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) 39562 (Completion Date 04/10/2024) and 29863 (Completion Date 11/09/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/10/2024 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-2170-1, WAC 388-78A-2450-1-a

The Department staff who did the on-site verification:
Anissa Bearden, Licensor
Regenia Coleman, ALF NCI CI

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 #: 29863
Investigator: Anissa Bearden
Investigation Date(s): 09/21/2023 through 11/09/2023
Complainant Contact Date(s): 10/25/2023

Provider Type: Assisted Living Facility

Intake ID: 95020
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1) resident didn't have clean clothes and was given another residents clothes to wear.
2) staff neglected the resident when they had fallen.

Investigation Methods:

Sample:	Total residents: 47 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Dining Resident care equipment Resident rooms Staff to resident interactions Medication administration
Interviews:	Business office manager Administrative staff Family members Residents Nursing staff Identified staff
Record Reviews:	Medical records Hospital records Incident investigation staffing schedules staff credentials/certificates Facility policies Personnel files Staff training records

Investigation Summary:

1) after interview, observation, and record review it was noted the facility has replaced multiple washer and dryers that has impeded in the ability to stay up with soiled linens. the facility has a plan in place and washer and dryers have been ordered. the

sampled residents observed and reviewed had their own clothing on and no concerns reported. no failed practice.
2) after interview and record review, the facility failed to have 2 caregivers implement their training and safety when they found a resident on the ground, complaining of pain to their head and had a head injury. The caregivers moved the resident without any directive from a trained medical professional and without knowing the extent of the injuries to the resident. The injuries resulted a displaced fracture to the back of their neck that resulted in the residents hospitalization and death 2 days later. facility failed to have caregivers training on to review resident service plans to know what care and services the residents need. the facility failed to have the service plans updated for the care staff to provide the most accurate care and services for the resident.

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 #: 29863
Investigator: Cory Cisneros
Provider Type: Assisted Living Facility
Intake ID: 95020
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 09/21/2023 through 11/09/2023
Complainant Contact Date(s): 10/25/2023

Allegation(s):

1) resident didn't have clean clothes and was given another residents clothes to wear.
2) staff neglected the resident when they had fallen.

Investigation Methods:

Sample:	Total residents: 47 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Dining Resident care equipment Resident rooms Staff to resident interactions Medication administration
Interviews:	Business office manager Administrative staff Family members Residents Nursing staff Identified staff
Record Reviews:	Medical records Hospital records Incident investigation staffing schedules staff credentials/certificates Facility policies Personnel files Staff training records

Investigation Summary:

1) after interview, observation, and record review it was noted the facility has replaced multiple washer and dryers that has impeded in the ability to stay up with soiled linens. the facility has a plan in place and washer and dryers have been ordered. the

sampled residents observed and reviewed had their own clothing on and no concerns reported. no failed practice.
2) after interview and record review, the facility failed to have 2 caregivers implement their training and safety when they found a resident on the ground, complaining of pain to their head and had a head injury. The caregivers moved the resident without any directive from a trained medical professional and without knowing the extent of the injuries to the resident. The injuries resulted a displaced fracture to the back of their neck that resulted in the residents hospitalization and death 2 days later. facility failed to have caregivers training on to review resident service plans to know what care and services the residents need. the facility failed to have the service plans updated for the care staff to provide the most accurate care and services for the resident.

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 # 29863
Plan of Correction	Beehive Retirement and Assisted Living Community	Completion Date
Page 1 of 12	Licensee: Caring Places Management, LLC	11/09/2023

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 09/21/2023 and 10/31/2023 of:

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

This document references the following complaint number(s): 95020

The following sample was selected for review during the unannounced on-site visit: 3 of 47 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Anissa Bearden, Licensor
Regenia Coleman, ALF NCI CI
Cory Cisneros, Field Manager

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

11/15/2023
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 Mjuka
Administrator (or Representative)

Nov 16 2023
Date

WAC 388-78A-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on interview and record, the facility failed to ensure one resident's safety and well-being when the staff did not implement fall training procedures after of 1 of 3 Residents (Resident 1 [R1]) was found after a fall, with bleeding from their head and staff moved the resident twice before emergency services could evaluate. These failures placed residents at risk of further harm, injury, and medical complications.

Findings included...

WAC 388-78A-2020 Definitions: "General responsibility for the safety and well-being of the resident" means the provision of any one or more of the following...

