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

01/06/2025

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

RE: Beehive Retirement and Assisted Living Community # 2148

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 52660 (Completion Date 01/06/2025) and 44066 (Completion Date 07/18/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/06/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

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:

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

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 #: 44066
Investigator: Pamela Horlick
Investigation Date(s): 07/12/2024 through 07/18/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 134767
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
Quality of Care/Treatment: Report of resident finding another resident in their bed at bedtime.

Investigation Methods:

Sample:	Total residents: 48 Resident sample size: 3 Closed records sample size: 1
Observations:	Identified resident Residents Activities Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents Business office manager
Record Reviews:	State reporting log Incident investigation Facility policies Care Plans Progress Notes/Alert Charting

Investigation Summary:
Facility failed investigate for one of two residents involved in the incident. Failed practice identified.
Facility failed to follow policy and procedure by not notifying the residents physician timely and failed to monitor the resident for adverse affects after the incident occurred. Failed practice identified.

Conclusion / Action:

- [x] 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 # 44066
Plan of Correction	Beehive Retirement and Assisted Living Community	Completion Date
Page 1 of 5	Licensee: Caring Places Management, LLC	07/18/2024

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 07/12/2024 and 07/23/2024 of:

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

This document references the following complaint number(s): 134767

The following sample was selected for review during the unannounced on-site visit: 3 of 48 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

07/25/2024
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.

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Residential Care Services

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 M Duke
Administrator (or Representative)

7/26/24
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:

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement their policy and procedure for physician notifications after an incident and the facility failed to implement their policy and procedure for alert charting for 1 of 3 (Resident 1 [R1]) sampled residents. This failure placed R1 at risk for their physician being unaware of their condition and placed them at risk for decreased quality of life.

Findings included...

<Notification to Provider>

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 R1's face sheet, undated, showed that R1 admitted to the facility on [redacted] 2024.

Review of Department Records showed that a report was made on 06/14/2024 at 11:20 AM notifying the Department that R1 found a man in their bed 06/14/2024 at 12:00AM.

Administrator (or Representative) Date

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Review of Department Records showed that a report was made on 06/14/2024 at 11:20 AM notifying the Department that R1 found a man in their bed 06/14/2024 at 12:00AM.

In an interview on 07/12/2024 at 1:28 PM, Staff B, Medication Aide (Med Aide), was asked what the process was when a resident finds another resident in their bed, Staff B stated, they would make sure they are safe and notify the residents Primary Care Physician (PCP) and Power of Attorney (POA). Staff B was asked when those notifications would be made, they stated, immediately.

In an interview on 07/12/2024 at 11:02 AM, Staff C, Medication Aide, was asked what the process was if they found a resident in another residents room or bed, they stated we will remove them, make sure both residents are safe. Staff C stated that they will make the proper notifications to the residents PCP and POA.

During a record request on 07/12/2024 at 10:55 AM, an investigation to show who was notified of the incident was not provided for R1.

Record review of R1's investigation, dated 07/14/2024 at 3:16AM, showed R1 came out of their room claiming there was a man in their bed. Upon the caregiver going into R1's room, another resident was found laying in R1's bed with their eyes closed. The caregiver removed the other resident. The other resident was "already on alert for behaviors towards the ladies." Under the section, "Notifications Made," showed R1's PCP was notified on 07/15/2024 at 10:15 AM, one month after the incident occurred.

In an interview on 07/18/2024 at 10:35 AM, Staff A, Executive Director, was asked what their expectation of staff was when a resident was found in another residents room, they stated they would remove them and notify the doctor. Staff A was asked when the notification would be made, they stated, immediately after making sure the residents were safe. Staff A was asked why the notification was made a month late, Staff A stated, it was a failure on the RCC (Resident Care Coordinator.)

<Alert charting>

Review of the facility policy, titled, "Resident Alerts", undated, stated, "All incidents, changes of condition in medication, etc. require an enhanced monitoring of the resident and potential changes in care. . The Med Aide on shift when the Alert Protocol is triggered will create the Medical Alert in CommuniCare beginning the Alert Charting Process .. The Med Aide will notify the Resident Care Coordinator and the Resident Representative when the Resident is placed on Alert Charting. .. Resident Care Coordinator will review resident vitals and the Alert Charting, documenting this review by digital signature, during the Alert process .. Documentation of the observed status of the Resident will be done once daily unless otherwise specified in the protocol."

During a record request on 07/12/2024 at 10:55 AM, alert charting for the incident for R1 was not provided for R1.

In an interview on 07/12/2024 at 11:02 AM, Staff C, Medication Aide, was asked what

In an interview on 07/12/2024 at 1:28 PM, Staff B, Medication Aide (Med Aide), was asked what the process was when a resident finds another resident in their bed, Staff B stated, they would make sure they are safe and notify the residents Primary Care Physician (PCP) and Power of Attorney (POA). Staff B was asked when those notifications would be made, they stated, immediately.

