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) 26545 (Completion Date 07/12/2023) and 18964 (Completion Date 03/27/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/12/2023 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:
RCW 70.129.030.4, RCW 70.129.030, WAC 388-78A-2120, WAC 388-78A-2120-3, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-4

The Department staff who did the on-site verification:
Paul Aube, ALF NCI

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Bonaventure of Lacey
Provider Type: Assisted Living Facility
License/Cert.#: 2036
Compliance Determination #: 18964
Intake ID: 64414
Investigator: Paul Aube
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 01/24/2023 through 03/27/2023
Complainant Contact Date(s):

Allegation(s):

1. Fraud/False Billing: Public report of facility increasing care costs without notification.
2. Financial Exploitation: Public report of facility increasing care costs without notification.

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 6 Closed records sample size: 0
Observations:	Residents Activities Dining Staff to resident interactions Resident to resident interactions
Interviews:	Local Health Jurisdiction Management Nursing staff Residents Family Resident Providers
Record Reviews:	Admission Logs Medical records Care Plans Progress Notes Hospital records Incident investigation Facility policies Personnel files Staff training records Resident Billing Statements

Investigation Summary:

1. Fraud/False Billing: Facility did not provide 30-day written notice to the resident, or the resident's representative when increasing care costs as per their policy. Failed

Practice Identified.
2. Financial Exploitation: Facility did not provide 30-day written notice to the resident, or the resident's representative when increasing care costs as per their policy. Failed Practice Identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Bonaventure of Lacey
Provider Type: Assisted Living Facility
License/Cert.#: 2036
Compliance Determination #: 18964
Intake ID: 62671
Investigator: Paul Aube
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 01/24/2023 through 03/27/2023
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/Treatment: Public report of facility failing to provide negotiated care and services to a resident.
2. Admission, Transfer & Discharge Rights: Public report of facility failing to provide negotiated care and services to a resident.

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 6 Closed records sample size: 0
Observations:	Residents Activities Dining Staff to resident interactions Resident to resident interactions
Interviews:	Local Health Jurisdiction Management Nursing staff Residents Family Resident Providers
Record Reviews:	Admission Logs Medical records Care Plans Progress Notes Hospital records Incident investigation Facility policies Personnel files Staff training records Resident Billing Statements

Investigation Summary:

1. Quality of Care/Treatment: Facility failed to collect a urinalysis, and failed to notify

the physician of the failed collection in November 2022, and during another occurrence on December 2022. This failure resulted in a resident decline which resulted in the resident being admitted to the hospital, and being treated for 10 days.
2. Admission, Transfer & Discharge Rights: Facility failed to collect a urinalysis, and failed to notify the physician of the failed collection in November 2022, and during another occurrence on December 2022. This failure resulted in a resident decline which resulted in the resident being admitted to the hospital, and being treated for 10 days.

Conclusion / Action:

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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
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800 NE 136th Ave, Suite 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 2036	Compliance Determination # 18964
Plan of Correction	Bonaventure of Lacey	Completion Date
Page 1 of 7	Licensee: Bonaventure of Lacey LLC	03/27/2023

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 01/24/2023 and 03/07/2023 of:

Bonaventure of Lacey
4528 Intelco Loop SE
Lacey, WA 98503

This document references the following complaint number(s): 63332, 62550, 64414, 62671

The following sample was selected for review during the unannounced on-site visit: 6 of 68 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave, Suite 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.

Cory Cisneros
Residential Care Services

04/03/2023
Date

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

Megan Harris
Administrator (or Representative)

4/21/2023
Date

RCW 70.129.030 Notice of rights and services -- Admission of individuals.

(4) The facility must inform each resident in writing in a language the resident or his or her representative understands before admission, and at least once every twenty-four months thereafter of: (a) Services, items, and activities customarily available in the facility or arranged for by the facility as permitted by the facility's license; (b) charges for those services, items, and activities including charges for services, items, and activities not covered by the facility's per diem rate or applicable public benefit programs; and (c) the rules of facility operations required under RCW 70.129.140 (2). Each resident and his or her representative must be informed in writing in advance of changes in the availability or the charges for services, items, or activities, or of changes in the facility's rules. Except in emergencies, thirty days' advance notice must be given prior to the change. However, for facilities licensed for six or fewer residents, if there has been a substantial and continuing change in the resident's condition necessitating substantially greater or lesser services, items, or activities, then the charges for those services, items, or activities may be changed upon fourteen days' advance written notice.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide the resident or resident representative a thirty-day written notice prior to a change in the charges for care and services after updating the Negotiated Service Agreement (NSA) for 1 of 2 residents (Resident 1). This failure placed 68 of 68 residents in the facility and their representatives at risk for increase in charges for services without notice.

Findings included...

