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

01/05/2026

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) 70897 (Completion Date 01/05/2026) and 63265 (Completion Date 11/13/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/05/2026 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

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

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

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

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

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

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

The Department staff who did the On Site verification:
Nicole Mcgraw, 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: 187432
Compliance Determination #: 63265
Region/Unit #: RCS Region 1 / Unit G
Investigator: Nicole Mcgraw
Investigation Date(s): 07/29/2025 through 11/13/2025
Complainant Contact Date(s):

Allegation(s):
A staff to resident incident.

Investigation Methods:

Sample:	Total residents: 69 Resident sample size: 12 Closed records sample size: 1
Observations:	Environment, Cares, 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.

Investigation Summary:
Observation, interview and record review showed that staff members witnessed a staff to resident incident, failed to intervene, failed to report it to management and to the department in a timely manner. Facility staff allowed the named staff member to provide resident care to residents after the allegation of abuse was made. The named resident's rights were violated during the staff to resident incident. Failed practice identified, Washington Administrative Code (WAC) 388-78A-2630 and WAC 388-78A-2660, reference Statement of Deficiencies dated 11/13/2025.

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: 188756
Compliance Determination #: 63265
Region/Unit #: RCS Region 1 / Unit G
Investigator: Nicole Mcgraw
Investigation Date(s): 07/29/2025 through 11/13/2025
Complainant Contact Date(s):

Allegation(s):
The named resident was mentally and physically abused by a named staff member.

Investigation Methods:

Sample:	Total residents: 69 Resident sample size: 12 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 incident report and investigation, Facility policies, personnel records.

Investigation Summary:
Observation, interview and record review showed that staff members witnessed a staff to resident incident failed to intervene, failed to report it to management and to the department in a timely manner. Facility staff allowed the named staff member to provide resident care to residents after the allegation of abuse was made. The named resident was mentally and physically abused during the staff to resident incident. Failed practice identified, Washington Administrative Code (WAC) 288-78A-2130(3)(a)(b), WAC 388-78A-2630(1)(a) and WAC 388-78A-2660(7), reference Statement of Deficiencies dated 11/13/2025.

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 07/29/2025, 09/02/2025 and 09/03/2025 of:

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

This document references the following complaint number(s): 187432, 187548, 187778, 188756

The following sample was selected for review during the unannounced on-site visit: 12 of 69 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Nicole Mcgraw, 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

11/21/2025
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)

12.7.25
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

This requirement was not met as evidenced by:

Based on interview and record review, the assisted living facility (ALF) failed to ensure allegations of abuse were reported immediately to the department's Complaint Resolution Unit (CRU) for 1 of 1 resident (Resident 1). This failure placed residents at risk of decreased quality of life and continued abuse.

Findings included...

Review of RCW 74.34.035 showed when there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department.

Review of facility's undated policy, titled, "Abuse, Neglect or Exploitation Policy," showed when a staff member suspects or alleges abuse, the staff member was responsible to immediately report the incident to their supervisor and contact CRU directly.

Record review of Resident 1's facility assessment 02/12/2025, showed that the resident

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) | Date

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

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(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

This requirement was not met as evidenced by:

Based on interview and record review, the assisted living facility (ALF) failed to ensure allegations of abuse were reported immediately to the department's Complaint Resolution Unit (CRU) for 1 of 1 resident (Resident 1). This failure placed residents at risk of decreased quality of life and continued abuse.

Findings included…

Review of RCW 74.34.035 showed when there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department.

Review of facility's undated policy, titled, "Abuse, Neglect or Exploitation Policy," showed when a staff member suspects or alleges abuse, the staff member was responsible to immediately report the incident to their supervisor and contact CRU directly.

Record review of Resident 1's facility assessment 02/12/2025, showed that the resident

[redacted]o the facility on [redacted]/2025 with diagnoses of [redacted] and [redacted].

<Incident 1>

Review of facility incident report, dated 07/17/2025, showed in early July 2025, Staff A, Caregiver, and Staff B, Medication Technician, observed Staff G, Medication Technician, shower Resident 1 even though the resident said no. Staff G removed Resident 1's wig and threw it in the sink under running water and forced the resident to shower.

Review of facility incident investigation, dated 07/29/2025, showed Staff B did not report the incident because they were intimidated by Staff G.

In an interview on 07/29/2025 at 12:13 PM, Staff A stated they did not report the incident to management or CRU of Staff G forcing Resident 1 to shower because they were fearful of Staff G.

[redacted]show[redacted]dent 1 was reported to CRU on 07/30/2025.

<Incident 2>

Review of an undated facility incident report showed Staff E, Resident Care Coordinator, was notified on 07/17/2025 that Staff G had mistreated Resident 1. The report showed in early July 2025, Staff B witnessed Staff G remove resident 1's wig from the resident's head without permission and placed the wig on another resident's head. The report stated the other resident walked around with Resident 1's wig on their head. Resident 1 was confused and agitated while searching for their wig. Staff G repeatedly said to Resident 1, "where is your wig, go find it." Staff G taunted Resident 1 with their wig for over 90 minutes.

