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) 70848 (Completion Date 01/05/2026) and 66953 (Completion Date 11/04/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/05/2026 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-2660-1, WAC 388-78A-2660-4, WAC 388-78A-2120-4, 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-2630-1-b, WAC 388-78A-2100-2-b, WAC 388-78A-2100-2-b-i, WAC 388-78A-2100-2-b-ii, WAC 388-78A-2100-2-b-iii, WAC 388-78A-2100-2-a

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 RN

Clinton Fridley, Community 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 #: 66953
Intake ID: 199950
Investigator: Anissa Bearden
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 10/09/2025 through 11/04/2025
Complainant Contact Date(s):

Allegation(s):
allegation that the resident came to the hospital with multiple injuries from multiple unwitnessed falls related to possible insufficient staffing and inadequate care being provided.

Investigation Methods:

Sample:
Total residents: 97
Resident sample size: 6
Closed records sample size: 1

Observations:
Residents
Resident rooms
Staff to resident interactions

Interviews:
Nursing staff
Residents
Administrative staff

Record Reviews:
Medical records
Hospital records
Incident investigation
Facility policies

Investigation Summary:
Based on interview and record review, the facility failed to take appropriate action to ensure the resident was safe implement appropriate interventions after a resident had multiple falls in the memory care that resulted in the resident being hospitalized with multiple injuries and required comfort measures for end of life care. failed practice.

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 #: 66953
Intake ID: 198651
Investigator: Anissa Bearden
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 10/09/2025 through 11/04/2025
Complainant Contact Date(s):

Allegation(s):
allegation resident fell and then 3 days later sent to emergency department and found to have hip fracture

Investigation Methods:

Sample:	Total residents: 97 Resident sample size: 6 Closed records sample size: 1
Observations:	Residents Dining Staff to resident interactions
Interviews:	Nursing staff Residents Administrative Staff
Record Reviews:	Medical records Hospital records State reporting log Incident investigation Facility policies

Investigation Summary:
after interview and record review, the facility failed to take appropriate action when the resident had a fall and the next day experienced severe hip pain and did not get taken to the hospital until 3 days after the fall that resulted in the resident having a hip fracture. Failed practice.

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 #: 66953
Intake ID: 197656
Investigator: Anissa Bearden
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 10/09/2025 through 11/04/2025
Complainant Contact Date(s):

Allegation(s):
allegation that the facility did not take appropriate action when a resident was assaulted by another resident and left all memory care residents at risk of harm and abuse by the aggressive resident.

Investigation Methods:

Sample:	Total residents: 97 Resident sample size: 6 Closed records sample size: 1
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions Medication administration
Interviews:	Identified resident Identified staff Nursing staff Administrative Staff Residents Family members
Record Reviews:	Medical records Hospital records State reporting log Incident investigation Facility policies

Investigation Summary:
after observation, interview and record review, the facility failed to complete a focused assessment on the aggressive resident when there was a change of condition in behavior and their negotiated service plan no longer addressed the residents current needs. The facility failed to protect all other resident per their right at the facility from harm and abuse of a resident with aggressive behaviors, and the facility failed to notify law enforcement when there was physical abuse and

assault with multiple incidents with residents in the memory care unit.

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 #: 66953
Intake ID: 195407
Investigator: Anissa Bearden
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 10/09/2025 through 11/04/2025
Complainant Contact Date(s):

Allegation(s):
allegation of resident to resident altercations with injury.

Investigation Methods:

Sample:
Total residents: 97
Resident sample size: 6
Closed records sample size: 1

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

Interviews:
Family members
Residents
Nursing staff
Identified staff
Identified resident

Record Reviews:
Incident investigation
Facility policies
State reporting log
Medical records
Hospital records

Investigation Summary:
after interview and record review, the facility failed to protect the resident from being harmed by another resident on multiple occasions that resulted in the resident with a bite wound and bruised eye from being hit, and psychological harm, that was against the residents right to remain free of abuse and harm. The facility failed to report the physical abuse to the law enforcement. failed practice.

Conclusion / Action:

☒ 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

Statement of Deficiencies	License #: 2036	Compliance Determination # 66953
Plan of Correction	Bonaventure of Lacey	Completion Date
Page 1 of 20	Licensee: Bonaventure of Lacey LLC	11/04/2025

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 10/09/2025 and 10/29/2025 of:

Bonaventure of Lacey
4528 Intelco Loop SE
Lacey, WA 98503

This document references the following complaint number(s): 195052, 195055, 195407, 197656, 198501, 198651, 198802, 199950

The following sample was selected for review during the unannounced on-site visit: 6 of 97 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Anissa Bearden, Licensor
Maria Salas, ALF 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.

Laurie Anderson — Residential Care Services
11/18/2025 — 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 Hz — Administrator (or Representative)
11/19/2025 — Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that residents were protected from harm and physical altercations for 2 of 2 residents (Resident 1 and 2). This failure resulted in Resident 1 and Resident 2 being subjected to abuse over multiple occasions which resulted in psychological harm and placed all residents in the memory care unit at risk of injury and a decreased quality of life.

Findings included...

Revised Code Washington (RCW) 70.129.130 "Abuse, punishment, seclusion Background checks. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion."

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."

Record review of the facility's policy titled, "Occurrence Reporting Policy", dated 05/21/2025, documented that all resident occurrences would be reported, as applicable, and appropriate resident specific measures put in place to reduce the risk of re-

occurrence and/or serious injury. After an incident occurred, the facility would take immediate steps to assist the residents and reduce the risk of reoccurrence. The purpose of each investigation first and foremost was to rule out abuse, evaluate the resident, determine why the incident occurred, and what steps could be taken to minimize reoccurrence and reduce the risk of re-occurring.