Review of a State of Washington Department of Social and Health Services, Aging and Long Term Support Administration, Dear Provider Letter, dated 09/15/2017, titled, "ALF #2017-012 NOTICE REQUIREMENTS FOR NEW CHARGES", regarding the facility's responsibility, showed, "ALFs [Assisted Living Facilities] are required to complete or update a Negotiated Service Agreement (NSA) [Resident Service Plan] whenever the resident's NSA no longer addresses the resident's current needs and preferences. Changes to care and services provided to the resident must be negotiated and agreed upon by the resident or resident representative. Resident charges may not be increased until the revised negotiated service agreement has been completed or updated in accordance with chapter 388-78A."

Review of a face sheet showed Resident 1 (R1) was admitted to the facility on [redacted]/2020.

Review of R1's "Rental and Residency Agreement," signed and dated by R1's representative on 08/31/2020, under section 8, titled "Adjustments to Monthly Rent, Assisted Living Service Fee, and Other Monthly Charges," stated, "Community will provide Resident with a

30-day prior written notice of any increase or decrease in the Assisted Living Service Fee whenever possible. If there is a change in Resident's condition, the prior written notice may not be possible. In such event, Community and Resident will work together to reach an agreement for a revised Resident Service Plan."

During an interview on 01/24/2023 at 4:18PM with Collateral Contact 1 (CC1), R1's representative, reported that the facility had been raising care costs without any notification. CC1 reported that they became aware of the charges after receiving bills which showed an increase in the monthly charges. "The bills that kept coming were getting larger. At one point it was like $500 or so for [R1's] care charges, and then the next month it was upwards of $2600. There was no signing off on the family on any of this."

During an interview on 01/24/2023 at 11:15AM, Staff A, Executive Director, stated they explained that the Special Care Unit (SCU) Service Fees listed on the billing statements were fees that were related to the cost of care that a resident required. Staff A explained that if a resident required more care, then this would directly reflect the bill amount.

Review of billing statements for R1 showed:
- August 2022: SCU Services Fees $405.98
- September 2022: SCU Service Fees $571.16
- October 2022: SCU Service Fees $966.06
- November 2022: SCU Service Fees $2611.48
- December 2022: SCU Service Fees $2239.30

On 01/24/2022, the Department requested R1's Resident Service Plan's to review for changes in care for September-December 2022 from Staff A. Staff A only provided Resident Service Plans for R1 from September 2022, and November 2022.

Record review of R1's Resident Service Plan, dated September 2022, showed no signatures from the resident, or resident representative.

Review of the Resident Service Plan, dated November 2022, showed no signatures from the resident, or resident representative.

The facility was unable to provide a signed Resident Service Plan for R1 to show that the increased costs were agreed upon.

During an Interview with Staff A on 02/16/2023 at 10:26AM, when asked to explain the process of informing residents and their representatives of a billing increase, Staff A stated, "The way we work a care plan change is that we send out an initial invitation for a care plan meeting by email. Then we give them a phone call and try to communicate with them, so they have an opportunity to join the meeting. We also phone them another time the day before. If they join us, then they are there for the entirety of it and we have the discussion. If they are not able to join, we email them the results of the care plan meeting, along with the page discussing the changes, in addition we also send over the new Resident Service Plan in its entirety. We also send them a 7-day notice that if they do not respond that it will be implemented." When asked how the facility ensured that the resident or resident's representative received the emails, Staff A stated, "We do not have an obligation to make sure they are checking their email. That is the extent that we are

obligated at." When asked to explain the increase in charges for R1 from the months of August 2022-December 2022, they stated that the reason for the increase was due to an increase in care for R1. When asked if the facility had any documentation showing a written 30-day notice to the resident or a representative, the facility provided emails to that were sent to R1's representative.

Review of the first email sent from the facility to R1's representative showed that the email was sent on 08/11/2023 at 10:27AM. The email stated, "We are sorry we missed you for your loved one's service plan meeting that was scheduled for 08/01/2022. Attached is a copy of the updated service plan for your review. If you agree with content pls sign and return to the community. If you have questions or need changes pls contact us before 08/13/2022 (7 days max). If we do not hear from you by 08/13/2022 (7-day max) the service plan will be activated as written. Please sign and return."

Review of an email sent from the facility to R1's representative showed that the email was sent on 10/17/ 2022 at 8:36PM. In the email it stated, "Please advise [R1's] new care plan. If I hear nothing back from you by 10/23/2022 the care plan will be activated as is."

Review of the R1's progress notes showed no documentation that the facility spoke with or attempted to call R1's representative to discuss any changes in care, or care costs.

The Department representative asked Staff A if they could provide any documentation of a 30-day notice given to R1's representative to reflect an increase in care and services and charges from August 2022 to September 2022, from September 2022 to October 2022, October 2022 to November 2022, and November 2022 to December 2022. Staff A was unable to provide any further documentation.

