STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

07/31/2026

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) 81058 (Completion Date 07/31/2026) and 76709 (Completion Date 05/26/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/31/2026 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:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

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

(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

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:

(a) There is a significant change in the resident's condition;

This document was prepared by Residential Care Services for the Locator website.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(3) Not use restraints on any resident;

(7) Not allow any staff person to abuse or neglect any resident; and

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

The Department staff who did the On Site verification:
Yvonne Chitekwe

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Nursing Home Allied Health Field Manager
Region 3, Unit E
Residential Care Services

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: Bonaventure of Salmon Creek
License/Cert.#: 2321
Compliance Determination #: 76709
Investigator: Yvonne Chitekwe
Investigation Date(s): 04/30/2026 through 05/26/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 221742
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1.Quality of Care/Treatment: Allegation that a resident was given wrong medication and was transported to the hospital without notifying the power of attorney.

Investigation Methods:

Sample:	Total residents: 54 Resident sample size: 4 Closed records sample size: 1
Observations:	Identified resident Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Residents Family members
Record Reviews:	Resident Characteristic Roster Staff List Face sheet Progress notes Negotiated service agreement Medical records Hospital records Incident investigation Facility policies

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 the allegation that facility

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did not have a safe medication administration system 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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Residential Care Services
Investigation Summary Report

Provider/Facility: Bonaventure of Salmon Creek
License/Cert.#: 2321
Compliance Determination #: 76709
Investigator: Yvonne Chitekwe
Investigation Date(s): 04/30/2026 through 05/26/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 221833
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1. Restraints/Seclusion-General: reported incident of a caregiver who barricaded a resident in their room with a cabinet furniture.

Investigation Methods:

Sample:	Total residents: 54 Resident sample size: 4 Closed records sample size: 1
Observations:	Identified resident Residents Activities Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified staff Nursing staff Residents Family members
Record Reviews:	Resident Characteristic Roster Staff List Incident investigation Facility policies Medical records Hospital records Staff training records Face sheet

Investigation Summary:

1. Restraints/Seclusion-General: The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews, and records review, failed facility practice in a reported incident of a memory care

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resident who was barricaded in a room with a cabinet furniture by a caregiver 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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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

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 04/30/2026 of:

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

This document references the following complaint number(s): 221742, 221833, 221813

The following sample was selected for review during the unannounced on-site visit: 4 of 54 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Yvonne Chitekwe

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

This document was prepared by Residential Care Services for the Locator website.

Statement of Deficiencies	License #: 2321	Compliance Determination # 76709
Plan of Correction	Bonaventure of Salmon Creek	Completion Date
Page 2 of 12	Licensee: Bonaventure of Salmon Creek LLC	05/26/2026

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.

Clinton Fridley, RN
Residential Care Services

06/04/2026
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)

6/17/26
Date

WAC 388-78A-2210 Medication services.

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(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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure medications were administered as directed for 2 of 4 residents (Resident 2 and Resident 3). This failure resulted in Resident 2 (R2) receiving Resident 3's (R3) heart medications which required transfer to the hospital for care and monitoring and placed residents at risk for medical complications and a decreased quality of life.

Findings included...

Record review of facility policy titled "Medication System," last revised 06/04/2025, stated that the facility will establish and maintain a safe, effective twenty-four hour medication delivery system for staff to administer, provide assistance for administration

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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

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to ensure medications were administered as directed for 2 of 4 residents
(Resident 2 and Resident 3). This failure resulted in Resident 2 (R2) receiving Resident 3's (R3) heart medications which required transfer to the hospital for care and monitoring and placed residents at risk for medical complications and a decreased quality of life.

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of prescription and non-prescription medications.

Record review of facility document titled “Medication Technician & QMAP Training,” revised 05/01/2023, showed the seven resident’s rights to medication, these rights are for staff administering medications to follow (right resident, right medication, right route, right dose, right time, right to refuse and right to know).

