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) 37484 (Completion Date 03/05/2024) and 32573 (Completion Date 12/28/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/05/2024 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-2130-1, WAC 388-78A-2130-1-a, WAC 388-78A-2130-1-b, WAC 388-78A-2130-1-c, WAC 388-78A-2130-3-b, WAC 388-78A-2450-3-d-i-A, WAC 388-112A-0200-2, WAC 388-112A-0200-2-a, WAC 388-112A-0200-2-b, WAC 388-112A-0200-2-c, WAC 388-112A-0220, WAC 388-112A-0220-1, WAC 388-112A-0220-2, WAC 388-112A-0220-2-a, WAC 388-112A-0220-3, WAC 388-112A-0220-4, WAC 388-78A-2464-2, WAC 388-78A-24642-1

The Department staff who did the on-site verification:
Anna Cairns, ALF Long Term Care Surveyor
Elaine Lopez, Licensor

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

Sincerely,

Gwin Kaercher

Gwin Kaercher, Field Manager
Region 1, Unit G

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Residential Care Services

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Residential Care Services
Investigation Summary Report

Provider/Facility: BONAVENTURE OF EAST WENATCHEE
Provider Type: Assisted Living Facility
License/Cert.#: 2026
Intake ID: 106393
Compliance Determination #: 32573
Region/Unit #: RCS Region 1 / Unit G
Investigator: Elaine Lopez
Investigation Date(s): 11/15/2023 through 12/28/2023
Complainant Contact Date(s):

Allegation(s):

1. The named resident pulled out their urine catheter, bled through the night and through their brief and onto bedding.
2. Facility staff do not have experience calling or dealing with hospice, and hospice did no come until 6 hours later. No management came to help.
3. Sometimes there was only one staff in the Assisted Living (AL) side from 4:00 PM to 10:00 PM that does all the care for all the residents.
4. Residents do not get their medication but it is marked as given because of short staffed.

Investigation Methods:

Sample:	Total residents: 41 Resident sample size: 3 Closed records sample size: 0
Observations:	Observations of the common areas, sampled resident apartments, resident to resident and resident to staff interactions were respectful.
Interviews:	The named residents, sampled residents, facility staff, and others not associated with the facility.
Record Reviews:	Resident characteristic roster, resident records (care plans, progress notes, temporary service plans), incident investigations, medication audit, staff records, staff roster, staff as worked schedule.

Investigation Summary:

1. 2. Interview and record review showed that the AL caregiver responded to the named resident's call light at 1:45 AM and found that they had pulled out their urine catheter which was laying on the floor near the bed. The incident investigation showed that the AL caregiver controlled the bleeding and they telephoned the ALF's Health Wellness Director (HWD) and followed their direction throughout the morning. The HWD notified their local hospice agency for a nursing visit. The AL caregiver requested the Medication Technician (MT), who was in the memory care, to assist with changing/moving the named resident. Records showed that the hospice nurse arrived

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at 6:15 AM. The named residents service plan did not mention they were on hospice services. Failed practice identified. See Statement of Deficiencies dated 12/28/2023. WAC 388-78a)-2130 (1)(a)(b)(c)(3).
3. Facility administration interviews showed that because of the census the staffing level was to have a total of three staff during the night shift. Facility administration interviews showed that the named staff member was the one staff member who worked on the AL side with a census of 40 AL residents during the night shift. Staff interviews showed that staff were able to complete resident care. Facility met minimum regulatory requirements; no failed practice identified.
4. The facility completed an investigation with interviews to MT's and residents and found no validity to MT's signing off as medications given when they were not given. The facility also completed medication pass observations and interviewed residents with no positive findings. Interviews and review of the medication audit/pass also showed that the facility nurse performed a medication audit that showed resident medication being given as prescribed. No failed practice identified.

Conclusion / Action:

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: BONAVENTURE OF EAST WENATCHEE
Provider Type: Assisted Living Facility
License/Cert.#: 2026
Intake ID: 107935
Compliance Determination #: 32573
Region/Unit #: RCS Region 1 / Unit G
Investigator: Elaine Lopez
Investigation Date(s): 11/15/2023 through 12/28/2023
Complainant Contact Date(s):

Allegation(s):

In the Memory Care Unit (MCU) :
1. No training given to any of the staff.
2. Staff on shift neglect residents every day. Residents do not get care and are left soiled.
3. If residents have a fall or a resident dies staff do not know what to do.
4. There is no sanitation for staff, no soap in bathrooms.
5. Manager in MCU does not care about residents.
6. Residents are always dirty and some have bruises that are unknown.

