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) 61454 (Completion Date 06/23/2025) and 58440 (Completion Date 05/01/2025).

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-2260 Storing, securing, and accounting for medications.

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

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

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
Investigation Summary Report

Provider/Facility: Bonaventure of Lacey
Provider Type: Assisted Living Facility
License/Cert.#: 2036
Compliance Determination #: 58440
Intake ID: 173046
Investigator: Pamela Horlick
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 04/23/2025 through 05/01/2025
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/Treatment: Report of staff not using gloves while performing personal care, not answering call lights, or sufficient staff to provide care to residents
2. Pharmaceutical Services: Report of residents medications being forgotten.

Investigation Methods:

Sample:	Total residents: 91 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Family members Maintenance staff
Record Reviews:	State reporting log Facility policies Care plan Medication Administration Record (MAR)

Investigation Summary:

1. Quality of Care/Treatment: Based on interview and observation, staff use gloves while performing care, call lights were answered timely and staff observed throughout facility. No failed practice identified.
2. Pharmaceutical Services: Based on interview and record review, med techs have a process in place to order medications. No missed medications noted on sample MARS. Unable to substantiate failed practice. While on site medication cart observed to be unlocked and unattended. 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 # 58440
Plan of Correction	Bonaventure of Lacey	Completion Date
Page 1 of 4	Licensee: Bonaventure of Lacey LLC	05/01/2025

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 04/23/2025 and 05/01/2025 of:

Bonaventure of Lacey
4528 Intelco Loop SE
Lacey, WA 98503

This document references the following complaint number(s): 174865, 173046

The following sample was selected for review during the unannounced on-site visit: 3 of 91 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

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Page 2 of 4	Licensee: Bonaventure of Lacey LLC	05/01/2025

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

05/08/2025
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)

5/12/25
Date

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

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

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure medication carts for 1 of 2 carts were locked to ensure that resident medications were secured and only accessible to designated staff persons. This failure placed 64 of 64 residents at risk for ingestion of potentially harmful medications and the medication cart was at risk to be accessed by unauthorized personnel.

Findings included...

Review of the facility's policy titled, "Medication System Summary," dated 05/01/2023, showed, The Community shall establish and maintain a safe, effective 24-hour medication delivery system for staff to administer, provide assistance for administration of, or allow residents to self-administration prescription and non-prescription (over-the-counter) medication/treatment, as allowed by state and pharmacy regulations." Under the section titled, "General Requirements," showed "Establish a medication room or other storage space that can be locked, which might be a room, cart, drawer, cabinet, etc." Under the section titled, "Storage and Disposal," showed, "Keep the medication room/space locked when not in use."

In an observation on 04/23/2025 at 10:58AM, a medication cart on the second floor close to the restrooms was observed to be unlocked and unattended.

In an interview on 04/23/2025 at 10:59 AM, Staff B, Caregiver was asked who the medication technician was for the day, they stated, Staff C, Assisted Living Director.

In an interview and observation on 04/23/2025 at 11:05 AM, Staff C returned to the medication cart and said, "sorry" and locked the cart. Staff C was asked what was in the top drawer of the cart, they stated creams, eye drops, and sprays. Staff C was asked what was in the second drawer, they stated, blood pressure medications, blood thinners and other medications. Eliquis (blood thinning medication) observed in the drawer. Staff C was asked what was in the third drawer, they stated acetaminophen, vitamins, and other prescription medications. Duloxetine (used to treat depression and anxiety) observed in the third drawer. Staff C was asked what was in the fourth drawer, they stated more prescription bottles. Jardiance (used to treat type 2 diabetes- condition that impacts blood sugar levels) observed in the fourth drawer.

In an observation on 04/23/2025 at 11:08 AM, residents were observed utilizing the elevator near the carts.

In an interview on 04/23/2025 at 11:09 AM, Staff C was asked what they were supposed to do when they stepped away from the cart, they stated they were supposed to make sure the cart were locked. Staff C stated they forgot to do that. Staff C was asked where they went, they stated, they were running medications upstairs to the third floor and down the hall. Staff C was asked why they didn't lock the cart, they stated they forgot.

In an interview on 04/23/2025 12:50 PM, Staff D, Medication Technician, was asked what they did when they had to step away from the medication cart, they stated, they lock the cart.

In an interview on 04/28/2025 at 3:15 PM, Staff A, Executive Director, was asked what was expected of staff when they step away from their medication carts, they stated if the medication technician stepped away out of line of site, they would expect them to make sure the cart was locked.

This is a recurring deficiency previously cited on 05/31/2023 for subsection 2 and 12/13/2022 for subsection 2 d.

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Page 4 of 4	Licensee: Bonaventure of Lacey LLC	05/01/2025

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) ~~6/15/25~~ 6/12/25 mH.

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

Administrator (or Representative) Date 5/12/25