



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

Caring Places Management, LLC
Beehive Retirement and Assisted Living Community
401 W Maple St
McCleary, WA 98557

RE: Beehive Retirement and Assisted Living Community License # 2148

Dear Administrator:

This letter addresses Compliance Determination(s) 61053 (Completion Date 06/12/2025) and 57884 (Completion Date 04/18/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/12/2025 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-3090-1-a, WAC 388-78A-3090-1-b, WAC 388-78A-3090-1-c, WAC 388-78A-3090-1-d, WAC 388-78A-3090-1, WAC 388-78A-2730-1-b, WAC 388-78A-2730-1-a, WAC 388-78A-2730-2-b-i

The Department staff who did the on-site verification:

Anissa Bearden, Licensors

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley, Adult Family Home Nurse Field Manager
Region 3, Unit E
Residential Care Services

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



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

Statement of Deficiencies	License # 2148	Compliance Determination #57884
Plan of Correction	Beehive Retirement and Assisted Living Community	Completion Date
Page 1 of 10	Licensee: Caring Places Management, LLC	04/18/2025

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 follow-up on 04/11/2025 of:

Beehive Retirement and Assisted Living Community
401 W Maple St
McCleary, WA 98557

This document references the following SOD dated: 04/18/2025

The following sample was selected for review during the unannounced on-site visit: 3 of 44 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensors
Celeste Vashey, ALF LTC Licensors

From:
DSHS, Aging and Long-Term Support 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 #: 2148	Compliance Determination #57884
Plan of Correction	Beehive Retirement and Assisted Living Community	Completion Date
Page 2 of 10	Licenses: Caring Places Management, LLC	04/18/2025

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.

Cory Cisneros

Residential Care Services

04/29/2025

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.

Michelle Dube

Administrator (or Representative)

5/7/25

Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

- (a) Provide a safe, sanitary and well-maintained environment for residents;
- (b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;
- (c) Keep facilities, equipment and furnishings clean and in good repair; and
- (d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to provide a safe, sanitary, and well-maintained environment for 2 of 2 (front entrance and kitchen facility) areas reviewed. These failures placed 44 of 44 residents at risk of a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date: 02/13/2025, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC (Washington Administrative Code) 388-78A-3090] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Administrator, signed the document on 03/04/2025. Staff A signed the "Plan/Attestation Statement" for all citations cited that

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Cory Cisneros

Residential Care Services

04/29/2025

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Administrator (or Representative)

Date

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read "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, [the facility] is or will be in compliance with this law and/or regulation on 03/29/2025."

Record review of the facility provided, "Plan of Correction", dated 02/25/2025, showed under WAC 388-78A-3090 the action section included that the facility would hire a general contractor to refurbish the existing structure of the walk-in refrigerator to meet compliance requirements. Staff C, Maintenance Supervisor, and Staff D, Corporate Project Manager, had been the responsible persons for this task. The completed date section showed that estimates were in progress. The ADA (Americans with Disabilities Act) doors were operable. The complete date section showed the task had been completed 03/29/2025. Under WAC 388-78A-2730 the action section showed the facility worked to obtain bids to replace the HVAC (heating ventilation and air conditioning) system in the kitchen. The completed date section showed that estimates were in progress.

Record review of the facility document titled, "Disclosure of Services", dated "02/2007", showed that the facility must maintain resident living quarters and other areas residents may use in a safe, clean, and comfortable condition.

Facility Front Entrance

Record review of Allegion Custom Quote, dated 03/11/2025, showed it was a quote to install and furnish the east, north, and south door ADA functions. The document was not signed or dated by the facility staff or the facility's corporation to show that the estimate was accepted for repairs.

In an observation on 04/11/2025 at 10:20 AM, the outside of the facility front doors had a button nearby that said, "press to operate". When the button was pressed, the automatic door did not open. The front door had to be manually opened. On the inside of the facility front doors had a button nearby that said, "press to operate". When the button was pressed, the automatic door did not open. There was no sign on the inside of the facility and outside of the facility that showed the buttons were out of order and did not work.

Record review of, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 04/01/2025, showed Resident 1 [R1] moved into the facility on [REDACTED]/2024.

Record review of R1's, "Service Agreement", dated 03/08/2025, showed under the ambulation section that R1 had a four wheeled walker and an electric scooter that they used. Under the skin section showed R1's legs were extremely swollen, hard, and warm to the touch. On an untitled and undated paper attached to R1's service agreement "Symptoms of Lymphedema (a chronic condition that caused swelling usually in the arms or legs due to build up of fluid in the tissues)" showed swelling, numbness, pain,

and decreased range of motion were all common symptoms.

In an interview on 04/11/2025 at 12:38 PM, R1 said they had lymphedema in their legs. R1 said the ADA button in the front of the facility was still broken. R1 said they used their feet to prop open the door which put pressure on their knees and caused them pain. R1 said if the ADA button worked it would save them from extra pressure on their body and therefore pain.

In an interview on 04/11/2025 at 12:55 PM, Staff C, Maintenance Supervisor, stated the ADA buttons for the doors did not work. Staff C stated they had reached out to the corporation staff that informed Staff C to get three new quotes to get a new system installed for the doors. Staff C stated corporate staff reviewed the quotes for the new system and did not want to proceed and told Staff C to get current quotes to repair the current ADA buttons and system that was already installed on the door. Staff C stated they were still in the process of getting the rest of the quotes for the current ADA system.

Kitchen Walk in Refrigerator

Record review of an email sent from Staff C titled, "Walk-in Rebuild", dated 03/28/2025, showed Staff C sent an email to inquire about costs to fix the walk-in refrigerator. The printed email showed a sticky note that read kitchen walk-in third contractor scheduled on 04/11/2025. In handwritten letters on the email showed "came out 4/1/25 waiting on estimate".

In an observation on 04/11/2025 at 11:25 AM, inside the walk-in refrigerator, on the ceiling in multiple areas throughout the entire refrigerator were multiple areas that had large areas of black spotted substance, and the ceiling was cracked or flaking white substance that exposed dark black and brown wood and substance. In the far-right corner near the ceiling was an area that showed the white wall was cracked and exposed dark brown and black wood and nails that was from the ceiling down quarter of the wall. The ceiling in the same area was cracked, flaking substance of white and black, and exposed solid black substance with spotted black dotted areas around the solid black substance. Some of the ceiling was cracked and caved inwards and some areas protruded down. There were other areas around the cracks that were black and spotted that resembled mold and rotten wood. It was observed throughout the ceiling there were multiple areas that showed the ceiling was bubbled or ripped and broke. There were large areas of spotted black substance that resembled mold around the areas of the ceiling that were bubbled, cracked, broke, or ripped. In the far-left corner of the walk-in refrigerator on the ceiling were large areas that was cracked, and had black substance exposed. There was white with spotted black substance around the area that resembled mold. On the fan that was on the ceiling near the entry way showed it had black and white substance all over the plastic grate and on the fan blades. There was dripping water on the three tubes that were connected to the fan unit and extended to the wall behind the fan unit.

Statement of Deficiencies	License # 2148	Compliance Determination #57884
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In an interview on 04/11/2025 at 11:40 AM, Staff C said the facility must obtain three separate bids before corporate would approve work to be completed on the walk-in refrigerator inside of the kitchen. Staff C said they currently had one bid.

Kitchen HVAC Unit

Record review of an email sent to Staff C titled, "Bid for HVAC for Kitchen...", dated 04/04/2025, showed it was a proposed bid to replace the kitchen's HVAC system. On top of the printed email had been a sticky note that read two quotes from Olympic Heating and Cooling, LLC (Limited Liability Company) and Ameri Cool Heating and Air conditioning. The email did not indicate that the estimate was accepted for repairs.

Record review of "Olympic Heating & Cooling LLC", dated 04/04/2025, showed it was a proposed bid to replace the Mitsubishi ductless heat pump and ceiling cassette in the kitchen. The proposal was valid for 15 days from the date of the proposal. The date of acceptance and signature section was not signed by the facility staff or the facility's corporation to show that the estimate had been accepted for repairs.

In an observation on 04/11/2025 at 11:30 AM, the HVAC in the kitchen above the island where food had been prepped had pieces from the unit that were missing.

In an interview on 04/11/2025 at 11:40 AM, Staff C said Staff D had changed their minds on what type of bid to obtain to fix the HVAC unit inside of the kitchen. Staff C said they had to work to obtain three new bids before the corporation would approve the work to the HVAC unit.

In an interview on 04/11/2025 at 1:28 PM, B, Assistant Administrator, acknowledged that the facility's ADA button to their front door did not work. Staff B confirmed the facility did not have three bids and a confirmed start date for work to be completed on the walk-in refrigerator and the kitchen's HVAC unit. Staff B stated the corporation had changed their minds on what type of bid needed to be completed for the HVAC unit. Staff B stated the facility needed to obtain three new bids to submit for approval. Staff B expressed their understanding that the facility would not be in compliance until they could provide confirmed start dates for the work to be completed on the facility front door's ADA button, the kitchen's walk-in refrigerator, and the kitchen's HVAC unit.

In an interview on 04/18/2025 at 10:54 AM, Staff A stated the corporation needed three bids before they would approve work to be completed in the kitchen. Staff A stated the type of bid for the kitchen's HVAC unit had been changed by corporate staff which resulted in the facility needing to obtain new bids to submit and therefore be approved. Staff A acknowledged the bids they received would expire before they could be approved which delayed the process.

This is an uncorrected deficiency previously cited on 02/13/2025 for subsection 1(a)(b)

Statement of Deficiencies	License # 2148	Compliance Determination # 57884
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(c)(d).

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, Beehive Retirement and Assisted Living Community is or will be in compliance with this law and / or regulation on (Date) 5/31/25.

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

Michelle M. Duke
Administrator (or Representative)

5/7/25
Date

WAC 388-78A-2730 Licensee's responsibilities:

(1) The assisted living facility licensee is responsible for:

(a) The operation of the assisted living facility;

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

(2) The licensee must:

(b) Maintain and post in a size and format that is easily read, in a conspicuous place on the assisted living facility premises:

(i) A current assisted living facility license, including any related conditions on the license;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Licensee failed to ensure the facility operated in compliance with licensing requirements for 1 of 1 facility reviewed. These failures impacted all 44 residents, staff, and visitors quality of life.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 02/13/2025, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC (Washington Administrative Code) 388-78A-2730] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Administrator, signed the document on:

(c)(d).

Plan/Attestation Statement

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Plan of Correction	Beehive Retirement and Assisted Living Community	Completion Date
Page 7 of 10	Licensee: Caring Places Management, LLC	04/18/2025

03/04/2025. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 03/29/2025."

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This is an uncorrected deficiency previously cited on 02/13/2025 for subsections 1(a)(b)2(b)(i).

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Plan of Correction	Beehive Retirement and Assisted Living Community	Completion Date
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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, Beehive Retirement and Assisted Living Community is or will be in compliance with this law and / or regulation on (Date) 5/31/25

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

Michelle Myers
Administrator (or Representative)

5/7/25
Date

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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, Beehive Retirement and Assisted Living Community 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

Plan of Correction for Beehive Retirement Community

1. Kitchen HVAC unit:

Replace current Mitsubishi HVAC system in the kitchen with a 18k Mini split using the existing lines and electrical. Remove ceiling mount unit, frame, sheetrock, mud, tape, texture and paint. Working around kitchen hours and needs.

This work will be started by 5/10/25 and completed by 5/31/25.

This work will be performed by Kelly Britz, Commercial Property Services

2. Walk-in Cooler repair:

Replace damaged mdf in the cooler with FRP, only repairing walls and ceiling where needed to keep a cleanable food safe surface. The condenser is functional does not need to be removed.

This work will be started by 5/10/25 and should be completed by 5/17/25.

This work will be performed by Josh Tucker and Brian Willis, CPM Maintenance



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

Statement of Deficiencies	License # 2148	Compliance Determination #53718
Plan of Correction	Beehive Retirement and Assisted Living Community	Completion Date
Page 1 of 53	Licensee: Caring Places Management, LLC	02/13/2025

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 the unannounced on-site full inspection and complaint investigation on 01/28/2025 and 02/13/2025 of:

Beehive Retirement and Assisted Living Community
401 W Maple St
McCleary, WA 98557

This document references the following complaint numbers: 163934, 163189, 162304, 161706, 161298.

The following sample was selected for review during the unannounced on-site visit: 7 of 46 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensors
Celeste Vashey, ALF LTC Licensors

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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Page 2 of 53	Licenses: Caring Places Management, LLC	02/13/2025

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.

Cory Cisneros

Residential Care Services

02/25/2025

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.

Michelle Dyke

Administrator (or Representative)

3/4/25

Date

WAC 388-78A-2030 Assisted living facility license required.

(1) An assisted living facility license is required to operate or maintain an assisted living facility as defined in chapter 18.20 RCW and this chapter.

(2) An assisted living facility license is required when any person other than a family member provides housing, one or more basic services, and one or more of the following:

(a) Assumes general responsibility for the safety and well-being of the residents except as provided in WAC 388-78A-2032 ;

(b) Provides domiciliary care which includes:

(i) Providing assistance with activities of daily living, either directly or indirectly as defined in this chapter and described in WAC 388-78A-2190 ;

(ii) Providing health support services, either directly or indirectly as defined in this chapter and described in WAC 388-78A-2200 ; or

(iii) Providing intermittent nursing services, either directly or indirectly as described in WAC 388-78A-2310

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure their annual licensing fee was paid to the Department and was current for 1 of 1 facility reviewed. This failure placed 46 of 46 residents at risk for displacement from the facility from not paying their annual licensing fee.

Findings included...

Record review on 01/24/2025 of the Department database, showed the facility's

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.

Cory Cisneros

Residential Care Services

02/25/2025

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-2030 Assisted living facility license required.

(1) An assisted living facility license is required to operate or maintain an assisted living facility as defined in chapter 18.20 RCW and this chapter.

(2) An assisted living facility license is required when any person other than a family member provides housing, one or more basic services, and one or more of the following:

(a) Assumes general responsibility for the safety and well-being of the residents except as provided in WAC 388-78A-2032 ;

(b) Provides domiciliary care which includes:

(i) Providing assistance with activities of daily living, either directly or indirectly as defined in this chapter and described in WAC 388-78A-2190 ;

(ii) Providing health support services, either directly or indirectly as defined in this chapter and described in WAC 388-78A-2200 ; or

(iii) Providing intermittent nursing services, either directly or indirectly as described in WAC 388-78A-2310 .

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure their annual licensing fee was paid to the Department and was current for 1 of 1 facility reviewed. This failure placed 46 of 46 residents at risk for displacement from the facility from not paying their annual licensing fee.

Findings included...

Record review on 01/24/2025 of the Department database, showed the facility's

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

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renewal invoice history which indicated their last paid invoice was due on 07/15/2023 and was effective from 09/01/2023 to 08/31/2024 with a balance of zero. The due date for their current invoice was on 07/15/2024 and showed they had a balance owed of \$7,076.00 for their coverage effective from 09/01/2024 – 08/31/2025.

In an observation on 01/28/2025 at 2:20 PM, the bulletin board that hung outside of Staff A's, Administrator, office showed a copy of the facility's assisted living license that had expired on 08/31/2024.

In an observation on 01/29/2025 at 11:02 AM, the bulletin board that hung outside of Staff A's office showed a copy of the facility's assisted living license which expired 08/31/2024.

In an interview and observation on 01/29/2025 at 11:16 AM, Staff A said the home office (facility's corporation office) updated the assisted living facility license annually. Staff A went to the bulletin board to look at the assisted living facility license that had been posted and acknowledged that the license that hung on the wall had been expired on 08/31/2024. Staff A said they promised the license had not expired. Staff A asked Staff B, Assistant Administrator, to review their emails to obtain a copy of the most up to date license. Staff B recommended to call home office to obtain a copy of the license. The Department informed Staff A that the Department's records showed their coverage to their license expired 08/31/2024.

In an interview on 01/29/2025 at 11:44 AM, Staff A said they followed up with home office who said they had no record of payment for the facility license they could provide. Staff A said Staff J, Corporate Accounts Payable, was the person responsible to ensure the assisted living license was updated.

