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) 62425 (Completion Date 07/11/2025) and 53366 (Completion Date 05/15/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/11/2025 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, WAC 388-78A-2690-1, WAC 388-78A-2690-5, WAC 388-78A-2690-7-b, WAC 388-78A-2690-7, WAC 388-78A-2690-7-a, WAC 388-78A-2690-10, WAC 388-78A-2690-10-a, WAC 388-78A-2690-10-b, WAC 388-78A-2690-11, WAC 388-78A-2690-12, WAC 388-78A-2371-3, WAC 388-78A-2371-2, WAC 388-78A-2371-1

The Department staff who did the on-site verification:
Laurel Knight, Community Complaint Investigator

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

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, ALF 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: 162168
Compliance Determination #: 53366
Region/Unit #: RCS Region 1 / Unit G
Investigator: Krista Connelly
Investigation Date(s): 01/22/2025 through 05/15/2025
Complainant Contact Date(s): 01/22/2025, 02/05/2025

Allegation(s):

1. Unidentified residents are being neglected.
2.The Identified Resident, alleged victim (AV) is neglected and does not receive medications as ordered.
3. An unidentified resident did not receive their insulin as ordered.

Investigation Methods:

Sample:	Total residents: 89 Resident sample size: 10 Closed records sample size: 1
Observations:	Identified resident Residents Dining Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents
Record Reviews:	Medical records Hospital records Incident investigation Facility policies

Investigation Summary:

1. Sampled Residents reported their needs were met, denied feeling abuse or neglect. No failed practice identifed.
2. The Identified Resident reported their needs were met, observation and record reviews showed cares provided as care planned and medications administered as prescribed. Failed practice identified with other Sampled Residents. Please refer to Statement of Deficiency dated 05/01/2025 WAC 388-78A-2210 (1)(b)(2)(a)(b).
3. Record reviews and interviews identified Sampled Residents did not receive medications as ordered. Failed practice identified. Please refer to the Statement of Deficiency dated 05/01/2025 WAC 388-78A-2210 (1)(b)(2)(a)(b).

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: BONAVENTURE OF THE TRI-CITIES
Provider Type: Assisted Living Facility
License/Cert.#: 2015
Intake ID: 164206
Compliance Determination #: 53366
Region/Unit #: RCS Region 1 / Unit G
Investigator: Krista Connelly
Investigation Date(s): 01/22/2025 through 05/15/2025
Complainant Contact Date(s):

Allegation(s):

1. Identified staff are not fully trained to give medications alone.
2. Identified staff make errors when inputting medication orders.
3. Identified staff does not follow proper medication practices.
4. Identified resident received the incorrect medication dose.

Investigation Methods:

Sample:	Total residents: 89 Resident sample size: 10 Closed records sample size: 1
Observations:	Identified resident Residents Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Identified resident Identified staff Nursing staff Residents Family members Business office manager
Record Reviews:	Medical records Hospital records Incident investigation Facility policies Personnel files

Investigation Summary:

1. Observations, interviews and record reviews showed identified staff trained and qualified to pass medications. No failed practice identified. 2., 3 & 4. Record reviews and interviews identified Sampled Residents did not receive medications as ordered. Failed practice identified. Please refer to the Statement of Deficiency dated 05/01/2025 for WAC 388-78a-2210 (1)(b)(2)(a)(b).

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: BONAVENTURE OF THE TRI-CITIES
Provider Type: Assisted Living Facility
License/Cert.#: 2015
Intake ID: 173432
Compliance Determination #: 53366
Region/Unit #: RCS Region 1 / Unit G
Investigator: Krista Connelly
Investigation Date(s): 01/22/2025 through 05/15/2025
Complainant Contact Date(s): 03/31/2025, 04/03/2025

Allegation(s):

1. Identified resident was not getting the cares and services needed.
2. Identified resident laid on the floor for multiple hours at a time.
3. Identified resident was not getting their medications on time.
4. Short staffing.
5. Staff not receiving correct training on how to care for residents
6. Representative not being able to contact facility staff to notify them of needed care.

Investigation Methods:

Sample:	Total residents: 89 Resident sample size: 10 Closed records sample size: 1
Observations:	Identified resident Residents Resident rooms and camera placement Staff to resident interactions
Interviews:	Identified resident Nursing staff Residents Identified staff Family members
Record Reviews:	Medical records including negotiated service agreement, notes, medication administration records, incident report and investigations.

