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

TROSPER ROAD LIMITED PARTNERSHIP
HAMPTON SPECIAL CARE - TUMWATER
1400 Trosper Rd SW
Tumwater, WA 98512

RE: HAMPTON SPECIAL CARE - TUMWATER License # 1579

Dear Administrator:

This letter addresses Compliance Determination(s) 56446 (Completion Date 03/17/2025) and 53078 (Completion Date 01/24/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/17/2025 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-2610-1, WAC 388-78A-2610-2-a, WAC 388-78A-2610-2-c, WAC 388-78A-2610-2-d, WAC 388-78A-2610-2-e, WAC 388-78A-2210-2, WAC 388-78A-2210-2-a, WAC 388-78A-2210-2-b, WAC 388-78A-2371, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2371-4, WAC 388-78A-2120-1, WAC 388-78A-2120-4, WAC 388-78A-2120-2-a, WAC 388-78A-3100-1, WAC 388-78A-3100-2, WAC 388-78A-3100-4, WAC 388-78A-2400-2, WAC 388-78A-2484-2, WAC 388-78A-2600-2-l, WAC 388-78A-2474-2-e, WAC 388-78A-2260-1, WAC 388-78A-2040-2, WAC 388-110-220-3-n, WAC 388-78A-2466-1-a, WAC 388-78A-2466-1-b, WAC 388-78A-2466-1

The Department staff who did the on-site verification:
Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor

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

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 #: 1579	Compliance Determination # 53078
Plan of Correction	HAMPTON SPECIAL CARE - TUMWATER	Completion Date
Page 1 of 36	Licensee: TROSPER ROAD LIMITED PARTNERSHIP	01/24/2025

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 the unannounced on-site full inspection on 01/14/2025 and 01/16/2025 of:
HAMPTON SPECIAL CARE - TUMWATER
1400 Trosper Rd SW
Tumwater, WA 98512

The following sample was selected for review during the unannounced on-site visit: 7 of 44 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor

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

Statement of Deficiencies	License #: 1579	Compliance Determination # 53078
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Page 2 of 36	Licensee: TROSPER ROAD LIMITED PARTNERSHIP	01/24/2025

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

02/04/2025
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.

Administrator (or Representative)

2-5-2025
Date

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(a) Develop and implement a system to identify and manage infections;

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

(d) Provide all resident care and services according to current acceptable standards for infection control;

(e) Perform all housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on observation, interviews, and record review, the facility failed to implement infection control hand hygiene practices during resident care for 6 of 6 staff (Staff C, Staff I, Staff K, Staff O, Staff P, Staff Q) observed. The facility also failed to provide necessary handwashing supplies in 1 of 1 (laundry room) areas of the facility. These failures placed 44 of 44 residents, staff, and visitors at risk for exposure and spread of infectious diseases and illness when care and services were provided.

Findings included...

Record review of the policy titled, "Preventing Transmission of Infection", dated 03/26/2021, showed hand washing was the most important infection control measure in the community. Contact with contaminated surfaces and objects could be a mode of transmission of infectious agents found in the community. The risk of contact with contaminated surfaces and the spread of infectious agents could be reduced by diligent

consistent use of cleaner and disinfectants. Alcohol-based hand cleaners were recommended if hands were not visibly soiled. Education about infection control practices shall be extended to all employees including housekeeping, laundry, and maintenance staff. All newly hired employees shall receive education about disease transmission, hand washing, barrier precautions, and basic hygiene.

Record review of the Centers for Disease Control and Prevention (CDC) website document titled, "About Hand Hygiene for Patients in Healthcare Settings", dated 02/27/2024, showed patients in healthcare settings were at risk of getting infections while receiving treatment for other conditions. Cleaning your hands could prevent the spread of germs, including those that were resistive to antibiotics, and protects healthcare personnel and patients. Alcohol-based hand sanitizers kill most of the bad germs that make a person sick. It was recommended to wash your hands with alcohol-based hand sanitizer or wash your hands with soap and water, rubbing the hands for 15 seconds, rinse, dry hands with paper towel, and then turn the water off with the paper towel. Wearing gloves alone was not enough for your healthcare provider to prevent the spread of infection.

Record review of CDC's website document titled, "Clinical Safety: Hand Hygiene for Healthcare Workers", dated 02/27/2024, showed hand hygiene protects both healthcare personnel and patients. Hand hygiene means cleaning your hands with handwashing with water and soap or with antiseptic hand rub (alcohol-based foam or gel hand sanitizer). CDC recommended that healthcare personnel were to perform hand hygiene immediately before touching a patient, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or patient's surroundings, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal.

