STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

Bonaventure of South Hill LLC
Bonaventure of Puyallup
14503 Meridian Avenue E
Puyallup, WA 98375

RE: Bonaventure of Puyallup License # 2555

Dear Administrator:

This letter addresses Compliance Determination(s) 30566 (Completion Date 10/10/2023) and 22781 (Completion Date 06/13/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/10/2023 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-2210-2-b, WAC 388-78A-2240

The Department staff who did the on-site verification:
Cathleen Davis, ALF Licensor
Shirley Grew, LTC Surveyor
Lisa Mason, NCI ALF Licensor
Melisa Moran, Assisted Living Facility Nursing Consultant Institutional

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Manfay Chan, Field Manager
Region 3, Unit D
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

Statement of Deficiencies	License #: 2555	Compliance Determination # 22781
Plan of Correction	Bonaventure of Puyallup	Completion Date
Page 1 of 6	Licensee: Bonaventure of South Hill LLC	06/13/2023

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 follow-up on 04/19/2023 and 04/19/2023 of:
Bonaventure of Puyallup
14503 Meridian Avenue E
Puyallup, WA 98375

This document references the following SOD dated: 06/13/2023

The following sample was selected for review during the unannounced on-site visit: 4 of 0 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Carol Gijima, Community Compalnt Investigator (NCI)

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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.

Jody Just Region 3 Field Services Administrator — 06-23-2023
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.

Administrator (or Representative)

7/14/2023
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 :

(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 interviews and record review, the Assisted Living Facility (ALF) failed to ensure that 2 of 4 sample residents received their medications as prescribed (Residents 1 & 2). This failure resulted in both residents not receiving medications as prescribed and placed them at risk for potential negative health outcomes and a decline in quality of life.

Findings Included...

Resident 1

Record review on 04/19/2023 showed that Resident 1 (R1) was admitted to the ALF on [redacted]2021 with diagnoses of [redacted] The Nursing Assessment dated 08/25/2022 showed that the facility staff were to administer R1's medications.

Review of R1's February 2023 and March 2023 Medication Administration Record (MAR) showed the following:

Docusate (medication to help with constipation) was ordered for twice a day. The MAR showed that R1 did not receive the 8:00pm dose on 02/16/2023, the 8:00am and 8:00pm doses on 02/17/2023, 02/18/2023, 02/19/2023, 02/20/2023, and the 8:00am dose on 02/21/2023 and 02/22/2023. The notes on these dates stated that the medication had not arrived.

Finasteride (mediation to help with bladder issues) was ordered to be taken daily. The MAR showed that R1 did not receive the medication on 02/03/2023, 02/04/2023, 02/05/2023, and 02/06/2023. The notes on these dates stated that the medication had not arrived.

Trulicity (medication for blood sugar) was ordered to be injected every week. The MAR showed that the medication was not administered to R1 on the following days, 02/03/2023, 02/10/2023, 02/17/2023, and 02/24/2023. The notes on these dates stated that R1 was physically unable to take, and another that stated, "don't have medication." There was no note explaining why or how the resident was physically unable to get the injection.

Atorvastatin (medication to lower cholesterol/fats in the blood) was ordered for once a day. The MAR showed that the medication was not administered to R1 on 03/05/2023, 03/06/2023, 03/07/2023, 03/08/2023, and 03/09/2023. There were no notes on each of these dates explaining why medication was not administered.

Trulicity (medication for blood sugars) was to be injected every week. The MAR showed that medication was not administered to R1 on 03/24/2023. The note for this date stated that resident was "physically unable to take." There was no note on this date explaining why or how the resident was physically unable to get the injection.

Resident 2

Record review on 04/19/2023 showed Resident 2 (R2) was admitted to facility on [redacted]/2021 with diagnosis of [redacted] The Negotiated Service Agreement dated 10/13/2022 showed that staff were to administer R2's medications.

Review of R2's February 2023 Medication Administration Record (MAR) showed the following:

Amoxicillin (an antibiotic for infection) was to be administered twice a day at 8:00am and 8:00pm. The MAR showed that R2 did not receive the medication on the following days, 02/11/2023, 02/12/2023, 02/13/2023, 02/14/2023, 02/15/2023, 02/16/2023, and 02/17/2023. The notes on these dates stated that the medication had not arrived.

During an interview on 06/13/2023 at 12:05pm, Staff B, Registered Nurse stated that there should be no reason a resident should not have their medications administered. Staff B stated that sometimes the facility has no control as they wait on delivery or to get signed orders.