Record review of facility records for R2 showed that the resident moved into the facility on [redacted]/2025 with diagnoses that include [redacted] and that the facility provided medication assistance.

Record review of incident report, dated 04/24/2026, showed that R2 was given, and took, medications that belonged to R3 on 04/23/2026. Incident reports showed that staff G misheard the room number of who needed assistance, and grabbed R3’s medications (metoprolol succinate ER 50mg one tablet by mouth every day), Calcium 333MG, Mag oxide 133MG, D35MCG and Zinc 5MG (take one tablet by mouth daily) and D-Mannose 1500MG Caps (take 1 cap by mouth daily) and gave them to R2.

Record review of R3’s Medication Administration Record (MAR), dated 04/2026, showed that R3 was ordered metoprolol succinate (a medication to control high blood pressure) 50 milligram (mg) daily and four dietary supplements taken daily. Is there a note in the MAR stating it was given to another resident

In an interview on 04/30/2026 at 11:30 AM, Staff G, medication technician, stated that they did not follow the seven rights of medication administration when they gave R2 medications that belonged to R3 by accident. The medications were metoprolol succinate and four dietary supplements.

In an interview on 04/30/2026, at 11:00 AM, Staff H, Registered Nurse, stated that Staff G did not follow the seven rights of medication administration before R3’s medications were wrongly administered to R2 causing them to get transferred to the hospital for evaluation.

In an interview on 04/30/2026, at 11:30AM Staff A, Travelling Health and Wellness, stated staff G medication technician was assigned to work on the medication care for the first time. Staff A stated that Staff G told them that they wrongly gave R3's morning medications to R2 and that they thought they were giving the medications to the right resident. Staff A stated that R1 was unwell following the medication error, R1 was taken to the hospital by ambulance for evaluation.

In an interview on 05/19/2026, at 03:01 PM, Collateral Contact 1. R2’s resident representative stated that they were in distress and worried about R2’s medical condition following a call from the hospital informing them that R2 was being treated for

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medication overdose.

Record review of R2's after visit summary dated 04/23/2026 showed that R2 was treated at an emergency department on 04/23/2026 for accidental drug ingestion/accidental medication error and released back to the facility the same day with discharge instructions for R2 not to take ordered carvedilol (a blood pressure medication) at bedtime and resume usual medications in the morning as scheduled.

This is a recurring citation previously cited on 11/18/2024 and 09/12/2024.

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) 7/10/26 .

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

Administrator (or Representative) 6/17/26 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:

(a) There is a significant change in the resident's condition;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify the resident's responsible party as required for suspected abuse for 1 of 4 residents (Resident 1) reviewed. This failure resulted in Resident 1's (R1) responsible party not being informed of suspected abuse and placed the residents at risk for a decreased quality of life and psychological harm.

Findings included...

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medication overdose.

Record review of R2's after visit summary dated 04/23/2026 showed that R2 was treated at an emergency department on 04/23/2026 for accidental drug ingestion/accidental medication error and released back to the facility the same day with discharge instructions for R2 not to take ordered carvedilol (a blood pressure medication) at bedtime and resume usual medications in the morning as scheduled.

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Administrator (or Representative) Date

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Based on interview and record review, the facility failed to notify the resident's responsible party as required for suspected abuse for 1 of 4 residents (Resident 1) reviewed. This failure resulted in Resident 1's (R1) responsible party not being informed of suspected abuse and placed the residents at risk for a decreased quality of life and psychological harm.

Findings included…

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Record review of facility policy titled “Resident Occurrence Reporting Policy,” last revised 05/21/2025, stated that occurrence (any incident that involves a resident that is out of the ordinary or unusual) notifications are to be made within the shift of the event and/or awareness of the event. Notification will be provided to the following physician, family, facility designee, State Agency (facility is required to provide self-reported notification for identified allegations/instances of abuse/neglect will be provided within 24 hours of the incident).

