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

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

RE: Bonaventure of Lacey License # 2036

Dear Administrator:

This letter addresses Compliance Determination(s) 65370 (Completion Date 09/09/2025) and 60606 (Completion Date 07/09/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/09/2025 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-2120-1, WAC 388-78A-2120-2, WAC 388-78A-2120-2-a, WAC 388-78A-2120-2-b, WAC 388-78A-2120-3, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120, WAC 388-78A-2120-4, WAC 388-78A-2210, WAC 388-78A-2210-1, WAC 388-78A-2210-1-a, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2, WAC 388-78A-2210-2-a, WAC 388-78A-2210-2-b, WAC 388-78A-2371, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3

The Department staff who did the on-site verification:
Anissa Bearden, Licensor

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 #: 60606
Intake ID: 180040
Investigator: Pamela Horlick
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 06/04/2025 through 07/09/2025
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/Treatment: Report of staff being given unsafe assignments possibly leading to unsafe conditions and care needs not being met.
2. Unqualified Personnel: Report of staff being unqualified to perform duties.
3. Falsification of Records/Reports: Report of medication logs being falsified.
4. Nursing Services: allegation that they aren't provided as required.

Investigation Methods:

Sample:
Total residents: 89
Resident sample size: 8
Closed records sample size: 0

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

Interviews:
Identified resident
Nursing staff
Residents

Record Reviews:
State reporting log
Facility policies
Personnel files
Staff training records
Medication Administration Records (MAR)
Care Plan
Progress Notes
After Visit Summary (AVS)
Training Checklist
Narcotic Book
Investigation
Staff List
Incident Report
Staff Working Schedule

Investigation Summary:

1. Quality of Care/Treatment: Review of staffing revealed, during investigation, that the minimum standards were met, unable to substantiate failed practice.
2. Unqualified Personnel: unable to substantiate allegation surrounding staff being unqualified.
3. Falsification of Records/Reports: Unable to substantiate failed practice related to falsification, but did identify issues with charting and medication reconciliation - failed practice identified and cited under medications.
4. Nursing Services: Unable to substantiate related to nursing services.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Bonaventure of Lacey
Provider Type: Assisted Living Facility
License/Cert.#: 2036
Compliance Determination #: 60606
Intake ID: 180755
Investigator: Pamela Horlick
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 06/04/2025 through 07/09/2025
Complainant Contact Date(s):

Allegation(s):

1. Nursing Services: Report of resident not receiving their prescribed medications.
2. Resident/Patient/Client Neglect: Report of resident not receiving their showers.

Investigation Methods:

Sample:
Total residents: 89
Resident sample size: 8
Closed records sample size: 0

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

Interviews:
Identified resident
Nursing staff
Residents

Record Reviews:
State reporting log
Facility policies
Personnel files
Staff training records
Medication Administration Records (MAR)
Care Plan
Progress Notes
After Visit Summary (AVS)
Training Checklist
Narcotic Book
Investigation
Staff List
Incident Report
Staff Working Schedule

Investigation Summary:

1. Based on interview and record review, unable to substantiate failed practice due to no documentation of medication being prescribed.
2. Based on interview and record review, bed baths were provided to resident. Unable to substantiate failed practice. Resident did sustain injury and was not investigated and was not monitored for injury. Failed practice identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Bonaventure of Lacey
Provider Type: Assisted Living Facility
License/Cert.#: 2036
Compliance Determination #: 60606
Intake ID: 181563
Investigator: Pamela Horlick
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 06/04/2025 through 07/09/2025
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/Treatment: Report of resident not receiving their prescribed pain medication.
2. Nursing Services: Report of resident not receiving pain medications.