Record review of the facility's policy titled, "Abuse, Neglect, or Exploitation", dated 02/15/2021, documented verbal, physical, or mental abuse, whether toward residents or staff, would not be tolerated. Any staff member that has reason to suspect an incident of physical assault was to report to local law enforcement emergency services number as soon as the resident was protected from further harm. All staff were mandatory reporters and the responsibility to report abuse as per RCW 70.129 and WAC 388-78a-2630.

Resident 3 (R3)
Record review of R3's Resident Service Plan, dated [redacted]/2025, documented R3 had dementia (a progressive brain disorder that affects a person's judgement, memory, and ability to carry out activities of daily living needs). Anything with loud noises would stimulate R3 with change in behavior and that R3 preferred to walk independently. R3 was known to walk without a purpose and go into other resident apartments frequently and staff were to redirect R3 that they were at a five staff hotel while their daughter was on vacation.

Record review of R3's charting notes showed...

- On [redacted]/2025 at 12:05 PM, R3 moved into the facility.
- On 07/02/2025 at 9:39 PM, R3 was agitated and resistive to care. A caregiver went to assist R3 with personal care when R3 grabbed the caregiver by the arm pulling the caregiver on top of the R3 and then grabbed the caregiver's fingers bent them backwards causing the caregiver pain.
- On 07/09/2025 at 9:02 PM, family requested that R3 get a sleep aid order from their primary care provider and let them know that R3 was increasingly urinating. At 9:04 PM, R3 refused personal care and had been agitated. R3 threatened the caregiver when they tried to help R3 change and get cleaned up.
- On 07/17/2025 at 11:12 PM, R3 was very agitated and aggressive that day. Care staff approached R3 to assist him with changing as R3 had been incontinent of bowel. R3 threatened the caregiver with a fork. The medication technician assisted R3 to get clean of the incontinent bowel when R3 kicked and hit the medication technician. The executive director came in to assist the caregiver and the medication technician. R3 was encouraged to take a shower but refused and pushed and hit all the staff.
- On 07/20/2025 at 3:56 AM, R3 was very agitated and had entered a female resident's room. The female resident screamed for help and for R3 to get out their room. The medication technician tried to redirect R3 out of the female resident's room, when R3 grabbed the medication technicians' arm very hard and refused to let go. The caregiver was able to help the medication technician to release R3's grip on the medication technicians' arm, when R3 swung his balled up fist and arm towards the medication technician's face. R3 followed the medication technician out of their room

and was required to be redirected back into their room and refused to have any personal care provided throughout the night.

- On 07/24/2025 at 10:40 AM, care staff were in R3's apartment room cleaning, when R3 grabbed the broom from the caregiver and broke the broom and yelled at the caregiver to get out.
- On 07/26/2025 at 8:59 PM, R3 had been in two physical altercations with two different caregivers. The first incident included when R3 was assisted to sit down on the toilet. The caregiver was lifting up R3 shirt to help them change it, when R3 wrapped the female caregiver up into their shirt and pulled the caregivers them backwards that resulted in the caregiver going to the hospital to get checked out. The second incident showed the caregiver encouraged the resident to take his pants off to get changed when R3 swung and hit the caregiver.
- On 08/03/2025 at 7:41 PM, R3 reached into the kitchen meal cart at dinner time, when the care staff asked R3 to not touch the food. R3 gabbed the care staff's arms and squeezed it very hard for 20 to 30 seconds. The care staff told R3 to stop as they were hurting them. At 7:44 PM, the care staff reported that prior to dinner, the care staff had gone to R3's room to assist him with changing as R3 was incontinent of bowel and was all over R3's cloths. R3 agreed and when the care staff squatted in front of R3 to pull their pants down and cleaned them up, R3 began to punch the care staff in their back, sides, and face.
- On 08/04/2025 at 9:50 AM, R3's primary care physician (PCP) faxed about R3's episodes of punching, slapping, and grabbing care staff. PCP replied "are there provoking incidents for these episodes? Can [R3] be distracted, or other techniques to help get them to resolve? Is [R3] refusing care that leads to these issues? Are you successful with diffusing [R3]'s anger issues? We would like to not have to medicate for these issues we can find other behavior approaches." There was no follow up fax replying to the PCP's questions or a follow up progress note to address these questions the PCP asked.
- On 08/05/2025 at 12:46 PM - R3 was agitated during resident care. At 10:17 PM care staff attempted to change R3 throughout the swing shift by each caregiver three times. Each caregiver stated R3 hit or kicked them while attempting to change them. R3 peed on the ground and then laid down on their couch. The medications technician got permission to take R3's boots off, when R3 started to kick the medication technician despite the medication technician explaining that R3's pants were wet. R3 continued to swat at the medication technician and continued to be agitated. The executive director and assisted living director came in to assist R3 with changing and were unable to get R3 changed and cleaned up.
- On 08/06/2025 at 11:26 AM, the medication technician and the caregiver attempted to change R3 when R3 got agitated, kicked and hit the medication technician and pushed the caregiver into the wall. At 12:54 PM R3 continued to be agitated towards staff, other residents and wandered the memory care hallways and tried to go into other resident apartments. At 9:48 PM R3 went into another resident's room and had a bowel movement in the trash can and continued to wander into other resident's rooms.
- On 08/07/2025 at 9:05 PM the medication technician and the caregiver went in to change R3 when R3 grabbed the medication technician's arm, squeezed and pulled them towards themselves and kicked them.
- On 08/08/2025 at 5:56 PM, R3 walked up to a female resident that was sitting at the dining table eating and yelled at them and took the female residents drink that startled the female resident.
- On 08/09/2025 at 3:40 AM, R3 entered R4's room and attempted to undress

himself. R4 yelled for help and pulled the chord in the hallway. R3 was redirected out of R4's room to their room, but then R3 left their room and entered R5's room letting the cat out and removed the top of the toilet tank that R3 swung at the medication technician. R3 became increasingly more agitated when the medication technician removed the top of the toilet tank from them.

