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

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) 34934 (Completion Date 01/09/2024) and 29803 (Completion Date 10/02/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/09/2024 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-2610-1, WAC 388-78A-2610-2, WAC 388-78A-2610-2-c, WAC 388-78A-2610-2-d, WAC 388-78A-2610

The Department staff who did the on-site verification:
Cory Cisneros, Field Manager
Paul Aube, ALF NCI
Anissa Bearden, Licensor
Regenia Coleman, ALF NCI CI

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

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

Statement of Deficiencies	License #: 2036	Compliance Determination # 29803
Plan of Correction	Bonaventure of Lacey	Completion Date
Page 1 of 7	Licensee: Bonaventure of Lacey LLC	10/02/2023

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 follow-up on 09/12/2023 and 09/21/2023 of:
Bonaventure of Lacey
4528 Intelco Loop SE
Lacey, WA 98503

This document references the following SOD dated: 10/02/2023

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

The department staff that inspected the Assisted Living Facility:

Paul Aube, ALF NCI
Anissa Bearden, Licensor
Regenia Coleman, ALF NCI CI

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.

Cory Cisneros
Residential Care Services

10/13/2023
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.

Statement of Deficiencies	License #: 2036	Compliance Determination # 29803
Plan of Correction	Bonaventure of Lacey	Completion Date
Page 2 of 7	Licensee: Bonaventure of Lacey LLC	10/02/2023

Administrator (or Representative) 10/13/23 Date

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

(d) Provide all resident care and services according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide necessary handwashing supplies in 1 of 1 memory care units. Additionally, the facility failed to implement proper infection control measures and implement appropriate hand hygiene during mealtimes services for 2 of 3 areas (memory care dining room, kitchen, and assisted living dining room). These failures placed all 66 of 66 residents, staff, and visitors at risk for spread of infectious disease or illness.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 07/12/2023, 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 enclosed 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 showed Staff B, Assistant Executive Director, signed the document on 08/08/2023. Staff B signed the "Plan/Attestation 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 08/26/2023."

Record review of the facility's policy, titled, "Section Three: Stop the Spread of Infection/Disease", undated, showed to control the spread of infection, hand washing was the best defense against spreading infection. They were to always wash their hands before contact with a client, eating, preparing food, putting on gloves, after contact with a client, any body fluids, contaminated items, pets, using the bathroom, removing gloves or personal protective equipment, blowing your nose, sneeze, cough, cleaning, and or smoking. The document showed under the section, "safety: proper handwashing

guidelines", to make sure you have everything you need to wash your hands at the sink, that included warm running water, liquid soap, trash can, and paper towels. The document showed that disposable gloves help control infection. The facility was to make sure that gloves were easy to find when they were needed.

Record review of the facility's document, titled, "Hand Washing 101", undated, showed the most common way germs were spread was direct contact and indirect contact was a close second. The document showed that everyone can stop the spread of infection with proper hand washing. Proper hand washing was the most important thing they could do to stop the spread of disease. Under the section titled, "Hand Washing", showed it was important to think about that their hands touched everything. Everything their hands touched could contaminate them. Staff were to ensure hands were clean before touching their face. There were many vulnerable places on a face that included nose, eyes, and mouth that germs could easily gain access into their body.

Review of the Center of Disease Control and Prevention (CDC) Hand Hygiene Guidance In Health Care Settings, dated 01/30/2020, showed, "Healthcare facilities should: Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations, ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled, and ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered."

Record review of CDC's fact sheet titled, "Hand Hygiene at Work", undated, showed good hand hygiene means regularly washing hands with soap and water for at least 20 seconds, and then drying them. It also meant using alcohol-based hand sanitizer with at least 60 percent alcohol if soap and water was not readily available. Under the section titled, "Tips for Protecting Employee Health", showed increased access to sinks that was accessible to all employees and in places such as bathrooms, food preparation areas, or in eating areas. Provide soap, water, and a way to dry hands so employees can wash and dry hands properly. Place hand sanitizer dispensers with at least 60% alcohol near frequently touched surfaces, in areas where soap and water were not easily accessible, such as near shared equipment, building entrances and exits and more.

Memory Care Unit Dining Room

In an observation on 09/13/2023 at 11:34 AM, the sink across from the South side of the memory care unit's washer and dryer, had a soap dispenser that was hanging up on the wall next to the paper towel dispenser. The soap dispenser gray lever was positioned backwards. Soap was attempted to be dispensed from the machine, but the lever was unable to be moved forward or backwards. No soap was able to be dispensed.

In an interview and observation on 09/13/2023 at 11:40 AM, Staff C, Housekeeping, stated they had worked in the memory care unit as the housekeeper for two weeks. Staff C stated they only cleaned the resident rooms. Staff C stated the unoccupied room 118 didn't have any soap in the dispenser, and stated residents regularly and frequently used the bathroom

of the unoccupied rooms, including room 118. Observation of the soap dispenser in the bathroom showed there was no soap visible inside the dispenser. The lever of the soap dispenser was pushed without any soap dispensed. Staff C stated they were unaware how to open the soap dispenser or to refill the soap. The soap dispenser was unable to express soap that was in the bathroom of the unoccupied room 118.

In an observation on 09/13/2023 at 11:56 AM, in the North side kitchen of the memory care unit, there was a cart with two coffee pitchers, coffee condiments, and a silver pan of muffins covered with clear plastic wrap sitting within the kitchen area behind the door. There was a sink with a soap dispenser next to the paper towel dispenser hanging on the wall. The soap dispenser did not have soap inside and the lever was compressed. The soap dispenser's lever was pushed without any soap being able to be expressed. The cold and hot water faucet knobs were turned on with no running water.

In an observation on 09/13/2023 at 12:00 PM, Staff D, Caregiver, had unlocked the South kitchen door in the memory care unit with their keys. Staff D then pulled the hot food cart that the kitchen staff delivered for lunch. Staff D was observed to put on disposable gloves on both hands without washing their hands, and proceeded to open the doors to the hot food cart. Staff D removed the silver pans of hot food that was wrapped with clear plastic wrap. Staff D then removed the clear plastic wrap and placed the silver pans into the steam table. Staff D grabbed a bag of salad with the same gloves, grabbed into the bag and removed some salad and placed inside a bowl. Staff D continue to fill multiple bowls of salad. Staff D then grabbed the handle on the container of salad dressing and poured it on the salads. Staff D then removed their gloves and exited the kitchen door. Staff D was not observed to wash their hands after removing their gloves. Staff D then grabbed the bowls and served them to the residents that were sitting at the tables. At 12:05 PM Staff D pulled her keys out of their pocket and unlocked the South side kitchen door. Staff D entered the kitchen and was observed to put on another pair of disposable gloves. Staff D was not observed to wash their hands prior to putting on the disposable gloves. Staff D then grabbed a plate and started to plate food from the steam table.

In an interview on 09/13/2023 at 12:06 PM, Staff D stated they should have washed or sanitized their hands before they put disposable gloves on and after they take them off. Staff D stated they were to wash or sanitize their hands after performing personal care, anytime their hands were visibly soiled, and any time they were in doubt about the cleanliness of their hands.