Investigation Summary:

1. Through observation, interview and record review the investigation was unable to substantiate that the Identified resident did not receive the cares and services needed. Identified resident and sampled residents were observed to be clean and well kept. Staff were observed providing resident care. Staff were observed responding to resident calls for assistance. Review of identified and sampled residents care plans showed needed care and services were outlined. No failed

practice identified.
2. The identified residents' representative brought concerns of the resident laying on the floor for extended periods after falls. Review of facility records showed no investigation was done to identify the cause of the fall or why the resident was left on the floor without staff assistance. Review of the identified residents' record showed no interventions were implemented to prevent further incidents. Review of a sampled residents record showed no documentation of an investigation being completed for the residents' multiple falls. Failed practice identified and cited for WAC 388-78-2371 (1)(2)(3) Investigations.
3. Through observation, interview and record review the investigation was unable to substantiate that the Identified resident did not receive medications as prescribed. Review of sampled resident records showed their medications were not given as prescribed. Failed practice identified and cited for WAC 388-78-2210 (1)(b)(2)(a)(b) Medication Services.
4. Observation showed staff were present and providing resident care. Observation showed staff were responding to resident call lights. The facility made efforts to ensure enough staff were available to provide resident care. Residents were observed clean and well kept. No failed practice identified.
5. Review of staff records showed that staff had received the required training to provide care and services to residents. Observation of resident care showed care was provided prompt and appropriately. No failed practice identified.
6. Interviews showed staff were educated on the importance of keeping the facility phone with them to be available to receive outside calls. Sampled residents representatives had no concerns of being able to contact facility staff by phone. Department investigator was able to contact the facility by phone. No 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

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 01/22/2025, 02/04/2025 and 05/01/2025 of:

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

This document references the following complaint number(s): 162168, 163029, 165635, 164206, 164515, 164982, 173432, 173748

The following sample was selected for review during the unannounced on-site visit: 10 of 89 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Krista Connelly, Community Nurse Consultant
Laurel Knight, Community Complaint Investigator

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.

Laura Williams-Davis — 05/20/2025
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) — 5/22/2025 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 observation, interview and record review, the assisted living facility (ALF) failed to ensure residents who were identified as needing medication assistance received medications as ordered for 4 of 5 residents (Resident 2 3, 4, & 5.) This failure resulted in delayed medical treatment, and put the residents at risk of unmanaged pain and worsening of chronic conditions.

Findings included...

Record review of the facility's policy titled, "Medication Systems," revised 10/11/2023,

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-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 observation, interview and record review, the assisted living facility (ALF) failed to ensure residents who were identified as needing medication assistance received medications as ordered for 4 of 5 residents (Resident 2 3, 4, & 5.) This failure resulted in delayed medical treatment, and put the residents at risk of unmanaged pain and worsening of chronic conditions.

Findings included…

Record review of the facility's policy titled, "Medication Systems," revised 10/11/2023,

showed the facility will establish and maintain a safe, effective 24-hour medication delivery system for staff to administer, aid with administration of, or allow resident self-administration of prescribed and over-the-counter medications. The policy showed a critical component of establishing and maintaining an effective medication delivery system including timely ordering of medications. The policy showed oversight of the medication delivery systems including routine audits of the medication administrations records (MARs) and MARs to medication carts that focused on medication availability and administration.

Resident 2

Resident 2's record review included a resident service plan (RSP) dated 11/27/2024, that showed the resident had a history of mental illness with symptoms that included paranoia and anxiety. The RSP showed Resident 2 required staff assistance with all activities of daily living and medication management.

Resident 2's record review included the following physician orders:

-Hydroxyzine HCL (a medication used to help control anxiety and nervousness) 25 milligrams (mg)tablets by mouth twice a day, ordered 12/12/2024.
-Paroxetine HCL (a medication used to help treat depression) 10 mg tablets by mouth twice a day, ordered 12/12/2024.
-Acetaminophen (a medication used to help manage discomfort) 500 mg tablet, by mouth three times a day, ordered 01/04/2024.
-Levothyroxine (a medication used to maintain thyroid hormone levels) 20 mg by mouth once a day, ordered 10/17/2022.

Resident 2's record review included MARs dated December 2024 that showed Resident 2 missed the following medications:

-Hydroxyzine HCL 25 mg tablets-(2) missed 13 doses (medication not arrived) unable to locate physician notification of missing medications on 12/12/2024, 12/13/2024 (twice,) 2/14/2024 (twice,) 12/15/2024, 12/16/2024 (twice,) 12/25/2024 (twice,) 12/26/2024 (twice,) and 12/27/2024.
-Paroxetine HCL 10 mg tablets- missed 2 doses (medication not arrived) unable to locate physician notification of missing medications on 12/12/2024 and 12/13/2024.