Investigation Methods:

Sample:
Total residents: 89
Resident sample size: 8
Closed records sample size: 0

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

Interviews:
Identified resident
Nursing staff
Residents

Record Reviews:
State reporting log
Facility policies
Personnel files
Staff training records
Medication Administration Records (MAR)
Care Plan
Progress Notes
After Visit Summary (AVS)
Training Checklist
Narcotic Book
Investigation
Staff List
Incident Report
Staff Working Schedule

Investigation Summary:

1. Based on record review and interview, resident received their scheduled medications and as needed medications. Unable to substantiate failed practice
2. Based on record review and interview, resident received their scheduled medications and their as needed medications. Unable to substantiate failed practice. Resident sustained injury that was not investigated and resident was not monitored after injury. 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 06/04/2025 and 06/05/2025 of:

Bonaventure of Lacey
4528 Intelco Loop SE
Lacey, WA 98503

This document references the following complaint number(s): 180040, 180047, 180755, 181563, 181919, 181333, 182652

The following sample was selected for review during the unannounced on-site visit: 8 of 89 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator
Anissa Bearden, Licensor

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

Statement of Deficiencies	License #: 2036	Compliance Determination # 60606
Plan of Correction	Bonaventure of Lacey	Completion Date
Page 2 of 14	Licensee: Bonaventure of Lacey LLC	07/09/2025

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.

Residential Care Services — Date: 07/22/2025

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: 7/22/25

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

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

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

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to monitor residents' well-being and take appropriate actions for 2 of 4 sampled residents (Resident 2 and Resident 4). This failure placed both residents at risk for unmet care needs and lack of response for decline in residents' condition.

Findings included...

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.

Residential Care Services — 07/22/2025 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

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This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to monitor residents' well-being and take appropriate actions for 2 of 4 sampled residents (Resident 2 and Resident 4). This failure placed both residents at risk for unmet care needs and lack of response for decline in residents' condition.

Findings included...

Record review of the facility's policy titled, "alert charting", dated 06/01/2023, showed 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 were not limited to the following: an occurrence/event, change in condition, new move in, return from a hospital stay or emergency room visit, and other reasons that affect a resident. Under the section titled, "following are steps in the alert charting process" showed residents placed on alert status would remain on alert for a minimum of 72 hours unless otherwise directed by the executive director or designee. After a resident was placed on alert charting, each shift medication technician would make a charting note for the resident as related to the alert concern.

An unannounced onsite inspection was conducted on 06/04/2025.

<Resident 4>

Record review of the facility's Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 06/04/2025, showed Resident 4 (R4) moved into the facility on [redacted]/2025.

Record review of R4's charting notes, dated 05/05/2025 at 2:02 PM, documented that the "resident went to the hospital today for swollen knee and pain."

Record review of R4's charting note, dated 05/05/2025 at 7:57 PM, showed care staff called the medication technician into R4's room as there were concerns about R4's leg. R4's knee was extremely swollen, and their foot was at a 90-degree angle. R4 told the medication technician that the night prior they were getting wheeled down to a meal when R4's leg got caught under the wheelchair and pulled. Assisted living director [Staff G] and the Executive Director [Staff A] were notified of the potential accident and would follow up with care staff accordingly.

Record review of R4's charting note, dated 05/05/2025 at 9:03 PM, showed R4 return to the facility. R4 had a referral to orthopedic physician and a follow up in one week for emergency department.

Record review of R4's charting note, dated 05/09/2025 at 1:33 PM, showed R4 was assessed for new move in. R4 was non-weight bearing on the left leg due to a tibial fracture (a break in the shinbone at the knee joint) on the left leg. There was no documentation prior to this note that showed how R4 was doing from returning to the facility from the emergency department and new tibial fracture.

<Resident 2>

Record review of the facility's Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 06/04/2025, showed Resident 2 (R2) moved into the facility on [redacted]/2024.

Record review of R2's charting notes, dated 05/24/2025 at 2:20 AM, documented R2 had been receiving dressing assistance, daily bed making, light housekeeping, and trash removal that was not care planned for the last 90 days and would need an increase in care needs.

Record review of R2's hospitalist discharge summary, dated [redacted]/2025, showed R2 admitted to the hospital on [redacted]/2025 and discharged from the hospital on [redacted]/2025. The documentation showed R2 was experiencing dysphagia (difficulty swallowing). The documentation showed R2 had their esophagus (canal that travels between the throat and stomach) stretched with tissue sampled taken for testing. R2 was to advance their diet as they tolerated.

Record review of R2's charting note, dated 05/31/2025 at 7:34 AM, showed "RN change of condition" R2 was assessed at the hospital. R2 was up walking with a two-wheel walker. R2 was at baseline and ready to return to the community. There was no prior documentation that showed when, where, or why R2 was out of the facility. There was no documentation on how R2 was eating, or condition was from the two day stay at the hospital.