In an observation on 09/13/2023 at 12:19 PM, Staff E, Activities, was observed to wash their hands in the public sink on the South side of the memory care unit. Staff E then walked to the South kitchen door, pulled their keys out of their pocket. Staff E unlocked the kitchen door. Staff E opened the door and reached in and grabbed some disposable gloves. Staff E put the disposable gloves on both of their hands. Staff E grabbed some plated plates and served them to the residents at the dining tables.

In an interview on 09/13/2023 at 12:20 PM, Staff F, Memory Care Director, stated they should wash or sanitize their hands before putting disposable gloves on and after removing them, before and after performing personal care, anytime their hands were

visibly soiled, and anytime they were in doubt about the cleanliness of their hands.

On 09/14/2023 at 5:20 PM, Staff F assisted in the memory care units dining room. Staff F repositioned a resident using their ungloved left hand, while holding a ready to serve dinner plate with their ungloved right hand. Staff F switched the ready to eat dinner plate to their ungloved left hand and touched their left thumb into the area of the dinner plate that contained the food. Staff F did not wash or sanitize their hands after they had touched and repositioned the resident and before their left thumb contacted the middle of the dinner plate.

In an observation and interview on 09/14/2023 at 6:25 PM, in the North side kitchen of the memory care unit, Staff F turned the hot and cold water handles of the sink's faucet, that showed there was not running water. Staff F stated that they couldn't wash their hands at that sink, as there was no running water, and there was no soap inside the soap dispenser that was beside the full paper towel dispenser.

In an observation and interview on 09/14/2023 at 6:35 PM, Staff F was observed to express soap from the soap dispenser above the sink across from the washer and dryer on the North side of the memory care unit. Staff F was unable to pull the lever back to dispense soap. Staff F stated the refilled soap was put in incorrectly. Staff F was then observed to push the lever back, but no soap was dispensed, and the lever remained back. Staff F stated they would get Staff C to fix the soap dispenser. Staff F and Staff A, Executive Director stated they weren't aware that Staff C did not know how to change the soap in the soap dispenser in the resident's rooms.

In an observation on 09/15/2023 at 11:56 AM, Staff L, Caregiver, was observed to unlock with ungloved hands, the South side of the memory care unit's kitchenette door. Staff L grabbed the door handle and opened the kitchenette door. Staff L grabbed the hot food cart and pulled the cart into the kitchenette area. Staff L then opened the door to the hot food cart with ungloved hands. Staff L removed a silver pan that was covered with clear plastic wrap out of the food cart. Staff L removed the clear plastic wrap from the silver pan with their ungloved hands and placed the pan into the steam table. During the entire observation, Staff L was not observed to wash their hands with soap and water or use hand sanitizer with change in touching surfaces.

Assisted Living Dining Room

In an observation on 09/14/2023 at 4:55 PM, Staff G, Assistant Executive Director, was observed to write the un-named residents at table 28's orders on an order slip. Staff G then placed the pen and order slip in their pocket of their pants. Staff G walked to table labeled 24 with two un-named residents. Staff G grabbed two clear glasses from the top of the table. Staff G walked to the kitchen door pushed with their hand on the door handle to open the door and walked inside the kitchen. Staff G opened the ice machine lid, grabbed the handle of the ice scoop that was inside, scooped ice and placed them inside the clear glass cups. Staff G then pushed the door open with their hand to exit the kitchen with the two clear glasses full of ice. Staff G entered the kitchenet outside of the kitchen and filled

the two clear glasses with water and returned to table 24 and served them to the two residents. During the entire observation Staff G was not observed to wash their hands with soap and water or with hand sanitizer.

In an observation on 09/14/2023 at 5:00 PM, Staff G entered the kitchen door. Staff G was not observed to wash their hands with soap and water or with hand sanitizer. Staff G placed four dessert fruit dishes onto a round, brown serving tray. Staff G carried the round brown serving tray out of the kitchen. Staff G served the fruit dessert dishes on the table and positioned them within reach for the resident that sat there. Staff G was not observed to wash their hands during the entire observation from the time Staff G entered the kitchen to the time Staff G served the fruit dessert.

In an observation on 09/14/2023 at 5:10 PM, Staff H, Cook, was observed to be standing between the grill and the steam table in the kitchen. Staff H wore clear disposable gloves on both of their hands. Staff H was observed to reposition their personal eyeglasses with one of their gloved hands. Staff H moved their eyeglasses from their face to the top of their head on their hair that was not covered with a hair net. Staff H was not observed to remove their glove or wash their hand with soap and water or hand sanitizer. Staff H was observed to pick up a silver serving spoon with their gloved hand that had touched their eyeglasses and their hair. Staff H picked up a clean plate with their same gloved hand. Staff H's thumb touched the center of the clean plate. Staff H ladled a spoon full of cooked chicken and plated it onto the clean plate they grabbed. Staff H was not observed to wash their hands or use hand sanitizer or change their gloves throughout the observation.

In an observation on 09/14/2023 at 5:15 PM, Staff I, Server, walked into the kitchen with a notepad and pen in ungloved hands after they took a resident food order. Staff I placed the pen and notepad on a prep table opposite the side of the prep table from the grill. Staff I put on a pair of clear disposable gloves, reached into a bag of ready to eat salad with the gloved hand. Staff I placed the salad onto a plate. Staff I removed their gloves from both hands. Staff I picked up the plate of food ungloved. Staff I's right thumb contacted the eating surface of the plate, and exited kitchen. Staff I placed the plate of food in front of an un-named resident. Staff I was not observed to wash their hands or use hand sanitizer through the entire observation.

In an interview on 09/14/2023 at 6:17 PM, Staff I, stated they washed their hands anytime dealing with something clean. Staff I stated if they were bussing dishes and then needed to serve plates, they would wash their hands before they served. Staff I stated the handles on the doors for the kitchen would not be considered clean. Staff I stated they "generally don't" wash their hands after they remove a pair of disposable gloves. Staff I stated that they were taught to wash their hands after removing gloves from their hands. Staff I stated they do not wash their hands after taking resident orders with their pen and order pad. Staff I stated they kept their pen in the personal pant pocket. Staff I stated that their pant pocket was not considered clean. Staff I stated they would start washing their hands after taking orders.

In an interview on 09/15/2023 at 11:31 AM, Resident 1, stated they do not see staff members wash their hands unless they were being watched or if the state licensors and

Statement of Deficiencies	License #: 2036	Compliance Determination # 29803
Plan of Correction	Bonaventure of Lacey	Completion Date
Page 7 of 7	Licensee; Bonaventure of Lacey LLC	10/02/2023

complaint investigators were at the facility.

In an interview on 09/15/2023 at 11:19 AM, Staff J, Dietary Service Manager, stated all servers were expected to wash their hands anytime they touch anything different, Staff J stated every time a kitchen staff member was to remove gloves from their hands, they were expected to wash their hands.

In an observation on 09/15/2023 at 12:01 PM, the soap dispenser on the North side of the memory care unit across from the washer and dryer was replaced with a new soap dispenser with soap. The door to the north side kitchenette had a sign that showed "kitchen is out of Service Do not use" with no food cart inside the kitchenette area.

