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

AMENDED

BONAVENTURE OF EAST WENATCHEE LLC
BONAVENTURE OF EAST WENATCHEE
3425 Boone Rd., SE
SALEM, OR 97317

RE: BONAVENTURE OF EAST WENATCHEE License # 2026

Dear Administrator:

This letter addresses Compliance Determination(s) 42653 (Completion Date 06/14/2024) and 35545 (Completion Date 04/18/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/14/2024 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-2630-1-b, WAC 388-78A-2630-1-a, WAC 388-78A-2630-1, WAC 388-78A-2600-2-a, WAC 388-78A-2660-7

The Department staff who did the on-site verification:
Nicole Velazquez, Community Complaint Investigator
Michelle Closner, Complaint Nurse Field Manager

If you have any questions, please contact me at (509)572-7394.

Sincerely,

Michelle Closner

Michelle Closner, Field Manager
Region 1, Unit C
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: BONAVENTURE OF EAST WENATCHEE
Provider Type: Assisted Living Facility
License/Cert.#: 2026
Intake ID: 114544
Compliance Determination #: 35545
Region/Unit #: RCS Region 1 / Unit G
Investigator: Nicole Velazquez
Investigation Date(s): 01/22/2024 through 04/18/2024
Complainant Contact Date(s):

Allegation(s):
A named resident was sexually abused.

Investigation Methods:

Sample:	Total residents: 52 Resident sample size: 4 Closed records sample size: 1
Observations:	Environment, Staff to resident interactions, Staff availability and response to resident's needs.
Interviews:	Residents, Staff and others not associated with the facility.
Record Reviews:	Characteristic roster, Resident Records, Facility Policy, Facility incident report and investigation, Personnel records, Local Law Enforcement Incident Report.

Investigation Summary:
Staff interview and record review showed that the named resident was sexually abused by staff and the facility failed to implement their policy, protect the resident and make reports to the department and Local Law Enforcement when there was an allegation of abuse.
Failed Practices Identified, WAC 388-78A-2600, WAC 388-78A-2630, and WAC 388-78A-2660; reference Statement of Deficiencies dated 04/08/2024.

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 EAST WENATCHEE
Provider Type: Assisted Living Facility
License/Cert.#: 2026
Intake ID: 117619
Compliance Determination #: 35545
Region/Unit #: RCS Region 1 / Unit G
Investigator: Nicole Velazquez
Investigation Date(s): 01/22/2024 through 04/18/2024
Complainant Contact Date(s): 02/06/2024, 03/19/2024

Allegation(s):

1) A named resident was sexually abused.
2) The facility did not make appropriate notifications to the named resident's family after an incident.

Investigation Methods:

Sample:	Total residents: 52 Resident sample size: 4 Closed records sample size: 1
Observations:	Environment, Cares, Residents, Staff to resident interactions, Staff availability and response to resident's needs.
Interviews:	Residents, Staff and others not associated with the facility.
Record Reviews:	Characteristic roster, Resident Records, Facility Policy, Facility incident report and investigation, Personnel records, Local Law Enforcement Incident Report.

Investigation Summary:

1) Observations showed residents were clean and groomed. Staff were observed to be available and responsive to resident's needs. Staff interview and record review showed that the named resident was sexually abused by staff and the facility failed to make reports to the department and Local Law Enforcement when there was an allegation of abuse.
Failed Practices Identified, WAC 388-78A-2660 and WAC 388-78A-2630 reference Statement of Deficiencies dated 04/08/2024.
2) Interviews and record review showed that the facility notified the family of the allegation and the named resident's family was aware of the incident. No failures 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 #: 2026	Compliance Determination # 35545
Plan of Correction	BONAVENTURE OF EAST WENATCHEE	Completion Date
Page 1 of 7	Licensee: BONAVENTURE OF EAST WENATCHEE LLC	04/18/2024

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 01/22/2024, 01/22/2024, 02/21/2024 and 02/21/2024 of:

BONAVENTURE OF EAST WENATCHEE
50 29TH STREET NW
EAST WENATCHEE, WA 98802

This document references the following complaint number(s): 108875, 114544, 111237, 113107, 117619

The following sample was selected for review during the unannounced on-site visit; 4 of 52 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Nicole Velazquez, 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.

Gwin Kaercher
Residential Care Services

04/30/2024
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.

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 01/22/2024, 01/22/2024, 02/21/2024 and 02/21/2024 of:

BONAVENTURE OF EAST WENATCHEE
50 29TH STREET NW
EAST WENATCHEE, WA 98802

This document references the following complaint number(s): 108875, 114544, 111237, 113107, 117619

The following sample was selected for review during the unannounced on-site visit: 4 of 52 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Nicole Velazquez, 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.