Investigation Methods:

Sample:	Total residents: 41 Resident sample size: 3 Closed records sample size: 0
Observations:	Observations of the common areas, sampled resident apartments, resident to resident and resident to staff interactions were respectful.
Interviews:	Sampled residents, facility staff, and others not associated with the facility.
Record Reviews:	Resident characteristic roster, resident records (care plans, progress notes, temporary service plans), incident investigations, medication audit, staff roster, staff as worked schedule, and staff records.

Investigation Summary:

1. 5. Interview with facility administration showed that all staff go through the required Orientation and Safety training in addition to training on a website that the facility uses for their staff training. Record review showed that sampled staff had not received their Orientation and Safety training, and the required background and fingerprint checks. Failed practice identified. See Statement of Deficiency dated 12/28/2023, WAC 388-78A-2462 (2), 388-78A-24642 (1), and 388-78A-2450 (3)(d)(i)(A)
2. 6. Observations during an onsite visit in the MCU showed sampled residents to be clean, apartments were clean and no odors noted, and no unexplained bruises on

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residents. Interviews with sampled residents showed no resident concerns with staff or resident care needs not being met. Interview with the facility administration showed that they had not received resident/family concerns regarding care not being met. No facility failed practice identified.
3. Interviews with facility staff showed they knew what to do if a resident fell or died and they would call their MT, the Health and Wellness Director in the MCU, and or the administrator. Review of the facility's policy for emergencies showed that the staff were to call their MT on shift for further assistance and direction and follow their emergency plan. No facility failed practice identified.
4. Observation during an onsite visit in the MCU did show one common bathroom that did not have soap in the soap dispenser. Interview with facility administration showed that staff working in their areas were responsible for replenishing soap in dispensers. Other soap dispensers in the MCU had soap and hand towels to dry hands. In addition, facility staff carry hand sanitizer for quick sanitization. No facility failed practice identified.

Conclusion / Action:

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

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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 # 32573
Plan of Correction	BONAVENTURE OF EAST WENATCHEE	Completion Date
Page 1 of 9	Licensee: BONAVENTURE OF EAST WENATCHEE LLC	12/28/2023

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 11/15/2023 and 11/29/2023 of:

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

This document references the following complaint number(s): 106393, 107935

The following sample was selected for review during the unannounced on-site visit: 3 of 41 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Elaine Lopez, Licensor
Anna Cairns, ALF Long Term Care Surveyor

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

01/04/2024
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.

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Administrator (or Representative)

01-10-24
Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(a) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority;

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to complete an initial service plan and/or update the service plan as required for 3 of 3 residents (Residents 1, 2, 3), who had service plans that did not include hospice service information. This failure resulted in lack of and/or no direction for staff to meet resident care needs.

Findings included...

On 11/15/2023 at 3:19 PM Staff A, Executive Director, stated that facility care staff would know which resident was on hospice services and/or how to provide care for a resident. Staff A stated that staff would read the resident's service plan that were located in the resident's individual binders. The service plan would show if the resident was on hospice services. In addition, Staff A stated that there was another binder that had all the ALF's residents service plans that staff could look at.

Resident 1

Record review of the ALF's characteristic roster provided on 11/15/2023 showed that Resident 1 moved into the facility in [redacted] 2021, and required home health and hospice services.

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Review of Resident 1's record did not include a service plan in their binder. Resident 1's record binder did include, a pink 8 x 10 sheet stating a local hospice phone number and after-hours instructions.

On 11/15/2023 at 4:20 PM Staff B, Assisted Living Director, stated that Resident 1 should have had a service plan in their binder and was not sure why there was not one in there.

Prior to leaving the facility on 11/15/2023, the facility reprinted and provided a service plan dated 08/11/2023 on Resident 1 that showed diagnosis of [redacted] and [redacted] The 08/11/2023 service plan did not mention that Resident 1 was on hospice services or directions for staff regarding end-of-life care specific to Resident 1.

Resident 2

Record review of the ALF's characteristic roster provided on 11/15/2023 showed that Resident 2 moved into the facility in [redacted] 2022, and that they required home health and hospice services.