Review of department records showed Incident 2 was reported to CRU on 07/18/2025.

In an interview on 09/03/2025 at 9:37 AM, Staff E, stated they received the reports for Incident 1 and Incident 2 on 07/17/2025 around 9:25 PM. Staff E stated they had not made the report to CRU when they received the allegations and asked Staff C, Assistant Executive Director to make the report on 07/18/2025.

This is a recurring deficiency previously cited on 12/21/2022, 04/18/2024 and 02/07/2025.

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) 12·28·25 .

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

Administrator (or Representative) — 12·7·25 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 observation, interview and record review, the assisted living facility failed to ensure a resident was free from abuse for 1 of 1 Resident (Resident 1). This failure resulted in Resident 1 being abused, being embarrassed and humiliated, the facility not protecting the resident, and placed the resident at risk of ongoing abuse.

Findings included...

Review of facility's undated policy, titled, "Abuse, Neglect or Exploitation Policy," stated if abuse was alleged, the resident was to be protected from further harm and staff were to assure the perpetrator was kept away from the resident and other residents.

Review of facility's undated policy, titled, "Resident Rights," showed that residents had the right to be treated with respect and dignity and the right to not be sexually, verbally, physically or emotionally abused, humiliated, intimidated or punished.

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. Mental abuse means a willful verbal or nonverbal action that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult.

Review of Resident 1's facility nursing assessment, dated 02/12/2025, showed the resident was admitted to the facility on [redacted]/2025 with diagnoses of [redacted] and

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:

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Based on observation, interview and record review, the assisted living facility failed to ensure a resident was free from abuse for 1 of 1 Resident (Resident 1). This failure resulted in Resident 1 being abused, being embarrassed and humiliated, the facility not protecting the resident, and placed the resident at risk of ongoing abuse.

Findings included…

Review of facility's undated policy, titled, "Abuse, Neglect or Exploitation Policy," stated if abuse was alleged, the resident was to be protected from further harm and staff were to assure the perpetrator was kept away from the resident and other residents.

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Review of Resident 1's facility nursing assessment, dated 02/12/2025, showed the resident was admitted to the facility on [redacted]/2025 with diagnoses of [redacted] and

[redacted].

<Incident 1>

Review of facility incident report dated 07/17/2025, completed by Staff E, Resident Care Coordinator, showed that Staff G, Medication Technician, showered Resident 1 even though the resident said no.

Review of Resident 1's incident report statement, dated 07/29/2025, written by Staff B, Caregiver, showed that at the beginning of July 2025, Resident 1 had been refusing their shower. Staff A, Caregiver, and Staff B asked Staff G for assistance with showering Resident 1. The statement showed that Staff G forcefully pushed the resident into the shower, removed Resident 1's wig and threw it in the sink under running water. Resident 1 became upset saying "No!" over and over, "I do not want to shower and what is wrong with you people? Did you get abused when you were younger?"

In an interview[redacted]7/29/2025 at 12:13 PM, [redacted] requested Staff G to train them on showering Resident 1. Staff A stated that they observed Staff G holding Resident 1 and made Resident 1 move into the shower and snatched the wig off the resident's head. When Staff G got Resident 1 into the shower, Staff G started spraying the resident with water. Staff G had removed the wig without permission and disregarded that the resident had refused to shower. Staff A further stated that Resident 1 was upset during and after the shower because the resident was not given a choice and Staff G forced the resident to shower.

<Incident 2>

Review of Resident 1's undated facility incident report, completed by Staff E, showed that Staff E had received a report that Staff G, had snatched Resident 1's wig from their head and put it on another resident's head.

Review of Resident 1's facility incident report statement written by Staff B, dated 07/29/2025, showed that at the beginning of July 2025, Staff B witnessed Staff G taunting Resident 1 saying, "look over there," and when Resident 1 turned, Staff G removed the wig off of Resident 1's head put it behind their back. Staff G further kept asking Resident 1, "where is your wig?" and then placed it on another resident's head. Resident 1 was confused and asked for their wig. Staff G would tell Resident 1 to go find their wig. After 90 minutes of Staff G taunting Resident 1, the resident went back to their room and did not want to come back out.

In an interview and observation on 07/29/2025 at 12:35 PM, Resident 1 was observed to be wearing their wig and stated that they had been forced to shower by staff. Resident 1 further stated that someone had removed their wig without their permission several

times at the facility. The resident stated that they felt humiliated and embarrassed when they were forced to take off their wig. During the interview, Resident 1 was observed reaching putting their hand on the top of their wig and with a frown on their face, and stated, "You are not going to take it off today."

Review of the facility's undated investigation summary, completed by Staff D, Executive Director, showed there were two separate occurrences at the beginning of July 2025 involving Resident 1 and Staff G. As a result of the investigation regarding the two incidents, Staff G was terminated.

In an interview on 08/15/2025 at 4:45 PM, Staff D stated they substantiated abuse for Incident 1 and Incident 2. Staff D further stated Staff G was terminated as a result of the facility investigations.