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) 5-9-2024 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

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure an allegation of sexual abuse was immediately reported to Local Law Enforcement (LLE) and to the department's Complaint Resolution Unit (CRU) hotline by 4 of 4 staff (Staff B, C, D, E). This failure resulted in a delayed investigation by the department and LLE.

Findings included...

The facility policy titled, "Abuse, Neglect or Exploitation Policy," undated, showed that any staff member who had a reason to suspect an incident of sexual abuse had occurred, will notify CRU and make a call to LLE as soon as the resident is protected from further harm.

WAC 388-78A-2020 defines Abuse as the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult. Sexual abuse means any form of nonconsensual sexual conduct, including, but not limited to, unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse also includes any sexual conduct between a staff person and a vulnerable adult living in that facility whether or not it is consensual.

Review of facility incident report dated 01/12/2024 showed that at 9:00 PM, Staff C, Caregiver had observed Staff A, Caregiver, touching, shaking and jiggling (fondling), Resident 1's breasts. The document further showed that CRU and LLE were not notified until 01/13/2024 at 6:07 PM.

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

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure an allegation of sexual abuse was immediately reported to Local Law Enforcement (LLE) and to the department's Complaint Resolution Unit (CRU) hotline by 4 of 4 staff (Staff B, C, D, E). This failure resulted in a delayed investigation by the department and LLE.

Findings included…

The facility policy titled, “Abuse, Neglect or Exploitation Policy,” undated, showed that any staff member who had a reason to suspect an incident of sexual abuse had occurred, will notify CRU and make a call to LLE as soon as the resident is protected from further harm.

WAC 388-78A-2020 defines Abuse as the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult. Sexual abuse means any form of nonconsensual sexual conduct, including, but not limited to, unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse also includes any sexual conduct between a staff person and a vulnerable adult living in that facility whether or not it is consensual.

Review of facility incident report dated 01/12/2024 showed that at 9:00 PM, Staff C, Caregiver had observed Staff A, Caregiver, touching, shaking and jiggling (fondling), Resident 1’s breasts. The document further showed that CRU and LLE were not notified until 01/13/2024 at 6:07 PM.

Statement of Deficiencies	License #: 2026	Compliance Determination # 35545
Plan of Correction	BONAVENTURE OF EAST WENATCHEE	Completion Date
Page 3 of 7	Licensee: BONAVENTURE OF EAST WENATCHEE LLC	04/18/2024

During an interview on 01/22/2024 at 1:55 PM, Staff E, Administrator, stated that they had been notified of the incident on the night of the incident, 01/12/2024; however, reports to CRU and LLE were not made until 01/13/2024.

During an interview on 02/21/2024 at 2:23 PM, Staff B, Medication Technician, stated that they did not make a report to CRU or LLE when they had been told by Staff C that Staff A had sexually abused Resident 1.

During an interview on 02/27/2024 at 1:07 PM, Staff D, Memory Care Director, stated that they did not call CRU or LLE on 01/12/2024 when they were notified of the sexual abuse of Resident 1 by Staff A.

During an interview on 03/15/2024 at 4:53 PM, Staff C, Caregiver, stated that when they observed the sexual abuse by Staff A toward Resident 1, they did not make a report to CRU or LLE.

This is a recurring deficiency previously cited on 12/21/2022 subsection (1)(a).

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 EAST WENATCHEE is or will be in compliance with this law and / or regulation on (Date) 6-1-2024

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

Linda K Chandler 5.9.2024

Administrator (or Representative) Date

WAC 388-78A-2600 Policies and procedures.

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

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to implement and train staff on the facility's policy regarding what staff were to do to protect a resident if they witnessed sexual abuse for 1 of 1 resident (Resident 1). These failures resulted in a staff (Staff A) who had sexually abused a resident, continuing to provide care to residents

During an interview on 01/22/2024 at 1:55 PM, Staff E, Administrator, stated that they had been notified of the incident on the night of the incident, 01/12/2024; however, reports to CRU and LLE were not made until 01/13/2024.

During an interview on 02/21/2024 at 2:23 PM, Staff B, Medication Technician, stated that they did not make a report to CRU or LLE when they had been told by Staff C that Staff A had sexually abused Resident 1.

During an interview on 02/27/2024 at 1:07 PM, Staff D, Memory Care Director, stated that they did not call CRU or LLE on 01/12/2024 when they were notified of the sexual abuse of Resident 1 by Staff A.

