STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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 License # 2535

Dear Administrator:

This letter addresses Compliance Determination(s) 78976 (Completion Date 06/17/2026) and 67276 (Completion Date 04/28/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/17/2026 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-2160

The Department staff who did the on-site verification:
Richard Westom, NCI, ALF Complaint Investigator

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

Sincerely,

Laurie Anderson

Laurie Anderson, Community 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 Vancouver **Provider Type:** Assisted Living Facility

License/Cert.#: 2535
Intake ID: 198560
Compliance Determination #: 67276
Region/Unit #: RCS Region 3 / Unit E
Investigator: Clinton Fridley
Investigation Date(s): 10/16/2025 through 04/28/2026
Complainant Contact Date(s):

Allegation(s):

1. Neglect: Resident was found down and suspect resident wasn't checked on for days.
2. Death: resident passed away at hospital after incident in facility.

Investigation Methods:

Sample:	Total residents: 59 Resident sample size: 3 Closed records sample size:
Observations:	Residents Dining Resident rooms Staff to resident interactions
Interviews:	Identified staff Residents Family members Housekeeping staff Business office manager Kitchen staff executive director local law enforcement
Record Reviews:	facility records Hospital records Incident investigation progress notes staff list-schedules medication records call logs menus meal order forms

Investigation Summary:

1. Neglect: Facility was investigated related to concerns noted in allegation and

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after interview of reporter, able to validate that the facility failed to either provide, or document, agreed upon care and services were provided as agreed upon in the negotiated service agreement, failed practice identified.
2. Death: Facility was investigated related to concerns noted in allegation and after interview of reporter, able to validate that the facility failed to either provide, or document, agreed upon care and services were provided as agreed upon in the negotiated service agreement, failed practice identified.

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 Vancouver **Provider Type:** Assisted Living Facility

License/Cert.#: 2535
Intake ID: 198560
Compliance Determination #: 67276
Region/Unit #: RCS Region 3 / Unit E
Investigator: Clinton Fridley
Investigation Date(s): 10/16/2025 through 04/28/2026
Complainant Contact Date(s):

Allegation(s):

1. Neglect: Resident was found down and suspect resident wasn't checked on for days.
2. Death: resident passed away at hospital after incident in facility.

Investigation Methods:

Sample:	Total residents: 59 Resident sample size: 3 Closed records sample size:
Observations:	Residents Dining Resident rooms Staff to resident interactions
Interviews:	Identified staff Residents Family members Housekeeping staff Business office manager Kitchen staff executive director local law enforcement
Record Reviews:	facility records Hospital records Incident investigation progress notes staff list-schedules medication records call logs menus meal order forms

Investigation Summary:

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after interview of reporter, able to validate that the facility failed to either provide, or document, agreed upon care and services were provided as agreed upon in the negotiated service agreement, failed practice identified.
2. Death: Facility was investigated related to concerns noted in allegation and after interview of reporter, able to validate that the facility failed to either provide, or document, agreed upon care and services were provided as agreed upon in the negotiated service agreement, failed practice identified.

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 Vancouver
Provider Type: Assisted Living Facility

License/Cert.#: 2535
Intake ID: 200585
Compliance Determination #: 67276
Region/Unit #: RCS Region 3 / Unit E
Investigator: Clinton Fridley
Investigation Date(s): 10/16/2025 through 04/28/2026
Complainant Contact Date(s):

Allegation(s):

1. Neglect: Resident was found down and suspect resident wasn't checked on for days, concerns of neglect from facility staff.

Investigation Methods:

Sample:
Total residents: 59
Resident sample size: 3
Closed records sample size:

Observations:
Residents
Dining
Resident rooms
Staff to resident interactions

Interviews:
Identified staff
Residents
Family members
Housekeeping staff
Business office manager
Kitchen staff
executive director
local law enforcement

Record Reviews:
facility records
Hospital records
Incident investigation
progress notes
staff list-schedules
medication records
call logs
menus
meal order forms

Investigation Summary:

1. Neglect: Facility was investigated related to concerns noted in allegation and after interview of reporter, able to validate that the facility failed to either provide,

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or document, agreed upon care and services were provided as agreed upon in the negotiated service agreement, failed practice identified.

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 10/16/2025 and 04/28/2026 of:

Bonaventure of Vancouver
9317 NE 86th Street
Vancouver, WA 98662

This document references the following complaint number(s): 198560, 198560, 198567, 198706, 200585

The following sample was selected for review during the unannounced on-site visit: 3 of 59 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Clinton Fridley, Community Nurse Field Manager

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

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Statement of Deficiencies	License #: 2535	Compliance Determination # 67276
Plan of Correction	Bonaventure of Vancouver	Completion Date
Page 2 of 4	Licensee: BONAVENTURE OF VANCOUVER LLC	04/28/2026

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

05/04/2026
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.