In an observation and interview on 01/14/2025 at 11:29 AM, inside the dirty side (entrance for soiled items to enter the room) of the laundry room inside the left side of the sink, there was a pink and white cloth incontinent pad that sat in the sink unbagged. On the white side of the pad there was a large area of brown substance. At the sink it was observed there was only soap available for use and no paper towels. Above the sink on the two cabinet door handles on the outside, that covered the entire silver part of the handle, there was thick, dried brown substance that resembled dried stool. Staff E, Maintenance Technician, stated the handles were not cleaned.

In an observation on 01/14/2025 at 2:24 PM, Staff C, Care Team, entered R5's room. R5 had sat in bed and was slumped over. R5 had a mat on the ground next to their bed. R5 had a blanket that had been partially on the mat and the ground. Staff C explained to R5 that they were wet and needed to be changed. Staff C informed R5 their buttocks needed to be wiped. Staff C entered R5's bathroom with their gloved hands and then took their gloves off. Staff C looked inside of R5's trash bin and said R5's bathroom needed more trash bags. Staff C exited R5's bathroom without performing hand hygiene. Staff C had been observed to go back into R5's room. Staff C picked up the mat and the blanket off the ground and set it aside at the end of R5's bed. Staff C grabbed R5's wheelchair. Staff C asked R5 to hug them as Staff C physically assisted R5 out of bed and into their wheelchair. Staff C brushed R5's hair. Staff C made R5's bed and opened the blinds inside of the room. Staff C had then been observed to wash their hands at 2:36 PM before they and R5 exited the room.

In an observation on 01/15/2025 at 12:09 PM, Staff P, Housekeeper, entered the dirty

side door (entrance for soiled items to enter the room) of the laundry room. Staff P looked into one of the cabinets and closed them. Staff P stated, "I have to wash my hands". Staff P turned the water on, got soap, rubbed hands together, and then rinsed with water. Staff P turned the water off with their bare hand. Staff P looked for paper towels to dry their hands and was unable to find them, shook their hands to dry then and then exited into the dryer and washing machine area of the laundry room. There were no paper towels available at the sink for Staff P to use.

In an observation on 01/15/2025 at 12:13 PM, inside the North dining room, a rack of ready to eat plates of food was delivered. Staff O, Care Team, removed disposable gloves from their pant pocket and put then on without performing hand hygiene prior to putting the gloves on. Staff O proceeded to pass out the ready to eat plates to the residents that were in the dining room. At 12:18 PM by one of the windows of the North dining room at a table Staff Q, Care Team Medication Technician, was charting on a computer. Staff Q got up from the computer and came to the medication cart. Staff Q grabbed their keys out of their pocket and unlocked the medication cart. Staff Q grabbed a bottle with a label of miralax (a medicated powder that helps soften and pass stool). Staff Q poured the miralax into a medication cup, closed and locked the medication cart, entered the dining room grabbed a cup that was full of white liquid. Staff Q poured the medication cup of miralax into the cup of white liquid and stirred it. Staff Q then gave the cup to Resident 4 to drink. Staff Q returned to the computer and began to chart again. During the entire observation there was no hand hygiene performed.

In an observation on 01/15/2025 at 3:29 PM in the back hallway outside of the North dining room, was the medication cart. Staff K, Medication Technician, was standing at the medication cart. Staff K was observed to be wearing blue disposable gloves on both hands while prepping medication. Staff K left the medication cart with the blue gloves on and medication in their hand and entered a resident's room. Staff K immediately came out of the room with the same blue disposable gloves on both hands and an empty medication cup. Staff K threw the medication cup into the trash. Staff K reached into their pocket and pulled out keys and unlocked the medication cart. Staff K opened the second drawer, unlocked the narcotic box and pulled out the narcotic book and used a pen to sign out a medication. Staff K put the narcotic book back into the narcotic box, closed, and locked the medication cart. Staff K left the medication cart at 3:30 PM and entered Resident 13's room. Prior to Staff K entering Resident 13's room there was no performed hand hygiene observed. Staff K returned to the medication cart with no gloves on. Staff K pulled their keys out of their pocket and unlocked the medications cart. Staff I, Medication Technician, came to Staff K and asked for disposable gloves. Staff K handed Staff I two blue disposable gloves from the box that was in the bottom left drawer of the medication cart. Staff I stated how the gloves were so big, and Staff K stated they had to have two XL size gloves and kept them in the medication cart. Staff I was observed to put the blue disposable gloves on both hands without any hand hygiene performed. Staff I was observed to wipe a seat in the television room that was across the hallway from the North dining room. Staff I then took the gloves off and walked back to the medication cart when they handed the disposed used blue gloves to Staff K that grabbed then and then threw them away. Staff K opened the door to the dining room, entered the dining room, put a pitcher in there, came back out to the medication cart. Staff K was not observed to perform hand hygiene after they handled Staff I's soiled used disposable gloves. Staff K then observed at 3:34 PM to put a pair of blue disposable gloves on both hands. Staff K typed on the medication cart computer with their gloved hands. Staff K then noted to open the narcotic box and pulled out a

