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) 41382 (Completion Date 05/16/2024) and 38645 (Completion Date 04/18/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/16/2024 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-f

The Department staff who did the on-site verification:
Pamela Horlick, NCI RN Complaint Investigator

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, 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 #:** 38645
**Investigator:** Pamela Horlick
**Investigation Date(s):** 03/21/2024 through 04/18/2024
**Complainant Contact Date(s):**

**Provider Type:** Assisted Living Facility

**Intake ID:** 121865
**Region/Unit #:** RCS Region 3 / Unit E

**Allegation(s):**
Quality of Care/Treatment: Facility report of resident being found on the floor after sustaining injury from a fall.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 41<br>Resident sample size: 3<br>Closed records sample size: 1 |
| **Observations:** | Identified resident<br>Residents<br>Resident rooms<br>Staff to resident interactions<br>Resident to resident interactions |
| **Interviews:** | Identified resident<br>Nursing staff<br>Administrator |
| **Record Reviews:** | State reporting log<br>Incident investigation<br>Facility policies<br>Care Plan<br>Progress Notes/Alert Charting<br>Face Sheets<br>Staff training records<br>Characteristic Roster |

**Investigation Summary:**
Quality of Care/Treatment: Facility failed to notify residents physician after resident sustained an injury from a fall and was sent out of the hospital the next day for evaluation due to that fall. Failed practice identified.

**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 #:38645 |
| Plan of Correction | Beehive Retirement and Assisted Living Community | Completion Date |
| Page 1 of 4 | Licensee: Caring Places Management, LLC | 04/18/2024 |

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 03/21/2024 and 04/23/2024 of:

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

This document references the following complaint number(s): 121665, 121461

The following sample was selected for review during the unannounced on-site visit: 3 of 41 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator

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

04/29/2024
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.

STATE OF WASHINGTON
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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 03/21/2024 and 04/23/2024 of:

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

This document references the following complaint number(s): 121865, 121481

The following sample was selected for review during the unannounced on-site visit: 3 of 41 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator

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

04/29/2024
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 Dubl
Administrator (or Representative)

4/29/24
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:

(i) In response to medical emergencies;

**This requirement was not met as evidenced by:**

Based on interview and record review, the facility failed to implement their policies and procedures for physician notifications after an incident for 1 of 3 (Resident 1 [R1]) sampled residents. This failure placed R1 at risk for their physician being unaware of their condition.

Findings included...

Record review of a facility policy titled, "Resident Incidents and Investigation", undated, showed under section 2, "Critical components of the Quality Assurance Investigation include.", documented, "Prompt reporting to:
- Supervisor
- Nurse
- Administrator
- Emergency contact(s)
- Medical professional(s)
- Abuse hotline (if abuse is even a remote consideration)
- Police (if required)"

Record review of a facility policy titled, "Minimizing Falls," undated, stated, "The facility's objective is to ensure resident safety, including minimizing falls, utilizing the least restrictive means available, while promoting quality of life and independence. In this care setting, falls will occur, but our objective is to minimize their occurrence." Under the section, "If a Fall Occurs" stated, " When an alleged fall occurs and it is obviously a serious injury call 911 immediately and notify the physician and family."

Record review of R1's face sheet showed that R1 admitted to the facility on [redacted] 2019.

Record review of the incident log showed R1 was found on the floor on 03/05/2024.

Record review of an investigation for R1, dated 03/05/2024, showed that on 03/05/2024

Administrator (or Representative) _____ 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:

(f) In response to medical emergencies;

**This requirement was not met as evidenced by:**

Based on interview and record review, the facility failed to implement their policies and procedures for physician notifications after an incident for 1 of 3 (Resident 1 [R1]) sampled residents. This failure placed R1 at risk for their physician being unaware of their condition.

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Record review of R1's face sheet showed that R1 admitted to the facility on [redacted]/2018.

Record review of the incident log showed R1 was found on the floor on 03/05/2024.