(4) Emergency assistance;...
(11) Responding appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning;..."

Record review of the facility's Relias training document titled, "About Falls", dated 2021 (no month or day), showed without fall prevention programs and knowing the risk factors that contribute to falls, older adults may suffer significant injuries and even death. Falls were the primary reason for an older adult's hospital emergency department visits for treatment of a related injury. If a staff member discovers a fall, their first action should be to stay with the person to ensure their immediate safety. Call for help and remain with the person until help arrives. Other staff actions following a fall included inspecting the person for injuries, activating the 911 system, if required, maintaining cervical spine support if a neck injury is suspected, assisting the person to a wheelchair or the bed after the nurse determines there is not an injury.

Record review of the facility's Relias training document titled, "What to do after the fall", dated 2023 (no month or day), showed falls that cause serious fractures, head injuries, or other physical problems could cause significant change in the life of an older adult. Under the section titled, "Formal Training", showed "anyone helping people who have a fall, without hurting them, requires formal instructions such as formal first aide training". The document showed training would help the staff intervene if the resident had an injury

related to a fall. Formal training provided a foundational skill that would teach them to recognize the signs of an injury and how to help the resident when a fall had occurred. Under the section titled, "after a fall", showed staff would use extreme caution when moving a person who had fallen." It was a natural instinct to want to help a person get up when they have fallen, but keep in mind that what seems like a minor fall, for example, a fall from a chair to the ground, can severely injure an older adult. Use extreme caution if you decide to move a person who has fallen. Injuries are often not obvious." Under the section titled, "unknown injuries", showed pain was usually the first sign of an injury you cannot see. Depending on where the person hurt, for example, their neck, ribs, abdomen, or hip, they could be seriously injured. As a caregiver, you were not trained to determine whether there was a serious injury associated with the pain. Paramedics and EMTs were trained to identify serious injuries. Sometimes, older adults were unable to verbalize that they were in pain, or they may not be in pain. Bleeding was often an indicator of an injury below the skin. A bleeding gash on a person's head could be the outward sign of a brain bleed. If there was a profound amount of blood, and you had received formal first aid training, you may implement the training you have, for example, applying direct pressure on the wound. Under the section titled, "frequent occurrence", showed hidden injuries from falls happen regularly. It was not uncommon for injuries to be worsened by untrained people trying to help. While the desire to help was always rooted in the best intentions, it was usually not in the best interests of the person who had fallen. There were many stories about people in home care who fell. The people caring for them helped them up. They usually placed them in a chair or their bed, only to discover many hours later that the person who fell was severely injured. This was particularly true for people who have difficulty communicating. It was important to remember that just because the person cannot tell you they were hurt, that does not mean they were not hurt. People who seem to be in pain and distress most of the time were often the ones who had severe injuries that were discovered when it was too late.

Record review of the Department of Social and Health Services (DSHS) Fundamentals of Caregiving 3rd edition, revise dated 08/2023, under the section "introduction" showed, the practical course was the home care aide core basic training. The practical course would provide knowledge and skills to provide personal care. After one completes all the home care aide training required, they would receive a 75-hour certificate of completion. Under the section "Lesson 2, Falls and Prevention", showed falls were the leading cause of fatal injury and the most common cause of nonfatal trauma related hospital admissions among older adults. Women fall more often than men. There are diseases that increased the risk of falls that included some but not all dementia (a progressive brain disorder that affects one's memory, cognition, and at times ability to perform activities of daily living), depression (an illness that characterized as persistent sadness and loss of interest in activities one enjoys), joint disease, and heart disease. Common injuries from falls included by not limited were fractures (broken bone) to the hip and spine, and traumatic brain injuries. Under the section, module 7 titled, "what to do if a client has fallen on the floor", showed if a client had trouble getting up from falling, caregiver or staff member could steady the client, but do not lift them up. If the client was injured, the caregiver or staff's role was to get the client medical help. The client would be kept comfortable as possible and kept warm until the emergency medical team (EMTs) or other medical help arrived. Do not give the client anything to drink or move them. Home Care Aides can help minimize the risk of falls by removing fall hazards and encouraging clients to make healthy and safe choices.