Resident 2's record review included MARs dated January 2025 that showed Resident 2 missed the following medications:

-Hydroxyzine HCL 25 mgs tablets (2) – missed 4 doses (medication not arrived, needs re-ordered and unable to locate during the time the medication was due) unable to locate physician notification of missing medications on 01/06/2025, 01/13/2025,

01/14/2025 and 01/29/2025.
-Acetaminophen 500 mg tablet – missed 3 doses (medication not arrived) unable to locate physician notification of missing medications on 01/26/2025 (twice) and 01/27/2025.

Resident 2's record review included a Resident Temporary Care Plan (TCP) dated 11/06/2024, written by Staff D, Assisted Living Director, that showed the resident returned to the facility on [redacted]/2024 following a stay in another facility for rehabilitation services, (structured program of exercises to build strength and improve balance.) The TCP showed Resident 2 needed full staff assistance with activities of daily living and had increased anxiety upon their return.

During an interview on 02/06/2025 at 4:00 PM, Staff E, previous Assisted Living Director (ALD), reported they had been reassigned from front desk receptionist to fill in as ALD, because the previous director left. Staff E stated they had not received any training on how the medication system worked and what the process was when a new medication order was received. Staff E stated this resulted in residents not receiving their prescribed medications for several days, including Resident 2.

During an interview on 02/15/2025 at 10:02 AM, Collateral Contact 6, (CC6), anonymous staff, stated Resident 2 was out of the facility getting therapy and when the resident returned to the facility, they were weaker, appeared anxious all the time and more confused. CC6 reported Resident 2 was so nervous their arms always shook.

During an interview on 04/07/2025 at 5:52 PM, Collateral Contact 1 (CC1), Resident representative stated Resident 2 began to develop more confusion, paranoid and anxious behavior in January 2025. CC1 reported Resident 2 required more assistance from staff during this time. CC1 stated they often found pills left sitting in a cup on a table near their couch, lying on the floor and in the garbage can although they had asked the staff to stay with Resident 2 until they swallowed the medication. CC1 stated they made the decision to move the resident to another setting because they did not feel they were getting the cares they needed and paid for.

Resident 3

Resident 3's medical record review included an RSP, dated 10/07/2024, showed the resident had recently had a stroke (when the blood flow to the brain is interrupted, resulting in brain injury or death) that left them unable to move the left side of their body. The RSP showed the resident had insulin dependent diabetes mellitus, (when the body does not make or use insulin needed to maintain blood sugar readings within normal limits.) The RSP showed the resident required staff assistance to administer the insulin (medication given just under the skin to keep their blood sugar readings within normal limits) and oral medications.

Resident 3's medical record review included the following physician orders:

-Clopidogrel Bisulfate (a medication used to prevent strokes or blood clots) 75 mg tablet by mouth every day, ordered 10/08/2024.
-Metformin HCL (a medication used to prevent high blood sugar levels) 500 mg 2 tablets by mouth twice a day, ordered 12/27/2024.
-Metoprolol Succinate ER (a medication used to help the blood flow through the arteries and veins) 50 mg tablet by mouth every day, ordered 10/08/2024.
-Torsemide (a medication to prevent fluid retention) 20 mg tablet by mouth every day, ordered 11/19/2024.
-Atorvastatin Calcium (a medication used to reduce cholesterol levels) 40 mg, half a tablet by mouth every evening, ordered 10/07/2024.

Resident 3's medical record included MARs dated January 2025 that showed Resident 3 missed the following medications:

-Clopidogrel Bisulfate – missed 36 doses (medication not available and physically unable to take) unable to locate physician notification of missing medications on 01/09/2025, 01/18/2025 and 01/19/2025.
-Metformin HCL- missed 3 doses (medication not available and physically unable to take) unable to locate physician notification of missing medications on 01/09/2025, 01/11/2025, and 01/18/2025.
-Metoprolol Succinate ER – missed 3 doses (medication not available and physically unable to take) unable to locate physician notification of missing medications on 01/09/2025, 01/18/2025 and 01/19/2025.
-Torsemide – missed 3 doses (medication not available and unable to swallow) unable to locate physician notification of missing medications on 01/09/2025, 01/18/2025 and 01/19/2025.
-Atorvastatin Calcium – missed 2 doses (medication not available and unable to take) unable to locate physician notification of missing medications on 01/09/2025 and 01/11/2025.

Resident 4

Resident 4's record review included an RSP dated 01/06/2025, that showed the resident was diabetic. The RSP showed the resident had insulin dependent diabetes mellitus (when the body does not make or use insulin needed to maintain blood sugar readings within normal limits.) The RSP showed the resident required staff assistance to administer the insulin (medication given just under the skin to keep their blood sugar readings within normal limits) and oral medications.

