16/2025 at 12:27 AM.

Record review of Resident 1's progress note dated 01/16/2025 at 12:34 AM, written by Staff B, showed the resident had a 2–3 inch bruise on their upper left thigh. The progress note showed Resident 1 was unsure how the injury happened. The note stated the previous shift saw the injury but did not know how the Resident got it. Staff B documented they did an occurrence report and notified Staff A.

Observation and interview on 02/07/2025 at 2:15 PM, showed Resident 1 sitting in a wheelchair just outside their apartment. With staff assistance, the resident was assisted into their apartment. Resident 1 recognized their belongings in the room, and was not sure of their room number, the name of the facility or how long they had lived there. When they were asked about bruising noted on their left upper thigh, they did not recall the injury or the cause of the bruising.

During an interview on 04/03/2025 at 12:17 PM, Collateral Contact (CC1), Resident Representative, reported they were not aware of the bruising. They stated they felt there were things that happened with Resident 1 that was not always communicated to them. CC1 stated the facility had not reported any fall or accident that may have caused injuries.

During an interview on 04/04/2025 at 9:54 AM, Staff A reported all staff were mandated reporters. When asked what the facility practice was regarding an injury of unknown source, they stated an investigation would be conducted to determine the cause. When asked about bruising found on Resident 1's upper thigh, they did not recall but agreed that was a reportable event. They were not able to relate why the injury was not reported to the Department's hotline.

This is a uncorrected deficiency previously cited on 11/07/2024.

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

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

_____ _____

Administrator (or Representative) Date

Residential Care Services
Investigation Summary Report

Provider/Facility: BONAVENTURE OF THE TRI-CITIES
Provider Type: Assisted Living Facility
License/Cert.#: 2015
Intake ID: 152467
Compliance Determination #: 49738
Region/Unit #: RCS Region 1 / Unit C
Investigator: Krista Connelly
Investigation Date(s): 11/04/2024 through 11/07/2024
Complainant Contact Date(s): 11/04/2024

Allegation(s):
An Identified Resident reported they were afraid of an Identified Staff.

Investigation Methods:

Sample:	Total residents: 72 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Dining Staff to resident interactions
Interviews:	Identified resident Nursing staff Residents
Record Reviews:	Medical records Hospital records Incident investigation Personnel files

Investigation Summary:
Observation showed all staff to resident interactions were appropriate and respectful. Identified Resident and other sampled residents reported concerns with Identified Staff Members. Interview and record review of investigations conducted by the facility met minimal regulatory guidelines. The facility failed to make a report to the Department's hotline per regulatory guidelines. Failed practice identified, see Statement of Deficiency dated 11/07/2024.

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 # 49738
Plan of Correction	BONAVENTURE OF THE TRI-CITIES	Completion Date
Page 1 of 7	Licensee: RIVERTON RETIREMENT & ASSISTED LIVING COMMUNITY LLC	11/07/2024

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 11/04/2024 and 11/04/2024 of:

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

This document references the following complaint number(s): 152467

The following sample was selected for review during the unannounced on-site visit: 4 of 72 current residents and 0 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 C
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.

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.

Administrator (or Representative) Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) staff failed to report to the Washington Department of Social and Health Services (Department) hotline for 3 of 3 residents (Residents 1, 2, & 3), who had a reportable incident of suspected abuse by a staff member. This failure placed residents at risk for abuse and neglect.

Findings included…

Review of RCW 74.34.035 titled, “Reports—Mandated and permissive—Contents—Confidentiality” showed that mandated reporters should immediately report a reasonable belief abuse or neglect occurred to department’s hotline for reported and/or suspected abuse or neglect.

Review of the facility’s undated policy titled, “Abuse, Neglect or Exploitation Policy,” showed that all staff members are mandated reporters and have the responsibility to immediately report when they have witnessed or have reason to believe that an incident is the result of abuse, exploitation or neglect to the Department’s hotline.

<Resident 1>

Record review of Resident 1’s medical record included a service plan dated 01/01/2024 that showed Resident 1 was alert, oriented and without any cognitive (thinking) impairment. The service plan showed Resident 1 required two staff maximum assistance to transfer in and out of their wheelchair, bed and showers.

Observation on 11/04/2024 at 11:21 AM, showed Resident 1 was unable to transfer from chair to bed independently.

During an interview on 11/04/2024 at 11:21 AM, Resident 1 reported they were not able to move their legs or bear much weight because of a disease that resulted in muscle weakness. The Resident reported they had to have staff assistance for everything, and commented that they tried to not make any additional work for the staff because some of the staff weren't very nice.

During an interview on 11/04/2024 at 11:21 AM, Resident 1 stated they did not like Staff D, Caregiver, because Staff D yelled at them when their pants were wet, asking Resident 1 why they kept wetting their pants. Resident 1 stated that Staff D made them nervous because Staff D became angry quickly and yelled at them. Resident 1 stated that they were afraid of Staff D, and they did not like it when Staff D was their assigned care giver.

During an interview on 11-04-2024 at 2:59 PM, Staff A, Assistant Executive Director, stated on 10/22/2024, they had been notified that Resident 1 was afraid of Staff D. Staff A said Resident 1 told them Staff D made them nervous and they rushed them during cares. Staff A reported they did an investigation into the allegations. Staff A stated that they did not make a report to the Department's hotline because they did not feel Resident 1's complaints were abuse or neglect.