small bottle with a syringe. Staff K wrote in the narcotic book and at 3:38 PM left the medication cart with the syringe and entered Resident 11's room. At 3:43 PM, Staff K returned to the medication cart still wearing the blue disposable gloves and took them off and disposed in the trash. Staff K opened the medication cart and proceeded to grab another residents' medications without any hand hygiene performed observed.

In an interview on 01/16/2025 at 12:11 PM, Staff M, Care Team, stated they were expected to wash their hands with hand sanitizer as much as possible. Staff M stated they were to perform hand hygiene between each resident's medication pass and all the time. Staff M stated they were to wash their hands before and after they put gloves on and anytime they touched a resident.

In an interview on 01/16/2025 at 12:21 PM, Staff J, Medication Technician, stated they were to use hand sanitizer three to four times and then wash their hands with soap and water. Staff J stated they were to wash their hands right after they removed their gloves if they administered medication with the gloves. Staff J stated they were to perform hand hygiene after each residents medication administration.

In an interview on 01/16/2025 at 2:22 PM, Staff B, Nursing Director, stated all hand washing sinks were to have soap and paper towels to wash your hands with. Staff B stated all employees at the facility were trained every quarter on hand hygiene and infection control practices. Staff B stated they were to use hand sanitizer or wash hands with soap and water anytime their hands were soiled, after gloves were removed and all the time.

This is a recurring deficiency previously cited on 09/13/2024, 07/31/2023, and 02/17/2022.

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, HAMPTON SPECIAL CARE - TUMWATER is or will be in compliance with this law and / or regulation on (Date) 2-28-2025 .

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

Administrator (or Representative) 2-5-2025 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 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to incorporate the resident's medication assistance and intermittent nursing services into their negotiated service agreements for 7 of 7 sampled residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3], Resident 4 [R4], Resident 5 [R5], Resident 6 [R6], Resident 7 [R7]). This failure placed 44 of 44 residents at risk of staff untrained on the resident's care and services.

Findings included...

Record review of the facility's policy titled, "Care/Service Plans", dated 05/20/2022, showed a resident-centered care/service plan was created and maintained for every resident. The purpose of the care/service plan was to provide a centralized coordination of the services that would be provided to each resident, based on their individual needs, abilities, and preferences. The care/service plan was developed with assistance and review from the resident, a registered or licensed nurse, if the resident received nursing services, medication assistance, or was unable to direct self-care. The care/service plan would ensure that associated services were specifically identified for the resident and described appropriately, define who provides the services, how the services would be provided to the resident. The care/service plan would include, but not limited to the following, medication management and/or assistance required. The care/service plan was developed by use of various assessment/evaluation tools selected by the community to identify the specific activities of daily living, socialization safety, and qualify of life needs of the resident. These tools included but not limited to the facility level of care evaluation.

R1

Record review of R1's, Face Sheet, dated 01/14/2025, showed R1 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted].

Record review of R1's, "[Facility name] Level of Care Evaluation Washington" (facility's version of their assessment), dated 12/27/2024 showed R1 required staff assist with all their medications and treatments. R1 received all their medications from the community pharmacy.

Record review of R1's document titled, "Nurse Delegation: Nursing Visit", dated 11/15/2024, showed R1 required nurse delegation for the following tasks that included oral and liquid medication administration as R1 was unable to perform the task independently.

Record review of R1's, "[Facility name] Service Agreement" (facility's version of the negotiated service agreement), dated 11/14/2024, showed there was nothing documented in R1's service plan that showed R1 received medication services. There was no documentation in the service plan that showed R1 received Registered Nurse (RN) delegated services for their medication services.

