STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Bonaventure of Lacey LLC
Bonaventure of Lacey
3425 Boone Rd SE
Salem, OR 97317

RE: Bonaventure of Lacey License # 2036

Dear Administrator:

This letter addresses Compliance Determination(s) 38656 (Completion Date 03/22/2024) and 34932 (Completion Date 01/24/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/22/2024 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-2320-3-c

The Department staff who did the on-site verification:
Anissa Bearden, Licensor

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

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Statement of Deficiencies	License #: 2036	Compliance Determination # 34932
Plan of Correction	Bonaventure of Lacey	Completion Date
Page 1 of 6	Licensee: Bonaventure of Lacey LLC	01/24/2024

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 follow-up on 01/09/2024 and 01/24/2024 of:
Bonaventure of Lacey
4528 Intelco Loop SE
Lacey, WA 98503

This document references the following SOD dated: 01/24/2024

The following sample was selected for review during the unannounced on-site visit: 3 of 77 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Pamela Horlick, NCI RN Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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	02/06/2024 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.

This document was prepared by Residential Care Services for the Locator website.

Megan Harrison
Administrator (or Representative)

2/6/2024
Date

WAC 388-78A-2320 Intermittent nursing services systems.

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(c) Chapter 246-840 WAC, Practical and registered nursing;

This requirement was not met as evidenced by:

Based on interview, and record review, the facility failed to ensure 2 of 3 staff (Staff D and Staff E) had the required Nurse Delegation training, supervision, and documentation by the Registered Nurse (RN) Delegator for 2 of 3 sampled residents (Resident 1 [R1], and Resident 2 [R2]) who received nurse delegated services. These failures resulted in Resident 1 receiving medications outside of parameters, and resulted in residents of receiving nurse delegated services from unqualified staff and placed all residents who received RN delegated services at risk for harm and injury due to untrained and unsupervised care staff.

Findings included...

"WAC 246-840-930 Criteria for delegation
(1) Before delegating a nursing task, the registered nurse delegator decides the task is appropriate to delegate based on the elements of the nursing process: ASSESS, PLAN, IMPLEMENT, EVALUATE. (3) Assess the patient's nursing care needs and determine the patient's condition is stable and predictable. A patient may be stable and predictable with an order for sliding scale insuli or terminal condition.(8) Verify that the nursing assistant or home care aide:(a) Is currently registere or certified as a nursing assistant or home care aide in Washington state without restriction; (b) Has completed both the basic caregiver training and core delegation training before performing any delegated task (c) Has a certificate of completion issued by the department of social and health services indicating completion of the required core nurse delegation training; (d) Has a certificate o completion issued by the department of social and health services indicating completion of diabete training when providing insulin injections to a diabetic client; and (e) Is willing and able to perform t task in the absence of direct or immediate nurse supervision and accept responsibility for their actions. (c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide (l) Document teaching done and a return demonstration, or other method for verification of competency."

"WAC 246-841-405 Nursing assistant delegation. Provision for delegation of certain tasks. (1) Nursing assistants perform tasks delegated by a registered nurse for patients in community-based care settings or in-home care settings each as defined in RCW 18.79.260 (3)(e). (2) Before performing any delegated task: (a) Nursing assistants-registered must show the certificate of completion of both the basic caregiver training and

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core delegation training from the department of social and health services to the registered nurse delegator. (b) Nursing assistants-certified must show the certificate of completion of the core delegation training from the department of social and health services to the registered nurse delegator. (c) All nursing assistants must comply with all applicable requirements of the nursing car quality assurance commission in WAC 246-840-910 through 246-840-970. (d) All nursing assistants, registered and certified, who may be completing insulin injections must give a certificate of completion of diabetic training from the department of social and health services to the registered nurse delegator."

Record review of the facility's policy, "Delegation- WA [Washington]", dated 10/11/2023, showed "delegation of registered nurse/RN tasks to unlicensed staff personnel shall take place in accordance with the state regulations that apply for the Community, and the requirements specified below. The person (s) who conducts and maintains the process of delegation shall be a registered nurse (RN)". Under the section, titled, "initial assessment-staff", showed "the delegating RN will verify that credentials and required certificates are present for all staff intended to perform delegate tasks prior to delegation. Documentation of such will be done using the "Nurse Delegation Credenti Verification" form and include a current printout from the provider credential search and all required certificates (Delegation Core and Diabetes Specialty). Under the section titled, "delegation binder", showed the facility would establish and maintain a delegation binder. The binders second section would have staff information that included credential verification forms, print out of current active credentials form the provider search website, delegation core and diabetes specialty certificates, ar proof of completion of core basic training with active nursing assistant registered (NAR) while obtaining full credentials. The delegation binder would be audited routinely as per the direction of th quality assurance section to assure ongoing compliance and completion of updates timely.

Record review of the "Department of Social And Health Services" document, Completion date 09/21/2023, showed "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 enclose report. 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." The administrator section showe Staff A, Executive Director, signed the document on 10/02/2023. Staff A signed the "Plan/Attestatio Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 11/05/2023."

Record review of the Department of Social and Health Services (DSHS) document, titled, "instructions- Nurse Delegation: Credentials and Training Verification", dated 04/2018, under step three training verification showed for all nursing assistance registered, home care aide, and nursing assistance certified, "nurse delegation training. The long-term care worker (LTCW) must complete the nine-hour nurse delegation for nursing assistance prior to delegation. If the LTCW will also be administering or drawing up insulin, they must also complete the three-hour special focus on diabetes prior to delegation".

Record review of facility's document "delegated medications technicians", dated 09/19/2023, show Staff D, Medication Technician, and Staff E, Medication Technician were not listed.

Record review of the Washington State (WA) Department of Health provider credential website on 01/09/2024 at 2:51 PM, showed Staff E had no records found for any

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credentials.

Record review of Staff D's employee file on 01/09/2024 at 11:49 AM, showed Staff D did not have any certificates of completion for core RN delegation and diabetes delegation for review.

Record review of Staff E's employee file on 01/09/2024 at 11:55 AM, showed Staff E did not have any credentials, certificate of completion for Core Delegation, and certification of completion for diabetes delegation.

R1

Record review of R1's face sheet showed, R1 moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted].

Record review of R1's quarterly nursing evaluation summary, dated 11/07/2023, showed for R1 the facility's medication technicians would manage all of R1's medications and required nurse delegate services for insulin administration.

Record review of R1's self-administration medication evaluation, dated 08/16/2023, showed R1 had limited range of motion, was hard of hearing, and had impaired vision that could affect the resident's ability to self-administer medications. R1 was unable to manage and control medications safely, consistently, and communicate effectively with their physician and would require the facility's medication technicians to administer all R1's medications.

Record review of R1's Nurse Delegation; Nursing Visit, dated 11/02/2023, showed Staff D, Medication Technician, was not listed as a long-term care worker for R1's delegated tasks.

Record review of R1's Medication Administration Record (MAR), dated 11/01/2023 through 11/30/2023, showed R1 had a current order for basaglar insulin (long acting insulin to help lower ar maintain blood sugar level low) to administer 40 units every day. Staff were to notify R1's MD (Medical Doctor) if their blood sugar was above 300 or lower than 70, if their blood sugar was belov 70 give orange juice and then recheck in 15 minutes. If blood sugar continued to be below 70 then call 911 and notify MD. If the blood sugar is above 70 follow insulin orders and take to meal. The medication orders showed "this task is a delegated task to be administered by delegated staffs only Review of the administrations documented showed Staff D, Medication Technician, administered R1's insulin on 11/26/2023 with a blood sugar reading of 40. The MAR documented the resident wa given their insulin outside of physician prescribed parameters.

R2

Record review of R2's face sheet showed R2 moved into the facility on [redacted]/2022, with multiple medical diagnoses that included [redacted].

Record review of R2's quarterly licensed nurse evaluation summary, dated 11/15/2023, showed R2 required nurse delegation for blood sugar testing and administration of eye

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drops.

Record review of R2's Resident Service plan, dated 12/08/2023, showed the medication technicians managed, stored, and administered all R2's medications.

Record review of R2's Nurse Delegation: Instructions for Nursing Task, dated 09/21/2023, showed R2 was delegated for blood sugar checks, insulin administration, and administration of eye drops. The RN delegator for the RN tasks was Staff B, RN delegator.

Record review of R2's Nurse Delegation: Nursing Visit, dated 10/12/2023, showed Staff E and Staff D were not listed as a long-term care worker for R2's delegated tasks.

Record review of R2's MAR, dated 11/01/2023 through 11/30/2023, showed R2 had an order for brimonidine tartrate (a prescribed medicated eye drop to help relieve pressure in the eye) eye drops that were administered two times daily. Review of the administration showed Staff D and Staff E administered R2's eye drops 12 of 60 administrations. R2 had an order for lantanoprost eye drops (prescribed medication to help an eye condition that causes blindness) to administer daily. Review o the administrations showed Staff D and Staff E administered 6 of 30 administration to R2. R2 had a order for timolol maleate eye drops (a prescribed eye drop that reduces the pressure in the eye) tha was to be administered two times a day. Review of the administration showed Staff D and Staff E administered R2's eye drops 12 of 60 administration. R2 had an order for their blood sugar to be checked four times daily. The order showed "this is a delegated task to be performed by delegated staff only. If resident pokes her own finger supervised by non delegated staff the MT [medication technician] needs to make a note of this in the MAR". Review of administration showed Staff E and Staff D performed the delegated task 6 times in an eight day time frame. There was no documentation on the MAR that R2 had poked her own finger for those 6 times.

Record review of R2's MAR, dated 12/01/2023 through 12/31/2023, showed Staff D administered R2's brimonidine tartrate eye drops 8 of 31 evening administrations. R2's lantanoprost eye drops were administered by Staff E 8 of 31 administrations. Review of the administration for timolol maleate eye drops showed Staff E administered 8 of 31 evening administrations to R2. Review of R2's blood sugar check administration showed Staff E performed the RN delegated task 14 of 62 checks.

In an interview on 01/09/2024 at 12:24 PM, Staff B, RN delegator, stated all staff that were delegated for RN tasks had their credentials and certification in the RN delegation binder for review Staff B stated in front of the RN delegation binder was a list of RN delegated medication technicians Staff B stated if Staff D and Staff E were not listed on the list or didn't have their credentials in the RN delegation binder then they were not RN delegated for delegated tasks. Staff B stated if a medication technician did not have credentials or certificates for core delegation and diabetes delegation, then the medication technician were unable to be delegated.

As of 01/12/2024 at 5:00 PM, the facility was unable to provide the Department credential verificatic for Staff E, and core delegation and diabetes delegation certificates for Staff E and Staff D for review.

In an interview on 01/24/2024 at Staff A, Executive Director, stated the nurse delegated medication technicians were responsible to sign off the nurse delegated tasks for the

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resident that they administered to on the residents MAR.

This is a uncorrected and recurring citation previously cited on 05/31/2023 and 09/21/2023.

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 Lacey is or will be in compliance with this law and / or regulation on (Date) 3/8/2024 .

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

Megan Harrison
Administrator (or Representative)

2/6/2024
Date

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STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

800 NE 136th Ave Ste 200, Vancouver, WA 98684

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 follow-up on 09/13/2023 and 09/21/2023 of:

Bonaventure of Lacey
4528 Intelco Loop SE
Lacey, WA 98503

This document references the following SOD dated: 09/21/2023

The following sample was selected for review during the unannounced on-site visit: 15 of 66 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Regenia Coleman, ALF NCI CI
Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor
Pamela Horlick, NCI RN Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.

Staci Oils, IDR PM Reg 3E
Residential Care Services

November 28, 2023
Date

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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.

Megan Ham — Administrator (or Representative)

11/28/23 — Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 2 of 2 sampled residents (Resident 1 and Resident 2) medications were available to be administered. This failure resulted in the residents not receiving their medications as ordered and placed the residents at risk for unmet care needs, delay in treating a medical condition, contributing to Resident 1 experiencing swelling to the right ankle, and placed the resident at risk for medical complications associated with not receiving medications as ordered.

Findings included...

Record review of the facility's document, "Medication System Summary Module 3", dated 05/01/2023, under the section titled, "Medication Not Available", showed when medication was not available for a scheduled time pass, staff shall take necessary steps to obtain the medications and properly notify as required and document the steps taken to obtain.

Record review of the facility document, titled, "Health Services Medication Technician & Qmap Training Manual", updated 05/01/2023, under the section titled, "Medication Not Available", showed when mediation was not available for a scheduled time pass, staff shall take necessary steps to obtain the medications and properly notify as required and document the steps taken to obtain. Under the section titled "Procedure", showed:
-Identify the needed medication that was not available.
-Fax and call the pharmacy (and/or notify the family if they were a possible source for delivery) about a plan to deliver the medication and document your contact. If medication could be purchased over the counter, contact family or your ED (Executive Director) to discuss pick-up options to avoid the resident to go without medications.
- Alert the physician about unavailability and ask for an order to hold the medication until the planned delivery.
- Notify the Executive Director and the Community LN (Licensed Nurse) about the missed dose.
- Document in CareSuite (facility's charting system) by completing an exception. Be as detailed as possible noting all your attempts and that PCP (Primary Care Provider) was notified.
- Place the resident on alert charting to observe for changes in condition related to the missed medication and indicate the expected delivery time.

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- Repeat steps each time a dose is missed, omitting step three if it does not apply each time.

Resident 1 (R1)

Record review of R1's Medication Administration Record (MAR), dated 07/01/2023 through 07/31/2023, showed R1 had an order for Ciprofloxacin HCL (hydrochloric acid) (antibiotic that kills a bacterial infection) 500 MG (Milligram) tablet take one tablet every 12 hours every day for seven days for a diagnosis of [redacted] ([redacted]). Review of administration for the ciprofloxacin for dates 07/25/2023 through 07/31/2023, showed R1 did not receive the ciprofloxacin for 6 of 13 dosages. The MAR showed there were notes for dates 07/25/2023 through 07/28/2023 that the medication had not yet arrived. On 07/26/2023 the notes section showed facility staff would call the pharmacy tomorrow. On 07/28/2023 the notes section read the medication was pending delivery and facility staff would follow up with the pharmacy.

Record review of R1's charting notes, dated 07/25/2023 through 07/28/2023, showed R1 was not placed on alert for their ciprofloxacin medication not being administered to them. There was no documentation that the physician was contacted, and no documentation the facility received an order to hold the medication until it was delivered and available for the facility to administer.

Record review of R1's MAR, dated 08/01/2023 through 08/31/2023, showed R1 did not receive their furosemide (medication used to treat fluid retention and swelling within the body, legs, and arms) for 10 of 31 days. The MAR showed notes were documented on dates, 08/07/2023 through 08/17/2023 that the medication had not yet arrived.

Record review of R1's charting notes, dated 08/07/2023 through 08/17/2023, showed R1 was not placed on alert for missing their Furosemide medication.

Record review of R1's Charting Note, dated 08/17/2023 at 1:19 PM and 08/18/2023 at 12:00 AM, Staff E, Registered Nurse Corporate Regional, documented R1 missed their furosemide for several days and R1 had mild swelling to their right ankle and foot.

Record review on 09/15/2023 of R1's hard medical chart in the facility, showed there were no faxes to R1's primary care provider that R1 had not started their ciprofloxacin when they had ordered the medication on 07/25/2023. There were no faxes to the primary care provider that the furosemide medication was not available to be administered between 08/07/2023 through 08/16/2023 and R1 missed their medications.

In an interview on 09/15/2023 at 2:20 PM, Staff G, Memory Care Director, stated the facility could not provide documentation that R1's primary care provider was notified R1 had missed their ciprofloxacin and furosemide medications.

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Resident 2 (R2)

Record review of R2's Medication Administration Record (MAR), dated 08/01/2023 through 08/31/2023, showed R2 had a medication order for quetiapine fumarate 25 MG (Milligram) tablets (a drug used to treat mental health disorders and behaviors) that started on 08/09/2023 to take one tablet every day at bedtime for a medical diagnosis of [redacted]. Record review of the MAR showed R2 had not received their quetiapine fumarate for dates 08/09/2023 through 08/21/2023, for a total of 13 days. The MAR showed under the notes, that on 08/09/2023 through 08/21/2023 the quetiapine fumarate medication had not yet arrived. On 08/14/2023 the MAR showed that facility staff called the primary care provider. On 08/15/2023, 08/20/2023, and 08/21/2023 the MAR showed that facility staff faxed the primary care provider.

Record review of R2's charting note, dated 08/03/2023 at 10:02 AM, showed Staff Q, Medication Technician, documented that the new order for R2's quetiapine fumarate had been sent to the wrong pharmacy. R2's primary care physician's office was called to get a new order to R2's pharmacy to have the medications delivered to the facility.

Record review of R2's charting notes dated 08/09/2023 through 08/15/2023 showed there was no documentation that the residents medication quetiapine fumarate was not available for administration. There was no documentation to show the facility had requested an order to hold the medications until it was available for administration. R2 was not placed on alert for not receiving the quetiapine fumarate.

Record review of R2's charting note dated 08/22/2023 showed R2 quetiapine fumarate arrived at the facility that afternoon.

In an interview on 09/14/2023 at 4:24 PM, Staff P, Medication Technician (MT), stated the MT on shift would need to fax and call the pharmacy about the medication. The MT's were to fax the residents physician that the medication was missed and place the resident on alert charting until the medication was available to be administered. Staff P stated they would do these steps every time a resident missed a dose of medication if it was not available for administration.

In an interview on 09/15/2023 at 2:20 PM, Staff G stated medication quetiapine fumarate medication was a new order from their primary care provider. Staff G stated the pharmacy had not received new medication order for the quetiapine fumarate for them to dispense and deliver to the facility. Staff G stated they were unaware if the physician was notified that the medication had not been delivered by the pharmacy and that R2 had not started the medications. Staff G was unable to say if the facility had received an order to hold R2's quetiapine fumarate medication until it was available to be administered. Staff G stated they would follow up with providing supporting documentation no later than 09/15/2023.

As of 09/15/2023 at 5:30 PM, the facility had not provided supporting documentation as

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to why there was a delay for R2 start their Quetiapine Fumarate medication. The facility was unable to provide documentation that showed the physician was notified that the medication hadn't been available to start or that they had gotten an order to hold the medication until it was available to be administered.

This is a recurring deficiency previously cited on 01/05/2022 and an uncorrected deficiency previously cited on 05/31/2023.

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 Lacey is or will be in compliance with this law and / or regulation on (Date) 11/15/2023 .

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

Administrator (or Representative) — Date: 11/28/2023

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to properly store and label food for 3 of 3 kitchens reviewed. These failures placed 66 of 66 residents at risk for exposure to food-borne illnesses.

Findings included...

"WAC 246-215-03610 Labeling—Food labels (FDA Food Code 3-602.11). (1) FOOD PACKAGED in a FOOD ESTABLISHMENT must be labeled as specified in LAW, including chapters 69.04 and 15.130 RCW; 21 C.F.R. 101 - Food Labeling; and 9 C.F.R. 317 - Labeling, Marking Devices, and Containers. (2) Label information must include: (a) The common name of the FOOD or, absent a common name, an adequately descriptive identity statement; (b) If made from two or more ingredients, a list of ingredients in descending order of predominance by weight, including a declaration of artificial color or flavor and chemical preservatives, if contained in the FOOD; (c) An accurate declaration of the

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quantity of contents; (d) The name and place of business of the manufacturer, packer, or distributor; (e) The name of the FOOD source for each MAJOR FOOD ALLERGEN contained in the FOOD unless the FOOD source is already part of the common or unusual name of the respective ingredient; (3) Bulk FOOD that is available for CONSUMER self-dispensing must be prominently labeled with the following information in plain view of the CONSUMER: (a) The manufacturer's or processor's label that was provided with the FOOD; or (b) A card, sign, or other method of notification that includes the information specified under subsection (2)(a), (b), and (f) of this section."

Record review of the facility's plan of correction binder that was provided to the department for review on 09/13/2023 at 8:33 AM, showed the facility had implemented an intervention for the management employees to conduct a daily audit of the kitchen area to ensure all food was stored, dated, and labeled properly.

In an observation on 09/13/2023 at 11:50 AM, showed in the memory care unit's North side of the kitchen, inside the cabinet had an open bottle of Davinci Strawberry syrup. There was no lid on the syrup bottle, no date as to when it was opened observed on the bottle. There was a bag of "giant rosters marshmallows" sitting in the cabinet not securely closed. There was no documented date when the bag had been opened observed on the package. There was a small clear bottle with label that showed "Torani" vanilla sugar free syrup that did not have a documented date when the item had been opened.

In an observation and interview on 09/13/2023 at 12:06 PM, in the memory care unit's South side kitchen refrigerator, there was a large disposable brown cup with black lid and two black straws sitting in the door on the top shelf. The cup had a label printed "cutters pointe" on the side. The cup did not have a label of what was inside or date when it had been opened for review. Staff L, Caregiver, stated the cup did not belong to a resident. On the inside of the door of the refrigerator was a container of "Yoplait strawberry yogurt" that had been opened. On the top of the container, it was partially covered with a clear plastic food wrap. The yogurt container and plastic wrap were undated. There was a small white styrofoam cup with a white lid that was undated and labeled "pb" stored on the top shelf of the refrigerator. The white Styrofoam cup had been opened. On the second shelf of the refrigerator was a square clear hard plastic container with a green lid that sat on top of the container. The lid and the container were undated. There was a second square clear plastic container with red and green diced food inside. The container was unlabeled and undated. There were three drink pitchers with one that had clear liquid, one with orange liquid, and one with light brown liquid inside of them. All three pitchers were unlabeled and undated.

In an observation on 09/13/2023 at 12:10 PM, in the memory care unit South side kitchen. Inside the freezer were two small blue bowls of white solid substance that resembled ice cream with mixed fruit on top. Both bowls were uncovered, unlabeled, and undated.

In an observation 09/14/2023 at 2:41 PM, in the kitchen on the counter next to the exit door to the independent living dining room was one bag of hamburger buns and one bag of hot dog buns that were open to air. The bags were undated. There was a silver rectangle pan of brown muffins. There was clear plastic wrap that partially covered the top of the silver pan and exposed the muffins to air. The silver pan was unlabeled and undated.

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In an observation on 09/14/2023 at 2:43 PM, inside the kitchen ice cream freezer, there were four tubs of ice cream that did not have lids on them. The four ice cream tubs were undated. There were two open bags of yellow frozen potato strips, one open bag of light brown and orange frozen potato wedges that were not closed properly and were undated.

In an observation on 09/14/2023 at 2:45 PM, the ice machine in the kitchen was observed to have an ice scoop stored on the inside of the ice machine on the right-hand side. The ice scoop was white with multiple black spots of matter on the outside surface of the scoop. The underside of the scoop was not immediately visible. The ice scoop was stored in a manner such as the handle was pointing downwards toward the clean ice which enabled any residual liquids to drain onto the clean ice.

In an observation on 09/14/2023 at 2:47 PM, in the kitchen, the juice dispensing machine was observed with black, wet matter covering the underside of the machine where the dispensing spouts exited the machine. Most of the black matter was concentrated in the area where the spout that dispensed the orange juice exited the machine. Orange liquid was observed in the tray directly below the juice dispensing spouts. The orange liquid filled approximately half of the containment area of the dispensing tray.

In an observation on 09/14/2023 at 2:53 PM, in the kitchens walk in refrigerator was a box of kale with black writing on the box that read “09/08” with no year labeled. The kale was observed in a cardboard box that was filled to the top of the box. Some of the kale hung over the edges of the box. The top layer of kale had large, dried areas of brown and yellow on the leaves.

In an interview on 09/14/2023 at 2:57 PM, Staff I, Corporate Dietary Executive Chef, stated they would not eat that kale if was served to them. Staff I stated, “It has not been served to the residents yet. I am sure the staff would have thrown the bad stuff out.”

In an observation on 09/14/2023 at 3:01 PM, in the dry storage area of the kitchen, there was an open bag of walnuts that were open to air and were undated.

In an observation on 09/14/2023 at 3:10 PM, an undated bag which contained soft, white substance was observed open on a silver table with the end wrapped in clear plastic. At 3:12 PM, Staff J, Server, stated the white substance was whipped cream. Staff J stated once the whipped cream was opened, the package should have been dated. Staff J verified the whipped cream package was undated.

In an interview on 09/14/2023 at 3:13 PM, Staff I stated the date on the item represented the date the item was opened. Staff I said the expectation of the staff were to date the items once they were opened. Staff I stated there was an additional date on some items that indicated when the facility received the item from the supplier.

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In an observation on 09/14/2023 at 3:16 PM, in the kitchen under the prep counter on the wall to the right of the grill were three large white plastic containers on wheels with clear lids. Inside the one container (farther to the left), there was large amounts of white powdery substance inside. Container two had a large amount of beige and white flakes inside, and container three had a large amount white granules inside. All three containers were unlabeled, undated.

In an interview on 09/14/2023 at 3:19 PM, Staff I stated inside the white containers were flour, sugar, and breadcrumbs. Staff I stated the white containers were unlabeled, undated, and unable to provide when the substance expiration dates were. Staff I stated the substances needed to be thrown away.

This is an uncorrected deficiency previously cited on 05/31/2023.

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 Lacey is or will be in compliance with this law and / or regulation on (Date) 11/5/2023

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

Administrator (or Representative) — Date: 10/28/2023

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

This requirement was not met as evidenced by:

Based on interview, observation, and record review the facility failed to provide a safe, sanitary, and well-maintained environment for 3 of 3 areas (Memory Care Unit, Kitchen, and Oxygen Storage) within the building. The facility also failed to keep equipment and furnishings clean. These failures placed 66 of 66 residents at risk to have a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

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Findings included...

Record review of the facility's Disclosure of Services, undated, showed housekeeping must maintain a resident's living quarters and other areas they may use in a safe, clean, and comfortable condition.

Memory Care Unit

In an observation on 09/13/2023 at 10:55 AM, the memory care unit showed an unoccupied resident room 120, was observed to have splattered dried brown substance inside of the toilet bowl.

In an observation on 09/13/2023 at 11:24 AM, the memory care unit showed the south side public silver sink closest to the charting room had a brown thick slimy substance on the bottom of the sink. There were brown rings around the bottom of the sink to the drain.

In an observation and interview on 09/13/2023 at 11:26 AM, Staff Q, Medication Technician, observed the south side public sink closest to the charting room. Staff Q stated they were unsure what the brown substance was inside of the sink. Staff Q stated they had sprayed chemicals on the substance and scrubbed it without the brown substance coming off. Staff Q was observed to take a brown paper towel and wipe the substance. Brown substance was removed off the sink onto the paper towel. The sink no longer had the brown substance where the paper towel was wiped. The sink was observed to be a shiny silver where the brown substance had been. Staff Q stated they were not sure who was responsible to clean the sink. Staff Q stated they had never observed housekeeping staff clean the sink.

In an observation on 09/13/2023 at 11:34 AM, the south side of the memory care unit showed the entry doors to the washer and drying machines were unlocked. The washing machine had residual granules of white substance that resembled powder laundry soap on top of the washer when the lid was opened. The washing machine had a large dried smeared brown substance inside on the white part of the front of the washer above the drum. The white part of the washer was unable to be visualized where the brown substance was.

In an observation on 09/13/2023 at 11:36 AM, the north side of the memory care unit showed the entry to the washer and drying machines had been locked but the lock was not latched and sat on top of a hole it should have been latched inside of. The latch was physically unable to be put through the hole leaving the entry doors open. The dryer vent had a thick layer of lint in the lint trap. There was a sign on the wall that showed "clean lint trap every time you use the dryer to prevent fires."

In an observation on 09/13/2023 at 11:39 AM, the north side of the memory care unit sink

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was observed to have a brown ring residue inside of it. The silver color of the sink was unable to be visualized underneath the brown substance.

In an interview on 09/13/2023 at 11:40 AM, Staff O, Housekeeping, stated they only cleaned the residents rooms inside of the memory care unit. Staff O stated the care staff were responsible for cleaning the common areas within the memory care unit. Staff O stated room 118 was an empty room but residents often go into the room to use the bathroom. Staff O stated there was no soap in room 118's bathroom for the residents to use. Staff O stated they did not know how to open and refill the soap containers.

In an observation on 09/13/2023 at 11:56 AM, the northside memory care kitchen showed there was no running water for the sink when the hot and cold handles were turned on. The soap dispenser was unable to dispense any soap out of the machine. There was a sign above the sink faucet that showed an image showing the sink was used for emergency eye washing.

In an observation on 09/14/2023 at 6:05 PM, the memory care unit showed the south side public sink still had brown substance rings around the bottom of the sink. The south side washing machine still had a brown substance that was smeared on the white part of the washer inside above the drum. The brown substance was smaller as it appeared that the washing machine was used and some of the brown substance was washed off. The north side kitchen sink showed it was still without running water and the soap dispenser was still unable to express any soap.

