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

06/23/2025

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) 61452 (Completion Date 06/23/2025) and 55879 (Completion Date 03/28/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/23/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2650 Reporting fires and incidents. The assisted living facility must immediately report to the department's aging and disability services administration:

(2) Any unusual incident that required implementation of the assisted living facility's disaster plan, including any evacuation of all or part of the residents to another area of the assisted living facility or to another address; and

(3) Circumstances which threaten the assisted living facility's ability to ensure continuation of services to residents.

The Department staff who did the On Site verification:
Phan Pham, Nurse Surveyor

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 #: 55879
Intake ID: 168828
Investigator: Pamela Horlick
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 03/05/2025 through 03/28/2025
Complainant Contact Date(s):

Allegation(s):
Quality of Care/Treatment: Report of a fall in the community when the power was out.

Investigation Methods:

Sample:
Total residents: 92
Resident sample size: 4
Closed records sample size: 1

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

Interviews:
Identified resident
Nursing staff
Residents
Family members

Record Reviews:
State reporting log
Incident investigation
Facility policies
Progress Notes
Care Plan
Incident log
Incident reports
Temporary care plan
roster

Investigation Summary:
Facility followed policy and procedure when resident had a fall and sustained injury. Notifications were made to the proper parties and resident was on alert to monitor for change in condition. Power outage was not reported to Complaint Resolution Unit. Failed practice identified.

Conclusion / Action:

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

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Statement of Deficiencies	License #: 2036	Compliance Determination # 55879
Plan of Correction	Bonaventure of Lacey	Completion Date
Page 1 of 6	Licensee: Bonaventure of Lacey LLC	03/28/2025

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 03/05/2025 and 04/01/2025 of:

Bonaventure of Lacey
4528 Intelco Loop SE
Lacey, WA 98503

This document references the following complaint number(s): 168828, 167394, 168514, 168959

The following sample was selected for review during the unannounced on-site visit: 4 of 92 current residents and 1 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.

Cory Cisneros
Residential Care Services

04/02/2025
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)

4/2/2025
Date

WAC 388-78A-2650 Reporting fires and incidents. The assisted living facility must immediately report to the department's aging and disability services administration:

(2) Any unusual incident that required implementation of the assisted living facility's disaster plan, including any evacuation of all or part of the residents to another area of the assisted living facility or to another address; and

(3) Circumstances which threaten the assisted living facility's ability to ensure continuation of services to residents.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to immediately report to the Department when the facility experienced a power outage for 1 of 1 facility reviewed. This failure placed the residents at risk for unmet care needs and injury.

Findings included...

Record review of the facility policy, titled, "Loss of Power," undated, showed, "If possible bring the resident to an area with power until their apartments power is restored. If this is not possible, provide a flashlight for the residents use... If power is out in large sections of the building, or the entire building, attempt to bring residents to common areas not affected or powered by the generator. Check on all residents left in affected rooms at least once every hour... If possible bring residents to common areas with power until their apartment's power is restored. If this is not possible, provide flashlights for the resident use. All staff should carry flashlights during a power outage."

Review of Department Records showed that a report was made by the facility on 02/25/2025 at 5:40 AM notifying the Department that during a power outage, R3 came

out to the hallway to find staff for assistance. R3 had blood coming from the side of their head down their neck. The report was made to report the injury, and did not contain information about the power outage mentioned in the report of R3's fall. There were no other reports by the facility reporting the power outage.

<R3>

Record review of R3's face sheet, undated, showed that R3 was admitted to the facility on [redacted]/2024.

Record review of facility provided incident log, dated February 2025, showed on 02/25/2025 at 5:40 AM, R3 had a fall with injury.

Record review of R3's incident report, dated 02/25/2025, showed R3 had a fall with injury. R3 walked out on the 2nd floor by the chart room with a cut/laceration on left side of their head, gushing blood down to their neck. Upon return, R3 stated they hit their head on a tall rack on the wall when they were getting up from the toilet. 911 was called and R3 was taken to the hospital. In the box for comments, it showed, "the power was out and apartment was completely dark."

Record review of R3's 30 days of progress notes, date range from 02/04/2025 through 03/01/2025, showed:

-02/25/2025- R3 had an unwitnessed fall with injury. R3 walked near the chart room on the second floor with laceration on the left side of their head and was gushing blood down to their neck. Medication Technician called 911 and came out and assessed resident and decided to take resident to the hospital.

Record review of R3's Temporary Care Plan (TCP), dated 02/25/2025, showed on 02/25/2025 R3 reported that they hit their head when they stood up from the toilet.

Record review of R3's After Visit Summary from the hospital, dated 02/25/2025, showed R3 incurred a 3cm (centimeter) laceration of the left forehead.