In an interview on 09/15/2023 at 12:03 PM, Staff K, Medication Aide, stated when they wash the resident's laundry in the memory care unit, they use gloves. Once they were done, they would remove their gloves and wash their hands at the sink across from the washer and dryer on both North and South side of the memory care unit's washer and dryers.

In an interview on 09/15/2023 at 12:16 PM, Staff F stated the door handles to the kitchenettes were considered dirty. Staff F stated multiple people touch the door handles. Staff F staff were required to wash their hands before they served any plates or dishes of food.

This is an uncorrected deficiency previously cited on 07/12/2023 and 03/30/2023, and a recurring deficiency previously cited on 01/12/2023, 07/28/2022, 06/17/2022, 01/13/2022, and 01/27/2021.

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) 11/16/2023

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

Administrator (or Representative) — Date: 10/13/23

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

Statement of Deficiencies	License #: 2036	Compliance Determination #26546
Plan of Correction	Bonaventure of Lacey	Completion Date
Page 1 of 6	Licensee: Bonaventure of Lacey LLC	07/12/2023

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 follow-up on 07/12/2023 and 07/12/2023 of:
Bonaventure of Lacey
4528 Intelco Loop SE
Lacey, WA 98503

This document references the following SOD dated: 07/12/2023

The following sample was selected for review during the unannounced on-site visit: 0 of 64 current residents and 0 former residents.

The department staff that inspected 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 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.

Cory Cisneros
Residential Care Services

07/25/2023
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.

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 07/12/2023 and 07/12/2023 of:

Bonaventure of Lacey
4528 Intelco Loop SE
Lacey, WA 98503

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Residential Care Services

Date

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

Administrator (or Representative) — Date: 8/7/23

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

(d) Provide all resident care and services according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to maintain a respiratory protection program to ensure all staff were fit tested for an N95 respirator for 5 of 6 staff (Staff D, Staff E, Staff F, Staff G, Staff H) and failed to provide necessary handwashing supplies in 1 of 1 memory care units. These failures placed all 64 of 64 residents, staff, and visitors at risk for spread of infectious disease.

Findings included...

FIT-TESTING & DOCUMENTATION:

Record review of the document titled, "L&I (Labor and Industries) and Department of Health (DOH) Respirator and Person Protection Equipment (PPE) guidance for Long Term Care: Employer responsibilities for respiratory protection program and provision of PPE", dated 03/30/2021, showed, "The Long-term care facilities (LTCF) are required to provide initial fit tests for each Health Care Worker (HCW) with the same model, style, and size respirator (N-95) that the HCW will be required to wear for protection against the COVID-19 [Corona Virus Disease 2019-a respiratory illness] and other airborne hazards. COVID-19 is an infectious disease caused by a virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, sore throat, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death. A "Fit test" is a procedure that tests the seal between the respirator's face piece and the HCW's face. It includes a medical evaluation and is completed by someone who is trained to fit test which takes a minimum of 15-20 minutes." The "fit test" is to be completed every 12 months."

Record review of the Department of Health document titled, "Respiratory Protection Program for Long-Term Care Facilities", undated, showed "providing your workforce with respiratory protection against respiratory hazards, such as the virus that causes COVID-19, is a safety standard regulated and enforced by the Washington Department of Labor and

Administrator (or Representative) Date

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Record review of the Department of Health document titled, “Respiratory Protection Program for Long-Term Care Facilities”, undated, showed “providing your workforce with respiratory protection against respiratory hazards, such as the virus that causes COVID-19, is a safety standard regulated and enforced by the Washington Department of Labor and

Industries (L&I). Employers have an obligation to protect their employees from hazards in the workplace (General Duty WAC 296-126-094). In healthcare facilities, the tight-fitting disposable 'N95' respirator is a commonly used for respiratory protection. Respirator fit testing ensures that tight-fitting respirators seal properly and helps protect employees from exposure to airborne particles such as viruses and bacteria. Keep your employees safe and working by getting them fit tested and ready to properly use a respirator."

WAC 296-842-12010 Keep respirator program records. "(1) A written copy of the current respirator program must be kept by the employer. (2) Keep each employee's current fit test record, if fit testing is conducted, until the next fit test is administered. Fit test records must include: (a) Employee name; (b) Test date; (c) Type of fit test performed; (d) Description (type, manufacturer, model, style, and size) of the respirator tested; (e) Results of fit tests, for example, for quantitative fit tests include the overall fit factor AND a printout, or other recording of the test."

Record review of the Dear Provider Letter (DPL) ALF# 2021-024, titled, "Employer Responsibilities for Respiratory Protection Program and Provision of Personal Protective Equipment (PPE)", dated 04/30/2021, directed LTCF's under WAC 296-842-12005 to develop and maintain a respirator program which included initial fit testing and providing staff with their fit tested respirator.

Review of the facility policy, titled, "COVID-19 Infection Control Response-WA", last updated on 11/07/2022, stated, "ALL STAFF IN ALL DEPARTMENTS will be required to wear masks and eye protection (aka goggles or face shields) as source control for the duration of each shift until the outbreak is resolved. Masks are to be NIOSH approved particulate respirators with N95 filters or higher (aka NOT surgical masks). When the use of N95 masks are directed for COVID positive presumptive or outbreak status) staff will wear the mask at all times for the duration of their shift and discard upon conclusion of their assigned shift…The community will coordinate the completion of medical evaluations, education and fit testing for employees in preparation for when N95 mask utilization is required/recommended. Completion of medical evaluation results and fit testing will be routinely audited to assure ongoing compliance."

Review of a facility staff list from 07/12/2023 showed that the facility had 68 current employees.

Review of the facility's Respiratory Program binder on 07/12/2023, showed five employees (Staff D, Staff E, Staff F, Staff G, and Staff H) fit-testing records were incomplete and were missing information such as the type of fit test performed, description/type of mask, including the model, and size of mask. Review of staff records fit testing records showed:

•Staff D, a Caregiver: Review of the staff list from 07/12/2023 showed that Staff D was hired on 06/25/2023 and had worked 81 hours since date of hire. Review of Staff D's fit testing records showed a completed Medical Clearance for Fit Testing, and an unsigned/incomplete staff training record. Review of Staff D's Filtering Facepiece Respirator Fit Test Record showed the record was blank.

•Staff E, a Caregiver: Review of the staff list from 07/12/2023 showed that Staff E was hired on 06/25/2023 and had worked 54 hours since date of hire. Review of Staff E's facility Respiratory Protection binder showed no documentation for the Staff E.

•Staff F, a Caregiver: Review of the staff list from 07/12/2023 showed that Staff F was hired on 06/24/2023 and had worked 70.25 hours since date of hire. Review of Staff F's fit testing records showed a completed Medical Clearance for Fit Testing, and an unsigned/incomplete staff training record. Review of Staff F's Filtering Facepiece Respirator Fit Test Record showed the record was blank.

•Staff G, a Medication Aide: Review of the staff list from 07/12/2023 showed that Staff G was hired on 06/26/2023 and had worked 61.25 hours since date of hire. Review of Staff G's fit testing records showed a completed Medical Clearance for Fit Testing, and an unsigned/incomplete staff training record. Review of Staff G's Filtering Facepiece Respirator Fit Test Record showed the record was blank.