In an interview on 01/29/2025 at 2:32 PM, Staff A stated the home office required Staff A to get a copy of the facility's license renewal invoice and send it to the home office to get the account paid.

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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, Beehive Retirement and Assisted Living Community is or will be in compliance with this law and / or regulation on: (Date) 3/4/25

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

Michelle Duke
Administrator (or Representative)

3/4/25
Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

- (a) Provide a safe, sanitary and well-maintained environment for residents;
- (b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;
- (c) Keep facilities, equipment and furnishings clean and in good repair; and
- (d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to provide a safe, sanitary, and well-maintained environment for 8 of 8 (kitchen, facility front entrance, activities room, memory care hallway, trash and recycle, Resident 3 [R3]'s room, memory care shower rooms, and Resident 5 [R5]'s room) areas reviewed. The facility failed to keep exterior grounds in good repair, equipment, and furnishings clean for 2 of 2 facility buildings (assisted living building and memory care building) reviewed. These failures placed 48 of 48 residents at risk to have a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included...

Record review of the facility document titled, "Disclosure of Services", dated "02/2007", showed that the facility must maintain resident living quarters and other areas residents may use in a safe, clean, and comfortable condition.

Record review of an email sent to the Department on 01/31/2025 at 3:04 PM, showed Staff B, Assistant Administrator, said the facility did not have a written policy to review related to maintenance, expectations of the facility environment, and upkeep of the building.

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, Beehive Retirement and Assisted Living Community is or will be in compliance with this law and / or regulation on (Date)_____.

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Administrator (or Representative)

Date

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Based on interview, observation, and record review, the facility failed to provide a safe, sanitary, and well-maintained environment for 8 of 8 (kitchen, facility front entrance, activities room, memory care hallway, trash and recycle, Resident 3 [R3]'s room, memory care shower rooms, and Resident 5 [R5]'s room) areas reviewed. The facility failed to keep exterior grounds in good repair, equipment, and furnishings clean for 2 of 2 facility buildings (assisted living building and memory care building) reviewed. These failures placed 46 of 46 residents at risk to have a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included...

Record review of the facility document titled, "Disclosure of Services", dated "02/2007", showed that the facility must maintain resident living quarters and other areas residents may use in a safe, clean, and comfortable condition.

Record review of an email sent to the Department on 01/31/2025 at 3:04 PM, showed Staff B, Assistant Administrator, said the facility did not have a written policy to review related to maintenance, expectations of the facility environment, and upkeep of the building.

Record review of the document titled, "Employee HR (Human Resources) List, undated, showed Staff H, Maintenance Supervisor, was hired at the facility on 03/22/2022.

Kitchen

In an observation on 01/28/2025 at 3:10 PM, the kitchen walls showed every wall observed was coated with a light brown substance. The walls had a variety of unknown matter splattered onto them. The kitchen floor had multiple tiles throughout the area that were partially or completely missing. In some of the areas that tile were missing there were indentations and unlevel concrete areas that had dark brown and black substance. The backdoor in the kitchen was once white had been coated in a brown substance. Darker brown soilage had been observed by the silver doorknob. The silver threshold at the bottom of the door had layered thick unknown substances embedded into it. Two of two light fixtures above the stove had missing covers. One light fixture did not have lights and there were yellow, black, red, and blue wires that were exposed.

In an observation on 01/28/2025 at 3:11 PM, inside the walk-in refrigerator, on the ceiling in multiple areas throughout the entire refrigerator were multiple areas that had large areas of black spotted substance, and the ceiling was cracked or flaking with a white substance that exposed dark black and brown wood and substance. In the far-right corner near the ceiling was an area that showed the white wall was cracked and exposed dark brown and black wood and nails that was from the ceiling down quarter of the wall. The level area of the top shelf of the silver rack that had hotdog buns stored on them and was leaned up against the cracked exposed area. The ceiling in the same area was cracked, flaking substance of white and black, and exposed solid black substance with spotted black dotted areas around the solid black substance. Some of the ceiling was cracked and caved inwards and some areas protruded down. There were other areas around the cracks that were black and spotted that resembled mold and rotten wood. It was observed throughout the ceiling there were multiple areas that showed the ceiling was bubbled or ripped and broke. There were large areas of spotted black substance that resembled mold around the areas of the ceiling that were bubbled, cracked, broke, or ripped. In the far-left corner of the walk-in refrigerator on the ceiling were large areas that was cracked, and had black substance exposed. There was white with spotted black substance around the area that resembled mold. On the fan that was on the ceiling near the entry way showed it had black and white substance all over the plastic grate and on the fan blades. There was dripping water on the three tubes that were connected to the fan unit and extended to the wall behind the fan unit.

In an observation and interview on 01/28/2025 at 3:14 PM, outside of the kitchen's tankless hot water heater closet next to the pantry shelf with food stored on it and the refrigerator showed a pipe above the door. The silver pipe had been covered in an unknown white substance. The white substance hung off the pipe in multiple areas that dangled in the air. When the closet door had been opened there was standing water on the floor in the entire area of the closet. Under the beige electronic box that hung up on the wall, had a broken blue pipe that was dripping water. The water continuously

dripped onto the ground and splashed water when it hit the water on the ground. There were two blue wires that were connected to the beige box on the wall that the water was dripping onto. To the left of the closet in the far-right corner near the ground was thick fuzzy black substance that was from the floor and up the wall two inches and covered two inches wide. Staff K, Cook, said they did not know that closet door opened and that the inside of the closet looked like that. Staff L, Dietary Aide, said inside of the closet was the tankless water heater. Staff L had been observed to look inside of the closet and said that the black fuzzy substance that formed was probably mold (a type of fungus that grows in moist environments and breaks down organic matter). Outside of the tankless hot water heater closet to the left, the wall that was behind the ice machine had been a hole near the bottom trim. The hole had concaved inward, and insulation and drywall had been observed to not be present.

In an observation and interview on 01/28/2025 at 3:18 PM, Staff H said the closet contained the tankless hot water heater and they had knowledge that the pipe in the closet broke a few days ago. Staff H opened the closet and said they did not know the pipe started to leak water and that there was standing water on the ground of the closet area. Staff H said they planned to try and fix the pipe themselves, but they had not had the time to physically go get the part to do so. Staff H acknowledged the hole in the drywall and said it had been like that for the last three years. Staff H said that they could not complete the repair since the kitchen staff had to prepare food in the area. Staff H acknowledged that the kitchen floor had tiles that were missing and was unlevelled. Staff H acknowledged that light fixtures in the kitchen did not have covers, and one light fixture did not have light bulbs or a cover with exposed wires observed. Staff H said the air conditioning unit above the food line had not worked for the last three years.

In an observation and interview on 01/28/2025 at 3:40 PM, Staff A, Administrator, observed the kitchen's tankless hot water closet door and said they had not been aware that inside the closet contained a leak that had dripped water onto the tankless hot water tanks wires. Staff A acknowledged that the walk-in refrigerator had damaged to the walls and the ceiling that exposed black substance, black and brown wood and nails, and spotted black substance.

In an interview and observation on 01/28/2025 at 3:19 PM, Anonymous 2 (A2), Facility Staff Member, opened the kitchen's tankless hot water closet door. A2 said they did not want to answer the question on what they thought the thick fuzzy black substance was. A2 said that the black fuzzy substance was in the tankless hot water closet for the last three years.

In an interview on 01/28/2025 at 3:25 PM, A2 acknowledged that the entire kitchen had been a concern. A2 said Staff I, Corporate Project Manager, had knowledge of the concerns in the kitchen. A2 said historically the facility staff had obtained bids for the work in the kitchen that needed to be completed. A2 said despite multiple bids being submitted for a variety of projects such as repair to the kitchen floor and air conditioning unit that corporate had not approved the repairs.

In an observation and interview on 01/28/2025 at 3:42 PM, Anonymous 1 (A1), Facility Staff Member, opened the kitchen's tankless hot water closet door. A1 acknowledged the fuzzy black substance inside of the tankless hot water closet area and declined to say what the substance was.

In an interview on 01/28/2025 at 3:50 PM, A1 said corporate had to approve any repair over \$500.00. A1 said the facility staff would inform the corporation of different repairs in the facility that needed to take place. A1 said corporate would ask for the facility to follow up and obtain bids for the projects that needed to be repaired. A1 said despite submission of bids to corporate, the work would not get approved. A1 acknowledged the unlevel and the poor condition of the kitchens floor. A1 said they were aware of some staff falling on the tile floor before because of the trip hazards.

In an interview on 01/30/2025 at 1:00 PM, Anonymous 3 (A3), Facility Staff Member, acknowledged the kitchen had multiple areas of concern such as mold, broken lights without covers, the walk in refrigerator had exposed black and brown wood nails on the walls and ceiling inside of it. A3 said they had reported their concerns to the facility and the corporation multiple times without follow up taken place.

In an interview on 01/29/2025 at 1:05 PM, Collateral Contact 1 (CC1), Deputy State Fire Marshal, stated they went into the facility kitchen, and they expressed concern that the kitchen had mold. CC1 said the air conditioner in the kitchen needed to be maintained. CC1 noted Staff H said the facility staff had to take parts of the air conditioner off to ensure the equipment did not fall onto the kitchen employee's.

In an interview on 01/30/2025 at 12:45 PM, Staff M, Dietary Manager, said the kitchen staff cleaned the walls as often as they could. Staff M said since the walls had textured paint when they tried to clean them the paint would chip and come off. Staff M acknowledged that light fixtures in the kitchen did not have lights or covers, the walk in refrigerator had exposed wood, black substance, and nails.

Facility Front Entrance

In an interview on 01/28/2025 at 11:41 AM, Resident 8 (R8), said that the front doors had a handicap button that did not work. R8 said they have lived in the facility since July 2024 and the buttons have not worked the entire time. R8 stated they use an electrical wheelchair and without the button it was hard to get in and out of the facility's front door without assistance.

In an observation on 01/28/2025 at 2:17 PM, the outside of the facility front doors had a button nearby that said, "press to operate". When the Department pressed the button, the automatic door did not open. The front door had to be manually opened. On the inside of the facility front doors had a button nearby that said, "press to operate". When the Department pressed the button, the automatic door did not open. There was no sign on the inside of the facility and outside of the facility that showed the buttons were out

of order and did not work.

In an observation on 01/29/2025 at 10:43 AM, the "press to operate" button located outside of the facility front doors did not open when pressed.

In an interview on 01/29/2025 at 11:04 AM, Staff H acknowledged that the ADA buttons to the front door of the facility were broken. Staff H said there had been a leak in the air compressor, and they had to deactivate the air compressor which resulted in the deactivation of the ADA button. Staff H said to their knowledge the ADA button had been broken for approximately three years. Staff H said to their knowledge one or two residents had expressed complaints that the ADA button had not been functional.

In an interview on 01/29/2025 at 1:40 PM, Staff A said the ADA button in the front of the facility had not been functional. Staff A said the button had been broken since end of Spring 2024. Staff A acknowledged that some residents at the facility expressed concern that the button was not operational. Staff A had been unsure on the follow up to get the ADA button repaired.

Activities Room

In an observation on 01/28/2025 at 12:23 PM, the activities room showed that the light above the refrigerator did not have a cover. Multiple wires hung downward and stuck out of the light fixture. Tables residents used for activities were placed under the light fixture.

In an interview on 01/28/2025 at 12:36 PM, Staff H, said the light fixture in the activity room had been without a cover and exposed wire for a couple of months. Staff H said they had the cover but had not had the opportunity to put the cover on the light.

Memory Care Hallway

In an observation and interview on 01/28/2025 at 11:22 AM, the memory care hallway outside of the laundry room's ceiling had a missing tile. The missing tile exposed silver and black pipes that had water droplets that had formed under the pipe. Under the pipe, on the carpet showed it had a circular shape where the carpet had been discolored from the dripping water. Staff A said they did not know what the plan was to fix the ceiling. Staff A called Staff H to the memory care unit. At 11:23 AM, Staff H said the pipe leaked water and the facility had been in the process of getting the pipe fixed. Staff H said when the pipe leaked it caused a watermark on the ceiling that turned into mold (a type of fungus that grows in moist environments and breaks down organic matter) so they removed that area of the ceiling. Staff H said the ceiling tile had been missing for six months. Staff H said they had sent the request to get the area fixed to the corporation's office for approval. Staff H stated they were unsure where the facility was at with getting the pipe and ceiling repaired and fixed.

In an interview on 01/28/2025 at 2:30 PM, Staff D, Caregiver, said the hole in the memory cares ceiling had been there for the last five months.

Trash and Recycle

In an observation and interview on 01/28/2025 at 12:28 PM, the outside trash and recycle area showed there were multiple dirt piles that had accumulated. There were a variety of boxes and other trash scattered throughout the area and embedded into the dirt piles. Staff A confirmed that some trash had been on the ground. Staff A said Staff H and kitchen employees were the people responsible for the upkeep of the trash area. Staff A said Staff H deep cleaned when needed but swept the area weekly. Staff A acknowledged the trash and recycle area needed to be cleaned up.

In an interview on 01/28/2025 at 12:46 PM, Staff H said they cleaned the trash and recycle area once a year. Staff H said they did not go outside and sweep the area weekly.

In an observation on 01/29/2025 at 10:56 AM, the outside trash and recycle area showed there had not been any changes observed since 01/28/2025.

In an observation on 01/30/2025 at 12:19 PM, the outside trash and recycle area showed there had not been any changes observed since 01/28/2025.

R3

In an observation and interview on 01/29/2025 at 2:00 PM, R3 bathroom floor had been sticky. When the Department staff went into the room their shoes stuck to the floor and made a noise as they lifted their foot. The back of R3's toilet riser had feces smeared onto it. R3 said they received housekeeping services twice a week and they thought their housekeeping days were on Tuesday's and Saturday's. R3 said they were not surprised that their bathroom floor had been sticky, R3 said they were not the cleanest.

In an interview on 01/30/2025 at 2:14 PM, Staff N, said R3 had been identified to need more housekeeping services and R3's services were recently increased to twice weekly on Tuesday's and Friday's. Staff N said in general they had encouraged facility staff members to come get them if the staff member had identified more cleaning was needed. Staff N said if they were notified cleaning needed to take place they could provide additional cleaning. Staff N noted the other facility staff members were encouraged to clean if needed as well. Staff N had been informed that R3's bathroom floor had been sticky and that R3 had feces on the back of their toilet riser.

In an observation on 01/31/2025 at 9:27 AM, R3's bathroom floor remained sticky, and

their toilet riser still had feces on the backside of it.

Memory Care Shower Rooms

In an observation on 01/28/2025 at 2:40 PM, inside the shower and bathroom across from room 212, the back of the toilet was missing. There was only a clear plastic bag that covered the open area of the toilet that you could see the water and all the internal components of the toilet. In the shower stall was a white shower chair. The frame on the front of the shower chair that was under the plastic seat part was observed to have exposed metal that had rusted and turned orange and brown. The white metal bar next to the brown and orange rusted exposed metal area had white paint breaking, peeling, and chipping off. The area was like this for half of the width of the plastic seat part and was observed with the plastic seat down where a residents' leg would sit if they used the shower bench. Each of the shower chairs legs had exposed metal that had brown and orange streaks that ran down the white metal leg to the gay rubber part on the bottom of the leg.

In an interview on 01/28/2025 at 2:47 PM, Anonymous 4 (A4), facility staff member, stated they used the shower chairs that were in the bathroom and shower rooms in the memory care building. A4 stated the shower chairs do not look to be safe with the exposed metal, rust, and broken and peeling paint that was on them. A4 stated they had followed up with Staff A, Administrator, about the condition of the shower chairs without a follow up. A4 stated the shower chair had been like that for over a year.

In an observation on 01/28/2025 at 2:50 PM, inside the bathroom and shower room across from room 215, in the shower stall was a white shower chair with a plastic seat. The shower chair had four legs with screws and holes down the entire length of the leg. Below each of the screw and hole areas of the leg, there was orange and brown rust colored drip marks that were down the white legs. Outside of the door on the ceiling in the vent, there was large amounts of brown thick fuzzy substance on the vents grates.