<R4>

Record review of R4's face sheet, undated, showed that R4 was admitted to the facility on [redacted]/2023.

Record review of facility provided incident log, dated February 2025, showed on 02/25/2025 at 7:14 AM, R4 had a fall with injury.

Record review of R4's incident report, dated 02/25/2025, showed R4 had a fall with injury. R4's wife went to the medication cart to alert the medication aide. Medication Aide entered the room and called an all staff to alert other staff members. R4 complained of hip pain and lower back pain. Power was out for the whole facility; room was pitch black. R4 stated they could not see in the dark and tripped over something fuzzy.

Record review of R4's 30 days of progress notes, date range from 02/20/2025 through 02/28/2025, showed:

-02/25/2025- R4 had a fall and was on the bathroom floor. Medication technician instructed R4 to stay where they were at. EMS (Emergency Medical Services) was called and R4 was taken to the hospital in a neck brace and back board.

Record review of R4's Temporary Care Plan (TCP), dated 02/25/2025, showed on 02/25/2025 R4 had a witnessed fall with injury to hips/lower back.

In an interview on 03/06/2025 at 8:55AM, Staff F, Memory Care Director, was asked what time the power went out on the day the report was submitted for R3, they stated they didn't know what time it went out. Staff F stated they came in at 6:45AM and it was out. Staff F stated in came back on at 9AM and then went back out 2PM. Staff F stated they thought it came back on at 5PM. They stated there were no other issues with the power after 5PM.

In an interview on 03/05/2025 at 1:29PM, Staff C, Medication Technician, was asked if anyone they were aware of had a fall recently, they stated, we had a lot of falls the day the power went out. Staff C stated there were 16 people on alert for falls. Staff C stated R4 had a fall and was complaining of hip pain. Staff C stated R3 fell on NOC (Night) shift and were told about it the next morning.

In an interview on 03/05/2025 at 1:57PM, Staff D, Caregiver, was asked if anyone had any falls the day the power went out, they stated they were off that day but had heard people fell.

In an interview on 03/05/2025 at 3:29PM, Staff E, Caregiver, was asked what they would do if the power in the facility went out, they stated they've never had the power go out. Staff E stated they don't know what they are supposed to do and they have never been told what they need to do.

In an interview on 03/05/2025 at 2:51PM, Staff A, Executive Director, was asked what the process was when the power went out they stated there was a generator that runs common area lights. The generator runs everything but the rooms. Staff go door to door and will make sure nobody was on the floor. Staff A stated staff will continue to walk the building over and over. Staff A stated the building was out of power multiple times. It was just one day, it was off and on, off and on.

During a records request on 03/05/2025, the department requested to review the disaster preparedness plan/policy regarding a power outage.

In an interview on 03/05/2025 at 3:45 PM, Staff A was asked if they were required to notify CRU (Complaint Resolution Unit) when they had to implement their disaster plan, they stated they didn't know after how many hours they were supposed to. Staff A stated it was off and on, off and on. Staff A was asked why the outage wasn't reported, they stated they know if there was a disruption with water they would. Staff A was asked if there was a disruption with power, they stated yes, everybody had one. Staff A was asked if the "Loss of Power" policy that was provided early was a part of the emergency disaster plan, they stated yes, it's a part of the plan.

In an interview on 03/28/2025 at 4:50PM, Staff B, Health and Wellness Director, was asked what the process was when the power goes out, they stated, the back up generators kick on. The caregivers make sure anyone with oxygen is ok and they do their rounds and checks. Staff B was asked how often caregivers round, they stated every 1-2 hours. Staff B was asked if the resident call lights work, they stated yes, just power is out. Staff B was asked during a power outage if they implement the disaster plan, they stated, only when they have to. Staff B stated they have never had to move residents. Staff B was asked if there was a disruption in service, they stated no. Staff B was asked if not having access to lights was a disruption, they stated, the residents went about their day as normal. Staff B was asked if staff were walking the building during the time of the power being out checking on residents, if that means the disaster plan had been implemented, they stated they would have to get back to the department on that. Staff B was asked when the power goes out at the facility if residents have lights to use in their apartments, Staff B stated No. Staff B was asked if residents have lights in their bathrooms, they stated no. Staff B was asked if the facility provided flashlights for the residents to use, they stated not that they were aware of.

Statement of Deficiencies	License #: 2036	Compliance Determination # 55879
Plan of Correction	Bonaventure of Lacey	Completion Date
Page 6 of 6	Licensee: Bonaventure of Lacey LLC	03/28/2025

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) 5/12/2025 .

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

Administrator (or Representative) Megan Harrison Date 4/2/2025