R2

Record review of R2's, Face Sheet, dated 01/14/2025, showed R2 moved into the facility on [redacted]/2024 with multiple medical diagnosis which included [redacted].

Record review of R2's, "[Facility name] Level of Care Evaluation Washington", dated 12/23/2024 showed R2 required staff assist with all their medications and treatments. R2 received all their medications from the community pharmacy.

Record review of R2's document titled, "Nurse Delegation: Nursing Visit", dated [redacted]/2024, showed R2 required nurse delegation for the following tasks that included oral and liquid medication administration as R2 was unable to perform the task independently.

Record review of R2's, "[Facility name] Service Agreement", dated 01/14/2025, showed there was nothing documented in R2's service plan that showed R2 received medication services. There was no documentation in the service plan that showed R2 received RN delegated services for their medication services.

R3

Record review of R3's Face Sheet, dated 01/14/2025, showed R3 moved into the facility on [redacted]2024 with multiple medical diagnoses that included [redacted].

Record review of R3's document titled, "[facility name] Level of Care Evaluation- Washington", dated 11/28/2024, showed R3 required staff assist with all their medications and treatments. R3 received all their medications from the community pharmacy.

Record review of R3's document titled, "Nurse Delegation: Nursing Visit", dated 11/15/2024, showed R3 required nurse delegation for the following tasks that included oral, liquid, and topical medications and mixing powder with liquid as R3 was unable to perform the task independently.

Record review of R3's "[facility name] Service Agreement", dated 01/14/2025, showed there was nothing documented in R3's service plan that showed how R3 received their medication services. There was no documentation in the service plan that showed R3 received RN delegated services for their medication services.

R4

Record review of R4's face sheet, dated 01/14/2025, showed R4 moved into the facility

on [redacted]/2019 with multiple medical diagnoses that [redacted].

Record review of R4's document titled, "[facility name] Level of Care Evaluation- Washington", dated 10/15/2024, showed R4 required staff assist with all their medications and treatments. R4 received all their medications from the community pharmacy.

Record review of R4's document titled, "Nurse Delegation: Nursing Visit", dated 11/15/2024, showed R4 required nurse delegation for the following tasks that included oral, liquid, rectal, and topical medications, mixing powder with liquid, oxygen, and nebulizers as R4 was unable to perform the tasks independently.

Record review of R4's "[Facility name] Service Agreement", dated 07/17/2024, showed there was nothing documented in R4's service plan that showed how R4 received their medication services. There was no documentation in the service plan that showed R4 received RN delegated services for their medication services.

R5

Record review of R5's, Face Sheet, dated 01/14/2025, showed R5 moved into the facility on [redacted]/2021 with multiple medical diagnosis which included [redacted].

Record review of R5's, "[Facility] Level of Care Evaluation Washington", dated 10/17/2024 showed R5 required staff assist with all their medications and treatments. R5 received their medications crushed. R5 received all their medications from the community pharmacy.

Record review of R5's document titled, "Nurse Delegation: Nursing Visit", dated 11/15/2024, showed R5 required nurse delegation for the following tasks that included oral, liquid, and topical medication administration, rectal suppository (medication inserted into the rectum that absorbed once it reaches body temperature), rectal enema (a procedure that involves injecting liquid into the rectum to relieve constipation and clean the colon), non-sterile wound care (cleaning and dressing a wound), and hospice kit (variety of prescribed medications provided by hospice team to provide the resident comfort) as R5 was unable to perform the task independently.

Record review of R5's, "[Facility name] Service Agreement", dated 08/21/2024, showed there was nothing documented in R5's service plan that showed R5 received medication services. There was no documentation in the service plan that showed R5 received RN delegated services for their medication services.

R6

Record review of R6's Face sheet, dated 01/14/2025, showed R6 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted]

Record review of R6's Pre-Admission Medical Report, dated 11/27/2024, showed it was completed by R6's physician. The document showed all residents in the secured units were required to have staff administer all medications, including over-the-counter, prescription, and topical medications.

Record review of R6's "[Facility name] Level of Care Evaluation- Washington", dated 12/19/2024, showed staff assisted with all of R6's medications and treatments. R6 used the community pharmacy to get their medications.

Record review of R6's document titled, "Nurse Delegation: Nursing Visit", dated [redacted]/2024, showed R6 required nurse delegation for the following tasks that included oral, liquid, and topical medications as R6 was unable to perform the tasks independently.

