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) 32088 (Completion Date 11/03/2023) and 28517 (Completion Date 08/29/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/03/2023 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-2600-2-g, WAC 388-78A-2600-2

The Department staff who did the on-site verification:
Paul Aube, ALF NCI

If you have any questions, please contact me at (360)397-9556.

Sincerely,

Jody Just

Jody Just, Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Beehive Retirement and Assisted Living Community
License/Cert.#: 2148
Compliance Determination #: 28517
Investigator: Paul Aube
Investigation Date(s): 08/23/2023 through 08/29/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 93204
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
Resident/Patient/Client Neglect: Facility report of discovered pressure ulcer and gangrenous wound to resident's left foot.

Investigation Methods:

Sample:	Total residents: 48 Resident sample size: 5 Closed records sample size: 1
Observations:	Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Management
Record Reviews:	Medical Records Clinic Records Incident investigation Facility policies Resident Care Plans Progress Notes

Investigation Summary:
Resident/Patient/Client Neglect: Facility investigated incident, and made all appropriate notifications. Facility failed to follow policies and procedures for monitoring the wounds to the residents foot after discovered. Failed practice identified.

Conclusion / Action:

- [X] Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Beehive Retirement and Assisted Living Community
License/Cert.#: 2148
Compliance Determination #: 28517
Investigator: Paul Aube
Investigation Date(s): 08/23/2023 through 08/29/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 93316
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
Quality of Care/Treatment: Facility report of a medication error involving a resident in the community.

Investigation Methods:

Sample:	Total residents: 48 Resident sample size: 5 Closed records sample size: 1
Observations:	Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Management
Record Reviews:	Medical Records Clinic Records Incident investigation Facility policies Resident Care Plans Progress Notes

Investigation Summary:
Quality of Care/Treatment: Facility investigated incident and notified all appropriate parties. Facility failed to follow policies and procedures for monitoring after the medication error discovered. Failed practice identified.

Conclusion / Action:

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

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Beehive Retirement and Assisted Living Community
License/Cert.#: 2148
Compliance Determination #: 28517
Investigator: Paul Aube
Investigation Date(s): 08/23/2023 through 08/29/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 93205
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
Quality of Care/Treatment: Facility report of a medication error involving a resident in the community.

Investigation Methods:

Sample:
Total residents: 48
Resident sample size: 5
Closed records sample size: 1

Observations:
Residents
Activities
Dining
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Nursing staff
Management

Record Reviews:
Medical Records
Clinic Records
Incident investigation
Facility policies
Resident Care Plans
Progress Notes

Investigation Summary:
Quality of Care/Treatment: Facility investigated incident, and notified all appropriate parties. Facility failed to follow policies and procedures for monitoring after the medication error discovered. Failed practice identified.

Conclusion / Action:

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

☐ N/A

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 # 28517
Plan of Correction	Beehive Retirement and Assisted Living Community	Completion Date
Page 1 of 5	Licensee: Caring Places Management, LLC	08/29/2023

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 08/23/2023 and 08/29/2023 of:

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

This document references the following complaint number(s): 93204, 92487, 93053, 93316, 93205

The following sample was selected for review during the unannounced on-site visit: 5 of 46 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI

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

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.

Jody Just
Residential Care Services

08/30/2023
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)

August 30, 2023
Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(g) When there are urgent situations in the assisted living facility requiring additional staff support;

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to follow policies and procedures after incidents occurred requiring staff intervention for 3 of 4 residents, (Resident 1 [R1], Resident 2 [R2], and Resident 3 [R3] reviewed. This failure placed these residents at an increased risk for harm due to lack of monitoring.

Findings included...

Review of an undated facility policy, titled "Resident Alerts," it stated, "All incidents, changes of conditions, changes in medication, etc. require an enhanced monitoring of the resident and potential changes in care." "Documentation of the observed status of the resident will be done once daily unless otherwise specified in the protocol." Under the section, "Alert Charting Protocol" it specifies for which conditions alert charting would be implemented, and the duration.
- For "Fall, Injury," it stated to "Record observations every shift for 3 days. Record observations of resident's ability to ambulate, transfer, injury, skin tear, discoloration of skin, headache, dizziness, sleepiness or confusion."
- For "Med [Medication]/Procedure," it stated to "Record observations every shift for 3 days. Record observations specific to side effects of that medication, and outcome, per nurse/MD (Medical Doctor) instruction."
- For "Skin/Pr. [Pressure] Ulcer," it stated to "Record observations every shift for 3 days, or until scabbed over and without signs of infection, such as redness, swelling, warmth, pain, or drainage. Continue on alert until no signs of infection observed for more than 72 hours. If signs of infection observed, monitor vital signs daily while on alert."

According to a Mayo Clinic article titled "Bedsores [Pressure Ulcers]", last reviewed on 05/13/2023, it stated, "Bedsores — also called pressure ulcers and decubitus ulcers — are injuries to skin and underlying tissue resulting from prolonged pressure on the skin. Bedsores most often develop on skin that covers bony areas of the body, such as the heels, ankles, hips and tailbone. People most at risk of bedsores have medical conditions that limit their ability to change positions or cause them to spend most of their time in a bed or chair. Bedsores can develop over hours or days."

During an interview with Staff A, the Executive Director, on 08/23/2023 at 2:14PM, Staff A was asked to explain the process for "Alert Charting" on residents. Staff A stated that for a variety of incidents in the facility, such as falls, medication errors, etc., the facility staff are required to monitor the resident for certain things, which are determined by the nurse. The staff would then be required to document in the resident record those observations for a period of 3-days, each shift (Dayshift, Evening Shift, and Night shift). Staff A stated that this would equate to 3-entries per day, about the resident incident. When asked what staff are required to do when they discover a wound on a resident. Staff A stated, "When we put a resident on alert, every shift needs to be documenting on changes, improvements etc. The time [duration] on alert for wounds is until the wound has been healed."

