



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) 31977 (Completion Date 11/01/2023) and 30141 (Completion Date 09/27/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/01/2023 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-2210-2

The Department staff who did the on-site verification:
Phan Pham, Nurse Surveyor

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

Sincerely,

A handwritten signature in cursive script that reads "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 #: 30141

Investigator: Phan Pham

Investigation Date(s): 09/27/2023 through 09/27/2023

Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 96093

Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

- 1) Pharmacy services - Named resident was given twice the amount of medication prescribed.
- 2) Quality of care - Staff members approved the orders without verifying the orders transcribed.

Investigation Methods:

Sample:	Total residents: 47 Resident sample size: 5 Closed records sample size: 0
Observations:	Named resident, residents, environment, staff interactions with residents, staff members providing care and services, infection control practice, and safety measures.
Interviews:	Named resident, residents, and interdisciplinary team members.
Record Reviews:	Sampled residents and incident reports.

Investigation Summary:

An on-site investigation was conducted, and the concerns related to 1) Pharmacy services and 2) Quality of care and treatments were reviewed. The Assisted Living Facility failed to ensure staff members followed the facility's medication transcription procedure to ensure orders were being correctly transcribed. Additional residents reviewed for medication services and quality of care, services and safety had no concerns.

Conclusion / Action:

- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A



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Statement of Deficiencies	License #: 2148	Compliance Determination # 30141
Plan of Correction	Beehive Retirement and Assisted Living Community	Completion Date
Page 1 of 3	Licensee: Caring Places Management, LLC	09/27/2023

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 09/27/2023, 09/27/2023 and 09/27/2023 of:

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

This document references the following complaint number(s): 96093, 97242

The following sample was selected for review during the unannounced on-site visit: 5 of 47 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Phan Pham, Nurse Surveyor

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.

Cory Cisneros

Residential Care Services

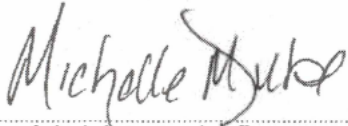
10/09/2023

Date

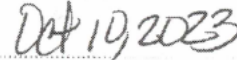
I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

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

Statement of Deficiencies	License #: 2148	Compliance Determination # 30141
Plan of Correction	Beehive Retirement and Assisted Living Community	Completion Date
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Administrator (or Representative)



Date

WAC 388-78A-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility failed to ensure staff members followed the facility's medication transcription procedure to ensure orders were being correctly transcribed for one of three residents (Resident 1) reviewed for medication services. This failure resulted in a significant medication error and placed the resident at risk for health complications from not receiving the medication as prescribed.

Findings included...

Review of the facility's medication transcription procedure, undated, stated staff were to fax the medication order to pharmacy for input into the eMAR (electronic Medication Administration Record). Before approving any medication in the eMAR, medication must be on hand, compare the original order and the medication against eMAR to make sure all had same instructions. Once verified then staff can approve the order in eMAR.

Review of Resident 1's face sheet showed the resident admitted to the facility on [REDACTED] 2023 with diagnoses including [REDACTED].

Review of Resident 1's service plan, dated 06/28/2023, documented Resident 1 had poor memory and required assistance with medication services.

On 09/27/2023 at 10:46 AM, Resident 1 was observed sitting in a chair in the television room. Resident 1 stated she took medications daily and staff members assisted her. Resident 1 was not able to provide additional information related to medication services.

Review of an incident investigation report, dated 08/30/2023 at 2:00 PM, showed the resident had an order for Fluconazole (antifungal) to be given one tablet daily for two days and repeat in one week. The pharmacy had transcribed the order incorrectly into the computer system as take one tablet two times daily for two days.

Review of the Resident 1's physician orders revealed on 08/24/2023 the resident had a physician order for Fluconazole 150 milligrams tablet to be administered one tablet daily

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for two days and repeat in one week. Review of the medication administration record for Resident 1 from 08/26/2023 to 08/30/2023 showed the facility's staff administered eight dosages of the medication. The resident was given twice the amount of the medication ordered.

In an interview on 09/27/2023 at 12:00 PM, Staff B, Medication Tech, stated usually a Medication Tech faxed new orders to the pharmacy and the pharmacy staff transcribed the orders into the computer system. Staff B said the pharmacy staff would alert the assisted living facility's staff when they had transcribed the orders for staff to review and approve. Staff B said two Medication Techs were responsible for reviewing the orders and verifying the orders to ensure pharmacy staff had correctly transcribed the orders into the computer system. Staff B stated she had been trained to review physician orders and verify orders in the computer system to ensure orders were correctly transcribed for all medications.

In an interview on 09/27/2023 at 12:15 PM, Staff A, Resident Care Nurse, said two Medication Techs were supposed to review the physician orders, verify to ensure pharmacy staff had correctly transcribed the orders into the computer system and initial the orders to show the orders had been reviewed and correctly transcribed. Staff A stated the Medication Techs had been trained to follow the facility's medication transcription procedures for all orders. Staff A stated the Medication Techs also email a copy of the physician orders for her to review. Staff A said she reviewed and verified the orders in the computer system to ensure orders were correctly transcribed when time permitted.

This was a recurring deficiency previously cited on 03/08/2023.

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) October 10, 2023.

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

Michelle M. Duke
Administrator (or Representative)

10/10/23
Date