Record review of R6's "[Facility name] Service Agreement", dated 01/03/2025, showed there was nothing documented in R6's service plan that showed how R6 received their medication services. There was no documentation in the service plan that showed R6 received RN delegated services for their medication services.

R7

Record review of R7's, Face Sheet, dated 01/14/2025, showed R7 moved into the facility on [redacted]/2020 with multiple medical diagnosis which included [redacted].

Record review of R7's, "[Facility] Level of Care Evaluation Washington", dated 12/22/2024 showed R7 required staff assistance with all their medications and treatments. R7 received their medications crushed. R7 received all their medications from the community pharmacy.

Record review of R7's document titled, "Nurse Delegation: Nursing Visit", dated 11/15/2024, showed R7 required nurse delegation for the following tasks that included oral, liquid, and topical medication administration, rectal suppository, and hospice kit as R7 was unable to perform the task independently.

Record review of R7's, "[Facility] Service Agreement", dated 04/15/2024, showed there was nothing documented in R7's service plan that showed R7 received medication services. There was no documentation in the service plan that showed R7 received RN delegated services for their medication services.

In an interview on 01/16/2025 at 2:20 PM, Staff B, Nursing Director, said they did not incorporate resident's medication services or their Register Nurse delegation services into their service agreements.

This is a recurring deficiency previously cited on 03/25/2024.

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, HAMPTON SPECIAL CARE - TUMWATER is or will be in compliance with this law and / or regulation on (Date) 2-28-2025.

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

Administrator (or Representative) MLA Date 2-5-2025

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.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to investigate, determine the circumstances of event, rule out possible abuse, and protect residents for 2 of 3 residents (Resident 3 [R3] and Resident 6 [R6]). This failure resulted in R3, R6, and other residents being at risk for potential on going injury from an unknown source.

Findings included...

Record review of the facility's policy titled, "incident reports", dated 05/20/2022, showed injury and unusual incidents would be reported in compliance with state regulatory requirements. Incident reports were completed in the electronic health record system. The unusual incident form was used to document and report any incident which was a threat to a resident's health, safety, welfare, or rights. That would include but not limited to injury, any violation of resident rights, and any incident that threatens the health, welfare, or safety of the resident. Any incident in which was a threat to a resident's health, safety, welfare, or right would be reported to the state licensing agency within seven days of the incident and a report made to via telephone within 24 hours of the incident. Direct care staff and supervisors were trained on the completion process of incident reports. Incidents were completed within the shift that the incident occurred and investigated within 48 hours of the occurrence.

Record review of the facility's policy titled, "complaints", dated 05/20/2022, showed

each resident had the personal right to be informed by the Executive Director (ED) (or a designated representative) of provisions of law regarding complaints and of procedures to confidentially register complaints, including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency. At the time of admission the ED or a designated representative informed the resident and their responsible party of the desire by the community and all community to accommodate resident requests, needs, complaints, and concerns. Caregivers bring all residents requests, concerns, and/or complaints to the attention of their immediate supervisor or the ED. The ED or the designated representative would investigate all complaints and discuss their findings with the resident and their responsible party.

Record review of the "Assisted Living Facility Guidebook, Partners in Protection", dated February 2018, under the section, "what to report", showed "substantial injuries of unknown source not related to suspected abuse or neglect (because under some circumstances the failure to take preventive measures may constitute abuse or neglect)." Under the section, "the investigation process", showed all significant injuries of unknown source and all alleged incidents of abuse must be thoroughly investigated. Investigations would be completed to determine what occurred and to make necessary changes to the care and services to prevent reoccurrence. A thorough investigation was a systematic collection and review of evidence/information that described and explained an event or a series of events. It would seek to determine if abandonment, abuse, neglect or misappropriation of resident property occurred and how to prevent further occurrence. Under the section titled, "the timeliness of the investigation", showed the facility must begin the investigation as soon as possible after protecting the residents in order to collect accurate data related to the incident. Any delay in starting the investigation could cause valuable information to be either lost or altered. The investigation should end with the identification of who was involved in the incident and what, when, where, why, and how the incident happened including the probable or reasonable cause. Under the section titled, "phase one" showed the initial investigation should be started within the first 24 hours. Review of appendix H, Definitions, showed "abuse" was defined in "RCW 74.34.020 meant the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who was unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish". Assisted living facilities must protect the health and safety of every resident, including those that are incapable of perception or who are unable to express themselves. In general, you must presume that abuse has occurred whenever there has been some type of impermissible, unjustifiable, harmful, offensive or unwanted contact with a resident. ABUSE – "PHYSICAL" as defined in RCW 74.34.020(2)(b) Physical abuse includes but is not limited to striking with or without an object, slapping, pinching, choking, kicking, shoving, or prodding." "INCIDENT" For the purposes of these guidelines, an incident means: An occurrence involving a resident in which mistreatment, neglect, abuse, misappropriation of resident property or financial exploitation are alleged or suspected; or A substantial injury of unknown source, or cause, or circumstance. All incidents require thorough investigation and reporting, as necessary, according to state and federal regulations. All such investigations attempt to determine if such injury or allegation of injury results from abuse or neglect. It may not always be possible to determine the cause of the incident. An allegation is a statement, or a gesture made by someone (regardless of capacity or decision-making ability) that indicates that abuse, neglect, financial exploitation, or misappropriation of resident property may have occurred and requires a thorough investigation. Documentation of the investigation for all incidents and the determination of "reasonably related" must be

