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) 39017 (Completion Date 03/28/2024) and 32187 (Completion Date 12/12/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/28/2024 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-2160

The Department staff who did the on-site verification:
Brittney Shull, 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: 105380
Compliance Determination #: 32187
Region/Unit #: RCS Region 1 / Unit G
Investigator: Brittney Shull
Investigation Date(s): 11/07/2023 through 12/12/2023
Complainant Contact Date(s):

Allegation(s):
The named resident is not being changed as needed and is being neglected.

Investigation Methods:

Sample:	Total residents: 51 Resident sample size: 3 Closed records sample size: 3
Observations:	Residents, Staff to resident interaction, Resident rooms, Resident cares and services.
Interviews:	Residents, Staff, Other's not associated with the facility.
Record Reviews:	Resident records, Medical records, Facility Policies, Disclosure of services.

Investigation Summary:
Interview and record review showed that the named resident passed away expectedly due to a known medical condition. Observations showed that most residents were groomed and staff were responsive to their needs. Interview and record review showed that the named resident did not receive care and services as outlined in their Negotiated Service Agreement (NSA). Failed Practice Identified, WAC 388-78A-2160 reference Statement of Deficiencies dated 12/13/2023.

Conclusion / Action:

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

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Statement of Deficiencies	License #: 2026	Compliance Determination # 32187
Plan of Correction	BONAVENTURE OF EAST WENATCHEE	Completion Date
Page 1 of 3	Licensee: BONAVENTURE OF EAST WENATCHEE LLC	12/12/2023

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 11/07/2023, 11/29/2023 and 11/08/2023 of:

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

This document references the following complaint number(s): 103756, 103994, 105380, 106336, 107297

The following sample was selected for review during the unannounced on-site visit: 3 of 51 current residents and 3 former residents.

The department staff that investigated the Assisted Living Facility:

Brittney Shull, 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

12/14/2023
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide care and services per the Negotiated Service Agreement (NSA) for 1 of 3 residents (Resident 1) reviewed for end-of-life care. This failure contributed to the resident's discomfort and placed the residents at risk for unmet care needs.

Findings included...

Record review of the facility's, "Disclosure of Services," dated March 2017, showed that the facility must coordinate services residents receive from health care providers in the community with the services they provide to the resident. Bed baths would be provided out of necessity on a short-term basis, for example, a hospice resident during end of life. It also showed that the facility would assist residents with toileting including providing care for bladder and bowel incontinence that included routinely cleaning the resident as necessary.

Review of the facility's policy, "Hospice/End of Life Care Disclosure," dated 10/30/2023, showed that hospice care was designed to support a resident during their expected (and many times rapid) decline and death. The facility could provide basic Activities of Daily Living (ADL) assistance and medication management for hospice residents. It further showed that if the resident's needs exceeded what could be provided by the facility in coordination with outside resources, alternate placement would need to be considered.

Review of Resident 1's "Resident Service Plan," (NSA) dated 11/02/2023, showed that Resident 1 was to be admitted to hospice on 11/03/2023 and required medication for pain and anxiety. Resident 1 was bed bound, nonverbal, unable to communicate their needs, and had frequent episodes of incontinence requiring routine skin checks, toileting every two hours, and bed baths.

Record review of a hospice nursing note titled, "Client Coordination Note Report," dated 11/05/2023 that was faxed to the facility, showed that Resident 1 had a lack of incontinence care by facility staff. It showed that the incontinence pad, shirt, and brief were all wet and the pad had a dark outline of old urine. It also showed that the Resident had a very strong smell of ammonia, and their oral mucosa (skin inside the mouth) was dry. It further showed that there were no incontinence supplies available in Resident 1's room. It

finally showed that a staff member was instructed and verbalized understanding of keeping Resident 1 clean and dry and that hospice would continue daily visits to assess Resident 1 for comfort and that they were clean and dry.

Record review of a hospice nursing note titled, "Client Coordination Note Report," dated 11/07/2023 that was faxed to the facility, showed that Resident 1 was found saturated with urine, grimacing, and moaning loudly with any care activity, despite staff reporting that the resident received medication 30 minutes ago. It also showed that hospice needed to increase the dose of pain medication and instructed staff to call hospice to coordinate care for symptom management of pain and anxiety. It lastly stated that facility staff required significant further education regarding end-of-life care and symptom management for Resident 1.

In an interview on 11/08/2023 at 11:17 AM, Staff A, Executive Director, stated that they had received complaints from hospice that Resident 1's pad was wet, and they were alerting staff to take care of it. They stated that hospice told them that Resident 1 should not have been that wet if staff had checked on Resident 1 more frequently.

In an interview on 11/21/2023 at 10:18 AM, Collateral Contact 1 (CC1), Resident Representative, stated staff had, "slipped up" and they (CC1) had observed that Resident 1 was wet a couple times when they were visiting. They further stated that maybe staff needed to check Resident 1 more often, and that they were aware that hospice had talked to the staff about it.

In an interview on 11/30/2023 at 4:00 PM, Collateral Contact 2 (CC2), Hospice Nurse, stated that during their visit on 11/07/2023, Resident 1 was wet, and their skin was wrinkled with linen marks half an inch deep, as if they had been in the same position for a long time. They went on to say that that end-of-life residents should be turned every two hours and checked if soiled. They further stated that an unidentified staff told them Resident 1 had been recently repositioned and medicated for pain during their visit, but because of their (CC2's) observations of the resident, they did not believe that to be true. CC2 stated that hospice had to revise the pain medication from as needed to scheduled every four hours, due to concern that Resident 1's symptoms of pain were not being appropriately assessed or managed.

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