Record review of the Mayo Clinic document titled, "Head Trauma: First Aid", dated 02/18/2023, showed to provide first aid for a person that had head trauma (a broad term of any injury on the head with the scalp, skull, break, tissue, and/or blood vessels with the head), they were to call 9-1-1 or your local emergency number. Any of the following symptoms may indicate a serious head injury that included but not limited to severe head or facial bleeding, bleeding or fluid leakage from the nose, confusion, agitation, and weakness. While you were waiting for emergency medical help to arrive, the following first-aid steps to administer included keep the person still. The injured person should lie down. Don't move the person unless necessary, avoid moving the person's neck.

Record review of the American Heart Association and American Red Cross document titled "First Aid", undated, showed the goal of the first aid provider was to preserve life, prevent further illness or injury and promote recovery. Generally, an ill or injured person should not be moved, especially when a spine or pelvic injury was suspected. If a person has been injured and the nature of the injury suggests a neck, back, hip, or pelvic injury, the person should not be rolled onto their side. Instead, they should be left in the position in which they were found, to avoid potential further injury.

Record review of the Health and Safety Institute (HSI) website, undated, showed HSI First Aid and CPR (CPR- a lifesaving measure to compress pressure to the heart to attempt to restart the heart beating) AED (automated external defibrillators- a device that shocks the heart to attempt to restart the heart beating) reflects the latest resuscitation science and treatment recommendations published by the International Liaison Committee on Resuscitation (ILCOR). and it conforms with the 2020 American Heart Association (AHA) Guidelines Update for CPR and emergency cardiac care and the annual Guidelines Update.

Record review of the National Library of Medicine article titled, Cervical Spine Fractures Overview, dated 04/03/2023, showed the cervical spine was a dynamic structure tasked with protecting nervous innervation (area the nerves go into) to the entire body while also maintaining a range of motion for the head and neck. Fractures of the cervical spine are a leading cause of mobility and mortality in trauma patients. C2 fractures typically occur due to a combination of compression, hyperflexion (over flexed), and hyperextension (over extended). If a C2 fracture was displaced greater than 3 millimeters (mm) treatment included reduction with halo placement (a device with pins and rods that hold the head still to allow bones to heal) or surgical fixation should be considered.

Record review of the facility's employee list, undated showed Staff E, Caregiver, was hired at the facility on 07/02/2019.

Record review of Staff E's adult first aid and CPR AED card showed they completed the training on 06/05/2023.

Record review of Staff E's certificate titled "75 hours of DSHS approved basic training", showed they completed the course on 10/18/2019.

Record review of an email received on 10/25/2023 at 11:03 AM, showed Staff F, Former Caregiver, was transferred to the facility on 05/17/2023 from another corporation's facility.

Record review of Staff F's American Heart Association first aid CPR, AED card, showed Staff F completed the course on 02/17/2023.

Record review of Staff F's certificate titled "75 hours of DSHS approved basic training", showed Staff F completed the course on 04/21/2022.

Record review of Resident 1's (R1) face sheet showed R1 moved into the facility on [redacted] 2019 with multiple medical diagnoses that included [redacted] and [redacted]. R1 was a fall risk. R1 used a four-wheeled walker and would often park their walker in a corner and forget to use it.

Record review of R1's Service Agreement (SA), dated 06/13/2023, showed the SA was a quarterly update. R1's memory had gotten worse and more forgetful with their activities of daily living (ADL's) needs. R1 could understand others and others were able to understand R1. R1 required more assistance with bathing, dressing, toileting, and cues to complete tasks. R1 had a history of falling at night. R1 woke up often to use the bathroom throughout the night. Staff were directed to check on R1 frequently. R1 needed stand by assistance when they used the bathroom for safety. Staff were directed to keep pathways clear of clutter. Staff were to investigate as to why R1 was awake if gotten up in the night. R1 was frequently incontinent of urine and occasionally with bowel. R1 required one person assistance with toileting needs for safety and decreased cognition. Staff was directed to routinely accompany R1 to and from the bathroom. R1 was able to transfer and move around in bed independently. R1 walked with a four wheeled walker.

Record review of R1's Investigation "injury", dated 07/12/2023, showed R1 was found on the floor with an injury at 11:40 PM. Staff D, Medication Aide, was called to R1's room. When Staff D got to R1's room, Staff D observed R1 was sitting on the floor with their back to the door. R1 had "red substance all of their face and hands". R1's caregivers got R1 up into their chair and assisted with being cleaned up as much as possible. Staff D had called 911 and the Emergency Medical Team (EMT's) came and evaluated R1. R1 requested be transferred to the emergency department. Staff D documented under the immediate action taken, showed R1 had complained of neck and left side pain. Staff D observed R1 for injuries and found to have a cut on bridge of their nose and lip, and red substance coming out of R1's nose. The report showed R1 was upset and crying.

