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 Salmon Creek LLC
Bonaventure of Salmon Creek
3425 Boone Rd SE
Salem, OR 97317

RE: Bonaventure of Salmon Creek License # 2321

Dear Administrator:

This letter addresses Compliance Determination(s) 32642 (Completion Date 11/21/2023) and 29139 (Completion Date 09/27/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/21/2023 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, WAC 388-78A-2120-3, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-4

The Department staff who did the on-site verification:
Yvonne Chitekwe

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

Sincerely,

Michael Burdick, Field Manager
Region 3, Unit I
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Bonaventure of Salmon Creek
License/Cert.#: 2321
Compliance Determination #: 29139
Investigator: Yvonne Chitekwe
Provider Type: Assisted Living Facility
Intake ID: 96152
Region/Unit #: RCS Region 3 / Unit I
Investigation Date(s): 09/05/2023 through 09/27/2023
Complainant Contact Date(s): 09/06/2023, 09/28/2023, 09/29/2023

Allegation(s):

1. Quality of Care/Treatment: Allegation that residents medical needs were not monitored and not documented.

2. Nursing services: Allegation that the resident's well being was not monitored and not documented.

3.Physical Environment: Allegation that resident's living space is unsafe.

4. Quality of Life: Allegation that resident's medical and physical needs were not monitored and not documented.

Investigation Methods:

Sample:	Total residents: 76 Resident sample size: 3 Closed records sample size: 1
Observations:	Identified resident Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Residents Family members
Record Reviews:	Medical records Hospital records Incident investigation Facility policies Personnel files

Investigation Summary:

1. Quality of Care/Treatment: The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews, observations and records review, resident well-being was not monitored and was not documented, facility failed practice was substantiated during the investigation.

2. Nursing services: The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews, observations and records review, resident well-being was not monitored and was not documented, facility failed practice was substantiated during the investigation.

3.Physical Environment: The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews, observations and records review, no failed facility practice was substantiated during the investigation. Additional residents reviewed for care, safety and services with no concerns.

4. Quality of Life: The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews, observations and records review, resident well-being was not monitored and was not documented, facility failed practice was substantiated during the investigation.

Conclusion / Action:

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

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Statement of Deficiencies	License #: 2321	Compliance Determination # 29139
Plan of Correction	Bonaventure of Salmon Creek	Completion Date
Page 1 of 3	Licensee: Bonaventure of Salmon Creek LLC	09/27/2023

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 09/05/2023 and 09/08/2023 of:

Bonaventure of Salmon Creek
13700 NE Salmon Creek Ave
Vancouver, WA 98686

This document references the following complaint number(s): 96152

The following sample was selected for review during the unannounced on-site visit: 3 of 76 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Yvonne Chitekwe

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit I
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.

Residential Care Services

10/05/2023
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.

Statement of Deficiencies	License #: 2321	Compliance Determination # 29139
Plan of Correction	Bonaventure of Salmon Creek	Completion Date
Page 2 of 3	Licensee: Bonaventure of Salmon Creek LLC	09/27/2023

Administrator (or Representative) 10/17/23 Date

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

(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 evaluate and take appropriate action for one of three sampled residents (Resident 1 [R1]) reviewed for changes in the resident's physical condition and increased confusion. These failures resulted in a delay in evaluation that was ordered by their Primary Care Physician (PCP) which contributed to increased falls, hospitalization, and worsening of their urinary tract infection.

Findings included...

Record review of undated "Disclosure of Service Agreement", stated "all boarding homes must coordinate services the resident receives from their health care providers".

Review of the "Initial Licensed Nursing Assessment" dated 03/17/2023, showed R1 was admitted to the facility on [redacted]/2022 with diagnoses including [redacted] and [redacted].

Review of R1's Negotiated Service Agreement (NSA) dated, 06/02/2023, showed the facility was to "schedule and coordinate non-Bonaventure services as appropriate."

Review of R1's chart notes dated, 07/06/2023, Staff B, Caregiver, documented R1 was found on floor complained of head, neck, chest, and back pain. R1 was sent to the Hospital for evaluation.

Review of R1's charting notes dated, 08/20/2023, Staff B, Caregiver, documented R1 was "very confused and poured water into a cup that had their pills in it".

Review of R1's "Temporary Care Plan" dated 08/28/2023, showed R1 had increased falls and confusion.

In an interview on 09/06/2023 at 4:25 PM with Collateral Contact 1 (CC1), they stated they received a call from the facility on 08/21/2023 informing them R1 was very confused and "may have a urinary tract infection". CC1 stated they notified R1's PCP that R1 had increased confusion and informed the facility that they will be contacted to collect a urine specimen.

In an interview with CC1 on 09/08/2023 at 11:23 AM, CC1 stated that the facility stated they did not collect the urine specimen, and that R1 fell on 08/28/2023 and was sent to a local hospital. CC1 stated R1's urine specimen that was collected at the hospital was positive for bacteria.

On 09/08/2023, at 1:00 PM, no additional documentation was received that showed R1's PCP was called, or a phone call was received from the PCP requesting any change in care or testing due to R1's increased confusion. No copy of R1's "After Visit Summary" report with discharge instructions from the hospital was available.

In an interview on 09/08/2023 at 12:10 PM, Staff A, Assisted Living Facility Director, confirmed that the facility received a phone call on 08/21/2023 from R1's PCP's office giving a verbal order to collect a urine specimen for R1, but they failed to follow up with the PCP. They also confirmed that on 08/28/2023 the facility did not collect the urine specimen, and there was no follow up documentation in R1's chart.

This is a recurring deficiency previously cited on 01/31/2023.

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 Salmon Creek is or will be in compliance with this law and / or regulation on (Date) 11/11/23 .

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

Administrator (or Representative) — 10/17/23 Date