In an observation and interview on 09/14/2023 at 6:25 PM, Staff A, Executive Director and Staff G, Memory Care Director, observed the south side washing machine with the dried brown substance. Staff G stated they did not know what the substance was. Staff A stated they needed to clean the washing machine with a disinfectant. Staff G was in agreement. Staff A and Staff G observed the north side kitchen. Staff G stated the kitchen area was where the emergency eye washing station was. Staff G stated that the emergency eye washing station was missing the device that sprayed the water upwards. Staff G stated they thought the kitchen had running water. Staff G was observed to attempt to turn the hot and cold water handles but the water did not dispense. Staff G acknowledged the water was not working and the soap dispenser was empty and not working for staff to use to wash their hands. Staff A and Staff G stated the housekeeping staff were responsible to clean the sinks in the common area of the memory care unit. Staff A and Staff G observed the south side public sink had a brown residue at the bottom of the sink near the drain and needed to be cleaned. Staff A and Staff G stated they were unaware that not all housekeeping staff knew how to refill and open the soap dispensers.

Kitchen

In an observation on 09/14/2023 at 2:25 PM, in the kitchen ice cream freezer there were four round tubs of ice cream sitting on top of some crates. The four ice cream tubs were stored without lids or a covering. The crates had pink and brown substance that resembled ice cream that was embedded through the slates of the crates. On top of the ice cream

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freezer sliding doors was a dried sticky brown substance.

In an observation and interview on 09/14/2023 at 2:56 PM, Staff I, Dietary Executive Chef Corporate, walked into the kitchen's freezer, Staff I's shoes made a tacky sound while they walked. Staff I stated the floor needed to be cleaned.

In an observation on 09/14/2023 at 2:56 PM, just inside the door of the kitchen's refrigerator there were gallons of milk stored on the top shelf. There was one gallon that was open. On the ground underneath the shelf where the milk was stored was a white liquid substance that resembled milk on the ground. There were no observed wet floor or cautions sign posted around the white liquid substance.

In an observation on 09/14/2023 at 3:00 PM, a sink labeled "handwash sink" closest to the dietary service manager's office, was completely dry, with light brown and yellow substance that covered the bottom of the sink. Above the sink on the wall, was white matter that covered the wall above the sink and underneath the soap dispenser.

In an interview on 09/14/2023 at 3:03 PM, Staff I stated the handwashing sink was used by the dishwashing staff and other staff that came back inside from the kitchens back door from smoking cigarettes. Staff I stated several of the staff members in the kitchen enter and leave the kitchen's back door to smoke. Staff I stated the handwashing sink was "dirty". Staff I stated the hand washing sink was dry and looked like it had not been used in a while.

In an observation on 09/14/2023 at 3:03 PM, the hood panels over the grill had a dark yellow substance with a thick brown fuzzy substance that was matted into the yellow substance on the hood panel. There was an air vent over the juice machine with brown fuzzy matter on it. The wall next to the air vent had brown fuzzy matter that was stuck to the wall. The brown fuzzy matter was moving back and forth in the air.

In an interview and observation on 09/14/2023 at 3:06 PM, Staff I stated the hood panels were cleaned once week. Staff I stated they would provide documentation for review that showed the hood vents had been cleaned the week prior. Staff I and Staff M, Dining Services Manager, were observed to look for a clip board with the cleaning logs. Staff I and Staff M stated they were unable to provide documentation to show the vents had been cleaned. Staff I stated that the maintenance department was responsible for cleaning the air vents on the ceiling monthly and as needed. Staff I stated they did not know when the air vents were last cleaned.

Oxygen Storage

In an observation and interview on 09/14/2023 at 4:36 PM, inside the entry way of the oxygen storage room was a big red bin that was overflowing with full closed sharp containers (a specialty designed container where needles and other items with blood or

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body fluids that are discarded inside to prevent bloodborne pathogens). Up against the wall to the left side of the room was an unopened white rectangular box that had multiple closed rectangle sharp containers stacked on top of the box. Observation of the sharp containers red base showed there were used needles and items inside that were visible. On one of the sharp containers the top white part that was closed, there were four red dried areas that resembled dried blood. Towards the back of the oxygen room were more full closed white topped red based sharp containers that were closed with used needles and items observed inside the red base. Staff S, Assisted Living Director, and Staff P, Medication Technician, were present and stated they were unaware of the process of how to dispose the sharps containers once they were closed and full. Staff S and Staff P stated they did not know who was responsible to pick up the sharps containers or how they were to be stored once they were full.

In an interview on 09/14/2023 at 4:39 PM, Staff G stated once sharps containers were closed and full, they were to be placed inside of a biohazard (a container to place biological or chemical substance and items inside that could be dangerous to humans, animals, and environment) box so the facility's pharmacy could then pick up the closed biohazard box and dispose of them properly.

In an interview on 09/14/2023 at 5:17 PM, Staff B, Assistant Executive Director, stated sharps containers were supposed to be placed inside of an empty biohazard box that was supplied by the facility's pharmacy. Staff B stated once the box was full they would have the pharmacy pick up the biohazard box for disposal. Staff B stated the facility's pharmacy was responsible to send a new biohazard box to the facility to dispose the used sharp containers inside. Staff B stated that they kept the biohazard box inside the oxygen supply room on the second floor across from the assisted living resident's laundry room.

This is an uncorrected deficiency previously cited on 05/31/2023.

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 Lacey is or will be in compliance with this law and / or regulation on (Date) 11/5/2023 .

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

Administrator (or Representative) — Date: 11/28/2023

WAC 388-78A-2320 Intermittent nursing services systems.

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable

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statutes and rules, including, but not limited to:

(c) Chapter 246-840 WAC, Practical and registered nursing;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure residents had the required Nurse Delegation oversight, training, and documentation by the Registered Nurse (RN) Delegator for 5 of 5 sampled residents (Resident 7, Resident 5, Resident 14, Resident 15, and Resident 4) receiving nurse delegated services. These failures placed all residents receiving RN delegated services and all medication technicians that administer RN delegated services at risk for harm and injury due to not having the appropriate RN delegation oversight, training, documentation and information available.

Findings included...

"WAC 246-840-930 Criteria for delegation.
(1) Before delegating a nursing task, the registered nurse delegator decides the task is appropriate to delegate based on the elements of the nursing process: ASSESS, PLAN, IMPLEMENT, EVALUATE.
(2) The setting allows delegation because it is a community-based care setting as defined by RCW 18.79.260 (3)(e)(i) or an in-home care setting as defined by RCW 18.79.260 (3)(e)(ii).
(3) Assess the patient's nursing care needs and determine the patient's condition is stable and predictable. A patient may be stable and predictable with an order for sliding scale insulin or terminal condition.
(4) Determine the task to be delegated is within the delegating nurse's area of responsibility.
(12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes:
(a) The rationale for delegating the nursing task;
(b) The delegated nursing task is specific to one patient and is not transferable to another patient;
(c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide;
(d) The nature of the condition requiring treatment and purpose of the delegated nursing task;
(e) A clear description of the procedure or steps to follow to perform the task;
(f) The predictable outcomes of the nursing task and how to effectively deal with them;
(g) The risks of the treatment;
(h) The interactions of prescribed medications;
(i) How to observe and report side effects, complications, or un-expected outcomes and appropriate actions to deal with them, including specific parameters for notifying the registered nurse delegator, health care provider, or emergency services;
(j) The action to take in situations where medications and/or treatments and/or procedures are altered by health care provider orders, including:
(i) How to notify the registered nurse delegator of the change;
(ii) The process the registered nurse delegator uses to obtain verification from the health care provider of the change in the medical order; and

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(iii) The process to notify the nursing assistant or home care aide of whether administration of the medication or performance of the procedure and/or treatment is delegated or not;
(k) How to document the task in the patient's record;
(l) Document teaching done and a return demonstration, or other method for verification of competency; and
(m) Supervision shall occur at least every ninety days. With delegation of insulin injections, the supervision occurs at least weekly for the first four weeks, and may be more frequent.
(13) The administration of medications may be delegated at the discretion of the registered nurse delegator, including insulin injections. Any other injection (intramuscular, intradermal, subcutaneous, intraosseous, intravenous, or otherwise) is prohibited. The registered nurse delegator provides to the nursing assistant or home care aide written directions specific to an individual patient.
(14) Delegation requires the registered nurse delegator teach the nursing assistant or home care aide how to perform the task, including return demonstration or other method of verification of competency as determined by the registered nurse delegator.
(15) The registered nurse delegator is accountable and responsible for the delegated nursing task. The registered nurse delegator monitors the performance of the task(s) to assure compliance with established standards of practice, policies and procedures and appropriate documentation of the task(s).
(17) The registered nurse delegator supervises and evaluates the performance of the nursing assistant or home care aide, including direct observation or other method of verification of competency of the nursing assistant or home care aide. The registered nurse delegator reevaluates the patient's condition, the care provided to the patient, the capability of the nursing assistant or home care aide, the outcome of the task, and any problems.
(19) The registered nurse must supervise and evaluate the performance of the nursing assistant or home care aide with delegated insulin injection authority at least weekly for the first four weeks. After the first four weeks the supervision shall occur at least every ninety days."

Record review of the facility's policy, "Delegation-WA (Washington)", dated 09/20/2017, showed "Delegation of registered nurse/RN tasks to unlicensed staff personnel shall take place in accordance with the state regulations that apply for the Community, and the requirements specified below. The person(s) who conducts and maintains the process of delegation shall be a registered nurse. All delegation shall be resident specified based on RN determination is stable and predictable". Under the section titled, "Initial Assessment-Staff", showed "For delegated insulin injections only: As part of the initial delegation process for assisting with insulin injections, the delegating RN will conduct weekly (every 7 days) observations on each staff/each resident for 4 consecutive weeks. observations will be documented on the "Nurse visit" form and kept in the delegation binder. These initial observations are required for any newly delegated insulin administration or newly hired medications technician (MT) conducting the delegated task. - initial training/education and as applicable the weekly insulin administration observations for all delegated staff will be documented using the "Nursing Visit" form. This form will be housed in the delegation binder and filed in the resident's chart section 2 when no longer applicable." "Task related Task related directions: information related to the delegated tasks, directions on how to provide the task, what to observe and when/who to report to shall be maintained using the "Nurse Delegation: Instructions for Nursing Task" or other applicable WA specific delegation forms and can include "job aides" for more task related procedural detail. Directions and associated forms will be available to the staff for reference at all times."

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Record review of the Department of Social and Health Services (DSHS) document titled, "Instructions for Completing Nurse Delegation: Instructions for Nursing Task", revised date 06/2021, showed "delegated Task and Expected Outcome: Enter the name of task and what outcome is anticipated. Separate task sheet is required for each task. List specific medication(s) delegated on this date: only complete if medications are delegated. Enter the name, dose, frequency, and route of each medication delegated. Steps to perform the task: Steps to perform the task should be written in simple language with individualized detail. Check box and describe if additional material(s) are attached. For example: medication information sheet, task procedure sheet, etc. RND (Registered Nurse Delegator) Name: Print RND Name. Telephone Number: Telephone number with area code. What to Report to RND: List individualized side effects or unexpected outcome to report to RND. 13. Healthcare Provider Name: Print Healthcare Provider Name 14. Telephone Number: Enter the telephone number with area code. 15. What to Report to Health Care Provider: List individualized side effects and unexpected outcome to report to the health care provider."

Record review of the Washington State Department of Social and Health Services document titled, Community Nurse Delegation Orientation, dated 2023 (no month or day), showed hand over hand is never allowed as an assistance.

Record review of the facility untitled document, with a handwritten date of 09/13/2023, was a list of the facilities employees. The document showed Staff R was hired at the facility on 06/28/2023.

Record review of Staff R's, Medication Technician, Nurse Delegation: Credentials and Training Verification, showed Staff E, Registered Nurse Regional Corporate, completed the verification for Staff R on 07/13/2023.

Record review of Resident 15's (R15) Resident Data Sheet, undated, showed R15 moved into the facility on [redacted]2022.

Record review of R15's Physician Orders, dated 07/23/2023, showed R15 had medication orders for Humalin N insulin (medication to treat diabetes[the bodies inability to produce insulin that helps reduce the amount of sugar in the blood]), inject give 10 daily at bedtime, lantus insulin (medication to treat diabetes) inject 10 units daily at bedtime, and R15 was to test their blood sugar levels daily for diabetes. All the orders showed "resident is able to poke her own finger for CBGS [continuous blood glucose/sugar] up to four times daily for diabetes."

Record review of R15's Quarterly Licensed Nurse Evaluation Summary, dated 08/15/2023, showed R15 had multiple medical diagnoses that included [redacted]. The assessment showed the facility managed R15's blood sugar and insulin.

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Record review of R15's, Resident Service Plan, dated 08/15/2023, under the section "health maintenance", showed R15 needed assistance with checking their blood sugar levels and assistance with administering their insulin. Under the section "Staff Support", the medication technicians were to monitor R15's blood sugar level and administer R15's insulin daily. Under the section, "cognitive" showed R15 was not appropriate for self-medication administration.

Record review on 09/15/2023 at 11:30 AM, the facility's RND binder showed there were no nurse delegated forms or tasks to review for R15.

In an interview on 09/15/2023 at 12:22 PM, Staff R, Medication Technician, stated they checked R15's blood sugar levels for them.

In an interview on 09/20/2023 at 8:26 AM, Staff R stated R15's hands shake and would require Staff R to hold R15's hands still to stop the shaking to allow R15 to poke their finger to check their blood sugar. Staff R stated R15's hands shake somedays more than others.

In an interview on 09/20/2023 at 2:37 PM, Staff E stated they were notified about R15's hands being shaky. Staff E stated R15 had required the medication technicians to hold R15's hands to stop the shaking to allow R15 to check their blood sugar or injection their insulin themselves. Staff E stated when the medication technicians hold R15's hands from shaking, and that gesture was hand over hand assistance. Staff E stated R15 required nurse delegation.

Resident 4 (R4)

Record review of R4's initial and Annual Licensed Nursing Assessment, dated 07/25/2023, showed R4 moved into the facility on [redacted]2023 with multiple medical diagnoses that included [redacted] and [redacted]. R4 was nonverbal or would say incoherent and nonsensical unrelated subjects during conversation.

Record review of R4's Medication Administration Record (MAR), dated 09/01/2023 through 09/30/2023, showed R4 had current orders for cetaphil moisturizing cream(medicated moisturize to help with dry or minor skin irritations) to apply to legs and feet two times daily, Ferrous sulfate (supplement that treats the lack of iron in the blood) 325 milligrams (mg) take one tablet two times daily, miconazole 2% powder (medicated powder that treats fungal rashes) apply externally to groin upper thigh area two times daily, multiple vitamin-iron (supplement medication that has multiple different vitamins and iron) one tablet daily, omeprazole 20 mg capsule take one capsule daily, quetiapine fumarate 100mg take one tablet daily at bedtime, quetiapine fumarate (prescribed medication to help treat behaviors and psychosis) 25mg take one tablet every afternoon, quetiapine fumarate 50mg take one tablet every morning, simvastatin (prescribed medication to help treat high cholesterol and reduce risk of heart and blood complications) 40 mg take one tablet at bedtime, warfarin

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sodium(prescribed medication to thin the blood) 5mg take one tablet daily at bedtime, acetaminophen (medication to help reduce pain and/or fever) 325mg take two tablets every four hours as needed for pain, clortrimazole 1 % cream (medicated cream for a fungal rash) apply externally to groin two times daily, and quetiapine fumarate 25mg take one tablet every eight hours as needed anxiety/agitation.

Record review of R4's Nurse Delegation: Nurse Visit form, dated 08/11/2023, showed R4 required nurse delegation for oral medications, topical creams, and all treatment related to advance dementia and cognitive impairment. Under the section "notes", showed R4 had dementia and short-term memory loss. R4 was only cognitive to self (not aware of others, safety, or environment).

Record review of R4's Nurse Delegation: Instructions for Nursing Task, dated 08/11/2023, showed the delegated task was for administering skin/topical medications. The form showed to complete steps six and seven if medications(s) delegated. Step six's directions showed "list specific medications(s), dosages and frequency of medications delegated on this dated" Staff E had documented in step six, showed "please see attachment". There was no healthcare provider or phone number documented on the form for R4.

Review of R4's Nurse Delegation: Instructions for Nursing Task, dated 08/11/2023, showed R4 required nurse delegation for "oral medications, administration; delegated staff will administer medications to resident, resident takes mediation, staff to document outcome." There were no medication names, dosages, frequency, and route were listed for step six.

Record review of R4's Physician's Orders dated 08/24/2023, showed R4's quetiapine fumarate 50mg directions were to take one tablet two times daily. The other medications name, dosage, and frequency were the same R4's September 2023 MAR.

Resident 7 (R7)

Record review of R7's Resident Data Sheet, undated showed R7 moved into the facility on [redacted]/2022.

Record review of R7's Nurse Delegation: Nurse Visit form, dated 08/11/2023, showed R7 required nurse delegation for blood sugar checks and insulin administration for their diabetes mellitus type 2 and dementia/cognitive decline. Staff E documented that R7 has had a recent cognitive decline related to dementia.

Record review of R7's Nurse Delegation: Nursing Visit form, dated 05/05/2023, showed R7 required nursing delegation for their blood sugar checks and insulin. Under the section, "long term care worker training/competency" showed Staff R was listed to perform the delegated tasks. The form showed Staff R was added on 07/13/2023.

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Record review on 09/15/2023 at 11:30 AM, of the RND binder showed there were no documented weekly observation by the RN delegator for Staff R administering R7's insulin injections for review.

Record review of R7's Nurse Delegation: Instructions for Nursing Task, dated 05/05/2023 showed R7 required their insulin pen to be administered by the delegated staff. The box was checked for step six that indicated additional form was attached.

Review of R7's addition form titled Physician's Orders, dated 05/10/2023, showed R7 had an order for Humalin insulin inject 21 units daily at breakfast and blood sugar check three times daily as needed for diabetes with scheduled times at 8 AM, 12 PM, and 1700 (5pm). Both orders showed "this is a delegated task to be performed by a delegated staff member". The physician order had 15 other medication orders listed.

Resident 14 (R14)

Record review of the facility's memory care resident characteristic roster and sample selection, dated 09/13/2023, showed R14 was identified to have RND services and cognitive impairment.

Record review of R14's Nurse Delegation: Nursing Visit form, dated 08/11/2023, showed R14 required nurse delegated services for their blood sugar checks and insulin administration related to their diabetes mellitus, dementia, and cognitive decline. Under the section titled, "long term care worker training", showed Staff R was listed as reviewed and approved to administer R14's insulin injections.

Record review on 09/15/2023 at 11:30 AM, of the RND binder showed there were no documented weekly observation by the RN delegator for Staff R administering R14's insulin injections for review.

Record review of R14's Nurse Delegation: Instructions for Nursing Task, dated 05/05/2023 showed R14 required their insulin pen to be administered by the delegated staff. The box was checked for step six that indicated an additional form was attached.

Record review of R14's Nurse Delegation: Instructions for Nursing Task, dated 05/05/2023 showed R14 required delegated staff to check their blood sugar level. The box was checked for step six that indicated an additional form was attached.

Review of R14's addition form titled, Physician's Orders, dated 05/10/2023, showed R14 had an order for lispro insulin (prescribed injected medication to help reduce the amount of sugar in the blood quickly) inject 10 units daily before meals, lantus insulin (prescribed injected medication to help reduce the amount of sugar in the blood over a long period of

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time/slow releasing) inject 22 units once daily. Both orders showed "this is a delegated task to be performed by a delegated staff member". The physician order had 13 other prescribed medication orders listed. There were no current orders for R14 to have their blood sugar levels checked. There was an order for the facility staff to send R14's 30-day worth of blood sugars on the first of every month for the prior month. The form showed "I have reviewed the above information… My signature certifies that this resident still needs the level of care indicated. This is based on my evaluation of the resident's current medical condition."

Resident 5 (R5)

Record review of the facility's memory care resident characteristic roster and sample selection, dated 09/13/2023, showed R5 was identified to have RND services and cognitive impairment.

Record review of R5's Nurse Delegation: Nursing Visit form, dated 08/11/2023, showed R5 required nurse delegation services for their oral medications, topical creams, and ointments related to R5's dementia, short-term memory loss, and cognitive decline.

Record review of R5's Nurse Delegation: Nursing Visit, dated 05/10/2023 showed, R5 required delegated staff to apply anti-fungal cream. There was a handwritten note that showed "08/11/2023 [Staff E's initials] all meds [medications] and treatments".

Record review of R5's Nurse Delegation: Instructions for Nursing Task, dated 08/11/2023, showed R5 required delegated staff to administer oral medications. The box was checked for step six that indicated an additional form was attached.

Review of R5's addition form titled, Physician's Orders, dated 05/11/2023, showed R5 had the following orders: aspirin (low dose medication to help thin the blood) 81 mg take daily, carvedilol (medication to help reduce high blood pressure) 12.5mg take two times daily with meals, famotidine (medication to help reduce acid in the stomach) 20mg take two times daily, furosemide (medication to help reduce the excessive amount of fluid with in the body) 40mg take one time daily, loratadine (medication to help reduce allergy symptoms) 10mg take one tablet daily, losartan (prescribed medication to help lower high blood pressure) 50mg take one tablet daily, potassium chloride (prescribed medication to help replace potassium electrolyte within the body) 20 milliequivalents take in four to eight ounces of liquid by mouth two times daily, vitamin b-1 (medications to increase vitamin b1 level) take one tablet by mouth daily, vitamin D3 (medication to increase vitamin d level in the blood) take one capsule daily, acetaminophen 500mg take two tables every eight hours as needed for pain, clotrimazole (antifungal medicated cream) 1% apply topically to affected area two times daily, oxycodone (prescribed medication to help with pain) take half to one tablet two times daily as needed for pain. The only medications that showed R5 was delegated for was the clotrimazole cream. The form showed "I have reviewed the above information… My signature certifies that this resident still needs the level of care indicated. This is based on my evaluation of the resident's current medical condition."

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In an interview on 09/15/2023 at 12:22 PM, Staff R stated "I'm not sure, that's a good question" when they were asked who their Registered Nurse delegator was. Staff R stated they were delegated to administer delegated tasks and often would administer them in the memory care unit. Staff R stated they would notify their assisted living director when there were changes with delegated medication and not the delegating nurse. Staff R stated they were unsure where to locate the delegated nurse contact information if they were to call them. Staff R stated Staff E, Registered Nurse Corporate Regional, had only observed them four times administering insulin to a resident. Staff R stated they had not been observed to administer insulin with all of the delegated residents that required insulin administration.

In an interview on 09/20/2023 at 2:37 PM, Staff E, Registered Nurse Corporate Regional, stated they were the RND for the facility. Staff E stated they were trained to not write the residents medications on the Nurse Delegation: Instructions for Nursing Task and to document the route of the prescribed medication the resident was required to have delegated. Staff E stated that they had not observed Staff R to administer insulin every week for four weeks with R15, R14, and R7. Staff E stated they were trained to watch a new medication technician to administer any delegated resident's insulin once a week for four weeks and document. Staff E stated that their contact information was not posted for the medication technicians to call with changes. Staff E stated they would try and update the nurse delegation task forms when the medication orders changed.

This is an uncorrected citation previously cited on 05/31/2023.

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 Lacey is or will be in compliance with this law and / or regulation on (Date) 11/15/2023 .

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

Administrator (or Representative) — Date: 11/20/2023

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

(4) How residents with special needs are individually protected without unnecessary restrictions on the general population.

This document was prepared by Residential Care Services for the Locator website.

This requirement was not met as evidenced by:

Based on record review, observation, and interview the facility failed to secure potentially hazardous supplies accessible to memory care and assisted living residents for 1 of 1 locations within the facility (salon on the 1st floor outside of memory care unit). This failure placed 66 of 66 residents at risk for ingesting potentially toxic materials.

Findings included...

Record review of the facility's document titled, "employee in-service attendance record", dated 07/21/2023 at 2:00 PM, showed Staff B, Assistant Executive Director, presented to the employees a lecture about proper storage of chemicals. There were 34 different employee signatures on the in-service that showed they had attended the lecture in-service.

In an observation on 09/13/2023 at 11:19 AM, the door to the salon room closest to the South entry doors of the memory care unit was open. Inside the cupboard by a black metal filing cabinet was a white plastic bottle with a snap lid partial open. The bottle had a light pink faded label that read "crème cleanser" (a cleaning chemical). The bottle was not locked or secured within the cabinet. In the top unlocked cabinet by the far-left wall was an aerosol spray can with a label "Tri flow superior lubricant penetrates and protects formulated with PTFE" (a spray petroleum oil and paraffin wax solution to help prevent and protect bikes from rust and corrosion on the chains and gears) sitting on the shelf.

In an observation on 09/14/2023 at 4:41 PM, in the salon outside of the South entry doors of the memory care unit, on the top self of an unsecured, unlocked cabinet was an aerosol spray can of mechanical lubricant labeled, Tri flow superior lubricant. Inside an unlocked lower cabinet was a white bottle that was labeled "Crème cleaner".

In an observation on 09/15/2023 at 12:12 PM, the door to the salon outside of the memory care unit doors was open. The bottle of crème cleanser was still in the bottom cabinet unlocked. The aerosol spray can of Tri flow superior lubricant was still in the top cabinet unlocked or secured.

In an interview on 09/15/2023 at 2:20 PM, Staff A, Executive Director, stated no chemicals should be stored in the salon outside of the memory care unit. Staff G, Memory Care Director, stated there shouldn't be chemicals in that room. Staff A stated they would remove the chemicals today.

This is an uncorrected deficiency previously cited on 05/31/2023.

Plan/Attestation Statement

This document was prepared by Residential Care Services for the Locator website.

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 Lacey is or will be in compliance with this law and / or regulation on (Date) 11/5/2023.

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

Administrator (or Representative) — 11/29/2023 Date

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

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to address and resolve 2 of 9 sampled residents (Resident 8 and Resident 9) grievances. These failures placed the residents at risk for experiencing decreased quality of life.

Findings included...

"RCW 70.129.060 Grievances. A resident has the right to: (1) Voice grievances. Such grievances include those with respect to treatment that has been furnished as well as that which has not been furnished; and (2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents."

Record review of the facility's "Community Complaint Form", dated 07/19/2023, showed Resident 8 (R8) expressed a grievance that there was slow service to where they had to wait an hour and a half to be served lunch. The notes section showed Staff A, Executive Director, wrote that one of the cooks had walked off the job which caused the delay. The action plan section showed the facility plan was to implement the ambassador schedule to ensure timely service. Staff A signed that the grievance was resolved on 07/20/2023.

Record review of the facility's "Community Complaint Form", dated 09/11/2023, showed Resident 9 (R9) expressed a grievance to Staff B, Assistant Executive Director, that the special had not been available and that there was slow service to where they had waited 50 minutes. The notes section showed that servers made excuses for the delay as to why food was not coming out instead of telling R9 the truth. The conclusion section showed Staff N,

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Cook, was fed up with a resident who stated their meal was not correct and kept sending their order back to the kitchen. The issue with another resident held up other resident orders and caused residents to leave. The action plan showed the facility plan was to remove independent living residents from breakfast service. Staff B signed that the grievance was resolved on 09/11/2023. The action plan did not address why the special was not available and how the facility was going to accommodate lunch and dinner wait times.

Record review of the facility's "Community Complaint Form", dated 09/15/2023, showed R9 expressed a grievance that they had waited an hour for breakfast and when it arrived it was cold.

In an interview on 09/15/2023 at 10:20 AM, R9 stated they had completed a grievance form on 09/11/2023 that the special had run out and that they had experienced long wait times during breakfast. R9 stated other residents who came to breakfast after they did get fed up with the long wait times and left before eating. R9 stated none of the facility staff followed up with them regarding their concern they reported on 09/11/2023. R9 stated they completed another grievance form today on 09/15/2023 regarding long wait times and when their food arrived it was cold. R9 stated their sausage was cold and their bread was not warm enough to melt the butter.

In an interview on 09/15/2023 at 10:24 AM, Resident 10, R9's Spouse, stated that today on 09/15/2023 they waited an hour to be served breakfast and when it finally arrived it was cold.

In an interview on 09/15/2023 at 10:46 AM, Staff A, Executive Director, stated if a resident expressed a grievance their goal would be to have it resolved within 24 hours. Staff A stated all resident grievances were reported and talked about at their daily stand up meeting. Staff A stated if they processed a resident's grievance they would have talked to the resident, talked to the facility staff associated with the concern, and then follow up with the resident to address what happened before signing that the grievance was resolved. Staff A reviewed R9's "Community Complaint Form", dated 09/11/2023, and stated they were not aware of the grievance. Staff A stated Staff B followed up and signed off that the grievance had been resolved. Staff A stated they received a "Community Complaint Form", dated 09/15/2023, this morning and had not followed up yet.

In an interview on 09/15/2023 at 11:04 AM, Staff M, Dining Services Manager, stated that residents had expressed the food was cold "from time to time." Staff M stated they did not have concerns that the daily specials were running out. Staff M stated R9's concern on 09/11/2023 about long wait times and that the special ran out was never addressed with them.

In an interview on 09/14/2023 at 4:35 PM, Resident 12 (R12) stated the food that was supposed to be served hot was not. R12 stated they had been served cold meals on several occasions. R12 stated at times they were not served dessert because the facility "ran out." R12 said, "It's just not right; some people have to go without dessert while others never go

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without." R12 stated the Independent Living residents got served first and at times there was not enough food prepared for the assisted living residents to eat what was on the menu.