- On 08/15/2025 at 10:15 PM, R3 stated, "your going to regret this", when the care staff and medication technician came in to assist R3 with getting changed. The care staff had to hold R3's arms with an open hand to ensure R3 did not hit the care staff but then R3 rolled and punched the medication technician in the chest twice and grabbed their fingers and attempted to dig their nails into the medication technician and care staff's arms.
- On 08/16/2025 at 12:15 AM, R3 went into R6's room. At 1:39 AM, R3 entered R6's room. R6 left their room to find staff. R6 told staff that R3 "scared me half to death and won't leave". R6 was visibly shaken up.
- On 08/09/2025 R3's PCP was faxed to request sleep aid per family's request. The facility received new orders for melatonin nightly for sleep.
- On 08/14/2025 at 6:37 PM, a care staff brought dinner into R3's room and encouraged R3 to eat when R3 got agitated and attempted to hit the care staff.
- On 08/20/2025 at 1:34 AM, R3's PCP sent back a fax to offer protein shakes up to three times daily when R3 was not eating.
- On 08/30/2025 at 10:15 PM, R2 had lost their balance while walking when R3 fell into R3 and had grabbed the back of R3's neck to prevent from falling to the ground. R3 became agitated and grabbed R2's arms. R3's PCP was notified about the incident and had replied back to "let them know if there are continued concerns and behaviors we can help address". The note R3's PCP sent to the facility was reviewed by Staff B, Health and Wellness Direction had reviewed on 09/05/2025.
- On 09/02/2025 at 5:30 PM, R2 was sitting on a green chair on the south side of the memory care unit doing their own thing by the television. R3 went over to R3 and provoked them. R3 tried to stand up to walk away, when R3 pushed R2 down to the ground and then stomped on R2's feet. R3 told the caregiver that something happened a couple days ago, and they needed to finish it. Staff were to keep R3 on the opposite side that R2 was residing.
- On 09/08/2025 at 10:00 PM, R3 entered R1's room when the care staff member was inside. Both the care staff and R1 asked R3 to leave the room. R1 became angry and began yelling at R3 and then grabbed R3 that caused R1 to yell louder. R3 and R1 ended up on the bed where they both continued to tussle and fell to the floor. Staff were implemented to keep R3 away from R1's room.
- On 09/10/2025, 09/11/2025, and 09/12/2025, showed R3 continued to go into other residents' apartments an continued to hit and kick at staff during personal care.
- On 09/19/2025 before dinner, care staff were called to R2's room where they found R3 sitting on R2's couch inside R2's room. R2 became agitated that caused R2 to launch over R3's lap. R2 continued to pull R3 off their couch, when R3 bit R2 on their left hand two times that cause R2 to panic and move their arms up and down. Staff continued to try and get R3 out of R2's room when R3 hit R2 in the face under the left eye leaving some puffiness and redness.
- On 09/19/2025 at 5:31 PM, Staff C, Registered Nurse, contacted the R3 PCP about R3's continued agitation and concern for staff members.
- On 09/21/2025 and 09/23/2025 continued to have some agitation and aggressiveness towards staff.
- On 10/04/2025 at 2:01 PM, The housekeeper heard a scuffle and noted that R3 entered R1's room and R3 was hitting R1 in the head with their hands and bit R1's

hand. R3 had a small abrasion on their neck and continued to be combative and agitated when care staff were checking R3 for any other injuries.

Record review of R3's Service Plan, dated [redacted]/2025, showed on 09/02/2025 it was added that resident was in an altercation with another resident and R3 was to remain separated at all meals, activity times, and redirected to opposite side of the unit. On 09/08/2025 it was added that R3 was in a resident-to-resident altercation when they entered another resident's room and became physical. R3 would "be kept separate and redirected away from said room".
Review of R3's Temporary Service Plan, dated 09/19/2025, showed R3 had entered R1's room and got violent why R3 hit R2 in the face and bit their hand. Staff were to ensure both residents were on separate sides.

During an interview on 10/09/2025 at 9:15 AM, Collateral Contact 1 (CC1), stated that when the facility was asked what they were doing to help protect all the memory care residents from R3's aggressive behaviors and entering their rooms. CC1 stated that management informed them that when a resident moves into the memory care facility, they sign a contract understanding that there was a possibility of resident-to-resident altercations and felt like the facility management was not taking the seriousness of R3's aggressive behaviors towards staff and other residents. CC1 stated that R1 was terrorized from the two altercations with R3 and the injuries that R1 sustained from R3.

During an interview on 10/09/2025 at 11:43 AM, Staff D, Caregiver, stated that all staff that worked would have to go in to help R3 get changed when they were incontinent as R3 would hit and be aggressive. Staff D stated that all of the other memory care residents are cautious when R3 was around in the common areas. Staff D stated that R3 wanders the hallways, goes into other rooms, was difficult to get R3 out of the rooms and needs constant redirection to keep R3 out of other resident's rooms. Staff D stated that they did not feel comfortable taking care of R3 as he is so aggressive and had been like this since R3 had admitted to the facility.

During an interview on 10/09/2025 at 11:49 AM, R2 stated that when they tried to step back R3 held them down and hurt them. R2 stated that another time R3 just came inside and hurt me and with a raised voice stated "no" when they were asked if they felt safe living at the facility.

During an interview on 10/09/2025 at 11:55 AM, Staff E, Medication Technician, stated that R3 wandered through the evening and night and required a lot of redirection to keep them from going into other resident's rooms. Staff E stated that R1 was fearful and did not come out of their room for meals after R3 hit R1 in their room on 10/04/2025 and R1 completely avoided being around R3.