Review of Resident 2's record included a service plan dated 05/10/2023 that had no documentation that Resident 2 was on hospice services.

On 11/15/2023 at 4:20 PM Staff B, stated that they were unsure why the service plan for Resident 2 did not have information that the resident was on hospice services.

Prior to leaving the facility on 11/15/2023, the facility reprinted and provided an updated service plan dated 08/09/2023 for Resident 2 that showed diagnosis that included [redacted] and [redacted] The 08/09/2023 service plan showed that Resident 2 was independent with mobility, eating, bathing, dressing, hygiene, toileting, laundry and taking out their own garbage daily. The 08/09/2023 service plan did not mention that Resident 2 was on hospice services.

Resident 3

Record review of the ALF's characteristic roster provided on 11/15/2023 showed that Resident 3 moved into the facility in [redacted] 2021 and that they required home health and hospice services.

Review of Resident 3's record did not include a service plan in their binder.

On 11/15/2023 at 4:20 PM Staff B, stated that they were unsure why there was no service

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plan for Resident 3 in their binder or documentation that they were on hospice services.

Prior to leaving the facility on 11/15/2023, the facility provided a service plan dated 06/14/2023 for Resident 3 that showed diagnosis that included [redacted] and [redacted] The 06/14/2023 service plan, under the section for medications, showed that the resident was currently on hospice and used two pharmacies, no further directions regarding hospice services and/or care was documented.

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) 02-15-24

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

Administrator (or Representative) — Date: 01-10-24

WAC 388-112A-0200 What is orientation training, who should complete it, and when should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training.

(2) Long-term care worker orientation. Individuals required to complete the seventy-hour long-term care worker basic training must complete long-term care worker orientation, which is two hours of training regarding the long-term care worker's role and applicable terms of employment as described in WAC 388-112A-0210 .

(a) All long-term care workers who are not exempt from certification as described in RCW 18.88B.041 hired on or after January 7, 2012, must complete two hours of long-term care worker orientation training before providing care to residents.

(b) Long-term care worker orientation training must be provided by qualified instructors that meet the requirements in WAC 388-112A-1260 .

(c) The department must approve long-term care worker orientation curricula and instructors.

WAC 388-112A-0220 What is safety training, who must complete it, and when should it be completed?

(1) Safety training is part of the long-term care worker requirements. It is a three hour training that must meet the requirements of WAC 388-112A-0230 and include basic safety precautions, emergency procedures, and infection control.

(2) The following individuals must complete safety training:

(a) All long-term care workers who are not exempt from certification as described in RCW

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18.88B.041 hired after January 7, 2012, must complete three hours of safety training. This safety training must be provided by qualified instructors that meet the requirements in WAC 388-112A-1260 .

(3) The department must approve safety training curricula and instructors.

(4) There is no test for safety training.

WAC 388-78A-2450 Staff.

(3) The assisted living facility must:

(d) Maintain the following documentation on the assisted living facility premises, during employment, and at least two years following termination of employment:

(i) Staff orientation and training or certification pertinent to duties, including, but not limited to:

(A) Training required by chapter 388-112A WAC;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure the two-hour of long-term care worker orientation training and the three-hour of safety training was completed for 5 of 6 staff (Staff E, F, G, H, I), who required the training prior to providing care to residents. This failure placed residents at risk of receiving care from untrained staff.

Findings included..,

Staff records were reviewed with Staff A, Executive Director (ED), on 11/29/2023 at 4:00 PM. Staff A stated that they were responsible for employee business files. Although, they had hired a new staff person for the Business Office Manager (BOM) and they were in the process of training them. In addition, Staff A stated that Staff C, contracted Registered Nurse (RN), was the qualified instructor for the facility.

-Staff E was hired as a caregiver on 04/30/2023. Their employee record showed that the two-hour long-term care worker orientation training and the three-hour safety training certificate was dated 09/25/2023.

Staff E worked 148 days providing care to residents without their long-term care worker orientation and safety training.

-Staff F was hired as a caregiver on 02/21/2023. Their employee record showed that the two-hour long-term care worker orientation training and three-hour safety training certificate was dated 04/05/2023.

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Staff F worked 44 days providing care to residents without their long-term care worker orientation and safety training.