R5

Record review of an email on 11/15/2023 at 9:16 PM, showed Collateral Contact 3 (CC3), Project Manager wrote that at the inspection the facility had a door holder that did not work properly and inquired if they wanted a quote for Staff I to order. CC3 noted that it would cost \$175.00 and that Staff H would install the part. On 11/16/2023 at 9:47 AM, Staff I emailed Staff H and Staff A and inquired what door closure needed to be replaced and that the quote had been a good price. In an observation on 01/28/2025 at 2:27 PM, R5's bedroom door had been fully opened against the wall. A black chair had been observed to keep the door propped open. R5's bedroom door did not have a magnet behind it.

In an observation on 01/31/2025 at 8:18 AM, R5's bedroom door had been fully opened against the wall. A black chair had been observed to keep the door propped open.

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In an interview on 01/31/2025 at 8:26 AM, Staff F, Resident Care Coordinator, said they did not think R5's magnet worked on their door which is why their door had been propped open. Staff F said R5's door was probably a fire door.

In an interview on 01/31/2025 at 9:50 AM, Collateral Contact 2 (CC2), R5's Power of Attorney, said the magnetic part of R5's door did not work. CC2 said R5 did not like to be enclosed inside of their room because it made R5 isolated. CC2 had been aware a chair had been used to keep R5's door propped open.

In an interview on 01/31/2025 at 10:10 AM, Staff H said R5's bedroom door's magnetic had been broken for approximately two years. Staff H said R5's door would be considered a fire door and typically would not be allowed to be obstructed with items.

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, Beehive Retirement and Assisted Living Community is or will be in compliance with this law and / or regulation on (Date) 3/29/25.

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

Michelle M. Duke
Administrator (or Representative)

3/4/25
Date

WAC 388-78A-2821 Design, construction review, and approval plans.

(2) The assisted living facility will meet the following requirements:

(a) Preconstruction. Request and attend a presubmission conference for projects with a construction value of two hundred and fifty thousand dollars or more. The presubmission conference shall be scheduled to occur for the review of construction documents that are no less than fifty percent complete, or as coordinated with plan reviewer.

(b) Construction document review. Submit construction documents for proposed new construction to the department for review within ten days of submission to the local authorities. Compliance with these standards and regulations does not relieve the facility of the need to comply with applicable state and local building and zoning codes. The construction documents must include:

(i) A written functional program consistent with WAC 388-78A-2361 containing, but not limited to, the following:

(A) Information concerning services to be provided and the methods to be used;

In an interview on 01/31/2025 at 8:26 AM, Staff F, Resident Care Coordinator, said they did not think R5's magnet worked on their door which is why their door had been propped open. Staff F said R5's door was probably a fire door.

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In an interview on 01/31/2025 at 10:10 AM, Staff H said R5's bedroom doors magnetic had been broken for approximately two years. Staff H said R5's door would be considered a fire door and typically would not be allowed to be obstructed with items.

Plan/Attestation Statement

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(i) A written functional program consistent with WAC 388-78A-2361 containing, but not limited to, the following:

(A) Information concerning services to be provided and the methods to be used;

(B) An interim life safety measures plan to ensure the health and safety of occupants during construction;

(C) An infection control risk assessment indicating appropriate infection control measures, keeping the surrounding area free of dust and fumes, and ensuring rooms or areas are well ventilated, unoccupied, and unavailable for use until free of volatile fumes and odors;

(D) An analysis of likely adverse impacts on current assisted living facility residents during construction and the facilities plans to eliminate or mitigate such adverse impacts including ensuring continuity of services;

(ii) Drawings and specifications to include coordinated architectural, mechanical, and electrical work. Each room, area, and item of fixed equipment and major movable equipment must be identified on all drawings to demonstrate that the required facilities for each function are provided;

(iii) Floor plan of the existing building showing the alterations and additions, and indicating location of any service or support areas;

(iv) Required paths of exit serving the alterations or additions; and

(v) Verification that the capacities and loads of infrastructure systems will accommodate the planned load.

(c) Resubmittals. The assisted living facility will respond in writing when the department requests additional or corrected construction documents;

(d) Construction. Comply with the following requirements during the construction phase:

(i) The assisted living facility will not begin construction until all of the following items are complete:

(A) Construction review services has approved construction documents or granted authorization to begin construction;

(B) The local jurisdictions have issued a building permit; and

(C) The construction review services will issue an "authorization to begin construction" when the construction documents have been conditionally approved.

(ii) Submit to the department for review any addenda or modifications to the construction documents.

(iii) Assure construction is completed in compliance with the final construction review services approved documents. Compliance with these standards and regulations does not relieve the facility from compliance with applicable state and local building and zoning codes. Where differences in interpretations occur, the facility will follow the most stringent requirement.

(vi) The assisted living facility will allow any necessary inspections for the verification of compliance with the construction documents, addenda, and modifications.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to submit construction documents to construction review services (CRS) before scheduled construction for 2 of

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2 areas (memory care roof and assisted living roof) within the facility. This placed 46 of 46 memory care and assisted living residents' safety at risk as CRS had not been able to ensure health and safety plans were in place for the residents, staff, and visitors during the construction.

Findings included...

Record review of Washington State Department of Health Construction Review Services website article, undated, showed construction and renovation could affect the existing life safety and fire protection systems of the facility. When the facility was occupied by staff and patients during construction, this could present an increased hazard to the occupants. To mitigate the conditions, CRS recommends that all phases of the project to be examined to identify potential hazards. Both life safety code and the fire code provided specific direction to the maintenance of the life safety systems during a fire. Major design elements that must be resolved by CRS before issuing an authorized to begin construction include but not limited to infection control risk assessment and interim life safety measures. An infection control risk assessment should address precautions such as but not limited to patient placement or relocation, standards for barriers or other protective measures required to protect adjacent areas and susceptible patients from airborne contaminants, protection from the products of demolition, and temporary provisions or phasing for construction or modification of heating, ventilation, air conditioning, and water supply system.

Record review on 01/24/2025, of the Washington State Department of Health Construction Review Services website, showed there were no records of any projects for year 2020 through 2024 found for the facility for review.

In an interview on 01/28/2025 at 10:40 AM, Staff A, Administrator, said the facility did not have any changes in their physical environment that needed approval from CRS.

In an interview on 01/29/2025 at 11:04 AM, Staff H, Maintenance Supervisor, said the memory care roof had just been repaired. Staff H said there was a water leak in the roof for the last two years. Staff H said four resident rooms were affected. Staff H said the contractors removed shingles and wood down to the studs from the roof to repair the damaged area. Staff H said to their knowledge the facility did not report the construction to the Department of Health CRS.

In an interview on 01/29/2025 at 1:23 PM, Staff A said they had forgotten that the memory care roof had repairs three months ago. Staff A said they had a leak in apartment 127 and 207 which resulted in the removal of shingles. Staff A said the contractors had to go down to the stud in apartment 207. At 1:40 PM, Staff A said Staff I, Corporate Project Manager, would be the person responsible to report the roof construction and send the plans into the Department of Health CRS for review and approval. Staff A said the Department of Health CRS did not come out to the facility to complete a walk through inspection before the construction began.

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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, Beehive Retirement and Assisted Living Community is or will be in compliance with this law and / or regulation on: (Date) 3/29/25

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

Michelle D. Duke
Administrator (or Representative)

3/4/25
Date

WAC 388-78A-2040 Other requirements.

- (1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.
- (2) The assisted living facility must have its building approved by the Washington state fire marshal in order to be licensed.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to maintain fire safety per the state fire marshal regulations related to the upkeep of the assisted living laundry water tank, maintaining carbon monoxide devices in the memory care unit, and maintaining fire extinguisher servicing in 2 of 2 facility buildings (Assisted living and memory care) observed. These failures placed 46 of 46 residents, staff, and visitors' life and safety at risk in the event of a fire.

Findings included...

State Fire Marshall regulation code IFC (International Fire Code) 603.1, 2018:

"The installation of nonportable gas-fired appliances and systems shall comply with the International Fuel Gas Code. The installation of nonportable liquid fuel-fired appliances and systems shall comply with this section and the International Mechanical Code. The installation of all other fuel-fired appliances, other than portable internal combustion engines, oil lamps and other portable devices such as blow torches, melting pots and weed burners, shall comply with this section and the International Mechanical Code."

State Fire Marshall regulation code IFC 603.2, 2021

"Abatement of unsafe conditions and electrical hazards. Conditions that constitute an electrical shock or fire hazard shall be abated."

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Administrator (or Representative)

Date

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Findings included...

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State Fire Marshall regulation code IFC 603.2, 2021

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State Fire Marshall regulation code IFC 915.5.2, 2021

"Carbon monoxide detectors shall be installed in the locations specified in Section 915.2. These locations supersede the locations specified in NFPA 72."

State Fire Marshall regulation code IFC 906.2 2015,2018

"Portable fire extinguishers shall be selected, installed, and maintained in accordance with this section and NFPA 10.

- Exceptions: 1. The distance of travel to reach an extinguisher shall not apply the travel distance to reach an extinguisher shall not apply to the spectator seating portions of Group A-5 occupancies.
2. Thirty-day inspections shall not be required, and maintenance shall be allowed to be once every three years for dry-chemical or halogenated agent portable fire extinguishers that are supervised by a listed and approved electronic monitoring device, provided that all of the following conditions are met:
- 2.1. Electronic monitoring shall confirm that extinguishers are properly positioned, properly charged and unobstructed.
 - 2.2. Loss of power or circuit continuity to the electronic monitoring device shall initiate a trouble signal.
 - 2.3. The extinguishers shall be installed inside of a building or cabinet in a noncorrosive environment.
 - 2.4. Electronic monitoring devices and supervisory circuits shall be tested every 3 years when extinguisher maintenance is performed.
 - 2.5. A written log of required hydrostatic test dates for extinguishers shall be maintained by the owner to verify that hydrostatic tests are conducted at the frequency required by NFPA10.
3. In Group 1-3, portable fire extinguishers shall be permitted to be located at staff locations."

Record review of the document, "Washington State Patrol Fire Protection Bureau", dated 01/29/2025, showed on 01/29/2025 an investigation took place. Findings during the inspection were code IFC 603.1, 2018 the gas piping in the assisted living clean laundry room should be examined for leaks and water heater areas to address leaks/smells of gas. The water heater in the assisted living clean laundry room had previously been included in a fire incident due to overheating and improper functioning. The water heater had been observed without a cover plate near the base. An inspection was required to ensure the appliance was safe to use. Code IFC 603.2, 2021 showed the kitchen light fixture by the gas range had been missing the required cover which exposed live wires, which presented a safety hazard. Code IFC 915.5.2, 2021 showed the facility failed to install all carbon monoxide detectors in accordance with the manufacturer recommendations. Carbon monoxide detection should be provided on the ceiling of the room that contained the fuel-burning appliance or heat source must be installed 20 feet away from the fuel. For added protection carbon monoxide detectors should be installed on the ceiling near sleeping area corridors. Staff A, Administrator signed the document that acknowledged the next fire marshal inspection would be on or after 03/04/2025. Collateral Contact 1 (CC1), Deputy State Fire Marshal signed the document.

Record review of the document, Applied Technical Systems Extinguisher Inspection Report, dated 11/14/2024, showed the interior facility fire extinguishers were serviced

on 11/14/2024 for the memory care and assisted living building. The document did not include fire extinguishers that were in the exterior of the facility.

Assisted Living Laundry Water Tank

In an observation and interview on 01/28/2025 at 11:03 AM, the assisted living laundry room's clean side that stored the facility dryers showed through the Department's surgical face masks the room smelt of gas (rotten eggs). Staff A acknowledged the smell of gas and said that it had been an ongoing issue that the facility experienced. The water tank on the left hand side had a rectangular shape panel piece that was missing at the bottom of the device. The absent panel allowed a glowing red light to shine through the open area under the hot water tank's structure. On the outside of the panel at the bottom of the tank showed one foot six inches up the hot water tank, black scorched marks that discolored the white surface. Some of the black scorched area was on the dial on the bottom of the hot water tank and wires. There were fuzzy substances observed on the top of water tank, behind the water tank that coated the floor and was embedded onto the walls.

In an interview on 01/28/2025 at 2:56 PM, Staff H, Maintenance Supervisor, said the laundry room did not typically smell of gas and if it did it would not be normal. Staff H said they had a gas detector and would follow up to make sure the water tank did not have a leak.

In an interview and observation on 01/29/2025 at 11:04 AM, Staff H observed the water tank in the laundry room and said it was normal for the device to omit flames at the bottom of the structure as it was a gas hot water tank.

Memory Care Carbon Monoxide Devices

In an Interview on 01/29/2025 at 1:15 PM, CC1 stated the carbon monoxide detectors in the memory building were noted to have been moved since they were installed and not in the correct location. CC1 stated that the carbon monoxide detectors should be secured to the wall to ensure that the memory care residents were unable to pick them up and remove them. CC1 stated the one carbon monoxide detector had thick substance on the devices that could contributed to the detector not working properly.

Fire Extinguishers

In an observation on 01/28/2025 at 9:40 AM, hung up on the wall just inside the facility's front door to the left was a fire extinguisher. The fire extinguisher's tag showed it was last serviced in November 2024. The tag showed there were no monthly checks since it had been serviced.

In an observation on 01/28/2025 at 10:22 AM, hung up on the wall at the end of the hallway exit door by room 128, was a fire extinguisher. The fire extinguisher's tag showed it was last serviced in November 2024. The tag showed there were no monthly checks since it had been serviced.

In an observation on 01/28/2025 at 10:32 AM, hung up on the wall by the exit door that lead to the kitchen building, was a fire extinguisher. The fire extinguisher's tag showed it was last serviced in November 2024. The tag showed there were no monthly checks since it had been serviced.

In an observation on 01/28/2025 at 11:04 AM, hung up on the wall in the assisted living laundry room, was a fire extinguisher. The fire extinguisher's tag showed it was last serviced in November 2024. The tag showed there were no monthly checks since it had been serviced.

In an observation on 01/28/2025 at 12:25 PM, hung up on the wall in the assisted living activity room, was a fire extinguisher. The fire extinguisher's tag showed it was last serviced in November 2024. The tag showed there were no monthly checks since it had been serviced.

In an observation and interview on 01/28/2025 at 12:30 PM, the fire extinguisher outside of the facility next to the gazebo for smokers showed it had been serviced October 2023 and was good for one year. Staff A confirmed the tag on the fire extinguisher showed it was last serviced October 2023 and was expired. Staff H said the company who serviced the fire extinguishers in November 2024, missed the facility fire extinguishers that were outside. Staff H could not provide a scheduled date of when the company would come out and reservice the outside fire extinguishers for the facility.

In an observation and interview on 01/28/2025 at 12:40 PM, the maintenance shed showed the fire extinguisher had been serviced in November 2024. The fire extinguisher tag did not have any monthly checks written on the tag to review. Staff H said they checked the fire extinguishers monthly. Staff H said the tag on the fire extinguisher should be signed off that the monthly check was completed.

In an observation on 01/28/2025 at 2:30 PM, hung up on the wall at the end by the entry door of the memory care building, was a fire extinguisher. The fire extinguisher's tag showed it was last serviced in November 2024. The tag showed there were no monthly checks since it had been serviced.

In an observation on 01/28/2025 at 2:37 PM, hung up on the wall in the hallway by the small hallway of the common area of the memory care building, was a fire extinguisher. The fire extinguisher's tag showed it was last serviced in November 2024. The tag showed there were no monthly checks since it had been serviced.

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In an observation on 01/29/2025 at 2:45 PM, hung up on the wall by the back hallway near the storage closet in the memory care building, was a fire extinguisher. The fire extinguisher's tag showed it was last serviced in November 2024. The tag showed there were no monthly checks since it had been serviced.

In an observation on 01/29/2025 at 3:02 PM, the kitchen's ABC (a portable device that puts out class A, B, and C fires) showed the fire extinguisher had been serviced in November 2024. The fire extinguisher tag did not have any monthly checks written on the tag to review.