Record review of R1's witness statement, dated 07/13/2023, showed Staff F completed and signed the form. The witness statement showed Staff F found R1 lying on their back with their head pointed to the corner behind the door and the wall. There was red fluid on the floor next to R1's head. The red fluid was on the door, R1's shirt, and lots on R1's face

and hands. R1 seemed very distressed, scared, and overwhelmed. R1 seemed to be in pain and was crying. Staff F documented that R1 was unable to respond clearly to the questions asked after the fall. The record showed that Staff F had asked R1 if they hit their head and R1 stated "Yes". Staff F documented that they ensured that R1 had no life-threatening injuries. Staff F helped their coworker (Staff E) to get R1 cleaned up and into R1's reclining chair while they waited for the EMT's to arrive.

Record review of R1's witness statement, undated, showed Staff E completed and signed the form. Staff E, one of two of the caregivers assigned to care for R1, documented they heard their co-worker, Staff F, (the second caregiver that was assigned to care for R1) calling for help. Staff E came to R1's room and observed R1 lying on the floor in their room. Staff E left to get assistance from Staff D, medication aide, that was in charge that was on shift. Staff E returned to R1's room and saw R1 was now sitting up next to the door with their coworker Staff F. Staff E documented R1 was very distressed and scared. Staff E documented that R1 was unable to state what they were doing or answer questions clearly. Staff E documented they asked R1 if they had hit their head and R1 stated "Yes". Staff E documented that after they had returned to R1's room from notifying the medication aide, Staff E assisted their coworker (Staff F) with getting R1 cleaned up and checked for further injuries. Staff E documented they helped R1 over to their reclining chair while Staff D called the EMT's and notified R1's family member.

Record review of R1's Emergency Department (ED) Physician Note, dated 07/13/2023, showed R1 came to the ED for an unwitnessed fall. "R1 was alert and oriented to person, place, and time." R1 had a head injury to the nose and complained of neck and back pain. R1 had a swollen upper lip and nose bleeding. R1 had a computed tomography (CT) scan (a scan that can look within the body and detect injuries or diseases) that showed they had a fractured (a broken bone) nose and at the cervical 2 (C2) (upper neck base of skull). The C2 fracture was displaced 5 mm. R1 required the use of a hard neck collar for several months. R1 was not a candidate for surgical repair of the C2 fracture related to R1's age and other medical factors. Under the section, "history of present illness", showed R1 had gotten up out of bed. R1 slipped went forward striking their face against the doorknob.

In an interview on 10/06/2023 at 6:20 AM, Staff E stated they had their home care aide certificate. Staff E stated they had a current CPR and first aid card. Staff E stated they completed continuous training through the online Relias routinely every few months. Staff E stated the night R1 had their fall, Staff F had called for help. Staff E stated when they arrived at R1's room, the door to the room was barely open and could see R1 lying on the ground and the rooms light was on. Staff E stated they left to get help from the medication aide. Staff E stated R1 was sitting up right when Staff E returned to the room. Staff E stated R1 was panicky, crying, and holding her face. Staff E stated R1 had red substance on their white dress and hands. Staff E stated they didn't want R1 on the ground. Staff E stated Staff F and Staff E made the decision to help R1 up off the ground. Staff E stated they helped R1 to change their night gown and assisted R1 to their chair. Staff E stated R1 complained and continued to cry out in pain when they had gotten R1 up, changed, and cleaned up. Staff E stated they thought it was worse on R1 to have R1 remain lying on the ground. Staff E was unable to explain why it was worse for R1 to continue to lie on the ground. Staff E stated the red substance was coming from R1's nose where the skin was open. Staff E would not elaborate what the red substance was. Staff E stated R1 continuously cried and held her face when Staff E and Staff F were assisting her with changing, cleaning up, and after R1

was assisted in their reclining chair. Staff E stated they were trained if a resident had a visual injury to not move them until the medication aide was called. Staff E stated once the medication aide comes to the resident, they make a physical assessment. Staff E stated the medication aide would notify the caregivers if they were to move the resident. Staff E stated caregivers were trained in a class how to be able to do a physical assessment as far as rotation of joints.