During an interview on 10/09/2025 at 12:21 PM, R1 stated that they avoided and did whatever they could to not be around R3. R1 stated that, multiple times, R3 was wild and dangerous to be around. R1 stated that when R3 came into their room on 10/04/2025, they tried to get R3 out of their room, when R3 just started to swing both

their hands closed fists continuously and there was no way to get out of not being hit. R1 stated that they have had nightmares since that night as R3 always entered other residents' rooms late at night. R1 stated that their son talked with Staff A, Executive Director, about the physical altercation, before they were moved upstairs to the assisted living side of the facility. R1 stated that that they know R3 would never be able to enter their new room or even find it.

During an interview on 10/09/2025 at 2:40 PM, Staff F, Caregiver, stated that R3 had aggressive behaviors since they moved into the facility. The aggressive behaviors were directed at staff and residents, which required R3 to be constantly redirected. Staff F stated that R3 was violent every time they needed to do personal care, and the care would require multiple staff and management at times to assist. Staff F stated that it had only been in the last week that an employee must stay on the side of the facility to watch R3 when they were out of their room.

During an interview on 10/09/2025 at 2:56 PM, Staff G, Caregiver, stated that they were afraid to take care of R3 as R3 was aggressive during personal care and not easy to take care of.

During an interview on 10/09/2025 at 2:56 PM, Staff G stated that R2 gets agitated when R3 comes around them in the common areas. R3 continuously goes into other residents' apartments and was aggressive and had done so since they moved into the facility.

During an interview on 10/09/2025 at 2:56 PM, Staff G stated that after the physical altercation with R1 and R3, R1 did not come out for meals for two or three days after the incident.

During an interview on 10/15/2025 at 1:53 PM, Collateral Contact 2 (CC2), stated that R2, after the altercation with R3 on 09/19/2025, would stiffen up and tell them that they needed to go, or have to leave when R3 would come in the area and R2 would just watch R3 until they were no longer in the area. CC2 stated that R3 took a chunk of flesh out of R2's hand when R3 bit them. CC2 stated that R2 would pull their hand away and tell them to be careful of that hand and that R2's physician prescribed antibiotics to help prevent infection since the wound was from a bite. CC2 stated that R2 had a black eye for over a week from R3 hitting R2's face. CC2 stated that the bite that R2 endured from R3 was too far and intrusive. CC2 stated that they observed R3 go in and out of other resident's apartments often and would be aggressive with the staff when they tried to redirect and it was not always easy for the staff to redirect. CC2 stated that since the altercation, R3 continued to go in and out of other resident's apartments.

During an interview on 10/23/2025 at 1:18 PM, Staff C, Registered Nurse, stated that R3 was aware at times what they were doing when they physical assaulted R1 and R2 as R3 would make comments, "I have to finish what I started" multiple times. Staff C stated that staff were afraid and at times refused to take care of R3 as they would get

kicked, slapped and punched when trying to assist R3 with personal care. Staff C stated that R3 was unpredictable with their behaviors and was a danger to the other residents and staff.

This is a recurring deficiency previously cited on 09/21/2023 and 05/31/2023.

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) 12/19/25 .

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

Administrator (or Representative) — Date: 11/19/25

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

(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 ensure appropriate care and services were implemented for 2 of 4 sampled residents (Resident 7 [R7] and Resident 9 [R9]) when they experienced a change of condition. This failure resulted in a delay in treatment, and a decreased quality of life which contributed to Resident 7 experiencing pain and discomfort. This failure contributed to R9 sustaining multiple falls with injuries which resulted in a decline of their health and a decreased quality of life.

Findings included...

Record review of the facility's policy titled, "Occurrence Reporting Policy", dated 05/21/2025, showed the facility expected that all resident occurrences be reported as applicable and appropriate resident specific measures put in place to reduce the risk of re-occurrence and/or serious injury. The facility reserved the right to access 911 services on behalf of the resident to expedite further evaluation by an appropriate licensed health care professional should the facility determine if the resident experienced a serious injury. The facility does not require permission from the resident or the legal representative to call 911 on behalf of the resident if such services are deemed necessary to the health and wellbeing of the resident. For immediate health risk, staff were expected to call 911 and examples may include complaints of severe pain after significant injury from a fall. When a significant change of condition occurs with a resident, the facility would evaluate the resident, and it may include use and coordination with 911 services and/or resident's primary care physician.

Resident 7 (R7)
Record review of R7's Resident Service Plan, dated 03/27/2025, documented R7 had a history of bone fracture (broken bone), muscle weakness, and dementia (progressive brain disorders that affect a person's memory, judgement, and ability to carry out activities of daily living needs). R7 was very active, enjoyed socializing, independently walked with two wheeled walker outside and throughout the locked unit. R7 dressed themselves with standby assistance from staff, and often independently toileted themselves, frequently forgetting to put a new brief on which required staff assistance. R7 did not require any medications for pain or expressed any pain issues that were managed by medication or non-pharmacological interventions. R7 was independent with their transfers, waking and sleeping schedules.

Record review of R7's charting notes showed:

- On 10/12/2025 at 9:45 PM, R7 had an unwitnessed fall with injury to their left hip.
- On 10/13/2025 at 2:50 PM, R7 was in bed all day after their fall. R7 winced when they were touched or changed. R7 complained of pain to their hip and did not want to get up for the day. At 9:20 PM, the note showed R7's power of attorney (POA) was called and a message left about R7 may need to go to the doctor and get checked out.
- On 10/14/2025 at 1:23 AM, the document showed R7 was in bed all day and struggled with range of motion exercises of their hand and staff would notify next shift to get the power of attorney to take R7 to urgent care. At 11:51 AM, notes showed R7 slept during most of the shift. At 5:14 PM, staff called R7's POA to inform them of R7's pain to their left hip during personal care with recommendation to take R7 to urgent care. Notes showed POA declined to take R7 to urgent care as they were attending a birthday party for their friend from out of town. POA requested the medication technician take R7 to urgent care and tech informed the POA that this was unable to be done. There was no documentation that showed the facility offered R7 to be sent to the emergency department for further evaluation. At 9:48 PM, R7 remained in bed all evening, did not eat much, and was in a lot of pain to their left hip that appeared swollen.
- On 10/15/2025 at 3:38 AM, R7 continued to have bruising to wrist with discoloration and unsure if R7 had feeling in the wrist. The notes showed that R7's power of attorney was advised to take action as soon as possible as R7 struggled with

range of motion and unable to make a closed fist. R7 continued to experience a lot of pain from the hip when the medication technician tried to do range of motion exercises. At 11:14 AM, R7 expressed severe pain in their left hip. At 11:00 AM, Staff C, Registered Nurse, was notified of R7's pain and advised staff to send the resident out to the hospital.

