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) 42286 (Completion Date 06/05/2024) and 37384 (Completion Date 04/18/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/05/2024 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, WAC 388-78A-2210-2, WAC 388-78A-2210-2-a, WAC 388-78A-2210-2-b

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 #: 37384
Investigator: Yvonne Chitekwe
Provider Type: Assisted Living Facility
Intake ID: 111787
Region/Unit #: RCS Region 3 / Unit I
Investigation Date(s): 02/26/2024 through 04/18/2024
Complainant Contact Date(s): 02/23/2024, 04/18/2024

Allegation(s):

1. Quality of Care/Treatment: Allegation that medication was not given to resident as ordered by their doctor.

Investigation Methods:

Sample:	Total residents: 66 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Identified resident Identified staff Residents Family members Pharmacy Staff
Record Reviews:	Medical records Facility policies Personnel files Care Plan Resident Assessment

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, failed facility practice in managing and administration of resident medications was substantiated during the investigation.

Conclusion / Action:

☒ 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 # 37384
Plan of Correction	Bonaventure of Salmon Creek	Completion Date
Page 1 of 5	Licensee: Bonaventure of Salmon Creek LLC	04/18/2024

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 02/26/2024 and 04/10/2024 of:

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

This document references the following complaint number(s): 111787

The following sample was selected for review during the unannounced on-site visit: 4 of 66 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 — 04/26/2024 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.

Administrator (or Representative) 5/14/24 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 4 residents (Resident 1/ R1) reviewed for availability of medications. This failure resulted in the resident not receiving medication as ordered for 11 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 "Resident will receive medications as prescribed and that medications 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] and [redacted]. The SP showed the facility was responsible for ordering R1's medications.

Record review of R1's December 2023 Medication Administration Record (MAR) documented the medication "Triamterene- HCTZ" (A water pill used to treat elevated blood pressure) 37.5 -25 milligram (mg) tablet "Give 1 tablet by mouth daily. Hold for Systolic (top number in blood pressure reading) Blood Pressure below 120". R1 was scheduled for 31 doses of the Triamterene- HCTZ in December and the December MAR showed that 11 of the 31 doses were not given due to "not given, medication not available". Doses missed per the MAR were 12/03/2023 through 12/13/2023.

In an interview on 02/23/2024 at 11:28 AM, Collateral Contact 1 (CC1), Representative for R1, reported that R1 was not given their Triamterene- HCTZ medication for eleven consecutive days and stated, "it was disappointing it happened again".

In an interview on 03/11/2024 at 10:41 AM, Staff A, Assistant Executive Director, stated the Executive Director of the Assisted Living Facility and a Medication Technician had not followed the process of re-ordering R1's Triamterene- HCTZ medication which resulted in R1 not getting 11 days of their prescription medication.

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In an interview on 03/11/2024 at 11:01 AM, Collateral Contact 2 (CC2) Hartland Pharmacy Medication Technician reported that R1's Triamterene – HCTZ is on automatic refill order and was delivered to the facility on 11/17/2023 for the month of December.

In an interview on 03/15/2024 at 12:01 PM, Staff B, Interim Executive Director, reported that R1's Triamterene – HCTZ could not be found, and it was unclear what had happened to the 11 days of R1's missed medications. They stated the facility failed to follow through appropriately with recognizing and responding to R1's Triamterene – HCTZ prescription not being available.

This is a recurring deficiency previously cited on 01/09/2024.

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) 6/2/2024 .

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

Administrator (or Representative) 5/14/24 Date

WAC 388-78A-2210 Medication services.

(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 ensure residents received medications as prescribed for 2 of 4 residents (Resident 1/ R1 and Resident 2/ R2) reviewed for medication service. This failure resulted in one resident (R2) not receiving medication as ordered for 5 days and one resident (R1) not receiving medication for 11 days and placed them at risk for medical 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 "Bonaventure Senior Living will provide medication assistance to Residents who request or need assistance. This service will be indicated on the Negotiated Service Agreement and will follow the States administrative rules and regulations and as ordered by the physician".

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

Record review of R1's December 2023 Medication Administration Record (MAR) documented the medication "Triamterene- HCTZ" (A water pill used to treat elevated blood pressure) 37.5 -25 milligram (mg) tablet "Give 1 tablet by mouth daily. Hold for Systolic (top number in blood pressure reading) Blood Pressure below 120". R1 was scheduled for 31 doses of the Triamterene- HCTZ in December and the December MAR showed that 11 of the 31 doses were not given due to "not given, medication not available". Doses missed per the MAR were 12/03/2023 through 12/13/2023.

In an interview on 02/23/2024 at 11:28 AM, Collateral Contact 1 (CC1), Representative for R1, reported that R1 was not given their Triamterene- HCTZ medication for eleven consecutive days and stated, "it was disappointing it happened again".

In an interview on 03/11/2024 at 10:41 AM, Staff A, Assistant Executive Director, stated the Executive Director of the Assisted Living Facility and a Medication Technician had not followed the process of re-ordering R1's Triamterene- HCTZ medication which resulted in R1 not getting 11 days of their prescription medication.

R2
Record review of R2's Service Plan (SP), not signed, dated 02/06/2024, documented that R2 had a diagnosis of [redacted] and [redacted]. The SP showed the facility is to provide R2 support with their medication administration and that staff would administer R2's medications according to the Doctor's orders.

In an interview on 03/15/2024 at 11:32 AM, Resident 2 (R2) reported that since admission to Bonaventure Assisted Living Facility (ALF) on [redacted]/2023, they were not given their prescribed medications for 5 days from [redacted]/2023 through 12/20/2023. They reported that their depressive mood symptoms increased, resulting in having suicidal ideation (suicidal thoughts).

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Record review of R2's Medication Administration Record (MAR) for December,2023 showed orders for Atorvastatin (cholesterol lowering drug), 20MG tablet - 1 tablet by mouth at Bedtime. Metoprolol ER (used to treat high blood pressure), 25MG tablet- take 1 tablet by mouth daily. Sertraline (used to manage and treat the major depressive disorder) 50MG tablet- take 1 tablet by mouth daily. The record showed R2 did not receive the 3 prescription medications for 5 days on [redacted]/2023 through 12/20/2023; missing a total of 15 doses of prescription medications.

Record review of R2's "Alert Charting Notes", dated 12/19/2023, documented R2 was found in their apartment bathroom "hysterically crying stating they want to die". The record documented on 12/21/2023 by a Registered Nurse showed R2 informed them they were not taking their antidepressant.

In an interview on 03/20/2024 at 11:09 AM, Collateral Contact 3, (CC3), representative for R2, reported that R2 admitted to ALF [redacted]/2023 with prescription medications Atorvastatin, Metoprolol ER and Sertraline which were hand delivered to Staff A, Assistant Executive Director. CC3 reported that on day 4 of R2's admission to the ALF, they were informed R2 was having suicidal thoughts. CC3 reports they discovered R2 had not been getting their prescription medications since they were admitted to ALF.

In an Interview on 04/01/2024 at 12:35PM, Staff C Executive Director stated that they did not have "an understanding of how, or why, R2 missed 15 doses of their medication".

This is a recurring deficiency previously cited on 01/27/2023.

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 Salmon Creek is or will be in compliance with this law and / or regulation on (Date) 6/2/24 .

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

Administrator (or Representative) 5/14/24 Date