Record review of Resident 1’s (R1) undated face sheet showed that R2 moved into the facility’s memory care on [redacted] 2024 with diagnoses that include [redacted].

Record review of Staff C Caregiver, statement related to the incident on 03/29/2026, showed that Staff C found R1 in their room at 2:05 AM, the door to the room was blocked by a hallway cabinet which prevented R1 from leaving the room. The statement from Staff C showed that the resident appeared confused, panicked while leaning over the cabinet and was unable to move it out of the way.

Record review of facility medical records for R1 showed no documentation that the R1’s representative was notified of the incident that happened on 03/29/2026.

In an interview on 05/04/2026 at 4:12 PM, Collateral Contact 2, R1’s representative, stated that they were not informed of the incident where R1 was barricaded in the room and was found to be in distress by staff.

In an interview on 04/30/2026 at 11:00 AM, Staff A, Traveling Health Services, stated that the facility did not notify R1’s representative.

In an interview on 05/01/2026 at 1:13 PM, Staff B, former Health and Wellness Director, stated that R1’s family was not notified.

In an interview on 05/20/2025 at 3:07 PM, Staff F Reginal Director of Operations stated that they were informed of the 03/29/2026 incident involving R1 and that it was abuse. Staff F acknowledged that they are mandated reporters and stated that the incident should have been reported to R1’s family immediately. Staff F stated that they thought Staff B had reported the incident.

Refer to WAC 388-78A-2660 Resident Rights.

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Statement of Deficiencies	License #: 2321	Compliance Determination # 76709
Plan of Correction	Bonaventure of Salmon Creek	Completion Date
Page 6 of 12	Licensee: Bonaventure of Salmon Creek LLC	05/26/2026

Plan/Attestation Statement

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

Administrator (or Representative) 6/17/26 Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(3) Not use restraints on any resident;

(7) Not allow any staff person to abuse or neglect any resident; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents were free from abuse and involuntary seclusion for 1 of 4 residents (Resident 1). The failure resulted in Resident 1 (R1) being isolated and barricaded in their room and placed this resident at risk for ongoing involuntary seclusion, improper restraints, abuse and ongoing harm.

Findings included...

RCW 70.129.130 Abuse, punishment, seclusion—Background checks. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. (1) The facility must not use verbal, mental, sexual, or physical abuse, including corporal punishment or involuntary seclusion.

WAC 388-78A-2020 defines abuse as: "Abuse" means the willful action or inaction that inflicts unreasonable confinement on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes improper use of restraint against a vulnerable adult, which have the following meanings: (5) "Improper use of restraint" means the inappropriate use of chemical, physical, or mechanical restraints for convenience or discipline or in a

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Administrator (or Representative) Date

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Findings included…

RCW 70.129.130 Abuse, punishment, seclusion—Background checks. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. (1) The facility must not use verbal, mental, sexual, or physical abuse, including corporal punishment or involuntary seclusion.

WAC 388-78A-2020 defines abuse as: "Abuse" means the willful action or inaction that inflicts unreasonable confinement on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes improper use of restraint against a vulnerable adult, which have the following meanings: (5) "Improper use of restraint" means the inappropriate use of chemical, physical, or mechanical restraints for convenience or discipline or in a

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manner that: (b) Is not medically authorized; or (c) Otherwise constitutes abuse under the section.

Record review of an undated facility policy titled “Abuse, Neglect or Exploitation” stated that the community will not tolerate verbal, physical, mental or sexual abuse including involuntary seclusion of any resident by any staff member.

Record review facility records for Resident 1 (R1) showed a facility move in date of [redacted]/2024 with diagnoses that include [redacted]. R1 resides in the locked memory care unit of the facility and identified as being at risk for elopement (the likelihood that someone will wander or run away from a safe, supervised environment without the staff or caregivers knowing). R1’s baseline cognition was noted to be confused most of the time.