In an observation on 01/29/2025 at 3:13 PM, in the kitchen hung up on the wall, by the double door freezer, was a fire extinguisher. The fire extinguisher's tag showed it was last serviced in November 2024. The tag showed there were no monthly checks since it had been serviced.

In an interview on 01/29/2025 at 1:05 PM, CC1, said they had concerns about the water tank in the assisted living building laundry room. CC1 acknowledged that the plate had been missing from the device and Staff H knew the plate had been missing. CC1 said it was not normal for a plate to be missing and for the water tank to have scorch marks on it. CC1 said the water tank needed to be serviced to determine if it was safe. CC1 had concerns that lint had been observed on the water tank, near the water tank on the floor and in the trash can, and on the walls. CC1 had concerns that the lint could ignite a fire. CC1 said there were no carbon monoxide detector located in the assisted living laundry room area. CC1 said they had concerns about the memory care units carbon monoxide detectors. CC1 said the type of carbon monoxide detector the facility had needed to be installed more than 15 feet away from the gas source. CC1 said the residents who resided in the unit had the carbon monoxide detector and it could have been tampered with. CC1 said they noted the carbon monoxide detector to have unknown substances on it. CC1 said the facility had two fire extinguishers outside that were not serviced annually. CC1 said the fire extinguishers would need to be inspected and retagged.

Plan/Attestation Statement

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

Michelle Duke
Administrator (or Representative)

3/4/25
Date

In an observation on 01/28/2025 at 2:45 PM, hung up on the wall by the back hallway near the storage closet in the memory care building, was a fire extinguisher. The fire extinguisher's tag showed it was last serviced in November 2024. The tag showed there were no monthly checks since it had been serviced.

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Administrator (or Representative)

Date

Statement of Deficiencies	License # 214B	Compliance Determination # 53718
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WAC 388-78A-2950 Water supply. The assisted living facility must:

(b) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

Fixed

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to maintain safe water temperatures in 2 of 2 buildings (Memory Care Building and Assisted Living Building) reviewed. This failure placed 40 of 40 residents, visitors, and staff at risk of injury from unsafe water temperatures and decreased quality of life.

Findings included...

Record review of the document titled, "Water Temperatures", dated 12/16/2024, showed the memory care dining room had a water temperature of 121 degrees and the tub/bath had a water temperature of 131 degrees.

Record review of the document titled, "Water Temperatures", dated 11/18/2024, showed the assisted living room 111 had a water temperature of 121 degrees. The memory care dining room, dining room had a water temperature of 121 degrees and the tub/bath had a water temperature of 136 degrees.

Record review of the document titled, "Water Temperatures", dated 10/16/2024, showed the memory care dining room had a water temperature of 121 degrees and the tub/bath had a water temperature of 128 degrees.

Record review of an email sent to the Department on 01/31/2025 at 3:04 PM, Staff B, Assistant Administrator, said the facility did not have a written water temperature policy to provide.

Record review of the document titled, "Employee HR (Human Resources) List, undated, showed Staff H, Maintenance Supervisor, was hired at the facility on 03/22/2022.

In an observation on 01/28/2025 at 11:25 AM, the bathroom inside of the memory care's dining room showed a water temperature of 135.8 degrees Fahrenheit (F).

In an observation on 01/28/2025 at 11:27 AM, in the memory care dining room sink, the hot water temperature was 136 degrees F. When the hot water was running, there was steam rising from the water and the hot water was hot to touch.

In an observation on 01/28/2025 at 11:30 AM, the bathroom inside of the memory care

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to maintain safe water temperatures in 2 of 2 buildings (Memory Care Building and Assisted Living Building) reviewed. This failure placed 46 of 46 residents, visitors, and staff at risk of injury from unsafe water temperatures and decreased quality of life.

Findings included...

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In an observation on 01/28/2025 at 11:27 AM, in the memory care dining room sink, the hot water temperature was 136 degrees F. When the hot water was running, there was steam rising from the water and the hot water was hot to touch.

In an observation on 01/28/2025 at 11:30 AM, the bathroom inside of the memory care

hallway located across from room 206 showed a water temperature of 138.0 degrees F.

In an observation on 01/28/2025 at 11:33 AM, in the bathroom/shower room in the memory care building across from room 215, the hot water temperature was 138.5 degrees F. The hot water was hot to touch and had steam rising from the hot running water that was observed.

In an interview on 01/28/2025 at 11:34 AM, Staff A, Administrator, said Staff H kept track of the hot water temperature logs for the facility.

In an interview on 01/28/2025 at 12:32 PM, Staff H, said they checked the hot water temperature at the facility monthly. Staff H said the hot water temperature range should be between 115 degrees F to 125 degrees F. Staff H said when they first got hired, they were given a paper resource with what the water temperature range for the facility was supposed to be. Staff H said they no longer had the water temperature resource available to them.

In an observation and interview on 01/28/2025 at 12:42 PM, Staff H checked the hot water temperature in the memory care building dining room sink with the facility's probe thermometer. Staff H's thermometer showed the hot water temperature was 132 degrees F. There was steam rising from the running hot water when Staff H was checking the hot water temperature. Staff H stated they had checked the hot water temperature for the facility last Thursday 01/23/2025 with all the hot water temperatures within the range of 115 degrees F and 125 degrees F. Staff H acknowledged that the hot water temperatures were above the assisted living facility regulations and needed to be addressed.

In an interview on 01/28/2025 at 12:50 PM, Staff A, had not been aware of what the water temperature range for the facility should be. Staff A had been informed and acknowledged the memory care building water temperatures had exceeded 130 degrees F. Staff A acknowledged the facility would need to follow up with an immediate safety plan to get the water temperature range in compliance.

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Michelle Duke
Administrator (or Representative)

3/4/25
Date

WAC 388-78A-2930 Communication system...

(i) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

(iii) Corridors, as well as common and outdoor areas accessible to residents.

(b) Provide the resident with personal wireless communication devices, such as pendants or wristbands, when a communication device is not installed in the resident's sleeping room, and when wireless communications are used:

(i) The system must be designed and installed consistent with industry standards and perform reliably throughout the facility; and

(ii) The facility must have a policy and procedure describing the mitigating measures in the event of system disruption, including for maintenance and loss of power; and

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to ensure 1 of 2 sampled areas (memory care building) reviewed had the means to summon on duty staff in common areas. This failure placed 18 of 18 residents, visitors, and staff at risk of not being able to summon staff when help was needed.

Findings included...

In an observation on 01/28/2025 at 11:29 AM, in the memory care building in the hallway near room 207, showed there was no call light or communication system available for use. There was a plastic base that was screwed to the wall, but nothing else that showed it was a communication system available for use.

In an observation on 01/28/2025 at 2:32 PM, in the memory care building in the

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Findings included...

In an observation on 01/28/2025 at 11:29 AM, in the memory care building in the hallway near room 207, showed there was no call light or communication system available for use. There was a plastic base that was screwed to the wall, but nothing else that showed it was a communication system available for use.

In an observation on 01/28/2025 at 2:32 PM, in the memory care building in the

bathroom and whirlpool room that was connected to the dining room, showed there was no call light or communication system available for resident and staff to use. On the wall was a plastic base that was screwed to the wall, but nothing else that showed it was a communication system available for use.

In an observation on 01/28/2025 at 2:36 PM, in the common area of the memory care building near the medication room, was an area that was set up like a laundry room. There was a sign that hung up on the wall that showed "laundry" and under the sign was a plastic base screwed to the wall. There was no pull cord or communication system available for use in the area observed.

In an observation on 01/28/2025 at 2:37 PM, the memory care building showed in the common living room next to the elder grow gardening box had a white rectangular box attached to the wall. The white rectangular box did not have the call light fixture attached to it.

In an observation on 01/28/2025 at 2:38 PM, the memory care building showed in the common hallway located next to the laundry room showed a white rectangular box attached to the wall. The white rectangular box did not have the call light fixture attached to it.

In an observation on 01/29/2025 at 1:04 PM, in the memory care building in the hallway near room 207, showed there was no call light or communication system available for use. There was a plastic base that was screwed to the wall, but nothing else that showed it was a communication system available for use.

In an observation on 01/29/2025 at 1:05 PM, the memory care building showed in the common hallway located next to the laundry room showed a white rectangular plastic base that was screwed to the wall. There was no communication system or pull cord on the plastic base available for use to call for assistance observed.

In an observation on 01/30/2025 at 8:24 AM, in the common area near the medication room of the memory care building, was an area that was set up like a laundry room. There was a sign that hung up on the wall that showed "laundry" and under the sign was a plastic base screwed to the wall. There was no pull cord or communication system available for use in the area observed.

In an observation on 01/30/2025 at 8:26 PM, in the memory care building in the hallway near room 207, showed there was no call light or communication system available for use. There was a plastic base that was screwed to the wall, but nothing else that showed it was a communication system available for use.

In an interview on 01/31/2025 at 8:19 AM, Staff O, Caregiver, said some of the memory care residents took the call light fixtures off the wall.

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In an interview on 01/31/2025 at 8:24 AM, Staff C, Medication Aide, said the memory care residents took the call light fixtures off the wall. Staff C said they had been unsure why the call lights in the memory care unit were missing but maybe it was because they needed maintenance.

In an interview on 01/31/2025 at 8:26 AM, Staff F, Resident Care Coordinator, acknowledged some of the call light fixtures in the memory care unit were missing. Staff F said Staff H, Maintenance Supervisor had been in the memory care unit the week prior to develop a plan on how to replace the missing call lights.

In an interview on 01/31/2025 at 10:12 AM, Staff H said the memory care residents took off the call lights that were attached to the wall.

In an interview on 01/31/2025 at 10:23 AM, Staff A, Administrator, acknowledged that some of the communication systems in the memory care building were missing and had the staff complete every two-hour checks.

This is a recurring deficiency previously cited on 05/16/2024 and 12/28/2023 for subsections 1(a) and 1(b)(3).

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

Michelle D. Duke
Administrator (or Representative)

3/4/25
Date

WAC 388-78A-2730 Licensee's responsibilities.

(1) The assisted living facility licensee is responsible for:

(a) The operation of the assisted living facility;

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

(2) The licensee must:

In an interview on 01/31/2025 at 8:24 AM, Staff C, Medication Aide, said the memory care residents took the call light fixtures off the wall. Staff C said they had been unsure why the call lights in the memory care unit were missing but maybe it was because they needed maintenance.

In an interview on 01/31/2025 at 8:26 AM, Staff F, Resident Care Coordinator, acknowledged some of the call light fixtures in the memory care unit were missing. Staff F said Staff H, Maintenance Supervisor had been in the memory care unit the week prior to develop a plan on how to replace the missing call lights.

In an interview on 01/31/2025 at 10:12 AM, Staff H said the memory care residents took off the call lights that were attached to the wall.

In an interview on 01/31/2025 at 10:23 AM, Staff A, Administrator, acknowledged that some of the communication systems in the memory care building were missing and had the staff complete every two-hour checks.

This is a recurring deficiency previously cited on 05/16/2024 and 12/28/2023 for subsections 1(a) and 1(b)(ii).

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, Beehive Retirement and Assisted Living Community 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-2730 Licensee's responsibilities.

(1) The assisted living facility licensee is responsible for:

(a) The operation of the assisted living facility;

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

(2) The licensee must:

(b) Maintain and post in a size and format that is easily read, in a conspicuous place on the assisted living facility premises:

(i) A current assisted living facility license, including any related conditions on the license;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Licensee failed to ensure the facility operated in compliance with licensing requirements for 1 of 1 facility reviewed. These failures resulted in the need for the facility to take immediate actions to ensure the facility was licensed and that all residents, staff, and visitors were not placed at risk of harm.

Findings included...

Revised Code of Washington (RCW) 18.20.110 "Inspection of assisted living facilities—Approval of changes or new facilities. (1) The department shall make or cause to be made, at least every eighteen months with an annual average of fifteen months, an inspection and investigation of all assisted living facilities. However, the department may delay an inspection to twenty-four months if the assisted living facility has had three consecutive inspections with no written notice of violations and has received no written notice of violations resulting from complaint investigation during that same time period. The department may at anytime make an unannounced inspection of a licensed facility to assure that the licensee is in compliance with this chapter and the rules adopted under this chapter. Every inspection shall focus primarily on actual or potential resident outcomes, and may include an inspection of every part of the premises and an examination of all records, methods of administration, the general and special dietary, and the stores and methods of supply; however, the department shall not have access to financial records or to other records or reports described in RCW 18.20.390. Financial records of the assisted living facility may be examined when the department has reasonable cause to believe that a financial obligation related to resident care or services will not be met, such as a complaint that staff wages or utility costs have not been paid, or when necessary for the department to investigate alleged financial exploitation of a resident. Following such an inspection or inspections, written notice of any violation of this law or the rules adopted hereunder shall be given to the applicant or licensee and the department. The department may prescribe by rule that any licensee or applicant desiring to make specified types of alterations or additions to its facilities or to construct new facilities shall, before commencing such alteration, addition, or new construction, submit plans and specifications therefor to the agencies responsible for plan reviews for preliminary inspection and approval or recommendations with respect to compliance with the rules and standards herein authorized.

(2) If a pandemic, natural disaster, or other declared state of emergency prevents the department from completing inspections according to the timeline in subsection (1) of this section, the department shall adopt rules to reestablish inspection timelines based on the length of time since last inspection, compliance history of each facility, and immediate health or safety concerns.

(a) Rules adopted under this subsection (2) are effective until the termination of the

pandemic, natural disaster, or other declared state of emergency or until the department determines that all facility inspections are occurring according to time frames established in subsection (1) of this section, whichever is later. Once the department determines a rule adopted under this subsection (2) is no longer necessary, it must repeal the rule under RCW 34.05.353.

(b) Within 12 months of the termination of the pandemic, natural disaster, or other declared state of emergency, the department shall conduct a review of inspection compliance with subsection (1) of this section and provide the legislature with a report."

On 01/28/2025 at 9:40 AM, the Department entered the facility for their full annual inspection.

Assisted Living Facility License

Record review on 01/24/2025 of the Department database, showed the facility's renewal invoice history which indicated their last paid invoice was due on 07/15/2023 and was effective from 09/01/2023 to 08/31/2024 with a balance of zero. The due date for their current invoice was on 07/15/2024 and showed they had a balance owed of \$7,076.00 for their coverage effective from 09/01/2024 – 08/31/2025.

In an observation on 01/28/2025 at 2:20 PM, the bulletin board that hung outside of Staff A's, Administrator, office showed a copy of the facility's assisted living license that had expired on 08/31/2024.

In an observation on 01/29/2025 at 11:02 AM, the bulletin board that hung outside of Staff A's office showed a copy of the facility's assisted living license which expired 08/31/2024.

In an interview and observation on 01/29/2025 at 11:16 AM, Staff A said the home office (facility's corporation office) updated the assisted living facility license annually. Staff A went to the bulletin board to look at the assisted living facility license that had been posted and acknowledged that the license that hung on the wall had been expired on 08/30/2024. Staff A said they promised the license had not expired. Staff A asked Staff B, Assistant Administrator, to review their emails to obtain a copy of the most up to date license. Staff B recommended to call home office to obtain a copy of the license. The Department informed Staff A that the Department's records showed their coverage to their license expired 08/31/2024.

In an interview on 01/29/2025 at 11:44 AM, Staff A said they followed up with home office who said they had no record of payment for the facility license they could provide. Staff A said Staff J, Corporate Accounts Payable, was the person responsible to ensure the assisted living license was updated.

In an interview on 01/29/2025 at 2:32 PM, Staff A stated the home office required Staff A to get a copy of the facility's license renewal invoice and send it to the home office to get the account paid.

Construction Review Services

Record review on 01/24/2025, of the Washington State Department of Health Construction review search website, showed there were no records found for the facility for review.

