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) 57608 (Completion Date 05/29/2025) and 43860 (Completion Date 10/31/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/29/2025 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-2600-2-i, WAC 388-78A-2640-1-c

The Department staff who did the on-site verification:
Carol Gijima, Community Compaint Investigator (NCI)

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

Sincerely,

Manfay Chan, Allied Health 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
Intake ID: 129908
Compliance Determination #: 43860
Region/Unit #: RCS Region 3 / Unit D
Investigator: Carol Gijima
Investigation Date(s): 07/09/2024 through 10/31/2024
Complainant Contact Date(s):

Allegation(s):
1. Unexpected death

Investigation Methods:

Sample:	Total residents: Resident sample size: Closed records sample size: 2
Observations:	General environment Residents in their rooms & common areas
Interviews:	Resident's representative - X 3 unsuccessful attempts
Record Reviews:	Resident Characteristic Roster List of discharged residents Resident assessments and negotiated service agreements including discharged Staff Staff progress notes Incident log / reports

Investigation Summary:
1. Per record review, interviews with residents' representatives, collateral contacts, and staff, facility failed to implement policies that addressed resident safety, and failed to notify representative of death. Failed facility practice identified. See Statement of Deficiency dated 10/31/2024.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Bonaventure of Puyallup
Provider Type: Assisted Living Facility

License/Cert.#: 2555
Intake ID: 134874
Compliance Determination #: 43860
Region/Unit #: RCS Region 3 / Unit D
Investigator: Carol Gijima
Investigation Date(s): 07/09/2024 through 10/31/2024
Complainant Contact Date(s):

Allegation(s):
1. Unexpected death

Investigation Methods:

Sample:	Total residents: Resident sample size: Closed records sample size: 2
Observations:	General environment Residents in their rooms & common areas
Interviews:	Resident's representative Staff
Record Reviews:	Resident Characteristic Roster List of discharged residents Resident assessments and negotiated service agreements including discharged Staff Staff progress notes Incident log / reports Provider notes

Investigation Summary:
1. Per record review, interviews with residents' representatives, collateral contacts, and staff, facility failed to notify representative of death. Failed facility practice identified. See Statement of Deficiency dated 10/31/2024.

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 #: 2555	Compliance Determination # 43860
Plan of Correction	Bonaventure of Puyallup	Completion Date
Page 1 of 5	Licensee: Bonaventure of South Hill LLC	10/31/2024

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 07/09/2024 and 07/09/2024 of:

Bonaventure of Puyallup
14503 Meridian Avenue E
Puyallup, WA 98375

This document references the following complaint number(s): 134874, 129908

The following sample was selected for review during the unannounced on-site visit: 0 of 0 current residents and 2 former residents.

The department staff that investigated the Assisted Living Facility:

Carol Gijima, 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 _____ 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

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

This requirement was not met as evidenced by:

Based on records review and interviews, the Assisted Living Facility (ALF) failed to implement policies and procedures to account for residents and their safety. This failure resulted in 1 of 2 sample residents (Resident 1 [R1]) not getting care timely, resulting in R1 passing away.

Findings included…

There was no policy to review relating to supervision or accounting for residents leaving the facility.
There was no meal roster to review.
There was no progress notes provided to review.

Record review of the incident report showed that R1's son had called the facility inquiring about the whereabouts of R1. Report stated that the caregiver did not return with information regarding R1's where abouts. Around 10:20pm, R1's son called the facility again as they were concerned and had not heard from R1, and when staff went to R1's room they found him without vitals, and cardiopulmonary resuscitation (CPR), an emergency procedure performed when the heart stops, couldn't be performed as R1 was stiff.

Record review of R1's negotiated service agreement dated 11/30/2023 did not address safety checks to ensure R1's wellbeing or how to account for his absence from the facility.

During an interview on 07/09/2024 at 9:40am, Collateral Contact was asked how often they checked on residents. Collateral Contact stated that they didn't before R1's incident. Collateral Contact stated that before R1's death, there was no system to account for residents. Collateral Contact stated that "nobody checked on him when he didn't show up for dinner."

During an interview on 07/09/2024 at 10:40am, Staff A, Administrator, was asked how the facility ensures that all residents were checked on and accounted for to ensure that they were safe. Staff A stated that they didn't do checks unless it was care planned. When asked when it would be a concern for a resident not seen for an extended period, Staff A stated that R1 was "super independent…was gone all day…still driving." When asked who last saw R1, Staff A stated that the therapist had seen R1 between 1:00pm-4:30pm. Staff A asked who had last seen R1 and when since the therapist had rescinded that statement on 05/14/2024. Staff A did not provide an answer. When asked if staff went into R1's room to check on him after R1's family had been calling multiple times and R1 had not signed out, Staff A stated that staff did not report back on R1's check status.

