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) 41175 (Completion Date 07/18/2024) and 34798 (Completion Date 04/08/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/18/2024 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-2350, WAC 388-78A-2350-2, WAC 388-78A-2350-2-a, WAC 388-78A-2350-2-b, WAC 388-78A-2350-3, WAC 388-78A-2350-7, WAC 388-78A-2350-7-a, WAC 388-78A-2350-7-b

The Department staff who did the on-site verification:
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

Residential Care Services
Investigation Summary Report

Provider/Facility: Bonaventure of Puyallup
Provider Type: Assisted Living Facility
License/Cert.#: 2555
Compliance Determination #: 34798
Intake ID: 105826
Investigator: Melisa Moran
Region/Unit #: RCS Region 3 / Unit D
Investigation Date(s): 01/05/2024 through 04/08/2024
Complainant Contact Date(s):

Allegation(s):

Named resident had a delay in care and Cardiopulmonary Resuscitation (CPR) performed when identified as a Do Not Resuscitate (DNR).

Investigation Methods:

Sample:
Total residents: 87
Resident sample size: 1
Closed records sample size: 1

Observations:
General outside environment assisted living facility (ALF), general inside environment ALF, including common areas, kitchen, bathrooms, and resident bedrooms

General appearance and demeanor of residents.

Staff-to-resident interactions

Interviews:
Collateral Contact
Resident 1's POA
Resident 2
Lead Medication Technician-Memory Care-Swing Shift

Record Reviews:
Managed Risk Agreement-Fall Intervention Plan dated 08/14/2023-Resident 1
Negotiated Service Agreement dated 10/12/2023-Resident 1
Face Sheet-Resident 1
Incident Report-Resident 1
MD Fax-Resident 1
Record of Resident Death-Resident 1
Incident Investigation Statement-Staff B
Incident Investigation Statement-Staff C
Incident Investigation Statement-Staff D
Statement of Incident Occurrence dated 01/18/2024-Staff B
Statement of Incident Occurrence dated 01/18/2024-Staff E
Progress Notes 7/5/2023 through 11/8/2023-Resident 1
Negotiated Service Agreement dated 11/07/2023-Resident 1
Negotiated Service Agreement-Resident 2
Face Sheet-Resident 2

Health Services Caregiver Training/Other CG Responsibilities policy
Health Services Medication Technician & QMAP Training policy
Facility RN Statement dated 01/18/2024
Statement from Assisted Living Caregiver received 03/12/2024

Investigation Summary:

Per staff written statements, record reviews and collateral contact interview, the facility failed to provide care and act in a timely manner in an emergency situation which caused a delay in care to Resident 1 (R1). This failure by the facility led to the R1 to experience a less than pleasant death with dignity. Failed practice identified.

Per staff written statements, interview and record reviews, the facility failed to provide care and services to R1 as stated in the NSA related to toileting resident. Failed practice identified.

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

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 01/05/2024 and 01/05/2024 of:

Bonaventure of Puyallup
14503 Meridian Avenue E
Puyallup, WA 98375

This document references the following complaint number(s): 105826

The following sample was selected for review during the unannounced on-site visit: 1 of 87 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Melisa Moran, Assisted Living Facility Nursing Consultant Institutional
Shirley Grew, LTC Surveyor

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.

Cory Cisneros for Manfay Chan
Residential Care Services

04/22/2024
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)

4/22/2024
Date

WAC 388-78A-2350 Coordination of health care services.

(2) The assisted living facility must develop, implement and inform residents of the assisted living facility's policies regarding how the assisted living facility interacts with external health care providers, including:

(a) The conditions under which health care information regarding a resident will be shared with external health care providers, consistent with chapter 70.02 RCW; and

(b) How residents' rights to privacy will be protected, including provisions for residents to authorize the release of health care information.

(3) The assisted living facility may disclose health care information about a resident to external health care providers without the resident's authorization if the conditions in RCW 70.02.050 are met.

(7) When coordinating care or services, the assisted living facility must:

(a) Integrate relevant information from the external provider into the resident's preadmission assessment and reassessment, and when appropriate, negotiated service agreement; and

(b) Respond appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning.

This requirement was not met as evidenced by:

Based on record reviews and interviews, the Assisted Living Facility (ALF) failed to coordinate care with an external health care provider and to respond timely and appropriately when there was an emergency for 1 of 1 resident (Resident 1 [R1]). This failure resulted in Resident 1 having a delay in care which resulted in R1 experiencing a less than pleasant death with dignity.