In an interview on 07/12/2024 at 11:02 AM, Staff C, Medication Aide, was asked what the process was if they found a resident in another residents room or bed, they stated we will remove them, make sure both residents are safe. Staff C stated that they will make the proper notifications to the residents PCP and POA.

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In an interview on 07/18/2024 at 10:35 AM, Staff A, Executive Director, was asked what their expectation of staff was when a resident was found in another residents room, they stated they would remove them and notify the doctor. Staff A was asked when the notification would be made, they stated, immediately after making sure the residents were safe. Staff A was asked why the notification was made a month late, Staff A stated, it was a failure on the RCC (Resident Care Coordinator.)

<Alert charting>

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During a record request on 07/12/2024 at 10:55 AM, alert charting for the incident for R1 was not provided for R1.

In an interview on 07/12/2024 at 11:02 AM, Staff C, Medication Aide, was asked what

kind of documentation was done when staff find a resident in another residents bed, they stated they do a progress note and the resident was put on alert to monitor for behaviors. Staff C was asked how long would the resident be on alert for, they stated usually a week.

In an interview on 07/12/2024 1:28 PM, Staff B, Medication Aide, was asked what the process was when staff find a resident in another residents room or bed, Staff B stated, they would assess them and make sure they were safe. They stated they would document behaviors in case it escalates.

Record review of an email dated 07/15/2024 at 11:38 AM from Staff D, Business Office Manager, showed that there was no alert charting available and no progress notes available for R1.

In an interview on 07/18/2024 at 10:35 AM, Staff A, was asked what was your expectation of staff when a resident was found in another residents room or bed, they stated, staff should remove the resident that was in the wrong room. They stated both residents should be put on alert and progress notes should be done on both residents. Staff A was asked what alert charting was, they stated, every shift documents for 7 days to ensure the resident has not had any negative reactions to the incident. Staff A stated for R1, we want to make sure she is safe and comfortable. Staff A was asked why R1 was not placed on alert, they stated the RCC forgot.

This is a recurring deficiency previously cited on 01/18/2024 and was a previous consultation on 10/06/2022.

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) 7/26/24

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

Michelle Dukes
Administrator (or Representative)

7/26/24
Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation, or accident or incident jeopardizing or affecting a resident health or life;

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In an interview on 07/12/2024 t 1:28 PM, Staff B, Medication Aide, was asked what the process was when staff find a resident in another residents room or bed, Staff B stated, they would assess them and make sure they were safe. They stated they would document behaviors in case it escalates.

Record review of an email dated 07/15/2024 at 11:38 AM from Staff D, Business Office Manager, showed that there was no alert charting available and no progress notes available for R1.

In an interview on 07/18/2024 at 10:35 AM, Staff A, was asked what was your expectation of staff when a resident was found in another residents room or bed, they stated, staff should remove the resident that was in the wrong room. They stated both residents should be put on alert and progress notes should be done on both residents. Staff A was asked what alert charting was, they stated, every shift documents for 7 days to ensure the resident has not had any negative reactions to the incident. Staff A stated for R1, we want to make sure she is safe and comfortable. Staff A was asked why R1 was not placed on alert, they stated the RCC forgot.

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(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to investigate and document investigative actions and findings for an incident for 1 of 3 residents (Resident 1 [R1]). This failure placed R1 at risk for unmet care needs.

Findings included...

Record review of the facility policy, titled, "Resident Incidents and Investigations," undated, stated, "All incidents require a thorough Quality Assurance Investigation to determine what occurred, to determine if any abuse has occurred, and to implement measures, as needed, to prevent recurrence."

Record review of R1's face sheet, undated, showed that R1 admitted to the facility on [redacted]2024.

Record review of Residential Care Services Online Incident Report, dated 06/14/2024 at 11:20 AM, showed a report was received to the Complaint Resolution Unit (CRU) regarding an incident where R1 walked out of their room and stated another resident was in their bed. The report stated that, the other resident was already on alert for inappropriate behaviors towards R1.

During a record request to the facility on 07/12/2024 at 11:56AM, an investigation for the incident on 06/14/2024 was requested and not provided for R1. There was no investigation documentation provided concerning the incident for R1 addressing investigative actions and findings for the incident.

In an interview on 07/18/2024 at 10:35 AM, Staff A, Executive Director, was asked what was your expectation of staff when a resident was found in another residents room or bed, they stated, care staff should remove the resident that was in the wrong room, notify the medication aide and start an investigation. Staff A was asked how soon an investigation would be started, they stated, immediately. Staff A was asked why an investigation wasn't done until a month later, they stated, it was a failure.

This is a recurring deficiency previously cited on 02/23/2023 for subsections (1)(2)(3).

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Statement of Deficiencies	License #: 2148	Compliance Determination # 44086
Plan of Correction	Beehive Retirement and Assisted Living Community	Completion Date
Page 6 of 6	Licensee: Caring Places Management, LLC	07/18/2024

Plan/Attestation Statement

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

Michelle Mylne — Administrator (or Representative)

7/26/24 — Date

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Administrator (or Representative) Date