In an interview on 09/14/2023 at 4:40 PM, Resident 13 (R13) said the facility food service needed improvement. R13 stated the kitchen staff needed to pay more attention to serving food faster and at the correct temperature. R13 said the hot foods were not hot and they were served lukewarm.

In an interview on 09/15/2023 at 10:45 AM, Resident 6 (R6) said they opted out of going to breakfast in the dining room. R6 stated, "I don't go down there anymore because I have tried a few times and I either received cold food, or I never got waited on, so I quit going down for breakfast."

In an interview on 09/15/2023 at 10:53 AM, Staff H, Server said they received complaints from multiple residents that breakfast was served cold this morning. Staff H stated, "that is not unusual; I hear that a lot."

In an interview on 09/13/2023 at 8:54 AM, Staff C, Chief Operating Office of Corporate, stated the facility goal from when a resident sat down for dining and was completed with their meal was within the timeframe of 40 minutes.

This an uncorrected deficiency previously cited on 05/31/2023 for 388-78A-2660 for subsections (2)(4).

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 Lacey is or will be in compliance with this law and / or regulation on (Date) 11/5/2023

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

Administrator (or Representative) — Date: 11/28/2023

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: Bonaventure of Lacey
Provider Type: Assisted Living Facility
License/Cert.#: 2036
Compliance Determination #: 23273
Intake ID: 78067
Investigator: Anissa Bearden
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 05/02/2023 through 05/31/2023
Complainant Contact Date(s):

Allegation(s):

1. lack of communication with administrative staff. Administrator never available to talk with.
2. activities canceled frequently when Activity Director needed to assist with other positions.
3. there are only two housekeepers for the facility. The housekeepers didn't have a vacuum to use.
4. the facility hasn't been able to provide an up today handbook to the assisted living residents
5. long wait times in the dining room
6. dining room is running out of dishes and utensils.
7. food runs out at meals, don't get deserts.
8. foods are tough, dry. poor food quality and no condiments available
9. not enough wait staff during meal times.
10. kitchen equipment needs repaired
11. walkers and wheelchairs are parked in front of exit doors in the dinning room.
12. roof is leaking on the 4th floor in room 486 and 488
13. activities scheduled same time as resident council
14. assisted living residents are not being weighed and vitals checked monthly

Investigation Methods:

Sample:
Total residents: 65
Resident sample size: 9
Closed records sample size: 0

Observations:
Identified resident
Residents
Activities
Facility Environment
Dining
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions
Medication administration
Kitchen
Food preparation

This document was prepared by Residential Care Services for the Locator website.

Interviews:	Identified resident Identified staff Nursing staff Administrative staff Residents Family members Maintenance staff Housekeeping staff Kitchen staff
Record Reviews:	Medical records Hospital records Grievance log State reporting log Incident investigation Facility policies Personnel files Staff training records Maintenance logs

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Investigation Summary:

1. The department has a new administrator that was readily available to the residents and department. There were complaints, but resident stated this was improving. no failed practice.
2. There were multiple activities provided for the residents attend. there were no concerned expressed about activities canceled. no failed practice.
3. Record review of the housekeeping schedule showed they had adequate housekeeping staff seven days a week. there was failed practice with some of the cleanliness of the environment.
4. interviews and record review the facility has an up to date handbook for the Assisted Living residents . Residents were provided a copy of the handbook. no failed practice.
5. observation and interview showed there were long wait times for AL residents in the dinning room for meal services. Failed practice identified for meal interval times.
6. There is a facility issue with dishes and utensils not being returned to the facility. the facility has an incentive in place for the residents if they return their dishes from their room. system in place. no failed practice.
7. observation and interview there were no complaints that food had run out during meals. there were many options and alternatives available for the residents to choose from. no failed practice.
8. the residents complained of the food quality. the previous food service director no longer employed. facility identified concern and have a new food service director in place and addressing the concerns. no failed practice facility has plan in place to address concern.
9. observation and interview the facility failed to have adequate staffing in the AL dinning room that contributed to the long wait times in the dinning room. failed practice.
10. observation of the kitchen didn't not show there was kitchen equipment that needed replaced. there was failed practice of the kitchen not being serviced in the required time frame.
11. observation and interview there were walkers and wheelchairs parked in front of exit doors of the dinning room. failed practice identified.
12. observation of room 486 was no signs of roof leaking. observation of room 488 showed there was a previous leak, but room was independent living and RCS has no jurisdiction for the room. no failed practice.
13. interview about the resident council meeting, there were no concerns about any

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conflicts with the time and the activities at the same time. no failed practice.
14. record review of sampled residents showed there was monthly vitals and weights documented. no failed practice.

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 Lacey
Provider Type: Assisted Living Facility
License/Cert.#: 2036
Compliance Determination #: 23273
Intake ID: 80611
Investigator: Anissa Bearden
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 05/02/2023 through 05/31/2023
Complainant Contact Date(s):

Allegation(s):

1) Facility reported concern that a residents closet door fell off the hinges, onto them, and caused an injury.

Investigation Methods:

Sample:
Total residents: 65
Resident sample size: 9
Closed records sample size: 0

Observations:
Identified resident
Resident care equipment
Resident rooms

Interviews:
Identified resident
Nursing staff
Family members
Maintenance staff

Record Reviews:
Medical records
State reporting log
Incident investigation
Facility policies
Maintenance logs

Investigation Summary:

1) Based on observation, interview, and record review the facility failed to investigate incidents that jeopardized a residents health. Based on observation, interview, and record review the facility failed to update the residents Negotiated Service Agreement following a change. Based on observation, interview, and record review the facility failed to keep exterior grounds safe and in good repair.

Conclusion / Action:

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

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☐ N/A

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Residential Care Services
Investigation Summary Report

Provider/Facility: Bonaventure of Lacey
Provider Type: Assisted Living Facility
License/Cert.#: 2036
Compliance Determination #: 23273
Intake ID: 81343
Investigator: Anissa Bearden
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 05/02/2023 through 05/31/2023
Complainant Contact Date(s):

Allegation(s):

1) Concern the facility was informing residents if the residents could not provide their pets vaccination records within 24 hours then the pet needed to be removed from the premises.

Investigation Methods:

Sample: Total residents: 65
Resident sample size: 9
Closed records sample size: 0

Observations: Residents
Activities
Dining

Interviews: Residents
Family members
Identified staff

Record Reviews: Facility policies

Investigation Summary:

1) Based on observation, interview, and record review the facility failed to ensure all pets on the premises had their pet records and were free from diseases.

Conclusion / Action:

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

This document was prepared by Residential Care Services for the Locator website.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

AMENDED
08/18/2023

Licensee: Bonaventure of Lacey LLC
Bonaventure of Lacey
3425 Boone Rd SE
Salem, OR 97317

RE: Bonaventure of Lacey License # 2036

Dear Administrator:

The Department completed a full inspection and a complaint investigation of your Assisted Living Facility on 05/31/2023 and found that your facility does not meet the Assisted Living Facility licensing requirements.

You requested an Informal Dispute Resolution (IDR) review. The IDR review resulted in the enclosed amended Statement of Deficiencies.

The Department:
- Wrote the enclosed Statement of Deficiencies (SOD) report; and
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- May inspect the facility to determine if you have corrected all deficiencies.

You Must:
- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
  - o Mail the Plan/Attestation Statement and report with original signatures to:

This document was prepared by Residential Care Services for the Locator website.

Cory Cisneros, Field Manager
Residential Care Services
Region 3, Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

You May:
• Receive a letter of enforcement action based on any deficiency listed on the enclosed report.

If You Have Any Questions:
• Please contact me at (253)254-3190.

Sincerely,

Staci Dilg, IDR PM for Cory Cisneros, Reg 3E

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

Enclosure

This document was prepared by Residential Care Services for the Locator website.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

800 NE 136th Ave Ste 200, Vancouver, WA 98684

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 the unannounced on-site full inspection and complaint investigation on 05/02/2023, 05/03/2023, 05/04/2023, 05/05/2023, 05/08/2023, 05/09/2023 and 05/31/2023 of:
Bonaventure of Lacey
4528 Intelco Loop SE
Lacey, WA 98503

This document references the following complaint numbers: 78067, 80611, 81343.

The following sample was selected for review during the unannounced on-site visit: 9 of 65 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor
Cory Cisneros, Field Manager

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.

Staci Dicks IDR PM for Reg 3E — August 18, 2023

Residential Care Services — Date

This document was prepared by Residential Care Services for the Locator website.

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.

Megan Harrison
Administrator (or Representative)

08/22/2023
Date

WAC 388-78A-2462 Background checks Who is required to have.

(1) Applicants for an assisted living facility license, as defined in WAC 388-78A-2740 , must have the following background checks before licensure:

(a) A Washington state name and date of birth background check; and

(b) A national fingerprint background check.

(2) The assisted living facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012 have the following background checks:

(a) A Washington state name and date of birth background check; and

(b) A national fingerprint background check.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 6 sampled staff (Staff A) completed a Washington State Name and Date of Birth Background Check. This failure to ensure a Washington State Background Check was conducted placed 65 of 65 residents at risk for being cared for by a staff member with a potentially disqualifying history.

Findings included...

Record review of the facility provided employee list, showed Staff A, Interim Executive Director, was hired on 03/28/2023.

Record review of a document titled, "Background check unit, office of human resources shared services. Serving the department of human services and the Oregon health authority", dated 05/02/2023, showed Staff A, was required to schedule an electronic fingerprints through the State of Oregon's contractor.

Record review of Staff A's file, showed there was not a completed Washington state Background check or fingerprints for review.

This document was prepared by Residential Care Services for the Locator website.

In an interview on 05/04/2023 at 09:04 AM, Staff A, stated that they had filled out all of their forms with the corporation office. They were unsure if they completed a Washington State Background check.

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 Lacey is or will be in compliance with this law and / or regulation on (Date) 7/15/2023.

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

Megan Hart — Administrator (or Representative)

8/22/2023 — Date

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure the facility's hot water temperature did not go below 105 and above 120 degrees Fahrenheit (F). This failure placed 65 of 65 residents and 59 staff at risk for potential skin burns.

Findings included...

Record review of the facility's policy, titled, "Water temperature Log- Washington", undated, showed water temperatures were to be checked every two weeks. Hot water in all sinks and bathing fixtures used by residents were required to be between 105 degrees F and 120 degrees F.

Record review of the facility document, titled, "Washington Temperature Log- Washington", dated 03/01/2023, showed the hot water was checked and all within range on 03/01/2023. There were no other dates that the hot water temperatures were checked and documented.

In an observation on 05/02/2023 at 11:49 AM, the public sink on the south side of the memory care unit had a hot water temperature of 124.9 degrees F.

In an observation on 05/02/2023 at 11:54 AM, the public accessible sink on north side of the memory care unit had a hot water temperature of 124.4 degrees F.

This document was prepared by Residential Care Services for the Locator website.

In an observation on 05/02/2023 at 12:18 PM, the public bathroom on the first floor had a hot water temperature of 131.3 degrees F. There was visual steam rising from the running water.

In an observation on 05/02/2023 at 12:21 PM, the second floor activity room's public sink had a hot water temperature of 127.7 degrees F.

In an interview on 05/02/2023 at 12:20PM, Staff F, Assisted Living Director, stated that the residents use the activity's room public sink to wash their hands during the happy hour activity.

In an observation on 05/02/2023 at 12:30 PM, the second floor assisted living laundry room's sink had a hot water temperature of 127.8 degrees F. There was visual steam rising from the running water.

In an observation and interview on 05/02/2023 at 12:46 PM, Staff A, Interim Executive Director, checked the second floor public bathroom water temperature. The hot water's temperature read at 134.2 degrees F. Staff A stated that was "hot". Staff A stated that maintenance staff checked the water temperatures routinely. Staff A stated the facility maintenance staff was adjusting the water temperatures from a mixing valve that was replaced. Staff A stated the maintenance staff from their sister facility would come over that day to turn down the hot water temperature.

In an interview on 05/03/2023 at 9:33 AM, Resident 10 (R10) stated that the water temperature in their room gets too hot.

In an observation on 05/03/2023 at 9:58 AM, R10's apartment sink on the fourth floor had a hot water temperature of 120.2 degrees F.

In an observation on 05/03/2023 at 11:16 AM, the hot water temperature of the second floor assisted living laundry room was at 122 degrees F.

In an interview on 05/03/2023 at 11:39 AM, Staff S, Maintenance, stated the facility didn't have a maintenance director. Staff S stated they had traveling maintenance staff come to assist with repairs that were needed. Staff S stated the facility hadn't had a maintenance staff member for about one month. Staff S stated the facility's hot water temperatures were checked every other week by the maintenance director. Staff S stated they had never been showed how to check and document water temperatures for the facility. Staff S stated that Staff B, Assistant Executive Director, stated that they needed to turn the hot water temperature down that day (05/03/2023). Staff S stated the hot water temperature that morning around 8:30 AM in the café on the first floor was 125 degrees F. Staff S stated the hot water was to be maximum temperature of 120 degrees F.

This document was prepared by Residential Care Services for the Locator website.

In an observation and interview on 05/03/2023 at 11:48 AM, Staff S checked the hot water temperature in the café on the first floor. The water temperature on Staff S's thermometer showed 122 degrees F. There was steam visually rising when the water was running. Staff S stated, "that isn't that hot".

In an observation and interview on 05/03/2023 at 11:50 AM, Staff S was in the hot water heater room on the first floor. The temperature gauge on the wall showed 123 degrees F. Staff S stated the dial was reading 130 degrees F before they had turned it down. Staff S stated the temperature was okay at 122 degrees F.

In an observation on 05/03/2023 at 1:45 PM, the handwashing sink in the kitchen had a hot water temperature of 86 degrees F.

In an interview on 05/03/2023 at 3:08 PM, Staff R, Traveling Maintenance – Corporate, stated they were not responsible for checking the hot water temperatures for the facility. Staff R stated the facility's maintenance director was to check the hot water temperatures. Staff R stated the facility currently did not have a maintenance director. Staff R stated Staff S was responsible for completing water temperature checks within the facility in the absence of the director. Staff R stated that he was informed by Staff B at 8:40 AM that morning that the hot water was too hot. Staff R stated they had checked the water temperature dial in the hot water heater room and it was 130 degrees F, which was too hot. Staff R stated they turned the water temperature down at that time, but they did not check the hot water temperature with a thermometer prior to or after turning the water temperature down.

In an observation on 05/04/2023 at 11:20 AM, Resident 7's apartment sink in the Memory Care unit had a hot water temperature of 102.9 degrees F.

In an interview on 05/04/2023 at 3:11 PM, Resident 2 (R2) stated the water temperature in their room was too hot. R2 stated they make sure to turn the cold water on to make sure the hot water doesn't burn them before using the water.

In an interview on 05/05/2023 at 10:45 AM, Staff T, Traveling Maintenance – Corporate, stated the hot water temperatures were supposed to be checked every two weeks.

In an observation on 05/05/2023 at 11:43 AM, the hot water temperature of the south side of the Memory Care common area laundry room sink, accessible to memory care residents, of 122.1 degrees F.

In an observation on 05/05/2023 at 12:15 PM, the hot water temperature of the public sink on the fourth floor assisted living laundry room of 122.9 degrees F.

In an interview on 05/05/2023 at 12:33 PM, Staff S stated that they hadn't checked the hot

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water temperature since 05/03/2023. Staff S stated that Staff R was checking the hot water temperatures. Staff S was unaware that the hot water was still running too hot.

In an interview on 05/05/2023 at 1:29 PM, Staff B stated they were unaware of who was designated to be checking the hot water temperatures. Staff B was unaware the water remained out of range.

Record review of the facility, Safety Plan - Water Temperatures, undated, showed hot water temperatures was checked on 05/05/2023 at 2:18pm. The hot water temperature was adjusted down on 05/05/2023 at 2:20 PM. The hot water temperature was to be checked on 05/05/2023 at 5:30 PM. If the temperature was not in acceptable range a plumber would be called out to service the system. The facility was to check the hot water temperatures three times daily for the next 72 hours to ensure hot water was within acceptable parameters.

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 Lacey is or will be in compliance with this law and / or regulation on (Date) 7/15/2023.

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

Megan Hart — Administrator (or Representative)

8/22/2023 — Date

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to stay in compliance with the local District State Fire Marshal. This failure placed 65 of 65 residents and 59 staff's life and safety at risk in the event of a fire.

Findings included...

Review of the state Fire Marshall regulation codes showed the facility was out of compliance with, "Code IFC 5303.5.3 2018: compressed gas containers, cylinders and tanks shall be secured to prevent falling caused by contact, vibration or seismic activity. Securing of compressed gas containers, cylinders and tanks shall be by one of the following methods: 1. Securing containers, cylinders and tanks to a fixed object with one

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or more restraints. 2. Securing containers, cylinders and tanks on a cart or other mobile device designed for the movement of compressed gas containers, cylinders or tanks. 3. Nesting of compressed gas containers, cylinders and tanks at container filling or servicing facilities or in sellers' warehouses not open to the public. Nesting shall be allowed provided that the nested containers, cylinders or tanks, if dislodged, do not obstruct the required means of egress. 4. Securing of compressed gas containers, cylinders and tanks to or within a rack, framework, cabinet or similar assembly designed for such use. Exception: Compressed gas containers, cylinders and tanks in the process of examination, filling, transport or servicing. "

Code IFC 607.3.3 2018: "Hoods, grease-removal devices, fans, ducts and other appurtenances shall be cleaned at intervals as required by sections 607.3.3.1 through 607.3.3.3."

In an observation on 05/02/2023 at 1:49 PM, there was a cylinder of carbon dioxide free standing unsecured in the kitchen's dry storage room.

In an observation on 05/02/2023 at 1:59 PM, the kitchen hood had a label that showed it was last serviced September 2022. The label showed the next service was due March 2023. The vents on the hood were observed to be yellow with brown dust matter on them, making it difficult to see the silver of the vents. There was a vent that was skewed off the track.

In an interview on 05/02/2023 at 2:03 PM, Staff N, Food Service Director Corporate, stated the kitchen hood was serviced every three to six months. Staff N stated that from the label on the hood, it should have been serviced in March 2023. Staff N stated that the company that comes out to service the kitchen hood would change the label that tells when it was serviced and when it was next due.

In an interview on 05/02/2023 at 2:18 PM, Staff A, Interim Executive Director, and Staff B, Assistant Executive Director, stated they didn't know how often the kitchen hood was to be serviced. Staff B, called Staff AA, Corporate Life Safety System Manager, and asked them how often the kitchen hood was to be serviced. Staff AA stated it was to be cleaned and serviced two times a year.

Record review of an email the department received on 05/08/2023 at 7:56 AM, showed Collateral Contact 1 (CC1), Local Fire Marshall stated that they observed the hood to be out of date with the required service requirement. CC1 stated they told the facility they needed to have the kitchen hood and duct cleaned and serviced.

This is recurring deficiency previously cited on 10/14/2022 and 09/15/2022.

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Plan/Attestation Statement

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Megan Hu — 8/22/2023

Administrator (or Representative) — Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(a) In containers with pharmacist-prepared label or original manufacturer's label;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure medications were stored properly and secured for 1 of 1 medication carts and 1 of 2 first aid kits. This failure placed 49 of 49 assisted living residents at risk to ingest non prescribed medications in error.

Findings included...

Record review of the facility's document, "Medication Systems Summary Module 2", dated 05/01/2023, under the section "medication Storage", showed to store an over the counter medication with its original label and, as possible, in the original container. It was to be marked/labeled to designate the resident user. Prescription medications were to be stored in all containers dispensed by the pharmacy and seek to maintain the original label as intake and legible. Store mediations in a locked container, cart, or refrigerator per the label of the indicated medication directions.

In an observation on 05/02/2023, at 12:30 PM, the Assisted Living resident laundry room on the second floor, had a first aid box, with a packet of two aspirin tablets that were inside, unsecured or locked.

In an observation on 05/03/2023 at 12:12 PM, the medication cart on the second floor by the medication/charting room was noted to have a paper medication cup with two brown colored round pills inside. The outside of one of the paper cups had a handwritten note that showed, "330 double popped".

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In an interview on 05/03/2023 at 12:15 PM, Staff H, Medication Aide, stated those pills had been in the cart like that since they came onto shift at 6:00 AM. Staff H stated they didn't know what the medications were and assumed they were from evening shift the day before.

In an observation and interview on 05/04/2023 at 4:35 PM, Staff L, Medication Aide, opened the top drawer of the medication cart. There was a paper cup with six different colored and shaped medications. There was not a label on the medications cup, no name, or any other identification that showed who's medications were in the cup. Staff L, stated that the medications in the paper cup were for Resident 3, that they had prepped, but not had given. Staff L, stated that they were only to store resident medications in their original packaging or bottles from the pharmacy or stores. Staff L stated if the medications were dispensed in error they were to destroy the medications. Staff L stated that they had dispensed out an extra dose of medications for Resident 4 on the evening of 05/02/2023. They had left them in a paper cup with a handwritten note "330 double popped". Staff L stated they should have discarded the medication, but had left them in the top drawer of the medication cart.

In an interview on 05/03/2023 at 1:30 PM, Staff F, Assisted Living Director, stated that medications were only to be stored in the medication cart in the original packaging from the pharmacy or the store.

Plan/Attestation Statement

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Megan Hamm — Administrator (or Representative)

8/22/2023 — Date

WAC 388-78A-2250 Alteration of medications. The assisted living facility must generally provide medications in the form they are prescribed when administering medications or providing medication assistance to a resident. The assisted living facility may provide medications in an altered form consistent with the following:

(1) Alteration includes, but is not limited to, crushing tablets, cutting tablets in half, opening capsules, mixing powdered medications with foods or liquids, or mixing tablets or capsules with foods or liquids.

(2) Residents must be aware that the medication is being altered or added to their food.

(3) A pharmacist or other practitioner practicing within their scope of practice must determine that it is safe to alter a medication.

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(4) If the medication is altered, documentation of the appropriateness of the alteration must be on the prescription container, or in the resident's record.

(5) Alteration of medications for self-administration with assistance is provided in accordance with chapter 246-888 WAC.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to have an order to crush a resident's medication or mix their medications with food or drinks from their provider. This failure placed 1 of 3 sampled residents (Resident 8) at risk of potential change in effects of the medications consumed.

Findings included...

Record review of the facility's document, "Medication System Summary Module 3", dated 05/01/2023, under the section titled "Preparing and Passing Medications, General Instructions", showed staff shall NOT cut/crush/alter/dilute a medication unless directed by a physician or appropriate licensed
health care person. Staff shall not mix medication in food without a physician's order and should tell the resident when offering medication in food.

Record review of the "Resident Data Sheet", for Resident 8 (R8) undated, showed they moved into the facility on [redacted]/2023.

Record review of the facility document titled, "Initial and Annual Nursing Assessment", dated 04/17/2023, showed R8 had multiple medical diagnoses including [redacted].

Record review of the facility document titled, "Discharge Medication Orders", dated 04/04/2023, showed there was no order for R8's medications to be crushed or mixed in food or drinks.

In an interview on 05/04/2023 at 4:35 PM, Staff L, Medication Aide, stated they had to crush R8's medications and mix with applesauce or their health drink for them to take.

In an interview on 05/05/2023 at 12:38 PM, Staff H, Medication Aide, stated that R8 had difficulty swallowing at times and would mix R8's medications in applesauce or pudding.

Record review of R8's records on 05/05/2023, showed there was no order for the resident to have their medications crushed or mixed in food/drinks.

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In an interview on 05/08/2023 at 10:06 AM, Staff Y, Medication Aide, stated they had to crush R8's medication and mix R8's medications with yogurt or applesauce. Staff Y stated they gave the medications with either soda or a health shake. Staff Y was unsure if there was an order to crush or mix R8's medications with food or fluids.

As of 05/10/2023, the department had not received documentation of an order for R8 to have their medications crushed or mixed with food or drinks.

Plan/Attestation Statement

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

Megan Hunt — Administrator (or Representative)

8/22/2023 — Date

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to notify the physician and monitor the resident after they refused their medications for 1 of 6 sampled residents (Resident 8). This failure placed the resident at risk for medical complications that resulted in constipation for the resident.

Findings included...

Record review of the facility's document, "Medication System Summary Module 3", dated 05/01/2023, under the section titled, "Refused Medications", showed the medication aide would make one or more attempts to offer the medication within the allowed medication pass time. They would document the refusal as the section titled, "Med Pass Exceptions" explained. The medication aide had a responsibility to place the resident on alert charting for any refused or missed medications. Notification would be sent to the primary care

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physician (PCP). The section titled "Med Pass Exception", showed the medication aide had to document using the exceptions option. They were to fax the residents PCP to notify them that the medication wasn't administered and the reason why. They were to document in the medication pass screen or as an entry in the progress notes that medications were refused and PCP was notified.

Record review of R8's MAR, showed Lidocaine patch 4 % was to be applied daily for 12 hours then removed off for 12 hours.

Record review of the R8's MAR, showed docusate and Senna 8.6-50 milligrams, take two tablets daily at bedtime to help with constipation.

Record review of R8's MAR, showed polyeth glycol 3350 17 grams mix in eight ounces of water and drink daily for constipation.

Record review of R8's Medication Administration Record (MAR), dated 04/10/2023 – 04/30/2023, showed the medication Lidocaine patch (pain medication patch) was refused 21 of 21 days. There was no documentation on the MAR that the physician was notified. The medication polyeth glycol (stool softener) was refused 9 of 21 days. There was no documentation that showed R8's physician was notified.

In an interview on 05/08/2023 at 10:06 AM, Staff Y, Medication Aide, stated if a resident refused their medication(s) they would reapproach them 15 – 20 minutes later. They would ask the resident as to why the resident was refusing to take their medication. Staff Y stated they "would trick the resident to take their medication and tell them that it was their pain medications". After the third attempt they would dispose of the medications and document on the MAR. Staff Y stated they would not notify the residents physician or place on alert charting.

Record review of R8's MAR, dated 05/01/2023- 05/04/2023, showed the medication Lidocaine patch was refused three of four days. There was no documentation that showed the physician was notified. The medications docusate and senna (stool softeners) were refused two of four days. There was no documentation that the physician was notified.

In an interview on 05/08/2023 at 4:37 PM, Collateral Contact 6 (CC6), Hospice Registered Nurse, stated they had just become aware that R8 had been severely constipated (inability to have a bowel movement). CC6 stated that they were unaware that the medication aides were not administering R8's stool softener medications, and that contributed to the resident becoming constipated. CC6 stated the hospice team and physician were not notified that the medications were refused.

Record review of R8's hospice provided Narrative notes, dated 04/11/2023 – 04/30/2023, showed there was no documentation that hospice was notified that R8 had refused their medications.

In an interview on 05/08/2023 at 10:30 AM, Staff E, Corporate Registered Nurse, stated if

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a resident refused their medication the medication aide would attempt on three separate occasions to administer the medication. If the resident continued to decline the medication, the medication aide would document the refusal on the MAR. They would document in the progress notes. If the medication was important such as a blood thinner (medication that thins blood), insulin (medication to lower blood sugar), or blood pressure medication they would place the resident on alert charting. Vitals signs would be obtained from the resident, documented, and the physician would be notified.

Record review of the progress notes dated 04/07/2023 – 05/04/2023, showed there was no documentation about R8 refusing their medications. There was no documentation that the physician and hospice team were notified.

This is recurring deficiency previously cited on 01/05/2022.

Plan/Attestation Statement

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Megan Hn — 8/22/2023

Administrator (or Representative) — Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 1 of 3 residents (Resident 8) medications were available to be administered. This failure contributed to Resident 8 not receiving medications as ordered.

Findings included...

Record review of the facility's document, "Medication System Summary Module 3", dated 05/01/2023, under the section titled, "Medication Not Available", showed when medication was not available for a scheduled time pass, staff shall take necessary steps to obtain the medications and properly notify as required and document the steps taken to obtain.

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Record review of the facility document, titled, "Health Services Medication Technician & Qmap Training Manual", updated 05/01/2023, showed, under the section titled, "Medication Not Available", showed when mediation was not available for a scheduled time pass, staff shall take necessary steps to obtain the medications and properly notify as required and document the steps taken to obtain. Under the section titled "Procedure", showed:
-Identify the needed medication that was not available.
-Fax and call the pharmacy (and/or notify the family if they were a possible source for delivery) about a plan to deliver the medication and document your contact. If medication could be purchased over the counter, contact family or your ED (Executive Director) to discuss pick-up options to avoid the resident to go without medications.
- Alert the physician about unavailability and ask for an order to hold the medication until the planned delivery.
- Notify the Executive Director and the Community LN (Licensed Nurse) about the missed dose.
- Document in CareSuite (facilities charting system) by completing an exception. Be as detailed as possible noting all your attempts and that PCP (Primary Care Provider) was notified.
- Place the resident on alert charting to observe for changes in condition related to the missed medication and indicate the expected delivery time.
- Repeat steps each time a dose is missed, omitting step three if it does not apply each time.