Record review of R7's Charting Notes, dated 10/12/2025 through 10/14/2025, showed there was no documentation that R7 was evaluated by the facility's nurse for a change of condition.

During an interview on 10/23/2025 at 1:18 PM, Staff C stated that they were taught that if the resident's representative or POA refused to have the resident sent out to the emergency department, then staff needed to follow what the representative wanted. Staff C stated that they were notified on 10/13/2025 that R7 fell the day prior. On 10/14/2025, R7 showed signs of increased pain. Staff C stated that when they talked with R7, R7 was their normal self. Staff C stated that 10/15/2025 was the first time the facility offered to send R7 to the emergency department for their increased hip pain after the fall on 10/12/2025. Staff C stated that R7's power attorney refused multiple times to take R7 to the urgent care facility.

Resident 9 (R9)
Record review of R9's Resident Service Plan, dated 10/08/2025, showed R9 had multiple medical diagnosis that included [redacted] and history of hip fracture (broken bone in the hip) in June 2025. The plan showed R9 liked to be social in activities and there were no activities that caused R9 any type of distress or overstimulation. R9 was confused most of the time and did not require constant reassurance or orientation due to their confusion, cognition or safety. R9 had a history of going into other residents' rooms and ambulated around the facility without purpose. R9 was unable to use the call system and staff were expected to do frequent checks when R9 was in their room. R9 was able to communicate their needs and wants with care staff and required one person assistance to use a gait belt (a strap that fits around a person's waist to assist with walking, standing or transfers), a transfer pole (medical device to assist a person to stand or sit), and a slide board (medical device used to move safely between surfaces). The plan showed R9 usually ambulated independently. On days when R9 felt weak and unable to independently ambulate, staff were to assist R9 with transfers and use their wheelchair to escort them to meals and activities. Staff were expected to report changes to memory care director, registered nurse, health and wellness director. The plan showed R9 was considered a fall risk and had several falls since moving into the community. Staff were expected to perform frequent safety checks and ensure R9 wore nonslip socks and/or shoes when R9 was out of their bed. Staff were expected to report any changes to assisted living director, registered nurse, or the health and wellness director. The plan showed R9 liked to go to bed around 8:30 PM.

Record review of the facility's Occurrence Tracking Log, dated August 2025, September 2025, and October 2025, showed R9 sustained multiple falls: 08/06/2025 at 6:44 AM and at 8:10 PM; 08/25/2025 at 2:00 PM and at 3:30 PM; 09/05/2025 at 10:45 PM; 09/13/2025 at 12:30 AM; 10/06/2025 at 3:45 PM; 10/16/2025 at 9:20 PM; 10/18/2025 at

6:15 PM; 10/20/2025 at 6:05 PM; 10/24/2025 at 6:22 PM; and one on 10/26/2025.

Review of R9's Charting Notes showed:

- On 09/06/2025 at 7:24 AM, R9 was in the common area at 10:45 PM, when R9 stood up from their wheelchair when the wheelchair moved out from under them causing R9 to fall to the ground.
- On 09/13/2025 at 12:58 AM, R9 was found lying on the floor in their room.
- On 10/06/2025 at 9:18 PM, R9 had taken their shoes off, then observed to stand up from their wheelchair independently lost their balance and fell on the floor on their back and had hit their head. There was redness to their lower back rear areas.
- On 10/21/2025 at 2:00 PM, R9 was observed to fall backwards hitting their back on the door frame and head on a chair. R9 was fully clothed and was walking around when they lost their balance. R9's wheelchair was in dining room at the table.

Record review of R9's Charting Note, dated 10/16/2025 at 10:15 PM, documented R9 was found inside their room, lying on their right side, in front of their bedroom door, fully dressed, with their shoes on.

Record review of R9's Resident Occurrent Report, dated 10/16/2025 at 9:20 PM, documented R9 had a non-witnessed fall in their apartment room. "NA" (not applicable) was documented in the resident statement section of the occurrence report and that R9 was confused most of the time.

Review of R9's Resident Occurrence Investigation Worksheet, dated 10/16/2025, documented the findings were completed on 10/17/2025. It was documented on the worksheet that staff completed R9's last safety check at 8:30 PM with no further details observed at that time. The document showed that R9 was messing around in their room, fell, and took off their shoes due to the shoes being uncomfortable. There was no documentation that this occurrence was witnessed and R9 was unable to provide a statement of what happened. The investigation documented that R9 was alone in their apartment at the time of the occurrence and had increased confusion.

Record review of R9's Resident Temporary Service Plan, dated 10/16/2025, showed the interventions and additional services provided included: ensuring R9 was fully clothed with socks and shoes. Staff were to encourage R9 to pull call light, use their wheelchair, and "suggest family to purchase new shoes that do not hurt the resident's feet". Per the service plan, R9 was in bed at 8:30 PM and independently got up out of bed.

Record review of R9's Charting Note, dated 10/18/2025 at 8:41 PM, documented R9 sat on the couch on the south side common area. R9 was fully dressed, with shoes, got up from the couch and began walking when they tripped over their feet and lost their balance, hitting the right side of their face and landed on their bottom.