Record review of R2's charting note, dated 06/05/2025 at 1:20 AM, showed primary care physician (PCP) fax response to a fax that was sent on 06/01/2025 with R2's request to change their order of daily prunes to as needed. PCP sent discontinued order and start as needed order for prunes. There was no documentation for dates 05/31/2025 through 06/05/2025 that showed when R2 returned to the facility or how R2 was doing since returning to facility.

Review of R2's medical record, titled "charting note", did not show documentation that the above-mentioned events were monitored according to facility alert charting policy.

In an interview on 06/04/2025 at 4:04 PM, Staff E, Medication Aide, stated they were to put the resident on alert for any change in medication, occurrence, change in behavior, new admission, and if the resident had an injury. Staff E stated R4 should have been put on alert when they came back to the facility from the emergency department with their knee injury.

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) 8/23/25 .

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

Administrator (or Representative) 7/22/25 Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to follow prescribed medication orders for 1 of 4 sampled residents (Resident 5 [R5]) and failed to implement a safe medication system for 2 of 3 residents (Resident 1 and 2 [R1 & 2]). These failures resulted in R5 receiving medications outside of physician parameters, all residents receiving medication administration by staff that were untrained and resulted in R1 and R2's narcotic medications being unaccounted for, and placed all residents at risk for injury, hospitalization, adverse effects of medications and medication errors.

Findings included...

Staff Training

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

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Findings included...

Staff Training

Record review of facility provided document titled, “Current Staff List”, undated, showed Staff B, Medication Aide, was hired at the facility on 12/07/2024.

Record review of the State of Washington Department of Health credential verification, dated 06/11/2025, showed Staff B first day they were credential as nursing assistance registration was on 06/06/2025.

Record review of Staff B’s "MT [Medication Technician]/QMAP [Qualified Medical Administration Person] skills checklist”, dated 05/01/2023, showed Staff B completed their training on “04/15” that was 129 days after Staff B was hired at the facility.

Record review of facility provided document titled, “Current Staff List”, undated, showed Staff C, Medication Aide, was hired at the facility on 04/09/2025.

Record review of the State of Washington Department of Health credential verification, dated 06/11/2025, showed Staff C did not have any records found on the database.

Record review of Staff C’s “MT /QMAP skills checklist”, dated 05/01/2023, showed Staff E completed their skills on 06/04/2025 that was 56 days after they were hired at the facility.

Record review of facility provided document titled, “Current Staff List”, undated, showed Staff E, Medication Aide, was hired at the facility on 03/26/2025.

Record review of the State of Washington Department of Health credential verification, dated 06/11/2025, showed Staff E had their Nursing Assistant Registration that expired on 04/26/2025.

Record review of Staff E’s document titled, “MT /QMAP skills checklist”, dated 05/01/2023, at the top of the document there was “retraining” handwritten. The document showed Staff E completed their skills on 06/04/2025 that was 70 days after being hired at the facility.

Record review of an email sent to the Department on 06/10/2025 at 4:43 PM, showed Staff D, Former Medication Aide, was hired at the facility on 05/01/2025.

Record review of the State of Washington Department of Health credential verification, dated 06/11/2025, showed Staff D’s nursing assistant registration was expired and their nursing assistant certification was closed.

Record review of an email sent to the Department on 06/06/2025 at 3:14 PM, Staff A, Executive Director, documented that the facility was unable to find the skills check lists for Staff B, Staff E, and Staff D. Staff A stated Staff C and Staff B were completing their training to get their basic training certification.

In an interview on 06/13/2025 at 12:00PM, Staff H, Director, stated a skills checklist would usually be completed by the end of training. Staff H was asked how long training is, they stated 3-5 days from hire.

Following Physician Orders

R5

Record review of the Mayo clinic's document titled acetaminophen (medication to help with pain and discomfort), dated 02/28/2025, showed acetaminophen was used to treat minor aches and pain and to reduce fever. Under the section titled, "proper use", showed acetaminophen was to be taken only as directed by your physician. Do not take more of the acetaminophen or take it more often and for longer time. Liver damage could occur if large amounts of acetaminophen were taken for a long time. Carefully check the labels of all other medicines that were being taken as they may contain acetaminophen. It is not safe to take 3000 milligrams (mg) of extra strength acetaminophen in 24 hours.