Record review of an undated statement by Staff C caregiver, showed that at 2:05 AM on 03/29/2026, while walking through the memory care unit, Staff C observed that the hallway cabinet had been moved directly in front of the doorway to R1’s room. R1 was in the room and began speaking with Staff C. Staff C described R1 as confused and visibly stressed, leaning over the cabinet and failing to move it out of the way. Staff C stated R1 asked them to please let them out (of the room) and that R1 wasn’t sure how the cabinet got in front of their door. Staff C attempted to remove the cabinet from in front of R1’s door but it was too heavy for Staff C to move. Staff C left to find help and found Staff D, caregiver, in a common area close to R1’s room, laying on a couch. Staff C documented that they woke Staff D up and asked directly if Staff D had moved the cabinet in front of R1’s doorway to their room. Staff C stated Staff D replied that they had because R1 was setting off the exit alarm. Staff C documented that they told Staff D it was wrong and illegal and documented that Staff D told them that they knew it was illegal to lock the residents in their room but that it was annoying that R1 was setting off the exit alarms. Staff C further documented that Staff D did help Staff C remove the cabinet from in front of R1’s door, R1 then exited the room and started walking down the hallway. Staff C documented that shortly after the incident, Staff D approached Staff C and complained that R1 had set the exit alarms off again.

On 05/01/2026 at 1:13 PM, Staff B, former Health and Wellness Director, stated they were notified by Staff C, via text message, of an incident involving R1 on 03/29/2026 at 3:00 AM. Staff C informed them that R1 was found barricaded in their room, a cabinet was moved in front of R1’s door preventing R1 from leaving the room. Staff B stated that after interviewing Staff D on 03/29/2026 about the incident, Staff D was terminated and the investigation continued. Staff B stated that they then interviewed Staff E, medication technician, who admitted helping Staff D move the cabinet in front of R1’s door to prevent R1 from leaving the room. Staff B stated that Staff E was terminated on 03/30/2026. Staff B stated they were unsure how long R1 was barricaded in their room. Staff B stated their last day of employment at the facility was 03/31/2026.

In an interview on 05/01/2026 at 01:05 PM, Staff E, medication technician, stated that Staff D put the heavy cabinet that barricaded R1 in their room causing them to fail to

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Statement of Deficiencies	License #: 2521	Compliance Determination # 76709
Plan of Correction	Bonaventure of Salmon Creek	Completion Date
Page 8 of 12	Licensee: Bonaventure of Salmon Creek LLC	05/26/2026

get out. Staff E stated that it was not right to put the cabinet that blocked and restricted R1 from moving around the unit.

In an interview on 05/04/2026 at 03:58 PM Staff C, caregiver, stated she was taking trash out through the memory care unit and heard someone crying for help and saw a heavy cabinet placed in front of R1's doorway. Staff C stated that when approaching the door saw R1 looking distressed, uncomfortable, red faced, and the incontinent brief was wet and that R1 asked Staff C to help them get out. Staff C stated that they went to find help, found Staff D sleeping on the couch. Staff C stated that they asked Staff D if they were the one who moved the cabinet and blocked R1's door to prevent R1 from leaving. Staff C stated that Staff D said, "she was pissing me off" and that Staff D was aware it was illegal. Staff C threatened to call the police if Staff D refused to help move the cabinet, Staff D assisted Staff C moving the cabinet. Staff C stated they notified their supervisor, Staff B, immediately via text.

In an interview on 05/05/2026 at 02:12 PM, Staff D, caregiver, stated that R1 had a habit of trying to escape and admitted to using furniture to block the alarmed memory care exit door but denied that they locked the R1 in their room. Staff D stated that R1 would keep trying to go through the emergency exit and set off the alarm, R1 would try to open doors 10 to 12 times a night. Staff D admitted that putting furniture in front of any door to stop residents from going through it was not acceptable and as a form of restraint.