In an interview on 10/13/2023 at 11:24 AM, Staff F stated they had heard a door slam. Staff F stated they checked in R1's room as the door was closed. Staff F stated they were able to open the door but couldn't open all the way. Staff F stated they saw R1 lying on the ground with their head towards the corner behind the door and next to the wall on their back. Staff F stated R1 was crying and asked for help. Staff F stated they could see R1's nose was bleeding profusely. Staff F stated R1 was able to move a little so Staff F could get into R1's room. Staff F stated they yelled for Staff E down the hallway for help with R1. Staff F stated they helped R1 up into a sitting position while Staff F waited for Staff E to arrive. Staff F stated they had to put their hands on R1's shoulders and physically help R1 to sit up right from the ground. Staff F stated they made the best decision to sit R1 up in the corner behind the door against the wall. Staff F stated they thought it would be safer than R1 to be upright with them bleeding then to have R1 lying on the ground. Staff F stated based on their training they knew they were not to move R1 as they were not aware if R1 had a neck or back injury. Staff F stated R1 was visibly upset, cried, and held their face during the entire interaction with R1. Staff F stated after R1 was sitting upright they could see R1 had a cut on their forehead and the bridge of their nose. Staff F stated Staff D had come to see R1 with Staff F. Staff F stated Staff D did not give Staff F any guidance or direction to get R1 cleaned up or moved into their reclining chair. Staff F stated that Staff D told Staff E and Staff F that they were going to call 9-1-1 and R1's family member. Staff F stated Staff E and Staff F made the decision to help lift and stand R1 up off the ground, clean her up, change R1's clothes and then sat R1 on their reclining chair to wait for the EMT's arrive for further medical evaluation. Staff F stated they did not want to move her as soon as they saw R1 on the ground in R1's room as Staff F did not know if R1 had a neck or back injury. Staff F stated they were never trained to a policy about falls, but to the caregiving class and online courses.

In an interview on 10/16/2023 at 1:57 PM, Staff G, Registered Nurse (RN) employed by the corporation, stated they were the RN responsible for the nursing care oversight for the facility. Staff G stated all employees upon hire had to complete computer based approved trainings for the facility orientation and safety documents that included aspects of resident falls and injuries. Staff G stated they were a DSHS approved trainer for the 75-hour home care aide core basic training class. Staff G stated the caregivers received their certificate once they completed the training. Staff G stated they train all caregiver students by the DSHS fundamentals of caregiving book and provided them their own copy to reference. Staff G stated if a caregiver found a resident that's on the ground with an injury, bleeding, was crying, or appeared to be in pain, the caregiver or staff member were directed to notify the medication aide and call 9-1-1. Staff G stated if there was visible injury or the resident expressed or showed pain, the caregiver should not move the resident. Staff G stated that staff should not move a resident to take their vital signs after an incident occurred. Staff G stated the caregiver were to leave the resident where they found them and wait until the EMT's arrived to assess the resident. Staff G stated the curriculum in the fundamentals of caregiving taught the home care aide to call for help 9-1-1 and do not move the resident. Staff G stated they were not aware of R1's fall with significant injury at the time of the

incident. Staff G stated they were contacted about R1's fall after they had passed away in the hospital after the fall.

In an interview on 10/16/2023 at 2:08 PM, Collateral Contact 1 (CC1), daughter of R1, stated they arrived at the facility soon after they were notified of the fall and found R1 slumped forward in their recliner chair with their nose profusely bleeding and cried out loud in pain. CC1 stated they saw a large red stain of blood on the carpet behind R1's door.

In an interview on 10/25/2023 at 11:58 AM, Staff A, Administrator, stated all staff employed upon hire at the facility completed the Relias training that included what to do in the event of a resident fall, when a resident was found on the ground with an injury and that staff should not move a resident that was found on the ground with an injury until EMT's arrived to assess the resident for additional injuries or potential for worsening existing injuries. Staff A stated all staff had on going trainings through the year with the computer-based trainings through Relias.

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) Nov 16, 2023.

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

Michelle Mube — Administrator (or Representative)

Nov 16, 2023 — Date

WAC 388-78A-2450 Staff.