During an interview on 06/13/2023 at 1:20pm, Staff A, Administrator stated that medication technicians were supposed to ensure that resident received their medications as ordered. Staff A stated that if they did not receive medications from pharmacy, they would contact family or have the pharmacy bill the facility. When asked if there would be any reason residents would not receive their medications as ordered, Staff A stated, "it depends."

This is an uncorrected deficiency previously cited on 11/02/2022.

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 Puyallup is or will be in compliance with this law and / or regulation on (Date) 7/28/23 .

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

Administrator (or Representative) 7/14/23 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 interviews and record review, the Assisted Living Facility (ALF) failed to ensure availability of medications for 2 of 4 sample residents (Resident 1 & 2). This failure resulted in both residents not receiving medications as prescribed and placed them at risk for a potential decline in health.

Findings Included...

Resident 1

Record review on 04/19/2023 showed that Resident 1 (R1) was admitted to ALF on [redacted]/2021 with diagnoses of [redacted] The Assessment dated 08/25/2022 showed that the facility staff were responsible for ordering and storing R1's medications.

Review of R1's February 2023 and March 2023 Medication Administration Record (MAR) showed the following:

Docusate (medication to help with constipation) was ordered for twice a day. The MAR showed that R1 did not receive the 8:00pm dose on 02/16/2023, the 8:00am and 8:00pm doses on 02/17/2023, 02/18/2023, 02/19/2023, 02/20/2023, and the 8:00am dose on 02/21/2023 and 02/22/2023. The notes on these dates stated that the medication had

not arrived.

Finasteride (mediation to help with bladder issues) was ordered to be taken daily. The MAR showed that R1 did not receive the medication on 02/03/2023, 02/04/2023, 02/05/2023, and 02/06/2023. The notes on these dates stated that the medication had not arrived.

Trulicity (medication for blood sugar) was ordered to be injected every week. The MAR showed that the medication was not administered to R1 on the following days, 02/03/2023, 02/10/2023, 02/17/2023, and 02/24/2023. The notes on these dates stated that R1 was physically unable to take, and another that stated, "don't have medication." There was no note explaining why or how the resident was physically unable to get the injection.

Atorvastatin (medication to lower cholesterol/fats in the blood) was ordered for once a day. The MAR showed that the medication was not administered to R1 on 03/05/2023, 03/06/2023, 03/07/2023, 03/08/2023, and 03/09/2023. There were no notes on each of these dates explaining why medication was not administered.

Trulicity (medication for blood sugars) was to be injected every week. The MAR showed that medication was not administered to R1 on 03/24/2023. The note for this date stated that resident was "physically unable to take." There was no note on this date explaining why or how the resident was physically unable to get the injection.

Resident 2

Record review on 04/19/2023 showed Resident 2 (R2) was admitted to facility on [redacted]/2021 with diagnosis of [redacted] The Negotiated Service Agreement dated 10/13/2022 showed that staff were responsible for ordering and storing R2's medications.

Review of R2's February Medication Administration Record (MAR) showed the following:

Amoxicillin (an antibiotic for infection) was to be administered twice a day at 8:00am and 8:00pm. The MAR showed that R2 did not receive the medication on the following days, 02/11/2023, 02/12/2023, 02/13/2023, 02/14/2023, 02/15/2023, 02/16/2023, and 02/17/2023. The notes on these dates stated that the medication had not arrived.

During an interview on 06/13/2023 at 12:05pm, Staff B, Registered Nurse stated that staff were responsible for ordering resident medications. Staff B stated that if using outside pharmacies, they try to reorder at least 14 days in advance. When asked what happens if they do not receive the medications on time, Staff B stated that they have an emergency drop.

During an interview on 06/13/2023 at 1:20pm, Staff A, Administrator stated that if they did not receive medications from pharmacy, they would contact family to get the medications.

This is an uncorrected deficiency previously cited on 11/02/2022.