Record review of a facility investigation conducted by Staff A was dated 10/22/2024. Staff A documented Resident 1 reported they had wet their pants twice and Staff D told them they shouldn't be doing that. Staff A documented Resident 1 said Staff D refused to wipe them, threatened to call for paramedics, rushed them, made them nervous and had refused to help them when they asked for help.

<Resident 2>

Observation on 11/04/2024 at 1:42 PM, showed Resident 2 moved slowly using their walker and needed one staff assistance to transfer to and from a chair. Resident 2 stated they had chronic pain in their shoulders and back making it difficult to get around. The resident stated not all the caregivers in the facility did a good job and some were mean to them.

Record review of Resident 2's medical record included a service plan dated 10/08/2024 that showed the resident had a history of bone weakness with fractures of their joints. The service plan showed Resident 2 needed one staff assistance for transferring, showering, getting dressed and using the bathroom.

During an interview on 11/04/2024 at 1:42 PM, Resident 2 stated Staff D and Staff E, Caregiver, were mean and shouldn't be working in a facility like this. The resident stated Staff D was mean, rude to them and became upset easily. They stated Staff D

gave them their medication and became upset when Resident 2 asked what the medication was. They stated that Staff D told them to quit asking that each time. Resident 2 stated there were times Staff D came into their room already upset and wouldn't speak to the resident at all which made them feel bad.

During an interview on 11/04/2024 at 1:42 PM, Resident 2 reported Staff E was very disrespectful to them and made inappropriate comments to them. Resident 2 reported when they called for assistance in the bathroom Staff E came into the room, loudly saying how much it stank. Resident 2 reported Staff E was rough when handling them.

During an interview on 11/04/2024 at 2:59 PM, Staff A, stated on 10/24/2024 Staff B, Caregiver, and Staff C, Caregiver, told them there were residents that were afraid of Staff D and Resident 2 was one of these residents. Staff A stated they did an investigation. Staff A stated they did not make a report to the Department's hotline because they did not feel their complaints were abuse or neglect.

Record review of a facility investigation conducted by Staff A showed it was dated 10/24/2024. Staff A documented Resident 2 stated that Staff D came into their room earlier that morning to help the resident get up and would not speak to them making them feel bad. Staff A documented Resident 2 reported Staff D was verbally rough with them and had not helped them out of bed once.

<Resident 3>

Record Review of Resident 3's medical record included a service plan dated 08/15/2024 that showed the resident required one staff assistance to transfer, toilet, shower and get dressed after they had a stroke (a brain event that affects the ability to voluntarily move the arms and legs.)

Observation on 11/04/2024 at 12:24 PM showed Resident 3 needed one staff assistance to transfer them from the bathroom into their wheelchair. Observation showed the resident was not able to move their right arm or leg independently.

During an interview on 11/04/2024 at 12: 24 PM, Resident 3 reported they were unable to do anything independently anymore. The resident stated there were staff that were rude and rough with Resident 3 when they moved Resident 3 around. Resident 3 stated there was a staff member that worked during the night that was rude and rough when helping them. Resident 3 stated they did not know the staff member's name and they had a heavy accent when they spoke.

During an interview on 11-04-2024 at 2:59 PM, Staff A, stated on 10/24/2024 Staff B, Caregiver, and Staff C, Caregiver, told them there were residents that were afraid of some caregivers and Resident 3 was one of these residents. Staff A stated they did an

investigation. Staff A stated they did not make a report to the Department's hotline because they did not feel their complaints were abuse or neglect.

Record review of a facility investigation conducted by Staff A showed it was dated 10/24/2024. Staff A documented Resident 3 reported they had felt threatened by someone in the past, and the person still worked with them during the night. Staff A documented Resident 3 reported they did not want this staff member to work with them anymore. Staff A documented Resident 3 reported this staff member worked after 10:00 PM and had a heavy accent. Staff A documented this person may be Staff F, Caregiver, that worked the night shift.

<Resident 4>

Record Review of Resident 4's medical record included a service plan dated 05/18/2024 that showed the resident required one staff assistance to move in bed, transfer in and out of their wheelchair, to get showered, dressed and assist them to use the bathroom.

Observation on 11/04/2024 at 12:41 PM, showed Resident 4 was unable to voluntarily move their right arm and leg. Resident 4 sat in a wheelchair and needed staff assistance to put their coat on.

During an interview 11/04/2024 at 12:41 PM, Resident 4 stated they needed one staff member to help them get around, get dressed, shower, and use the bathroom. Resident 4 stated there was a mean caregiver that worked with Resident 4 during the night. The resident stated Staff F had a very heavy accent, was rough with Resident 4, and they tried to not ask Staff F for help with anything. Resident 4 stated Staff F always turned the heat in their room down low. Resident 4 stated they did not complain because they were afraid it would make it worse on them.

During an interview on 11-04-2024 at 2:59 PM, Staff A, stated on 10/24/2024 they were told there were residents that were afraid of some care givers and Resident 4 was one of these residents. Staff A stated they talked to the resident. Staff A did not make a report to the Department's hotline because they did not feel their complaints were abuse or neglect.

Record review of a facility investigation conducted by Staff A showed it was dated 10/24/2024. Staff A documented they were told Resident 4 only wanted some staff to shower them because there were staff that were rough handling them. The investigation did not include documentation of an interview with the resident regarding their allegations.

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)_____ .

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

_____ _____

Administrator (or Representative) Date