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

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) 39389 (Completion Date 04/08/2024) and 27686 (Completion Date 10/02/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/08/2024 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-2660-1, RCW 70.129.030.6.a.ii

The Department staff who did the on-site verification:
Nicole Velazquez, Community Complaint Investigator

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

Sincerely,

Gwin Kaercher

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

Residential Care Services
Investigation Summary Report

Provider/Facility: BONAVENTURE OF EAST WENATCHEE
Provider Type: Assisted Living Facility
License/Cert.#: 2026
Intake ID: 89533
Compliance Determination #: 27686
Region/Unit #: RCS Region 1 / Unit G
Investigator: Gwin Kaercher
Investigation Date(s): 08/07/2023 through 10/02/2023
Complainant Contact Date(s):

Allegation(s):

1) Notification to named resident's family member were not made there were changes in condition.
2) The named resident was sent to the hospital after having a change in condition and was diagnosed with a [redacted].

Investigation Methods:

Sample:	Total residents: 63 Resident sample size: 8 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.

Investigation Summary:

1) Observations showed that resident's were clean and groomed. Staff were observed to be available and responsive to resident's needs. Staff interview and record review showed that the facility staff failed to notify the named resident's family when they had changes in condition.
2) Observations showed that resident's were clean and groomed with staff available and responsive to resident's needs. Staff interview and record review showed that the named resident had a choking incident that required a first aid procedure resulting in the named resident sustaining a fracture of the sternum.
Deficient practice was identified for staff failing to family of the resident's change in condition.
Citations written for WACs 388-78A-2660.

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 # 27686
Plan of Correction	BONAVENTURE OF EAST WENATCHEE	Completion Date
Page 1 of 4	Licensee: BONAVENTURE OF EAST WENATCHEE LLC	10/02/2023

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 08/07/2023 and 08/07/2023 of:

BONAVENTURE OF EAST WENATCHEE
50 28TH STREET NW
EAST WENATCHEE, WA 98802

This document references the following complaint number(s): 89533, 89789, 90958, 90900, 92912

The following sample was selected for review during the unannounced on-site visit: 8 of 93 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Nicole Velazquez, Community Complaint Investigator
Stephanie Jenks, Community Field Manager

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.

S.M
Residential Care Services

10/13/2023
Date

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 08/07/2023 and 08/07/2023 of:

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

This document references the following complaint number(s): 89533, 89789, 90859, 90900, 92912

The following sample was selected for review during the unannounced on-site visit: 8 of 63 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Nicole Velazquez, Community Complaint Investigator
Gwin Kaercher, Community Field Manager
Stephanie Jenks, Community Field Manager

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

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

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) — 10-20-23 Date

RCW 70.129.030 Notice of rights and services -- Admission of individuals.

(6) Notification of changes.

(a) A facility must immediately consult with the resident's physician, and if known, make reasonable efforts to notify the resident's legal representative or an interested family member when there is:

(ii) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications).

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

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify a resident's representative when there was a significant change in the resident's condition for 1 of 5 residents (Resident 1). This failure resulted in a medical emergency, contributed to a delay in medical attention and placed the resident at risk of harm due to weight loss and choking risk.

Findings included...

Facility policy titled, "Occurrence Reporting Policy," dated 12/2009, showed that after any occurrence involving a resident, that is out of the ordinary, the family or responsible party must be notified.

Review of Resident 1's undated medical record showed that they were diagnosed with a [redacted] and a [redacted].

Review of Resident 1's Negotiated Service Agreement (NSA), dated 07/02/2023, showed Resident 1 had lost teeth and required soft texture food diet and had some weight loss.

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

RCW 70.129.030 Notice of rights and services -- Admission of individuals.

(6) Notification of changes.

(a) A facility must immediately consult with the resident's physician, and if known, make reasonable efforts to notify the resident's legal representative or an interested family member when there is:

(ii) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications).

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

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify a resident's representative when there was a significant change in the resident's condition for 1 of 5 residents (Resident 1). This failure resulted in a medical emergency, contributed to a delay in medical attention and placed the resident at risk of harm due to weight loss and choking risk.