Resident 4's medical record review included a physician order dated 06/05/2024, directed staff to remind the resident to check their blood sugar levels and assist with giving their 15 ml bolus (a single dose of medication given all at once) before each meal. The physician order did not include the name/type of the insulin (either short or long-acting insulin) the resident received with the bolus.

Resident 4's medical record review included a progress note, dated 12/06/2024, written by Staff G, Medication Aide, that showed Resident 4 slurred was slurring their words and when they checked their glucose meter it was not functioning. Staff G documented they checked Resident 4'stheir blood sugar manually and it was 21 mg/dl (measure of milligrams of sugar per deciliter of blood, with the recommended range of 70-180.) Staff G documented Resident 4 was sent by ambulance to the hospital.

The next progress note dated 12/08/2024, written by Staff G showed Resident 4 returned to the facility after a "major blood sugar drop and malfunctioning glucose (sugar) pump." Staff G documented a physician at the hospital recommended dropping Resident 4's insulin doses by 20% and finding a secondary way of delivering insulin. The record did not include evidence showing Resident 4's physician was notified of the recommendation or action taken by the facility to follow up with the recommendation.

Observation on 02/04/2025 at 11:40 AM, showed Resident 4 was seated in their recliner, and on the table next to their chair was an aerosol inhaler for Albuterol (a medication used to treat shortness of breath) and a prescription bottle with several pills, labeled Amoxicillin (an antibiotic used to treat infections) 500 mg twice a day, filled 12/14/2025. Resident 4 stated the staff helped him with his medications, reported they had been to the hospital a couple of times and thought it was one of those times the antibiotics were ordered. Resident 4 could not recall the dates but stated they had pneumonia and trouble with their blood sugars.

Observation on 02/04/2025 at 11:44 AM, when Staff D entered Resident 4's room and announced they needed to check their blood sugar before lunch. Staff D stated they weren't sure why the medications were left unattended with the resident. Staff D stated Resident 4 had a Libre sensor (a continuous glucose monitoring (CGM) system that uses a small sensor applied to the back of the arm to measure glucose levels in interstitial fluid)) and an insulin pump (a small, computerized device that delivers the insulin through a thin tube under the skin). Staff D stated they were not able to get a blood sugar reading because the sensor disk needed replaced. Staff D stated Resident 4 received a bolus of insulin with the pump before meals. Staff D did not attempt to obtain a blood sugar reading using an alternate method and did not know which insulin or how much insulin they received with the pump.

During an interview on 02/06/2025 at 4:00 PM, Staff E reported Resident 4's pump and sensor often malfunctioned, beeping continuously and they would have to silence the alarms. Staff E reported none of the staff were trained to manage either device.

Resident 5

Resident 5's record review included an RSP dated 10/25/2024, that showed the resident was diabetic. The RSP showed the resident had insulin dependent diabetes mellitus, (when the body does not make or use insulin needed to maintain blood sugar readings within normal limits.) The RSP showed the resident required staff assistance to administer the insulin (medication given just under the skin to keep their blood sugar readings within normal limits) and oral medications.

Resident 5's record review included the following physician orders:

-Warfarin Sodium (a medication used to prevent heart attacks and strokes) 5 mg by mouth daily, ordered 11/20/2024.
- Levetiracetam (a medication used to prevent seizures) 25 mg by mouth daily, ordered 12/30/2023.
-Insulin Glargine (a long-acting insulin injected under the skin to help prevent elevated blood sugar readings) 100 unit/ml. 12 units daily, ordered 06/26/2024.
-Insulin Aspart (a rapid-acting insulin injected under the skin to help prevent elevated blood sugar readings) 100 unit/ml, 10 units with meals daily, ordered
05/07/2024.
-Topiramate (a medication used to prevent seizures and treat migraine headaches) 25 mg by mouth daily, ordered 12/30/2024.
-Magnesium Oxide (a mineral supplement) 400 mg by mouth daily, ordered 04/09/2024.
-Omeprazole 20 mg (a medication used to prevent stomach upset) 20 mg by mouth daily, ordered 12/30/2023.
-Prednisolone Acetate, 1% suspension (eye drops used to reduce elevated eye pressure) 1 drop in the right eye twice daily, ordered 12/29/2023.
-Jardiance (medication used to lower blood sugar levels) 25 mg by mouth daily, ordered 12/30/2023.
-Losartan Potassium (a medication used to prevent high blood pressure) 25 mg by mouth daily, ordered 12/30/2023.
-Tamsulosin HCL (a medication used to prevent urinary retention) 0.4 mg by mouth daily ordered, 12/29/2023.
-Atorvastatin Calcium (a medication used to reduce the risk of heart disease) 40 mg by mouth daily, ordered 12/29/2023.