During an interview on 03/15/2024 at 4:53 PM, Staff C, Caregiver, stated that when they observed the sexual abuse by Staff A toward Resident 1, they did not make a report to CRU or LLE.

This is a recurring deficiency previously cited on 12/21/2022 subsection (1)(a).

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 EAST WENATCHEE 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-2600 Policies and procedures.

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

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to implement and train staff on the facility's policy regarding what staff were to do to protect a resident if they witnessed sexual abuse for 1 of 1 resident (Resident 1). These failures resulted in a staff (Staff A) who had sexually abused a resident, continuing to provide care to residents

unsupervised.

Findings included...

Record review of facility policy titled, "Abuse, Neglect or Exploitation Policy," undated, showed the facility staff were to receive training on abuse, neglect, and exploitation at least annually. The policy further stated that the facility staff's responsibility was to protect the named resident from further harm by assuring [sic] the alleged perpetrator was kept away from the resident or other residents.

WAC 388-78A-2020 defines Abuse as the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult. Sexual abuse means any form of nonconsensual sexual conduct, including, but not limited to, unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse also includes any sexual conduct between a staff person and a vulnerable adult living in that facility whether or not it is consensual.

Facility incident report dated 01/12/2024 at 9:00 PM, showed that at approximately 9:00 PM, Staff C, Caregiver observed Staff A, Caregiver, touching, shaking and jiggling (fondling), Resident 1's breasts. Staff C then walked out of the room and proceeded to call Staff D, Memory Care Director to inform Staff D of their observations.

During an interview on 02/27/2024 at 1:07 PM, Staff D, Memory Care Director, stated that Staff C had reported to them that they had left Resident 1's room to call Staff D and left Staff A with Resident 1 after observing Staff A abuse Resident 1. Staff D further stated that they there had not been any staff training on how staff were to respond if staff were to observe an incident of abuse.

During an interview on 03/15/2024, Staff C, Caregiver, stated that they had left Staff A in Resident 1's room with Resident 1 after the observed sexual abuse and had not intervened to stop Staff A. They further stated that they had not received abuse training on how to intervene in an abuse situation and that they did not know how to respond.

During an interview on 03/29/2024 at 1:31 PM with Staff E, Administrator, stated that they have not trained staff on how to respond and protect residents if they were to walk in on an abuse situation.

Record review of Staff A's facility timecard for 01/12/2024 showed that Staff A did not clock out until the end of their shift at 9:57 PM, one hour after observed abusing Resident

unsupervised.

Findings included…

Record review of facility policy titled, “Abuse, Neglect or Exploitation Policy,” undated, showed the facility staff were to receive training on abuse, neglect, and exploitation at least annually. The policy further stated that the facility staff’s responsibility was to protect the named resident from further harm by assuring [sic] the alleged perpetrator was kept away from the resident or other residents.

WAC 388-78A-2020 defines Abuse as the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult. Sexual abuse means any form of nonconsensual sexual conduct, including, but not limited to, unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse also includes any sexual conduct between a staff person and a vulnerable adult living in that facility whether or not it is consensual.

Facility incident report dated 01/12/2024 at 9:00 PM, showed that at approximately 9:00 PM, Staff C, Caregiver observed Staff A, Caregiver, touching, shaking and jiggling (fondling), Resident 1’s breasts. Staff C then walked out of the room and proceeded to call Staff D, Memory Care Director to inform Staff D of their observations.

During an interview on 02/27/2024 at 1:07 PM, Staff D, Memory Care Director, stated that Staff C had reported to them that they had left Resident 1’s room to call Staff D and left Staff A with Resident 1 after observing Staff A abuse Resident 1. Staff D further stated that they there had not been any staff training on how staff were to respond if staff were to observe an incident of abuse.

During an interview on 03/15/2024, Staff C, Caregiver, stated that they had left Staff A in Resident 1’s room with Resident 1 after the observed sexual abuse and had not intervened to stop Staff A. They further stated that they had not received abuse training on how to intervene in an abuse situation and that they did not know how to respond.

During an interview on 03/29/2024 at 1:31 PM with Staff E, Administrator, stated that they have not trained staff on how to respond and protect residents if they were to walk in on an abuse situation.

Record review of Staff A’s facility timecard for 01/12/2024 showed that Staff A did not clock out until the end of their shift at 9:57 PM, one hour after observed abusing Resident

1.

During an interview on 04/08/2024 at 12:15 PM, Staff E stated that Staff A's shift ended at 10:00 PM and she had not been aware that Staff A had stayed and completed their full shift after Staff C observed the sexual abuse against Resident 1 by Staff A at 9:00 PM.