•Staff H, a Receptionist: Review of the staff list from 07/12/2023 showed that Staff H was hired on 06/20/2023 and had worked 115 hours since date of hire. Review of Staff H's fit testing records showed a completed Medical Clearance for Fit Testing, and an unsigned/incomplete staff training record. Review of Staff H's Filtering Facepiece Respirator Fit Test Record showed employee name, date, type of mask fitted for, and solution used. However, there was no indication of a pass, or fail designated on the record.

During an interview with Staff A, Executive Director, on 07/12/2023 at 2:07PM, when asked the expectation of fit testing, and when it should be completed, Staff A stated, "It should be done at orientation." Staff A stated that the expectation was that fit testing was completed before the staff "hit the floor." Staff A was asked why records for Staff E were not in the Respiratory Protection binder. Staff A stated that it was possible that this staff member had not yet worked. Information regarding Staff E's fit testing was requested to be sent to the Department by 07/13/2023 at 12:00PM, to which Staff A agreed.

As of 07/13/2023 at 1:10PM, no additional documentation or information was provided or received.

HANDWASHING:

Review of the Center of Disease Control and Prevention (CDC) Hand Hygiene Guidance In Health Care Settings, dated 01/30/2020, showed, "Healthcare facilities should: Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations, ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled, and ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered."

Review of the CDC Hand Hygiene in Healthcare settings for Healthcare Providers, last

reviewed on 01/08/2021, under “Techniques for Washing Hands with Soap and Water”, showed, “When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet.”

Review of the facility policy, titled, “COVID Policies and Procedures,” last reviewed on 11/07/2022, under section D showed, “Gloves & Handwashing... Gloves are to be worn during all ADL (Activities of Daily Living) care where a person can anticipate encountering body fluids. Gloves are to be removed immediately if soiled, have come into contact with blood/bodily fluids and/or after care is given and thrown in trash prior to leaving the resident’s suite. Wash hands immediately with soap and water. Wash hands for a min.[minimum] of 20 seconds. Dry with a paper towel. Use paper towel to turn water off and open the door.”

In observations made on 07/12/2023 at 9:10AM, of hand hygiene products in Memory Care resident’s rooms, showed:
•Room 108: In this shared, double occupancy resident room, there was no soap, gloves, or paper towels present on either resident sink, and in the shared resident bathroom.
•Room 125: In this single resident room, no soap, gloves, and paper towels were observed.
•Room 123: In this single resident room, no soap, gloves, and paper towels were observed.

Observation of the South Side handwashing station on 07/12/2023 at 9:12AM, across from the laundry closet, showed there was soap in the wall mounted soap dispenser, paper towels, but no garbage can. Observation of a second hand-washing station on the South Side, next to the janitor closet showed there was soap in the wall mounted soap dispenser, paper towels, but no garbage can. Observation of the Men’s public restroom across from the Independent Dining Area showed no soap in the soap dispenser, only hand Sanitizer was available.

During an interview with Staff B, a Medication Technician, on 07/12/2023, at 12:25PM, when asked how staff wash their hands after providing care to residents, Staff B stated that soap, and paper towels were in a locked cabinet in resident rooms. Staff B stated that prior to care, they would take out the supplies needed from the locked cabinet so they would be available for use after care. Staff B was asked to open the locked cabinet. A blue basket was removed from the cabinet which was observed to be containing a pump soap container, and loose paper towels and gloves.

During an observation of care on 07/12/2023 at 9:27AM, Staff C, a caregiver, was seen entering resident room 123 with clean gloves, and an empty garbage bag in their hands. Staff C provided a brief change to an incontinent resident and got them up out of bed and into their wheelchair for the day. Upon entering the resident room, a garbage bag was observed sitting on the floor next to the bed with a soiled brief inside. Staff C was observed to still be wearing the same gloves used during the resident’s brief change. There was no blue basket of hand hygiene products observed anywhere available in the resident room. Staff C continued touching doors, resident clothing, and light switches. Staff C was

then observed to remove their gloves and place them in the garbage bag. Without washing their hands, Staff C began brushing the resident's hair. After the brushing was completed, Staff C tied off the garbage bag, and hung it on the back of the resident's wheelchair. Staff C then opened the door and pushed the resident towards one of the South Side Handwashing Stations. Staff C then washed their hands with soap and water, and after completion used a paper towel to turn off the faucet. Staff C noticed there was no garbage can at this handwashing station, and carried the used paper towels in their hand, and continued to push the resident in their wheelchair, towards the North Side Handwashing Station where they threw away their used paper towels. Staff C was then observed to reach into their pocket for keys, and opened a closet to throw away the garbage bag with the soiled brief and gloves that was hanging on the back of the resident's wheelchair.

During an interview with Staff A on 07/12/2023 at 2:07PM, when asked the rationale behind unavailability of soap in resident rooms in the Memory Care Unit, Staff A stated "The last that I understand is that it is because of a risk of residents drinking the soap, and that we have a strict rule. But I also feel that handwashing needs to be accessible to everybody, to not only staff, but residents and their families." Staff A was informed of observations of caregivers, and multiple breaks in infection control practices while touching residents, and other objects with soiled hands (ie: staff contaminating uniform, keys, door handles, light switches, and any touching of other objects/residents on the way to the handwashing station). Staff A also notified of lack of garbage cans at handwashing stations. Staff A acknowledged and expressed understanding.

This is an uncorrected deficiency previously cited on 03/30/2023, and a recurring deficiency previously cited on 01/12/2023, 07/28/2022, 06/17/2022, 01/13/2022, and 01/27/2021.

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) ~~9/8/2023~~ 8/26/2023.

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

Meghan Harris — Administrator (or Representative)

8/8/2023 ~~8/7/23~~ — Date

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During an interview with Staff A on 07/12/2023 at 2:07PM, when asked the rationale behind unavailability of soap in resident rooms in the Memory Care Unit, Staff A stated "The last that I understand is that it is because of a risk of residents drinking the soap, and that we have a strict rule. But I also feel that handwashing needs to be accessible to everybody, to not only staff, but residents and their families." Staff A was informed of observations of caregivers, and multiple breaks in infection control practices while touching residents, and other objects with soiled hands (ie: staff contaminating uniform, keys, door handles, light switches, and any touching of other objects/residents on the way to the handwashing station). Staff A also notified of lack of garbage cans at handwashing stations. Staff A acknowledged and expressed understanding.

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

_____ _____

Administrator (or Representative) Date

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

Statement of Deficiencies	License #: 2036	Compliance Determination # 21030
Plan of Correction	Bonaventure of Lacey	Completion Date
Page 1 of 6	Licensee: Bonaventure of Lacey LLC	03/13/2023

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 follow-up on 03/09/2023 and 03/13/2023 of:
Bonaventure of Lacey
4528 Intelco Loop SE
Lacey, WA 98503

This document references the following SOD dated: 03/13/2023

The following sample was selected for review during the unannounced on-site visit: 3 of 51 current residents and 0 former residents.