Resident 5's record review included December 2024 MARs that showed the resident missed the following medications:

-Warfarin Sodium 5 mg – missed 2 doses (unable to find medication) unable to locate physician notification of missing medications on 12/02/2024 and 12/03/2024.
-Levetiracetam 750 mg- missed 3 doses (medication not arrived) unable to locate physician notification of missing medications on 12/24/2024, 12/25/2024 and 12/26/2024.
-Insulin Glargine – missed 1 dose (blood sugar was too low) unable to locate parameters

for holding the medication and physician notification of the missing medication on 12/20/2024.
-Insulin Aspart – missed 1 dose (blood sugar was too low) unable to locate parameters for holding the medication and physician notification of the missing medication on 12/20/2024.
-Topiromate – missed 3 doses (medication not arrived) unable to locate physician notification of missing medications on 12/24/2024, 12/25/2024 and 12/26/2024.
-Magnesium Oxide – missed 2 doses (medication not arrived) unable to locate physician notification of missing medications on 12/24/2024 and 12/25/2024.
-Omeprazole – missed 3 doses (medication not arrived) unable to locate physician notification of missing medications on 12/24/2024, 12/25/2024 and 12/25/2024.
-Prednisolone Acetate – missed 1 dose (medication not arrived) unable to locate physician notification of missing medication on 12/24/2024.
-Jardiance – missed 3 doses (medication not arrived) unable to locate physician notification of missing medications on 12/24/2024, 12/25/2024 and 12/26/2024.
-Losartan Potassium – missed 3 doses (medication not arrived) unable to locate physician notification of missing medications 12/24/2024, 12/25/2024 and12/26/2024.
-Tamsulosin – missed 2 doses (medication not arrived) unable to locate physician notification of missing medications on 12/24/2024 and 12/25/2024.
-Atorvastatin Calcium – missed 2 doses (medication not arrived) unable to locate physician notification of missing medications on 12/24/2024 and 12/25/2024.

Resident 5's record review included a clinic note dated 12/03/2024, that showed the resident was evaluated for high blood pressure, swelling in both legs and phlebitis (inflammation of a vein in the leg.) The clinic note included the following physician orders:

-Blood pressure checked daily with a goal reading below 130/80 ordered 12/03/2024.
-Losartan (a medication used to prevent high blood pressure) 25mg by mouth daily ordered 12/03/2024.
-Doxycyline Hyate (an antibiotic used to treat infections) 100 mg capsule by mouth for 5 days ordered 12/03/2024.
-Aspirin (a medication used to thin blood to prevent strokes) 325 mg tablet by mouth every day ordered 12/03/2024.

Resident 5's record review included December 2024 MARs that showed the resident missed the following medications/orders:

-Missed blood pressure checks daily 12/04/2024 through 12/31/2025.
-Doxycyline Hyate – missed 10 doses (medication not transcribed/ordered when received) unable to locate physician notification of missing medications on 12/03/2023, 12/04/2024, 12/05/2024, 12/06/2024 and 12/07/2024.
Losartan – received an additional 25 mg daily for 28 days (without facility clarification of dosage) unable to locate physician notification of medication errors 12/04/2024 through 12/31/2024.
-Aspirin – missed 28 doses medication not transcribed/ordered when received) unable to locate physician notification of missing medications on 12/04/2024 through12/31/2024.

Resident 5's record review included January 2025 MARs that showed the resident missed the following medications/orders:

-Missed blood pressure checks daily 01/01/2025 through 01/31/2025.
-Losartan – received an additional 25 mg daily for 31 days (without facility clarification of dosage) unable to locate physician notification of medication errors on 01/0/2025 through 01/31/2025.
-Aspirin – missed 31 doses medication not transcribed/ordered when received, unable to locate physician notification of medication errors on 01/01/2025 through 01/31/2025.

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) 6/27/2025 .

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

Administrator (or Representative) 5/22/25 Date

WAC 388-78A-2690 Electronic monitoring equipment Resident requested use.

(1) Audio or video monitoring equipment may not be installed in the assisted living facility to monitor any resident apartment or sleeping area unless the resident or the residents' representative has requested and consents to the monitoring.

(5) The release of audio or video monitoring recordings by the facility is prohibited. Each person or organization with access to the electronic monitoring must be identified in the resident's negotiated service agreement.

(7) The assisted living facility must:

(a) Reevaluate the need for the electronic monitoring with the resident at least quarterly; and

(b) Have each reevaluation in writing, signed and dated by the resident.