kept readily available for state review, internal risk management, and federal authorities. Review of Appendix H, "INJURIES OF UNKNOWN SOURCE" means any injury sustained by a resident where the source of the injury was not observed directly by a staff person, or not identified through the process of assessment for a superficial injury or not identified through the process of a thorough investigation for a substantial injury, or determined not to be reasonably related to the resident's condition, diagnosis, known and predictable interaction with surroundings or related to a known sequence of prior events, and the resident is not able to report/inform how the injury occurred.

R3

Record review of R3's Face Sheet, dated 01/14/2025, showed R3 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted].

Record review of R3's document titled, "[facility name] Level of Care Evaluation- Washington", dated 11/28/2024, showed staff were to report any changes or problems with the clinical service director. There was no documentation to show that R3 had a history of bruising.

Record review of R3's "[facility name] Service Agreement", dated 01/14/2025, showed R3 was a danger to themselves and required a secured unit and line-of-sight supervision. R3 required assistance with all activities of daily living from the caregivers. There was no documentation to show that R3 had a history or was at risk of bruising to their skin.

Record review of R3's progress note, dated 01/05/2025 at 9:04 PM, showed R3 was assisted to the bathroom that evening around 9:00 PM, when the staff member noticed large bruise marks on R3's upper arms with an unknown origin.

Record review of the facility's "resident incident/accident" log, dated 01/15/2025, showed there was no listed incident documented for R3 on 01/05/2025.

On 01/15/2025 at 10:56 AM, the Department requested to review R3's incident and investigation of the unknown origin bruises to upper arms.

In an interview on 01/15/2025 at 1:55 PM, Staff B, Nursing Director, stated there was no incident report or investigation completed for R3. Staff B stated they were responsible to complete all the investigations for all the resident incidents and did not recall that incident with R3. Staff B stated the medication technician had put the resident on alert, but did not complete the incident report to have the bruises investigated.

R6

Record review of R6's Face sheet, dated 01/14/2025, showed R6 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted], and [redacted].

Record review of R6's "[Facility name] Service Agreement", dated 01/03/2025, under section titled, "behavior management plan", showed R6 had behaviors of resisting care

and could become combative and hit. Staff were to redirect and re-approach R6 if they displayed the behaviors. Staff were to report the behaviors to the medication assistant or the nurse immediately.

In an interview on 01/15/2025 at 10:57 AM, Collateral Contact 1 (CC1), Power of Attorney for R6, stated within a few weeks of R6's stay at the facility, R6 reported that a large black man caregiver had taken a hold of R6's thumb and bent it back causing R6 to have pain when the caregiver was giving R6 a shower. CC1 stated earlier that day R6 was refusing care and to take a shower from all the female caregivers.

In an interview on 01/16/2025 at 12:21 PM, Staff J, Medication Technician, stated on 01/11/2025, R6's spouse came to them and reported that R6 complained of their thumb hurting after they were provided a shower that day. Staff J stated that R6 was refusing care and a shower to be provided to them and was combative with the female caregivers. Staff J stated Staff K, Medication Technician, was able to get R6 to take a shower. Staff J stated they expressed concerns that R6 was complaining of pain to their thumb after the shower was provided by Staff K to Staff L, Medication Technician Staff J stated they did not report it to Staff B, Nursing Director, or document the complaint of pain, or complete an incident report for further investigation. Staff J stated that R6 was extremely combative that day striking out, kicking, and aggressive when care was attempted to be performed.