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 Puyallup is or will be in compliance with this law and / or regulation on (Date) ~~7/26/23~~ 7/24/23

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

Administrator (or Representative) — 7/5/2023 Date

Residential Care Services
Investigation Summary Report

Provider/Facility: Bonaventure of Puyallup
Provider Type: Assisted Living Facility
License/Cert.#: 2555
Compliance Determination #: 8268
Intake ID: 25865
Investigator: Carol Gijima
Region/Unit #: RCS Region 3 / Unit D
Investigation Date(s): 05/05/2022 through 11/02/2022
Complainant Contact Date(s):

Allegation(s):

1. Resident went without his medication
2. Not receiving laundry or dining services

Investigation Methods:

Sample:	Total residents: Resident sample size: 3 Closed records sample size:
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Residents, including named resident Resident representatives Staff
Record Reviews:	Resident Characteristic Roster Resident assessments and negotiated service agreements including the records of the named resident Medication administration records (MAR) Staff progress notes

Investigation Summary:

1. Per record review and interviews, the facility failed to administer medications as ordered. The ALF demonstrated failed provider practice as documented in a Statement of Deficiencies dated 11/02/2022.
2. Per observations of lunch meal, and interviews with residents and staff, there was not sufficient information to either support or refute this allegation.

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
PO Box 99250, Lakewood, WA 98496

Statement of Deficiencies	License #: 2555	Compliance Determination #8268
Plan of Correction	Bonaventure of Puyallup	Completion Date
Page 1 of 8	Licensee: Bonaventure of South Hill LLC	11/02/2022

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 05/05/2022 and 10/24/2022 of:

Bonaventure of Puyallup
14503 Meridian Avenue E
Puyallup, WA 98375

This document references the following complaint number(s): 25865

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

The department staff that investigated the Assisted Living Facility:

Carol Gljima, Community Compaint Investigator (NCI)

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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

11/07/2022
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)

11-15-2022
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 :

(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 interviews and record review, the Assisted Living Facility (ALF) failed to ensure that 3 of 3 sample residents received their medications as prescribed. This failure placed all 3 residents at risk for potential negative health outcomes and a decline in quality of life.

Finding Included...

Resident 1

Record review on 09/22/2022 showed that Resident 1 (R1) admitted to ALF on [redacted]/2021 with diagnoses of [redacted] A nursing assessment dated 11/16/2021 showed that there was no "self-administration of medication" for R1, insulin management was not addressed.

Review of the November 2021 medication administration record (MAR) showed that R1 did not receive his medications, including insulin until 11/10/2021. A progress note on 11/07/2021 at 12:27pm showed resident's daughter was upset that R1's medications were still in his room. Progress note stated the facility did not have orders for medications. A review of the physician's orders showed that insulin administration was to be monitored and documented by staff every morning and evening to ensure proper self-administration by the resident. There was no documentation verifying that R1 was properly self-administering insulin.

December 2021 MARs showed R1 had insulin 33 Units in the morning and 20 Units in the evening. Staff were to verify R1 had administered it appropriately. There was no documentation verifying R1 was properly self-administering insulin.

January 2022 MARs showed R1 had insulin 33 Units in the morning and 20 Units in the evening. Staff were to verify R1 had administered it appropriately. There was no

documentation verifying R1 was properly self-administering insulin.

February 2022 MARs showed R1 had insulin 33 Units in the morning and 20 Units in the evening. Staff were to verify R1 had administered it appropriately. There was no documentation verifying R1 was properly self-administering insulin.

March 2022 MARs showed R1 had insulin 33 Units in the morning and 20 Units in the evening. Staff were to verify R1 had administered it appropriately. There was no documentation verifying that R1 was properly self-administering insulin.

April 2022 MARs showed R1 had insulin 33 Units in the morning and 20 Units in the evening. Staff were to verify R1 had administered it appropriately. There was no documentation verifying that R1 was properly self-administering insulin.

There was no documentation in the progress notes verifying that R1 was properly administering insulin.

Resident 2

Record review on 09/22/2022 showed Resident 2 (R2) admitted to ALF on [redacted]/2021 with diagnosis of [redacted] A negotiated service agreement dated 03/01/2022 showed staff were to administer R2's medications according to physician's orders.

March 2022 MARs showed R2 did not receive the following medications, Amlodipine 5mg (for blood pressure), Lysine 500mg (infection supplement), Carbidopa-Levodopa 25-100mg (for Parkinson's'), Lisinopril 20mg (for blood pressure), and Acyclovir 400mg (for infection), from 03/21/2022–03/31/2022 as "medications not arrived."

April 2022 MARs showed R2 did not receive the following medications, Amlodipine 5mg, Lysine 500mg, and Rytary 36.25-145mg (for Parkinson's) from 04/01/2022–04/16/2022 as the "medications not arrived."