In an interview on 04/30/2026 at 11:00 AM, Staff A, Traveling Health Services, who is acting as the executive director, stated they reported the incident that occurred to R1 on 03/29/2026. Staff A stated that the incident involving R1 took place between the hours of 10:00 PM on 03/28/2026 and 3:00 AM on 03/29/2026. Staff A stated that Staff C found R1 barricaded in their room when a piece of furniture was placed in front of R1's door blocking the exit and acknowledged that R1's rights were violated.

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) 7/10/26.

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

Administrator (or Representative) 06/17/26 Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

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get out. Staff E stated that it was not right to put the cabinet that blocked and restricted R1 from moving around the unit.

In an interview on 05/04/2026 at 03:58 PM Staff C, caregiver, stated she was taking trash out through the memory care unit and heard someone crying for help and saw a heavy cabinet placed in front of R1's doorway. Staff C stated that when approaching the door saw R1 looking distressed, uncomfortable, red faced, and the incontinent brief was wet and that R1 asked Staff C to help them get out. Staff C stated that they went to find help, found Staff D sleeping on the couch. Staff C stated that they asked Staff D if they were the one who moved the cabinet and blocked R1's door to prevent R1 from leaving. Staff C stated that Staff D said, "she was pissing me off" and that Staff D was aware it was illegal. Staff C threatened to call the police if Staff D refused to help move the cabinet, Staff D assisted Staff C moving the cabinet. Staff C stated they notified their supervisor, Staff B, immediately via text.

In an interview on 05/05/2026 at 02:12 PM, Staff D, caregiver, stated that R1 had a habit of trying to escape and admitted to using furniture to block the alarmed memory care exit door but denied that they locked the R1 in their room. Staff D stated that R1 would keep trying to go through the emergency exit and set off the alarm, R1 would try to open doors 10 to 12 times a night. Staff D admitted that putting furniture in front of any door to stop residents from going through it was not acceptable and as a form of restraint.

In an interview on 04/30/2026 at 11:00 AM, Staff A, Traveling Health Services, who is acting as the executive director, stated they reported the incident that occurred to R1 on 03/29/2026. Staff A stated that the incident involving R1 took place between the hours of 10:00 PM on 03/28/2026 and 3:00 AM on 03/29/2026. Staff A stated that Staff C found R1 barricaded in their room when a piece of furniture was placed in front of R1's door blocking the exit and acknowledged that R1's rights were violated.

Plan/Attestation Statement

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Administrator (or Representative) Date

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(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify law enforcement when a crime was suspected and failed to timely notify the Department when abuse and involuntary seclusion was suspected for 1 of 4 residents (Resident 1) R1. This failure resulted in law enforcement not being notified and a delay in notification to the Department, both of which required immediate notification, and placed all residents at risk for harm in a facility that failed to notify the Department and law enforcement as required.

Findings included…

RCW 74.34.035 Reports—Mandated and permissive—Contents— Confidentiality (1) When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department.

Record review of an undated facility policy titled, “Abuse, Neglect or Exploitation” showed that all staff members are mandatory reporters and have the responsibility to report abuse, neglect, and/or exploitation to the proper authorities without fear of retaliation.

In an interview on 04/30/2026 at 11:00 AM, Staff A, Traveling Health Services, who is acting as the executive director, stated they reported the incident that occurred to R1 on 03/29/2026, the report was called into the Department on 04/24/2026. Staff A stated that the incident involving R1 took place between the hours of 10:00 PM on 03/28/2026 and 3:00 AM on 03/29/2026. Staff A stated that Staff C found R1 barricaded in their room when a piece of furniture was placed in front of R1’s door blocking the exit. Staff A stated that they reported the incident to State when they were told that facility had not reported incident to Department.

In an interview on 05/01/2026 at 1:13 PM, Staff B, former Health and Wellness Director, stated that the duty to report this incident, after discussion with other management members, was the acting executive director’s responsibility and that they did not report this incident to the Department, law enforcement or R1’s representative. Staff B stated their last day of employment at the facility was 03/31/2026.

This document was prepared by Residential Care Services for the Locator website.