(10) For the purposes of consenting to any audio electronic monitoring, the term "resident" includes:

(a) The individual residing in the assisted living facility; or

Resident 5's record review included January 2025 MARs that showed the resident missed the following medications/orders:

-Missed blood pressure checks daily 01/01/2025 through 01/31/2025.
-Losartan – received an additional 25 mg daily for 31 days (without facility clarification of dosage) unable to locate physician notification of medication errors on 01/0/2025 through 01/31/2025.
-Aspirin – missed 31 doses medication not transcribed/ordered when received, unable to locate physician notification of medication errors on 01/01/2025 through 01/31/2025.

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

WAC 388-78A-2690 Electronic monitoring equipment Resident requested use.

(1) Audio or video monitoring equipment may not be installed in the assisted living facility to monitor any resident apartment or sleeping area unless the resident or the residents' representative has requested and consents to the monitoring.

(5) The release of audio or video monitoring recordings by the facility is prohibited. Each person or organization with access to the electronic monitoring must be identified in the resident's negotiated service agreement.

(7) The assisted living facility must:

(a) Reevaluate the need for the electronic monitoring with the resident at least quarterly; and

(b) Have each reevaluation in writing, signed and dated by the resident.

(10) For the purposes of consenting to any audio electronic monitoring, the term "resident" includes:

(a) The individual residing in the assisted living facility; or

(b) The resident's court-appointed guardian or attorney-in-fact who has obtained a court order specifically authorizing the court-appointed guardian or attorney-in-fact to consent to electronic monitoring of the resident.

(11) If a resident's decision maker consents to audio electronic monitoring as specified in (10) above, the assisted living facility must maintain a copy of the court order authorizing such consent in the resident's record.

(12) If the assisted living facility determines that a resident, resident's family, or other third party is electronically monitoring a resident's room or apartment without complying with the requirements of this section, the assisted living facility must disconnect or remove such equipment until the appropriate consent is obtained and notice given as required by this section.

This requirement was not met as evidenced by:

Based on interview, observation and record review, the Assisted Living Facility (ALF) failed to ensure the electronic monitoring equipment requested by the representative met the requirements for 3 of 3 residents (Resident 1, 6 and 7.) These failures left residents at risk of their privacy being violated when both audio and visual monitoring occurred in their apartments.

Findings included…

Review of the facility policy titled “Electronic Monitoring Equipment: Audio and Video Cameras ADM 1-00.9” undated, showed the Community, Power of Attorney (POA) Conservator and/or the resident representative would always prioritize the dignity and privacy of the resident first. The policy showed that before any electronic monitoring occurs that the ALF would ensure that the monitoring would not violate chapter 9.73 of the Revised Code of Washington (RCW).

- The resident should indicate approval for video monitoring in their apartment with specific duration for monitoring in writing.
- A resident representative or POA is not authorized to make the decision to monitor even if the resident is in memory care.
- The resident must have signage on the apartment door upon entering regarding the monitoring occurring. Unless the representative is a court appointed guardian the resident must agree and be present at the signing of the monitoring agreement. (Even if the resident is nonverbal).
- The agreement must include the signed agreement if they decide to install the camera including why and where.
- The agreement will be held in the residents’ file and documented in the Resident Service Plan.
- The assisted living must reevaluate the need for the electronic monitoring at least quarterly and have it signed and dated.
- The resident representative or POA/Conservator shall be mindful of the resident’s rights and will not place the camera in a designated area that will violate the resident's privacy and dignity.

• The ALF must immediately stop electronic monitoring if the resident no longer wishes to have the electronic monitoring.

Resident 1

Review of Resident 1's ALF Resident Service Plan (RSP) dated 10/28/2024, showed that Resident 1 had a diagnosis of [redacted].
The NSA showed there was a change in ability to maintain balance, left Resident 1 with decreased mobility and at risk of falls. Resident 1's RSP showed no documentation related to resident requested electronic monitoring or the need for consent and re-evaluation of the monitoring.

During an onsite visit on 04/01/2025 at 7:15 AM, two cameras were observed in Resident 1's apartment. One camera covered the entrance to the apartment and the other was focused on the resident's living room. No signage was on the apartment door to indicate electronic monitoring was in place.

During an interview on 04/01/2025 at 7:20 AM, Collateral Contact 2 (CC2), Resident 1's representative, stated that the camera footage was able to be viewed, on an application, on their cellular phone.

In a further interview on 04/25/2025 at 2:28 PM, CC2 stated that the cameras had been installed 07/10/2024 at 1:00 PM.

Resident 6
Review of Resident 6's RSP dated 01/22/2025, showed that Resident 6 had a diagnosis of a [redacted] and required hands on assistance with their Activities of Daily Living (ADL's). Resident 6's RSP showed no documentation related to resident requested electronic monitoring or the need for consent and re-evaluation of the monitoring.