During an interview on 10/18/2024 at 1:23pm, Staff B, Registered Nurse, was asked what their procedures were on checking on residents. Staff B stated that they did not conduct safety checks unless it was care planned. When asked about R1, Staff B stated that it was not unusual not to see R1. Staff B stated that R1 was still able to drive. When asked at what point they would be concerned with resident's absence or if resident was alive, especially for an extended period, Staff B stated that "we would get worried if he (R1) wasn't driving and at home."

During an interview on 10/29/2024 at 10:45am, Staff C, Health and Wellness Director, was asked how the facility ensured the safety and wellbeing of residents, Staff C stated that they checked residents at mealtimes, that they have a meal roster and have "eyes on assisted living residents for each meal." When asked for a copy of the meal roster showing that staff checked on R1 for meals, Staff C stated that they only kept those records for a month. Staff C stated they had no policy on safety checks for residents and it depended on their needs. When asked how staff would know if a resident was alive or not especially for residents who were more independent than others, Staff C stated, "good question." Staff C was asked if anyone had seen R1 for any meals, Staff C stated that they were not sure. When asked if any staff member had inquired about R1's whereabouts, and why he was not at dinner, Staff C stated, "no one questioned". When asked who last saw R1 and when, Staff C stated that they were not sure, that they would have to check the incident report and get back to investigator. As of the writing of this statement of deficiency on 10/31/2024, Staff C had not contacted complaint investigator.

During an interview on 10/29/2024 at 12:18pm, Resident 1's Representative (RR1) stated that they were concerned about R1 since he had not answered any of their calls or text messages which was not like him. RR1 stated that the family started calling the facility around 10:00am and were informed that R1 was out of the building. When they had not heard from R1 by late afternoon, RR1 stated they called the facility around 3:30pm asking for someone to check on R1. RR1 stated that the facility informed them that they would send someone to check on R1. RR1 stated they had no response from R1 and called the facility around 5:30pm dinner time and were told that they sent staff to check on R1, and that R1 was not in his apartment. RR1 stated that staff did not check on R1 otherwise they would have found him in the room earlier as R1 had not left his apartment. RR1 stated family drove to facility and found upon arrival that R1 had passed. RR1 stated it was traumatizing seeing an ambulance at the facility entrance

that "…heart dropped and had a gut feeling that the ambulance was for him (R1)". RR1 stated that the medical team could not perform CPR as R1 was too stiff, "he had been gone for a long time and no one knew…, no one actually checked on him (R1)."

During an interview on 10/29/2024 at 2:18pm, Resident 1's Representative (RR3) stated that the facility failed and "dropped the ball" when it came to his father. RR3 stated he started calling the facility around 10:00am inquiring about resident as it was unusual for him to not respond to phone calls or text messages. RR3 stated that the facility was supposed to check on resident at least for a couple of meals to ensure wellbeing, and did not believe they checked on him. Otherwise, they would have found him in his room sooner and probably would have received help.

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)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(c) The resident dies.

This requirement was not met as evidenced by:

Based in record review, the Assisted Living Facility (ALF) failed to notify representatives of the passing of 2 of 2 sample residents (Resident 1 & 2 [R1 & 2]). This failure resulted in emotional distress, complicating the grieving process.

Findings included…

Record review of the ALF's investigations showed that family was not notified of R1 & R2's passing. There was no progress notes provided to review for both residents.

A witness statement from staff dated 06/15/2024 showed that they told RR2 that they

were not “able to get any O2 (oxygen levels) or BP readings (blood pressure). The witness statement stated that RR2 asked them to explain what that meant, and staff wrote “I did my best to explain that he may have passed between checks.”

During an interview on 07/09/2024 at 10:40am, Staff A, Administrator, stated that R1’s family found out about R1’s death upon arrival to facility. Staff A did not provide an answer when asked why R1’s family was not called immediately since they had been calling throughout the day with concerns about his wellbeing. Staff A stated that R2’s Representative (RR2) was upset because staff did not state that R2 had passed away. Staff A stated that staff panicked and informed RR2 that they couldn’t obtain vitals.

During an interview on 10/17/2024 at 9:08am RR2 stated that they received a call around 6:00am stating that they couldn’t get vitals from R2. RR2 stated that they informed the staff that they were on their way to the facility, and upon arrival found R2 deceased. RR2 stated they were distraught as they had asked the staff if R2 had passed away and staff couldn’t tell them. RR2 stated that they thought R2 was just struggling with his vitals as he had been having problems days prior.

During an interview on 10/29/2024 at 12:18pm, Resident 1’s Representative RR1 stated that since there had not been able to contact R1 the entire day, they decided to go to the ALF. RR1 stated that when family arrived at the ALF, they saw an ambulance in the driveway, and they instantly knew that something had happened with R1. RR1 stated that the facility didn’t not notify them that R1 had died, and they had to find out when they arrived at facility.

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)_____ .

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

_____ _____

Administrator (or Representative) Date