In an interview on 09/03/2025 at 9:37 AM, Staff E stated that Staff G was terminated on 07/18/2025 around 8:00 AM and acknowledged that Staff G had provided resident care on the morning of 07/18/2025, after Staff E had received the allegation of abuse on 07/17/2025 at 9:25 PM. Staff E stated that Staff G provided resident care from 5:56 AM until 8:00 AM on 07/18/2025. They further stated that they were not sure why Staff G had been allowed to work after the allegations were made.

In an interview on 09/03/2025 at 9:51 AM, Staff D stated that it was a mistake on their part that Staff G worked on 07/18/2025 after Staff E had received the allegations of abuse on 07/17/2025.

This is a recurring deficiency previously cited on 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) 12·26·25 .

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

Administrator (or Representative) — 12·7·25 Date

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

(3) Review and update each resident's negotiated service agreement consistent with

times at the facility. The resident stated that they felt humiliated and embarrassed when they were forced to take off their wig. During the interview, Resident 1 was observed reaching putting their hand on the top of their wig and with a frown on their face, and stated, “You are not going to take it off today.”

Review of the facility’s undated investigation summary, completed by Staff D, Executive Director, showed there were two separate occurrences at the beginning of July 2025 involving Resident 1 and Staff G. As a result of the investigation regarding the two incidents, Staff G was terminated.

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In an interview on 09/03/2025 at 9:37 AM, Staff E stated that Staff G was terminated on 07/18/2025 around 8:00 AM and acknowledged that Staff G had provided resident care on the morning of 07/18/2025, after Staff E had received the allegation of abuse on 07/17/2025 at 9:25 PM. Staff E stated that Staff G provided resident care from 5:56 AM until 8:00 AM on 07/18/2025. They further stated that they were not sure why Staff G had been allowed to work after the allegations were made.

In an interview on 09/03/2025 at 9:51 AM, Staff D stated that it was a mistake on their part that Staff G worked on 07/18/2025 after Staff E had received the allegations of abuse on 07/17/2025.

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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

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

(3) Review and update each resident's negotiated service agreement consistent with

[redacted]-2120 : [redacted]

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(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 observation, interview and record review, the assisted living facility (ALF) failed to update the care plan based on the residents change in condition and preferences for 1 of 1 resident (Resident 1). This failure placed Resident 1 at risk for not receiving cares and services that relate to the residents' needs and preferences.

Findings included…

Review of Resident 1's facility assessment, dated 02/12/2025, showed the resident was admitted to the facility on [redacted]/2025, with diagnoses of [redacted] and [redacted].

Review of Resident 1's care plan (known as the Negotiated Service Agreement), dated 03/24/2025, showed the resident was independent with showering, dressing, grooming, toileting, and housekeeping needs. The resident did not require safety checks and was able to recognize and remember not to leave the facility unsupervised. Resident 1 did not require routine queueing, assistance or other staff intervention for orientation, anxiety, confusion or other reasons.

Review of Resident 1's progress note, dated 06/02/2025, showed the resident had transitioned from the assisted living to the memory care unit on 06/01/2025.

As of 06/02/2025, prior to Resident 1 transferring to the memory care unit on 06/01/2025, there was no documentation in the resident's record of any functional change of condition or updated care plan since 03/24/2025.

Review of Resident 1's care plan, dated 06/02/2025, showed the resident was standby assist with showering, independent with personal hygiene needs, toileting, dressing but may need reminders to change their clothes, and independent with housekeeping. Review of Resident 1's progress note, dated 06/03/2025, showed they required staff assistance with toileting.

Review of Resident 1's care plan, dated 07/01/2025, showed the residents was independent with toileting, required stand by assistance with showers and they were resistive to bathing/showers.

[redacted]

In an interview on 07/29/2025 at 12:35 PM, Resident 1 stated they prefer to wear their wig during the day and did not like to remove it unless they showered. Resident 1 was observed wearing their wig during the interview.

In an interview on 09/03/2025 at 9:00 AM, Staff D, Executive Director, stated Resident 1 was moved into the memory care unit due to their cognitive decline, increased wandering, refusing showers, refusing to change their clothes, increased care needs with daily tasks (showers, toileting and dressing), forgetting they ate and asking repetitive questions. Staff D stated Staff F, Registered Nurse, was supposed to complete an assessment for Resident 1 before they were moved into the memory care unit.

In an interview on 09/03/2025 at 11:08 AM, Staff F stated they had not been aware the resident had a wig until July 2025. Staff F stated the resident required increased assistance with decision making, personal hygiene, dressing, showers, housekeeping, behaviors of hallucinations, delusions and refusing c[redacted]

In an interview on 10/13/2025 at 11:00 AM, Staff D acknowledged Resident 1's progress notes were absent of any documentation that showed they needed to be moved into a memory care unit due to the need for more assistance with toileting, bathing, cognitive reminders and increased confusion.

As of 09/03/2025, Resident 1 care plan had not addressed the following:
-Resident 1's preference on wearing a wig and how to care for the wig.
-Resident 1's hallucinations and delusions.

This is a recurring deficiency previously cited on 12/28/2023.

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) 12·29·25 .

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

Administrator (or Representative) — Date: 12·7·25