Record review of R9's Resident Occurrence Report, dated 10/18/2025 at 6:15 PM, documented R9 sat on the couch on the south side common area. R9 was fully dressed, with shoes, got up from the couch and began walking when they tripped over their feet and lost their balance, hitting the right side of their face and landed on their bottom. There was "NA" documented for the resident's statement of the occurrence and R9 was confused most of the time.

Record review of R9's Resident Occurrence Investigation worksheet, dated 10/18/2025, was completed on 10/19/2025. The worksheet documented R9 was in an activity. R9 was being watched by the caregivers and caregivers unable to get to R9 fast enough to prevent the fall. R9 was impulsive and unable to understand their personal safety awareness. R9 continued to take falls and with the history of the hip fracture, R9 was not strong when standing. The worksheet documented that all of R9's interventions on the service agreement were followed.

Record review of R9's Resident Temporary Service Plan, dated 10/18/2025, showed interventions and additional services provided included: R9 placed on alert charting for 72 hours; staff were to ensure R9 wore socks and shoes, used their wheelchair, and asked for assistance. Staff were to ensure that R9 was closer to staff during activities and meals, that R9 put their shoes back on if they removed them in the common areas, and to continue to ensure R9 used their wheelchair, dependent on the strength in their legs.R9 was fully dressed, and staff were in the area with R9. Staff were unable to get to R9 fast enough.

Record review of R9's Charting note, dated 10/24/2025 at 10:02 PM, documented that a caregiver went into apartment 108 when the door would not open. Upon opening a little, R9 was observed to be fully dressed, with socks and shoes, sitting on their buttocks in front of the door on the ground in the apartment.

Record review of R9's Resident Occurrence Report, dated 10/24/2025 at 6:22 PM, documented R9 had a unwitnessed fall in apartment 108. R9 was confused most of the time and there was "NA" documented for the resident's statement of occurrence.

Record review of R9's Resident Occurrence Investigation Worksheet, dated 10/24/2025, showed that R9 was in the commons/activities area. The worksheet notes showed that during dinner time, R9 independently wandered into another resident's apartment room and fell. The notes showed R9 had increased weakness in their legs and hip due to a previous break and R9 was impulsive with independently getting up and attempting to walk around.

Record review of R9's Resident Temporary Service Plan, dated 10/24/2025, showed interventions and additional services provided included: encouraging R9 to ask for assistance, use their wheelchair, placed R9 on alert charting for 72 hours, ensure R9's socks and shoes were on at all times when walking, and staff to ensure R9 remained seated for duration of meal and then escorted to activity or toilet. R9 was fully dressed and was in the dining room with staff present for dinner when R9 got up and walked away.

On 10/31/2025, record review of the Department's Secure Tracking and Reporting System (STARS) database showed R9 was sent to the hospital after multiple unwitnessed falls. The database showed the hospital diagnosed R9 with [redacted] and [redacted]. Records showed R9's overall change of condition impacted their care and R9 was transitioned to comfort care services.

During an interview on 10/29/2025 at 1:59 PM, Staff D, Caregiver, stated that R9 used a wheelchair to get around. Staff D stated that R9 did not like to be in the wheelchair and fell frequently when they attempted to get out of the wheelchair. Staff D stated that staff were to provide close observation and frequent checks of R9.

During an interview on 10/29/2025 at 2:08 PM, Staff E, Medication Technician, stated that more than three months prior, R9 had a fall and sustained a femur fracture (a broken bone of the upper thigh area). Staff E stated that R9 used a wheelchair as R9 was very unsteady and would fall when they tried to walk independently. R9 was known to get restless and then tried to transfer and walk on their own.

During an interview on 10/29/2025 at 2:56 PM, Staff I, Assistant Executive Director, stated that Staff B, Health and Wellness Director, reviewed the residents' incidents and if Staff B was not available then Staff A, Executive Director, or Staff J, Assisted Living Director, would then review the incidents. Staff I stated that whoever reviewed the incident report was to ensure to initiate a new intervention that would be put on a temporary service plan and then added to the resident's service plan.

During an interview on 10/30/2025 at 6:00 PM, Collateral Contact 4 (CC4), stated that R9 would not return to their prior level of function related to R9's injuries and health. CC4 stated that the hospital physician said R9's multiple rib fractures were alleged to be related to R9's multiple unwitnessed falls that occurred while residing at the facility. R9 would benefit from end-of-life care and comfort care.

On 10/31/2025 at 12:35 PM, Staff C, Registered Nurse, stated that R9 was in a wheelchair most of the time and when staff were not around, R9 would try to stand up and would fall. Staff I stated that they were not involved with the resident's service plan or implementing interventions after resident incidents and accidents occurred. Staff C stated that they were involved only if the residents had skin impairment that needed to be addressed by them.

This is a recurring deficiency previously cited on 07/09/2025 and 03/27/2023.

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) 12/19/25 .

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

Administrator (or Representative) — Date: 11/19/25

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to report to law enforcement when residents were involved in a physical altercations for 3 of 4 incidents (Incident 1, Incident 2 and Incident 3). This failure resulted in the facility failing to notify law enforcement regarding physical altercations between Resident 3 and Resident 1, and Resident 3 and Resident 2 on multiple occasions as required by regulations.

Findings included...

Washington Administrative Code 388-78A-2020 Definitions: (2) "Physical abuse" means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, or prodding.

Record review of the facility's policy titled, "Occurrence Reporting Policy", dated 05/21/2025, documented that all resident occurrences would be reported as applicable and notification to law enforcement would be made in accordance with the State's specific guidelines.

Record review of the facility's policy titled, "Abuse, Neglect, or Exploitation", dated 02/15/2021, documented verbal, physical, or mental abuse, whether toward residents or staff, would not be tolerated. Any staff member that has reason to suspect an incident of physical assault was to report to local law enforcement emergency services number as soon as the resident was protected from further harm. All staff were mandatory reporters and the responsibility to report abuse as per RCW 70.129 and WAC 388-78a-2630.