M Landsverk
Administrator (or Representative)

5/14/26
Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to consistently implement agreed upon services, safety checks and meal delivery, as outlined in a temporary service plan for 1 of 3 residents (Resident 1). This failure contributed to a delay in identifying Resident 1's (R1) condition on [redacted]2025, when R1 was found minimally responsive on the floor of their bedroom.

Findings included...

Record review of facility document titled "Resident Temporary Service Plan," dated 09/23/2025 documented the facility would provide R1 with meal trays three times daily, a morning and evening safety check, a 9:00 am reminder to wake up daily, and a 9:00 pm reminder to go to bed.

Record review of facility provided "Room Tray Order Form" showed R1 last ordered a meal on 10/08/2025. No documentation was provided showing meals were ordered, delivered or refused on 10/09/2025, 10/10/2025 or [redacted]/2025.

Record review of facility provided "Caregiver Task Sheet" dated 10/10/2025 showed Resident 1 received a safety check and refused a shower. No other caregiver tasks

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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 _____

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to consistently implement agreed upon services, safety checks and meal delivery, as outlined in a temporary service plan for 1 of 3 residents (Resident 1). This failure contributed to a delay in identifying Resident 1's (R1) condition on [redacted]/2025, when R1 was found minimally responsive on the floor of their bedroom.

Findings included…

Record review of facility document titled "Resident Temporary Service Plan," dated 09/23/2025 documented the facility would provide R1 with meal trays three times daily, a morning and evening safety check, a 9:00 am reminder to wake up daily, and a 9:00 pm reminder to go to bed.

Record review of facility provided "Room Tray Order Form" showed R1 last ordered a meal on 10/08/2025. No documentation was provided showing meals were ordered, delivered or refused on 10/09/2025, 10/10/2025 or [redacted]2025.

Record review of facility provided "Caregiver Task Sheet" dated 10/10/2025 showed Resident 1 received a safety check and refused a shower. No other caregiver tasks

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sheets were provided showing safety checks were completed on any other days

On 10/27/2025 at 2:46 PM, Staff B, caregiver, stated that on [redacted] 2025 at 2:15 PM they entered R1's apartment to perform a safety check, called R1's name, and checked each room. Staff B observed leftover dinner left on the table and all lights off but did not locate R1 and left the apartment. Staff B stated they returned to the apartment a short time later to clean up the kitchen area, noted the dinner tray appeared to have been there for some time, called out to R1 with no response, and assumed R1 was out with family as it was not unusual for R1 to leave the facility. Staff B stated they followed up with the swing shift medication technician regarding R1's whereabouts but that individual did not know, and Staff B did not follow up further and did not deliver the evening dinner tray to R1 that night. Staff B stated that at shift change they reported to Staff A, caregiver/medication technician, that R1 was assumed to be out of the facility. Staff A directed Staff B to re-enter R1s apartment to verify R1's whereabouts. Staff B stated that upon entering R1's bedroom they observed R1 on the floor next to the window, initially believed R1 to be deceased, but found R1 to be alive when approached. R1 was minimally responsible and able to say only yes. Staff B stated 911 was called and R1 was transported to the hospital.

Record review of facility "Charting Notes" for R1 showed an entry by Staff A on [redacted]/2025 documenting that at shift change, Staff B reported R1 was assumed to be out of the facility. Staff A documented Staff B went to recheck R1's apartment and found R1 on the floor of the bedroom minimally responsive and able to say only "yep," 911 being called, and R1 being transported to the hospital. Staff A documented notifying R1's power of attorney, who stated they had been unable to reach R1 for the previous two nights. Staff MT) further documented that review of the communication log showed R1 had been asked and refused a shower on 10/10/2025.

Record review of hospital records, dated [redacted]/2025, documented R1 arrived in the emergency department with stable blood pressure and heart rate, breathing normally on room air, and without visible signs of injury or infection. The record further documented an abnormal heart tracing (EKG) and an elevated creatine kinase (CK) level (CK is a muscle enzyme that rises in the bloodstream when muscle tissue is damaged from prolonged pressure or immobility). The hospital provider documented these findings consistent with early rhabdomyolysis (a breakdown of muscle tissue that occurs when a person remains on a hard surface for an extended period). R1 was admitted to the hospital with diagnoses of [redacted] and [redacted].

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Statement of Deficiencies	License #: 2535	Compliance Determination # 67276
Plan of Correction	Bonaventure of Vancouver	Completion Date
Page 4 of 4	Licensee: BONAVENTURE OF VANCOUVER LLC	04/28/2026

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 Vancouver is or will be in compliance with this law and / or regulation on (Date) 6/12/2026 .

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

Administrator (or Representative) Date 5/14/26

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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 Vancouver 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

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