During an interview on 04/09/2024 at 12:50 PM, Staff B, Medication Technician stated that after Staff A had left Resident 1's room, they observed Staff A going in to provide care for two other residents before Staff A left the memory care unit.

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 EAST WENATCHEE is or will be in compliance with this law and / or regulation on (Date) 6-1-2024

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

Brenda K Chamberlain — Administrator (or Representative)

5.7.2024 — Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(7) Not allow any staff person to abuse or neglect any resident.

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to prevent sexual abuse for 1 of 1 resident (Resident 1)by a staff member. This failure resulted in the resident being sexually abused and placed other residents at risk of abuse.

Findings included...

Review of the ALF's policy, titled, "Abuse, Neglect or Exploitation," undated, showed that staff are mandated reporters and are responsible for protecting the residents from all forms of abuse. The policy further defines sexual abuse to include a staff member engaging in sexual contact with a resident whether consensual or not.

WAC 388-78A-2020 defines Abuse as the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult. Sexual abuse means any form of nonconsensual sexual conduct, including, but not limited to, unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing,

1.

During an interview on 04/08/2024 at 12:15 PM, Staff E stated that Staff A's shift ended at 10:00 PM and she had not been aware that Staff A had stayed and completed their full shift after Staff C observed the sexual abuse against Resident 1 by Staff A at 9:00 PM.

During an interview on 04/09/2024 at 12:50 PM, Staff B, Medication Technician stated that after Staff A had left Resident 1's room, they observed Staff A going in to provide care for two other residents before Staff A left the memory care unit.

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 EAST WENATCHEE 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-2660 Resident rights. The assisted living facility must:

(7) Not allow any staff person to abuse or neglect any resident.

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to prevent sexual abuse for 1 of 1 resident (Resident 1)by a staff member. This failure resulted in the resident being sexually abused and placed other residents at risk of abuse.

Findings included…

Review of the ALF's policy, titled, "Abuse, Neglect or Exploitation," undated, showed that staff are mandated reporters and are responsible for protecting the residents from all forms of abuse. The policy further defines sexual abuse to include a staff member engaging in sexual contact with a resident whether consensual or not.

WAC 388-78A-2020 defines Abuse as the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult. Sexual abuse means any form of nonconsensual sexual conduct, including, but not limited to, unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing,

and sexual harassment. Sexual abuse also includes any sexual conduct between a staff person and a vulnerable adult living in that facility whether or not it is consensual.

Resident 1's assessment dated 10/31/2023, showed that they had dementia (impaired ability to remember, think or make decisions, that interfere with daily activities), and needed assistance with personal care and hygiene.

Facility incident report dated 01/12/2024 at 9:00 PM, showed that at approximately 9:00 PM, Staff C, Caregiver observed Staff A, Caregiver, touching, shaking and jiggling (fondling), Resident 1's breasts. Staff C then walked out of the room and proceeded to call Staff D, Memory Care Director to inform Staff D of their observations.

Record review of the Investigative Summary of "Douglas County Sheriff Office Incident Report," dated 01/13/2024 at 9:39 AM. showed that on 01/12/2024, Staff C had reported to Staff D that they observed Staff A fondling Resident 1's breasts. It further showed that Staff C and Staff B had reported that Staff A had a scratch on their arm from Resident 1 scratching Staff A. The Investigative Summary showed that Staff C reported that during the observation of Staff A fondling Resident 1's breasts that Staff A had an erection. The document further showed that on 01/25/2024 at 4:39 PM, Staff A was arrested for Indecent Liberties RCW 9A.44.100 (a felony for sexual abuse toward a vulnerable adult).

During an interview on 02/21/2024 at 2:23 PM, Staff B, Medication Technician, stated that on 01/12/2024, it took Staff A more than 30 minutes longer than usual to assist Resident 1 getting ready for bed. Staff B stated that when they had gone in to administer Resident 1's medications, they had asked Staff A what was taking them so long to dress Resident 1 and Staff A responded to them by saying that Resident 1 "liked them." Staff B stated that the comment made them feel uncomfortable. Staff B still left the room and let Staff A continue to dress Resident 1. After approximately 45 minutes that Staff A was in assisting Resident 1, Staff B went in to Resident 1's room and Resident 1 was still naked. Staff B intervened and assisted Resident 1 to get dressed. While Staff B was assisting Resident 1, Resident 1 started touching Staff B's breasts which was not a normal action for Resident 1.