Incident 1
Record review of Resident 3's (R3) Resident Occurrence Report, dated 09/02/2025, documented R3 pushed Resident 2 (R2) to the ground when R2 attempted to stand up and get away. While R2 was on the ground, R3 stomped on R2's feet. There was no documentation that law enforcement was notified.

Record review of R2's Resident Occurrence Report, dated 09/02/2025, documented R2 tried to stand up from the green chair and get away, when R3 pushed R2 to the floor and then stomped on their feet. There was no documentation that law enforcement was notified.

Incident 2

Record review of the Departments database documented on 09/19/2025 at 4:00 PM, R2 and R3 were found in R2's room punching each other and was the second altercation reported for the residents. R2 had a black eye and a bite wound on their hand. The residents primary care physician, power of attorneys for both residents, the facility executive director, and the Department were notified. There was no documentation that law enforcement was notified of the physical altercation.

Record review of R2's Resident Occurrence Report, dated 09/19/2025, documented R2 was bit on the hand twice and hit with the back of R3's hand that left a bruise under R2's right eye. There was no documentation that law enforcement was notified.

Record review of R2s charting note, dated 09/20/2025, documented before dinner on 09/19/2025, the medication technician was called to R2's room and upon entering R2's room, R3 was sitting on R2's couch. R2 tried to pull R3 off the couch, when R3 bit R2's left had twice and hit R2 in the face under their left eye. R2 panicked and moved their arms up and down while staff were trying to assist. The facility management, nurse, and residents power of attorneys' were notified. There was no documentation that law enforcement was notified.

Incident 3
Record review of R1's Resident Occurrence Report, dated 10/04/2025, documented R3 hit and bite R1. R1 had a medium sized lump on their head, bruise under their eye, and a bite mark on their hand. There was no documentation that law enforcement was notified.

Record review of R3's Resident Occurrence Report, dated 10/04/2025, documented R3 was observed hitting R1 on the head with their hand and bit R1's hand. R3 had a small abrasion on the back of their neck. There was no documentation that law enforcement was notified.

Record review of R1 and R3's charting notes, dated 10/04/2025, documented there was no documentation that law enforcement was notified.

In an observation on 10/09/2025 at 12:21 PM, R1 was sitting in his room talking about the incident and it was observed that their right eye continued to have significant deep purple bruising around the entire right eye and down their cheek.

On 10/23/2025 at 1:11 PM, Staff H, Medication Technician, stated they do not call law enforcement for resident-to-resident altercations when an injury occurred or when a physical assault has occurred. Staff H stated the residents family members could call law enforcement and that they had never been told to notify law enforcement or thought that it was a standard of practice to call law enforcement. Staff H stated that when R3 bit, punched, pushed, and yelled at the residents that these were examples of physical assault/abuse.

On 10/23/2025 at 1:18 PM, Staff C, Registered Nurse, stated the incidents with R1 and R2 when R3 bit and hit the residents and left bite marks and bruising to their faces and heads was physical abuse.

In an interview on 10/23/2025 at 3:45 PM, Staff B, Health and Wellness Director, stated they knew when assisted living residents got into a physical altercation they were to notify law enforcement, but it was different for memory care due to their cognitive deficit and did not call law enforcement. Staff A stated in all the years they had worked in assisted living they were not aware that they were to call law enforcement with memory care resident-to-resident altercation with physical abuse and significant injury occurred.

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) 12/19/25 .

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

Administrator (or Representative) 11/19/25 Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

(iii) When the resident has an injury requiring the intervention of a practitioner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete on going assessments focused on residents identified problems, a change of condition, and when

they had an injury requiring practitioner intervention for 1 of 3 sampled residents (Resident 3 [R3]). This failure placed R3 at risk for unmet care needs.

Findings included...

Record review of the facility's Health Services Manual, dated 04/02/2025, documented, that when a change of condition was noted, the facility would maintain an effective system of communicating changes and the registered or licensed nurse would complete assessment and oversight. The community would use the following as a general reference regarding changes of condition that include a significant change of condition meaning a major deviation from the most recent evaluation that may affect multiple areas of functioning or health that is not expected to be short term and imposes significant risk to the residents. The nurse would complete a full or focused assessment applicable to the noted changes and document in the resident's chart.

Record review of R3's Pre-Move in Evaluation, dated 06/12/2025, documented R3 had multiple medical diagnoses that included [redacted] and was only oriented to self. R3 recently had a hospitalization when they became belligerent. Noise was an environmental factor that impacted the resident's behavior patterns and did not sleep in the dark. R3 required staff support or intervention related to their cognitive, mental health, or behavior status, but there were no interventions listed that staff were to implement. R3 was incontinent but did not say if it was for bowel, bladder, or both and that R3 would require help related to being in memory care. R3 did not have any behaviors or history of harming others. R3 had a history of not eating and drinking, but weight loss has been stable for the last six months.

Record review of R3's Resident Service Plan, dated [redacted]2025, showed R3 had dementia (a progressive brain disorder that affects a person's judgement, memory, and ability to carry out activities of daily living needs). Anything with loud noises would stimulate R3 with change in behavior and prefer to walk independently. R3 was not at risk for elopement, did not become easily angered that required intervention to prevent harm to others, was not resistive to care and did not require constant reassurance or orientation related to their cognition or safety concerns. R3 was known to walk without a purpose and go into other resident apartments frequently and staff were to redirect R3 that they were at a five staff hotel while their daughter was on vacation. R3 did not have any support needed regarding his nutrition needs and staff were to report change of condition changes to memory care director or the registered nurse. R3 showered themselves with assistance with dressing and cueing to use soap and shampoo during the shower and was easy going when it came to choosing an outfit for the day. R3 only required cueing for personal hygiene and was able to perform themself and could be incontinence overnight, but toilets themselves during the day.