Resident 8

Record review of the "Resident Data Sheet", for Resident 8 (R8), undated, showed R8 moved into the facility on [redacted]/2023.

Record review of the documented titled, "Initial and Annual Nursing Assessment", dated 04/17/2023, showed R8 had multiple medical diagnoses including [redacted]), and recent [redacted]

Record review of R8's Medication Administration Record (MAR), dated 04/10/2023 – 04/30/2023, showed Acetaminophen (pain medication) was not available for administration for three of five doses for two days. The medications, Atorvastatin (reduces amount of cholesterol in the body), Trazadone (sleep aid/mood stabilizer), melatonin (sleep aid), Aspirin (blood thinning medications) were not available for one of two days. The medications, Docusate and Senna (stool softeners), levetiracetam (medication to control seizures), Lidocaine patch (pain medication patch), and Senna (stool softener) were not available for administration for two of two days. There was no documentation that showed the PCP was notified the medications were missed as they weren't available at the facility to administer.

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Record review of R8's MAR, dated 05/01/2023 – 05/04/2023, showed the medication atorvastatin (helps reduce the cholesterol) was not available for administration for two of four days. There was no documentation that the physician was notified. The medication, Trazadone (to help with sleep and mood), showed it was unavailable for administration for two of four days. There was no documentation that the physician was notified.

Record review of the hospice provider Narrative notes, dated 04/11/2023 – 04/30/2023, showed there was no documentation that hospice was notified that R8's medications were not available to be administered.

Record review of R8's progress notes, dated 04/07/2023 – 05/04/2023, showed there was no documentation that R8's medications were unavailable and were not administered. There was no documentation the physician or the hospice provider was notified. R8 was not placed on alert charting for the missed medications.

In an interview on 05/08/2023 at 10:06 AM, Staff Y, Medication Aide, stated if a resident's medication were not available, they would check the medication cart and room for the medication. They would then check the MAR to verify if the medication had been unavailable. They would call the pharmacy or provider to see when the medication would be delivered. They stated they wouldn't notify the physician that the resident missed the medication as the medications are through a third party. They stated the resident would only be placed on alert charting if they had missed more than 3 days of their medication.

In an interview on 05/08/2023 at 10:30 AM, Staff E, Regional Corporate Registered Nurse, stated "the medication aides were to call the pharmacy to see when the medication would be delivered. The medication that was not available would be considered missed. The resident would be placed on alert charting if the medication was important. The unavailable medication would be documented in the progress notes and on the medication administration record as missed. The primary care physician would be notified by fax that the medication was unavailable to be administered."

In an interview on 05/08/2023 at 4:37 PM, Collateral Contact 6 (CC6), Hospice Registered Nurse, stated that R8 had been severely constipated (inability to have a bowel movement). CC6 stated that they were unaware that the medication aides were not administering R8's stool softener medications, and that contributed to the resident becoming constipated.

This is recurring deficiency previously cited on 01/05/2022.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 8/22/2023

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(a) Provide a minimum of three meals a day:

(i) At regular intervals;

This requirement was not met as evidenced by:

Based on record review, observation, and interview the facility failed to provide meals at regular time intervals for 5 of 5 sampled residents (Resident 4, Resident 8, Resident 9, Resident 10, and Resident 13). This failure resulted in meals being served late and placed 65 of 65 residents at risk of a diminished quality of life.

Findings included...

Record review of the facility policy, titled, "Dining Room Service Policy", dated July 2009, showed each community was to provide dining room service with high standards of graciousness and hospitality. The Executive Director and Food Service Director were jointly responsible to assure the quality of the dining experience.

Record review of the facility's document, "Meal Times", flyer, undated, showed the service times for meals of the AL (Assisted Living) dining room were: breakfast was from 7:30 AM – 9:30 AM, lunch was from 12:00 PM – 1:00 PM, and dinner was from 5:00 PM – 6:00 PM.

Record review of the facility Complaint Tracking log, dated April 2023, showed on 04/04/2023 there were two complaints reported regarding the kitchen food and service. There was a complaint reported on 04/07/2023 regarding the meal wait times. There was a complaint on 04/07/2023 regarding the kitchen service. There was a complaint reported on 04/08/2023 regarding the temperature of the food. There was a complaint reported on 04/14/2023 regarding the kitchen service. There was a complaint on 04/15/2023 regarding the kitchen wait times. There was a complaint on 04/19/2023 regarding the kitchen service. There was a complaint reported on 04/21/2023 regarding the kitchen

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service. There was a complaint on 04/23/2023 regarding the meal service. There was a complaint on 04/28/2023 regarding the kitchen.

Record review of the facility's, Complaint Tracking log, dated May 2023, showed there was a complaint reported on 05/02/2023 regarding the kitchen service. There was a complaint on 05/03/2023 regarding the kitchen.

In an interview on 05/02/2023 at 9:33 AM, Resident 10, stated they had expressed concern regarding long wait times for meals. R10 stated they had not recieved any follow up.

In an observation on 05/02/2023 at 12:43 PM, showed multiple assisted living residents had not been served their meals.

In an interview on 05/02/2023 at 12:45 PM, Staff F, Assisted Living Director, stated that the facility served meals restaurant style. Staff F stated the residents would first be served drinks, then offered soup or salad, and then would be served their main meal. Staff F stated the residents should be served their meals between 15-20 minutes of sitting down.

In an observation on 05/03/2023 at 12:05 PM, showed Resident 4 (R4) had already sat down in the dining room for lunch. At 12:28 PM, Staff Z, Medication Aide asked R4 if they were tired because their head was down with their chin to their chest. At 12:41 PM, Staff P, came to take R4's order and verbally stated "R4 was knocked out and they would continue to let R4 sleep."

In an observation on 05/03/2023 at 12:05 PM, showed Resident 8 (R8) had already sat down in the dining room for lunch. At 12:42 PM, Staff P, took R8's meal order. At 12:54 PM, R8's food was delivered.

In an observation on 05/03/2023 at 12:05 PM, showed Resident 9 (R9) and Resident 10 (R10) had already sat down in the dining room for lunch. At 12:24 PM, Staff P took R9 and R10's meal order. At 12:52 PM, R9 and R10's food was delivered.

In an observation on 05/03/2023 at 12:05 PM, showed Resident 13 (R13) had already sat down for lunch. Staff Z, checked on R13 at 12:30 PM. R13 shouted in a frustrated tone, "I've got nothing, I've got no coffee or anything!" At 12:44 PM, Staff P took R13's meal order. R13 stated he was tired of waiting. At 12:54 PM R13's food was delivered.

In an observation on 05/03/2023 at 12:24 PM, Staff P, Server, was the only staff member that took residents orders for lunch. Staff P was observed to start taking residents orders at 12:24 PM.

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In an interview on 05/03/2023 at 2:51 PM, Staff H, Medication Aide, stated there were not enough servers. Staff H stated there was one server who took orders for the assisted living dining room. Staff H stated the facility had instructed other departments to help during mealtimes. Staff H stated R4 was asleep during lunch today. Staff H stated if R4 did not have to wait for their meal so long then they would not have fallen asleep.

In an interview on 05/03/2023 at 3:11 PM, Staff P stated when they took orders during meals, "It's just me." Staff P stated they would get help from other servers with bringing food out to the residents. Staff P stated that the resident's often expressed frustration with the long wait times.

In an interview on 05/03/2023 at 3:18 PM, Staff O, Cook, stated there were supposed to be at least two servers that took orders during mealtimes. Staff O stated due to staffing issues, the facility had not been able to properly serve the assisted living dining room by providing two servers for all meals. Staff O stated the facility had been having this issue since as long as they had worked there.

Record review of the facility provided employee list, showed Staff O, Cook, was hired on 12/10/2021.

In an interview on 05/08/2023 at 2:44 PM, Staff B, Assistant Executive Director, stated when a resident sat down for mealtimes, they should be served their drink within five minutes. Staff B stated at that time if the residents were ready to order they can order their meals. Staff B stated the facility would like the start to finish dining process be completed within 30 – 45 minutes. Staff B stated based on current census there should be three-four servers that helped during mealtimes.

In an interview on 05/08/2023 at 2:45 PM, Staff C, Registered Nurse Regional Director of Operations, stated the servers started serving independent living dining residents first and then move to assisted living dining residents. Staff C stated the servers were supposed to move back and forth between the two dining rooms during mealtimes.

Plan/Attestation Statement

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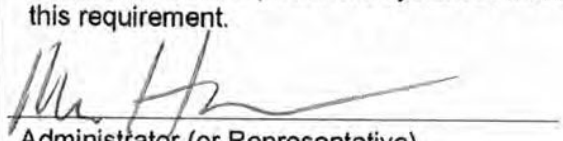

Administrator (or Representative)

8/22/2023

Date

This document was prepared by Residential Care Services for the Locator website.

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(a) Orientation and safety;

(d) Cardiopulmonary resuscitation and first aid; and

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 3 of 6 sampled staff (Staff A, Staff I, and Staff X) had an up to date First Aid/CPR (cardiopulmonary resuscitation) card on file. The facility failed to ensure 4 of 6 sampled Staff (Staff I, Staff V, Staff W, and Staff X) had completed their facility orientation. These failures placed 65 of 65 residents at risk for staff not being trained on life saving measures and staff not being unaware of facility protocols upon hire.

Findings included...

Record review of the provider letter sent by the Department, dated 09/22/2022 amended date 10/07/2022, showed CPR and first aid training no longer had emergency rules in place. All facilities were to be back in compliance by 10/27/2022.

First Aid

Record review of the facility provided staff list, undated, showed Staff A, Interim Executive Director (IED), was hired on 03/28/2023.

Record review of Staff A's personnel file, undated, showed Staff A's First Aid/CPR course was expired. The course was completed on 01/07/2017. The document showed the card was good for 2 years from the date of class and expired on 01/07/2019.

Record review of the facility provided staff list, undated, showed Staff I, Caregiver, was hired on 04/25/2023.

Record review of Staff I's personnel file, undated, showed Staff I did not have a First Aid/CPR card to review.

Record review of the facility provided staff list, undated, showed Staff X, Memory Care Director, was hired on 04/08/2020.

This document was prepared by Residential Care Services for the Locator website.

Record review of Staff X's personnel file, undated, showed Staff X did not have a First Aid/CPR card to review.

In an interview on 05/08/2023 at 2:37 PM, Staff B, Assistant Executive Director, stated they were responsible for ensuring the facility staff had their current First Aid/CPR certifications.

Facility Orientation

Record review of the facility provided staff list, undated, showed Staff I, Caregiver, was hired on 04/25/2023.

Record review of Staff I's Personnel File Checklist, undated, showed Staff I had not completed the facility orientation.

Record review of the facility provided staff list, undated, showed Staff V, Receptionist, was hired on 04/05/2023.

Record review of Staff V's Personnel File Checklist, undated, showed Staff V had not completed the facility orientation.

Record review of the facility provided staff list, undated, showed W, Cook/Server, was hired on 03/27/2023.

Record review of Staff W's Personnel File Checklist, undated, showed Staff W had not completed the facility orientation.

Record review of the facility provided staff list, undated, showed Staff X, Memory Care Director, was hired on 04/08/2020.

Record review of Staff X's Personnel File Checklist, undated, showed Staff X had not completed the facility orientation.

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 Lacey is or will be in compliance with this law and / or regulation on (Date) 7/15/2023.

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

This document was prepared by Residential Care Services for the Locator website.

Administrator (or Representative) — Date: 8/22/2023

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure staff received their food handlers training for 5 of 6 sampled staff (Staff F, Staff I, Staff V, Staff X, and Staff BB). The facility failed to properly store and label food for 2 of 2 kitchens reviewed . These failures placed 65 of 65 residents at risk for receiving food that was incorrectly prepared by an unqualified staff and at risk for exposure to food-borne illnesses.

Findings included...

WAC 246-217-015 (1)
"(1) All food service workers must obtain a food worker card within fourteen calendar days from the beginning of employment at a food service establishment, except as provided in subsection (4) of this section."

WAC 246-217-025 (1)(8)(9)
"(1) In order to qualify for issuance of an initial or renewal food worker card, an applicant must demonstrate his/her knowledge of safe food handling practices by satisfactorily completing an examination conducted by the local health officer or designee.
(8) Copies of food worker cards for all employed food service workers must be kept on file by the employer or kept by the employee on his or her person and open for inspection at all times by authorized public health officials."

WAC 246-217-035 (1) (5)(c)
"(1) All initial cards are valid for two years from the date of issuance.
(5) The card shall be approximately three inches by five inches in size and contain the following information: (c) Printed (or typed written) name and signature of the food service worker

Food Handlers Cards

This document was prepared by Residential Care Services for the Locator website.

Record review of the facility employee list, undated, showed Staff I, Caregiver, was hired on 04/25/2023.

Record review of Staff I's Personnel File, showed there was no Washington State Food Worker Card for review.

Record review of facility provided staff list, undated, showed Staff X, Memory Care Director, was hired on 04/08/2020.

Record review of the document, "Food Handler Solutions", showed Staff X completed a food handler course on 05/02/2023. Staff X had not completed their food handlers' course through the Washington State Food Worker program. There was no previous food worker card for review.

Record review of Staff V's, Receptionist, Personnel File Checklist, undated, showed Staff V was hired on 04/04/2023.

Record review of the document, "Washington State Food Worker Card", showed Staff V, had completed their food handlers' course on 05/03/2023. There was no previous food worker card for review.

Record review of the facility provided staff list, undated, showed Staff BB, Caregiver, was hired on 11/22/2017.

Record review of the document, "Washington State Food Worker Card", showed Staff BB's food handlers' card expired on 02/19/2023. There was not another food worker card provided to review.

In an interview on 05/02/2023 at 1:45 PM, Staff N, Food Service Director Corporate stated the staff's food handlers' cards should be located in their employee files.

Storage and Labeling

Observation on 05/02/2023 at 12:24 PM, showed in the activities kitchen the refrigerator had a container of butter without a lid. The butter was not labeled and dated. The refrigerator had a container that was filled with a white granulated substance that did not have a lid. The white granulated substance was not labeled and dated. The freezer had two chocolate chip cookies that were in a container without a lid. The cookies were not labeled and dated.

Observation on 05/02/2023 at 1:45 PM, showed the kitchen pantry had two croissants in a zip lock bag that were not labeled and dated. There were two bags of Barilla wheat pasta

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was rolled up and had duct tape that left the bag open to air. The two bags of pasta were not labeled and dated.

In an interview on 05/02/2023 at 2:02 PM, Staff O, Cook/Server, stated once a food item had been opened the expectation was that it was transferred into another container. The container was covered and labeled with the date it was opened.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 8/22/2023

WAC 388-78A-2080 Qualified assessor. The assisted living facility must ensure the person responsible for completing a preadmission assessment of a prospective resident:

(1) Has a master's degree in social services, human services, behavioral sciences or an allied field and two years social service experience working with adults who have functional or cognitive disabilities; or

(2) Has a bachelor's degree in social services, human services, behavioral sciences, or an allied field and three years social service experience working with adults who have functional or cognitive disabilities; or

(3) Has a valid Washington state license to practice nursing, in accordance with chapters 18.79 RCW and 246-840 WAC; or

(4) Is a physician with a valid state license to practice medicine; or

(5) Has three years of successful experience acquired prior to September 1, 2004, assessing prospective and current assisted living facility residents in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, assisted living facility, or adult family home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure the pre-admission assessment was completed by a qualified staff member for one of one resident (Resident 8). This failure resulted in the resident being assessed by an unqualified assessor and placed them at risk of unmet care needs.

This document was prepared by Residential Care Services for the Locator website.

Findings included...

Record review of the facility policy titled, "Initial and Annual Licensed Nursing Assessment", dated 08/27/2020, showed, "Assessments will be conducted by licensed nurses who are qualified assessors."

Record review of the personnel file for Staff F, Assisted Living Director, showed they were hired at the facility on 01/11/2023. They had been working as a cashier prior to becoming the ALF Director. There were no certificates of trainings or evidence of social services experience for review. There was a Home Care Aide license, dated 05/04/2023, that showed the license was "pending," and not currently active.

Record review of the "Resident Data Sheet", for Resident 8 (R8) undated, showed they moved into the facility on [redacted]/2023.

Record review of R8's "Residents Service Plan", dated [redacted]/2023, showed R8 did not have any medical diagnosis. R8 previously had a visit at a skilled nursing facility. There was no documentation of any hospitalizations or emergency room visits. R8 didn't have any active depression or mood problems. R8 did not require any cueing, assistance, or interventions from staff for redirection related to confusion or mental health concerns. R8 was able to cope with change and challenging situations "very well". R8 was able to understand and be understood by staff. R8 was not known to have a history of falls or known risk of falls. R8 was not at risk for weight loss or had recent weight loss. R8 didn't require any nutritional services with their food textures. R8 was documented to not need regular treatment for skin issues. R8 did not take any antidepressants (mood stabilizing medications), antianxiety (medication to help relieve anxiousness feeling). R8 was documented to have no wounds or skin issues. R8 did not require or request safety checks due to change in/or short-term condition. R8 did not experience pain issues that were managed by medications or non-pharmacological (medication) interventions.

Record review of R8's charting note, dated 04/14/2023 at 2:31 AM, showed R8 told Staff EE, Medication Aide, they had brain surgery. R8 had a riddle in their mind that they couldn't remember.

Record review of R8's charting note, dated 04/15/2023 at 3:53 AM, showed R8 called for assistance from the staff, but was unable to recall why they needed assistance. R8 was confused. R8 had multiple medical conditions and diagnoses. The note showed on 03/11/2023 R8 had a fall that caused a fracture (broken bone) to the left clavicle (upper chest area). R8 required a visit to the local hospital for the fall and the fracture. On 03/20/2023 R8 had surgery at the hospital on their brain to remove a growth. R8 was told they weren't expected to have a good outcome from the growth removal. R8 had gone to a skilled nursing facility from the hospital prior to admitting to the facility. R8 has had weight loss and weakness to their legs. They required use of a wheelchair. R8's pain was managed with pain medication.

Record review of the hospice "Narrative" note for R8, dated 04/10/2023, showed R8 had a surgical incision with staples to their head. R8 reported that they had dull pain. R8 had

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been taking pain medications for their pain control. R8 had an open wound to the left ear.

Record review of the hospice "Narrative" note for R8, dated 04/17/2023, showed R8 complained of feeling depressed (feeling of sadness). R8 was having a hard time sleeping. R8 had mild forgetfulness. R8 was having more difficulty swallowing and taking their meals.

In an interview on 05/02/2023 at 12:54 PM, Staff F, Assisted Living Director, stated that they completed the Residents Service Plans to determine the cost for the residents prior to admission.

In an interview on 05/04/2023 at 12:58 PM, Staff F stated that either they or a nurse go out to evaluate the residents. Staff F stated that Staff F went out to evaluate what kind of care and services R8 required at the skilled nursing facility, prior to the nurse completing an evaluation for R8. Staff F stated they filled out the Service Plan within the computer system. Staff F showed the document, "Resident Service Plan" dated [redacted]/2023 for review. Staff F stated that R8's health condition had declined since he admitted to the facility. Staff F stated R8 had active cancer that caused him a lot of pain, and required multiple pain medications to help reduce the pain. Staff F stated R8 had not been eating well and required soft foods to eat from having troubles swallowing. Staff F stated R8 then only ate a few bites from their meals. Staff F stated since R8 moved to the facility, they had had a few falls.

In an interview on 05/02/2023 at 12:38 PM, Staff F, stated that they had not yet signed up for the Long Term Care Worker/Home Care Aide required trainings.

This is recurring deficiency previously cited on 12/08/2021.

Plan/Attestation Statement

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

Meghan Hu — 8/22/2023

Administrator (or Representative) — Date

WAC 388-78A-2400 Protection of resident records. The assisted living facility must:

(2) Maintain resident records and preserve their confidentiality in accordance with applicable state and federal statutes and rules, including chapters 70.02 and 70.129 RCW;

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This requirement was not met as evidenced by:

Based on observation and interviews, the facility failed to ensure the residents medical charts and clinical records were kept secured and confidential. This failure placed 49 of 49 resident records at risk for being reviewed and available to visitors and unauthorized personal and their records being unprotected.

Findings included...

RCW 70.129.050 Privacy and confidentiality of personal and medical records.
The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Record review of the facility's document, "Medication System Summary Module 3", dated 05/01/2023, under the section titled, "Routine Med Pass, Routine", showed once a resident's medication was prepared the medication aide will secure the electronic medication administration record by clicking the "black sunglass icon" on top of the screen and then go administer the medication to the resident.

In an observation on 05/04/2023 at 4:35 PM, the laptop on top of the medication cart on the second floor was open with 10 resident pictures and names presented on the screen. Observation showed the laptop server would advance to the resident's medication administration records. Resident 3, Resident 1, and Resident 15's pictures, names, and records were all displayed and accessible.

In an observation on 05/04/2023 at 4:45 PM, Staff L, Medication Aide, came down the hallway and closed the laptop on top of the medication cart. Staff L stated that they were to either keep the laptop shut or lock the screen if they leave the medication cart to protect the residents' records.

In an observation on 05/05/2023 at 12:37 PM, the charting room door storing all the assisted Living resident charts and records was propped open with a rubber door stopper. There weren't any staff in the charting room or office.

In an observation on 05/08/2023 at 10:48 AM, the assisted living charting room was propped open with a rubber stoper without a facility staff member in the charting area or office. All 49 assisted living resident records were available to access.

In an interview on 05/08/2023 at 2:37 PM, Staff B, Assistance Executive Director, stated that the doors to the charting rooms with resident records were to be shut at all times when there weren't any staff around.

Plan/Attestation Statement

This document was prepared by Residential Care Services for the Locator website.

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 Lacey is or will be in compliance with this law and / or regulation on (Date) 11/5/2023 .

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

Administrator (or Representative) — Date: 8/22/2023

WAC 388-78A-2070 Timing of preadmission assessment.

(1) Unless there is an emergency, the assisted living facility must complete the preadmission assessment of the prospective resident before each prospective resident moves into the assisted living facility.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to complete a pre-admission assessment prior to the residents move in date for 2 of 2 sampled residents (Resident 7 and Resident 8). This failure placed both residents at risk for having unmet care needs and an inappropriate admission to the facility.

Findings included...

Record review of the facility document, "Service Planning & Coordination of Care", dated 08/27/2020, showed under the section titled, "Initial/Annual RN[Registered Nurse]/LN[Licensed Nurse] assessments", showed the community nurse consultant was to conduct initial and ongoing assessments of each resident's condition. Once completed the assessments were to be printed out, signed and placed in the resident's record.

Resident 7 (R7)

Record review of Memory Care Facility Resident Characteristic Roster and Sample Selection, dated 04/29/2023, showed R7 was admitted to the facility on [redacted]/2022.

Record review of the "Initial and Annual Licensed Nursing Assessment", dated 01/05/2023, showed R7 had a medical diagnosis of [redacted]. The assessment showed that R7 admitted to the facility on [redacted]/2022. The assessment was not signed or dated.

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Resident 8 (R8)

Record review of R8's "Resident Data Sheet" undated, showed they moved into the facility on [redacted]/2023.

Record review R8's, "Initial and Annual Nursing Assessment", dated 04/17/2023, showed R8 had multiple medical diagnoses including [redacted]. The assessment showed R8 moved into the facility on [redacted]/2023. The assessment was signed by Staff BB, Corporate Registered Nurse, and dated 04/17/2023.

In an observation and interview on 05/04/2023 at 12:30 PM, Staff F, Assisted Living Director, stated all resident's pre-admission assessments were kept in their charts. Staff F presented a document for review titled, "Initial and Annual Nursing Assessment", dated 04/17/2023. Staff F stated that was the pre-admission assessment.

In an interview on 05/08/2023 at 10:30 AM, Staff E, Corporate Registered Nurse, stated that all pre-admission assessments were completed before the potential resident was admitted to the facility. The assessment was to determine if the resident was appropriate to be at the facility and that the staff would be able to provide care and services adequately for the resident's needs. Staff E stated that sometimes the assessments had been completed after the resident admitted to the facility.

This is recurring deficiency previously cited on 12/08/2021.

Plan/Attestation Statement

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

Megan Hz — 8/22/2023

Administrator (or Representative) — Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(b) Provide the necessary care and services for residents, including those with special needs;

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This requirement was not met as evidenced by:

Based on interview and record review the facility failed to implement and follow the facility policy and procedure for alert charting for 4 of 6 residents (Resident 2, Resident 8, Resident 9, and Resident 10). This failure placed the residents at risk for unmet care needs when they experienced a change in condition.

Findings included...

Record review of the facility's policy, "Health Services Manual", undated, under the section "Alert Charting", showed "the community had established an alert charting system for special attention to, and documentation about, residents who required additional monitoring or intervention. Need for increased attention might be an event, change in condition or medications, or the reasons that affects a resident. The following systems in the alert charting process included...

When a resident was listed, the medication aide shall make a progress note for the resident as related to the alert concern.

The document identified the indications for alert charting included...

Falls with or without injury, new or change in medications, infection or illness, change in level of consciousness, any behavior changes, change in appetite, and change in residents' ability to routinely function."

In an observation and interview on 05/05/2023 at 5:00 PM, in the Assisted Living medication charting room, there was a document hanging up titled, "Alert Charting Policy" dated August 2009. Staff L, Medication Aide, stated these are the forms they referenced when they had questions or if they needed to place a resident on alert.

Record review of the document, "Alert Charting Policy", dated August 2009, showed a resident was to be placed on alert charting for a non-injury or injury falls, behavior changes, move into the facility, return from the hospital, any new medications, any medications mistakes, and any infections with treatment. The policy showed, "When a listed resident condition/concern is resolved, progress notes should specify "condition resolved," "no longer on alert charting" or similar notice that monitoring is no longer needed. Resolved alert charting can be done by the ED, RCC, PM, or Community Nurse."

Resident 8 (R8)

Record review of R8's "Resident Data Sheet", undated, showed they moved into the facility on [redacted]2023.

Record review of R8's, "Initial and Annual Nursing Assessment", dated 04/17/2023, showed R8 had multiple medical diagnoses including [redacted]

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[redacted]), [redacted], and [redacted]

Record review of R8's "Residents Service Plan", dated [redacted]2023, showed R8 did not have any active depression or mood problems. R8 did not require any cueing or assistance or interventions from staff for redirection due to confusion or mental health concerns. R8 was able to cope with change and challenging situations "very well". R8 was able to understand and be understood by staff. R8 was known to have a history of falls or known risk of falls. R8 was not at risk for weight loss or had recent weight loss. R8 didn't require any nutritional services with their food textures.

Record review of R8's charting note, dated [redacted]2023 -04/11/2023, showed there was no documentation that R8 had admitted to the facility.

Record review of R8's charting note, dated 04/12/2023 at 1:06 PM, showed R8 was having multiple bathroom trips related to loose stools.

Record review of R8's charting note, dated 04/13/2023 -04/24/2023, showed there was no further documentation about R8 experiencing loose stools.

Record review of R8's charting note, dated 04/15/2023 at 3:53 AM, showed R8 was confused and unable to remember why they had called for assistance.

Record review of R8's charting note, dated 04/25/2023 at 5:04 AM, showed R8 appeared more confused than usual. R8 needed assistance from Staff DD, Medication Aide, to pull up their pants after use of the bathroom. Staff DD documented they would continue to chart for any further changes.

Record review of R8's charting notes, dated 04/26/2023 – 05/02/2023, showed there was no further documentation or alert charting related to R8's confusion.

Record review of R8's charting note, dated 04/27/2023 at 12:40 PM, showed R8's left ear was bleeding profusely and had been for the last two days. Staff H, Medication Aide, got approval to call emergency services to come evaluate.

Record review of R8's charting notes, dated 04/27/2023 – 05/02/2023, showed there was no further documentation that showed what the emergency medical services determined on 04/27/2023 , whether R8 was sent to the hospital or not. There was no further documentation about the left ears condition, if any changes were made about R8's left ear bleeding profusely.

Record review of R8's charting note, dated 04/30/2023 at 5:06 PM, showed R8 refused soft foods for breakfast and dinner. There was no documentation that hospice or physician

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was notified. There was no documentation about the refusal of meals.

The facility was unable to provide alert charting documentation and alert charting resolution documentation for R8's loose stools, confusion, and left ear condition.

Resident 2 (R2)

Record review of R2's "Resident Data Sheet", undated, showed R2 admitted to the facility on [redacted]2022.

Record review of R2's, "Resident Service Plan", dated 10/04/2022, showed R2 had a diagnosis of [redacted]. Under the section miscellaneous showed staff were to report to the Assisted Living Director and Registered Nurse for any changes in condition and for an evaluation.

Record review of R2's charting note, dated 04/28/2023, showed R2 reported that their legs were swollen. Staff H, Medication Aide, charted that R2 stated they had been swollen for quite a while. Staff H educated R2 to notify staff to any changes that they had experienced. Staff H observed R2's legs and confirmed they were somewhat swollen. Staff H informed R2 they would get in touch with their provider. Staff H instructed R2 to keep their legs elevated when they were in their chair to help alleviate the pressure and swelling.

Record review of R2's charting notes, dated 02/01/2023 – 05/04/2023, showed there were no other charting notes to review regarding R2's swollen legs.