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide care agreed upon in the service agreement (the facility's version of the negotiated service agreement [NSA]) for 2 of 3 residents reviewed for NSA's (Resident 2 and Resident 3). This failure diminished the resident's quality of life by not having their care needs met and put the residents at risk for injuries.

Findings included...

Review of the facility's Caregiving Handbook, last updated February 2019, directed caregivers to do the following when transferring a resident, "Wash hands, explain to resident what you are doing. Place nonslip shoes, socks, or slippers on resident. Place Gait belt low on waste of resident, tighten to be less than two finger width from body so it does not ride up under arms when pulled on. Scoot resident to edge of bed so feet touch floor. Per service agreement on one- or two-person assistance. AVOID LIFTING UNDER RESIDENT ARM PITS. a. If two staff, one person holds on each side [of Gait belt]. Remove Gait belt."

Review of the facility's Caregiving Handbook, last updated February 2019, gives care staff the following direction regarding service agreements, "Service agreements are written for each resident telling caregivers what the resident can and cannot do, preferences, and specifically tells caregivers what and how to perform tasks for resident. Caregivers are required and expected to read the service plans of the resident they are caring for before caring for resident. Caregivers are responsible to read and update the service agreement as the assistance provided changes and/or needs increase. Each service agreement should be read by caregiver then initialed on last page verifying caregiver knowledge of resident needs. Caregivers are expected to read alerts when service agreements have been changed or added to, review the changes, and initial the changed position of the service agreement."

<Resident 2 (R2)>

Record review of R2's face sheet documented R2 was admitted to the facility on [redacted]2016, with diagnoses including [redacted] and [redacted]. R2's face sheet also identified R2 as being, "a fall risk, unaware of their safety, a HX [history] of attempting to self-transfer [move from one area to another independently] or ambulate [walk] and uses a safety alarm when in bed or wheelchair to help alert staff."

Record review of the facility's incident/accident log dated 03/21/2023 through 09/21/2023, showed the following was documented for R2: 09/21/2023 unwitnessed fall.

In a review of R2's service agreement, quarterly update, dated 08/13/2023, signed by R2's power of attorney and Staff J, Resident Care Coordinator on 08/14/2023, the following was documented for R2:
Safety alarms were to be always placed on while in bed and wheelchair to help alert care staff. R2 was able to take their alarm off and will at times. Check that alarms were on and functioning correctly.

In an observation on 09/21/2023 at 1:35 PM, R2 was observed seated in their wheelchair on the Memory Care Unit. A yellow device was observed tucked into the back pocket of R2'

s wheelchair. The yellow device had a string attached to it with a clip at the end of the string; the device was not attached to R2.

In an interview on 09/21/2023 at 1:37 PM, with Staff H, Caregiver, they were asked what the yellow device was. Staff H stated it was a chair alarm and it was there because R2 had a fall this morning. When asked why it was not clipped on R2's person, Staff H stated the night shift would have gotten R2 up and should have put the chair alarm on R2 at that time.

In an observation on 09/21/2023 at 1:40 PM, Staff H, walked away from R2; Staff H did not clip the chair alarm on R2's person before they walked away.

In an observation on 09/21/2023 at 1:49 PM, R2 was observed seated in their wheelchair in the Memory Care Unit dining room; there were no staff members present. R2 did not have their chair alarm clipped on to their person. R2's chair alarm was tucked into the pocket on the back of R2's wheelchair.

In an observation on 09/21/2023 at 1:59 PM, Staff B, Resident Care Nurse, entered the Memory Care Unit with Staff E, Caregiver. By this time, R2 had been alone, unsupervised by staff for 10 minutes. R2 was observed without their chair alarmed clipped to their person.

In an observation on 09/21/2023 at 2:01 PM R2 was observed with an area the size of a 50-cent piece on the middle portion of the back of their head. The area was covered with a dark red, dried substance stuck to their hair. When Staff C, Caregiver, was asked what the substance was, they stated, "It's dried blood from when [R2] fell this morning. EMTs (Emergency Medical Technicians) had been called but [R2] refused any treatment from them [EMTs] once they got here." R2 was observed without their chair alarm clipped to their person.

In an observation on 09/21/2023 at 2:05 PM, R2 was observed sitting in their wheelchair in the dining room of the Memory Care Unit with their chair alarm tucked into the back pocket of R2's wheelchair, not clipped to R2's person.

<Resident 3 (R3)>

Record review of R3's face sheet documented R3 was admitted to the facility on [redacted] 2022, with diagnoses including late onset [redacted].