The department staff that inspected 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

03/21/2023
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.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

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Residential Care Services

Date

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

Administrator (or Representative) 3/26/23 Date

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

(d) Provide all resident care and services according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on observation, record review and interview, the facility failed to provide necessary handwashing supplies in 1 of 1 memory care units reviewed. Additionally, the Facility failed to follow infection control measures by failing to document and maintain employee N95 respirator fit testing records for 12 of 18 employees (Staff C, Staff D, Staff E, Staff F, Staff G, Staff H, Staff I, Staff J, Staff K, Staff L, Staff M, Staff N). These failure placed all 51 of 51 residents, staff, and visitors at risk for spread of infectious disease.

Findings included...

HANDWASHING:
Review of the Center of Disease Control and Prevention (CDC) Hand Hygiene Guidance In Health Care Settings, dated 01/30/2020, showed, "Healthcare facilities should: Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations, ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled, and ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered."

Review of the CDC Hand Hygiene in Healthcare settings for Healthcare Providers, last reviewed on 01/08/2021, under "Techniques for Washing Hands with Soap and Water", showed, "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet."

On 03/09/2023 at 1:10PM, when asked for the facility hand-washing policy, the facility

Administrator (or Representative) Date

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On 03/09/2023 at 1:10PM, when asked for the facility hand-washing policy, the facility

provided a policy titled, “COVID Policies and Procedures.” Review of the facility policy titled, “COVID Policies and Procedures,” last reviewed on 11/07/2022, under section D showed, “Gloves & Handwashing... Gloves are to be worn during all ADL (Activities of Daily Living) care where a person can anticipate encountering body fluids. Gloves are to be removed immediately if soiled, have come into contact with blood/bodily fluids and/or after care is given and thrown in trash prior to leaving the resident’s suite. Wash hands immediately with soap and water. Wash hands for a min. of 20 seconds. Dry with a paper towel. Use paper towel to turn water off and open the door.”

On 03/09/2023 at 2:37PM, an observation of resident room 103, a single resident room, showed there was no soap, paper towels, or gloves. Upon observation of resident room 104, a shared/double room, showed that there were no gloves in the room. There were also no soap/soap dispensers or paper towels at each of the individual residents sinks. In the shared/conjoined bathroom, a soap dispenser was visualized which was filled with soap, but there were no paper towels or gloves present. Observation of resident room 109, showed no gloves, soap/soap dispensers, or paper towels available in the room.

Observation of the North Side handwashing station on 03/09/2023 at 2:26PM showed that there was no soap in the soap dispenser. There were paper towels and a garbage can present. Observation of another handwashing station on the North Side showed soap in the soap dispenser, paper towels, but no garbage can.

During an interview with Staff U, the current Memory Care Director, on 03/09/2023 at 1:40PM, was asked how staff wash their hands after providing care to a resident when there was no soap in the rooms. Staff U responded that staff were supposed to carry hand sanitizer in their pockets, and that they would use it before exiting the room. At that point they will go to a hand washing station on the unit to perform handwashing with soap.

During an interview with Staff L, Caregiver, on 03/09/2023 at 2:17PM, when asked where they would wash their hands after providing care to a resident, they stated, “If there is soap in the room, we will do it in the room. If there is no soap in the room, we would sanitize with hand sanitizer and then go and wash at a handwashing station.” When asked what they would do if they were in a situation where hand sanitizer would no longer be sufficient, such as their hand becoming soiled with feces during a brief change, they stated, “I would rinse it off, and then I would go to a hand washing station.”

During an interview with Staff A, the Executive Director, on 03/09/2023 at 4:03PM, when asked what their expectations were for staff regarding hand hygiene, they stated that staff were expected to wash their hands before the shift begins. Staff A stated that before and after each care task that was performed, staff should use at least hand sanitizer, and wash their hands with soap and water when visibly soiled. Staff A was notified of the observations of no soap, gloves and paper towels in resident rooms. When asked how staff wash their hands after providing resident care if they became visibly soiled, given there was no soap and paper towels in the resident rooms, Staff A stated that staff would rinse their hands with water, and then exit the resident room and wash their hands at the nearest hand washing station. Staff A stated that staff could opt to get their keys from their pocket and unlock the soap from the locked cabinets in the resident room and wash their

hands. Staff A was informed that staff exiting the room with soiled hands, (ie: touching the doorknob with soiled hands) reaching into their pockets with soiled hands, (ie: contaminating uniform, and keys) and touching of any other objects on the way to the handwashing station would cause a break in infection control practices. Staff A acknowledged and expressed understanding.

FIT-TESTING & DOCUMENTATION:
Review of a "Declaration Letter" sent to the facility, dated 12/26/2022, from the Local Health Jurisdiction stated, "On 26 December 2022, the [Local Health Jurisdiction] was notified of 11 case(s) of COVID-19 [Corona Virus Disease 2019- a respiratory illness] in 7 residents and 4 staff members. A single facility-acquired case in a resident within a facility designates an outbreak." It continued, "Staff should wear a fit tested N95 mask and eye protection, at all times, while on the unit. When staff are providing care, they should be wearing full PPE (N95's, eye protection, gown, and gloves) for all resident encounters."

Review of the DOH document titled, "Interim Recommendation for SARS-CoV-2 Infection Prevention and Control in Healthcare Settings,", last reviewed 10/31/2022, had an infographic table titled, "PPE Patients, HCPs and Visitors Should Wear in Healthcare Settings." This infographic explained that Health Care Providers (HCP's) providing "close contact with patients presumed or confirmed COVID+, or in observation/quarantine" were to wear a "fit tested N95."

Review of the facility policy, titled, "COVID-19 Infection Control Response-WA", last updated on 11/07/2022, stated, "ALL STAFF IN ALL DEPARTMENTS will be required to wear masks and eye protection (aka goggles or face shields) as source control for the duration of each shift until the outbreak is resolved. Masks are to be NIOSH approved particulate respirators with N95 filters or higher (aka NOT surgical masks). When the use of N95 masks are directed for COVID positive presumptive or outbreak status) staff will wear the mask at all times for the duration of their shift and discard upon conclusion of their assigned shift…The community will coordinate the completion of medical evaluations, education and fit testing for employees in preparation for when N95 mask utilization is required/recommended. Completion of medical evaluation results and fit testing will be routinely audited to assure ongoing compliance."

Review of the CDC website titled, "Healthcare Respiratory Protection Resources: Fit Testing," last reviewed on 02/04/2021, had an infographic titled, "Summary of Respiration Fit Test Requirements." This infographic explained that "all employees required to wear tight-fitting respirators, including N95 filtering facepiece respirators" were required to be fit tested before a respirator can be worn. A fit test ensured a proper seal between the respirator facepiece and the wearer's face. A proper fit decreased the risk of the wearer contracting the disease. Fit tests must be done "yearly, and after any physical changes that may affect the fit (weight gain/loss, dental work, etc." The infographic also stated that fit testing records must be kept on file until the next annual test is performed.

Review of WAC 296-842-12010, "Keep respirator program records," showed that "A written copy of the current respirator program must be kept by the employer." Part of the respirator program was to "keep each employee's current fit test record, if fit-testing is conducted, until the next fit test is administered. Fit test records must include the

employee's name, test date, type of fit-test performed, description (type, manufacturer, model, style, and size) of the respirator tested, results of fit tests."