Record review of an email, dated 05/16/2023 at 3:26 PM, showed Staff B, Assistant Executive Director, stated R2's swelling of their legs that was documented on 04/28/2023 in the chart notes for R2, was a one time occurrence.

Record review of an email, dated 05/16/2023 at 3:26 PM, showed Staff B, stated R2's swollen legs was a onetime occurrence and R2 had not experienced any issues since. There was no further charting notes provided for review.

The facility was unable to provide alert charting resolution documentation for R2's swollen legs.

Resident 9 (R9)

Record review of R9's, Resident Service Plan, dated 02/24/2023, showed R9 admitted to the facility on [redacted]2021. The diagnosis section showed R9 had diagnoses of [redacted]

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([redacted]) and [redacted]

Record review of R9's charting note, dated 04/08/2023, showed R9 was driving their scooter and ran their arm into the corner of the dining table. R9 had a big skin tear the size of three inches long to two inches wide. R9 refused to go to the hospital. R9 wanted their arm cleaned and bandaged. R9 was put on alert.

Record review of R9's charting notes, dated 04/09/2023-04/11/2023, showed there were no alert charting notes to review regarding R9's skin tear. The alert charting notes resumed on 04/12/2023.

In an interview on 05/02/2023 at 9:33 AM, Resident 10 (R10), Spouse to R9, stated the facility staff changed R9's dressing on their arm from when they had hit it on the table in April 2023.

In an interview on 05/08/2023 at 10:15 AM, R10 stated R9 did not see a provider after they hit their arm. R10 stated the facility had been treating R9's arm at the facility.

The facility was unable to provide alert charting documentation and alert charting resolution documentation for R9's arm injury.

Resident 10 (R10)

Record review of R10's, Resident Service Plan, dated 02/24/2023, showed R10 admitted to the facility on [redacted]/2021. The diagnosis section showed R10 had diagnoses of [redacted] ([redacted]) and [redacted] ([redacted])

Record review of R10's After Visit Summary, dated 04/12/2023 – 04/13/2023, showed R10 was at an outpatient care unit due to diagnosis of [redacted]) and [redacted]

In an interview on 05/03/2023 at 9:33 AM, R10 stated they had surgery on their left shoulder on 04/12/2023 due to their socket coming out of place.

Record review of R10's charting note, dated 04/19/2023 at 2:07 PM, showed R10 was placed on alert from returning from the hospital stay. The charting note did not indicate what procedure R10 had.

Record review of R10's charting notes, dated 04/13/2023 – 04/18/2023, showed there

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was no documentation that R10 returned from the hospital to the facility.

Record review of R10's charting note, dated 04/24/2023 at 9:19 PM, showed R10 recently had surgery . R10 was moving too much it reopened their stitches. Staff took too long to change R10's bandage so the family called 911.

Record review of R10's charting note, dated 04/25/2023-05/04/2023, showed there was no further documentation regarding R10's shoulder.

In an interview on 05/04/2023 at 4:35 PM, Staff L, Medication Aide, stated that they placed residents on alert charting for falls, change in care needs, and change in mental status. They were to chart on the residents daily until they were removed from alert charting.

In an interview on 05/08/2023 at 10:06 AM, Staff Y, Medication Aide, stated they would place a resident on alert charting if they had confusion, after a fall, change in behavior, or change in condition.

In an interview on 05/08/2023 at 10:30 AM, Staff E, Regional Corporate Registered Nurse, stated that the resident would be placed on alert for all change in condition, falls, or any change at all for the residents.

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 Lacey is or will be in compliance with this law and / or regulation on (Date) 7/15/2023 .

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

Administrator (or Representative) — Date: 8/22/2023

WAC 388-78A-2665 Resident rights Notice Policy on accepting medicaid as a payment source. The assisted living facility must fully disclose the facility's policy on accepting medicaid payments. The policy must:

(1) Clearly state the circumstances under which the assisted living facility provides care for medicaid eligible residents and for residents who become eligible for medicaid after admission;

(2) Be provided both orally and in writing in a language that the resident understands;

(3) Be provided to prospective residents, before they are admitted to the home;

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(4) Be provided to any current residents who were admitted before this requirement took effect or who did not receive copies prior to admission;

(5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point; and

(6) Be signed and dated by the resident and be kept in the resident record after signature.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents were provided a Medicaid Policy for 1 of 9 sampled Residents (Resident 5). This failure placed resident 5 and their responsible party at risk of making uninformed decisions about placement with consideration of potential changes in their financial circumstances.

Findings included...

Record review of the, Memory Care Facility Resident Characteristic Roster and Sample Selection, dated 04/29/2023, showed Resident 5 (R5) was admitted to the facility on [redacted]/2018.

Record review of R5's chart showed there was not a Medicaid policy on file to review.

In an interview on 05/04/2023 at 5:08 PM, Staff B, Assistant Executive Director, stated R5 did not have a Medicaid policy on file.

In an interview on 05/08/2023 at 2:37 PM, Staff C, Registered Nurse Regional Director of Operations, stated the Medicaid Policy was expected to be completed prior to the resident's admission to the facility.

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 Lacey is or will be in compliance with this law and / or regulation on (Date) 7/15/2023 .

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

Administrator (or Representative) — Date: 8/22/2023

This document was prepared by Residential Care Services for the Locator website.

RCW 70.129.070 Examination of survey or inspection results -- Contact with client advocates. A resident has the right to:

(1) Examine the results of the most recent survey or inspection of the facility conducted by federal or state surveyors or inspectors and plans of correction in effect with respect to the facility. A notice that the results are available must be publicly posted with the facility's state license, and the results must be made available for examination by the facility in a place readily accessible to residents; and

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to have the most recent survey or inspection publicly posted and easily available for 1 of 1 inspection binders. This failure resulted in all residents and visitors right to be able to have knowledge of the facility's inspection results.

Findings included...

In an interview on 05/02/2023 at 1:28 PM, Staff Q, Receptionist, was asked where the facility inspection binder was located. Staff Q was unable to locate the binder and inquired with staff A, Interim Executive Director (ED) and Staff B, Assistant Executive Director (AED) where the binder was located.

In an interview on 05/02/2023 at 1:29 PM, Staff A, ED, stated the inspection binder should be out in the facility. Staff B stated the binder should be in the lobby unless someone had stolen it.

In an interview on 05/02/2023 at 2:18 PM, Staff Q was asked to provide the licensing binder that contained the last full inspection. Staff Q found a binder in the back office of the reception area that was not accessible to residents and stated they needed to confirm with Staff B, AED if the binder they had was the accurate one. Staff B informed Staff Q the binder they had was from 2008 and the staff were currently looking for an updated survey binder to provide.

In an interview on 05/02/2023 at 2:23 PM, Staff B stated the staff found the survey binder. Staff B stated the former Executive Director redid the binder.

In an observation on 05/02/2023 at 2:24 PM, showed the survey binder that was provided was outdated. The binder had reports that were dated back to 2019 but nothing current was available to review.

Plan/Attestation Statement

This document was prepared by Residential Care Services for the Locator website.

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Administrator (or Representative) — 8/22/2023 Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

This requirement was not met as evidenced by:

Based on interview, observation, and record review the facility failed to provide a safe, sanitary, and well-maintained environment for 4 of 4 areas within the building (memory care, assisted living courtyard, laundry room, and the kitchen). The facility failed to keep exterior grounds in good repair, equipment, and furnishings clean. These failures placed 65 of 65 residents at risk for to have a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included...

Record review of the facility's Disclosure of Services, undated, showed housekeeping must maintain a resident's living quarters and other areas they may use in a safe, clean, and comfortable condition.

Memory Care

In an observation on 05/02/2023 at 11:37 AM, showed the Memory Care unit kitchens microwave door handle was broken off and yellow insulation was exposed.

In an observation on 05/04/20203 at 11:26 AM, showed the Memory Care Unit had a soiled brief in the common trashcan in the living room next to the handwashing sink.

This document was prepared by Residential Care Services for the Locator website.

In an interview on 05/04/2023 at 11:27 AM, Staff J, Memory Care Activities Director, stated it was common for the residents to hide their soiled briefs on their person and then throw them away in the community trash.

Assisted Living Courtyard

In an observation on 05/02/2023 at 12:05 PM, showed the assisted living courtyard had various trash blocking the Memory Care unit's doorway. There was a bed frame, two wheelchairs, a washing machine, a drying machine, a dresser, two desks, and a shopping cart with boxes inside of it.

In an observation on 05/02/2023 at 12:07 PM, showed the assisted living courtyard outside of the kitchen doorway had a crate, a mat laying up against the wall, a dirty wrag bin, a bucket with mops inside of it, and a half coiled hose alongside the wall.

In an observation on 05/08/2023 at 11:19 AM, showed the assisted living courtyard had a washing machine outside against the wall in the common courtyard.

In an observation on 05/09/2023 at 10:38 AM, showed the various trash blocking the Memory Care unit's doorway was still present. The washing machine outside against the wall was still present.

Laundry Room

In an observation on 05/02/2023 at 12:13 PM, showed multiple soiled plates and a sock inside of a drawer within the first floor laundry room.

In an interview on 05/02/2023 at 12:13 PM, Staff F stated the facility requested the residents bring their soiled dishes into the laundry room and staff would pick up the dishes and return them to the kitchen.

Kitchen

In an observation on 05/02/2023 at 1:44 PM, showed the food storage pantry had onion shavings on the floor. There was an unknown sauce packet underneath the shelving. Underneath the shelving had dirt debris covering the floor.

In an observation on 05/02/2023 at 1:54 PM, showed the freezer had an orange floor that was coated in brown debris. Observation showed the Licensor's shoe stuck to the floor and then made a sticky, squelchy, sound with every step.

This document was prepared by Residential Care Services for the Locator website.

In an observation on 05/02/2023 at 1:56 PM, showed the ice machine had brown debris on the inner backside white wall of the ice machine. The ice scoop to the machine had brown debris flakes inside of it.

In an observation on 05/02/2023 at 2:04 PM, showed 16 light fixtures in kitchen had dead bugs and debris inside of them.

In an interview on 05/02/2023 at 2:14 PM, Staff N, Food Service Director - Corporate, acknowledged there were areas of concern regarding the kitchen light fixtures.

Plan/Attestation Statement

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Administrator (or Representative) — Date 8/22/2023

WAC 388-78A-2703 Safety of the built environment. The assisted living facility must provide a safe environment and promote the safety of each resident whenever the resident is on the premises or under the supervision of staff persons consistent with the resident's negotiated service agreement, and must maintain the premises and equipment used in resident care so as to be free of hazards, including:

(3) Keeping exterior grounds, assisted living facility structures, and component parts safe, sanitary, and in good repair.

This requirement was not met as evidenced by:

Based on record review, observation, and interview the facility failed to keep exterior grounds and assisted living structures safe and in good repair for 4 of 4 areas within the facility (Resident 5's room, the assisted living dining room, the assisted living courtyard, and the independent living dining room). This failure placed 65 of 65 residents at risk due to unsafe and unmaintained living conditions.

Findings included...

Resident 5 (R5)

Record review of the facility's Memory Care Facility Resident Characteristic Roster and

This document was prepared by Residential Care Services for the Locator website.

Sample Selection, dated 04/29/2023, showed R5 was admitted to the facility on [redacted]2018.

Record review of R5's Resident Data Sheet, undated, showed they had a diagnosis of [redacted]).

Record review of a Resident Occurrence Report, dated 04/30/2023, showed R5 had crawled out of their room on their hands and knees. R5 stated they were opening their closet door and it fell on top of them. Medication aid entered R5's room and residents closet door was laying down with the bottom of the closet door on the floor and the top of the closet door on R5's bed.

In an observation on 05/04/2023 at 10:58 AM, showed R5's closet door was completely off the hinges and their clothing and personal items were exposed. The other side of the rooms closet door was opened and a closet door was propped up within the closet leaning against the wall.

In an observation and interview on 05/04/2023 at 11:28 AM, Staff J, Memory Care Activities Director, stated R5 does not have a closet door because there was an incident where the door fell on R5. Staff J stated they were waiting for maintenance staff to replace the closet door. Staff J was shown that the closet door was propped up within the closet on the other side of the room. Staff J acknowledged this was a safety concern.

In an interview on 05/04/2023 at 11:35 AM, Staff J stated they were unsure if a work order was submitted to get R5's closet door replaced.

In an interview on 05/05/2023 at 11:11 AM, Staff K, Caregiver, stated once they were informed by a colleague that R5's closet door was still inside of R5's room on the adjacent side, they asked maintenance to remove it. Staff K acknowledged that the door remaining in the room was a safety concern. Staff K stated the closet door fell on R5 once, we don't need it falling on R5 or anyone else who goes into the room again.

In an interview on 05/08/2023 at 10:45 AM, Staff T, Traveling Maintenance – Corporate, stated they had received a work order on 05/01/2023 to remove R5's closet door because it had fallen on them. Staff T stated the work order was completed on 05/03/2023. Staff T stated they were unaware that the closet door was left inside the room propped open in the adjacent rooms closet. Staff T stated they do not have a work order in the system to replace R5's closet door. Staff T stated maintenance and the caregiving staff should have put a work order in stating R5 needed a new closet door.

In an interview on 05/15/2023 at 10:41 AM, Collateral Contact 3 (CC3), Family Member, stated since the fall R5 had a fracture, and the doctor notified the family the fall could had contributed to R5's decline in health.

This document was prepared by Residential Care Services for the Locator website.

Assisted Living Dining Room

In an observation on 05/02/2023 at 12:02 PM, showed there was a resident's electronic scooter parked in front of the assisted living dining rooms exit door.

In an interview on 05/02/2023 at 12:02 PM, Staff F, Assisted Living Director, stated the electronic scooter belonged to Resident 10 (R10). Staff F stated it was common for R10 to park their scooter in front of the doorway. Staff F acknowledged the scooter being parked in front of the doorway was a safety risk.

Assisted Living Courtyard

In an observation on 05/02/2023 at 12:05 PM, showed the assisted living courtyard had various trash blocking one of the Memory Care unit's doorways. There was a bed frame, two wheelchairs, a washing machine, a drying machine, a dresser, two desks, and a shopping cart with boxes inside of it in front of the door. In the event of an emergency that required an evacuation the doorway would not be able to be opened and used.

In an observation on 05/09/2023 at 10:38 AM, showed the various trash in the assisted living courtyard blocking the Memory Care unit's doorway was still present.

Independent Living Dining Room

In an observation on 05/02/2023 at 12:09 PM, showed a front wheel walker in front of the independent living dining room exit door.

In an interview on 05/02/2023 at 12:09 PM, Staff F stated it was common for the assisted living residents to eat in the independent living dining room. Staff F stated there were currently 8 assisted living residents in the independent dining room.

Plan/Attestation Statement

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This document was prepared by Residential Care Services for the Locator website.

Administrator (or Representative) — Date: 9/22/2023

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(2) Ensure animals living on the assisted living facility premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

(b) Are certified by a veterinarian to be free of diseases transmittable to humans;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure 1 of 3 sampled pets (Resident 12's pet) and all other pets living on the premises had regular examinations and were certified by a veterinarian to be free of diseases transmittable to humans. This failure placed 65 of 65 residents and 59 staff at risk of being exposed to diseases which could impact their health.

Findings included...

Record review of the facility's Pet Policy, dated 05/16/2005, showed "residents wishing to have pets must discuss with the Administrator prior to the pet being in the building. A rental agreement addendum must be signed by the resident or responsible party in order for the pet to be residing in the apartment...Residents are responsible for the care and feeding of their pet. The pet must be well behaved, well managed and cared for...Pets must be properly vaccinated and free from disease and fleas. A record of all immunizations needs to be kept in the resident's apartment and in the resident administrative file."

Record review of the document, Create and/or update Pet Binders, undated, showed a photo of the pet, a face sheet that includes the veterinarians name, all vet records and vaccines, the groomers contact information, the name and contact information of the person responsible for the pet, a copy of the service plan (assisted living only), and progress notes of pertinent information for all independent living residents. The record showed the binder was to be done by the front desk and updated quarterly.

Record review of independent living residents' pets' records showed there was no documentation of current vaccines and rabies information on file to review.

Record review of Resident 12's (R12), pet record, showed there was no documentation of their cat's current vaccines and rabies information on file to review.

This document was prepared by Residential Care Services for the Locator website.

In an interview on 05/03/2023 at 2:45 PM, Staff V, Receptionist, that worked at the front desk, stated they wanted their supervisor Staff B, Assistant Executive Director (AED), present while being interviewed. When the Department Licensor asked Staff V questions regarding pets within the facility Staff B answered. Staff B stated the assisted living residents care plan would indicate if they had a pet. The process for residents who had pets was for the facility to have a copy of the pet record on file. The facility would call the family for updated pet records as needed. Staff B stated they were unaware the facility had to keep track of the independent residents' pets or keep a copy of their records on file. Staff B stated they would follow up to obtain vet records for all pets living on the premises.

In an observation and interview on 05/04/2023 at 11:45 AM, Collateral Contact 7 (CC7), Independent Living Resident, was observed to walk out of the first floor elevator with a small black and brown leashed dog. CC7 stated the dog resided at the facility in their apartment.

In an interview on 05/08/2023 at 12:17 PM, Collateral Contact 5 (CC5), Resident representative, stated the facility called them on 05/02/2023 and stated they need to provide R12's cat's vaccination records. CC5 stated they were able to complete this task. CC5 stated the next day on 05/03/2023 they had received a call from the facility stating if they did not provide the cat's rabies vaccination records.

In an interview on 05/08/2023 at 1:29 PM, Staff B, stated they will clarify with all assisted living residents and independent residents that they need to follow up on providing the facility their pet records. Staff B stated the facility preferred to have the pet records provided upon admission.

Plan/Attestation Statement

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

Megan Hamm — Administrator (or Representative)

8/22/2023 — Date

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

(2) For purposes of WAC 388-78A-2481 through 388-78A-2489 , "staff person" means any assisted living facility employee or temporary employee of the assisted living facility, excluding volunteers and contractors.

This document was prepared by Residential Care Services for the Locator website.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 6 of 6 sampled Staff (Staff A, Staff G, Staff W, Staff V, Staff L, and Staff I) received their Tuberculosis (infectious bacterial disease of the lungs) test within three days of hire. This failure placed 65 of 65 residents and 59 staff at risk for exposure to Tuberculosis.

Findings included...

Record review of the facility provided employee list, undated, showed Staff A, Interim Executive Director, was hired at the facility on 03/28/2023.

Record review of the personnel file for Staff A, showed there was no document to review that a tuberculosis (TB) test was completed.

Record review of facility provided staff list, undated, showed Staff G, Medication Aide, was hired on 01/01/2023.

In an interview on 05/05/2023 at 11:29 AM, Staff G, stated the facility administered their TB test yesterday on 05/04/2023. Staff G stated they previously had completed their TB test, but the record was lost.

Record review of facility provided staff list, undated, showed Staff W, Cook/Server was hired on 03/27/2023.

Record review of personnel file for Staff W showed, there was no documentation to review that a TB test was completed.

Record review of the personnel file, for Staff V, Receptionist, showed they were hired on 04/04/2023.

Record review of the document, "Tuberculin Skin Testing Authorization for Employees", dated 04/04/2023, for Staff V, showed there was nothing documented for the first and second administration of the TB testing. The document showed Staff V answering the questions and signed the document. There was no other documentation on the form.

Record review of the facility provided staff list, undated, showed Staff L, Medication Aide, was hired on 12/15/2021.

This document was prepared by Residential Care Services for the Locator website.

In an interview on 05/04/2023 at 4:45 PM, Staff L stated that they had just received their first TB test from the facility today since they were hired.

Record review of the personnel file for Staff I, Caregiver, showed they were hired on 04/25/2023. There was no document to review that a TB test was completed.

In an interview on 05/08/2023 at 2:37 PM, Staff B, Assistant Executive Director, stated they were responsible for ensuring all staff had completed their TB testing.

Plan/Attestation Statement

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Megan Hz — Administrator (or Representative)

8/22/2023 — Date

WAC 388-78A-2320 Intermittent nursing services systems.

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(c) Chapter 246-840 WAC, Practical and registered nursing;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure staff had the required Nurse Delegation training, supervision, and documentation by the Registered Nurse (RN) Delegator for 11 of 11 sampled residents (Resident 6, Resident 8, Resident 21, Resident 11, Resident 19, Resident 20, Resident 15, Resident 17, Resident 18, Resident 5, and Resident 7) receiving nurse delegated services. These failures placed all residents receiving RN delegated services at risk for harm and injury due to untrained and unsupervised care staff.

Findings included...

WAC 246-840-930 Criteria for delegation.
(1) Before delegating a nursing task, the registered nurse delegator decides the task is appropriate to delegate based on the elements of the nursing process: ASSESS, PLAN,

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IMPLEMENT, EVALUATE.
(2) The setting allows delegation because it is a community-based care setting as defined by RCW 18.79.260 (3)(e)(i) or an in-home care setting as defined by RCW 18.79.260 (3)(e)(ii).
(3) Assess the patient's nursing care needs and determine the patient's condition is stable and predictable. A patient may be stable and predictable with an order for sliding scale insulin or terminal condition.
(4) Determine the task to be delegated is within the delegating nurse's area of responsibility.
(5) Determine the task to be delegated can be properly and safely performed by the nursing assistant or home care aide. The registered nurse delegator assesses the potential risk of harm for the individual patient.
(6) Analyze the complexity of the nursing task and determine the required training or additional training needed by the nursing assistant or home care aide to competently accomplish the task. The regis-tered nurse delegator identifies and facilitates any additional train-ing of the nursing assistant or home care aide needed prior to delegation. The registered nurse delegator ensures the task to be delegated can be properly and safely performed by the nursing assistant or home care aide.
(7) Assess the level of interaction required. Consider language or cultural diversity affecting communication or the ability to accomplish the task and to facilitate the interaction.
(8) Verify that the nursing assistant or home care aide:
(a) Is currently registered or certified as a nursing assistant or home care aide in Washington state without restriction;
(b) Has completed both the basic caregiver training and core delegation training before performing any delegated task;
(c) Has a certificate of completion issued by the department of social and health services indicating completion of the required core nurse delegation training;
(d) Has a certificate of completion issued by the department of social and health services indicating completion of diabetes training when providing insulin injections to a diabetic client; and
(e) Is willing and able to perform the task in the absence of direct or immediate nurse supervision and accept responsibility for their actions.
(9) Assess the ability of the nursing assistant or home care aide to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision.
(10) If the registered nurse delegator determines delegation is appropriate, the nurse:
(a) Discusses the delegation process with the patient or authorized representative, including the level of training of the nursing assistant or home care aide delivering care.
(b) Obtains written consent. The patient, or authorized representative, must give written, consent to the delegation process under chapter 7.70 RCW. Documented verbal consent of patient or authorized representative may be acceptable if written consent is obtained within thirty days; electronic consent is an acceptable format. Written consent is only necessary at the initial use of the nurse delegation process for each patient and is not necessary for task additions or changes or if a different nurse, nursing assistant, or home care aide will be participating in the process.
(11) Document in the patient's record the rationale for delegating or not delegating nursing tasks.
(12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes:
(a) The rationale for delegating the nursing task;
(b) The delegated nursing task is specific to one patient and is not transferable to another patient;

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(c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide;
(d) The nature of the condition requiring treatment and purpose of the delegated nursing task;
(e) A clear description of the procedure or steps to follow to perform the task;
(f) The predictable outcomes of the nursing task and how to effectively deal with them;
(g) The risks of the treatment;
(h) The interactions of prescribed medications;
(i) How to observe and report side effects, complications, or un-expected outcomes and appropriate actions to deal with them, including specific parameters for notifying the registered nurse delegator, health care provider, or emergency services;
(j) The action to take in situations where medications and/or treatments and/or procedures are altered by health care provider orders, including:
(i) How to notify the registered nurse delegator of the change;
(ii) The process the registered nurse delegator uses to obtain verification from the health care provider of the change in the medical order; and
(iii) The process to notify the nursing assistant or home care aide of whether administration of the medication or performance of the procedure and/or treatment is delegated or not;
(k) How to document the task in the patient's record;
(l) Document teaching done and a return demonstration, or other method for verification of competency; and
(m) Supervision shall occur at least every ninety days. With delegation of insulin injections, the supervision occurs at least weekly for the first four weeks, and may be more frequent.
(13) The administration of medications may be delegated at the discretion of the registered nurse delegator, including insulin injections. Any other injection (intramuscular, intradermal, subcutaneous, intraosseous, intravenous, or otherwise) is prohibited. The registered nurse delegator provides to the nursing assistant or home care aide written directions specific to an individual patient.
(14) Delegation requires the registered nurse delegator teach the nursing assistant or home care aide how to perform the task, including return demonstration or other method of verification of competency as determined by the registered nurse delegator.
(15) The registered nurse delegator is accountable and responsible for the delegated nursing task. The registered nurse delegator monitors the performance of the task(s) to assure compliance with established standards of practice, policies and procedures and appropriate documentation of the task(s).
(16) The registered nurse delegator evaluates the patient's responses to the delegated nursing care and to any modification of the nursing components of the patient's plan of care.
(17) The registered nurse delegator supervises and evaluates the performance of the nursing assistant or home care aide, including direct observation or other method of verification of competency of the nursing assistant or home care aide. The registered nurse delegator reevaluates the patient's condition, the care provided to the patient, the capability of the nursing assistant or home care aide, the outcome of the task, and any problems.
(18) The registered nurse delegator ensures safe and effective services are provided. Reevaluation and documentation occurs at least every ninety days. Frequency of supervision is at the discretion of the registered nurse delegator and may be more often based upon nursing assessment.
(19) The registered nurse must supervise and evaluate the performance of the nursing assistant or home care aide with delegated insulin injection authority at least weekly for the first four weeks. After the first four weeks the supervision shall occur at least every

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ninety days.

Record review of the facility's policy, "Delegation-WA (Washington)", dated 09/20/2017, showed "Delegation of registered nurse/RN tasks to unlicensed staff personnel shall take place in accordance with the state regulations that apply for the Community, and the requirements specified below. The person(s) who conducts and maintains the process of delegation shall be a registered nurse. All delegation shall be resident-specified based on RN determination is stable and predictable". Under the section titled, "Initial Assessment-Staff", showed "the RN shall not delegate to anyone who is not knowledgeable and proficient for the task delegation. RN shall be responsible for verify that credentials and required certificates are present for all staff intended to perform delegated task prior to delegation. When a delegating RN will no longer be available and an oncoming RN will assume responsibility for the tasks delegated, transfer of delegation shall take place without gaps in coverage." Under the section, "Delegation Binder", showed the facility would establish and maintain a delegation binder.

Record review of the document, "Memory Care and Assisted Living Resident Characteristic Roster", dated 04/29/2023, showed there were 15 residents that required nurse delegated services.

In an observation on 05/04/2023 at 3:07 PM, the facility provided four nurse delegation binders that contained nurse delegation forms for years 2017, 2018, and 2022. There were no current nurse delegation forms for the year 2023.

In an interview on 05/04/2023 at 9:20 AM, Staff C, Registered Nurse/Regional Director of Operations, brought in one nurse delegation binder. Staff C stated Staff M was the RN delegator for the facility. Staff E, Registered Nurse Corporate, was at the facility two to three times a week to follow up with change of conditions, move-in assessments, weight assessments, and skin conditions for the residents.

Record review of the nurse delegation binder that was provided on 05/04/2023, showed there was no staff credentials provided for review for any of the medication aides.

Record review of the one nurse delegation binder showed:

Resident 21 (R21)

Record review of R21's, Nurse Delegation, Nursing Visit form, undated, showed they were delegated for blood glucose testing (blood test to check how much sugar was in the blood) and insulin administration. The form was undated and unsigned by the nurse delegator.

Record review of R21's, Nurse Delegation: instructions for Nursing Task: insulin pen administration, showed the document was not signed or dated by the nurse delegator.

Record review of R21's, Nurse Delegation: Instructions for Nursing Task: blood glucose testing, showed the document was undated and unsigned by the nurse delegator.

Resident 11 (R11)
Record review of the facility's, "Memory Care Facility Resident Characteristic Roster and Sample Selection", dated 04/29/2023, showed R11 was not identified to have nurse delegated services.

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Record review of R11's, Nurse Delegation: nursing visit for insulin administration and blood glucose checks, dated 03/23/2023, showed the document was signed and dated by the nurse delegator Staff M.

Record review of R11's, Nurse Delegation: Consent for delegation process, dated 03/24/2023, showed the document was signed and dated by the Nurse delegator Staff M.

Record review of R11's, Nurse Delegation: instructions for Nursing Task for insulin pen administration, showed the document was undated and unsigned by the nurse delegator.

Record review of R11's, Nurse Delegation: instructions for Nursing Task for blood glucose testing, showed the document was undated and unsigned by the nurse delegator.

Resident 6 (R6)
Record review of R6's, Nurse Delegation: Nursing Visit form for insulin administration and blood glucose checks, showed the document was signed by Staff M nurse delegator and dated 03/24/2023.