Resident 3

Record review on 05/05/2022 showed Resident 3 (R3) admitted to ALF on [redacted]/2021 with diagnosis of [redacted] A pre-move in assessment dated 06/23/2022 showed R3 needed assistance with medications including insulin. The resident service plan dated 06/23/2022 did not address medication or insulin administration needs.

March 2022 MARs showed R3 did not receive the following medications, Atorvastatin

80mg, Felodipine 10mg, and Trulicity insulin on the following days 03/16/2022, 03/17/2022, 03/18/2022 and 03/24/22–03/31/2022 as "medications not arrived."

April 2022 MARs showed R3 did not receive Finasteride 5mg from the 04/26/2022–04/30/2022, did not receive Atorvastatin 80mg for all of April 2022 except for 04/07/2022 and 04/08/2022. Medications had not arrived from pharmacy.

May 2022 MARs showed R3 did not receive Atorvastatin 80mg from 05/01/2022–05/16/2022. There was no documentation of Tresiba 70 Units for insulin being administered on 05/07/2022. From the 05/18/2022–05/23/2022, Tresiba 70 Units was not administered as the medications had not arrived.

During an interview on 05/02/2022 at 4:06pm, Resident 1's representative (RR1) stated R1 was admitted to facility on [redacted]/2021, and for the first 3 or so days he did not receive his medications. RR1 stated she brought the medications with her when R1 was admitted. RR1 stated staff were supposed to be watching R1's diet and insulin administration to ensure R1 did it correctly. Staff did not, resulting in R1 having unstable blood sugars and hospital transfers. RR1 stated she spoke to Staff A about medication concerns and Staff A stated she was sorry.

During an interview on 09/26/2022 at 4:22pm, Resident 3's representative (RR3) stated R3 had been sent to the hospital multiple times as a result of low blood sugars which were not properly managed. She stated the ALF was supposed to manage R3's medications and diet because of diabetes.

During an interview on 09/29/2022 at 4:01pm, Collateral Contact 1 (CC1), R3's primary care doctor's nurse stated ALF was not managing R3's diet and insulin. She stated resident had to go to the hospital for dangerous low blood sugars. CC1 stated the facility didn't have a nurse to follow up on blood sugar parameters or teach the med techs not to give insulin if R3 did not eat.

During an interview on 05/05/2022 at 10am, Staff B, Memory Care Director stated that residents should receive their medications as ordered. When asked when a resident would be allowed to go without medications, Staff B stated when the pharmacy doesn't deliver. Staff B stated families were given 10 days' notice if residents were running out of medications. Staff B did not provide an alternative for staff/facility to ensure residents received their medications if pharmacy didn't deliver them.

During an interview on 09/18/2022 at 11:25am, Staff C, Assisted Living Director stated that when residents were admitted to facility, their medication list was faxed to the pharmacy. She was responsible for approving the medications along with a medication technician (Med tech). Staff C stated there should be no reason residents should not get their medications.

During an interview on 09/20/2022 at 2:43pm, Staff D, Assisted Living Director stated that prior to residents moving in, the delegating nurse should review the medications, input them into the MAR and fax to pharmacy. Staff D stated the facility did not have a nurse and the regional nurse was not available and new admits sometimes did not have their medications. Staff D stated R3 did not get his insulin at times because the facility didn't have his medications, and there were questions about the strength of his medications. She stated nothing was done to ensure R3 received his insulin. Staff D stated that R1's daughter had complained about R1 not getting his medications. Staff D stated RR1 provided his medications, and she always had them available.

During an interview on 05/05/2022 at 9:15am, Staff E, Medication technician (Med tech) stated med techs were responsible for re-ordering resident medications. Staff was asked when residents would not receive their medications. Staff E stated that residents would not receive their medications as ordered if the order was pending or when the medications had not been delivered by the pharmacy.

During an interview on 09/20/2022 at 12:36pm, Staff F, Registered nurse stated when a resident admitted to the facility, they obtain orders from their primary physician which is faxed to the pharmacy. When asked who was responsible for ordering the medications and ensuring they were delivered, Staff F stated that it was the med techs. Staff F stated Staff A was aware of residents not getting their medications and told Staff B to fix it. Staff F stated residents didn't complain, but family members did complain about medications not being administered.

During an interview on 09/20/2022 at 12:56pm, Staff G, Registered nurse stated their marketing department was responsible for obtaining admit orders from the doctor. Staff G stated it was the Assisted Living Director's and Memory Care Director's responsibility to ensure orders were obtained from the doctor for new admits, faxed, and received by the ALF. Staff G stated staff in the marketing department moved residents into facility without orders, and no one consulted her. Staff G stated that the facility did not have orders for new admits or refills. Staff G stated R3 had orders for staff to verify correct self-administration of insulin, and check blood sugars but no one checked. Staff G stated that resident had episodes of low blood sugar where he had to be sent to the hospital.