Record review of facility's incident/accident log dated 03/21/2023 through 09/21/2023 documented the following for R3:
06/15/2023, found on floor.

06/16/2023, found on floor.
06/17/2023, witnessed fall.
07/14/2023, found on floor.
07/21/2023, found on floor.
07/28/2023, found on floor. (added to care plan- clip alarm in place while in wheelchair).
08/01/2023, found on floor.
08/01/2023, found on floor.
08/01/2023, found on floor. (3 separate incidents)
08/03/2023, found on floor.
08/12/2023, found on floor.
09/07/2023, found on floor.
Record review of R3's undated and unsigned service agreement documented the following care requirements for R3: R3 was unable to bear weight and transfer independently and required the assistance of two care staff and a Gait belt (an assistive device which was to be secured around the waist to allow a caregiver to grasp the belt instead of the person, to assist in walking, lifting, or moving a person). 08/03/2023 – bed matt alarm (a sensor pad placed under a person, which detects a changes in pressure, resulting in sounding of an alarm) – to help alert care staff when in need of assistance. 08/18/2023 Place alarm on after every transfers.

In an observation on 09/21/2023, at 1:18 PM, R3 was observed in their room lying in bed on their right side. There was no Gait belt or other assistive devices observed in the room. A call light hung over the end of R3's bed, out of the reach of R3. R3 had a bed matt alarm placed underneath them, positioned on the upper part of their body, touching their shoulders. R3 repositioned their head which caused the bed alarm to sound. The bed alarm sounded four times before any staff entered R3's room.

In an observation on 09/21/2023 at 1:25 PM, Staff H, Caregiver, entered R3's room, and told R3 they were not in a good position and should scoot down. Staff H grabbed onto R3's left shoulder with their right hand/forearm, put their left hand/forearm on R3's right lower leg, and in one move assisted R3 to a seated position on the bed. Staff H placed one arm under each of R3's underarms and used their strength to assist R3 to a standing position. Staff H asked R3 to step to the right; Staff H repeated this process twice. There were no other staff members present to assist Staff H and no Gait belt was used. While R3 was in a standing position, Staff H let go of R3 with their right hand and repositioned the bed matt alarm to a lower position in the bed. Staff H placed both arms under R3's underarms and assisted R3 to a seated position lower in the bed. Staff H grabbed both of R3's legs with their left hand/forearm, placed their right hand/forearm behind R3's neck, and assisted R3 to a supine position.

In an observation on 09/21/2023 at 1:40 PM, in an interview with Staff H, they said they would know if R3 was a fall risk because it would be in R3's care plan; Staff H said R3 was not a fall risk and did not have any recent falls. When asked if R3 needed any kind of safety alarm, would it be written in R3's care plan, Staff H said they had never seen anything about alarms written on a resident care plan. When Staff H was asked how they are made aware about any updates to a resident's care needs Staff H said they were supposed to read the updates prior to their shift. When Staff H was asked if they felt adequately trained to care for the residents, Staff H stated, "It does makes me nervous sometimes because I am pretty new here and I haven't read everyone's care plans yet."

In an interview with Staff A, Administrator, on 10/25/2023, at 11:58 AM, they stated new care staff went through resident orientation from Staff B, Resident Care Nurse, and were then teamed up with an experienced caregiver who had been with the facility for a while. Staff A stated care staff could find specific resident care and service needs in the working care plan binder, located in a dining room cabinet which could be accessed by all staff members. Staff A stated R2 had a chair alarm in use when up in their wheelchair and if a staff member noticed it was not clipped on R2's person, the staff member should have alerted the med aide if they were not comfortable putting on the chair alarm, or any alarm that should be on a resident, for assistance. Staff A stated R3 required one person if they were being assisted from a sitting to a standing position, however, if R3 had a fall, it would have required two care staff (to assist R3). Staff A stated R3's care plan was changed a couple of weeks ago and R3 now required two person assist with all transfers and was placed on hospice care. Staff A stated, "Every caregiver and every med aid were given and are to use a Gait belt with the residents." Staff A also stated, "Yes, every day the care staff are to check the working care plans [of each resident] for any updates or changes and follow [the care plan] as it is written."

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) Nov 16, 2023.

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

Michelle Mulk — Administrator (or Representative)

Nov 16, 2023 — Date