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

06/03/2025

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

RE: Bonaventure of Lacey # 2036

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 60510 (Completion Date 06/03/2025) and 54899 (Completion Date 02/27/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/03/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

The Department staff who did the On Site verification:
Anissa Bearden, Licensor
Pamela Horlick, NCI RN Complaint Investigator

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley

Clinton Fridley, Adult Family Home Nurse 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 #: 54899
Intake ID: 163935
Investigator: Pamela Horlick
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 02/18/2025 through 02/27/2025
Complainant Contact Date(s):

Allegation(s):
Quality of Care/Treatment: Facility report of a resident sustaining an injury after falling in the community.

Investigation Methods:

Sample:
Total residents: 67
Resident sample size: 4
Closed records sample size: 0

Observations:
Identified resident
Residents
Activities
Dining
Resident rooms
Staff to resident interactions
Resident to resident interactions
Medication administration

Interviews:
Identified resident
Nursing staff
Residents
Family members

Record Reviews:
State reporting log
Incident investigation
Facility policies
progress notes
TCP
incident report

Investigation Summary:
Facility failed to monitor resident after resident returned to the community after falling and sustaining a hip fracture. 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 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 complaint investigation on 02/18/2025 and 03/04/2025 of:

Bonaventure of Lacey
4528 Intelco Loop SE
Lacey, WA 98503

This document references the following complaint number(s): 163935, 166368, 165875

The following sample was selected for review during the unannounced on-site visit: 4 of 67 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator

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

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Jody Just
Residential Care Services

03/07/2025
Date

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

Megan Harrison
Administrator (or Representative)

3/9/2025
Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement and follow the facility policy and procedure for alert charting for 1 of 3 residents (Resident 1 [R1]). This failure placed R1 at risk for unmet care needs when they experienced a change in condition.

Findings included...

Review of the facility policy, titled, "Health Services", dated 06/01/2023, under the section, "Alert Charting," stated, "The community has established an alert charting system for special attention to, and documentation about, residents who require additional monitoring or intervention. Needs for increased attention could include but are not limited to the following: an occurrence/event, change in condition or medication, new move in, return from a hospital stay/ER visit, resident to resident altercation or other reason that affects a resident." Listed are examples of reasons for alert status and what observations/monitoring would be applicable to address in each note. One example is "Return from hosp/rehab/skilled: Document any changes in care needs, reason resident was sent out, changes/side effects for new or changed medications, acceptance of any increased care services."

Review of R1's face sheet, undated, showed that R1 was admitted to the facility on

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.

Jody Just
Residential Care Services

03/07/2025
Date

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

Administrator (or Representative)

Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement and follow the facility policy and procedure for alert charting for 1 of 3 residents (Resident 1 [R1]). This failure placed R1 at risk for unmet care needs when they experienced a change in condition.

Findings included...

Review of the facility policy, titled, "Health Services", dated 06/01/2023, under the section, "Alert Charting," stated, "The community has established an alert charting system for special attention to, and documentation about, residents who require additional monitoring or intervention. Needs for increased attention could include but are not limited to the following: an occurrence/event, change in condition or medication, new move in, return from a hospital stay/ER visit, resident to resident altercation or other reason that affects a resident." Listed are examples of reasons for alert status and what observations/monitoring would be applicable to address in each note. One example is "Return from hosp/rehab/skilled: Document any changes in care needs, reason resident was sent out, changes/side effects for new or changed medications, acceptance of any increased care services."

Review of R1's face sheet, undated, showed that R1 was admitted to the facility on

[redacted]/2022.

Record review of the last 30 days of progress notes for R1, dated 01/15/2025 through 02/18/2025, showed the following:

-[redacted]/2025- R1 was taken to the hospital after they fell and complained of pain in their right hip.
-01/21/2025- Resident had sustained a right hip fracture that required surgery. R1 would be transferred to a skilled nursing facility following discharge for additional rehab and physical therapy.
-01/22/2025- PCP (Primary Care Provider) faxed back response to being notified of the fall

There were no additional notes for R1 after 01/22/2025.

In an interview and observation on 2/18/2025 at 11:23 AM, R1 stated they wanted to lay down and was observed to be agitated. R1 stated they didn't sleep well. R1 apologized.

In an interview on 02/18/2025 at 10:02 AM, Staff D, Medication Aide/Activities Director, was asked what the process was when a resident had returned to the community after being sent out for a fall, they stated they would be put on alert. While on alert they would obtain vital signs, check for latent injuries and monitor for a change in mentation. Staff D stated they would be put on alert when they came back from the hospital.

In an interview on 02/18/2025 at 10:20 AM, Staff C, Medication Aide, was asked what the process was when a resident had a fall with injury, they stated the medication technician would assess for injuries and call for 911 if needed. Staff C stated when the resident returned to the community they would be put on alert to monitor them and take vitals once a shift for 72 hours. Staff C stated they chart on the residents behaviors and their injuries.

In an interview on 02/18/2025 at 2:21 PM, Staff A, Regional Nurse, was asked what the process was when a resident falls and sustained an injury causing them to be sent out of the facility, they stated, someone would call family and let them know. The nurse was responsible to call and follow up with the hospital if the resident was admitted or not. Staff B stated once the resident returned to the community they were supposed to be on alert charting for 72 hours. Staff B was asked what would the resident be monitored for, they stated they would monitor for signs of infection, monitor for pain. Staff B stated alert charting would be done on every shift and have vital signs taken. Staff B was asked if anyone coming back from the hospital would be on alert, they stated yes. They stated alert charting is done on every shift. Staff B was asked when R1 came back from the hospital, they stated they came back on [redacted]2025. Staff B was asked if there was any alert charting for R1 after they came back from the hospital, they stated there was no alert charting done. Staff B stated R1 was now on alert.

Statement of Deficiencies	License #: 2036	Compliance Determination # 54899
Plan of Correction	Bonaventure of Lacey	Completion Date
Page 4 of 4	Licensee: Bonaventure of Lacey LLC	02/27/2025

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Bonaventure of Lacey is or will be in compliance with this law and / or regulation on (Date) ~~4/2/2025~~ MH 4/13/2025

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

Megan Harrison
Administrator (or Representative)

3/9/2025
Date

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)_____ .

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

_____ _____

Administrator (or Representative) Date