OKLAHOMA
State Department
of Health

Delivery via email to: lmeacham@beehivehomes.com

May 10, 2022

License Number: AL7242

Ms. Lisa Meacham, Administrator/Director
Beehive Homes Of Glenpool
12570 South Vancouver Ave
Glenpool, OK 74033

Survey Event ID: PS1T11

Dear Ms. Meacham:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **April 28, 2022**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 426-8200.

Sincerely,

Lisa Calvin

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: **Beehive Homes of Glenpool**
Address: **12570 South Vancouver Ave.**
City, State, Zip: **Glenpool, Ok. 74033**
Provider #: **AL7242**
Complaint #: **OK00058688**
Investigation Date(s): **04/25/22 through 04/28/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center neglected to provide adequate supervision to ensure resident safety, and failed to assess and monitor a resident with behaviors and medication changes.	**US**
2. The center failed to follow their abuse policy to ensure residents were not involuntarily secluded and failed to report sexually inappropriate behavior.	**US**

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on Monday, April 25, 2022 at 1:40 p.m.

A sample of three residents including any identified resident, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.
A tour of the facility was conducted on arrival and throughout the survey. Residents were observed participating in activities of daily, participating in group activities, socializing in common areas and during mealtime, and spending private time in their rooms. Confused and wandering residents were observed to receive timely redirection and encouragement. All residents were observed to be clean (the men clean shaven), properly dressed in clean clothing, and over-all well groomed.

Staff were observed assisting residents with activities of daily living, providing/participating and assisting with activities, socializing in the common areas with residents at mealtime and between meals, and providing assistance in resident rooms when needed. Staff were observed to provide redirection and encouragement for confused and wandering residents.

Residents were interviewed and stated the staff were very kind, considerate, and caring. They stated they felt safe in their home and got along well with their neighbors and friends in the facility. During one interview, another resident waited at the entry to the interviewed resident's door and only after receiving a wave to enter, did she do so. By observation, the resident entered only to check to confirm the interviewed resident was safe, giving a critical eye toward the surveyor and a questioning nod to the interviewed resident. The interviewed resident stated the visitor was a friend who checked on him throughout the day and told her he was fine. Staff knocked and entered right behind the resident and after this short interaction, redirected and encouraged the visiting resident to return to the common areas.

Staff were interviewed and stated the facility was a locked memory care center for assisted living residents. The facility staff stated they received training on providing care to residents with dementia. Staff stated they monitored residents who wandered and encouraged all residents to interact in the common areas and not in their personal rooms. The staff stated some residents preferred to spend their time in their rooms. The admin stated local ordinances required locks be placed on all resident doors. She stated some of the residents prefer to carry their room key and lock their door and others do not. She stated all residents have the ability to exit their rooms without a key but may need a key to re-enter. She stated staff do have keys to the rooms to allow for assistance and supervision.

The facility staff stated any concerns related to residents was brought to the attention of the administration, the resident's physician, family and hospice (if appropriate).

The sampled residents' clinical records were reviewed and documented concerns were addressed with the residents' families, physicians, and hospice providers when appropriate. The records documented families were notified of physician's orders, test results, and outcomes. The review documented the staff encouraged family participation in their residents' lives, empowered families through education and options in care for their family member, and worked with families to provide additional resident support such as a private sitters and/or mental health services.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.
A facility tour was conducted on arrival and throughout the survey. Resident rooms were observed to have locks on their doors. The door locks were observed to have two settings, one setting allowed the door to automatically lock after opening, requiring a key for re-entry. The other setting required the lock to be manually pushed to lock otherwise re-entry was possible without a key. There was no observation of involuntary seclusion.

Some resident bedroom doors were observed opened and others closed.

Residents were interviewed and stated they chose if their door was closed or remained open and chose if they socialized in the common areas or spent time alone in their rooms. All interviewed denied involuntary seclusion.

Staff were interviewed and stated they received dementia care training to include behavior management. Staff stated they balanced the need to monitor residents with respecting residents' wish for personal time. They stated they constantly encouraged residents to participate in daily activities and socialize with other residents

and staff in the common areas. Staff denied any resident was involuntarily secluded. Staff stated some residents exhibited inappropriate sexual behavior at times but were easily redirected. They stated their training included how to manage behavioral incidents and they communicated such instances with the administrative staff, resident physicians, and appropriate families.

Sampled residents' clinical records were reviewed and documented the facility communicated concerns with the resident's family, physician, and hospice provider when appropriate. The clinical records documented the facility and physician worked with the resident and family to provide care, addressing needs and concerns, making changes to resident care, monitoring outcomes, and adjusting the care as needed. The facility documented the communication with family and physician through such concerns as physical/social needs, accidents/injuries, and behaviors/mental health concerns. There was no documentation of involuntary seclusion.

Informal family council meetings were noted. Incident reports and State Reportable Incident Reports were reviewed.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation one and two. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

B. Garrison By Ed Rotl

B. Garrison, R.N.

Date report completed: 05/04/2022

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7242	A. BUILDING: _____ B. WING _____	C 04/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF GLENPOOL	12570 SOUTH VANCOUVER AVE GLENPOOL, OK 74033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A complaint investigation (#OK00058688) was conducted from 04/25/2022 through 04/28/2022. No deficiencies were cited.	C 000		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE