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

04/03/2025

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

RE: BONAVENTURE OF EAST WENATCHEE # 2026

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 57420 (Completion Date 04/03/2025) and 51369 (Completion Date 02/07/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/03/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
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.

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,

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 EAST WENATCHEE
Provider Type: Assisted Living Facility
License/Cert.#: 2026
Intake ID: 156981
Compliance Determination #: 51369
Region/Unit #: RCS Region 1 / Unit G
Investigator: Nicole Velazquez
Investigation Date(s): 12/09/2024 through 02/07/2025
Complainant Contact Date(s): 12/06/2024

Allegation(s):
The named resident was abuse by another resident.

Investigation Methods:

Sample:	Total residents: 53 Resident sample size: 4 Closed records sample size: 0
Observations:	Environment, Cares, Resident 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:
Observations showed that resident to resident interactions were appropriate and respectful. Staff were observed to be available and responsive to resident's needs. Staff interview and record review showed that after the allegation was made, the facility staff failed to notify the department of the incident. Failed practice identified, WAC 388-78A-2630 reference Statement of Deficiencies dated 02/05/2025.

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: 158462
Compliance Determination #: 51369
Region/Unit #: RCS Region 1 / Unit G
Investigator: Nicole Velazquez
Investigation Date(s): 12/09/2024 through 02/07/2025
Complainant Contact Date(s):

Allegation(s):
The named resident had a fall with significant injury.

Investigation Methods:

Sample:	Total residents: 53 Resident sample size: 4 Closed records sample size: 0
Observations:	Environment, Cares, Residents, 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:
Observation, interview and record review showed that the resident to resident and staff to resident interactions were appropriate and respectful. Staff interview and record review showed that the named resident had an unwitnessed fall with significant injury and failed to notify the department. Failed practice identified, WAC 388-78A-2630 reference Statement of Deficiencies dated 02/05/2025.

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 12/09/2024 of:

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

This document references the following complaint number(s): 156981, 158462

The following sample was selected for review during the unannounced on-site visit: 4 of 53 current residents and 0 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.

Laura Williams-Davis
Residential Care Services

02/19/2025
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)

2·19·25
Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

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(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 each staff person made a report to the Department's Complaint Resolution Unit (CRU) hotline when an incident with significant injury that required outside intervention occurred or allegations of abuse were made for one of one resident (Resident 1). This failure resulted in delayed investigations by the Department and placed residents at risk for lack of protection when there was potential abuse allegations.

Findings included...

Resident 1's facility record showed that their diagnoses included [redacted] and [redacted].

<Allegation of Abuse>

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
Residential Care Services

02/19/2025
Date

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Administrator (or Representative)

Date

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This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure each staff person made a report to the Department's Complaint Resolution Unit (CRU) hotline when an incident with significant injury that required outside intervention occurred or allegations of abuse were made for one of one resident (Resident 1). This failure resulted in delayed investigations by the Department and placed residents at risk for lack of protection when there was potential abuse allegations.

Findings included...

Resident 1's facility record showed that their diagnoses included [redacted] and [redacted].

<Allegation of Abuse>

Record review of undated facility document, titled, “Abuse, Neglect or Exploitation Policy,” showed, "Any staff member who has reason to suspect an incident of sexual or physical assault has occurred will report to the CRU hotline (866) 363-4276 and to the local law enforcement emergency services number as soon as the resident is protected from further harm.”

During an interview on 12/09/2024 at 10:30 AM, Staff A, Executive Director stated that the allegations in November and December 2024, of sexual abuse made by Resident 1 were not reported to CRU. They further stated that even after the sheriff and adult protective services had been to the facility on a new complaint about sexual abuse allegation, they did not make a report to CRU.

Record review showed that the facility staff did not complete an incident report when Resident 1 made an allegation of abuse.

During an interview on 12/09/2024 at 10:46 AM, Staff B, Registered Nurse, stated that they did not make a report to CRU when they became aware of the allegations of sexual abuse made by Resident 1 in November 2024. They further stated that they did not notify CRU when a second report was received when a sergeant from the sheriff's office notified them of the allegation made to the hospital staff at Confluence Health.

<Fall with injury>

Review of facility incident report dated 11/25/2024 showed that Resident 1 had a fall that resulted in a brain bleed. The document showed that a report to CRU was not made for this unwitnessed fall with significant injury.

Review of Resident 1’s 11/25/2024 progress note written by Staff C, Medication Technician, showed that the resident had a fall with injury and was sent to the hospital for evaluation and treatment.

Review of Resident 1’s 11/26/2024 progress note, written by Staff C, showed that the resident had sustained a brain bleed from the fall on 11/25/2025.

Review of Resident 1’s 11 /30/2024 progress note, written by Staff B showed that Resident 1’s fall on 11/25/2024 resulted in the resident sustaining a brain bleed and displace fracture of the right side of their nose.

On 12/09/2024 at 12:30 PM, Staff A stated that they had directed Staff B to make a report to CRU.

Review of Department's records showed that a report to CRU was not made when Resident 1 had an unwitnessed fall with a brain bleed on 11/25/2024.

This is a recurring deficiency previously cited on 04/18/2024 and 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) 2·19·25 .

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

Administrator (or Representative) 2·19·25 Date

Review of Department's records showed that a report to CRU was not made when Resident 1 had an unwitnessed fall with a brain bleed on 11/25/2024.

This is a recurring deficiency previously cited on 04/18/2024 and 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