Findings included...

Collateral contact (CC), Coordinated Care External Health Care Provider interviewed on 01/05/2024 at 7:58 am reported that when the 911 operator received the phone call from facility staff, facility staff were instructed to intervene and get R1 released from the bedside commode which they were stuck in and to position R1 in a safe position to begin CPR until EMTs arrived. CC reported that facility staff were instructed on three to four different occasions to do so and hesitated to intervene by stating, "They were afraid to move R1 because it might cause more damage." CC instructed facility staff further that in order for R1 to survive, they will need to move R1 to the floor to make sure to open the airway so R1 can breathe and begin CPR or R1 will die. CC reported as well throughout the 911 call that staff questioned were not certain of the code status of R1, not knowing if they were a "Do

Administrator (or Representative) Date

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Not Resuscitate" (DNR) versus a full code which also led to a delay in providing medical care and staff initiating CPR.

In an interview on 04/01/2024 at 11:45 AM Staff B reported that on [redacted]/2023 she was called to assist with R1 as Staff E was not handling and taking the emergent medical situation of R1 well. About 15 minutes before 9:45 pm (around 9:30 pm), staff from the Assisted Living side reported to Staff B that they had checked on R1 and stated that R1 was sleeping and that they had changed R1's brief/depend and night shirt and repositioned R1 in the middle of the bed. Staff B reported that when they arrived to R1's room, Staff E was nowhere around. Staff B entered R1's room, R1 was found with their brief/depend down below their ankles and that R1 had clearly assisted themselves to the bedside commode. R1 was found unresponsive with their neck struck on the inside of the arm of the bedside commode. Staff B reported that per the instruction of EMTs, once they got R1 unstuck from the arm of the bedside commode, they began performing CPR on R1 until EMTs arrived and took over the care.

In an interview with Staff A, Executive Director, on 02/09/2024 at 1:10 pm, Staff A reported that it is the facility's policy and protocol that if it is not easily identifiable or staff are not able to locate DNR paperwork or a POLST form, then it is the exception that medical attention be provided and approached as full code status unless otherwise determined by checking the facility's electronic charting system.

Staff D, Assisted Living Caregiver, provided a witness statement reporting that on [redacted]/2023 she saw R1 about 15 minutes before the incident and that R1 was in the middle of their bed and she and other staff made sure R1 was okay. Staff D reported that when she went back to check on R1 at 9:45 pm they found R1 on the side of the bed on the floor with their neck in the bedside commode. R1 had all their clothing and bandages off. Staff D called the AL Medication Technician on duty and let her evaluate the situation.

Staff E, Assisted Living Lead Medication Technician (ALLMT), who was person in charge on shift, provided a witness statement on 01/18/2024 reporting the incident that occurred on [redacted]/2023 with R1. Staff E reported that Caregiver, Staff B, Staff C, Memory Care Caregiver, & Staff D had gone to check on R1 while she was completing the rest of her medication pass. Staff E reported that she was radioed to come to R1's room where she found R1 in an awkward position with their neck wedged into the arm bars of the commode. Staff E reported due to not wanting to cause further damage to R1, being in a panic, and not having information from the facility RN on what Hospice program R1 was on, she called Staff F, the facility's Assisted Living Director. This provided a delay in care to R1 and R1 receiving prompt medical attention by the facility staff, Emergency Medical Technicians (EMTs), 911 operator and to receive the instructed Cardiopulmonary Resuscitation (CPR) by the 911 operator. Staff E reported in their statement dated 01/18/2024 that after first responders (EMTs) left it was then that she and Staff B noticed R1's POLST form posted on R1's kitchen cabinet and admitted that during the time of incident, she, Staff E, had run straight to the room and was not focused on the kitchen area due to the level of stress of the occurrence/incident.

Staff F, Assisted Living Caregiver, provided a witness statement reporting that on

[redacted]/2023 she saw R1 about 15 minutes before 9:45 pm and stated that R1 was sleeping. Staff F reported that when she went to check on R1 at 9:45 pm she found R1 on the ground with her neck in the bedside commode. Staff F reported that R1 had their bandages, socks and brief off. Staff F reported she and another staff with her called the Assisted Living (AL) lead Medication Technician on duty to let her evaluate the situation. Staff F reported then when she entered R1's room and discovered R1 on the ground. Staff F reported that Staff B arrived at the unit to provide assistance and began CPR on R1.

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) 5/23/2024.

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

Administrator (or Representative) — Date: 4/22/2024

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