Statement of Deficiencies	License #: 2321	Compliance Determination # 76709
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Record review of R1's facility records showed no documentation of the 03/29/2026 incident, no investigation, no monitoring or documentation showing that notifications to the Department, law enforcement and resident representative were made.

In an interview on 05/20/2025 at 3:07 PM, Staff F, Reginal Director of Operations, stated that they were informed of the 03/29/2026 incident involving R1 and stated that it was abuse. Staff F acknowledged that they are mandated reporters and stated that the incident should have been reported to the Department, law enforcement and family immediately. Staff F stated that they thought Staff B had reported the incident.

Refer to WAC 388-78A-2660 Resident Rights.

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) 7/10/26.

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

Administrator (or Representative) 6/17/26 Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to investigate and document actions and findings for suspected abuse jeopardizing residents' health for 1 of 4 sampled residents (Resident 1). This failure resulted in the facility being unable to determine the circumstances of the event, institute, and document appropriate measures to prevent similar situations, and protect the residents during the course of the investigation placing all residents for a decreased quality of life.

Findings included...

Record review of an undated facility policy titled "Abuse, Neglect or Exploitation" stated

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Record review of R1's facility records showed no documentation of the 03/29/2026 incident, no investigation, no monitoring or documentation showing that notifications to the Department, law enforcement and resident representative were made.

In an interview on 05/20/2025 at 3:07 PM, Staff F, Reginal Director of Operations, stated that they were informed of the 03/29/2026 incident involving R1 and stated that it was abuse. Staff F acknowledged that they are mandated reporters and stated that the incident should have been reported to the Department, law enforcement and family immediately. Staff F stated that they thought Staff B had reported the incident.

Refer to WAC 388-78A-2660 Resident Rights.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to investigate and document actions and findings for suspected abuse jeopardizing residents' health for 1 of 4 sampled residents (Resident 1). This failure resulted in the facility being unable to determine the circumstances of the event, institute, and document appropriate measures to prevent similar situations, and protect the residents during the course of the investigation placing all residents for a decreased quality of life.

Findings included…

Record review of an undated facility policy titled "Abuse, Neglect or Exploitation" stated

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that the community will gather information, prepare an incident report for any abuse, neglect or exploitation to determine the circumstances of the event and to determine appropriate measures to prevent similar future situations.

Record review of facility records for Resident 1 (R1) showed a facility move in date of [redacted]/2024 with diagnoses that include [redacted]. R1 resides in the locked memory care unit of the facility and identified as being at risk for elopement (the likelihood that someone will wander or run away from a safe, supervised environment without the staff or caregivers knowing). R1's baseline cognition was noted to be confused most of the time.

Record review of R1's facility records showed no documentation of the 03/29/2026 incident, no investigation, no monitoring or documentation showing that incident that happened to R1 was recording and measures were put in place to prevent such incident from happening again.

In an interview on 04/30/2026 at 11:00 AM, Staff A, Traveling Health Services, who was acting executive director, stated that they did not investigate the incident that happened to R1 on 03/29/2026 where R1 was found barricaded in their room. Staff A stated that they were told that Staff B did the investigation and reported it to the Department on 04/24/2026. Staff A could not provide copy of the investigation to the investigator when asked and stated they did not have it.

In an interview on 05/01/2026 at 1:13 PM, Staff B, former Health and Wellness Director, stated that the investigation into R1's incident was started on 03/29/2026 with the interviews of the staff members that were involved in the incident. Staff B stated that their last day of employment at the facility was 03/31/2026 and folder with investigations of the incident was left behind in their office.

In an interview on 05/20/2025 at 3:07 PM, Staff F Reginal Director of Operations stated that they were informed of the 03/29/2026 incident involving R1. Staff F stated that the incident should have been investigated and findings documented. Staff F stated that they thought Staff B had completed the investigation.

Refer to WAC 388-78A-2660 Resident Rights.

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_____ _____

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