-Staff G was hired as a caregiver on 07/15/2022. Their employee record showed that the two-hour long-term care worker orientation training and the three-hour safety training certificate was dated 04/04/2023.

Staff G worked 503 days providing care to residents without their long-term care worker orientation and safety training.

Staff A stated that they did not realize the orientation and safety training needed to be completed for Staff E, F, and G.

-Staff H was hired as the Health Wellness Director on 09/05/2023. Their employee record did not have the two-hour long term care worker orientation training and the three-hour safety training certificate.

Staff H worked 85 days providing supervision to residents.

Staff A stated that Staff H did not have the two-hour orientation training and the three-hour safety training certificate. Staff A stated that when Staff H was
hired, they had gone to the corporate office for all their training and when Staff H returned Staff A did not realize the facility orientation and safety training
needed to be completed.

-Staff I was hired as a caregiver on 04/28/2023. Their employee record showed that the two-hour long-term care worker orientation training and the three-hour safety training certificate was dated 09/23/2023.

Staff I worked 148 days providing care to residents without their long-term care worker orientation and safety training.

On 12/28/2023 at 11:15 AM Staff A stated that Staff I's orientation and safety training certificate was not completed until 09/28/2023.

Plan/Attestation Statement

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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) 02-15-24

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

Administrator (or Representative) — Date: 01-10-24

WAC 388-78A-2464 Background checks Process Background authorization form. Before the assisted living facility employs, directly or by contract, an administrator, staff person or caregiver, or accepts any volunteer, or student, the home must:

(2) Submit to the department's background check central unit, including any additional documentation and information requested by the department.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure the requested documentation was provided to the Washington state name and date of birth background check unit for 1 of 1 staff (Staff F), who had a pending background check. This failure placed all residents at risk from receiving care from an unqualified staff member.

Findings included...

Staff records were reviewed with Staff A, Executive Director (ED), on 11/29/2023 at 4:00 PM. Staff A stated they were responsible for employee business files. Although, they stated that they had hired a new staff person for the Business Office Manager (BOM) who was in the process of being trained.

-Staff F was hired as a caregiver on 02/21/2023. As of 11/29/2023 their employee file did not contain results of the Washington state name and date of birth background check. Staff F worked 282 days providing care and services to residents without a Washington state name and date of birth background check.

Staff A stated that the ALF had received a notice from the background check unit that the request was pending and needed additional documents which they did not submit until recently.

Plan/Attestation Statement

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

Administrator (or Representative) — Date: 01-10-24

WAC 388-78A-24642 Background checks National fingerprint background check.

(1) Administrators and all caregivers who are hired after January 7, 2012 and are not disqualified by the Washington state name and date of birth background check, must complete a national fingerprint background check and follow department procedures.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure a national fingerprint background check was completed for 4 of 5 staff (Staff D, E, G, I), who were hired in the last 16 months to provide care, services, and supervision to residents. This failure placed all residents from receiving care from an unqualified staff member.

Findings included...

Staff records were reviewed with Staff A, Executive Director (ED), on 11/29/2023 at 4:00 PM. Staff A stated that they were responsible for employee business files. Although, they had hired a new staff person for the Business Office Manager (BOM) that was in the process of being trained.

-Staff D was hired as a caregiver on 11/16/2023. As of 11/29/2023 their employee file did not contain results of a national fingerprint background check.

Staff A stated that they did not think they had set up a fingerprint appointment yet.

-Staff E was hired as a caregiver on 04/30/2023. As of 11/29/2023 their employee file did not contain results of a national fingerprint background check.

Staff A stated that a fingerprint background check was never submitted for Staff E.

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-Staff G was hired as a caregiver on 07/15/2022. As of 11/29/2023 their employee file did not contain results of a national fingerprint background check.

Staff A stated that they did not think a fingerprint background check had been submitted by the facility on Staff G.

-Staff I was hired as a caregiver on 04/28/2023. As of 12/28/2023 their employee file did not contain results of a national fingerprint background check.

Staff A stated that a fingerprint background check was never submitted for Staff I.

On 11/29/2023 at 4:00 PM, Staff A, ED, stated that they had hired a new staff person for the Business Office Manager (BOM) although they were in the process of training them. Staff A stated that they probably needed to do fingerprints.

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) 02-15-24

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

Administrator (or Representative) — Date: 01-10-24

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