Record review of R6's, Nurse Delegation: Consent for Delegation Process, dated 03/24/2023 showed it was signed and dated by the nurse delegator Staff M.

Record review of R6's, Nurse delegation: instructions for Nursing Task for Insulin pen administration, showed the document was undated and unsigned by the nurse delegator.

Record review of R6's, Nurse delegation: instructions for Nursing Task for blood glucose testing, showed the document was undated and unsigned by the nurse delegator.

Record
review of R6's MAR, dated 04/01/2023 – 04/30/2023, showed R6 had Timolol mal
eye drop, apply one drop in each eye administered daily in the morning. R6 had Lantanoprost eye drop, apply one drop
to each eye daily at bedtime.

In an interview on 05/04/2023 at 4:35 PM, Staff L stated they administered R6's eye drops.

In an observation on 05/04/2023 at 4:55 PM, the medication cart for the Assisted Living residents, there were two bottles of two different prescribed medicated eye drops for R6.

In an interview on 05/05/2023 at 11:53 AM, R6 stated, that the Medication Aide's administer their prescribed medicated eye drops for them. R6 stated "I can't do them".

Record review showed there was no nurse delegation documentation for staff to administer R6's prescribed medicated eye drops.

Resident 19 (R19)
Record review of the facility's, "Memory Care Facility Resident Characteristic Roster and Sample Selection", dated 04/29/2023, showed R19 was not identified to have nurse

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delegated services.

Record review of R19's, Nurse Delegation: Nursing Visit for insulin administration and blood glucose checks, dated 03/24/2023, showed it was signed and dated by the nurse delegator, Staff M.

Record review of R19's, Nurse Delegation: Instructions for Nursing Task: for administering skin/topical medications, showed the document was undated and unsigned by the nurse delegator.

Record review of R19's, Nurse Delegation: Instructions for Nursing Task: for insulin pen administration, delegated staff will administer insulin pen, showed the document was unsigned or dated by the nurse delegator.

Record review of R19's, Nurse Delegation: Instructions for Nursing Task, for blood glucose testing, showed the document was unsigned and dated by the nurse delegator.

Resident 20 (R20)
Record review of the facility's, "Memory Care Facility Resident Characteristic Roster and Sample Selection", dated 04/29/2023, showed R20 was not identified to have nurse delegated services.

Record review of R20's, Nurse Delegation: Nurse visit form, showed the document was undated and signed by the nurse delegator Staff M.

Record review of R20's, Nurse Delegation: Consent for Delegation Process, dated 03/24/2023, showed the document was signed and dated by Staff M.

Record review of R20's, Nurse Delegation: Instructions for Nursing Task, undated, for Insulin pen administration, showed the document was unsigned or dated by the nurse delegator.

Record review of R20's, Nurse Delegation: Instructions for nursing Task, for blood sugar glucose testing, showed the document was unsigned and undated by the nurse delegator.

Resident 7 (R7)
Record review of R7's, "Resident Service Plan", dated 3/13/2023, showed R7 had diagnoses of [redacted] and [redacted].

Record review of the facility's, "Memory Care Facility Resident Characteristic Roster and Sample Selection", dated 04/29/2023, showed R7 was marked as had nurse delegated services under the section, Nursing Services.

Record review on 05/04/2023, showed there was no nurse delegation visit forms or nurse delegation consent forms for R7 to review.

In an interview on 05/05/2023 at 10:49 AM, Staff B, Assistant Executive Director, stated they were unaware as to why R7 was identified for nurse delegated services.

In an interview on 05/05/2023 at 11:20 AM, Staff K, Caregiver, stated they administered

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R7's insulin for them and was a nurse delegated task.

In an interview on 05/05/2023 at 11:29 AM, Staff G, Medication Aide, stated they administered R7's insulin for them daily. They stated Staff C, RN Regional Director of Operations, and Staff D, RN Director of Nursing- Corporate, told them they were expired and needed to get another medication aide within the facility to provide insulin to diabetic residents. They stated they needed to wait for the nurse to watch them administer insulin to the residents.

Resident 5 (R5)

Record review of the facility's, "Memory Care Facility Resident Characteristic Roster and Sample Selection", dated 04/29/2023, showed R5 was identified to have nurse delegated services.

Record review of R5's document, Resident Service Plan, dated 12/29/2022, showed R5 took their medications crushed in applesauce or yogurt without difficulty. R5 had an order on file that crushed medication was not medically necessary but preferred by R5.

Record review of R5's document, "Physician's Orders", dated 04/01/2023, showed R5 had an order that staff may crush all crushable medications.

In an interview on 05/05/2023 at 11:11 AM, Staff K, Caregiver, stated R5 required their medications to be crushed.

Record review showed there was no nurse delegation documentation that staff were delegated to crush R5's medications.

Resident 15 (R15)
Record review of the facility's, "Memory Care Facility Resident Characteristic Roster and Sample Selection", dated 04/29/2023, showed R15 was not identified to have nurse delegated services.

In an observation on 05/04/2023 at 4:55 PM, the medication cart for the Assisted Living residents, there was diclofenac (medication to help relieve pain) medicated cream with Resident 15's (R15) name on the prescription label.

In an interview on 05/04/2023 at 4:35 PM, Staff L stated they spoon fed the medications to R15.

Record review showed there was no nurse delegation documentation that staff were delegated to apply topical creams and administer medications for R15.

Resident 8 (R8)
Record review of the facility's, "Memory Care Facility Resident Characteristic Roster and Sample Selection", dated 04/29/2023, showed R8 was not identified to have nurse delegated services.

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In an interview on 05/04/2023 at 4:35 PM, Staff L, Medication Aide, stated they crushed R8's medications, mixed them with applesauce or yogurt, and spoon fed R8's medications to them occasionally.

Record review showed there was no nurse delegation documentation that staff were delegated to crush medications for R8.

In an interview on 05/03/2023 at 12:05 PM, Staff F, Assisted Living Director, stated Staff M, RN, was the nurse delegator for the facility.

In an interview on 05/04/2023 at 9:20 AM, Staff C, RN/Regional Director of Operations, stated Staff M, was the nurse delegator for the facility. They were to delegate the medication aides for all tasks that required nurse delegation.

In an interview on 05/04/2023 at 9:29 AM, Staff M stated that they were the RN delegator for the facility. Staff M stated they hadn't delegated any of the medication aides to crush medications, apply creams or patches, or administer eye drops for any of the Memory Care or Assisted Living residents. Staff M stated they only delegated staff to administer resident's insulin injections. Staff M stated that Staff F was the person required to delegate the medication aides for all other nurse delegated tasks other than insulin. Staff M stated Staff F was not a nurse. Staff M stated that there wasn't a nurse delegation binder for them to update as the binder had been missing since February 2023. Staff M stated they had been asking Staff F for help preparing the nurse delegation forms.

Record review on 05/04/2023, showed there was no documentation that the weekly checks for the insulin administration observation had been completed for any medication aide in the one nurse delegation binder provided. There were no nurse delegation consent forms for R5, R7, R19 and R21 for review.

In an interview on 05/05/2023 at 12:38 PM, Staff H, Medication Aide, stated they administer prescribed medicated eye drops for Resident 17 (R17), Resident 6, Resident 18, Resident 20, and just recently stopped for R15. Staff H stated they apply medicated creams for R15, R17, R20, and R19.

In an interview on 05/10/2023 at 2:28 PM, Staff D, RN Director of Nursing Corporate, and Staff GG, Chief Operating Officer for Corporation, stated that the nurse delegation binder was destroyed and were out of compliance with nurse delegation services.

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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 Lacey is or will be in compliance with this law and / or regulation on (Date) 7/15/2023 .

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

Administrator (or Representative) — Date: 8/22/2023

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

(2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure the Resident Service Plans (Negotiated Service Agreements) for 7 of 9 sampled residents (Resident 1, Resident 2, Resident 3, Resident 5, Resident 7, Resident 8, and Resident 10) were agreed to and signed at least annually by the resident, resident's representative, and representative of the assisted living facility. This failure placed the residents and their responsible party at risk for not being involved in their care decisions and the services being provided.

Findings included...

Resident 1 (R1)

Record review of R1's Resident Service Plan, dated 04/18/2023, showed no signatures from the Resident, Residents Responsible Party, and a representative of the assisted living facility.

Resident 2 (R2)

Record review of R2's Resident Service Plan, dated 10/28/2022, showed no signatures from the Resident, Residents Responsible Party, and a representative of the assisted living facility.

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Resident 3 (R3)

Record review of R3's Resident Service Plan, dated 04/03/2023, showed no signatures from the Resident, Residents Responsible Party, and a representative of the assisted living facility.

Resident 5 (R5)

Record review of R5's Resident Service Plan, dated 12/29/2022, showed no signatures from the Resident, Residents Responsible Party, and a representative of the assisted living facility.

Resident 7 (R7)

Record review of R7's Resident Service Plan, dated 03/13/2023, showed no signatures from the Resident, Residents Responsible Party, and a representative of the assisted living facility.

In an interview on 05/08/2023 at 9:50 AM, Collateral Contact 4 (CC4), Family Member, for R7 stated they had attended the last meeting to update R7's Resident Service Plan. CC4 stated the family did not sign the Resident Service Plan because the facility was going to make amendments to the document.

Resident 8 (R8)

Record review of R8's Resident Service Plan, dated [redacted]/2023, showed no signatures from the Resident, Residents Responsible Party, and a representative of the assisted living facility.

Resident 10 (R10)

Record review of R10's Resident Service Plan, dated 02/24/2023, showed no signatures from the Resident, Residents Responsible Party, and a representative of the assisted living facility.

In an interview on 05/02/2023 at 12:54 PM, Staff F, Assisted Living Director, stated they update the resident service plans, review with the family and resident. Once the service plans were reviewed, they would be signed by the resident or resident responsible party and themself. They would be signed before any changes in cost would be applied.

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In an interview on 05/04/2023 at 2:02 PM, Staff B, Assistant Executive Director, stated resident service plans were updated every 90 days. Staff B stated staff would sign the resident service plan after it had been updated.

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 Lacey is or will be in compliance with this law and / or regulation on (Date) 7/15/2023 .

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

Meghan Hr — 8/22/2023

Administrator (or Representative) — Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to follow prescribed medication orders and incorporate medication services into the residents negotiated service agreement (NSA) for 2 of 9 sampled residents (Resident 5 and Resident 10). These failures resulted in Resident 5 receiving medications outside of their physician orders, and resulted in Resident 10 receiving treatment without physician orders.

Findings included...

Resident 5 (R5)

Record review of the Memory Care Facility Resident Characteristic Roster and Sample Selection, dated 04/29/2023, showed R5 admitted to the facility on [redacted]2018.

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Record review of R5's Resident Service Plan, dated 12/29/2022, showed R5 had a diagnosis of [redacted]

Record review of R5's Medication Administration Record (MAR), dated 03/01/2023–03/31/2023, showed R5's Losartan (medication that that helps lower high blood pressure) had prescribed medication parameters to hold the medication if the Systolic Blood Pressure (SBP- top number of the blood pressure reading) was less than 90 and the Diastolic Blood Pressure (DBP, the number on the bottom of the blood pressure reading) was less than 60.

Record review of R5's MAR, showed on 03/05/2023, R5's DBP was 55, and the was medication administered.

Record review of R5's MAR, dated 03/01/2023–03/31/2023, showed R5 had a prescribed medication, Carvedilol (medication that helps lower high blood pressure), that had prescribed parameters to call the physician for a medication change if R5's SBP was greater than 150 and DBP was greater than 100.

Record review of R5's MAR, showed on 03/05/2023, R5's morning SBP was 150, the medication was administered. There was no documentation that the physician was notified.

Record review of R5's MAR, showed on 03/06/2023, R5's morning SBP was 162. R5 was administered their medication. There was no documentation that the physician was notified.

Record review of R5's MAR, dated 04/09/2023, showed R5's morning Carvedilol medication, the SBP was 159. R5 was administered the medication. There was no documentation that the physician was notified.

Record review of R5's MAR, dated 04/09/2023, showed R5's afternoon Carvedilol medication, the SBP was 156. R5 was administered the medication. There was no documentation that the physician was notified.

Record review of R5's, MAR, dated 04/24/2023, showed R5's afternoon Carvedilol medication, the SBP was 155. R5 was administered the medication. There was no documentation that the physician was notified.

Record review of R5's, MAR, dated 04/28/2023, showed R5's morning Carvedilol medication, the SBP was 163. R5 was administered the medication. There was no documentation that the physician was notified.

Record review of R5's MAR, dated 04/30/2023, showed R5's Carvedilol medication, the SBP

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was 159. R5 was administered the medication. There was no documentation that the physician was notified.

Record review of R5's, MAR, dated 04/01/2023 – 04/30/2023, showed R5 had a medication Furosemide (a medication to help reduce fluid retention and swelling), that had prescribed parameters to hold if R5's SBP was less than 110 or pulse was less than 60.

Record review of R5's, MAR, dated 04/21/2023, showed R5's pulse was 58. R5 was administered the medication.

Record review of R5's, MAR, dated 04/28/2023, showed R5's pulse was 54. R5 was administered the medication.

In an interview on 05/24/2023 at 10:02 AM, Staff B stated the prescribed parameters for any residents medications were documented on the MAR for the medication technician to follow. Staff B stated that if a resident had multiple prescribed medication that required parameters, only one of the medications would have the prompt to input the vital that was required. Staff B stated the administrative team completes weekly and monthly audits of the MAR's for all Memory Care and Assisted Living residents to ensure medications were administered within the prescribed parameters.

Resident 10 (R10)
Record review of R10's, Resident Service Plan, dated 02/24/2023, showed R10 admitted to the facility on [redacted]2021. The diagnosis section showed R10 had diagnoses of [redacted].

Record review of R10's, Initial and Annual Licensed Nursing Assessment, dated 04/14/2023, showed R10 had a left shoulder fracture (broken bone) revision related to osteoporosis.

In an interview on 05/03/2023 at 9:33 AM, R10 stated they had surgery on their left shoulder on 04/12/2023.

Record review of R10's, Wound Assessment, dated 05/04/2023, showed on 05/03/2023 Staff E, Regional Registered Nurse Corporate, documented a note that R10 had left shoulder surgery with a large incision on their left shoulder. Staff E had replaced the old bandage and noticed the old drainage. Staff E had cleansed the wound with wound cleanser and applied a thick dressing to help absorb the drainage. Staff E placed gauze on R10's armpit area to absorb the drainage and a transparent dressing to help keep the bandages intact. Staff E documented R10's surrounding skin on their left shoulder was dry and intact. Staff E would continue to monitor R10's skin issue until it was healed. The wound assessment did not indicate previous bandage changes from facility staff. The wound assessment for R10 did not indicate what the current wound treatment order was, or the

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frequency of the wound bandaged that needed to be changed.

Record review of an emailed received on 05/16/2023 at 2:42 PM, showed Staff B provided a document for R10 that was titled, After Visit Summary, dated 04/12/2023 – 04/13/2023, and it showed R10 was seen at the outpatient care unit for their left infected shoulder. R10 had a surgical procedure for their left shoulder. There was an order from the physician for R10 to be evaluated by skilled nursing home health services. R10 was to keep their left should free of weight bearing (weight placed on the affected area) of their left upper shoulder. R10 was required to wear and maintain a shoulder sling. R10 had an order for a PICO dressing (a dressing applied to allow a constant suction power of the surgical site) that was for 7 days. The summary didn't show any further wound care instructions for R10's left shoulder.

In an interview on 05/03/2023 at 10:52 AM, R10 stated Staff E, Regional Registered Nurse Corporate, had changed the bandage on their left shoulder.

In an interview on 05/03/2023 at 11:54 AM, Staff E, stated they had changed R10's bandage today (05/03/2023). They stated, "it was gross".

In an interview on 05/05/2023 at 10:45 AM, Staff B, Assistant Executive Director, stated they weren't aware of what the current wound care orders were for R10's left shoulder. Staff B stated they would follow up on the order.

In an interview on 05/08/2023 at 10:15 AM, R10 stated that the following staff had helped them change their bandage: Staff H, Medication Aide, Staff Y, Medication Aide, and Staff Z, Medication Aide. R10 stated Staff F, Assisted Living Director (ALD), had tried to change the bandage, but the bandaged had come off shortly after they applied it.

In an interview on 05/08/2023 at 12:51 PM, Staff H, Medication Aide, stated they helped R10 change their shoulder bandage. Staff H stated the bandage was saturated (heavily soiled and wet) with blood and drainage. Staff H stated they were not supposed to provide wound care. Staff H stated the facility did not have a current order for R10's wound care.

In an interview on 05/15/2023 at 4:12 PM, Staff B stated they would follow up on obtaining R10's current physician order from R10's surgery that took place on 04/12/2023.

In an interview on 05/24/2023 at 2:48 PM, Staff B stated R10's bandage on their left shoulder needed to be changed every few days. Staff B stated they were unsure how often it needed to be changed.

As of 05/16/2023 at 5:00 PM there was no other documentation for R10's surgical wound care orders from a physician that was provided to the Department for review.

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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 Lacey is or will be in compliance with this law and / or regulation on (Date) 9/16/2023

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

Administrator (or Representative) — Date: 8/22/2023

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to investigate and document actions and findings for incidents jeopardizing residents' health for 3 of 6 sampled residents (Resident 1, Resident 4, and Resident 5). This failure resulted in the facility being unable to determine the circumstances of the events, institute, and document appropriate measures to prevent similar situations, and protect the residents during the course of the investigation.

Findings Included...

Record review of the facility provided, "Safe Handling/Evaluating Residents Fall Potential" policy for falls, dated 08/27/2023, showed "the community shall provide initial and ongoing evaluations of each resident's mobility needs as well as seek to minimize risk of injury from falls while promoting resident independence and safety... After any resident falls, staff will review specific care coordination needs and seek to minimize recurrence... Step 3... the service plan must specify any trends, contributing factors and intervention(s) to be used as well as residents preferred level of participation in interventions which could include but not limited to refusal of offered increased assistance, participation in outside therapies, participation in community exercise/activity programs etc."

Resident 5 (R5)

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Record review of Memory Care Facility Resident Characteristic Roster and Sample Selection, dated 04/29/2023 showed R5 had admitted to the facility on [redacted]2018.

Record review
of R5's charting note, dated 04/30/2023 at 10:32 AM, showed the medication aide called emergency services to have R5 evaluated since R5 verbalized being in extreme pain.

Record review of the facilities Resident Occurrence Report, dated 04/30/2023, showed R5 had crawled out of their bed in their room on their hands and knees. R5 stated they were opening their closet door and it fell on top of them. Medication Aid entered R5's room and the residents closet door was laying down with the bottom of the closet door on the floor and the top of the closet door on R5's bed.

Record review
of R5's, After Visit Summary, dated 05/03/2023, showed R5 was seen by a physician for their compression fracture (broken bone) of the low back area and age-related osteoporosis (a condition which bones become weak and brittle).

Record review of R5's Resident Data Sheet, undated, showed R5 had a diagnosis of [redacted].

In an observation on 05/04/2023 at 10:58 AM, showed R5's closet door was completely off the hinges and their clothing and personal items were exposed. The other side of the rooms closet door was opened and a closet door was propped up within the closet leaning against the wall.

In an observation and interview on 05/04/2023 at 11:28 AM, Staff J, Memory Care Activities Director, stated R5 did not have a closet door because there was an incident where the door fell on R5. Staff J stated they were waiting for maintenance staff to replace the closet door. Staff J was shown that the closet door was propped up within the closet on the other side of the room. Staff J acknowledged this was a safety concern. Staff J stated they are unsure if a work order was submitted to get R5's closet door replaced.

In an interview on 05/05/2023 at 11:11 AM, Staff K, Caregiver, stated they were informed by a colleague that R5's closet door was still inside of R5's room on the adjacent side they asked maintenance to remove it. Staff K acknowledged that the door remaining in the room was a safety concern. Staff K stated, " the closet door fell on R5 once and we don't need it falling on R5 or anyone else who goes into the room again."

In an interview on 05/08/2023 at 10:45 AM, Staff T, Traveling Maintenance – Corporate, stated they had received a work order on 05/01/2023 to remove R5's closet door because

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it had fallen on them. Staff T stated the work order was completed on 05/03/2023. Staff T stated they were unaware that the closet door was left inside the room, propped open in the adjacent rooms closet.

In an interview on 05/15/2023 at 10:41 AM, Collateral Contact 3 (CC3), Family Member, stated since R5 fell, R5 had a fracture, and the doctor notified the family the fall could had contributed to R5's decline in health.

Record review showed there was not documentation of a follow up or facility investigation of how the closet door fell on R5. There was no information about whether or not the R5 required medical attention. There was no documentation that the facility took measures to prevent future occurrences of the closet door falling on R5.

Resident 1 (R1)

Record review of the "Resident Occurrence Tracking Log", dated January – March 2023, showed R1 had three falls in March 2023.

Record review the "Resident Occurrence Report", dated 03/13/2023 at 1:55 PM, showed R1 was found on the floor. The report identified that R1 had similar event happen in the last 90 days. They were to be escorted to meals and activities. There was no documentation of new interventions or updates to the service plan to protect the resident from recurring falls.

Resident 4 (R4)

Record review of the "Resident Occurrence Report", dated 04/04/2023 at 12:30 PM, showed Resident 4 (R4), reported they had a fall and gotten themselves up. R4 had multiple bruising to their left hip and back side. There were no immediate action or interventions put in place documented on the report.

Record review of the "Resident Occurrence Report", dated 04/05/2023 at 7:16 PM, showed R4 was found sitting on the ground. R4's walker was not close enough for the resident to reach that caused them to fall and hit their head. The report showed there was no re-education or training for the staff that resulted from the occurrence. There was no documentation to show there were updates made to the service plan to protect the resident from recurring falls.

Record review of the "Resident Occurrence Report", dated 04/25/2023 at 7:30 PM, showed R4 was found on the floor in their bathroom. R4 was advised to always call for assistance with transfers to the bathroom. There were no documented staff re-education or training related to this event. No updates to R4's service plan related to occurrence.

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Record review showed no documentation that the facility follow up to see if R1 and R4 needed medical attention or if there was a change in their condition. There was no documentation to show if actions were taken to prevent future falls.

In an interview on 05/24/2023 at 10:02 AM, Staff B, Assistant Executive Director, stated that interventions for all occurrences were discussed at the time of the event. The interventions would be documented on the occurrence report by the person completing the occurrence that would include themselves, the executive director, resident care coordinator, or the memory care director.

This is recurring deficiency previously cited on 01/05/2022 and 11/14/2022.

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 Lacey is or will be in compliance with this law and / or regulation on (Date) 7/15/2023.

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

Megan [illegible] — Administrator (or Representative)

8/22/2023 — Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

(c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;

This requirement was not met as evidenced by:

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Based on observation, interview and record review, the facility failed to document in the resident's Negotiated Service Agreements (NSA) the plan to provide the care and services necessary to support the residents care needs, the plan to provide assistance with activities of daily living, and the plan to provide intermittent nursing services for 5 of 9 sampled residents (Resident 10, Resident 8, Resident 1, Resident 6, and Resident 7). This failure placed the residents at risk for unmet care needs.

Findings included...

Record review of the facility's "Medication Technician & QMAP Training" dated 05/01/2023, under the section titled, "Other MT [medication technician]/QMAP Responsibilities, health care agency", showed procedure four... update the service plan for the resident that received services to specify condition requiring treatment, services that were provided, name of the agency providing the service with contact information for day and evening, and when the agency should be contacted about the resident's condition between visits or after hours.

Resident 10 (R10)
Record review of R10's Resident Service Plan, (facilities version of the NSA), dated 02/24/2023, showed R10 admitted to the facility on [redacted]2021. The diagnosis section showed R10 had a diagnosis of [redacted]. Under the section, Health Maintenance, showed R10 does not have any would or skin issues. Under the section, bathing, showed R10 was independent with their showers and ADL's (activities daily living) and did not require staff assistance.

Record review of R10's Initial and Annual Licensed Nursing Assessment, dated 04/14/2023, showed R10 had a left shoulder fracture (broken bones) revision (repair) related to osteoporosis. The assessment indicated R10 had a left shoulder fracture revision related to osteomyelitis (infection of the bone) within the last 12 months. The assessment did not indicate R10 used any assistive devices. R10's assessment did not indicate they had any skin issues. R10 was independent with activities of daily living (activities of personal care).

Record review of R10's After Visit Summary, dated 04/12/2023 – 04/13/2023, showed R10 was at an outpatient care unit due to diagnosis of [redacted] and [redacted]

In an interview on 05/03/2023 at 9:33 AM, R10 stated they had surgery on their left shoulder on 04/12/2023 due to their socket coming out of place. R10 stated that after surgery they required use of a shoulder sling that they must wear at all times. R10 stated after surgery the staff had assisted them with bathing since they cannot get the sling wet. R10 stated they needed help because they couldn't reach certain parts of their body due to limited mobility of their arm. R10 stated the staff helped change their bandage from where the surgical site was located and was still draining. R10 stated the staff do not appear to be trained on changing bandages. R10 stated that the bandage had come off multiple times after the staff had placed it on for them.

In an observation on 05/03/2023 at 9:33 AM, showed R10's left shoulder was in an arm sling. R10 had a had a bandage to the left shoulder that had large amounts of red and purple coloring. There was minimal amounts of the bandage that observed white. The

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bandage was loose fitting on R10's skin. When R10 moved their arm, the bandage separated from the skin that caused a gap near the armpit of R10's arm with movement.

Record review of R10's, charting note, dated 04/19/2023 at 2:07 PM, showed R10 was placed on alert for returning back to the facility from the hospital. The documentation showed R10 reported they felt weak, which was to be expected after their surgery.

Record review of R10's, charting note, dated 04/24/2023 at 9:19 PM, showed R10 recently had surgery and from moving too much it reopened the surgical wound on the left shoulder. The charting notes do not indicate when and how often staff helped R10 change their shoulder bandage.

Record review of R10's, Wound Assessment, dated 05/04/2023, showed on 05/03/2023, Staff E, Regional Corporate Registered Nurse, wrote a note stating R10 had left shoulder surgery. R10 had a large incision on their left shoulder. Staff E had replaced the old bandage and noticed the old drainage. Staff E had cleansed the wound with wound cleanser and applied abdominal pad (a thick dressing) to absorb the drainage. Staff E placed gauze on the armpit area to help absorb the drainage and applied a transparent dressing to keep bandages intact. Staff E documented the surrounding skin on R10 was dry and intact. Staff E continue to monitor R10's skin issue until it was healed. R10's wound assessment did not show any prior bandage changes from facility staff. R10's wound assessment did not show how often R10's shoulder bandage was needing to be changed.

In an interview on 05/03/2023 at 10:52 AM, R10 stated Staff E came into their room and changed the bandage on their shoulder.

In an interview on 05/03/2023 at 11:54 AM, Staff E, stated they changed R10's bandage today. They stated, "it was gross".

In an interview on 05/08/2023 at 10:15 AM, R10 stated that the facility Medication Aides would come in to help change their shoulder bandage after surgery. Staff H, Medication Aide, Staff Y, Medication Aide, and Staff Z, Medication Aide, had changed the bandage. R10 stated Staff F, Assisted Living Director, had tried to help change the bandage. R10 stated at times they had to change their shoulder bandage themselves.

In an interview on 05/08/2023 at 12:51 PM, Staff H, Medication Aide, stated they had helped R10 change their shoulder bandage due to it being saturated (heavily wet) with blood and drainage. Staff H stated they are not supposed to provide wound care, but they had to go in and help based on how the bandage looked. Staff H stated the facility did not have a current order therefore they were not supposed to do wound care. Staff H stated if it was an emergency then they are going to help the resident.

Resident 8 (R8)
Record review of R8's "Resident Data Sheet", undated, showed they moved into the facility on [redacted] 2023.

Record review of R8's, "Initial and Annual Nursing Assessment", dated 04/17/2023, showed R8 moved into the facility on [redacted] 2023. The assessment was R8's initial evaluation. R8 had multiple medical diagnoses including [redacted].

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[redacted]). R8 recently had a right frontal craniotomy and tumor resection (surgery to open part of the skull and removed abnormal growth) on 03/20/2023. R8's mobility was unsteady with a history of falls in the last 12 months. R8 had recent physical and occupational therapy (services that help with strengthening for the body). R8 used a wheelchair and a bedside commode. R8 had poor skin turgor (skins ability to retract), chronic skin issues, and current skin issues that included skin cancer lesion on the right wrist area and the left parotid area (left side of the face near the ear). R8 had a poor appetite with unplanned/significant weight loss in the last 6 months. R8 experienced chronic ongoing pain management with routine scheduled pain medications and as needed for breakthrough pain. R8 took psychoactive (medication that affects the mind) medication to help with sleep.

Record review of R8's Service Plan dated [redacted]/2023, showed they were not at risk for falls. R8 required assistance with two showers a week. R8 required physical hands on dress and undressing assistance twice daily from the caregivers. R8 was able to perform their own personal hygiene needs and cleaning up after toileting. R8's Service Plan did not show that the resident was admitted to the facility with hospice services related to terminal illness.
There was no documentation about R8's cancerous tumor to the left side of his face and the care that was required for it. There was no documentation for R8 that a decline in health was anticipated and what to do when that occurred. R8 was identified to not have a history of pattern of falls and no known fall risk. R8 was not at risk for weight loss or had a recent weight loss. R8 was able to be understood by staff and able to communicate their desires to staff and visitors. There was no documentation how R8 took their medication or if they required nurse delegated tasks.

