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

BONAVENTURE OF VANCOUVER LLC
Bonaventure of Vancouver
3425 Boone Rd SE
Salem, OR 97317

RE: Bonaventure of Vancouver # 2535

Dear Administrator:

This document references Compliance Determination 32907 (12/18/2023), which included complaint number(s) 99620, 104623, 105203, 105267.
The Department completed a complaint investigation of your Assisted Living Facility on 12/18/2023 and found that your facility does not meet the Assisted Living Facility requirements.

The department staff who did the inspection and provided consultation:

Jacob Ubl, ALF NCI CI

Consultation:

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:

(d) When a resident stops breathing or a resident's heart appears to stop beating, including, but not limited to, any action staff persons must take related to advance directives and emergency care;

The Facility has a policy requiring care staff to have their Cardiopulmonary Resuscitation certificate (CPR) and the Facility failed to have a staff Medication Technician obtain their CPR after they had worked at the Facility for 4 months.

You Must:
- Begin the process of correcting the deficiency or deficiencies immediately; and
- Complete correction as soon as possible.

You Are Not:
- Required to submit a plan-of-correction for the deficiency or deficiencies found.

The Department May:
- Inspect the facility to determine if you have corrected all deficiencies.

You May:
- Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:
- Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  - o What specific deficiency or deficiencies you disagree with;
  - o Why you disagree with each deficiency; and
  - o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  - o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:
- Please contact me at (360)450-1218.

Sincerely,

Michael Burdick, Field Manager
Region 3, Unit I
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Bonaventure of Vancouver **Provider Type:** Assisted Living Facility

License/Cert.#: 2535
Intake ID: 104623
Compliance Determination #: 32907
Region/Unit #: RCS Region 3 / Unit I
Investigator: Jacob Ubl
Investigation Date(s): 11/21/2023 through 12/18/2023
Complainant Contact Date(s):

Allegation(s):

1. Unqualified personnel: Allegation that staff do not have Food Cards or Cardiopulmonary Resuscitation (CPR) cards.

2. Physical environment: Allegation that the facility environment is poorly maintained.

3. Administration/ personnel: Allegation that Administrative staff are not providing employees what they need to care for the residents.

4. Dietary Services: Allegation that undercooked chicken is possibly being served to residents.

Investigation Methods:

Sample:	Total residents: 77 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident staff Nursing staff Residents Family members Housekeeping staff Maintenance staff Kitchen staff
Record Reviews:	Medical records Incident investigation Facility policies

Staff training records
Staff patterns

Investigation Summary:

1. Unqualified personnel: Failed practice identified. The Facility has a policy requiring care staff to have their Cardiopulmonary Resuscitation certificate (CPR) and the Facility failed to have a staff Medication Technician obtain their CPR after they had worked at the Facility for 4 months.

2. Physical environment: The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews, observations and records review, no failed facility practice was substantiated during the investigation. Additional residents reviewed for care, safety and services with no concerns.

3. Administration/ personnel: The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews, observations and records review, no failed facility practice was substantiated during the investigation. Additional residents reviewed for care, safety and services with no concerns.

4. Dietary Services: The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews, observations and records review, no failed facility practice was substantiated during the investigation. Additional residents reviewed for care, safety and services with no concerns.

Conclusion / Action:

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