Findings included…

Facility policy titled, "Occurrence Reporting Policy," dated 12/2009, showed that after any occurrence involving a resident, that is out of the ordinary, the family or responsible party must be notified.

Review of Resident 1's undated medical record showed that they were diagnosed with a [redacted] ([redacted]), [redacted], [redacted], and a [redacted].

Review of Resident 1's Negotiated Service Agreement (NSA), dated 07/02/2023, showed Resident 1 had lost teeth and required soft texture food diet and had some weight loss.

In an interview on 08/07/2023 at 11:55AM, Complainant Contact 1 (CC1), stated that they had received a call on 07/11/2023, about Resident 1 being sent to the hospital due to shortness of breath, at which time CC1 found out that Resident 1 had choked on food a week prior requiring the facility staff to administer life saving measures to dislodge the blockage. CC1 stated that that they were told that Resident 1 had several broken teeth and had lost several other teeth. CC1 further stated that they were told that Resident 1 likely experienced weight loss and a choking incident due to the dental issues.

Review for Resident 1's progress notes showed the following:

-04/06/2023- Resident 1 had complained of tooth pain around the area where they had two missing teeth.

-04/17/2023- Resident 1 had an unexpected weight loss of seven pounds that was likely related to Resident 1's missing teeth and required softer foods.

-07/06/2023- Resident 1 had a choking incident during lunch and staff did the Heimlich maneuver (first aid procedure when someone is choking) to dislodge the food.

-07/11/2023- Resident 1 had complained of troubles breathing and was sent to the hospital to be assessed at which time they were diagnosed with a [redacted]

Resident 1's record did not show documentation that the representative was notified when:

Resident 1 had lost teeth on 04/06/2023.

Resident 1 had weight loss on 04/17/2023.

Resident 1 had a choking incident on 07/06/2023.

In an interview on 08/07/2023 at 12:32 PM, Staff A, Registered Nurse Consultant, stated that the facility had not notified the family about Resident 1's weight loss, lost teeth or when the resident had a choking incident.

Plan/Attestation Statement

In an interview on 08/07/2023 at 11:55AM, Complainant Contact 1 (CC1), stated that they had received a call on 07/11/2023, about Resident 1 being sent to the hospital due to shortness of breath, at which time CC1 found out that Resident 1 had choked on food a week prior requiring the facility staff to administer life saving measures to dislodge the blockage. CC1 stated that that they were told that Resident 1 had several broken teeth and had lost several other teeth. CC1 further stated that they were told that Resident 1 likely experienced weight loss and a choking incident due to the dental issues.

Review for Resident 1's progress notes showed the following:

-04/06/2023- Resident 1 had complained of tooth pain around the area where they had two missing teeth.

-04/17/2023- Resident 1 had an unexpected weight loss of seven pounds that was likely related to Resident 1's missing teeth and required softer foods.

-07/06/2023- Resident 1 had a choking incident during lunch and staff did the Heimlich maneuver (first aid procedure when someone is choking) to dislodge the food.

-07/11/2023- Resident 1 had complained of troubles breathing and was sent to the hospital to be assessed at which time they were diagnosed with a [redacted].

Resident 1's record did not show documentation that the representative was notified when:

Resident 1 had lost teeth on 04/06/2023.

Resident 1 had weight loss on 04/17/2023.

Resident 1 had a choking incident on 07/06/2023.

In an interview on 08/07/2023 at 12:32 PM, Staff A, Registered Nurse Consultant, stated that the facility had not notified the family about Resident 1's weight loss, lost teeth or when the resident had a choking incident.

Statement of Deficiencies	License #: 2026	Compliance Determination # 27666
Plan of Correction	BONAVENTURE OF EAST WENATCHEE	Completion Date
Page 4 of 4	Licensee: BONAVENTURE OF EAST WENATCHEE LLC	10/02/2023

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) 11/16/2023

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

Administrator (or Representative) 10/20/23 Date

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