Record review of the facility's Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 06/04/2025, showed R5 moved into the facility on [redacted]/2024.

Record review of R5's medication administration record (MAR) dated 05/01/2025 through 05/31/2025, showed R5 had multiple medical diagnoses that included [redacted].

Record review of R5's current medication list dated 05/06/2025, showed R5 had an order for acetaminophen 1000 milligrams (MG) take three times daily as needed and hydrocodone acetaminophen 5-325 mg per tablet, take one tablet every six hours as needed for pain.

Record review of R5's community physician communication, dated 05/09/2025, showed R5's physician on 05/10/2025 wrote new medication orders for acetaminophen 1000 mg three times daily for 14 days. Do not exceed 3000 mg in 24 hours.

Record review of R5's after visit summary, dated 05/09/2025, showed R5 had a sacral fracture (a broken bone in the base of the spine) and displaced left inferior pubic ramus fracture (broke bone to the lower part of the pubic bone). R5's current medication list as of 05/09/2025 at 4:07 PM, showed acetaminophen take 1000 mg three times daily as needed and hydrocodone acetaminophen 5-325 mg take every six hours as needed for pain.

Record review of R5's medication administration record (MAR) dated 05/01/2025 through 05/31/2025, showed R5 had a current order that started 12/09/2023 for acetaminophen take 1000 mg every eight hours routine for pain management. Not to exceed three grams (3000 MG) of acetaminophen in 24 hours from all sources. The acetaminophen was administered three times daily except for three doses. R5 had an order for hydrocodone acetaminophen 5-325mg take one tablet every six hours as needed for pain. review of administrations showed R5 was administered 13 doses of their hydrocodone acetaminophen. On 05/06/2025, 05/08/2025, 05/09/2025, and 05/12/2025 R5 was administered 3625 mg of acetaminophen in 24 hours and on 05/03/2025, 05/11/2025, 05/13/2025, 05/16/2025, and 05/17/2025 R5 was administered 3325 mg of acetaminophen in 24 hours. The MAR did not show that that the acetaminophen was only as needed and starting on 05/10/2025 through 05/24/2025 the acetaminophen was routine per the physician order that was sent to the pharmacy on 05/10/2025.

In an interview on 06/13/2025 at 12:00PM, Staff H was asked if MAR audits are completed for medication orders, they stated, yes, they are completed by the ALD (assisted living director) and MCD (memory care director). Staff H stated they believed the audits were supposed to be done twice monthly. Staff H stated when a new order is received, it is inputted by one med tech, another med tech would review the order and approve it, and then management would review it for accuracy. Staff H stated they would review the order to ensure it has the correct parameters. Staff H stated that they would hold the medication if it was outside the parameters. Staff H stated, "we would follow exactly what the order says."

Schedule Medication Discrepancy

Revised Code of Washington (RCW) 69.41.210 "Definitions. The terms defined in this section shall have the meanings indicated when used in RCW 69.41.200 through 69.41.260… (3) "Legend drug" means any drugs which are required by state law or regulation of the commission to be dispensed as prescription only or are restricted to use by prescribing practitioners only and shall include controlled substances in Schedules II through V of chapter 69.50 RCW."

RCW 69.41.042 "Record requirements. A pharmaceutical manufacturer, wholesaler, pharmacy, or practitioner who purchases, dispenses, or distributes legend drugs shall maintain invoices or such other records as are necessary to account for the receipt and disposition of the legend drugs."

Record review of the Washington State Department of Social and Health Services document titled, “Fundamentals of Caregiving third edition”, dated “10/2024”, under the section titled, “storage of controlled substances” showed scheduled drugs have a high potential for abuse and must be stored securely. In assisted living facilities, these drugs need to be doubled locked and counted each shift by two qualified staff members.