Review of the facility's respiratory program binder on 01/24/2023 showed that the employee respirator fit-tests were conducted by Staff B, the former Memory Care Director.

During an interview with Staff A, the Executive Director, on 02/16/2023 at 10:26AM, they stated Staff B was no longer working with the facility. When asked what type of training Staff B received regarding employee fit-testing, Staff A stated that Staff B went through a training that the Department [DSHS] offered. "They came out to the facility to work with [Staff B]. They came on the 9th of January." When asked how many types of N95's were available to the employees for use, Staff A stated, "Only one." On 02/24/2023 at 2:25PM, the Department sent an e-mail to Staff A, asking if they could explain the reasoning behind only 16 of their staff being listed in the fit-testing log. The Department never received a response.

During an interview with Staff C, and Staff D, Medication Technicians, on 01/24/2023 at 10:01AM and 10:37AM respectively, both stated that they had been fit-tested at the facility for an N95.

Review of a facility staff list showed that the facility had 67 employees on staff.

Review of the facility's respiratory program binder on 01/24/2023 showed that a total of 16 employees records that were included. Of the employees that were included in the binder, 10 employees were fit-tested. These 10-employee fit-testing records were incomplete and were missing information such as the type of fit test performed, description/type of mask, including the model, and size of mask. Review of staff records fit testing records showed:

• Staff E, a Medication Technician (Med Tech): Review of Staff E's Filtering Facepiece Respirator Fit Test Record showed their name, the date of testing, a result of a pass. Review of the record did not show the type of fit-test performed, and description of the respirator tested.
• Staff F, in maintenance: Review of Staff F's Filtering Facepiece Respirator Fit Test Record showed their name, the date of testing, a result of a pass. Review of the record did not show the type of fit-test performed, and description of the respirator tested.
• Staff G, the Assistant Executive Director: Review of Staff G's Filtering Facepiece Respirator Fit Test Record showed their name, the date of testing, a result of a pass. Review of the record did not show the type of fit-test performed, and description of the respirator tested.
• Staff H, a receptionist: Review of Staff H's Filtering Facepiece Respirator Fit Test Record showed their name, the date of testing, a result of a pass. Review of the record did not show the type of fit-test performed, and description of the respirator tested.
• Staff I, a Server: Review of Staff I's Filtering Facepiece Respirator Fit Test Record showed their name, the date of testing, a result of a pass. Review of the record did not show the type of fit-test performed and showed only a partial description of the respirator tested.
• Staff J, a Caregiver: Review of Staff J's Filtering Facepiece Respirator Fit Test Record showed their name, and the date of testing. A result of fail or pass is not designated. Review of the record did not show the type of fit-test performed, and description of the

respirator tested.
• Staff K, a Server: Review of Staff K's Filtering Facepiece Respirator Fit Test Record showed their name, the date of testing, a result of a pass. Review of the record did not show the type of fit-test performed and showed only a partial description of the respirator tested.
• Staff L, a Caregiver: Review of Staff L's Filtering Facepiece Respirator Fit Test Record showed their name, the date of testing, a result of a pass. Review of the record did not show the type of fit-test performed, and description of the respirator tested.
• Staff M, a Med Tech: Review of Staff M's Filtering Facepiece Respirator Fit Test Record showed their name, the date of testing, a result of a pass. Review of the record did not show the type of fit-test performed and showed only a partial description of the respirator tested.
• Staff N, in maintenance: Review of Staff E's Filtering Facepiece Respirator Fit Test Record showed their name, the date of testing, and the type of fit-test performed. A result of fail or pass is not designated. Review of the record showed only a partial description of the respirator tested.
• Review of the other 6 included employees, Staff O in housekeeping, Staff P a caregiver, Staff Q a caregiver, Staff R a caregiver, Staff S a Med Tech, and Staff T a server, showed that they were not medically cleared to be fit-tested. During the review of the respiratory program binder, noted that Staff C, and Staff D did not have any records in the binder. Due to this, the Department was unable to verify that Staff C and D were fit-tested for an N95 mask.

This is an uncorrected deficiency previously cited on 01/12/2023 and a recurring deficiency previously cited on 07/28/2022, 06/17/2022, 01/13/2022, and 01/27/2021.

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) 4-15-2023.

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

[signature] 3/26/23

Administrator (or Representative) Date

respirator tested.
• Staff K, a Server: Review of Staff K's Filtering Facepiece Respirator Fit Test Record showed their name, the date of testing, a result of a pass. Review of the record did not show the type of fit-test performed and showed only a partial description of the respirator tested.
• Staff L, a Caregiver: Review of Staff L's Filtering Facepiece Respirator Fit Test Record showed their name, the date of testing, a result of a pass. Review of the record did not show the type of fit-test performed, and description of the respirator tested.
• Staff M, a Med Tech: Review of Staff M's Filtering Facepiece Respirator Fit Test Record showed their name, the date of testing, a result of a pass. Review of the record did not show the type of fit-test performed and showed only a partial description of the respirator tested.
• Staff N, in maintenance: Review of Staff E's Filtering Facepiece Respirator Fit Test Record showed their name, the date of testing, and the type of fit-test performed. A result of fail or pass is not designated. Review of the record showed only a partial description of the respirator tested.
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_____ _____
Administrator (or Representative) Date

Residential Care Services
Investigation Summary Report

Provider/Facility: Bonaventure of Lacey
Provider Type: Assisted Living Facility
License/Cert.#: 2036
Compliance Determination #: 17133
Intake ID: 60454
Investigator: Paul Aube
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 12/08/2022 through 01/12/2023
Complainant Contact Date(s):

Allegation(s):

1. Neglect: Public complaint of facility failing to provide care per the resident's Negotiated Service Agreement.
2. Quality of Care/Treatment: Public complaint of facility failing to provide care per the resident's Negotiated Service Agreement.

Investigation Methods:

Sample:
Total residents: 71
Resident sample size: 3
Closed records sample size: 1

Observations:
Residents
Dining
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Identified resident
Nursing staff
Residents
Family members
Management
Maintenance staff

Record Reviews:
Medical records
Facility policies
Disclosure of Services
Resident Negotiated Service Agreements
Staff Schedules
Employee Personnel Files
Progress Notes

Investigation Summary:

1. Neglect: Facility failed to provide documentation of care/showers for a resident after allegations that care/showers was made. This caused psychosocial harm to that resident. Facility withheld documentation requested by the department which is needed to ensure resident health and safety. Facility also failed to follow CDC

recommended guidance for hand hygiene. Facility failed to provide soap in resident rooms, and often did not have gloves available to care staff. Failed practice identified.
2. Quality of Care/Treatment: Facility failed to provide documentation of care/showers for a resident after allegations that care/showers was made. This caused psychosocial harm to that resident. Facility withheld documentation requested by the department which is needed to ensure resident health and safety. Facility also failed to follow CDC recommended guidance for hand hygiene. Facility failed to provide soap in resident rooms, and often did not have gloves available to care staff. Failed practice identified.