During an interview on 10/26/2022 at 2:33pm, Staff A, Administrator stated the process for medications was whenever a resident reserves a suite, they sign a release authorization, orders were signed by doctor, faxed to pharmacy, and received at facility prior to arrival. Administrator stated the Assisted Living Director and Memory Care Director were responsible for obtaining the authorizations, orders, history and physicals and faxing orders to the pharmacy. Administrator stated that residents should not be without medications unless they were an emergency admission from the hospital. Administrator stated if they did not receive medications before admitting, family would need to assist with medications, resident would be classified as independent, and medication services would not be charged. Administrator stated she could not explain why medications were not administered and would have to ask a med tech.

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 Puyallup is or will be in compliance with this law and / or regulation on (Date) 12/23/22

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

Administrator (or Representative) 11-15-22 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 interviews and record review, the Assisted Living Facility (ALF) failed to ensure availability of medications for 2 of 3 sample residents (Resident 2 and 3). This failure placed the residents at risk for a potential decline in health.

Findings Included...

Resident 2

Record review on 09/22/2022 showed Resident 2 (R2) admitted to ALF on [redacted]/2021 with diagnosis of [redacted] Orders showed staff were to order R2's medications two weeks in advance. A negotiated service agreement dated 03/01/2022 showed that staff were to order, store and administer R2's medications.

March 2022 MARs showed R2 did not receive 5 medications from 03/21/2022-03/31/2022 as medications were not available. An exception note stated, "medications not arrived."

Resident 3

Record review on 09/22/2022 showed Resident 3 (R3) admitted to ALF on [redacted]/2021 with diagnosis of [redacted]

March 2022 MARs showed R3 did not receive 3 medications including insulin on 03/16/2022, 03/17/2022, 03/18/2022, and 03/24/2022-03/31/2022 as medications were not available. An exception note stated, "medications not arrived."

April 2022 MARs showed R3 did not receive Finasteride 5mg from 04/26/2022-04/30/2022, did not receive Atorvastatin 80mg for all of April except for 04/07/2022 and 04/08/2022 as medications had not arrived from pharmacy.

May 2022 MARs showed R3 did not receive Atorvastatin 80mg from 05/01/2022-05/16/2022. Tresiba 70 Units for Insulin was not documented as being administered on 05/07/2022. Tresiba 70 Units was not administered from 05/18/2022-05/23/2022. An exception note stated, "medications not arrived".

During an interview on 08/18/2022 at 11:25am, Staff C, Assisted Living Director stated for refills, staff call the pharmacy 5 days in advance. Staff C was asked what the process was when medications were not delivered. Staff C stated they follow up with the pharmacy and if no response they order from a local pharmacy across the street.

During an interview on 09/20/2022 at 12:36pm, Staff F, Registered nurse stated residents did not get their medications for "almost an entire month" because they were not delivered by the pharmacy. Staff F stated Staff B was made responsible for medication management. Staff F stated the Administrator was aware that residents were not getting their medications.

During an interview on 09/20/2022 at 2:43pm, Staff D, Assisted Living Director was asked who was responsible for ensuring the residents received their medications and refills on time. Staff D stated that was a "fairly good question, med techs I guess." Staff D stated there was no system in place.

During an interview on 10/26/2022 at 2:33pm, Staff A, Administrator stated their policy was to obtain medications prior to residents admitting to the facility. She stated medication technicians were responsible for re-ordering medications and following up with pharmacy and family if medications have not been received. Administrator stated the Assisted Living and Memory Care Directors were responsible for following up.

When asked why Residents 2 and 3 did not get their medications as ordered, Administrator stated she "assumed" they were not available. Administrator stated they broke their own policy, and the Assisted living did not have a director at the time. She stated she cannot answer as to why medications were not available.

Statement of Deficiencies	License #: 2555	Compliance Determination #8268
Plan of Correction	Bonaventure of Puyallup	Completion Date
Page 8 of 8	Licensee: Bonaventure of South Hill LLC	11/02/2022

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 Puyallup is or will be in compliance with this law and / or regulation on (Date) 12/23/22 .

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

Administrator (or Representative)

11-15-22
Date