Record review of the facility’s document titled, “job description Medication Aide (Washington)”, dated 01/2011, showed the medication aide was responsible for medications, treatments, and resident care duties as assigned by the resident care coordinator. The position administers medications according to acceptable standards. Under the section titled, “duties and responsibilities”, showed administers medication and treatments as assigned within the scope of practice, passes morning, afternoon, and evening medications, stays with the resident until the medication was consumed, then charts appropriately, responsible for recording and/or restocking medications from the pharmacy after receiving proper instructions, responsible for locking and storing narcotics (according to protocol) until turned over to pharmacy, Notifies supervisor at once if awareness of medication error. Under the section titled, “education”, showed the employee must be either certified home care aide, or nursing assistant.

On 06/05/2025 at 12:28 PM, the facility’s policy on on-boarding training for medication technicians and the medication technician medication handbook manual was requested for review.

Record review of the facility’s Health Service Manual, dated 03/13/2024, under the section titled, “narcotic tracking”, showed specific procedures were established to assure the proper handling and tracking of controlled medications included the establishment of a “double locked” space for storage. Procedures must meet regulations that apply and must provide direction about receipt into the community, storage, shift inventory counts, administration to residents, and disposal. Detailed directions for steps and related documentation for handling/tracking controlled medications was located in the medication technician training manual. This document was the only document that was sent from the health services manual for review.

On 06/09/2025 at 12:39 PM, the facility was requested to send the health services manual that “detailed directions for steps and related documentation for handling/tracking controlled medications is located in the MT training Manual” for review.

As of 06/10/2025 at 5:00 PM, the Department had not received the medication technician training manual about documentation for handling/tracking controlled medications.

Record review of the facility document that was untitled, and undated, showed it was

the medication cart 2 and 4 narcotic book sign in and sign out log that was for dates 05/11/2025 through 05/13/2025, showed 0n 05/12/2025, Staff B had signed oncoming with off going night shift medication aide Staff F. Staff B signed off going for day shift with on-coming evening shift Staff C that signed, and for evening off going shift and night on coming shift, there were no signatures documented.

R1

Record review of the facility's Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 06/04/2025, showed R1 moved into the facility on [redacted]/2024.

Review of R1's medication administration record (MAR), dated 05/01/2025 through 05/31/2025, showed R1 had multiple medical diagnoses that included [redacted], and [redacted]. The MAR showed R1 had medication order for tramadol (a prescribed strong pain medication) take every eight hours for pain. The MAR showed R1 was out of the facility on 05/04/2025 through 05/05/2025, 05/09/2025 through 05/11/2025, and 05/25/2025 through 05/26/2025.

Record review of the facility's medication cart narcotic book number "2 and 4" on page 71 that was untitled and undated, showed the page was for R1 and their tramadol medication. On 05/12/2025 at 12:00 AM, Staff F, Medication Aide, document they administered one tablet of tramadol to R1. Under the column labeled "qty [quantity] remaining" showed "54" tablets remained. Review of the entry documented by Staff B, dated "05/12 at 12", showed one tablet was signed out. Under the section titled, "qty remaining" was blank. Review of the entry documented by Staff C, dated "05/12 at 7:00 PM", showed there was one tramadol tablet signed out. Under the section titled, "qty remaining" was blank. On "05/13 at 3:05 AM" documented by Staff D, one tablet was signed out and under the section titled, "qty remaining" was "46". On the bottom of the page showed under the section titled "balance (qty) transferred to: 47" was put on page 72 by Staff B.

Record review of the facility's medication cart narcotic book number "2 and 4" page 72 that was untitled and undated, showed the page was for R1's tramadol. The page showed the same prescription number as listed on page 71 for R1's tramadol with quantity received was 47. On "05/13 at 3:05 AM", Staff D signed out one tablet with the quantity remaining 46.

R2

Record review of the facility's Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 06/04/2025, showed R2 moved into the facility on [redacted]/2024.

Record review the facility's medication cart narcotic book number "2 and 4" page 62 that was untitled and undated, showed it was for R2's tramadol tablet medication. Review of the documentation of R2's tramadol dispensing showed on 05/11/2025 at 10:40 PM, Staff F documented that they administered R2 two tablets with 19 remaining tablets. On 05/12/2025 at 10:40 PM, Staff D documented they administered R2, two tablets with remaining amount 16.