Record review of R6's progress notes, dated 12/02/2024 through 01/14/2025 showed there was no documentation that R6 had complained of pain to their thumb after R6 was provided a shower.

Record review of the facility's "resident incident/accident" log, dated 01/15/2025, showed there was no listed incident documented for R6 on 01/11/2025.

In an interview on 01/15/2025 at 3:16 PM, Staff K stated they had given R6 a shower. Staff K stated R6 was striking out at them through the shower. Staff K stated they talked with R6 that they were there to help them with the shower. Staff K stated it was only themselves and R6 during the shower.

In an interview on 01/16/2025 at 3:10 PM, Staff B stated Staff K had provided R6 a shower. Staff B stated R6 was combative with care. Staff B stated the medication technician should have put R6 on alert and told them about the concern of R6 thumb was hurt by being bent back in the shower.

This is a recurring deficiency previously cited on 03/02/2023.

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, HAMPTON SPECIAL CARE - TUMWATER is or will be in compliance with this law and / or regulation on (Date) 2-28-2025

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

Administrator (or Representative) [signature] Date 2-5-2025

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to monitor resident well-being and take appropriate actions for 2 of 7 sampled residents (Resident 4 [R4] and Resident 6 [R6]). This failure placed both residents at risk for unmet care needs and resident decline due to lack of the identification of and response to resident condition changes.

Findings included...

Record review of the facility's policy titled, "Alert Charting", dated 2017 (no month or day documented), showed the policy was implemented to ensure that all residents with a change of condition were assessed and monitored appropriately and that there was documentation in the resident record to reflect the resident's condition. Anytime the resident had a change of condition, or otherwise required closer observation as directed by the alert charting guidelines, or directed by the licensed nurse or administrator, alert charting would be initiated.

R4

Record review of R4's face sheet, dated 01/14/2025, showed R4 moved into the facility on [redacted]/2019 with multiple medical diagnoses that included [redacted], and [redacted].

[redacted]).

Record review of R4's Medication Administration Record, dated 12/01/2024 through 12/31/2024, showed R4 had an order for ipratropium-albuterol solution(a prescribed medication that is inhaled through mist to help relax the muscles in the airways and increase air flow to the lungs) inhale one vial two times daily in the morning and evening.

Record review of R4's document titled, "The Home Doctor", dated 12/19/2024, showed R4's ipratropium-albuterol solution inhalation was to be given daily in the evening with the previous order discontinued.

Record review of R4's progress note, dated 12/20/2024 at 8:58 AM, showed R4 was seen by their primary care physician (PCP) on 12/19/2024. PCP sent over changes in their medication ipratropium- albuterol solution inhalation by nebulizer to be given daily in the evening and the fax was sent to the pharmacy. There were no further progress notes about how R4 adjusted to the medication decrease.

R6

Record review of R6's Face sheet, dated 01/14/2025, showed R6 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted]), [redacted], and [redacted]).

In an interview on 01/15/2025 at 10:57 AM, Collateral Contact 1 (CC1) stated within a few weeks of R6's stay at the facility, R6 reported that a black man that took a hold of R6's thumb and bent it back causing R6 to have pain. CC1 said that this incident occurred when R6 was provided a shower by the man. CC1 stated earlier that day R6 was refusing care from all the female caregivers and was refusing to take a shower.

In an interview on 01/16/2025 at 12:21 PM, Staff J, Medication Technician, stated on 01/11/2025, R6's spouse came to them and reported that R6 complained of their thumb hurting after they were provided a shower that day. Staff J stated that R6 was refusing care to be provided to them and was combative with the female caregivers. Staff J stated Staff K, medication Technician, was able to get R6 to take a shower. Staff J stated they expressed concerns that R6 was complaining of pain to their thumb after the shower was provided by Staff K to Staff L, Medication Technician.

Record review of R6's progress notes, dated 12/02/2024 through 01/14/2025 showed there was no documentation that R6 had complained of pain to their thumb after R6 was provided a shower.

In an interview on 01/15/2025 at 3:16 PM, Staff K stated all residents would be put on alert charting for any medication changes that included a dose or frequency increased or decreased to watch for any negative effects or benefits from the changes.

In an interview on 01/15/2025 at 3:48 Pm, Staff I, Medication Technician, stated all residents would be put on alert for any new medications, change in dose of

medications, and anything that would need to observe the resident for any possible changes. Staff I stated the residents would be on alert for three days with three chart notes a day totaling nine chart notes before the resident would be taken off alert.