During an interview on 03/15/2024 at 4:53 PM, Staff C stated that on 01/12/2024 they had left the room to go assist another resident and when they went back into Resident 1's room at approximately 9:00 PM to check on Staff A who was helping Resident 1, that is when they observed Resident 1 still naked and Staff A fondling Resident 1's breasts. They had told Staff A to stop, and Staff A stopped fondling Resident 1's breasts but continued to provide personal care. Staff B left the room to call Staff D, Memory Care Director to inform them that they had observed Staff A fondling Resident 1's breasts. They stated that they felt uncomfortable and did not know what to do.

During an interview on 03/18/2024 at 2:45 PM Staff E, Executive Director, stated that the completed investigation for 01/12/2024 showed abuse was substantiated, and Staff A was terminated on 01/16/2024.

During an interview on 04/19/2024 at 2:46 PM, Collateral Contact 1 (CC1) stated that Staff A was scheduled for a criminal law trial for incident liberties on 04/24/2024.

and sexual harassment. Sexual abuse also includes any sexual conduct between a staff person and a vulnerable adult living in that facility whether or not it is consensual.

Resident 1's assessment dated 10/31/2023, showed that they had dementia (impaired ability to remember, think or make decisions, that interfere with daily activities), and needed assistance with personal care and hygiene.

Facility incident report dated 01/12/2024 at 9:00 PM, showed that at approximately 9:00 PM, Staff C, Caregiver observed Staff A, Caregiver, touching, shaking and jiggling (fondling), Resident 1's breasts. Staff C then walked out of the room and proceeded to call Staff D, Memory Care Director to inform Staff D of their observations.

Record review of the Investigative Summary of "Douglas County Sheriff Office Incident Report," dated 01/13/2024 at 9:39 AM, showed that on 01/12/2024, Staff C had reported to Staff D that they observed Staff A fondling Resident 1's breasts. It further showed that Staff C and Staff B had reported that Staff A had a scratch on their arm from Resident 1 scratching Staff A. The Investigative Summary showed that Staff C reported that during the observation of Staff A fondling Resident 1's breasts that Staff A had an erection. The document further showed that on 01/25/2024 at 4:39 PM, Staff A was arrested for Indecent Liberties RCW 9A.44.100 (a felony for sexual abuse toward a vulnerable adult).

During an interview on 02/21/2024 at 2:23 PM, Staff B, Medication Technician, stated that on 01/12/2024, it took Staff A more than 30 minutes longer than usual to assist Resident 1 getting ready for bed. Staff B stated that when they had gone in to administer Resident 1's medications, they had asked Staff A what was taking them so long to dress Resident 1 and Staff A responded to them by saying that Resident 1 "liked them." Staff B stated that the comment made them feel uncomfortable. Staff B still left the room and let Staff A continue to dress Resident 1. After approximately 45 minutes that Staff A was in assisting Resident 1, Staff B went in to Resident 1's room and Resident 1 was still naked. Staff B intervened and assisted Resident 1 to get dressed. While Staff B was assisting Resident 1, Resident 1 started touching Staff B's breasts which was not a normal action for Resident 1.

During an interview on 03/15/2024 at 4:53 PM, Staff C stated that on 01/12/2024 they had left the room to go assist another resident and when they went back into Resident 1's room at approximately 9:00 PM to check on Staff A who was helping Resident 1, that is when they observed Resident 1 still naked and Staff A fondling Resident 1's breasts. They had told Staff A to stop, and Staff A stopped fondling Resident 1's breasts but continued to provide personal care. Staff B left the room to call Staff D, Memory Care Director to inform them that they had observed Staff A fondling Resident 1's breasts. They stated that they felt uncomfortable and did not know what to do.

During an interview on 03/18/2024 at 2:45 PM Staff E, Executive Director, stated that the completed investigation for 01/12/2024 showed abuse was substantiated, and Staff A was terminated on 01/16/2024.

During an interview on 04/19/2024 at 2:46 PM, Collateral Contact 1 (CC1) stated that Staff A was scheduled for a criminal law trial for incident liberties on 04/24/2024.

Statement of Deficiencies	License #: 2026	Compliance Determination # 35545
Plan of Correction	BONAVENTURE OF EAST WENATCHEE	Completion Date
Page 7 of 7	Licensee: BONAVENTURE OF EAST WENATCHEE LLC	04/18/2024

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 EAST WENATCHEE is or will be in compliance with this law and / or regulation on (Date) 6.1.2024.

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

Brenda K Chambers 5.7.2024

Administrator (or Representative) 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 EAST WENATCHEE 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