Record review of an email, dated 09/12/2024 at 4:45 PM, showed Staff H, Maintenance Supervisor, sent an email to Staff I, Corporate Project Manager about the memory care roof and assisted living rooms 102 and 107 flooding issue. Staff H sent information about the memory care roof and included four inspections that took place at the facility. Staff H noted that in conclusion the contractors stated that half the roof needed to be replaced. The assisted living room related to room 107 roof appeared wavy which indicated the plywood had been warped from water damage. Staff H indicated that the assisted living roof would need to be replaced as well. Staff H indicated that the assisted living roof had the same issue as the memory care roof which was that water had leaked through the ceiling, down the windows, and got inside. Staff H indicated Staff A, Administrator, and themselves talked about the next steps to repair assisted living room 102 which was for Staff H to initiate the work independently.

Record review of an email sent to the Department on 02/10/2025 at 10:43 AM, Staff H said the memory care roof repair started on 01/23/2023. Staff H stated the assisted living roof also had repairs. Staff H noted that Staff I had been aware of the construction scheduled to take place.

Record review of "CommuniCare" "Maintenance Purchase", undated, showed the memory care roof leaked and caused damaged inside of the walls. The project start date was 03/03/2023.

Record review of "CommuniCare" "Maintenance Purchase", undated, showed the roof leaked down into the walls inside of the building. The project start date was 01/23/2023 and estimated completion date of 07/15/2023. Staff I had approved the project on 05/05/2023.

Record review of an email, dated 10/14/2024 at 8:23 AM, showed Staff A emailed Staff I and informed them the repairs to the memory care roof had been completed over the weekend. Staff A said the contractors would be back this weekend to repair the room over room 107 in the assisted living building.

In an interview on 01/28/2025 at 10:40 AM, Staff A said the facility did not have any changes in their physical environment that needed approval from CRS.

In an interview on 01/29/2025 at 11:04 AM, Staff H, Maintenance Supervisor, said approximately one year ago half the memory care roof had repairs. Staff H said water leaked last year and the year before. Staff H said four resident rooms were affected. Staff H said the contractors removed shingles from the roof. Staff H said to their knowledge the facility did not report the construction to the Department of Health CRS.

In an interview on 01/29/2025 at 1:23 PM, Staff A said they had forgotten that the memory care roof had repairs three months ago. Staff A said they had a leak in apartment 127 and 207 which resulted in the removal of shingles. Staff A said the contractors had to go down to the stud in apartment 207. At 1:40 PM, Staff A said Staff I, Corporate Project Manager, would be the person responsible to report the roof construction and send the plans into the Department of Health for review. Staff A said the Department of Health did not come out to the facility to complete a walk through inspection before the construction began.

Environment

Kitchen

Record review of a document titled, Proposal, dated 10/11/2023, showed it was a proposed bid to replace the kitchen's Mitsubishi system (kitchens air conditioning unit) and put a new system installed with the cost. There was no signature of acceptance of the proposal document by the facility staff or the facility's corporation.

Record review of a document titled, "Olympic heating and cooling", dated 07/01/2024, showed it was an estimate for the kitchen's Mitsubishi ductless heat pump ceiling cassette system and install a new system. The document was not signed by the facility staff or the facility's corporation to show that the estimate was accepted for repairs. The estimate was only valid for 30 days from the date of proposal.

Record review of the facility document titled, "americool", undated, showed it was an estimate to have the ductless heat pump system installed in the kitchen. The estimate was not signed or dated that the facility or the facility corporation had accepted the estimate.

In an observation on 01/28/2025 at 3:10 PM, the kitchen walls showed every wall observed was coated with a light brown substance. The walls had a variety of unknown matter splattered onto them. The kitchen floor had multiple tiles throughout the area that were partially or completely missing. In some of the areas that tile were missing there were indentations and unlevel concrete areas that had dark brown and black substance. The backdoor in the kitchen was once white had been coated in a brown substance. Darker brown soilage had been observed by the silver doorknob. The silver threshold at the bottom of the door had layered thick unknown substances embedded into it. Two of two light fixtures above the stove had missing covers. One light fixture did not have lights and there were yellow, black, red, and blue wires that were

exposed.

In an observation on 01/28/2025 at 3:11 PM, inside the walk-in refrigerator, on the ceiling in multiple areas throughout the entire refrigerator were multiple areas that had large areas of black spotted substance, and the ceiling was cracked or flaking white substance that exposed dark black and brown wood and substance. In the far-right corner near the ceiling was an area that showed the white wall was cracked and exposed dark brown and black wood and nails that was from the ceiling down quarter of the wall. The level area of the top shelf of the silver rack that had hotdog buns stored on them and leaned up against the cracked exposed area. The ceiling in the same area was cracked, flaking substance of white and black, and exposed solid black substance with spotted black dotted areas around the solid black substance. Some of the ceiling was cracked and caved inwards and some areas protruded down. There were other areas around the cracks that were black and spotted that resembled mold and rotten wood. It was observed throughout the ceiling there were multiple areas that showed the ceiling was bubbled or ripped and broke. There were large areas of spotted black substance that resembled mold around the areas of the ceiling that were bubbled, cracked, broke, or ripped. In the far-left corner of the walk-in refrigerator on the ceiling were large areas that was cracked, and had black substance exposed. There was white with spotted black substance around the area that resembled mold. On the fan that was on the ceiling near the entry way showed it had black and white substance all over the plastic grate and on the fan blades. There was dripping water on the three tubes that were connected to the fan unit and extended to the wall behind the fan unit.

In an observation and interview on 01/28/2025 at 3:14 PM, outside of the kitchen's tankless hot water heater closet next to the pantry shelf with food stored on it and the refrigerator showed a pipe above the door. The silver pipe had been covered in an unknown white substance. The white substance hung off the pipe in multiple areas that dangled in the air. When the closet door had been opened there was standing water on the floor in the entire area of the closet. Under the beige electronic box that hung up on the wall, had a broken blue pipe that was dripping water. The water continuously dripped onto the ground and splashed water when it hit the water on the ground. There were two blue wires that were connected to the beige box on the wall that the water was dripping onto. To the left of the closet in the far-right corner near the ground was thick fuzzy black substance that was from the floor and up the wall two inches and covered two inches wide. Staff K, Cook, said they did not know that closet door opened and that the inside of the closet looked like that. Staff L, Dietary Aide, said inside of the closet was the tankless water heater. Staff L had been observed to look inside of the closet and said that the black fuzzy substance that formed was probably mold (a type of fungus that grows in moist environments and breaks down organic matter). Outside of the tankless hot water heater closet to the left, the wall that was behind the ice machine had been a hole near the bottom trim. The hole had concaved inward, and insulation and drywall had been observed to not be present.

In an observation and interview on 01/28/2025 at 3:18 PM, Staff H said the closet contained the tankless hot water heater and they had knowledge that the pipe in the closet broke a few days ago. Staff H opened the closet and said they did not know the pipe started to leak water and that there was standing water on the ground of the closet area. Staff H said they planned to try and fix the pipe themselves, but they had not had

the time to physically go get the part to do so. Staff H acknowledged the hole in the drywall and said it had been like that for the last three years. Staff H said that they could not complete the repair since the kitchen staff had to prepare food in the area. Staff H acknowledged that the kitchen floor had tiles that were missing and was unlevel. Staff H acknowledged that light fixtures in the kitchen did not have covers, and one light fixture did not have light bulbs or a cover with exposed wires observed. Staff H said the air conditioning unit above the food line had not worked for the last three years.

In an observation and interview on 01/28/2025 at 3:40 PM, Staff A observed the kitchen's tankless hot water closet door and said they had not been aware that inside the closet contained a leak that had dripped water onto the tankless hot water tanks wires. Staff A Staff A knowledge that the walk-in refrigerator had damaged to the walls and the ceiling that exposed black substance, black and brown wood and nails, and spotted black substance.

In an interview and observation on 01/28/2025 at 3:19 PM, Anonymous 2 (A2), Facility Staff Member, opened the kitchens tankless hot water closet door. A2 said they did not want to answer the question on what they thought the thick fuzzy black substance was. A2 said that the black fuzzy substance was in the tankless hot water closet for the last three years.

In an interview on 01/28/2025 at 3:25 PM, A2 acknowledged that the entire kitchen had been a concern. A2 said Staff I, had knowledge of the concerns in the kitchen. A2 said historically the facility staff had obtained bids for the work in the kitchen that needed to be completed. A2 said despite multiple bids being submitted for a variety of projects such as repair to the kitchen floor and air conditioning unit that corporate had not approved the repairs.

In an observation and interview on 01/28/2025 at 3:42 PM, Anonymous 1 (A1), Facility Staff Member, opened the kitchen's tankless hot water closet door. A1 acknowledged the fuzzy black substance inside of the tankless hot water closet area and declined to say what the substance was.

In an interview on 01/28/2025 at 3:50 PM, A1, said corporate had to approve any repair over \$500.00. A1 said the facility staff would inform the corporation of different repairs in the facility that needed to take place. A1 said corporate would ask for the facility to follow up and obtain bids for the projects that needed to be repaired. A1 said despite submission of bids to corporate, the work would not get approved. A1 acknowledged the unlevel and the poor condition of the kitchens floor. A1 said they were aware of some staff falling on the tile floor before because of the trip hazards.

In an interview on 01/30/2025 at 1:00 PM, Anonymous 3 (A3), Facility Staff Member, acknowledged the kitchen had multiple areas of concern such as mold, broken lights without covers, the walk in refrigerator had exposed black and brown wood nails on the walls and ceiling inside of it. A3 said they had reported their concerns to the facility and

the corporation multiple times without follow up taken place.

In an interview on 01/29/2025 at 1:05 PM, Collateral Contact 1 (CC1), Deputy State Fire Marshal, stated they went into the facility kitchen, and they expressed concern that the kitchen had mold. CC1 said the air conditioner in the kitchen needed to be maintained. CC1 noted Staff H said the facility staff had to take parts of the air conditioner off to ensure the equipment did not fall onto the kitchen employee's.

In an interview on 01/30/2025 at 12:45 PM, Staff M, Dietary Manager, said the kitchen staff cleaned the walls as often as they could. Staff M said since the walls had textured paint when they tried to clean them the paint would chip and come off. Staff M acknowledged that light fixtures in the kitchen did not have lights or covers, the walk in refrigerator had exposed wood, black substance, and nails.

Facility Front Entrance

In an interview on 01/28/2025 at 11:41 AM, Resident 8 (R8), said that the front doors had a handicap button that do not work. R8 said they had lived in the facility since July 2024 and the buttons had not worked the entire time. R8 stated they used an electrical wheelchair and without the button it was hard to get in and out of the facility's front door without assistance.

In an observation on 01/28/2025 at 2:17 PM, the outside of the facility front doors had a button nearby that said, "press to operate". When the Department pressed the button, the automatic door did not open. The front door had to be manually opened. On the inside of the facility front doors had a button nearby that said, "press to operate". When the Department pressed the button, the automatic door did not open. There was no sign on the inside of the facility and outside of the facility that showed the buttons were out of order and did not work.

In an observation on 01/29/2025 at 10:43 AM, the "press to operate" button located outside of the facility front doors did not open when pressed.

In an interview on 01/29/2025 at 11:04 AM, Staff H acknowledged that the ADA (American with Disabilities Act) buttons to the front door of the facility were broken. Staff H said there had been a leak in the air compressor, and they had to deactivate the air compressor which resulted in the deactivation of the ADA button. Staff H said to their knowledge the ADA button had been broken for approximately three years. Staff H said to their knowledge one or two residents had expressed complaints that the ADA button had not been functional.

In an interview on 01/29/2025 at 1:40 PM, Staff A said the ADA button in the front of the facility had not been functional. Staff A said the button had been broken since end of Spring 2024. Staff A acknowledged that some residents at the facility expressed concern that the button was not operational. Staff A had been unsure on the follow up to get the ADA button repaired.

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Refer to Washington Administrative Code (WAC) 388-78A-2930, WAC 388-78A-2821, and WAC 388-78A-3090.

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, Beehive Retirement and Assisted Living Community is or will be in compliance with this law and / or regulation on (Date) 3/29/25.

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

Michelle Dube
Administrator (or Representative)

3/4/25
Date

WAC 388-78A-2450 Staff:

- (2) The assisted living facility must:
 - (d) Document and retain for twelve weeks, weekly staffing schedules, as planned and worked;
- (3) The assisted living facility must:
 - (d) Maintain the following documentation on the assisted living facility premises, during employment, and at least two years following termination of employment:
 - (i) Staff orientation and training or certification pertinent to duties, including, but not limited to:
 - (A) Training required by chapter 388-112A WAC;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to document and retain staff schedules for 2 of 2 facility buildings (memory care and assisted living building) reviewed. The facility failed to ensure 1 of 2 sampled staff (Staff E) completed their home care aide certification within the required time frame. These failures placed all 48 of 48 residents and staff at risk of not having access to accurate documentation and for residents being cared for by unqualified and untrained staff.

Findings included...

Washington Administrative Code (WAC) 388-112A-0110 "(1) All long-term care workers must obtain home care aide certification as provided in chapter 246-980 WAC. (2) The

Refer to Washington Administrative Code (WAC) 388-78A-2030, WAC 388-78A-2821, and WAC 388-78A-3090.

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, Beehive Retirement and Assisted Living Community 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-2450 Staff.

(2) The assisted living facility must:

(d) Document and retain for twelve weeks, weekly staffing schedules, as planned and worked;

(3) The assisted living facility must:

(d) Maintain the following documentation on the assisted living facility premises, during employment, and at least two years following termination of employment:

(i) Staff orientation and training or certification pertinent to duties, including, but not limited to:

(A) Training required by chapter 388-112A WAC;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to document and retain staff schedules for 2 of 2 facility buildings (memory care and assisted living building) reviewed. The facility failed to ensure 1 of 2 sampled staff (Staff E) completed their home care aide certification within the required time frame. These failures placed all 46 of 46 residents and staff at risk of not having access to accurate documentation and for residents being cared for by unqualified and untrained staff.

Findings included...

Washington Administrative Code (WAC) 388-112A-0110 "(1) All long-term care workers must obtain home care aide certification as provided in chapter 246-980 WAC. (2) The

following individuals must obtain home care aide certification as follows: ... (c) Assisted living facility administrators or their designees, within 200 calendar days of the date of hire;"

Staff Credentials

Record review of the document titled, "Employee HR (Human Resources) List, undated, showed Staff E, Caregiver, was hired at the facility on 05/21/2024.

Record review on 01/28/2025 at 3:19 PM, showed the facility did not provide Staff E's Washington state Department of Health credentials for review.

Record review of an email sent to the Department on 01/29/2025 at 7:55 PM, showed Staff E was still waiting on their test date for their Washington State Department of Health credentials.

In an interview on 01/29/2025 at 12:26 PM, Staff B, Assistant Administrator, stated Staff E was waiting to get their test date for their home care aide credentials. Staff B stated Staff E submitted the information to Washington state Department of Health and the facility did not have any documentation to show when the information was submitted for test date.

In an interview on 01/31/2025 at 10:23 AM, Staff A stated Staff E did not have a test date scheduled to obtain their home care aid certification. Staff A acknowledged that Staff E was to have had their home care aid certification no later than 12/07/2024 that was 55 days past the required time frame.

Staff Schedules

Record review of the facility provided untitled document, dated 01/05/2025 through 01/25/2025, showed it was a list of employees' timecards that had worked for review.

In an interview on 01/28/2025 at 10:20 AM, Staff A, Administrator, said Staff B, Assistant Administrator, had been the person responsible for the facility staff's records.

In an interview on 01/28/2025 at 1:10 PM, Staff B said they do not keep a schedule to show who was scheduled to work, if there were call ins, and what staff member filled in documented for review. Staff B stated their system did not allow the facility to document that and was only able to provide the employee's that worked timecards.

In an interview on 01/29/2025 at 1:38 PM, Staff A said there was no way the facility

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could provide documentation to review that broke up the facility staff schedules. There were no records to review that showed 12-weeks of worked and planned staff schedules for review.

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, Beehive Retirement and Assisted Living Community is or will be in compliance with this law and / or regulation on (Date) 3/29/25.