Record review of R8's hospice "Narrative note", dated 04/07/2023, showed they received a referral on 04/05/2023 to admit R8 to services. R8 had a fall at home in the past. R8 had spreading cancer that had a very poor prognosis. R8 had a mass to the left side of face near their ear. R8 was to discharge from the skilled nursing facility to the Assisted living facility.

Record review of R8 charting note, dated 04/15/2023, at 3:52 PM, showed R8 was confused and unable to remember why they called for assistance.

Record review of R8 charting note, dated 04/27/2023 at 12:40 PM, showed R8's left ear was bleeding profusely and had been for last two days. Staff H, Medication Aide, got approval to call emergency services to come evaluate from hospice provider.

Record review of R8's charting note, dated 04/30/2023 at 5:06 PM, showed R8 refused soft foods for breakfast and dinner.

Record review of R8's charting note, dated 05/03/2023 at 6:31 PM, showed R8 had a fall today. R8 had generalized weakness and was encouraged to call for staff assistance with toileting.

Record review of R8's charting note, dated 05/03/2023 at 2:13 PM, showed R8 urinated on the ground in their apartment. R8 was weak that caused them to fall. R8 required assistance to get up off of the ground and cleaned up.

Resident 6 (R6)
Record review of R6's, Resident Service Plan dated 11/03/2022, showed R6 was not a fall

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risk or had a pattern of falls. R6 walked with a steady balance. R6 was able to check their own blood sugar and didn't require any assistance from staff. R6 required assistance with insulin (medication to help reduce high levels of sugar in the blood) administration. R6 wasn't identified to have any difficulties with sleeping pattern.

Record review of R6's, Quarterly Licensed Nurse Evaluation Summary, dated 04/18/2023, for R6 showed they had a few falls this quarter but not fall trends. Interventions were in place. R6 was independent with all daily personal care activities. R6 required assistance with their socks and shoes from staff. R6 had difficulties sleeping at night and took medication nightly to help with sleeping. R6 had all of their medications administered for them. Under the section, Nurse Delegation, R6 required services for medication and insulin administration along with first aid services.

Record review of R6 charting note, dated 02/09/2023 at 1:43 AM, showed R6 was on alert charting for a fall while dancing with another resident that caused them to have skinned knees.

In an interview on 05/05/2023 at 11:53 AM, R6 stated that the medication aide's administered their eye drops. In an interview on 05/05/2023 at 12:38 PM, Staff H, Medication Aide, stated they administer R6's eye drops.

In an interview on 05/03/2023 at 1:55 PM, R6 stated that they had a pacemaker (device to keeps the heart beating at a specific rate). They stated they had some falls recently. They have difficulty with sleeping at night that required them to take medication to help. R6 stated that the medication aide's administered their insulin for them.

Resident 1 (R1)
Record review of R1's, Nursing Assessment, dated 04/13/2023, showed they moved into the facility on [redacted]2023 with multiple medical diagnoses included [redacted] R1 experienced memory problems with some confusion. R1 had an unsteady balance with a history of falls in the last 12 months. R1 experienced back pain and required a wheelchair for long distance transfers. R1 had interventions for fall trends that were located on the service plan. R1 recently had a fall that caused a fracture (broken bone) to their low back area. R1 was ordered by a physician to use a back brace.

Record review of R1's, Resident Service Plan, dated 04/18/2023, showed they didn't not have any medical diagnoses. R1 was able to communicate needs and understood others without any concerns. R1 did not have any behavior, mood, or memory impairments. R1 required stand by, no hands-on assistance with their transfers. R1 used a wheelchair. R1 didn't require stand by assistance due to instability for transfers. R1 was identified to have had more than three falls in the last month. There were no documented interventions for R1 to assist in reducing further falls. There wasn't a community based provider documented for R1. There was no documentation that R1 had a cat. There was no documentation that R1 required a back brace and was not compliant with the use. R1's Resident Service plan showed R1 ate in the dining room without tray services to their apartment.

Record review of R1 charting note, dated 03/13/2023 at 2:41 PM, showed R1 was found on the floor by the staff. R1 reported they had walked backwards and tripped causing them to fall.

Record review of R1 charting note, dated 03/31/2023 at 11:43 AM, showed R1 had a fall

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on 03/30/2023 and was sent to the local hospital. R1 was confused with present time or place. R1 required one person assistance from staff for all transfers and dressing needs. R1 was placed on every two the three hourly checks.

Record review of R1 charting note, dated 04/05/2023 at 11:42 PM, showed there was new orders for the resident to start physical therapy services (someone that works with muscle strengthening) for their back fracture. The physician was to be notified if R1 refused to use their back brace.

Record review of R1 charting note, dated 04/07/2023 at 4:31 PM, showed R1 was more confused to time and place. They were unable to navigate their way around the community. Staff were required to escort them to all meals, activities, and to the lobby for appointments.

Record review of R1 charting note, dated 04/10/2023 at 10:30 AM, R1 refused to wear their back brace.

Record review of R1 charting note, dated 04/15/2023 at 1:42 PM, showed R1 required their meals to be brought to their room.

Record review of R1 charting note, dated 04/18/2023 at 12:13 PM, showed R1 would have outside physical therapy provider come out to the facility and evaluate them.

Record review of R1 charting note, dated 05/01/2023 at 3:29 PM, showed R1 had a physical therapist come to work with them at the facility.

Record review of R1 charting note, dated 04/21/2023 at 1:36 PM, showed R1 doesn't remember to call for staff assistance.

Record review of R1 charting note, dated 04/28/2023 at 1:47 PM, showed R1 was reminded to call for assistance with transfers and their wheelchair. R1 needed constant reminders to not do personal care needs alone.

Record review of R1 charting note, dated 05/02/2023 at 9:54 PM, showed R1 was on alert for a back brace. R1 refused to wear the brace.

In an observation and interview on 05/04/2023 at 10:49 AM, there was a long haired brown cat that was in R1's room. R1 stated that staff assist them with cleaning the cat box and feeding their cat. observation showed there was a four wheel walker and a wheelchair in R1's room for them to use. R1 stated it was the year of 1931. R1 stated that they had fell and broke their back. R1 stated they participate in therapy services in their room. R1 stated they required more assistance from the staff since they fell.

Resident 7 (R7)
Record review of the Memory Care Facility Resident Characteristic Roster and Sample Selection, dated 04/29/2023, showed R7 was admitted to the facility on [redacted]2022.

Record review of R7's, Resident Service Plan, dated 3/13/2023, showed R7 had diagnoses of [redacted]. Under Health Maintenance section showed that R7 had a follow up appointment

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with urology on 03/30/2023.

Record review of R7's, Quarterly Licensed Nurse Evaluation Summary, dated 04/16/2023, showed R7's current level of functioning was that he had an indwelling catheter (a tube that enters into the bladder that drains urine for the body). R7 was seen at their Physicians office monthly. Under coordination of care section showed that a urology (specialist for catheter care) nurse comes to the facility monthly to change R7's indwelling catheter.

In an interview on 05/05/2023 at 11:20 AM, Staff K, Caregiver, stated R7 goes out of the facility to receive catheter care.

In an interview on 05/05/2023 at 11:29 AM, Staff G, Medication Aide, stated R7 goes out of the facility to receive catheter care because facility staff were not able to clean and change the catheter.

In an interview on 05/08/2023 at 9:50 AM, Collateral Contact 4 (CC4), R7's Family Member, stated R7 received catheter care in the community because the facility staff are unable to provide catheter care. CC4 stated due to R7's [redacted] diagnosis this had caused hardship on the family who are responsible for getting R7 to their provider. CC4 stated it was difficult to get R4 in the car and that they cannot leave R7 alone at any time otherwise they will wander off. CC4 stated the last time R7 had an appointment they had an episode of incontinence (lack of voluntary control over urination or defecation) to where R7 had experienced an infection after.

In an interview on 05/08/2023 at 2:44 PM, Staff B, Assistant Executive Director, and Staff C, Registered Nurse Regional Director of Operations, stated the facility staff cannot accommodate R7's catheter care. Staff B and Staff C stated they were unaware of the hardship the catheter care treatments caused R7's family members.

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 Lacey is or will be in compliance with this law and / or regulation on (Date) 7/15/2023.

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

Meghan Hamm — Administrator (or Representative)

8/22/2023 — 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 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

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(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, observation, and record review the facility failed to update the Negotiated Service Agreement for 3 of 9 sampled residents (Resident 5, Resident 1, and Resident 8). This failure placed the residents at risk for unmet care needs by staff unaware of most updated care and servicers for the residents.

Findings included...
Record review of the facility's policy, Service Planning and Coordination of Care, dated 08/27/2020, showed adequate coordination of care should mean that staff especially the assisted living director and the facility nurse consider all factors contributing to a resident's condition and how they might relate to one another. A resident's service plan was used to identify resident care needs, how staff should monitor/observe for them and interventions for each resident hat staff can apply if necessary. The initial, annual, and quarterly Licensed Nurse assessments documents were to be a requirement to use to help establish and support the service plan approach.
Resident 5 (R5)
Record review of Memory Care Facility Resident Characteristic Roster and Sample Selection, 04/29/2023, showed R5 was admitted to the facility on [redacted]2018.

Record review of R5's Resident Data Sheet, undated, showed they had a diagnosis of [redacted].

Record review of R5's, Resident Service Plan, dated 12/29/2022, showed R5 ambulated independently with a four-wheel walker. R5 did not need assistance with transfers and ambulation. R5 was not considered a fall risk and had a steady balance with walking.

Record review of R5's, Resident Occurrence Report, dated 04/30/2023, showed R5 crawled out of their room on their hands and knees. The report showed R5 had opened their closet door. The closet door then fell on top of R5. The medication aide observed R5's room and the residents closet door was laying down with the bottom of the closet on the floor and the top of the closet on R5's bed.

Record review of R5's, After Visit Summary, dated 05/03/2023, showed R5 was seen by a physician to for their compression fracture (broken bone) of the low back area and age-related osteoporosis (a condition which bones become weak and brittle).

Record review of R5's charting note, dated 04/30/2023 at 10:32 AM, showed the medication aide called emergency services to have R5 evaluated since R5 verbalized being in extreme pain.

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Record review of R5's charting note, dated 05/01/2023 at 1:09 PM, medication aide stated R5 struggled to walk and needed to use a wheelchair to be transported to meals.

Record review of R5's charting note, dated 05/02/2023 at 5:53 PM, showed Staff E, Registered Nurse Corporate Regional, documented R5 had a change of condition. R5 had verbalized being in pain and would cry out and moan. R5 needed two-person assistance to get R5 out of bed. R5 had been ambulatory (able to walk) but was no longer able to.

In an observation on 05/04/2023 at 10:58 AM, R5 was sitting in a wheelchair in the memory care dining room. R5's right hand had multiple bruises that were a deep purple color. R5 did not have recollection of the fall with injury that took place on 04/30/2023.

In an interview on 05/15/2023 at 10:41 AM, Collateral Contact 3 (CC3), Family Member, stated R5's son was notified of the fall that took place on 04/30/2023. CC3 stated since the occurrence R5 has had a decline in condition and the doctor contributed it to the occurrence that occurred on 04/30/2023.

Record review of R5's chart showed that the resident service plan was not updated after a change of condition was identified for R5. There were no interventions documented for R5's fall. The service plan wasn't updated for R5's pain that was caused from the compression fracture after the closet door fell on her. The service plan didn't show that staff were required to assist R5 with their transfers and escort R5 in their wheelchair. The service plan didn't show that R5 was unable to walk independently with their walker.

Resident 1
Record review of R1's, Resident Data Sheet, showed Resident 1 (R1) moved into the facility on [redacted]2023.

Record review of R1's, initial and annual Licensed Nursing Assessment, dated 04/13/2023 showed the assessment would be conducted by licensed nurses who are qualified assessors within 14 days of move in, and annually thereafter using this form. The assessment was R1's initial assessment. The document showed R1 moved into the facility on [redacted]2023. R1 had multiple medical diagnoses that included [redacted] The assessment showed R1 had short term memory problems with periods of confusion to time and place. It showed R1 was unsteady with walking. The assessment showed in the last 12 months, R1 recently had some falls. . R1 used a wheelchair for long distances related to their back pain and a walker. The assessment showed there were documented interventions for fall trends on the service plan. Under the section, medication management, showed R1 recent had a fall that results in a low back fracture (broken bone) that required the resident to use a back brace daily. R1 had urine accidents that required them to use briefs daily. R1 had an open sore on their left leg and knee that were scabbed over. R1 had a history of picking at the scabbed areas.

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Record review of R1's, Resident Service Plan (facility version of the Negotiated Service Agreement), updated 04/18/2023, showed R1 they didn't have any medical diagnoses listed as indicated on the License Nurse assessment. The service plan wasn't updated that R1 had a emergency visit that required treatment for their fracture in their back. The service plan indicated that R1 was independent with all activities of daily living. The service plan showed R1 was independent with daily routine. R1 did not required assistance with transfers or walking. R1 was independent with daily routine and did not require assistance from staff with their showers. The assessment showed R1 did not require redirection or staff interventions for any confusion or memory concerns. The service plan under the section, health maintenance, showed R1 did not have any pain issues that required management by prescribed medications. Under the section supportive services, showed there was no documentation that R1 was on community services for therapy from their recent fall that resulted in a fracture. The service plan didn't indicate that R1 had a cat that resided with them at the facility and staff assisted with the care of the pet.

Record review of R1's charting note, dated 04/07/2023 at 4:31 PM, showed R1 had some abnormal behaviors. R1 was mistaking their son for their spouse. R1 was confused with current time and date. R1 was often lost and difficult to find their way around the community.

Record review of R1's charting note, dated 04/08/2023 at 1:31 PM, showed R1 was on alert for an unwitnessed fall with injury of a lumbar fracture (low back broken bone). R1 was in some pain.

Record review of R1 charting note, dated 04/24/2023 at 3:13 PM, showed R1 started to walk with the help of the physical therapy.

Record review of R1 charting note, dated 04/27/2023 at 8:23 PM, showed R1 was very confused that night.

Record review of R1 charting note, dated 04/28/2023 at 1:47 PM, showed R1 was reminded to call for assistance with transfer and use of the wheelchair. R1 required to be reminded continuously to not do things alone and ask for help.

In an interview and observation on 05/04/2023 at 10:49 AM, R1 was lying on their bed with a big fluffy cat that was in the chair beside them. R1 stated that they had a fall and injured their back. R1 stated that the caregivers help them with their showers, clean their cats litter box, and giving them their medications. R1 stated they received assistance with dressing and sometimes after use of the toilet. The stated that they currently resided in Germany. R1 stated that they had a fall and broke their back. They stated they were in a great deal of pain and were required to wear a back brace all the time. R1 stated that they needed more assistance from the staff since they had fallen.

Resident 8 (R8)
Record review of R8's, "Initial and Annual Nursing Assessment", dated 04/17/2023,

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showed R8 had multiple medical diagnoses including [redacted]. The assessment showed R8 was unsteady with walking and had falls in the last 12 months. R8 had a cancerous growth to the left side of their face and a cancerous growth to their right wrist area. R8 was showed they had reported to have lost weight over the last six months and has a poor appetite. R8 has chronic pain that requires prescribed pain medication.

Record review of R8's "Residents Service Plan", dated [redacted]/2023, showed R8 did not have any medical diagnosis as indicated on the licensed nurse assessment. R8 previously came to the facility from a skilled nursing facility. The service plan did not show that R8 recently had surgery on their head that required a hospital stay. The service plan did not reflect the emergency room visit when R8's growth on their head was bleeding profusely. The service plan showed R8 did not have any problems with their mood. R8 did not require any cueing, assistance, or interventions from staff for redirection related to confusion or mental health concerns. R8 was documented to be able to cope with change and challenging situations "very well". R8 was documented to not have a history of falls or at risk to have fall. There were no interventions in place for the recent falls since R8 admitted to the facility. R8 required one person staff assistance with transfers. R8 was not at risk for weight loss or had recent weight loss. The service plan didn't reflect that R8's was not eating or that they were having difficulties swallowing. The history of R8's weight loss in the last six months was not documented. R8 didn't require any nutritional services with their food textures. R8 did not need regular treatment for skin issues. The service plan did not have any documentation about the cancerous growth to the left side of their head or their right wrist. R8 did not require or request safety checks due to change in/or short-term condition. R8 did not experience pain issues that were managed by medications or non-pharmacological interventions.

Record review of R8's charting note, dated 05/03/2023 at 6:31 PM, showed Staff E, Regional Registered Nurse, showed R8 had a fall earlier that day. R8 has a large tumor to the left side of the face that was draining.

In an interview on 05/04/2023 at 12:58 PM, Staff F, Assisted Living Director, stated R8 was declining in their health condition. Staff F stated R8 was on hospice services for a cancerous growth to their face that was spreading throughout their body. Staff F stated R8 had a lot of pain from the cancer that required administration of prescribed pain medication. Staff F stated R8 was having difficulty swallowing and required to eat soft foods. This was not showed on the service plan. Staff F stated that hospice told Staff F, that R8's health was declining near end of life. R8 required more assistance from staff for safety, eating, activities of daily living that was not indicated on the service plan.

In an interview on 05/05/2023 at 12:47 PM, Staff Z, Caregiver/Medication Aide, stated R8 required assistance with dressing, getting in and out of bed, being taken to the dining room for all meals, and recently required to have meals brought to their room. Staff Z stated that R8 had multiple skin areas on them including the large growth that was on the left side of their face by their ear. Staff Z stated that R8 has gotten more confused in the last couple of weeks. Staff Z stated that R8 was not independent with any of their care as the service plan indicated and required staff to help with everything.

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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 Lacey is or will be in compliance with this law and / or regulation on (Date) 7/15/2023 .

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

Administrator (or Representative) — Date: 6/22/2023

WAC 388-78A-2100 On-going assessments. The assisted living facility must:

(2) Complete an assessment specifically focused on a resident's identified problems and related issues:

(a) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(b) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

(c) When the resident has an injury requiring the intervention of a practitioner.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to complete on going assessments focused on residents identified problems, a change of condition, and when they had an injury requiring practitioner intervention for 1 of 9 sampled residents (Resident 10). This failure placed the residents at risk for unmet care needs by staff untrained of the most updated care and service needs for the residents.

Resident 10 (R10)

Record review of R10's Resident Service Plan, dated 02/24/2023, showed R10 admitted to the facility on [redacted] 2021. The diagnosis section showed R10 had diagnoses of [redacted]) and [redacted]). Under the section titled, "Safe Resident Handling", showed R10 occasionally used their walker and scooter to get around. There was no other documentation of any medical equipment or device needed for R10. Under the section, "health maintenance", showed R10 did not have any wound or skin issues. Under the section, "bathing", showed R10 was independent and did not require assistance. The service plan indicated R10 was independent with their ADL's (Activity Daily Living – activities related to personal care) and did not require assistance. Staff were to

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observe and report any changes to the Assisted Living Director/Registered Nurse.

Record review of R10's Initial and Annual Licensed Nursing Assessment, dated 04/14/2023, showed the assessment was an annual assessment. The assessment indicated R10 had a left shoulder fracture (broken bone) revision related to osteomyelitis (infection of the bone) within the last 12 months. The assessment did not indicate R10 utilized any assistive devices. The assessment did not indicate R10 had any skin issues.

Record review of R10's, After Visit Summary, dated 04/12/2023 – 04/13/2023, showed R10 was at an outpatient care unit due to diagnosis of [redacted].

In an interview on 05/03/2023 at 9:33 AM, R10 stated they had surgery on their left shoulder on 04/12/2023 due to their socket coming out of place. R10 stated that after the surgery they had a shoulder sling that they must always wear. R10 stated after surgery they required assistance from staff for bathing. R10 stated they couldn't reach certain parts of their body due to limited mobility of their left shoulder. R10 stated the staff helped change their bandage from where the surgical site was located and that it was still draining. R10 stated the staff would help them put their socks on if they happen to be in the room while they were getting dressed. R10, spouse of R9, stated R9 required assisted from R10 get dressed with their clothes.

Record review of R10's charting note, dated 04/24/2023, at 9:19 PM, showed R10 recently had surgery. R10 had moved their left shoulder more than recommended causing the stitches (a medical device used to hold body tissue together) to separate and the surgical incision to reopened.

In an interview on 05/04/2023 at 9:19 AM, Staff C, Registered Nurse Regional Director of Operations, stated if a resident were considered waived on the characteristic roster, they was still considered assisted living residents. Staff C stated waived residents were considered independent with ADL's, but had an assisted living contract. Staff C stated the facility nurse would still conduct skin assessments as needed. Staff C stated the facility still completed care plans every three months or if there was a change of condition.

Record review of R10's charting notes, dated 02/01/2023 – 05/04/2023, showed there was no documented licensed nurse assessments related to change of condition of R10's left shoulder.

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 Lacey is or will be in compliance with this law and / or regulation on (Date) 7/15/2023.

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

Administrator (or Representative) — Date: 8/22/2023

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

(4) How residents with special needs are individually protected without unnecessary restrictions on the general population.

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to secure potentially hazardous supplies accessible to memory care and assisted living residents for 2 of 2 locations within the facility (assisted living laundry room and the memory care unit). This failure placed 65 of 65 residents at risk for ingesting potentially toxic materials.

Findings included...

Memory Care

In an observation and interview on 05/02/2023 at 11:45 AM, the laundry doors of the south side of the memory care unit were unlocked. A measuring cup with residual white powder was on top of the washing machine that was running. Staff F, Assisted Living Director, stated the doors were to be locked when unattended.

Assisted Living

In an observation on 05/02/2023 at 12:58 PM, in the third-floor assisted living laundry room was a bottle unlabeled with clear liquid inside. The bottle was under the sink

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unsecured and accessible to residents.

In an interview on 05/02/2023 at 12:58 PM, Staff F stated they were unable to confirm what the liquid was inside. Staff F then removed the lid and smelled the liquids and stated they thought it was Febreze (liquid to spray to remove bad smells).

In an observation on 05/02/2023 at 12:20 PM, on the second floor outside of Resident 16's room was a housekeeping cart that was left unattended. There was "crema" cleaner (removes spots, buildups, scuffs, grease, mold, mildew, and soap scum) and general-purpose cleaner unsecured on the cart. There was a bottle of carpet extraction cleaner.

In an observation on 05/02/2023 at 12:21 PM, the second-floor hospitality room contained," lime away turbo powder" (a cleaner that is supposed to remove mineral deposits and rust) under the sink unsecured. The label read "do not drink."

In an observation on 05/02/2023 at 12:31 PM, the second-floor assisted living laundry room contained a a bottle of Clorox bleach (a commercial bleaching agent) that was unsecured in a cabinet. There also was a clear chemical in a spray bottle that was unlabeled, unsecured, and accessible to residents.

In an observation on 05/04/2023 at 3:50 PM, on the fourth floor of showed a housekeeping cart unattended. There was Lysol hydrogen peroxide (sanitizers to kill germs on surfaces), TB (Tuberculosis – a contagious bacterial infection of the lungs) disinfectant cleaner, cascade complete (cleaner for washing dishes), and crème cleanser.

In an interview on 05/24/2023 at 2:48 PM, Staff B, Assistant Executive Director, stated the expectation was that cleaning chemicals are not in the hallways accessible to residents to grab and use for themselves. Staff B stated there should not be dishwashing detergent, disinfectant, or toilet cleaner accessible to residents.

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 Lacey is or will be in compliance with this law and / or regulation on (Date) 7/15/2023.

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

Administrator (or Representative) — Date: 8/22/2023

This document was prepared by Residential Care Services for the Locator website.

WAC 388-78A-2410 Content of resident records. The assisted living facility must organize and maintain resident records in a format that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

(3) Resident's written acknowledgment of receipt of:

(a) Required disclosure information prior to moving into the assisted living facility; and

(b) Information required by long-term care resident rights per RCW 70.129.030 .

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure written acknowledgment of the facility disclosure of services was received and signed for 9 of 9 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, and Resident 9). This failure resulted in 65 of 65 residents and their resident representative's being uneducated about their rights and responsibilities while living at the facility.

Findings included...

"RCW 70.129.030 (1) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The notification must be made prior to or upon admission. Receipt of the information must be acknowledged in writing."

Record review of Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 04/29/2023, showed Resident 1 (R1) admitted to the facility on [redacted]/2023.

Record review of R1's chart showed there was no signed disclosure of services for review.

Record review of Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 04/29/2023, showed Resident 2 (R2) admitted to the facility on [redacted]/2022.

Record review of R2's chart showed there was no signed disclosure of services for review.

In an interview on 05/04/2023 at 3:11 PM, R2 stated they do not recall receiving a disclosure of services form upon admission. R2 stated they had heard other residents within the community had not received a disclosure of services either.

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Record review of the, Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 04/29/2023, showed Resident 3 (R3) admitted to the facility on [redacted]2021.

Record review of R3's chart showed there was no signed disclosure of services for review.

Record review of the Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 04/29/2023, showed Resident 4 (R4) admitted to the facility on [redacted]2021.

Record review of R4's chart showed there was no signed disclosure of services for review.

Record review of the, Memory Care Facility Resident Characteristic Roster and Sample Selection, dated 04/29/2023, showed Resident 5 (R5) admitted to the facility on [redacted]2018.

Record review of R5's chart showed there was no signed disclosure of services for review.

Record review of the Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 04/29/2023, showed Resident 6 (R6) admitted to the facility on [redacted]/2017.

Record review of R6's chart showed there was no signed disclosure of services for review.

Record review of the Memory Care Facility Resident Characteristic Roster and Sample Selection, dated 04/29/2023, showed Resident 7 (R7) admitted to the facility on [redacted]2022.

Record review of R7's chart showed there was no signed disclosure of services for review.

Record review of the, Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 04/29/2023, showed Resident 8 (R8) admitted to the facility on [redacted]2023.

Record review of R8's chart showed there was no signed disclosure of services for review.

Record review of the Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 04/29/2023, showed Resident 9 (R9) admitted to the facility on [redacted]/2021.

This document was prepared by Residential Care Services for the Locator website.

Record review of R9's chart showed there was no signed disclosure of services for review.

In an interview on 05/04/2023 at 2:02 PM, Staff B, Assistant Executive Director (AED), stated they gave the residents a copy of the disclosure of services form when they moved into the facility. Staff B stated the facility does not require the residents to sign an acknowledgement that they had received the disclosure of services upon move in. Staff B stated were unable to provide any sign disclosure of services signed for any of the residents residing at the facility for review.

In an interview on 05/04/2023 at 2:16 PM, Staff B inquired where in the rules and regulations showed that it was required for the resident to sign a disclosure of services form and file in their records. Staff B stated they were unaware of the requirement.

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 Lacey is or will be in compliance with this law and / or regulation on (Date) 7/15/2023.

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

Megan Hart — Administrator (or Representative)

8/22/2023 — Date

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

(7) When coordinating care or services, the assisted living facility must:

(a) Integrate relevant information from the external provider into the resident's preadmission assessment and reassessment, and when appropriate, negotiated service agreement; and

(b) Respond appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to coordinate care and services from external providers, respond appropriately when a resident experienced a change in their health, and integrate external providers information into the Negotiated Service Agreements for 3 of 9 sampled residents (Resident 8, Resident 10, and Resident 1).

This document was prepared by Residential Care Services for the Locator website.

This failure placed the residents at risk for unmet care needs.

Findings included...

Resident 8 (R8)
Record review of R8's "Resident Data Sheet", undated, showed they moved into the facility on [redacted]2023.

Record review of R8's Residents Service Plan (facility version of the Negotiated Service Plan (NSA), dated [redacted]/2023, showed R8 did not have any medical diagnoses. R8 was documented to not need regular treatment for skin issues. R8 did not require or request safety checks due to change in/or short-term condition. R8 did not experience pain issues that were managed by medications or non-pharmacological interventions. Under the section titled, Supportive Services, showed R8 did not receive any outside community-based services. There was no documentation on R8's service plan that showed R8 was on hospice services, when staff were to notify hospice services for any changes with R8, and contact information for the hospice provider.

Record review of R8's, "Initial and Annual Nursing Assessment", dated 04/17/2023, showed R8 had multiple medical diagnoses including [redacted]. The type of assessment for R8 was titled, "initial". The assessment showed R8 moved into the facility on [redacted]2023. Under the section titled, skin integrity, the nurse documented that R8 was currently followed by hospice for their skin cancer. Under the section titled Medication Management, showed R8 was followed by hospice care for their pain medications related to their skin cancer. There was no other documentation that R8 was on hospice services and what specific hospice services they provided to R8. There was no hospice provider name, contact information, or information when to contact the provider for R8.

Record review of R8's, "Narrative note", dated [redacted]/2023, showed R8 moved into the facility and had hospice provider start services for R8 on the same day ([redacted]/2023). R8 was admitted for hospice services related to their poor prognosis of their skin cancer that had spread to the brain and caused a growth to the left side of their ear and face.

Record review of R8's, "Narrative Note", dated 04/10/2023, showed the hospice provider told Staff F, Assisted Living Director, the need to notify the hospice provider 24 hours a day seven days a week.

Record review of R8's "Residents Service Plan", dated [redacted]/2023, showed no documentation that R8 was on hospice services, when staff were to notify hospice services for any changes with R8, and contact information for the hospice provider.

Resident 10 (R10)

This document was prepared by Residential Care Services for the Locator website.

- Record review of R10's, Resident Service Plan, dated 02/24/2023, showed R10 admitted to the facility on [redacted]/2021. The diagnosis section showed R10 had diagnoses of [redacted].

Record review of R10's After Visit Summary, dated 04/12/2023–04/13/2023, showed R10 was at an outpatient care unit due to diagnosis of [redacted]. The provider placed an order for home health skilled nursing (treatment by trained registered nurses), home health physical therapy (help injured or ill people improve movement and manage pain) and home health occupational therapy (encourages rehabilitation through the performance of activities required in daily life) to evaluate and treat R10 after their procedure. There was no documentation to show these orders were integrated into the NSA or coordinated by the facility with the home health provider.

Record review of R10's, Initial and Annual Licensed Nursing Assessment, dated 04/14/2023, showed R10 had a left shoulder fracture revision related to osteoporosis. The assessment indicated R10 received physical therapy and occupational therapy in the last 12 months. The assessment did not show who provided R10 services and when.

In an interview on 05/03/2023 at 9:33 AM, R10 stated they had surgery on their left shoulder on 04/12/2023 due to their socket "coming out of place".

In an interview on 05/08/2023 at 10:15 AM, R10 stated that they did not currently have home health to come in and change their bandage. R10 stated the last time they needed a bandage change, they did it themselves. R10 stated the facility Medication Aides would come in to help change their shoulder bandage after their surgery. R10 stated Staff H, Medication Aide, Staff Y, Medication Aide, Staff Z, Medication Aide and Staff F, Assisted Living Director had helped them change their shoulder bandage.

In an interview on 05/08/2023 at 12:51 PM, Staff H, Medication Aide, stated that they had helped R10 change their shoulder bandage. Staff H stated the bandage was saturated (heavily soiled and wet) with blood and drainage. Staff H stated they were not supposed to provide wound care. Staff H stated the facility did not have a current order for R10's wound care.

In an interview on 05/16/2023 at 10:47 AM, Collateral Contact 2 (CC2), R10's Family Member, stated R10 was supposed to have home health services after their shoulder surgery for physical and occupational therapy.

In an interview on 05/24/2023 at 2:48 PM, Staff B, Assistant Executive Director, stated R10 had home health for nursing, physical therapy, and occupational therapy. Staff B stated home health could not come out after the first surgery on 04/12/2023 because R10 needed another surgical procedure on their left shoulder on 05/12/2023.

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In an interview on 05/25/2023 at 12:19 PM, R10 stated home health had not come in to help them with physical therapy, occupational therapy, or wound care after their first procedure on 04/12/2023 or their second procedure on 05/12/2023. R10 stated Staff E, Registered Nurse Corporate Regional, and the facility Medication Aides helped them with their bandage changes.

Resident 1
Record review of R1's, Resident Data Sheet, showed Resident 1 (R1) moved into the facility on [redacted]/2023.

Record review of R1's, initial and annual Licensed Nursing Assessment, dated 04/13/2023 showed this was R1's initial assessment. R1 moved into the facility on [redacted]/2023, this was different than indicated on the resident data sheet for R1. R1 had multiple medical diagnoses that included [redacted]. The assessment showed R1 recently had falls that caused back pain. R1's back pain required them to use a wheelchair for long distances and a walker. Under the section, "medication management", showed R1 recent had a fall that resulted in a low back fracture (broken bone) that required the resident to use a back brace daily. There was no documentation that R1 was seen by home health physical therapy services for the recent fall with pain and injury. The assessment showed "initial and annual assessments included the license nurse review of the service plan/negotiated service agreement to assure content if reflective of care needs related to assessed areas."

Record review of R1's, Resident Service Plan, dated 04/18/2023, showed R1 moved into the facility on [redacted]/2023. R1 didn't have any medical diagnoses. They were independent with all activities of daily living. Under the section supportive services, showed there was not documented community services they received.

Record review of R1's charting note, dated 04/05/2023 at 10:36 AM, showed R1's doctor had called and placed an order for physical therapy and a back brace for the resident.

Record review of R1 charting note, dated 04/06/2023 at 10:20 AM, showed the home health provider called the facility and requested the doctor to prescribe an order for home health therapy services to help manage R1's pain and weakness from the recent fall.

Record review of R1 charting note, dated 04/18/2023 at 9:36 PM, showed R1 was scheduled to have home health provider physical therapy services come out on 04/19/2023 for evaluation.

Record review of R1 charting note, dated 05/01/2023 at 3:29 PM, showed R1 had home health physical therapist visit the resident that day.

In an observation and interview, on 05/04/2023 at 10:49 AM, R1 stated they had a fall

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recently and were working with therapy services that come to the facility. Observation showed exercise documents from the home health provider that showed daily exercises that R1 was to complete for strengthening. R1 stated that they had to do therapy since they were in a great deal of pain from the fall.

Record Review of R1's Resident Service Plan, dated 04/18/2023, showed the home health services were not integrated into R1's NSA and showed no documentation of coordinated with the home health provider.

This is recurring deficiency previously cited on 04/14/2021.

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 Lacey is or will be in compliance with this law and / or regulation on (Date) 7/15/2023

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

Megan Hu — Administrator (or Representative)

8/22/2023 — Date

WAC 388-78A-3170 Circumstances that may result in enforcement remedies.

(1) The department is authorized to impose enforcement remedies described in WAC 388-78A-3160 if any person described in subsection (2) of this section is found by the department to have:

(l) Knowingly or with reason to know, made false statements of material fact in the application for the license or the renewal of the license or any data attached thereto, or in any matter under investigation by the department;

(n) Refused to allow department representatives or agents to examine any part of the licensed premises including the books, records and files required under this chapter;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure three of three records binders (Nurse delegation binder, Temporary Service Plan binder, and Outside Agency binder) were correct and available to the Department. This failure placed 65 of 65 residents at risk of inaccurate records and resulted in the Department being prevented from reviewing necessary records to determine compliance with required state regulations.

Findings included...

This document was prepared by Residential Care Services for the Locator website.

Correct and Available Documentation
Record review of the nurse delegation, nursing visit forms, undated, showed under the long-term care worker training/competency section 10, showed an attestation statement of "I have verified, informed, taught and instructed the caregiver(s) to perform the delegated task (s)."

In an interview on 05/03/2023 at 12:09 PM, Staff H, Medication Aide, stated Staff M, Registered Nurse (RN), was the RN delegator for the facility. Staff H stated Staff M was no longer working at the facility. Staff H stated Staff E, Regional Corporate RN, had observed them that morning administering insulin (injected medication to help lower high levels of sugar in the blood) to a resident. Staff H stated prior to today, Staff E had "never watched them pass medication or administer insulin".

In an interview and observation on 05/03/2023 at 3:07 PM, Staff A, Interim Executive Director, retrieved a binder that was labeled "Nurse Delegation". Staff A opened the binder and stated the forms were dated for year 2022. Staff B, Assistant Executive Director, retrieved three other binders that were labeled "Nurse Delegation". Staff B opened one binder and stated that it was from the year 2017. They opened another and stated it was from the year 2018.

In an interview and observation on 05/04/2023 at 9:07 AM, Staff B was asked for the nurse delegation binder. Staff D, RN Director of Nursing (DNS) corporate was observed putting documents in a binder. Staff D stated, "oh I'm just condensing it down to just one binder rather than four binders. "

Record review of the Nurse delegation nursing visit form for Resident 19, dated 02/24/2023, showed there were two different handwritings on the forms. The first handwriting had documented R10's name, date of birth, and the nurse delegated task was small, legible, fine lined print written on portions of the documented R19's name, date of birth and the task that required nurse delegation. Under the section, "Notes", there was a second handwriting that was bold, darker, and not as legible. That handwriting had documented the medication services that was to be delegated. The handwriting was more pronounced than the handwriting on the upper part of the form. Under the section long term care worker training/competency there were five medications aides listed. The second medication aide list was Staff Y. There were check marks that Staff Y had demonstrated or was observed, and they had completed verbal description of the delegated tasks. The check marks for Staff Y were checked differently from the other check marks for Staff H, Staff L, and Staff Z. Review Staff Z's name that was documented as the fourth medication aide, there was white out under their name. Staff F was listed as a medication aide for evaluation but didn't have any check marks that they had been observed, demonstrated, or able to give verbal description of the delegated tasks.

Record review of the Nurse Delegation Nursing Visit form dated 03/24/2023, for Resident 6(R6), showed there were two different handwritings on the form. The handwriting for the resident's name, date of birth, diagnosis, and the nurse delegate task was written in

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smaller font, fine print ink, clearer penmanship and more petite. The handwriting under the section "notes", showed a more bold, darker pen markings, and writing that was more difficult to decipher. There were five medication aides that were delegated for the task, Staff H, Staff L, Staff F, Staff Y, and Staff Z. The boxes on the form that showed the medication aides were observed, or demonstrated, reviewed to have credentials, and were verbally reviewed for the requirements for the specific delegation services by the registered nurse delegator, were blank for the five listed medication aides. Staff M's name was printed under the section RND (registered nurse delegator) section in between their signature and date.

Record review of the Nurse Delegation Nursing Visit form dated 03/24/2023, for Resident 11 (R11), showed there were two different handwritings on the form. The handwriting for the resident's name, date of birth, diagnosis, and the nurse delegate task was written in smaller font, fine print ink, clearer penmanship and more petite. The handwriting under the section "notes", showed a more bold, darker pen markings, and writing that was more difficult to decipher. There were five medication aides that were delegated for the task, Staff H, Staff L, Staff F, Staff Y, and Staff Z.

Record Review of the Nurse delegation Nursing visit form for Resident 20 (R20), undated, showed there were two different handwritings documented on the form. The handwriting for the resident's name, date of birth, diagnosis, and the nurse delegate task was written in smaller font, fine print ink, clearer penmanship and more petite. The handwriting under the section "notes", showed a more bold, darker pen markings, and was writing that was more difficult to read. Under the section, long term care worker training/competency, there were five medication aides that were listed, Staff H, Staff Y, Staff L, Staff Z, and Staff F. Staff Y was the only medications aide that was checked to have been cleared to have been observed or demonstrated and verbally reviewed for the specific delegated task. Under Staff F's name there was white out used.

In an interview and observation on 05/04/2023 at 9:20 AM, Staff C, RN Regional Director of Operations, brought one nurse delegation binder for review. Staff C stated that Staff M was on a contract to complete the nurse delegation for the facility. Staff C stated Staff E, Regional Corporate RN was at the facility two to three times a week to complete assessments for new and potential residents, change of conditions, weight loss/gain with residents.

In an interview on 05/04/2023 at 9:29 AM, Staff M stated they were the RN delegator for the facility. Staff M stated that the RN delegation binder had been missing from the facility since February 2023. They stated they had only delegated for the assisted living residents the following medication aide's: Staff H, Staff L, and Staff Z. They stated they had never delegated nor met Staff Y, Medication Aide. Staff M stated they weren't allowed to use white out on the nurse delegation forms if an error was made.

In an interview on 05/04/2023 at 3:01 PM with Staff B Assistant Executive Director (AED), stated Staff M completed the nurse delegation and Staff E completed the assessments for the residents.

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In an interview on 05/04/2023 at 3:08 PM, Staff B stated, "it should only be the nurse delegator that filled out the forms and no one else". They stated that Staff M's handwriting was difficult to read.

In an interview on 05/04/2023 at 4:38 PM, Staff B stated that Staff E was assisting Staff M with filling out the nurse delegation forms.

In an observation and interview on 05/05/2023 at 10:43 AM, Staff B brought in one nurse delegation binder that was thicker and heavier than the day prior. When asked why there was a change to the binder. Staff B stated Staff D had condensed the binders. Staff B was unable to describe what documents were added to the binder.

In an interview on 05/05/2023 at 11:00 AM, Staff D stated with Staff C present that the staff credentials were added to the nurse delegation binder. Staff D stated they were in another binder, and this was the reason for the binder being thicker and heavier.

In an interview on 05/08/2023 at 10:30 AM, Staff E, stated they took over the nurse delegation on 05/04/2023.

Record review of a handwritten documented untitled, dated 05/09/2023, showed Staff E had worked with Staff M on the RN delegation. Staff E stated they had completed the top portion of the RN delegation nursing Visit forms and the names of the Medication Aides. Staff E stated that they were conducting observations of the medication aides but had stopped. Staff Y had not completed their trainings or required certifications. Staff E stated Staff M then used the forms dated 03/24/2023 that Staff E had partially filled out. Staff E wrote that they had used white out on a few of the nurse delegation forms and was aware that this should have not been used.

In an interview on 05/09/2023 at 9:05 AM, Staff M stated they were the only one to fill out the forms and no one else. They stated they didn't communicate or coordinate with Staff E for the nurse delegation forms.

In an interview on 05/10/2023 at 10:03 AM, reviewed nurse delegation forms with Staff M for Resident 21, R11, R6, Resident 19, R20. Staff M stated they had signed all the nurse delegation forms except the form dated 03/24/2023, for R6. Staff M stated they don't write their signature with a tail at the end of their S of their last name. They stated they didn't handwrite their first and last name as it was documented on the form. Staff M stated that they didn't add the check marks for Staff Y. Staff M had never met Staff Y nor delegated Staff Y to preform delegated tasks.

Temporary Service Plan Binders

This document was prepared by Residential Care Services for the Locator website.

In an interview and observation on 05/03/2023 at 2:49 PM, Staff L, Medication Aide, stated there was a binder with temporary care plans that would tell them what new care and services the residents needed after a change of condition or occurrence. Staff L pointed to the shelf above the resident charts and stated it was usually kept on a shelf labeled "care plan" for the staff to access and review.

In an interview on 05/08/2023 at 10:06 AM, Staff Y, Medication Aide, stated they fill out a temporary service plan for the residents with any changes that occurred. They stated they are kept in a binder that was kept in the charting room. Staff Y stated that the binder was not in the charting room for review.

In an interview on 05/08/2023 at 10:30 AM, Staff E stated that there was a binder that all temporary service plans were located for any change in residents care needs. The binder was to be accessible for all staff in the charting room.

In an observation and interview on 05/08/2023 at 10:47 AM, Staff E was unable to provide the binder for review. They stated the temporary service plan binder should have been in the charting room.

On 05/08/2023 at 11:27 AM the temporary service plan binder was requested by the department for review.

In an interview on 05/08/2023 at 11:49 AM, Staff X, Memory Care Director, stated they inquired what temporary service plans the department needed. The department clarified that the temporary service plan binder was requested for review. Staff X stated that there were active and non-active temporary service plans. The department requested both types, and the binder for temporary services plans for review.

In an observation on 05/08/2023 at 12:30 PM, Staff X brought the department three loose temporary service plan forms for three different residents. There was no binder brought with non-active temporary service plans.

Outside agency binders.

In an interview and observation on 05/05/2023 at 12:38 PM, Staff H, Medication aide, stated an outside provider filled out an outside agency form and they get filed in an outside agency binder. Staff H pointed to a shelf on the wall and stated that the binder was not there.

In an interview on 05/08/2023 at 10:30 AM, Staff E stated that outside agency providers would fill out an agency form and leave it for the staff to review. The forms were then filed in a binder called "outside agency".

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In an observation and interview on 05/08/2023 at 10:47 AM, Staff E was unable to provide the outside agency binder for review. They stated the binder should have been in the charting room.

In an interview on 05/08/2023 at 3:40 PM, Collateral Contact 8, Hospice RN, stated they fill out an outside provider from and turn it in to the front desk after they visit the resident at the facility.

In an interview on 05/08/2023 at 4:37 PM, Collateral Contact 6, Hospice RN, stated they fill out an outside agency form and turn in at the front desk for every visit they make for any hospice resident they visit at the facility.

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 Lacey is or will be in compliance with this law and / or regulation on (Date) 7/15/2023.

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

Administrator (or Representative) — Date: 8/22/2023

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

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

(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 facility failed to ensure the care for 1 of 1 resident (Resident 8) was provided in a dignified manner and failed to address and resolve 5 of 9 residents (Resident 4, Resident 8, Resident 9, Resident 10, Resident 13) grievances. These failures resulted in Resident 8 not receiving hygiene care and living in unsanitary conditions, and placed the residents at risk for experiencing decreased quality of life.

This document was prepared by Residential Care Services for the Locator website.

Findings included...

RCW 70.129.140 Quality of life—Rights. (1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. (5) A resident has the right to: (a) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

RCW 70.129.060 Grievances. A resident has the right to: (1) Voice grievances. Such grievances include those with respect to treatment that has been furnished as well as that which has not been furnished; and (2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

Record review of R8's hospice, "Narrative Note", dated 05/01/2023, showed R8 had dried blood around the entire left side of their face that was coming from R8's left ear. The hospice RN asked the medication aide and caregiver to coordinate care to clean up R8's face after they were administered pain medication 20 minutes before cleansing.

Record review of R8's hospice, "Narrative Note", dated 05/03/2023, showed R8 had dried blood on their neck, chest, and shoulder. R8's fingernails were imbedded with dried discharge from the cancerous lesion on the left side of their face.

Record review of R8's hospice, "Narrative Note", dated 05/04/2023, showed R8 was lying in their bed. The cancerous lesion to the left side of R8's face continued to grow. R8 had dried blood around the lesion, their face and neck.

Record review of R8's hospice, "Narrative Note", dated 05/06/2023, showed R8 was found in their bed. R8 was disheveled and cachectic (weakness or wasting of the body due to illness). There was moderate amount of dried blood down the left side of R8's face.

Record review of R8's hospice, "Narrative Note" dated 05/07/2023, showed R8's "left ear remains affected by a larger cancerous lesion with dried blood to the surrounding area."

In an observation and interview on 05/03/2023 at 10:59 AM, R8 was sitting on the floor in their apartment with their back up against the bed frame with their legs out in front of them. R8 didn't have any clothes on. They were yelling for "help". The pull cord (a string that a resident can pull that will notify the facility staff they need assistance) was coiled up against the far wall near the bathroom entrance. R8 was not observed to have a wrist pendent(a wearable button that residents could push to notify the facility staff they need assistance on. The room had a foul pungent odor. There were brown spots on the carpet near the bedside commode (portable toilet). R8 had long fingernails with brown matter in them. There were large amounts of dark red and black drainage on the left side of their

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face and cheek area.

In an interview on 05/04/2023 at 12:58 PM, Staff F, Assisted Living Director, stated R8 was on hospice services. R8 's health was declining and was requiring more care and services to be provided. Staff F stated that R8 was near end of life.

In an observation and interview on 05/04/2023 at 2:05 PM, R8 was lying in their bed. There was a strong pungent odor to the room. There were no sheets on R8's bed. There were large dark red, light red, and bright red areas that resembled dried blood on the mattress that R8 was lying on. There was a pillow that R8 had their head resting on that was not covered. There were multiple areas of bright, light, and dark red areas scattered all over the pillow (Resembling dried blood) around and under R8's head. R8 stated that he was not doing "very well". R8 had a facial droop to the left side. R8 had facial hair that was black, white, and long on their chin, cheeks, and upper lip area. R8 had a large growth to the side of their head near the left ear that was draining dark red drainage. There was a thick matter that was black and dark red imbedded in their facial hair. R8's skin was unable to be seen related to the thick, flaky, dark red matter. R8 was observed to pick at the thick matter on the left side of their chin. R8 stated that the facility does their laundry. R8 was observed to have long fingernails on both hands. R8's fingernails were dark yellow in color and had brown, black, red substance under the nails. When R8 was talking their lips were dry and cracked. Their tongue was dry and there was brown matter on their teeth. R8 stated they were very thirsty. R8 stated that they preferred to be shaved daily as they didn't like to have long hair for their beard or mustache. R8 stated they "call staff so much and no one comes".

In an interview on 05/05/2023 at 10:43 AM, Staff B, Assistance Executive Director, stated that for R8 the hospice nurse came into visit them daily. Staff B stated that the hospice team were the ones to manage the growth to the left side of R8's face.

In an observation and interview on 05/05/2023 at 12:11 PM, R8 was lying in their bed on their right side. Upon entering R8's room, there was a strong pungent smell of feces and unidentified odor. R8's arm was lying on a pillow that was not covered and had multiple areas of dark, light, and bright red spots that resembled dried blood. The growth to the left side of R8's face had dark red drainage dripping onto R8's cheek and neck. R8 stated that they hadn't been offered a shower. R8 was asked about shaving their facial hair and stated, "I wouldn't mind doing that". There was an electric shaver that was on the bedside table next to the window. R8 fingernails were long and yellow. There was brown and black matter under R8's fingernails. R8's face on their left cheek, chin, around their lips, and down the left side of their neck had thick red and black matter. The skin was unable to be visualized in those areas due to the thickness of the matter.

In an interview on 05/05/2023 at 12:47 PM, Staff Z, Medication Aide/Caregiver, stated they help R8 with getting in and out of their bed. They help R8 with dressing and undressing. Staff Z stated that hospice and R8's friend assisted R8 with shaving. Staff Z stated that R8 preferred to not have facial hair and shaved daily. Staff Z stated they were needing to help R8 more with toileting and escorts to the dining room for meals. They stated that R8 was noted to be more confused the last few weeks.

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In an observation on 05/08/2023 at 10:01 AM, The room that R8 occupied had a strong pungent odor of feces. R8 was lying on their bed that had large red areas on the mattress that resembled dried blood. R8 remained in an unkept condition. When R8 was talking their lips and tongue were dry and cracked. Their teeth had brown matter on them and was difficult to see the whiteness of the teeth. R8 stated that they couldn't get anyone to answer their questions.

In an interview on 05/08/2023 at 10:06 AM, Staff Y, Medication Aide, stated they weren't shaving R8 because they were near end of life. Staff Y stated they were provided R8 toileting assistance. Staff Y stated they gave R8 their medication. They had not offered to wash R8's face or hands. They stated that the hospice staff for R8 provided all the showers.

In an interview on 05/08/2023 at 10:30 AM, Staff E, Regional Registered Nurse (RN), stated R8 needed one person assistance with all their activities of daily living. Staff E stated the facility staff were to offer to wash R8's face, shave, toilet, and any care needs and services they may require. Staff E stated that hospice staff were the decisions makers all R8's care needs and oversees all the care.

In an interview on 05/08/2023 at 3:04PM, Collateral Contact 8 (CC8), Friend of R8, stated the facility wasn't doing their due diligence for R8. The condition of R8's room and appearance were unacceptable.

In an interview on 05/08/2023 at 3:16 PM, CC8, stated that they visited R8 on 05/06/2023 and the smell in their room was "really bad". CC8 stated they couldn't stay long because of the smell in R8's room. CC8 stated they had expressed the concern of the smell to the facility staff. The facility staff would tell CC8 that they were assigned to R8's room. CC8 stated that today (05/08/2023) they entered R8's room and scrunched their nose and stated the smell was so bad. CC8 stated they just want R8 to be taken care of. CC8 stated when they were in R8's room they saw bowel movement all over the floor, window, walls and carpet. R8 was also covered in bowel movement. R8 didn't have any clean clothes or bedding. R8 was lying on their bed without any sheets or blankets.

In an interview on 05/08/2023 at 3:47 PM, Collateral Contact 9 (CC9), Hospice RN, stated inside R8's room there was bowel movement on the walls, bed sheets, the window blinds, the floor, and on R8. CC9 stated that R8's mattress was stained with blood and bowel movement. CC9 stated that "R8's face was badly crusted with drainage and R8's fingernails were long, dirty with bowel movement imbedded underneath them". CC9 stated that caregivers were not approaching R8 because R8 was dirty. CC9 stated that the hospice caregiver came out twice a week to provide R8 a bath, but the facility staff were to offer a shower and hygiene care for the rest of the days. CC9 stated that today they trimmed R8's nails and helped remove some of the crusted matter on R8's face. CC9 stated they trimmed R8's beard. CC9 stated they placed a disposable pad over R8's blood-stained pillow and mattress.

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In an interview on 05/08/2023 at 4:37 PM, Collateral Contact 6 (CC6), Hospice RN, stated that R8 would often pick at the growth on the left side of their face. CC6 stated that the growth would bleed and drain down the left side of R8's face, chin, and neck area. CC6 stated that R8 was paying for shower services. CC6 stated the hospice caregiver only provided showers for R8 twice a week. CC6 stated the facility had asked if they were to provide showers for R8. CC6 educated them that the facility staff that provided showers to R8, were required. CC6 educated that hospice services were an addition to their care and services the facility provided.

In an interview on 05/08/2023 at 2:45 PM, Staff B stated that they were unaware of R8's uncleanliness or the condition of R8's room. Staff B stated that the facility staff continue to provide care and services to any resident that was on hospice services. Staff B stated that the care from hospice staff was an additional service to the resident.

Record review of the facility's, "Grievance Procedure for Residents Policy", undated, showed "residents, and family members and or responsible parties are encouraged to voice their concerns and provide suggestions to improve and or compliment customer service without fear of retribution. All formal complaints are to be documented on a complaints concern form and final resolution achieved within two weeks. Section 5 showed the executive director or regional director of operations will conduct the investigation within 72 hours."

Grievances

Record review of a Community Complaint Form, dated 04/04/2023, showed multiple residents expressed concern regarding having to wait over an hour to be served their food. Some residents waited up to two hours to be served. There was only one server during the mealtime. The notes section was blank. Section 2 stated it was to be completed by the Executive Director. The conclusion and action plan section were blank. Staff B, Assistant Executive Director (AED) signed that the complaint was resolved on 04/18/2023 without providing any documentation as to how the issue was addressed.

Record review of a Community Complaint Form, dated 04/19/2023, showed a resident expressed concern regarding a group of four residents who come early to breakfast and still get served late. The resident expressed concern that "residents get attacked" in the dining room when they sit near the window. The resident expressed concern that it takes over an hour to be served their first drink at dinner. The conclusion and action plan section were blank. The date resolved section was blank. The executive director did not sign or date the document.

Record review of a Community Complaint Form, dated 04/21/2023, showed multiple residents expressed concern regarding long wait times to get food, the wait staff were not paying attention to the assisted living side, and the food quality was poor. Under the notes section it read that this had been a long-standing issue and was reported by multiple residents. The conclusion and action plan section were blank. The date resolved section was blank. The executive director did not sign or date the document.

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In an interview on 05/03/2023 at 9:33 AM, Resident 10 (R10), stated when they had a concern, they were supposed to call the front desk. R10 stated often there was no follow up to the concern reported. R10 stated the facility staff stated their concerns are put on a list and were addressed. R10 stated they had expressed concern regarding long wait times for meals and food that was supposed to be served had ran out. R10 stated there was no follow up about the reported concerns.

In an observation on 05/03/2023 at 12:05 PM, showed Resident 4 (R4) had already sat down for lunch. At 12:28 PM, Staff Z, Medication Aide asked R4 if they were tired because their head was down with their chin to their chest. At 12:41 PM, Staff P, Server, came to take R4's order and verbally stated R4 was "knocked out" and they would continue to let R4 sleep.

In an observation on 05/03/2023 at 12:05 PM, showed Resident 8 (R8) had already sat down for lunch. At 12:42 PM, Staff P, took R8's meal order. At 12:54 PM, R8's food was delivered.

In an observation on 05/03/2023 at 12:05 PM, showed Resident 9 (R9) and Resident 10 (R10) had already sat down for lunch. At 12:24 PM, Staff P took R9 and R10's meal order. At 12:52 PM, R9 and R10's food was delivered.

In an observation on 05/03/2023 at 12:05 PM, Resident 13 (R13) had already sat down for lunch. Staff Z checked on R13 at 12:30 PM. R13 shouted in a frustrated tone, "I've got nothing, I've got no coffee or anything!" At 12:44 PM, Staff P took R13's meal order. R13 stated he was tired of waiting. At 12:54 PM, R13's food was delivered.

In an interview on 05/03/2023 at 2:51 PM, Staff H, Medication Aide, stated the servers were short staffed. Staff H stated R4 was asleep during lunch today. Staff H stated if R4 did not have to wait so long then they would not have fallen asleep.

In an interview on 05/03/2023 at 3:11 PM, Staff P, stated that the resident's often expressed frustration with the long wait times.

In an interview on 05/08/2023 at 2:44 PM, Staff B, Assistant Executive Director, stated grievance reports should be completed within two weeks. Staff B stated the Executive Director was responsible for overseeing completion of the task and that the complaint was resolved on the grievance report. Staff B stated when a resident sits down for mealtimes, the start to finish dining process should be completed within 30 – 45 minutes.

This is a recurring deficiency previously cited on 08/21/2020 and 07/23/2020.

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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 Lacey is or will be in compliance with this law and / or regulation on (Date) 7/15/2023 .

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

Megan Hamm — 8/22/2023

Administrator (or Representative) — Date

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