During an onsite visit on 05/01/2025 at 11:38 AM, two cameras were observed in Resident 6's apartment. One camera was in the front window and focused on the apartment and the other was in the resident's bedroom focused on the foot of the bed and toward the dresser.

During an interview on 04/07/2025 at 8:53 AM, Collateral Contact 6 (CC6), Resident representative, reported Resident 6 had two cameras in their apartment. They stated they placed a camera in the resident's living room and another in their bedroom. They stated whenever there was motion in either room a notification was sent to their personal phone, and they were able to see and hear what the resident was doing at the time. CC6 stated they were advised to do so by Staff H, Medication Aide, several weeks prior. CC6 stated Staff A, Assistant Executive Director, was aware of the cameras and they had not signed a consent form.

Resident 7

Review of Resident 7's RSP dated 03/11/2025, showed that Resident 7 had diagnoses including [redacted], and needed frequent safety checks. Resident 7's RSP showed no documentation related to resident requested electronic monitoring or the need for consent and re-evaluation of the monitoring.

During an onsite visit on 05/01/2025 at 11:13 AM two cameras were observed in Resident 7's apartment. One camera was in the front window and focused on the apartment and the other was in the resident's bedroom focused on the foot of the bed.

During an interview on 04/30/2025 at 9:37 AM, Collateral Contact 4 (CC4) and Collateral Contact 5 (CC5), Resident representatives stated they had installed the camera at the time of admission on [redacted]/2023 for peace of mind as Resident 7 has had a broken back and now pneumonia. CC5 stated that they did not recall signing any consent for the electronic monitoring at any time during Resident 7's stay.

During an interview on 04/01/2025 at 9:45 AM with Staff A, Assistant Executive Director, stated that there were two cameras present in Resident 1's apartment. Staff D, Resident Care Coordinator (RCC) stated that two other residents [Resident 6 and 7] had cameras in their apartment that the facility was aware of. Staff A and D stated that they were not aware that the facility needed to have consent for the monitoring equipment.

During an interview on 04/08/2025 at 11:00 AM Staff C, Executive Director stated that they had just started working at the facility three weeks prior. They stated that they determined there were three resident apartments [Resident 1, 6 and 7] with electronic monitoring that had both audio and visual components being used. The residents did not have evaluations or consents in place for monitoring.

As of 05/01/2025, the cameras remained in place and used by the residents [Resident 1, 6 and 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, BONAVENTURE OF THE TRI-CITIES is or will be in compliance with this law and / or regulation on (Date) 6/27/2025 .

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

Administrator (or Representative) 5/22/2025 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

This requirement was not met as evidenced by:

Based on observations, interviews and record reviews, the assisted living facility (ALF) failed to investigate, determine circumstances of falls and develop preventive measures for 2 of 3 residents (Resident 1 and 2) identified as high risk for falling. This failure resulted in repeated falls with the potential of significant injury.

Findings included...

Resident 1

Resident 1's record review included a Resident Service Plan (RSP), dated 07/30/2025, that showed the resident had a history of Parkinson's disease (progressive neurologic disease that affects movement) with symptoms that included weakness and falls. The RSP showed Resident required staff assistance with all activities of daily living. The RSP showed there was a change in the ability to maintain balance, leaving Resident 1 with decreased mobility and at risk of falls.

Record review of the facility Charting Notes, dated 03/19/2025, showed that Resident 1 was found on the floor on 03/18/2024 at 11:30 PM.

During an interview on 03/31/2025 at 8:15 PM, Collateral Contact 5, (CC5) resident representative, stated that on 03/18/2024 at 11:30 PM they noticed Resident 1 lying on the floor when they checked their camera application on their phone. CC5 stated they

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

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

This requirement was not met as evidenced by:

Based on observations, interviews and record reviews, the assisted living facility (ALF) failed to investigate, determine circumstances of falls and develop preventive measures for 2 of 3 residents (Resident 1 and 2) identified as high risk for falling. This failure resulted in repeated falls with the potential of significant injury.

Findings included…

Resident 1

Resident 1's record review included a Resident Service Plan (RSP), dated 07/30/2025, that showed the resident had a history of Parkinson's disease (progressive neurologic disease that affects movement) with symptoms that included weakness and falls. The RSP showed Resident required staff assistance with all activities of daily living. The RSP showed there was a change in the ability to maintain balance, leaving Resident 1 with decreased mobility and at risk of falls.

Record review of the facility Charting Notes, dated 03/19/2025, showed that Resident 1 was found on the floor on 03/18/2024 at 11:30 PM.