In an interview on 06/04/2025 at 4:04 PM, Staff E stated the medication aide was responsible to complete the narcotic count on the medication carts at every shift change. Staff E stated the off going medication aide would have the narcotic book to verify the narcotic number written and the oncoming medication aide would be verifying the actual medication tablets amount was the same as the narcotic book number. Staff E stated if the count was correct, both the oncoming and off going medication aides would sign off in the front of the narcotic book.

In an interview on 06/11/2025 at 10:56AM, Staff B was shown the medication cart narcotic book number "2 and 4" page 71, entry dated "05/12 at 12", where it showed one tablet was signed out. Under the section titled, "qty remaining" was blank. and was asked why it was left blank. Staff B stated the narcotic count was off. They stated the count was inaccurate, so they didn't want to put the quantity remaining because they didn't want to further mess up the count. Staff B stated they alerted Staff A, Staff H or Staff G that day. Staff B was asked if they sign the front of the book if the count is correct, they stated yes. Staff B was asked if they would sign the front of the book if it was off, they stated no. They won't sign the book until management comes and fixes the count. Staff B stated management would do an investigation to see what happened. Staff B was asked if they recall it being fixed, they stated they didn't remember. Staff B was shown the front of the narcotic book where they would sign off on the count. Staff B was asked if they signed on 05/12/2025 mid shift with Staff C, they stated yes. Staff B was asked if they signed with Staff C stating the count was correct, they stated yes. Staff C was asked why they signed it if the count was not correct, they stated they could have been in a rush.

In an interview on 06/04/2025 at 3:22PM Staff A was asked to explain the medication cart narcotic book on 05/12/2025 at "12" where Staff B signed and on 05/12/2025 at 7:00PM where the "quantity remaining" column was blank. Staff B stated they didn't know and that no one brought it to their attention.

In an interview on 06/11/2025 at 12:06PM, Staff G, Assisted Living Director, was asked if they were made aware of the narcotic count being off, they stated they were not. Staff G stated they believed Staff A and Staff H were made aware. Staff G stated if the count was off, staff would sign the book. By signing the book they were assuming responsibility of the cart. Staff G stated if they do not sign the book, they would notify management.

In an interview on 06/11/2025 at 12:18PM, Staff A stated when the med techs

administer a narcotic, they document the number of pills given, the remaining count and sign that they gave the medication. Staff A stated at shift change, the person coming on shift and the person going off shift would do a narcotic count. After the count is done, both med techs will sign the date for in and out. Staff A was asked what does that mean when they sign their names, they stated it means that the count is correct, and they are accepting responsibility for the medication cart.

This is a recurring deficiency previously cited on 03/04/2025, 5/31/2023 for subsections 1b and 2b, and 12/13/2022 for subsection (2).

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) 8/23/25 .

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

Administrator (or Representative) — 7/22/25 Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to investigate and document actions and findings for any incident that resulted in a significant injury for 1 of 2 sampled residents (Resident 4). This failure resulted in the facility being unable to determine the circumstances of the event, institute, and document appropriate measures to prevent similar situations, and protect the resident during the course of the investigation.

Findings included...

Record review of the facility's policy titled, "occurrence reporting", dated 05/21/2025,

administer a narcotic, they document the number of pills given, the remaining count and sign that they gave the medication. Staff A stated at shift change, the person coming on shift and the person going off shift would do a narcotic count. After the count is done, both med techs will sign the date for in and out. Staff A was asked what does that mean when they sign their names, they stated it means that the count is correct, and they are accepting responsibility for the medication cart.

This is a recurring deficiency previously cited on 03/04/2025, 5/31/2023 for subsections 1b and 2b, and 12/13/2022 for subsection (2).

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Administrator (or Representative) _____ Date _____

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This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to investigate and document actions and findings for any incident that resulted in a significant injury for 1 of 2 sampled residents (Resident 4). This failure resulted in the facility being unable to determine the circumstances of the event, institute, and document appropriate measures to prevent similar situations, and protect the resident during the course of the investigation.