During an interview with Staff D, a Medication Technician, on 08/23/2023 at 1:35PM, asked Staff D to explain the process of alert charting for residents who are found to have wounds. Staff D stated, "We would put them on alert for redness, sores, etc." Staff D was asked how long residents would remain on alert. Staff D stated that the residents would remain on alert until it is healed, or until the alert was removed by the nurse.

During an interview with Staff C, the Resident Care Coordinator, on 08/23/2023 at 1:21PM, asked Staff C to explain the process of alert charting for residents who are found to have wounds. Staff C stated, "We would put the resident on alert, fax the physician and notify family. The residents would remain on alert until the wound was healed and documented on every shift."

<R1>
Review of R1's face sheet showed that R1 was admitted to the facility on [redacted]/2022.

Review of an Incident Report for R1 dated 08/10/2023 at 7:11PM showed that R1 was involved in a medication error, to which the evening medications were dispensed by staff and left at the R1's bedside, not taken. The next morning, R1 took these medications, assuming the medications were their morning medications. This error resulted in the resident missing their evening medications, and also resulted in the resident taking scheduled medications at the wrong time.

Review of the R1's Alert Charting and Progress Notes showed that the medication error was documented. In an untimed progress note dated 08/10/2023, it stated, "This morning I gave [R1] [their] medications and after [they] swallowed [their] AM medications [R1] stated, "I just took some meds." In another untimed progress note dated, 08/13/2023, it stated "PCP (Primary Care Physician) faxed back about our fax on 08-10-23. Day shift found meds on counter. PCP response: Continue to monitor blood pressure and encourage hydration; Please ensure patient takes medication and they are not left on a counter." These notes for the incident are the only notes in the resident record referencing the medication error. There is no Alert Charting/monitoring of the resident for possible side effects from the medication error documented for 08/10/2023, 08/11/2023, 08/12/2023, and 08/13/2023 in the resident record.

<R2>
Review of R2's face sheet showed that R2 was admitted to the facility on [redacted]2022.

Review of an Incident Report for R2 dated 08/09/2023 at 6:54PM showed that R2 was involved in a medication error to which the evening medications were administered to the resident before they were due. This error resulted in the resident taking the scheduled medications at the wrong time.

Review of R2's Alert Charting and Progress Notes showed only one, untimed note regarding this medication error, dated 08/10/2023. It stated, "Received fax back from PCP (Noted to watch for blood pressure and pulse deviations)." No other notes were provided for review. Review of the resident record showed no Alert Charting/monitoring of the resident for possible side effects from the medication error documented for 08/09/2023, 08/10/2023, 08/11/2023, and 08/12/2023 in the resident record.

<R3>
Review of R3's face sheet showed that R3 was admitted to the facility on [redacted]2019.

Review of the R3's Progress Notes showed an untimed progress note, dated 07/27/2023 which was titled, "WOUND CARE TO FOOT." It stated, "Received wound care orders from the Mobile Dermatology. Placed in chart and on cart." Review of the resident record showed that R3 was not placed on alert monitoring for the wound on their foot at this time.

Review of an untimed progress note dated 07/30/2023, it stated, "R3 requested to be sent to [Hospital] on dayshift, [R3] has since returned to the facility. Discharge paperwork states [R3] was seen for extremity [leg] pain. Advised to continue with [antibiotics] and to follow up with [Primary Care Physician]. If pain/redness persist and do not improve within the next 3-4 days, return to the ER (Emergency Room)." Review of the resident record showed that R3 was not placed on alert monitoring at this time.

Review of an untimed progress note dated 08/03/2023, it stated, "[R3] returned from the ER with a new order, they also made [R3] an appointment with the podiatry for Monday 08/07/23 at 2PM they faxed the order to our Pharmacy. Placing on alert." Review of the alert charting notes showed that R3 was placed an alert, which was monitored and documented on 08/04/2023, 08/05/2023, and 08/06/2023. Although R3's wound was not documented as resolved, the alert monitoring was ended at this time.

Review of an incident report for R3, dated 08/09/2023 at 9:48AM, it stated, "[R3] was seen by podiatry (foot specialist) for a [follow up] from an ER visit. Upon return from the podiatry office paperwork stated that the wound to the heel was a pressure ulcer and [R3] also had a wound to her toe. Per resident, MD (Medical Doctor) stated the wound to the toe was gangrene." Review of the resident record showed that the R3 was not placed on alert monitoring for the pressure ulcer and gangrenous wound to their toe.

According to a Mayo Clinic article titled "Gangrene", last reviewed on 06/17/2022, it stated "Gangrene is death of body tissue due to a lack of blood flow or a serious bacterial infection. Gangrene commonly affects the arms and legs, including the toes and fingers."

During an interview with Staff A on 08/23/2023 at 2:14PM, Staff A was asked why the R1. and R2 were not placed on alert after they were involved in medication errors. Staff A stated, "They [Staff] know better." Staff A was asked if R3 should have been placed on alert monitoring after being diagnosed with a [redacted] and [redacted]. Staff A stated, "The resident should have been placed on alert at that time."

During an interview with Staff B on 08/23/2023 at 2:24PM, Staff B was asked if R3 should have been placed on alert monitoring after being diagnosed with a [redacted] and [redacted]. Staff B stated, "Staff should have placed the resident on alert at that time, yes." Staff B stated, "I know they were [monitoring], but I don't know if they were documenting it."

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) Sept 29, 2023

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

Michelle Mylod — Administrator (or Representative)

August 30, 2023 — Date