Record review of an investigation for R1, dated 03/05/2024, showed that on 03/05/2024

R1 was found on the floor with a red substance on the back of their head. R1 hit their head on a drawer, breaking the drawer. The back of their head had a large semi circle cut on the back of her head. EMS [Emergency Medical Services] was called and did not take them to the hospital. R1 was tired and complained of a bad headache. On 03/06/2024, R1 blew their whistle and complained of a bad headache and said she thought she needed to go to the hospital. EMS was called and R1 was taken to the hospital for evaluation.

Record review of R1's Investigation showed R1's physician was notified of the fall on 03/05/2024 at 7:00 PM.

In an interview on 03/21/2024 at 2:30 PM, Staff B, Resident Care Coordinator, was asked to provide confirmations that faxes were sent to R1's primary care physician. Staff B stated they needed to look for them and they would email them to the department.

In an interview on 03/22/2024 at 4:54 PM, Collateral Contact 1, Registered Nurse for R1's primary care physician, was asked if they were notified of a fall with injury that R1 sustained on 03/05/2024. CC1 stated, they received notification yesterday (03/21/2024). CC1 stated R1's physician signed it and sent it back today (03/22/2024).

Record review of fax confirmation for R1 showed the fax was sent to R1's provider on 03/05/2024 at 8:55PM. The fax transmission was unsuccessful and showed a result of "no answer". On 3/21/2024, R2's provider wrote a response to the facility acknowledging the event and on 3/22/2024 the message was faxed back to the facility.

In an interview on 03/21/2024 at 10:44 AM, Staff D, Medication Technician, was asked what they do when a resident was found on the floor with an injury. Staff D stated, we immediately call 911 to have them assessed. Staff D stated they notify the family and fax the residents doctor and let them know what happened.

In an Interview on 03/21/2024 at 1:09 PM, Staff A, Executive Director, was asked what the expectation was of staff when a resident was found down on the ground with an injury. Staff A stated 911 would be called to assess the resident. Staff A stated then all the proper notifications would be made to the Resident Care Coordinator, family and the residents PCP (primary care physician). Staff A was asked when the notifications would be made, they stated, as soon as the resident was safe and we are able to. They stated it should be done within 24 hours, but actually done within their shift.

In an interview on 04/18/2024 at 9:49 AM, Staff B, Resident Care Coordinator, was asked how the doctor was notified when a resident had fallen and had an injury, Staff B stated, the doctor was faxed the same day. Staff B stated if we don't get a hold of them we will keep sending it until we get a response. We always try to get a response. Staff B was asked how they ensure that the doctor received the fax, they stated, we keep records so if it goes through we have the receipt. Staff B was asked what they would do if a message of "no answer" was on the fax confirmation, they stated, we would verify the fax number and refax it. They stated they will continue to try and double check and if we cant reach them

then we will call the provider to get the message through. Staff B was asked if there was any other documentation that other attempts were made to reach R1's doctor, they stated they didn't have any. Staff B stated we just keep fax attempts and put it in their file. Staff B stated they only see the fax attempts on 03/05/2024 and 03/21/2024. Staff B was asked if the fax confirmation on 03/05/2024 says "no answer", Staff B stated yes, but that the doctors office said they saw the notification on 03/05/2024 and didn't respond back.

In an interview on 04/18/2024 at 1:36 PM, Collateral Contact 2, Patient Access Specialist, was asked if they see any other documentation that they were notified of R1's fall with injury on 03/05/2024. CC2 stated, no they just see an ambulance report on 03/06/2024. CC2 stated there was no documentation from the facility until 03/21/2024. CC2 stated, that documentation was received on 03/21/2024, signed by the doctor and faxed back to the facility on 03/22/2024.

**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) April 29, 2024

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

Michelle Mube
Administrator (or Representative)

April 29, 2024
Date

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

_____ _____

Administrator (or Representative) Date