Conclusion / Action:

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

Statement of Deficiencies	License #: 2036	Compliance Determination # 17133
Plan of Correction	Bonaventure of Lacey	Completion Date
Page 1 of 8	Licensee: Bonaventure of Lacey LLC	01/12/2023

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 12/08/2022 and 12/29/2022 of:

Bonaventure of Lacey
4528 Intelco Loop SE
Lacey, WA 98503

This document references the following complaint number(s): 57266, 57851, 60454

The following sample was selected for review during the unannounced on-site visit: 3 of 71 current residents and 1 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

01/18/2023 — 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.

Administrator (or Representative) 2/3/23 Date

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

(d) Provide all resident care and services according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to provide necessary supplies for employees to prevent and limit the spread of infection and perform handwashing after providing resident care for 3 of 3 resident rooms, and 2 of 3 staff reviewed. This failure placed all residents at risk for spread and infection of an communicable disease.

Findings included...

Review of the Center of Disease Control and Prevention (CDC) Hand Hygiene Guidance In Health Care Settings, dated 01/30/2020, stated, "Healthcare facilities should: Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations, ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled, and ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered."

During an interview with Anonymous Collateral Contact 1 (CC1) on 12/08/2022 at 7:04pm, CC1 stated "We asked if they had gloves or paper towels [in Resident 1's (R1)], and the caregiver stated that they did not have gloves in the facility because they spent so much money that their manager did not buy any more. It's incredible." CC1 stated that while visiting Resident 2 (R2), "There were no gloves or paper towels in that room either. [R2's] [family] says that usually the soap is missing, even after they personally bring some into the room to use."

An observation of R2's room on 12/09/2022 at 7:50am, showed there were paper towels in the room, but there were no soap/soap dispensers, or gloves available in the room. The room to the left and right of R1's room both had no soap/soap dispensers, or gloves available in the rooms.

During an interview with Staff D, Caregiver, on 12/09/2022 at 9:41am, when asked where they do their handwashing Staff D responded, "We wash our hands at a hand washing station, there is one in the dining room, and another over there [pointed in the direction of

the other sink]." When asked if they ever wash their hands in the resident rooms after care, they stated, "Sometimes we do, and sometimes we don't." Staff D stated that sometimes there was no soap available in the resident rooms. "We come out and wash our hands out in the stations." When asked if gloves were kept in resident rooms they stated, "No gloves are kept inside resident rooms. I carry my gloves in my pocket." When asked about the availability of supplies, Staff D stated, "We run out of gloves, paper towels and soap, yes." When asked how often this happened, they stated, "Not frequently, but it does sometimes happen. We just try to do the best we can when that happens."

During an interview with Staff C, Medication Technician, on 12/09/2022 at 9:51am, when asked where they do their hand hygiene, Staff C stated, "We do our hand hygiene at the hand washing stations. We also have to wash our hands in the resident room after care, before leaving the room." When asked about there being no gloves and no soap in the resident rooms Staff C stated, "We cannot leave personnel hygiene items out because they [residents] can ingest them. We keep hand sanitizer on us, in our pocket. Mine is on the cart actually right now. We use hand sanitizer before leaving the room, and we come out of the room and do washing at the hand washing stations." When asked about the availability of supplies, Staff C stated, "Yes we do run out of things like soap and gloves." When asked how often this happened, Staff C took a long pause and then replied, "This happens often."

During an interview with Collateral Contact 2 (CC2), R2's representative, on 12/09/2022 at 12:04pm, while visiting R2, CC2 stated, "I would take soap over there but when I would go to use the soap, I couldn't find them anymore. I couldn't wash my hands."

This is a recurring deficiency previously cited on 07/28/2022, 06/17/2022, 01/13/2022, and 03/15/2021, 01/27/2021.

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) 3/1/23.

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

Administrator (or Representative) 2/3/23 Date

WAC 388-78A-3140 Responsibilities during inspections. The assisted living facility must:

(1) Cooperate with the department during any on-site inspection or complaint investigation;

(2) Provide requested records to the representatives of the department; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide the department requested documents during a complaint investigation. This failure prevented the Department from collecting necessary information while conducting investigations to ensure residents' health and safety for one of one complaint investigation.

Findings included…

During an interview with Anonymous Collateral Contact 1, (CC1) on 12/08/2022 at 7:04pm they stated, that Resident 1 (R1) discharged from the Assisted Living Facility and was admitted to another facility on [redacted]/2022.

On 12/09/2022 at 9:15am, the Department asked Staff A, the Assisted Living Director, while onsite at the facility to provide R1's face sheet, and Negotiated Service Agreement to the department for review. At 12:45pm, the requested documents were still not provided, and were requested again from Staff A while onsite at the facility. On 12/09/2022 at 2:36pm, the Department called the facility for a third request for R1's records. At this time, the Department notified Staff A that these documents could be emailed to the department by end of the business day on Monday, 12/12/2022.

On 12/13/2022 at 8:15am, the Department received no emails from the facility for the requested documentation for R1.

During an interview with Staff C, a Medication Technician, on 12/09/2022 at 12:07pm, when asked if shower refusals were documented in the Communication Log, Staff C confirmed, "Yes they are." The Department asked Staff C to provide the Communication Log, and Staff C stated that they gave the log to Staff A. When asked if the Communication Log was electronic, or a physical binder, Staff C confirmed that it was a physical binder. "It is our shift communication log; we write in there if they refuse so then the next shift can try working on showers that were missed." When asked how far back the log goes, Staff C stated, "They only keep a months' worth of information in there." At that time Staff C stated that she was instructed that day by Staff A that they need to start documenting resident shower refusals electronically. When asked if staff documented that residents were getting showers, Staff C stated, "No." When asked how the staff knew if residents were actually getting showered, Staff C stated, "If there are no refusals listed in the communication binder then it is assumed that the resident is getting their showers."

On 12/09/2022 at 12:45pm, the Department requested the Shower/Communication Binder from Staff A, the Assisted Living Director, for review. Staff A stated that they were instructed that they do not have to provide the logbook since it was an internal document. Staff A stated that it only held information on the last 72 hours' worth of communication for residents. At that time a purple binder was observed, titled, "SCU Communication Log," which was approximately 4 to 5 inches thick full of documents, and was sitting on Staff A's desk. Staff A was asked if that was the communication log and Staff A confirmed that it was. Staff A stated that they were told by their superiors to not provide it to the Department staff.

The is a recurring deficiency previously cited on 06/17/2022.

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) 3/1/23.

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

Administrator (or Representative) — Date: 2/3/23

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.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide care and services to ensure residents maintained their dignity and hygiene for 1 of 3 residents (Resident 1 (R1)) reviewed. This placed R1 and residents with similar health problems at risk for skin breakdown, risk of infection, and risk for decreased quality of life. This failure resulted in R1 feeling depressed and experiencing a decreased quality of life.

Findings included...

On 12/09/2022 at 09:15am, the Department requested Staff A, the Assisted Living Director, to provide R1's face sheet, and Negotiated Service Agreement for review. At 12:45pm, the requested documents were still not provided, and were requested again from Staff A. At 2:36pm, the Department called the facility for a third request for R1's records. At that time, Staff A was notified that the documents could be emailed to the Department by end of the business day on Monday, 12/12/2022. On 12/13/2022 at 8:15am, the Department had not received the requested documentation.