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

Michelle Dwyer
Administrator (or Representative)

3/4/25
Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012, meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(b) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure of 1 of 3 sampled staff (Staff A) completed their continuing education units (CEU) which included dementia training and mental health specialty training to provide care to vulnerable adults. This failure placed 46 of 46 residents at risk of receive care by an unqualified staff member.

Findings included...

WAC 388-112A-0511

"(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described in this section.

(a) The following long-term care workers must complete 12 hours of continuing education by their birthday each year:

(v) An assisted living facility administrator or the administrator designee as provided under WAC 388-112A-0360.

(i) Must complete 12 hours of continuing education by the long-term care worker's birthday each calendar year worked thereafter; or...

could provide documentation to review that broke up the facility staff schedules. There were no records to review that showed 12-weeks of worked and planned staff schedules for review.

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, Beehive Retirement and Assisted Living Community 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-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure of 1 of 3 sampled staff (Staff A) completed their continued education units (CEU) which included dementia training and mental health specialty training to provide care to vulnerable adults. This failure placed 46 of 46 residents at risk of receive care by an unqualified staff member.

Findings included...

WAC 388-112A-0611

"(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described in this section.

(a) The following long-term care workers must complete 12 hours of continuing education by their birthday each year:

(v) An assisted living facility administrator or the administrator designee as provided under WAC 388-112A-0060.

(i) Must complete 12 hours of continuing education by the long-term care worker's birthday each calendar year worked thereafter; or..."

WAC 388-112A-0400

"What is specialty training and who is required to take it?

(1) Specialty training refers to approved curricula that meets the requirements of RCW 18.20.270 and 70.128.230 to provide basic core knowledge and skills to effectively and safely provide care to residents living with mental illness, dementia, or developmental disabilities.

(2) Specialty training classes are different for each population served and are not interchangeable. Specialty training curriculum must be DSHS developed, as described in WAC 388-112A-0010 (36), or DSHS approved.

(a) In order for DSHS to approve a curriculum as a specialty training class, the class must use the competencies and learning objectives in WAC 388-112A-0430, 388-112A-0440, or 388-112A-0450.

(b) Training entities must not use classes approved as alternative curriculum for specialty training that are not using the competencies and learning objectives in WAC 388-112A-0430, 388-112A-0440, or 388-112A-0450 to meet the specialty training requirement.

(c) Curricula approved as specialty training may be integrated with basic training if the complete content of each training is included.

(3) Assisted living facility administrators or their designees, enhanced services facility administrators or their designees, adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that service residents who have special needs, including developmental disabilities, dementia, or mental health, must take one or more of the following specialty training curricula:

(c) Mental health specialty training as described in WAC 388-112A-0450."

WAC 388-110-220

"(3) In an assisted living facility with an enhanced adult residential care-specialized dementia care services contract, for residents served under that contract, the contractor must:

(d) Ensure that each staff who works directly with residents has at least six hours of continuing education per year related to dementia, including Alzheimer's disease. This six hours of continuing education may be part of the ten hours of continuing education required by WAC 388-112-0205.

Appropriate topics include, but are not limited to:

- (i) Agitation: Caregiving strategies;
- (ii) Challenging behaviors: Strategies for managing aggression and sexual behavior;
- (iii) Delusions and hallucinations;
- (iv) Using problem-solving strategies in dementia care;
- (v) Depression and dementia;
- (vi) Fall prevention for people with dementia;
- (vii) Personal care as meaningful activity;
- (viii) Promoting adequate food and fluid consumption;
- (ix) Promoting pleasant and purposeful activity;
- (x) Resistance to care: Caregiving strategies; and
- (xi) Recognizing and assessing pain in people with dementia."

Record review of the facility's "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 01/23/2025, showed 26 of 46 residents were labeled to have dementia (a condition that effects thinking, remembering, reasoning, and effects

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daily life)/Alzheimer's (condition causing memory loss and reduced functional abilities)/Cognitive Impairment (condition affecting thinking, memory, and decision-making). The roster showed 9 of 46 residents had behaviors/psychosocial issues (events or disruptions in a person's life that affect their mental health and wellbeing).

Record review of the document titled, 'Employee HR (Human Resources) List, undated, showed Staff A, Administrator, was hired at the facility on 03/01/2021 and their date of birth was January 18,

Record review of Staff A's training records showed 0.6 of 12 CEU's from 01/18/2024 – 01/18/2025 and 0 of 6 CEU's that were focused on dementia.

Record review of an email sent to the Department, on 01/29/2025 at 7:55 PM, showed Staff B said the facility did not have any more CEU's for Staff A to review that fell in the review period of 01/18/2024 – 01/18/2025. Staff B said Staff A did not have the mental health specialty training certificate to provide to review.

In an interview on 01/26/2025 at 10:20 AM, Staff A said Staff B, Assistant Administrator had been the person responsible for the facility staff's training and records.

In an interview on 01/29/2025 at 1:40 PM, Staff A expressed that the facility had a memory care building and an assisted living building. Staff A said some residents who resided in the assisted living building had dementia.

In an interview on 01/31/2025 at 9:09 AM, Staff B said they did not realize Staff A had been required to complete CEU's or to complete their mental health specialty training certification. Staff B said the process for the staff that were required to complete CEU's included to assign 12 CEU's six of which were dementia related that were due for the year by their birthdate.

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, Beehive Retirement and Assisted Living Community is or will be in compliance with this law and / or regulation on (Date) 3/29/25.

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

Michelle Duke
Administrator (or Representative)

3/4/25
Date

daily life)/Alzheimer's (condition causing memory loss and reduced functional abilities)/Cognitive Impairment (condition affecting thinking, memory, and decision-making). The roster showed 9 of 46 residents had behaviors/psychosocial issues (events or disruptions in a person's life that affect their mental health and wellbeing).

Record review of the document titled, "Employee HR (Human Resources) List, undated, showed Staff A, Administrator, was hired at the facility on 03/01/2021 and their date of birth was January 18.

Record review of Staff A's training records showed 0.5 of 12 CEU's from 01/18/2024 – 01/18/2025 and 0 of 6 CEU's that were focused on dementia.

Record review of an email sent to the Department, on 01/29/2025 at 7:55 PM, showed Staff B said the facility did not have any more CEU's for Staff A to review that fell in the review period of 01/18/2024 – 01/18/2025. Staff B said Staff A did not have the mental health specialty training certificate to provide to review.

In an interview on 01/28/2025 at 10:20 AM, Staff A said Staff B, Assistant Administrator had been the person responsible for the facility staff's training and records.

In an interview on 01/29/2025 at 1:40 PM, Staff A expressed that the facility had a memory care building and an assisted living building. Staff A said some residents who resided in the assisted living building had dementia.

In an interview on 01/31/2025 at 9:09 AM, Staff B said they did not realize Staff A had been required to complete CEU's or to complete their mental health specialty training certification. Staff B said the process for the staff that were required to complete CEU's included to assign 12 CEU's six of which were dementia related that were due for the year by their birthdate.

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Administrator (or Representative)

Date

WAC 388-78A-2462 Background checks Who is required to have.

(2) The assisted living facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012 have the following background checks:

(a) A Washington state name and date of birth background check; and

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 2 of 4 sampled staff (Staff C and Staff F) had submitted a new Washington state name and date of birth background check upon hire. This failure placed 46 of 46 residents at risk for being cared for by a staff member with a potentially disqualifying history.

Findings included...

Washington Administrative Code (WAC) 388-78A-2468 "Background checks—Employment—Conditional hire —Pending results of Washington state name and date of birth background check. The assisted living facility may conditionally hire an administrator, caregiver, or staff person directly or by contract, pending the result of the Washington state name and date of birth background check, provided that the assisted living facility: (1) Submits the background authorization form for the person to the department no later than one business day after he or she starts working"

Staff C, Medication Technician

Record review of the document titled, "Employee HR (Human Resources) List, undated, showed Staff C was hired at the facility on 09/20/2024.

Record review of Staff C's interim Washington State Name and Date of Birth background check showed it was completed on 04/11/2022.

Record review of Staff C's Current Washington State Name and Date of Birth background check was completed on 01/29/2025. The background check was completed 294 days past the required timeframe.

Record review of an email sent to the Department, on 01/29/2025 at 7:55 PM, Staff B, Assistant Administrator said the facility did not have an updated background check to review that was completed when Staff C's employment had been reinstated at the facility on 09/20/2024. Staff B said the most updated background check for Staff C to review was dated 01/29/2025.

Staff F, Resident Care Coordinator

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Record review of the document titled, "Employee HR (Human Resources) List, undated, showed Staff F was hired at the facility on 08/16/2022.

Record review of Staff F's Interim Washington State Name and Date of Birth background check showed it was completed on 04/16/2021.

Record review of Staff F's Current Washington State Name and Date of Birth background check was completed on 06/07/2023. The background check was completed 52 days past the required timeframe.

Record review of an email sent to the Department, on 01/29/2025 at 7:55 PM, Staff B said Staff F had been reinstated (restarted their employment at the facility) on 08/16/2022. Staff B acknowledged that another background check had been completed when Staff F was reinstated.

In an interview on 01/26/2025 at 10:20 AM, Staff A, Administrator, said Staff B had been the person responsible for the facility staff's records.

In an interview on 01/31/2025 at 7:16 AM, Staff B said if an employee left employment at the facility and returned within one year, they would reinstate the employee. Staff B said if the employee left employment at the facility and returned more than one year, they would redo all the new hire paperwork including the interim Washington state Name and Date of Birth background check. Staff B stated for all employees that were reinstated, they would not recheck their Washington State Name and Date of Birth background check as it had not been two years.

Plan/Attestation Statement

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

Michelle M. Wibe
Administrator (or Representative)

3/4/25
Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in

Record review of the document titled, "Employee HR (Human Resources) List, undated, showed Staff F was hired at the facility on 08/16/2022.

Record review of Staff F's Interim Washington State Name and Date of Birth background check showed it was completed on 04/16/2021.

Record review of Staff F's Current Washington State Name and Date of Birth background check was completed on 06/07/2023. The background check was completed 52 days past the required timeframe.

Record review of an email sent to the Department, on 01/29/2025 at 7:55 PM, Staff B said Staff F had been reinstated (restarted their employment at the facility) on 08/16/2022. Staff B acknowledged that another background check had been completed when Staff F was reinstated.

In an interview on 01/28/2025 at 10:20 AM, Staff A, Administrator, said Staff B had been the person responsible for the facility staff's records.

In an interview on 01/31/2025 at 7:16 AM, Staff B said if an employee left employment at the facility and returned within one year, they would reinstate the employee. Staff B said if the employee left employment at the facility and returned more than one year, they would redo all the new hire paperwork including the interim Washington state Name and Date of Birth background check. Staff B stated for all employees that were reinstated, they would not recheck their Washington State Name and Date of Birth background check as it had not been two years.

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)

Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in

support of services that are provided and are necessary to:

(b) Provide the necessary care and services for residents, including those with special needs;

(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;

(l) To manage residents' medications, consistent with WAC 388-78A-2210 through 388-78A-2290 ; sending medications with a resident when the resident leaves the premises;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to follow their policy and procedure for non-availability or medications, alert charting related to when a resident missed their medications, and when to notify a resident's medical doctor for 5 of 7 residents (Resident 2 [R2], Resident 7 [R7], Resident 3 [R3], Resident 6 [R6], and Resident 1 [R1]) reviewed. These failures resulted in the residents not receiving their medications as ordered, placed the residents at risk for unmet care needs and lack of response for decline in resident conditions, and medical complications associated with not receiving medications as ordered. These failures impacted the physician's ability to evaluate the significance of the residents not getting their medication and provide instructions.

Findings included...

WAC 388-78A-2240

"When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner."

WAC 388-78A-2230

"(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;..."

Record review of the facility's policy, "Missing or unavailable medication procedure", undated, showed if medication had not been delivered from the family or pharmacy the following steps must be taken notify the nurse or resident care coordinator before the first missed dosage, contact the pharmacy about an emergency supply, notify the medical doctor that the medication had not been available and why. The resident would

be placed on alert charting to monitored for side effects of not receiving the medication. Notify the family or power of attorney of the medication issue and request that they follow up with the medical doctor if a refill was needed. The facility staff were to fill out an incident report and document in a progress note the side effects of the missed medication and what was being done to obtain the medication. No resident should ever miss a dosage of medication, it was the facility responsibility to obtain medications. All medication aides were to re-order all medications seven to ten days before they ran out.

Record review of the facility's policy, "Resident Alerts", dated 01/30/2025, showed all changes in medication required an enhanced monitoring of the resident and potential changes in care. The procedure section showed the medication aide on shift would create the medical alert and begin the alert charting process. Documentation of the observed status of the resident would be done once daily unless otherwise specified. This could be done in alert notes or as a progress note. The alert charting protocol section showed resident alerts would be initiated based on alert sub-type. When alert sub-types were entered into the system a "what to look for (signs & Symptoms)" field. The infection/Antibiotic section showed record observations every shift for 48 hours. Record side effects to medications. The medication procedure section showed record observations every shift for three days. Record observations specific to side effects of that medication, outcome, and nurse or medication doctor instruction.

Record review of an untitled, and undated document showed when to notify the medical doctor. The doctor could be faxed 24 hours a day. The doctor should be notified when there was a refusal of medication.

R2

Record review of R2's Resident Information Sheet, undated, showed R2 moved into the facility on [REDACTED] /2024 with multiple medical diagnoses that included [REDACTED]

and [REDACTED]

Record review of R2's Service Agreement, dated 11/18/2024, showed the facility would manage all of R2's medication that included storing, ordering, and administering. The facility would order R2's medications from the facility's house pharmacy.

Record review of R2's document "fax", dated 12/31/2024, showed the facility was completely out of R2's latanoprost (prescribed medicated eye drops to help reduce the pressure in the eyes to help treat glaucoma) eye drops and requested a new prescription be sent to the pharmacy to have the medication filled. R2's physician replied back on 01/06/2025, that they had sent the order that day on 01/06/2025.

Record review of R2's Medication Administration Record (MAR), dated 11/01/2024 through 11/30/2024, showed on 11/04/2024 at 8:52 AM, R2 refused their fluticasone-salmeterol inhaler (a prescribed medicated inhaler to help and prevent asthma attacks by reducing swelling in the lungs and airways) and dorzolamide-timolol (prescribed medicated eye drops to help lower the pressure in the eyes and preserve vision) eye drops. Under the notes of the MAR showed R2 would not take, tried three times. There was no documentation that R2's physician was notified. The MAR showed on 11/12/2024 at 8:26 PM and on 11/16/2024 at 9:30 PM, R2's medications finasteride (prescribed medication to block the body's production of the male hormone that can cause the prostate to enlarge), tamsulosin (prescribed medication to help treat symptoms related to enlarged prostate), and mirtazapine (prescribed medication to help treat depression) were all not administered. Under the medication notes it showed waiting on medications to arrive and none in cart, not billable until 19th, notified registered nurse. There was no documentation that R2's physician was notified that they missed their medications for those dates.

Record review of R2's MAR, dated 12/01/2024 through 12/31/2024, showed on 12/21/2024 at 8:41 PM, R2 did not receive their Florastor (medication to help prevent growth of bad bacteria in the stomach) medication. Under the notes of the MAR, showed the medication was "not in salad pack". There was no documentation that showed R2's physician was notified that R2 didn't receive their medication. On 12/31/2024 at 8:33 PM, R2 did not receive their latanoprost eye drops. Under the notes of the MAR, showed waiting on new prescription from doctor.

Record review of R2's MAR, dated 01/01/2025 through 01/28/2025, showed on 01/01/2025 through 01/04/2025, R2 did not receive their latanoprost eye drops. Under the notes of the MAR, showed waiting on new order from the doctor, needs new prescription contacting doctor. There was no documentation that showed that R2's physician was notified.

Record review of R2's progress note, dated 01/19/2025, showed R2's physician had sent back a fax that showed "it was sent today", when the facility had requested a prescription for R2's latanoprost eye drops. There were no other notes from dates 11/01/2024 through 01/27/2025 that showed R2's physician was notified that they didn't receive their medications.