Record review of R3's progress notes showed...

- On [redacted]/2025 at 12:05 PM, R3 moved into the facility.
- On 06/25/2025 at 12:25 PM, R3 had been increasingly agitated and refusing staff to help with personal care. At 12:53 PM, R3 refused their shower times by three different staff members.
- On 06/30/2025 at 7:17 AM and 07/01/2025 at 4:07 AM, R3 was confused and kept going into other neighbor resident's room. R3 refused to cooperate with staff and get out of the room.
- On 07/02/2025 at 9:39 PM, R3 was agitated and resistive to care. A caregiver went to assist R3 with personal care when R3 grabbed the caregiver by the arm pulling the caregiver on top of R3 and then grabbed the caregiver's fingers bent them backwards causing the caregiver pain.
- On 07/09/2025 at 9:02 PM, family requested that R3 get a sleep aid order from their primary care provider and let them know that R3 was increasingly urinating. At 9:04 PM, R3 refused personal care and had been agitated. R3 threatened the caregiver when they tried to help R3 change and get cleaned up.
- On 07/17/2025 at 11:12 PM, R3 was very agitated and aggressive that day. Care staff approached R3 to assist him with changing as R3 had been incontinent of bowel. R3 threatened to staff the caregiver with a fork.
- On 07/20/2025 at 3:56 AM, R3 was very agitated and had entered a female resident's room. The medication technician tried to redirect R3 out of the room, when R3 grabbed the medication technician's arm very hard and refused to let go. Care staff assisted R3 to let go of the medication technician's wrist and then with a balled up fist, R3 swung at the medication technician's face.
- On 07/22/2025 at 10:19 AM, R3's primary care provided faxed back that they acknowledged that R3 was refusing their medications, and that they had not heard that it was happening routinely.
- On 07/23/2025 at 12:23 AM, R3 was seen by the dentist with new orders for staff to supervise R3 during brushing their teeth to ensure R3's brushes for two to three minutes with prescription toothpaste.
- On 07/26/2025 at 8:59 PM, R3 had been in two physical altercations with two different caregivers. The first incident included when R3 was assisted to sit down on the toilet. The caregiver was lifting up R3 shirt to help them change it, when R3 wrapped the female caregiver up into their shirt and pulled the caregivers them backwards that resulted in the caregiver going to the hospital to get checked out. The second incident included with the wife was present, the caregiver encouraged the resident to take his pants off to get changed when R3 swung and hit the caregiver.
- On 08/05/2025 at 12:46 PM, R3 was agitated during resident care. At 10:17 PM care staff attempted to change R3 throughout the swing shift by each caregiver three times. Each caregiver stated R3 hit or kicked them while attempting to change them. R3 peed on the ground and then laid down on their couch. The medications technician got permission to take R3's boots off, when R3 started to kick the medication technician despite the medication technician explaining that R3's pants were wet. R3 continued to swat at the medication technician and continued to be agitated. The executive director and assisted living director came in to assist R3 with changing and were unable to get R3 changed and cleaned up.
- On 08/06/2025 at 11:26 AM, the medication technician and the caregiver attempted to change R3 when R3 got agitated, kick and hit the medication technician and pushed the caregiver into the wall. At 12:54 PM R3 continued to be agitated towards staff, other residents and wandered the memory care hallways and tried to go into other resident apartments. At 9:48 PM R3 went into another residents room and

had a bowel movement in the trash can, continued to wander into other residents rooms and was agitated when they were redirected.

- On 08/09/2025 R3's PCP was faxed to request sleep aid per family's request. The facility received new orders for melatonin nightly for sleep.
- On 08/14/2025 at 6:37 PM, a care staff brought dinner into R3's room and encouraged R3 to eat when R3 got agitated and attempted to hit the care staff.
- On 08/20/2025 at 1:34 AM, R3's PCP sent back a fax to offer protein shakes up to three times daily when R3 was not eating.

Record review of R3's Medication Administration Record, dated 08/01/2025 and through 09/30/2025, showed R3 was refusing their medications on multiple occasions.

On 10/09/2025 at 3:09 PM, Staff A, Executive Director, stated the facility was unaware of R3's behaviors. Staff A stated as R3 resided at the facility, they learned that high pitch voices set R3 off and if any staff or resident used a raised voice towards R3 they would experience some fear and anxiety.

In an interview on 10/15/2025 at 4:23 PM, Collateral Contact 3 (CC3), stated R3 was resistive to showers and personal care when they tried to help them and that R3 would grab their arm. R3 would get up most nights and wander throughout the house and go into another room of the house to sleep and that R3 was doing this more since they moved into the facility. CC3 stated when R3 was hospitalized they were belligerent with the staff, refused care and to work with them, and one time pushed a nurse and became aggressive in the emergency department.

On 10/14/2025 at 2:42 PM, all R3's assessments were requested for review. At 4:32 PM, there were no assessments provided that were completed for R3 from [redacted]/2025 through 09/02/2025 with their change in behavior and condition for review.

On 10/23/2025 at 1:18 PM, Staff C, Registered Nurse, stated R3 should have had a change of condition completed earlier than 09/03/2025 as R3 had a change in behavior, ability to perform activities daily living needs, inability to sleep at night, and multiple altercations. Staff C that facility had the regional registered nurse oversighting the facility until they started at the facility on 08/15/2025.

On 10/23/2025 at 3:45 PM, Staff A, Executive Director, acknowledged that a change of condition assessment should have been completed for R3, but the facility did not have a nurse at the time when the changes were identified other than the facility's corporation registered nurse.

Statement of Deficiencies	License #: 2036	Compliance Determination # 66953
Plan of Correction	Bonaventure of Lacey	Completion Date
Page 20 of 20	Licensee: Bonaventure of Lacey LLC	11/04/2025

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) 12/19/25 .

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

Administrator (or Representative) 11/19/25 Date