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) 37382 (Completion Date 03/05/2024) and 32303 (Completion Date 01/03/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/05/2024 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-2240

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 #: 32303
Investigator: Yvonne Chitekwe
Provider Type: Assisted Living Facility
Intake ID: 105036
Region/Unit #: RCS Region 3 / Unit I
Investigation Date(s): 11/09/2023 through 01/03/2024
Complainant Contact Date(s): 01/03/2024, 11/07/2023, 11/29/2023

Allegation(s):
1. Quality of Care/Treatment: Allegation of mismanagement of resident medications.

Investigation Methods:

Sample:	Total residents: 71 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Staff to resident interactions Medication administration
Interviews:	Identified resident Identified staff Nursing staff Medication technician Residents Family members
Record Reviews:	Medical records Hospital records Facility policies Personnel files Staff training records

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, there is a failed facility practice in the management of resident medication that 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

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 #: 2321	Compliance Determination #:32303
Plan of Correction	Bonaventure of Salmon Creek	Completion Date
Page 1 of 3	Licensee: Bonaventure of Salmon Creek LLC	01/03/2024

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 11/09/2023 and 11/09/2023 of:

Bonaventure of Salmon Creek
13709 NE Salmon Creek Ave
Vancouver, WA 98686

This document references the following complaint number(s): 105035

The following sample was selected for review during the unannounced on-site visit: 3 of 71 current residents and 0 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 — 01/09/2024 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.

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 11/09/2023 and 11/09/2023 of:

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

This document references the following complaint number(s): 105036

The following sample was selected for review during the unannounced on-site visit: 3 of 71 current residents and 0 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

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.

Krysta Kendall, Representing Rachel Turner
Administrator (or Representative)

1/19/2024
Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to obtain a prescribed medication for 1 of 3 residents (Resident 1/ R1) reviewed for availability of medications. This failure resulted in the resident not receiving medication as ordered for 6 days and placed them at risk for health complications.

Findings included...

Record review of a facility policy, titled, "Med 11-07 – MEDICATION ADMINISTRATION PROGRAM POLICY", dated 07/2009, regarding the facility's responsibility for medication administration, showed "Medication will be available to the Resident in a correct and timely manner."

Record review of R1's Service Plan (SP), dated 07/11/2023, documented that R1 had a diagnosis of [redacted]. The SP showed the facility was responsible for ordering R1's medications.

Record review of R1's October 2023 Medication Administration Record (MAR) documented the medication Potassium Chloride (A mineral that is important for many body functions) 10 Milliequivalents (mEq) "Give 2 tablets by mouth twice daily" and the medication was scheduled for 8:00 AM and 5:00 PM. R1 was scheduled for 62 doses of the Potassium Chloride in October and the October MAR showed that 6 of the 62 doses were not given due to "not given, medication not available". Doses missed per the MAR were 10/28/2023 through 10/31/2023.

Record review of R1's November 2023 MAR documented the medication Potassium Chloride 10 mEq's "Give 2 tablets by mouth twice daily" and scheduled for 8:00 AM and 5:00 PM. R1 was scheduled for 60 doses of the Potassium Chloride in November and the November MAR showed that 6 of the 60 doses were not given due to "not given, medication not available". Doses missed per the November MAR were 11/01/2023 through 11/03/2023.

In an interview on 11/07/2023 at 11:37 AM, Collateral Contact 1 (CC1), Representative for

Administrator (or Representative) Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to obtain a prescribed medication for 1 of 3 residents (Resident 1/ R1) reviewed for availability of medications. This failure resulted in the resident not receiving medication as ordered for 6 days and placed them at risk for health complications.

Findings included…

Record review of a facility policy, titled, “Med 11-07 – MEDICATION ADMINISTRATION PROGRAM POLICY”, dated 07/2009, regarding the facility’s responsibility for medication administration, showed “Medication will be available to the Resident in a correct and timely manner.”

Record review of R1’s Service Plan (SP), dated 07/11/2023, documented that R1 had a diagnosis of [redacted]. The SP showed the facility was responsible for ordering R1’s medications.

Record review of R1’s October 2023 Medication Administration Record (MAR) documented the medication Potassium Chloride (A mineral that is important for many body functions) 10 Milliequivalents (mEq) “Give 2 tablets by mouth twice daily” and the medication was scheduled for 8:00 AM and 5:00 PM. R1 was scheduled for 62 doses of the Potassium Chloride in October and the October MAR showed that 6 of the 62 doses were not given due to “not given, medication not available”. Doses missed per the MAR were 10/28/2023 through 10/31/2023.

Record review of R1’s November 2023 MAR documented the medication Potassium Chloride 10 mEq’s “Give 2 tablets by mouth twice daily” and scheduled for 8:00 AM and 5:00 PM. R1 was scheduled for 60 doses of the Potassium Chloride in November and the November MAR showed that 5 of the 60 doses were not given due to “not given, medication not available”. Doses missed per the November MAR were 11/01/2023 through 11/03/2023.

In an interview on 11/07/2023 at 11:37 AM, Collateral Contact 1 (CC1), Representative for

R1, reported that R1 did not have Potassium medication for six consecutive days and that it was unacceptable.

In an interview on 11/09/2023 at 11:29 AM, Staff C, Medication Technician, reported that the facility has a policy on how staff are to recognize and respond when a resident's prescription is not available. Staff C reported the facility failed to follow through appropriately with recognizing and responding to R1's potassium prescription not being available.

In an interview on 11/09/2023 at 12:50 PM, Staff B, Memory Care Director, reported that it is not acceptable for a resident to go six days without their prescribed medication, and it is important for R1 to get their Potassium prescription as prescribed.

In an interview on 11/09/2023 at 12:55 PM, Staff A, Executive Director, reported that it is not acceptable for a resident to go six days without their prescribed medication. Staff A reported that the facility has a policy on how staff are to recognize and respond when a resident's prescription is not available. Staff A reported the facility failed to follow through appropriately with recognizing and responding to R1's potassium prescription not being available.

This is a recurring deficiency previously cited on 09/20/2022 and 12/14/2022.

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) 2/1/2024.

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

Kayla Kendall, Representing Rachel Turner
Administrator (or Representative)

1/15/2024
Date

R1, reported that R1 did not have Potassium medication for six consecutive days and that it was unacceptable.

In an interview on 11/09/2023 at 11:29 AM, Staff C, Medication Technician, reported that the facility has a policy on how staff are to recognize and respond when a resident's prescription is not available. Staff C reported the facility failed to follow through appropriately with recognizing and responding to R1's potassium prescription not being available.

In an interview on 11/09/2023 at 12:50 PM, Staff B, Memory Care Director, reported that it is not acceptable for a resident to go six days without their prescribed medication, and it is important for R1 to get their Potassium prescription as prescribed.

In an interview on 11/09/2023 at 12:55 PM, Staff A, Executive Director, reported that it is not acceptable for a resident to go six days without their prescribed medication. Staff A reported that the facility has a policy on how staff are to recognize and respond when a resident's prescription is not available. Staff A reported the facility failed to follow through appropriately with recognizing and responding to R1's potassium prescription not being available.

This is a recurring deficiency previously cited on 09/20/2022 and 12/14/2022.

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)_____ .

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

_____ _____

Administrator (or Representative) Date