Record review of R2's Resident Alerts, dated 11/01/2024 through 01/21/2025, showed there was no documentation that showed R2's physician was notified that they refused and missed their medications. The documentation showed R2 was not put on alert for the refused and missed medication per the facility's policy.

R7

Record review of R7's Resident Information Sheet, undated, showed R7 moved into the facility on [REDACTED]/2022 with multiple medical diagnoses that included [REDACTED]

[REDACTED]

Record review of R7's Service Agreement, dated 12/13/2024, showed staff were to administer all R7's medication. Staff were to order R7's medication through the facility house pharmacy.

Record review of R7's MAR, dated 11/01/2024 through 11/30/2024, showed R7 had an order for latanoprost eye drops to be given every day in the evening. Review of the administrations showed on 11/09/2024 through 11/11/2024, R7 did not receive their latanoprost eye drops. Under the notes on the MAR, showed pharmacy needs new prescription, no more eye drops available, waiting for new prescription from doctor, and should be in tomorrow. There was no documentation that showed the physician was notified that R7 was out of their latanoprost eye drops.

Record review of R7's Progress Notes, dated 11/11/2024, showed R7 had ran out of their latanoprost eye drops and requested a refill of the medication. The pharmacy had responded that they needed a new prescription for the latanoprost eye drops to fill. A communication was sent to the physician to get a new prescription and R7 was put on alert charting that day for any effects from not getting the eye drops. There was no other documentation to R7's physician prior to 11/11/2024 that R7 was out of the latanoprost eye drops.

Record review of R7's Resident Alerts, dated 11/11/2024, showed R7 was put on alert for their latanoprost eye drops being out and not receiving the medicated eye drops. There was no other documentation prior to 11/11/2024 that showed R7 was on alert on the first they did not get the latanoprost eye drops on 11/09/2024 and that R7's physician and pharmacy was notified then for review.

Record review on 01/30/2025 at 8:30 AM, of R7's hard medical chart showed R7's physician was not notified on 11/09/2024 that they were out of their latanoprost eye drops and did not receive the medicated eye drops on 11/09/2024 through 11/11/2024 for review.

R3

Record review of R6's Service Agreement, dated 12/26/2024, the medical care management section showed the facility staff stored, ordered, and reordered all R3's medications. The facility staff would communicate with R3's medical doctor. The facility staff would observe and report any medication side effects.

Record review of R3's, "MAR", dated 11/01/2024-11/30/2024, showed R3 had an order for felodipine (medication that treated high blood pressure). On 11/23/2024 the reason the medication had not been given showed the medication order had been out for

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clarification. On 11/24/2024 the reason the medication had not been given showed the medication had been out for clarification and the notes section showed waiting on the medical doctor. On 11/25/2024 the reason the medication had not been given showed the medication had been out for clarification and the notes section showed the facility staff would call the pharmacy for delivery update when they opened.

Record review of R6's, "Resident Progress Note", dated 11/23/2024, showed Staff Q, Medication Aide, wrote R6's felodipine had been unavailable and was reordered at the pharmacy and would be available in two days on Monday. R6 could have side effects that included headache (pain or discomfort in the head or scalp), swelling, bloating, and dizziness.

Record review of R6's, "Resident Alerts", dated 11/23/2024, showed R3 was placed on alert for facility staff to record observations every shift for three days. The facility staff were to record observations specific to side effects of the missed medication felodipine.

Record review of R6's, "Resident Alert", dated 11/23/2024 – 12/22/2024, showed there were no other alert charting notes to review related to R6's side effects of their missed felodipine medication on 11/23/2024.

R6

Record review of R6's "Service Agreement", dated 07/09/2024, the medical care management section showed the facility staff stored, ordered, and reordered all R6's medications. The facility staff would communicate with R6's medical doctor. The facility staff would observe and report any medication side effects. The facility staff ordered R6's medications through the house pharmacy.

Record review of R6's, "MAR", dated 12/01/2024 – 12/31/2024, showed R6 had an order for Atorvastatin Calcium (a medication used to lower the amount of cholesterol in the blood). On 12/08/2024 the reason the medication had not been given showed R6 refused their medication and the notes showed resident had been tired of pills.

Record review of R6's, "Resident Progress Note", dated 12/05/2024 – 01/24/2025, showed there were no progress notes to review when R6 refused their Atorvastatin Calcium medication.

Record review of R6's, "Resident Alerts", dated 12/05/2024 – 01/29/2025, showed there were no alert charting notes to review when R6 refused their Atorvastatin Calcium medication.

Record review of R6's, "MAR", dated 01/01/2025 – 01/28/2025, showed R6 had an order for Atorvastatin Calcium. On 01/01/2025, the reason the medication had not been given showed R6 refused their medication, and the notes showed the facility staff reapproached multiple times but R6 still refused.

Record review of R6's, "Resident Progress Note", dated 01/01/2025 – 01/24/2025, showed there were no progress notes to review when R6 refused their Atorvastatin Calcium medication.

Record review of R6's, "Resident Alerts", dated 01/01/2025 – 01/29/2025, showed there were no alert charting notes to review when R6 refused their Atorvastatin Calcium medication.

Record review of an email sent to the Department, on 01/30/2025 at 1:33 PM, Staff B, Assistant Administrator, said the facility had been unable to provide documentation fax to show R6's medical doctor had been notified when they refused their Atorvastatin Calcium on 01/01/2025.

R1

Record review of R1's Resident Information Sheet, undated, showed R1 moved into the facility on [REDACTED]/2024 with multiple medical diagnoses that included [REDACTED].

Record review of R1's Service Agreement, dated 05/23/2024, showed R1 required the medication technician to administer all R1's medications. The facility was to communicate with R1's primary care physician and other health care physicians as needed.

Record review of R1's MAR, dated 12/01/2024 through 12/31/2024, showed on 12/07/2024 at 1:29 PM, R1 did not take their acetaminophen (a medication that helps with reducing pain, fever, and discomforts). Under the notes on the MAR, showed R1 had grabbed the spoon of medications and rubbed it on the medication technician's shirt and dropped most of the medication on the floor. There was no documentation that R1's physician was notified.

Record review of R1's Resident Alerts, dated 12/01/2024 through 12/31/2024, showed there was no documentation to show that R1's physician was notified that R1 refused their acetaminophen on 12/07/2024.

Record review of R1's progress notes, dated 11/01/2024 through 01/03/2025, showed there was no documentation to show that R1's physician was notified that R1 refused their acetaminophen on 12/07/2024 for review.

Record review on 01/30/2025 at 8:28 AM, of R1's hard medical chart showed there was no physician notifications or fax's for review that R1 refused their acetaminophen on 12/07/2024 in the chart for review.

In an interview on 01/29/2025 at 2:46 PM, Staff F, Resident Care Coordinator (RCC), stated if a resident refused their medication, the resident's physician would be faxed or notified. Staff F stated the resident would then be put on alert for the refused medication for three days. Staff F stated that the registered nurse, family, and administration staff would be notified that the resident refused their medication. Staff F stated if the resident's medication was not available for administration and resident missed their medication, the resident would be put on alert charting for the missed medication. Staff F stated the resident's physician, responsible party, nurse, and administration would all be notified of the resident missing their medication. Staff F stated the resident's physician would be continued to be contacted until the resident's medication was available for administration. Staff F stated the resident would remain on alert charting until the resident's medication was delivered and available for administration.

In an interview on 01/29/2025 at 3:17 PM, Staff P, Resident Care Coordinator, stated the medication technicians were to notify the registered nurse, RCC, administration, and the residents primary care physician, and the resident's power of attorney or responsible party, that the resident's medication was not available for administration. Staff P stated the resident would be put on alert with the progress note. Staff P stated the residents primary care physician would continue to be contacted and notified that the resident was not getting their medication until it arrived and available for administration. Staff P stated if the resident when over 24 hours without the medication, once they restarted the medication the resident would be continued on alert charting for the restart of the medication and any possible side effects.

In an interview on 01/30/2025 at 2:22 PM, Staff D, Caregiver, said the facility caregivers had access to completed progress notes and alert charting for the facility residents. Staff D said if a resident missed or refused a dosage of their medication then the protocol was for the resident to have a progress note about the missed medication and then be placed on alert. Staff D said the progress note should contain information on how long the resident would be placed on alert for.

In an interview on 01/30/2025 at 2:47 PM, Staff F said the facility protocol if a resident missed or refused one dosage of their medication was for the staff to fax the residents medical doctors, put the resident on alert, notify the facility nurse, administration, and the residents family. Staff F said the facility staff would continue to request the medication from the pharmacy until the medication had been received. The facility staff continued to notify the residents medical doctor until the facility received the medication.

In an interview on 01/30/2025 at 3:34 PM, Staff P said the facility protocol was to reorder residents medications seven to ten days in advance.

This is a recurring deficiency previously cited on 07/18/2024.

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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, Beehive Retirement and Assisted Living Community is or will be in compliance with this law and / or regulation on: (Date) 3/29/25

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

Michelle M. M. M.
Administrator (or Representative)

3/4/25
Date:

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

- (1) The care and services necessary to meet the resident's needs, including:
 - (c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;
 - (e) The resident's preferences for how services will be provided, supported and accommodated by the assisted living facility.
- (2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan.
- (a) Exclusively for the individual resident, or

This requirement was not met as evidenced by:

Based on interview, observation, and record review the facility failed to have the Resident Service Agreement (facility's version of the Negotiated Service Agreements) show the care and services necessary to meet the residents needs for 6 of 7 sampled residents (Resident 2 [R2], Resident 1 [R1], Resident 3 [R3], Resident 5 [R5], and Resident 6 [R6]). This failure placed the residents at risk for unmet care needs and care and services not being provided per the negotiated service agreements.

Findings included...

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)

Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

- (1) The care and services necessary to meet the resident's needs, including:
 - (c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;
 - (e) The resident's preferences for how services will be provided, supported and accommodated by the assisted living facility.
- (2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:
 - (a) Exclusively for the individual resident; or

This requirement was not met as evidenced by:

Based on interview, observation, and record review the facility failed to have the Resident Service Agreement (facility's version of the Negotiated Service Agreements) show the care and services necessary to meet the residents needs for 5 of 7 sampled residents (Resident 2 [R2], Resident 1 [R1], Resident 3 [R3], Resident 5 [R5], and Resident 6 [R6]). This failure placed the residents at risk for unmet care needs and care and services not being provided per the negotiated service agreements.

Findings included...

Washington Administrative Code (WAC) 388-78A-2320 "Intermittent nursing services systems. (2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include... (e) Implementation of the nursing component of each resident's negotiated service agreement..."

Record review of the facility policy titled, "Service Agreement Policy", dated 01/31/2025, showed service agreements must be completed quarterly after the 30-day update that followed admission. The service agreement content must be specific to resident strengths, preferences, and limitations. The service agreement would include assistance that would be performed by the family and should include names for personalization. The service agreement said do not specify as to frequency unless frequency was required for residents' health or safety. The service agreement indicated that the categories bathing, hygiene, medication management, housekeeping and laundry would be incorporated. A written description of who would provide the services and what, when, how, and how often the services would be provided would be notated. The service agreement would incorporate the use of supportive devices. The service agreement would monitor and document any changes in the resident's physical, mental, or emotional and social ability to cope with activities of daily living. If changes had occurred that would alter the resident service agreement, then the changes should be noted, the resident and family should be notified, and appropriate action should be taken.

R2

Record review of R2's Resident Information Sheet, undated, showed R2 moved into the facility on 2024 with multiple medical diagnoses that included

and

In an observation and interview on 01/29/2025 at 12:38 PM, R2 was sitting at a dining room table drinking liquid. The liquid was a light brown color and was thin. Staff T, Caregiver, stated R2 required thickened liquids to drink. Staff G, Medication Aide, stated the facility had pre-thickened liquids for R2 to drink or they have the powder and make any liquid thickened for them to drink and in their coffee. Staff G stated R2's liquids were to be nectar thick. Staff G observed the liquid that R2 was drinking and stated that it was coffee, and it was not nectar thick consistency. Staff G stated it was often that R2 would get their own coffee themselves and drink the coffee quickly without the staff knowing R2 had thin liquids.

Record review of R2's Service Agreement, dated 11/18/2024, showed R2 speaks in clear English and able to vocalize any concerns or problems. R2 has issues with eating and aspirates (when food or fluid particles go into the lungs rather down into the stomach) R2 required thicken liquids, ate very slowly, and chewed their food thoroughly. There was no documentation that R2 refused to use the thickened powder in their drinks, or that they would get thin liquids and drink them fast without the staff knowing and that

R2's physician was aware of R2's noncompliance with the thicken liquids. Under the section titled, "behaviors", showed there was no known triggers and R2 was easy going and sociable.

In an interview on 01/29/2025 at 3:17 PM, Staff P, Resident Care Coordinator, stated R2 was to drink only thickened liquids. Staff P stated the facility provides R2 with pre thickened liquids or there was powder to thicken any liquid to the nectar consistency R2 required per their physician's order. Staff P stated there was always pre thickened coffee for R2 to drink that they would just need to warm up in the microwave to drink.

In an interview on 01/31/2025 at 9:17 AM, Staff G stated the facility staff assist R2 with their liquids to ensure they were thickened to the right consistency. Staff G stated it was often that R2 goes into the dining room independently and got their own coffee to drink. Staff G stated R2 did not thicken their liquids before consuming as R2 was not aware of how to thicken their liquids. Staff S, Registered Nurse (RN) Delegator, stated R2 had the right to refuse to have their liquids thickened. Staff G stated at times R2 would refuse to have their liquids thickened to nectar consistency, but often R2 would just drink thin liquids that they got on their own without the facility staff always knowing. Staff G stated they typically would document in the progress notes about R2 drinking thin liquids and notify the physician of R2's noncompliance. Staff S acknowledged that R2's service agreement was not updated to reflect that R2 drank thin liquids against R2 physician orders, refused to have liquids thickened, and that the physician was to be notified when R3 did drink thin liquids and placed them at increased risk for aspiration.

R1

Record review of R1's Resident Information Sheet, undated, showed R1 moved into the facility on [REDACTED] 2024 with multiple medical diagnoses that included [REDACTED]. Record review of R1's Delegation Assessment, dated 12/17/2024, showed R1 required delegated services for all their oral medications. The assessment showed R1 had dementia and required their medications to be crushed and administered to them.

Record review of R1's Service Agreement, dated 05/23/2024, showed R1 required the medication technician to administer all R1's medications. There was no documentation that R1 required RN delegation services.

Record review of an email sent to the Department on 01/30/2025 at 1:33 PM, showed the service agreement dated 05/23/2024 was the most current signed care plan. The facility was in the process of updating a service agreement but was not signed or completed.

R3

Record review of R3's, "Resident Info Sheet", undated, showed R3 moved into the

facility on [REDACTED] 2024. R3 had medical diagnosis which included [REDACTED]

Record review of R3's Service Agreement, dated 12/26/2024, showed R3's short term and long term memory were fair. R3 had multiple falls when they reached for items they could not reach. Under bed mobility showed R3 was independent, and the equipment section was left blank. The housekeeping and laundry section showed R3 received services once weekly on Tuesdays.

In an interview and observation on 01/29/2025 at 2:00 PM, R3 requested the Department pick up their CPAP (a device that delivered pressurized air to keep airways open when you slept) machine off the ground and put it on their nightstand. R3 said they were able to operate and clean the device independently. R3 said they received housekeeping services twice a week and they thought their housekeeping days were on Tuesday's and Saturday's.

In an interview on 01/30/2025 at 2:14 PM, Staff N, Housekeeper, said R3 had been identified to need more housekeeping services and R3's services were recently increased to twice weekly on Tuesday's and Friday's.

Record review of R6's Service Agreement, dated 12/26/2024, did not show that R3 used a CPAP machine and that R3 had the ability to manage and clean the device independently. The service agreement did not indicate R3's increase in housekeeping services to twice weekly and which additional day R3 received housekeeping.