Review of the facility's Disclosure of Services, revised March 2017, showed under the "Toileting" category, "The facility will provide the following optional services: Provide care for bladder incontinence, including routinely cleaning you as necessary, and provide care for bowel incontinence, including routinely cleaning you as necessary." Under the "Bathing" category it stated, "The facility will provide the following optional services: Physical assistance getting into/out of the bathtub or shower, help washing areas that may be hard for you to reach, such as your back or feet, total bathing assistance if you cannot bathe yourself, and bed baths."

During an interview with Staff D, Caregiver, on 12/09/2022 at 9:41am, when asked about care for incontinent residents, and how often they were taken to the bathroom or had their brief checked, Staff D stated, “During report the previous care aide will let me know when they were last changed. I would check them every 2 hours. But if they pee more [often], then I would take them [to the bathroom] more. Or if a resident asks, I will take them to the bathroom.” When asked if they found a resident to be soiled or smelled of urine/stool what they would do, Staff D stated, “I would change them.” When asked what they would do if the resident refused care, they stated, “If the resident refused, I would notify the med tech, and they would come back into the room and try as well. We would keep trying to change the resident and convince them.”

During an interview with Staff C, a Medication Technician, on 12/09/2022 at 9:51am, when asked how often an incontinent resident was checked/changed and taken to the bathroom they stated, “They are toileted 3 times a shift.” When asked what they would do if they found a resident to be smelling of urine, or stool they stated, “I would change them. Change their bedding, change their clothes, shower them, whatever they need to get them clean.” When asked what they would do if the resident refused, they stated, “If they refused, I wouldn’t leave them, but I would try to convince them to get cleaned up.”

During an interview with Staff E, a Medication Technician, on 12/09/2022 at 9:57am, when asked how often an incontinent resident was checked/changed and taken to the bathroom they stated, “Every 2 hours.” When asked what they would do if they found a resident to be soiled or urine or stool, they stated, “Change them right away.” When asked what they would do if the resident refused, they stated, “If refused we try to redirect and get them to allow us to change them. We call other staff to attempt as well.”

During an interview with the Collateral Contact 1 (CC1), a long-term care provider, on 12/08/2022 at 7:04pm they stated, “While doing [R1’s] assessment before [R1] got here, I was told by staff that [R1] likes to refuse care often. While entering [R1’s] room, it is painfully strong, the urine smell I mean. It was so bad to where I had to walk out of the room. But I toughed it out because I wanted to evaluate [R1]. [R1] was covered in bowel movement (BM) and pee. The ammonia was so saturated it was bleaching [R1’s] clothes. They were using ripped towels as incontinent pads. There was a wheelchair that [R1] was using that had soiled, dried bowel movement on it. I couldn’t believe it. [R1’s] bed looked like it was wet, [R1’s] hair was disgusting.” CC1 continued, “I went back with a caregiver a different day, and we had to shower [R1]. [R1] had BM all up their back.” R1 eventually discharged to another facility to where CC1 is employed. CC1 stated, “[R1] showers every other day here, and even after the first week [R1’s] hair still smelled like urine.”

During an interview with R1 on 12/08/2022 at 7:20pm, they stated, “They [Facility Staff] didn’t really come to help me get cleaned up. I was supposed to have a shower twice a week, and I didn’t get those. They kept saying they were going to do it, but then they would say, we haven’t got time.” When asked how often this was happening, R1 stated,

"Just about every day." When asked how long he would go without a shower R1 stated, "I went for 3 weeks one time without getting one."

During an observation of resident rooms on 12/09/2022 at 7:50am, the Department observed that R1's room was still vacant after R1's discharge on [redacted]/2022, with their name still on the door. Upon entering the room, the room was empty, and the room had a strong, pungent odor of urine. Two other adjacent resident rooms, including R2's room, was noted to have a strong odor of urine.

At 10:13am on 12/09/2022, Staff A, the Assisted Living Director, stated that there were no shower records for residents.

Review of an undated "Shower Log" document on 12/09/2022 stated, "Showers that are not done needs to be written in the logbook and how many times they were attempted."

During an interview with Staff B, a covering Executive Director from a sister facility, on 12/09/2022 at 10:52am, stated that the facility charted by "exception," and they do a daily internal communication log for residents who refused showers, which was recorded electronically. Staff B stated that the communication log was not kept after the end of the day. When asked to clarify they stated, "They do not keep that log." When asked if a shower refusal was considered an "exception," they stated, "Yes, it is." The Department showed Staff B the facility's "Shower Log," which stated showers not done needed to be documented in a logbook, in addition to the number of attempts from staff. Staff B then stated that it was possible that these things may be documented in the resident progress notes. At that time the Department requested and reviewed progress notes for R1 and R2 with Staff B. The progress notes for R1 and R2 showed no documentation of refused/incomplete showers. Staff B stated, "What was explained to me was that they do not do a progress note when someone refuses a shower. They chart this on the communication log so that the next shift can re-offer. And that log is not kept." Staff B stated, "There is no RCW that states we need to maintain a log of showers." The Department notified Staff B that per facility "Shower Log" document, there should be a logbook. Staff B stated that there is no such logbook.

During an interview with Staff C on 12/09/2022 at 12:07pm when asked if shower refusals were documented in the Communication Log, Staff C confirmed, "Yes they are." The Department asked Staff C to provide the Communication Log, and Staff C stated that they gave the log to Staff A. When asked if the Communication Log was electronic, or a physical binder, Staff C confirmed that it was a physical binder. "It is our shift communication log; we write in there if they refuse so then the next shift can try working on showers that were missed." When asked how far back the log goes, Staff C stated, "They only keep a months' worth of information in there." At that time Staff C stated that she was instructed that day by Staff A that they need to start documenting resident shower refusals electronically.

When asked if staff documented that residents were getting showers, Staff C stated, "No." When asked how the staff knew if residents were actually getting showered, Staff C stated, "If there are no refusals listed in the communication binder then it is assumed that the resident is getting their showers."

On 12/09/2022 at 12:45pm, the Department requested the Shower/Communication Binder from Staff A, the Assisted Living Director, for review. Staff A stated that they were instructed that they do not have to provide the logbook since it was an internal document. Staff A stated that it only held information on the last 72 hours' worth of communication for residents. At that time a purple binder was observed, titled, "SCU Communication Log," which was approximately 4 to 5 inches thick full of documents, and was sitting on Staff A's desk. Staff A was asked if that was the communication log and Staff A confirmed that it was. Staff A stated that they were told by their superiors to not provide it to the Department staff.

During an Interview with R1 on 12/19/2022 at 11:37am, R1 was asked how many showers they remembered they were supposed to receive a week and R1 stated, "I was supposed to be getting 2 showers a week, but I never did. There was one guy, a caregiver, that would give me my showers all the time, but he left because he was so pissed off about how they were treating people there." When asked how it made R1 feel when the facility did not provide incontinence care, and showers as agreed upon R1 stated, "Not really good. I wasn't able to do it myself very well. I don't want to be dirty. It made me feel depressed and disappointed. I didn't get what I was paying for."

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) 3/1/23.

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

Administrator (or Representative) — Date: 2/3/23