Findings included…

Record review of the facility's policy titled, "occurrence reporting", dated 05/21/2025,

showed it was the expectation of the community that all resident occurrences, defined as any incident involving a resident or resident(s) that was out of the ordinary or unusual to that resident, would be document, investigated, and reported as applicable and appropriate resident specific measures put in place to reduce the risk of re-occurrence and/or serious injury. Under the section titled, “documentation of the incident”, showed the occurrence report was to be completed by the first person witnessing or becoming aware of the incident had occurred, but also could be completed by supervisory staff person (in conjunction with the person first becoming aware of the incident). All incidents require full completion of an occurrence report that included date, time, resident type, location of event, type of occurrence, type of injury, description of the occurrence, resident statement, and immediate action taken. Under the section titled, “investigation”, showed administrations or the designee would review the incident related documentation and direct the related investigation to determine why the incident occurred and what steps can be taken to minimize the reoccurrence. The primary purpose of each investigation was to first and foremost rule out abuse and secondarily to evaluate the resident, circumstances of the occurrence as well as contributing factors to determine next steps in reducing the risk of re-occurrence.

Record review of the facility’s Assisted Living Facility Resident Characteristic Roster and Sample Selection, dated 06/04/2025, showed R4 moved into the facility on [redacted]/2025.

Record review of R4’s progress notes, dated 05/02/2025 through 06/05/2025, documented:

- 05/02/2025- R4 moved into the community from an Adult Family Home.
- [redacted]/2025 through 05/05/2025- Resident was on alert for new move into the community.
- 05/05/2025 2:02 PM- Resident went to the hospital for swollen knee and pain.
- 05/05/2025 7:57 PM- Care staff called Med tech into the residents room due to concerns about R4’s leg. “Residents knee was extremely swollen and [their] foot was at what appeared to be a 90 degree angle. Resident stated, the night before [they] were getting wheeled down to a meal when [their] leg got caught under the wheelchair and pulled. ALD (Assisted Living Director) and ED (Executive Director) have been informed of the potential accident and will follow up with care staff accordingly.”
- 05/05/2025 9:03PM- Resident on alert for RTF (return to facility). Resident stated they were in a lot of pain.
- 05/06/2025-05/08/2025 No notes documented.
- 05/09/2025 1:33PM- Resident is non- weight bearing on their left leg due to a tibial fracture.
- 05/16/2025- 05/21/2025- No notes documented.
- 05/22/2025- Med Tech to check for AVS on 5/5. No facility changes at this time.
- 05/23/2025- 05/27/2025- no notes documented.
- 05/28/2025- no notes regarding R4’s tibial fracture.
- 05/29/2025- 06/01/2025 outside agency note- no notes regarding R4’s tibial fracture.
- 06/02/2025- 06/05/2025- no notes regarding R4’s tibial fracture.

Record review of facility provided document titled, "Resident Occurrence Tracking Log," dated May 2025, showed no entry was logged for the injury R4 sustained on 05/04/2025.

During an onsite visit on 06/04/2025, an investigation for R4's tibia fracture was requested and as of 5:30 PM no investigation was provided.

In an interview on 06/04/2025 at 4:04 PM, Staff E, Medication Aide, stated an occurrence report should have been completed for R4's knee injury as it was caught under their wheelchair.

In an interview on 06/11/2025 at 12:18PM, Staff A, Executive Director, stated they did not know about an investigation for a bone fracture for R4. Staff A stated they saw that the nurse put in a note about it but was not notified of it. Staff A stated they were not able to find an AVS (After Visit Summary). Staff A stated the nurse should have completed an occurrence report and an investigation. Staff A stated there was nothing.

This is a recurring deficiency previously cited on 05/31/2023 for subsections (1)(2(3)(4) and on 12/06/2023 for subsections (1).

Plan/Attestation Statement

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Administrator (or Representative) 7/22/25 Date

Record review of facility provided document titled, “Resident Occurrence Tracking Log,” dated May 2025, showed no entry was logged for the injury R4 sustained on 05/04/2025.

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In an interview on 06/04/2025 at 4:04 PM, Staff E, Medication Aide, stated an occurrence report should have been completed for R4’s knee injury as it was caught under their wheelchair.

In an interview on 06/11/2025 at 12:18PM, Staff A, Executive Director, stated they did not know about an investigation for a bone fracture for R4. Staff A stated they saw that the nurse put in a note about it but was not notified of it. Staff A stated they were not able to find an AVS (After Visit Summary). Staff A stated the nurse should have completed an occurrence report and an investigation. Staff A stated there was nothing.

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_____ _____

Administrator (or Representative) Date