R5

Record review of R5's, "Resident Info Sheet", undated, showed R5 moved into the facility on [REDACTED] 2024. R5 had diagnosis of [REDACTED] and [REDACTED]

Record review of R5's Service Agreement, dated 11/01/2024, showed R5's objective had been to enjoy quality of life with their spouse in a safe environment. The bathing section showed R5 liked to shower in the morning. The bathing day section showed it was blank. The behavior section showed R5's spouse had been at a skilled nursing facility and R5 got upset when they thought their spouse was out with friends rather than at home with them. The medical care management section showed R5's family would continue to order their medication and deliver it to the facility. The ambulation section showed R5 used a front wheeled walker. The housekeeping day and laundry day section showed it was blank.

Record review of R5's "Resident Progress Note", dated 11/18/2024, showed Staff Q, Medication Aide, wrote R5's primary care provider submitted a home health order for

physical therapy.

Record review of R5's "Resident Progress Note", dated 12/20/2024, showed Staff Q wrote R5 had home health physical therapy today.

In an observation on 01/28/2025 at 11:33 AM, R5's bedroom showed there had been one bed inside of the room.

In an interview on 01/31/2025 at 9:50 AM, Collateral Contact 2 (CC2), R5's Power of Attorney, said when R5 moved into the facility it had been with their spouse. CC2 said R5 spouse died, and they now lived independently. CC2 said they had been unsure how often R5 received showers at the facility. CC2 said R5 received home health services at least once weekly for therapy on how to teach R5 how to use their walker.

In an interview on 01/30/2025 at 2:47 PM, Staff F, Resident Care Coordinator (RCC), said R5 received physical therapy through home health. Staff F said they were unsure how often R5 received home health services. Staff F said if a resident received home health, then the information should be incorporated into their service agreement.

Record review of R5's Service Agreement, dated 11/01/2024, did not show the updated information that R5's spouse had passed away and that they lived at the facility independently. The bathing section did not incorporate what days R5 received showers. The behavior section did not include updated information related to how R5 coped without living with their spouse. The medical care management section did not incorporate a back up plan if R5's family had been unable to bring them their medication. The service agreement did not incorporate R5's home health information. The service agreement did not include what day R5 received housekeeping and laundry services.

R6

Record review of R6's, "Resident Info Sheet", undated, showed R6 moved into the facility on [REDACTED] 2023. R6 had diagnosis of [REDACTED]

Record review of R6's Service Agreement, dated 07/09/2024, the medical care management section showed R6 received as needed medications. The bathing section showed R6 liked to shower in the evening. The bathing day section showed it was blank. The housekeeping day and laundry day section showed it was blank.

Record review of R6's, Delegation Assessment, dated 03/09/2024, showed R6 required delegation for oral medication.

Record review of R6's, Delegation Assessment, dated 09/01/2024, showed R6 required delegation for oral medication, topical medication, and nasal spray.

Record review of R6's Service Agreement, dated 07/09/2024, did not indicate that R6 received delegated nursing services. The bathing section did not incorporate what days R6 received showers. The service agreement did not include what day R6 received housekeeping and laundry services.

In an interview on 01/30/2025 at 2:40 PM, Staff A, Administrator, said the facility did not complete family assistance with medication plans for the residents. Staff A said if a resident's family had been identified to provide the resident their medication they did not have a backup plan if the family could not do so.

In an interview on 01/30/2025 at 2:47 PM, Staff F said today 01/30/2025 was the first day they had the opportunity to update resident service agreements. Staff F said the week prior is when they first learned how to update resident service agreements. Staff F stated they had started the position of RCC in October 2024.

In an interview on 01/30/2025 at 3:34 PM, Staff P said they transitioned to the resident care coordinator position in either October or November 2024. Staff P said they actively were in the process of how to learn and how to update and complete resident service agreements. Staff P said the facility caregivers and medication aides could handwrite new information into resident service agreements. If a resident had been identified to have a new behavior or need additional help the facility staff were to notify the resident care coordinator and the registered nurse. Staff P said they would type updated information into resident service agreements and then have a family care conference to review the updates. Staff P said what days residents received showers should be incorporated into the service agreements. Staff P said if a residents family brought them their medication, then a back up plan should be incorporated into the service agreement. Staff P said the resident families had been aware that resident's medications needed to be at the facility. Staff P said to their knowledge the facility would be the back up plan to obtain resident medications if the family had been unable to bring them in.

In an interview on 01/31/2025 at 10:23 AM, Staff A stated the facility did not include the residents scheduled showers day onto the resident's service agreements. Staff A stated the residents laundry days would be the same for the resident's shower days.

Statement of Deficiencies	License # 2148	Compliance Determination # 53718
Plan of Correction	Beehive Retirement and Assisted Living Community	Completion Date
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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, Beehive Retirement and Assisted Living Community is or will be in compliance with this law and / or regulation on: (Date) 3/29/25

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

Michelle Dube
Administrator (or Representative)

3/4/25
Date

WAC 388-110-220 Enhanced adult residential care service standards:

(3) In an assisted living facility with an enhanced adult residential care-specialized dementia care services contract, for residents served under that contract, the contractor must:

(a) Complete a full assessment of residents as specified in chapter 388-78A WAC, at a minimum, on a semi-annual basis.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 4 sampled residents (Resident 1 [R1] and Resident 6 [R6]) had a completed semiannual assessment. This failure placed the residents at risk for unmet care needs and staff untrained on the care and services that needed to be provided.

Findings included...

Washington Administrative Code (WAC) 388-110-220 Enhanced adult residential care service standards. (3) In an assisted living facility with an enhanced adult residential care-specialized dementia care services contract, for residents served under that contract, the contractor must: (a) Complete a full assessment of residents as specified in chapter 388-78A WAC, at a minimum, on a semi-annual basis.

Record review of the Department database on 01/24/2025, showed the facility had an enhanced adult residential care contract with a start date of 08/01/2025 and an end date of 07/31/2028.

In an interview on 01/29/2025 at 12:03 PM, Staff A, Administrator, said resident service agreements and assessments were completed on the same document.

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, Beehive Retirement and Assisted Living Community 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 388-110-220 Enhanced adult residential care service standards.

(3) In an assisted living facility with an enhanced adult residential care-specialized dementia care services contract, for residents served under that contract, the contractor must:

(a) Complete a full assessment of residents as specified in chapter 388-78A WAC, at a minimum, on a semi-annual basis;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 2 of 4 sampled residents (Resident 1 [R1] and Resident 6 [R6]) had a completed semiannual assessment. This failure placed the residents at risk for unmet care needs and staff untrained on the care and services that needed to be provided.

Findings included...

Washington Administrative Code (WAC) 388-110-220 Enhanced adult residential care service standards. "(3) In an assisted living facility with an enhanced adult residential care-specialized dementia care services contract, for residents served under that contract, the contractor must: (a) Complete a full assessment of residents as specified in chapter 388-78A WAC, at a minimum, on a semi-annual basis".

Record review of the Department database on 01/24/2025, showed the facility had an enhanced adult residential care contract with a start date of 08/01/2025 and an end date of 07/31/2028.

In an interview on 01/29/2025 at 12:03 PM, Staff A, Administrator, said resident service agreements and assessments were completed on the same document.

R1

Record review of R1's Resident Information Sheet, undated, showed R1 moved into the facility on [REDACTED] 2024 with multiple medical diagnoses that included [REDACTED]

Record review of the R1's Service Agreement, dated [REDACTED]/2024, showed this was R1's initial service agreement.

Record review of R1's Service Agreement (facility's version of the negotiated service agreement and assessment), dated 05/23/2024, showed this was the most updated service agreement the facility had for R1 for review. There was no other service agreements provided or completed for review.

Record review of an email sent to the Department on 01/30/2025 at 1:33 PM, showed the service agreement dated 05/23/2024 was the most current signed care plan. The facility was in the process of updating a service agreement but was not signed or completed.

R6

Record review of R6's, "Service Agreement", dated [REDACTED]/2023, showed the document had been agreed upon and signed by the R6's Power of Attorney and the facility Nurse/Resident Care Coordinator on [REDACTED] 2023.

Record review of R6's, "Service Agreement", dated 07/09/2024, showed the documents had been agreed upon and signed by R6's responsible party and Staff A on 07/09/2024.

Record review of an email sent to the Department, on 01/30/2025 at 1:33 PM, Staff B, Assistant Administrator, said the facility could not provide a semi annual assessment for R6 to review. Staff B said the only two service agreements for R6 to review were dated [REDACTED] 2023 and 07/09/2024.

In an interview on 01/30/2025 at 2:46 PM, Staff F, Resident Care Coordinator (RCC), said today 01/30/2025 was the first day they had the opportunity to update resident service agreements. Staff F stated they had been in the RCC position since October 2024. Staff F said the week prior was when they first learned how to update resident service agreements and today 01/30/2024 was the first day they had a chance to work on the service agreements since they took the position. Staff F said they were supposed to update resident service agreements every 15 days after a resident admitted into the facility, then again at 30 days, and then quarterly thereafter.

In an interview on 01/30/2025 at 3:34 PM, Staff P, Resident Care Coordinator, said they

Statement of Deficiencies	License #: 2148	Compliance Determination # 53718
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transitioned to the resident care coordinator position in either October or November 2024. Staff P said they actively were in the process of how to learn how update and complete resident service agreements. Staff P said the facility caregivers and medication aides could handwrite new information into resident service agreements. If a resident had been identified to have a new behavior or need additional help the facility staff were to notify the resident care coordinator and the registered nurse. Staff P said they would type updated information into resident service agreements and then have a family care conference to review the updates.

In an interview on 01/31/2025 at 9:39 AM, Staff S, Registered Nurse Delegator, stated the RCC for the facility were responsible to update the residents service agreements.

In an interview on 01/31/2025 at 10:23 AM, Staff A, Administrator, acknowledged that the resident service agreements were not updated semiannually per the enhanced adult residential care services.

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, Beehive Retirement and Assisted Living Community is or will be in compliance with this law and / or regulation on (Date) 3/29/25.

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

Michelle Duke
Administrator (or Representative)

3/4/25
Date

transitioned to the resident care coordinator position in either October or November 2024. Staff P said they actively were in the process of how to learn how update and complete resident service agreements. Staff P said the facility caregivers and medication aides could handwrite new information into resident service agreements. If a resident had been identified to have a new behavior or need additional help the facility staff were to notify the resident care coordinator and the registered nurse. Staff P said they would type updated information into resident service agreements and then have a family care conference to review the updates.

In an interview on 01/31/2025 at 9:39 AM, Staff S, Registered Nurse Delegator, stated the RCC for the facility were responsible to update the residents service agreements.

In an interview on 01/31/2025 at 10:23 AM, Staff A, Administrator, acknowledged that the resident service agreements were not updated semiannually per the enhanced adult residential care services.

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, Beehive Retirement and Assisted Living Community 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

Beehive Retirement

Plan of Correction

Statement of Deficiencies Report Dated 2-25-2025

	Actions	Responsible Person(s)	Due Date	Completed Date
WAC 388-78A-2030 Assisted Living Facility License Required	We have added a calendar reminder to follow up with Home Office to ensure our license is renewed annually.	Administrator	3/29/2025	2/26/2025
WAC 388-78A-3090 Maintenance and Housekeeping	The trash and recycling area will be swept and pressure washed as needed. Maintenance Supervisor will inspect weekly to ensure upkeep.	Maintenance Supervisor and Administrator	3/29/2025	3/29/2025
	Kitchen walls have been deep cleaned and repainted. Kitchen staff have added scrubbing walls nightly to their daily closing checklist.	Kitchen Manager, Administrator and Kitchen Staff	3/29/2025	3/24/2025

Beehive Retirement

	We are hiring a general contractor to refurbish the existing structure of our walk-in to meet compliance requirements.	Project Manager, Administrator and Maintenance Supervisor	3/29/2025	Estimates are in progress
	Kitchen overhead leaking pipe has been repaired and tankless water heater closet has been scrubbed and sanitized.	Maintenance Supervisor, Administrator and Kitchen Staff	3/29/2025	3/29/2025
	Overhead lights in kitchen no longer have exposed wires.	Maintenance Supervisor and Administrator	3/29/2025	3/3/2025
	ADA doors are operable. We replaced the hydraulic arms and air fittings.	Project Manager, Maintenance Supervisor and Administrator	3/29/2025	3/29/2025
	Overhead light in Activities Room will have new cover installed	Maintenance Supervisor and Administrator	3/29/2025	3/29/2025
	Memory Care Hallway has had the hole in the ceiling and leaking pipe has been repaired	Maintenance Supervisor and Administrator	3/29/2025	3/14/2025
	Shower chairs and shower benches for Memory Care shower rooms have all been replaced with new ones	Assistant Administrator and Administrator	3/29/2025	3/28/2025

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

Beehive Retirement

WAC 388-78A-2821 Design, Construction Review and Approval Plan WAC 388-78A-2040 Other Requirements	We are currently working with Food Service Equipment (FSE) to let us know if oven door can be replaced or if we need to replace the whole oven.	Maintenance Supervisor and Administrator	3/29/2025	Currently in progress
	R5's bedroom door will have the inoperable magnetic door stop replaced	Project Manager	3/29/2025	3/29/2025
	Kitchen floor vinyl has been repaired and new vinyl laid	Maintenance Supervisor	3/29/2025	3/14/2025
	We have submitted plans to DOH for retroactive inspection and approval for roof repairs in Memory Care	Maintenance Supervisor	3/29/2025	3/28/2025
	Carbon Monoxide detectors have been placed in Memory Care per mandated locations	Project Manager and Maintenance Supervisor	3/29/2025	3/14/2025
	All interior and exterior fire extinguishers have been inspected and properly tagged Cover plate for hot water heater in Assisted Living Laundry Room is currently on order	Project Manager, Maintenance Supervisor and Administrator	3/29/2025	3/29/2025

Beehive Retirement

WAC 388-78A-2950 Water Supply	Our water temperatures are now within the safe range based on State requirements. We have added the policy with proper temperatures to the bottom of our temperature logs	Project Manager and Maintenance Manager	3/29/2025	3/14/2025
WAC 388-78A-2930 Communications System	Our call lights and paging system are all up and working properly.	Project Manager, Corporate IT and Maintenance Supervisor	3/29/2025	2/25/2025
WAC 388-78A 2730 Licensee's Responsibilities	We are currently obtaining estimates to replace HVAC system in kitchen	Project Manager and Maintenance Supervisor	3/29/2025	Currently receiving estimates
WAC 388-78A-2450 Staff	Staff E has completed the application for her HCA credentials test	Assistant Administrator	3/29/2025	Waiting for DOH to provide clearance for test date
WAC 388-78A-2474 Training and Home Care Aide Certification Requirements	We have changed our process for employee schedules. Once the schedule is posted, it is printed and put in a binder. Any changes in the schedule will be kept in electronic form.	Assistant Administrator	3/29/2025	2/02/2025

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

Beehive Retirement

WAC 388-78A-2474 Training and Home Care Aide Certification Requirements	Staff A has completed her Mental Health Training and is scheduled to complete her Specialty Dementia Training on 04/02/2025. 12 annual CEU's will be completed annually	Administrator	3/29/2025	4/02/2025
WAC 388-78A-2462 Background Checks. Who is required to have	We have changed our practice during any rehires. Background checks will be performed for all new hires and rehires.	Assistant Administrator	3/29/2025	3/01/2025
WAC 388-78A-2600 Policies and Procedures	We retrained our Med Aides on our policy of alerting PCP and family when medications are not available through the pharmacy.	Oversight Nurse and RCC	3/29/2025	2/12/2025
WAC 388-78A-2230	We have implemented a new policy that requires Med Aides to alert PCP, family, oversight nurse, RCC and Administrator when a medication is refused by a resident.	Oversight Nurse and RCC	3/29/2025	2/12/2025
WAC 388-78A-2140 Negotiated service agreement contents	All negotiated service agreements are up to date and current based on resident needs and preferences.	Oversight Nurse, RCC, Administrator	3/29/2025	3/29/2025

Beehive Retirement

WAC 388-110-220 Enhanced adult residential care service standards	All health assessments are current and being completed quarterly along with their negotiated service agreements.	Oversight Nurse and RCC	3/29/2025	3/29/2025
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