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

01/09/2025

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

RE: Bonaventure of Salmon Creek # 2321

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 52832 (Completion Date 01/09/2025) and 48102 (Completion Date 11/18/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/09/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210 Medication services.

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

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

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
Investigation Summary Report

Provider/Facility: Bonaventure of Salmon Creek
License/Cert.#: 2321
Compliance Determination #: 48102
Investigator: Yvonne Chitekwe
Provider Type: Assisted Living Facility
Intake ID: 147867
Region/Unit #: RCS Region 3 / Unit I
Investigation Date(s): 10/01/2024 through 11/18/2024
Complainant Contact Date(s):

Allegation(s):

1.Nursing service: Facility reported inappropriate administration of antipsychotic medication as ordered by the Doctor.

2. Quality of care/treatment: Facility reported failure to administer antipsychotic medication as ordered by the Doctor.

Investigation Methods:

Sample:	Total residents: 63 Resident sample size: 3 Closed records sample size: 0
Observations:	Staff to resident interactions Resident to resident interactions Medication administration Identified resident Residents Activities
Interviews:	Identified resident Identified staff Residents Family members
Record Reviews:	Medical records Incident investigation Facility policies

Investigation Summary:

1.Nursing service: 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 in the nursing services when resident's medications were wrongly administered was substantiated during the investigation.

2. 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, a failed facility practice to administered resident's medication as they were ordered by their doctor 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 # 48102
Plan of Correction	Bonaventure of Salmon Creek	Completion Date
Page 1 of 3	Licensee: Bonaventure of Salmon Creek LLC	11/18/2024

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 10/01/2024 and 10/01/2024 of:

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

This document references the following complaint number(s): 147867

The following sample was selected for review during the unannounced on-site visit: 3 of 63 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

11.18.2024
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) Date 12/2/24

WAC 388-78A-2210 Medication services.

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

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

This requirement was not met as evidenced by:

Based on interview and record review the assisted living facility failed to administer medication as ordered by the physician for 1 of 3 sampled residents (Resident 1/R1) reviewed for medication services. This failure placed the resident at risk of medical complication and potentially worsening behaviors.

Findings included...

Review of R1's Service Plan, dated 06/29/2024 showed R1 had diagnoses including [redacted] ([redacted]) and [redacted] ([redacted]).

Review of R1's July 2024 Medication Administration Record showed an order for Risperidone (medications used to treat irritability) 1milligram (mg) tablet to give one-half tablet (0.5 mg total) two times per day.

Review of R1's Chart Notes, dated 09/17/2024, showed R1 was given 1 mg of Risperidone twice a day instead of 0.5 mg of the medication twice a day from 08/14/2024 to 09/17/2024.

Review of R1's Chart Notes, dated 09/17/2024 at 12:53PM showed that the registered nurse delegator was informed of R1's medication error. The record documented that staff assumed a whole pill of 1mg was to be administered to R1.

In an interview on 10/01/2024 at 12:02 PM, Staff A, Assistant Executive Director, stated that R1 was given the incorrect dose of their Risperidone and the indicated the error occurred multiple times.

In an interview on 10/01/2024 at 12:28 PM, Staff B, Medication Technician, stated that

Statement of Deficiencies	License #: 2321	Compliance Determination # 48102
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the medication error with R1 receiving the Risperidone incorrect dose was "an easy mistake that should not have happened, but it did".

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) 1/2/25 .

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

Administrator (or Representative) 12/2/24 Date