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) 4/21/2023

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

Meghan Harris — Administrator (or Representative)

4/21/2023 — Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview, and record review, the facility failed to take appropriate actions and obtain labs as needed to address a resident's changing needs for 1 of 2 residents (Resident 2). This failure contributed to a delay in treatment which resulted in Resident 2 (R2) being hospitalized for 10 days.

Findings included...

Review of Resident 2's (R2) face sheet showed that the resident was admitted to the facility on [redacted]/2022.

Review of the facility's incident log showed that the R2 was involved in a resident-to-resident altercation on 12/17/2022. Review of the facility incident report, dated 12/17/2022, showed that during the incident, R2 became combative with another resident, and "walked up to 126 [a resident] and started hitting [them] with [R2's] walker then proceeded to hit other resident 126 in the face."

Review of R2's Temporary Care Plan, created on 12/17/2022, under "What interventions/additional services will be provided," it stated, "Checking for UTI" [Urinary Tract Infection] to determine if R2's behaviors were related to the infection.

During an interview with Collateral Contact 3, (CC3), R2's representative on 01/24/2023 at 12:52PM, they stated, "I went in there and one of the med techs told me that they suspected [R2] had a UTI. They said that they suspected it three days prior. When I asked if there was a urine sample done, they stated no, because they couldn't get a sample. I called [R2's Provider], which was his primary physician. They said they sent the order over twice, and the facility didn't do anything." CC3 stated after a few days, R2 was not improving, and CC3 called dispatch health. Dispatch health came to evaluate R2 at the facility and determined that R2 did in fact have a UTI, during their assessment they did not collect a urine sample for culture and sensitivity test. (A culture and sensitivity test (C&S) is a laboratory test where the urine can be tested to determine which bacteria is causing the infection. The result of the C&S will determine which antibiotics to use.) Per CC3, Dispatch Health came to evaluate R2 at the facility, determined R2 did in fact have a UTI, and prescribed Ciprofloxacin, an antibiotic, to treat the UTI. Per R2's representative, R2 did not improve on the antibiotics and became more disoriented over the next few days. On [redacted]/2022, R2's representative brought R2 into the ER. They stated that R2 was admitted into the hospital for 10 days with a UTI and severe dehydration.

During an interview with Staff A, the Executive Director, on 02/16/2023 at 10:26AM, when asked what the process was for the facility if they suspected a resident had a UTI, Staff A

stated, "We would either call the doctor and let them know about our concerns and get an order to perform a UA in house, or if it is more urgent, we would communicate with the family and have them sent to the emergency room to be tested. Or we call EMS and have them transferred to the hospital." When Staff A was asked if the resident's provider would be notified if the facility were unable to collect the sample, Staff A replied that they would notify the resident's provider via fax, and document it in the resident's chart.

Review of R2's medical record from the month of December 2022, showed no fax notification to R2's provider to notify them of the need for a Urinalysis [UA]. Review of R2's medical record also showed there were no fax notifications to the provider notifying them that they were unable to collect the sample.

Review of R2's medical record, showed a physician order, dated 11/17/2022, for the facility to collect a UA from R2. Review of R2's laboratory results showed no results for a UA in R2's chart for November 2022, or December of 2022. Review of R2's progress notes for November 2022 and December 2022 showed no documentation of a UA collection, or any failed attempts to collect.

During an interview with Collateral Contact 2 (CC2), R2's provider, on 01/27/2022 at 12:25PM, they stated that 11/17/2022, seemed to be the start of R2's increased behaviors and agitation. During that time a UA was ordered. CC2 confirmed that they never received a result from that order. CC2 then verified that that on 12/18/2022, CC3, called in and requested a UA. CC2 stated that the order for a UA was sent to the facility on 12/18/2022. Then again on 12/21/2022, CC3 called again to inform them that R2 was seen by Dispatch Health and started on Ciprofloxacin and wanted to ensure that R2 was on the correct medication. CC2 notified her that without a UA they would not be able to determine the medication effectiveness. CC2 then looked through their laboratory websites and confirmed that they did not receive any urine samples for R2 in November of 2022, or December of 2022. CC2 stated that on 12/24/2022, CC3 called again to notify them that R2 was not improving on the medication. CC2 recommended R2 be sent to the Emergency Room (ER) for evaluation. CC2 then verified that they had a record of R2 going to the ER on [redacted]2022.

Review of R2's medical records from their hospitalization showed that R2 was admitted on [redacted]/2022. The admitting diagnosis showed [redacted] as a result from a UTI. (Encephalopathy is a term for any disease of the brain that alters brain function or structure. Encephalopathy can be caused by infections, such as a UTI. The most common symptoms of acute encephalopathy can include confusion, and personality changes.) R2 was given a five-day course of ceftriaxone, an Intravenous (IV) antibiotic, and given multiple liters of IV fluids. R2 was hospitalized for 10 days.

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) 4/21/2023 .

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

Megan Harrison
Administrator (or Representative)

4/21/2023
Date