During an interview on 03/31/2025 at 8:15 PM, Collateral Contact 5, (CC5) resident representative, stated that on 03/18/2024 at 11:30 PM they noticed Resident 1 lying on the floor when they checked their camera application on their phone. CC5 stated they

immediately phoned the facility multiple times but there was no answer. CC5 stated they drove to the facility and notified the facility staff when they arrived that the resident had been on the floor for over two hours. CC5 stated that there was no follow up from the facility regarding the fall.

Resident 1's record review showed no incident reports or investigations were completed to determine the cause of the fall or why they were on the floor without staff assistance. Review of the record showed no documentation of any interventions to prevent falls. Further review of the record showed no documentation addressing why the resident's representative was unable to notify facility staff via phone call of the need for resident assistance.

Resident 2

Resident 2's record review included a Resident Service Plan, (RSP) dated 11/27/2024 that showed the resident was sent to the hospital for increased weakness on 10/24/2024 and returned to the facility on [redacted]/2024. was recently in rehabilitation for increased weakness. The RSP showed Resident 2 needed staff assistance and needed staff assistance with mobility and activities of daily living. The RSP showed Resident was a fall risk with a history of several falls.

Resident 2's record review included the review of several incident reports dated 12/31/2024 through 02/09/2025 that showed the resident had nine falls that occurred on the evening shift.

Resident 2's record review included the following incident reports:

- An incident report dated 12/31/2024 at 7:00 PM, showed staff found Resident 2 on the floor when they entered their room. Resident 2's record did not include documentation showing the circumstances of the fall or documentation of preventative interventions regarding falls.
- An incident report dated 01/02/2025 at 5:30 PM, showed Resident 2 was found on the floor by a visitor. Resident 2's record did not include documentation showing the circumstances of the fall or documentation of preventative interventions regarding falls.
- An incident report dated 01/05/2025 at 9:25 PM, showed Resident 2 was found on the floor by staff when they entered their room. Resident 2's record did not include documentation showing the circumstances of the fall or documentation of preventative interventions regarding falls.
- An incident report dated 01/11/2025 at 9:55 PM, showed Resident 2 was found on the floor by staff when they entered their room. Resident 2's record did not include documentation showing the circumstances of the fall or documentation of preventative interventions regarding falls.
- An incident report dated 02/02/2025 at 9:00 PM, showed Resident 2 was found on the floor by staff when they entered their room. Resident 2's record did not include documentation of the circumstances of the fall until 04/08/2025, 65 days after the fall. Resident 2's record did not include documentation of preventative interventions

regarding falls.
• An incident report dated 02/04/2025 at 5:30 PM, showed Resident 2 was found on the floor by staff when they entered their room. Resident 2's record did not include documentation of the circumstances of the fall or documentation of preventative interventions regarding falls.
• An incident report dated 02/05/2025 at 4:50 PM, showed Resident 2 was found on the floor by staff when they entered their room. Resident 2's record did not include documentation of the circumstances of the fall or documentation of preventative interventions regarding falls.
• An incident report dated 02/09/2025 at 3:00 PM, showed Resident 2 was found on the floor by staff when they entered their room. Resident 2's record did not include documentation of the circumstances of the fall or documentation of preventative interventions regarding falls.

During an interview on 01/22/2025 at 12:47 PM, Staff A, Assistant Executive Director, reported the facility practice for investigations was the first responder (first person aware of an incident either by witnessing or hearing it from another source) initiated an incident report with the details of what occurred and when. Staff A stated they and Staff D, Assisted Living Director, worked together to complete the investigation and make any changes to the residents' care plans as needed.

During an interview on 02/15/2025 at 10:02 AM, CC 6, Anonymous, stated they were trained that anytime a fall occurred, or someone got injured they were supposed to complete an incident report and notify Staff A & D. CC 6 reported they notified the residents' family at the time of the fall and notified their physician by sending a faxed message to their office.

During an interview on 04/04/2025 at 9:54 AM, Staff A reported the facility used the two-page incident reports, the first page was initiated by the staff that first became aware of an incident. Staff A stated the second page was used as an investigation worksheet and should include the investigative actions, what the cause of the incident was and what measures they took to prevent recurrence. Staff A stated if there were any incident reports without the investigative worksheet completed and signed off, they may not have received the incident report from the first responder.

Statement of Deficiencies	License #: 2015	Compliance Determination # 53366
Plan of Correction	BONAVENTURE OF THE TRI-CITIES	Completion Date
Page 16 of 16	Licensee: RIVERTON RETIREMENT & ASSISTED LIVING COMMUNITY LLC	05/15/2025

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) 6/27/2025 .

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

Administrator (or Representative) 5/22/2025 Date

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