In an interview on 01/16/2025 at 12:40 PM, Staff B, Nursing Director, stated the facility alert charting for residents was the resident would be put on alert and each shift would chart on the change with the resident for a total of nine chart notes and 72 hours.

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, HAMPTON SPECIAL CARE - TUMWATER is or will be in compliance with this law and / or regulation on (Date) 2-28-2025.

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

Administrator (or Representative) — Date: 2-5-2025

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

(4) How residents with special needs are individually protected without unnecessary restrictions on the general population.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to secure potentially hazardous supplies accessible to memory care residents for 8 of 8 locations (North shower/bathroom, Resident 1's [R1] bathroom, Resident 4 [R4]'s bathroom, Nurses station and front desk area, Resident 3 [R3]'s bathroom, Resident 6 [R6]'s bathroom and room, Resident 5 [R5]'s bathroom and room, and Resident 7 [R7]'s bathroom). This failure placed 44 of 44 residents at risk for ingesting potentially toxic materials.

Findings included...

Record review of the facility's "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated showed 32 of 44 residents were labeled to have dementia (a condition that effects thinking, remembering, reasoning, and effects daily life)/Alzheimer's (condition causing memory loss and reduced functional abilities)/Cognitive Impairment (condition affecting thinking, memory, and decision-making).

North Shower and Bathroom

In an observation on 01/14/2025 at 11:20 AM, inside the unattended and unlocked North shower/bathroom, on top of the unlocked double door black cabinet, was a one-gallon jug that was a quarter full of clear liquid that had a label that showed "OdoBan Eliminates Odor's Disinfectant Laundry and Air freshener". The label showed it had ingredients that included alkyl dimethyl benzyl ammonium chloride (a chemical compound used in disinfectant and antimicrobial cleaning products that can cause adverse health effects). The label showed that OdoBan helped eliminate unpleasant odors on washable surfaces such as upholstery, carpet, bedding, showers, walls, and floors while leaving a fresh sent. The label showed, "Hazards to Humans and Domestic animals. DANGER-causes irreversible eye damage." Do not get in eyes or on clothing. Avoid contact with skin. Wash thoroughly with soap and water after handling. The label showed, "NOTE to PHYSICIAN: probable mucosal [thin membrane that lines the body cavities and passages] damage may contraindicate the use of gastric lavage [pumping of the stomach contents]. Call a poison control center or doctor for treatment advice."

R1's Bathroom

Record review of R1's, "The [Facility] Service Agreement", dated 11/14/2024, under the behavior management/redirect section showed R1 could not determine danger to self. R1 was at risk of being exposed to or displaying high risk behavior.

In an observation on 01/14/2024 at 2:14 PM, R1's bathroom showed on the counter had been a container of 33.8 fluid ounces of Colgate 12-hour protection (mouthwash) with R1's initials handwritten on it. Under the sink in an unlocked cabinet showed a grey shower caddy that had dove daily moisture conditioner with R1's initials handwritten on it, a container of Colgate toothpaste, and dove advanced care deodorant. Inside of the shower there was 24 fluid ounces of Amazon basics, eight fluid ounces of first choice hand and body lotion, and Dove hair therapy shampoo.

In an observation and interview on 01/16/2025 at 12:09 PM, R1's bathroom showed on the counter had a container of mouth wash and a container of hand lotion. Staff J, Medication Technician, said items such as mouth wash, hand lotion, toothpaste, shampoo, and conditioners should be stored in locked cabinets. Staff J acknowledged R1's cabinet under their sink had the ability to lock but was left unlocked. Staff J said all resident rooms had a locking mechanism to store items since this was a memory care facility and residents could potentially consume the products. Staff J said the facility

staff had keys to open the locks.

R4's bathroom

In an observation on 01/14/2025 at 2:14 PM, inside R4's bathroom inside the unlocked cabinet that was hung up on the wall by the mirror, was a bottle that was half full of "ACT" anticavity fluoride mouthwash.

Nurses & Front Desk

In an observation on 01/14/2025 at 2:25 PM, in the front desk area that was conjoined with the nurses station was Resident 8 [R8]. There were no staff members present in the area or in the nurses station that R8 was in. R8 was observed to be looking through the cabinets and items on the desk. R8 was greeting the visitors that were entering the locked door into the facility living area.

In an observation on 01/14/2025 at 3:03 PM, the nurse's station had a spray bottle with an orange liquid that sat on the counter next to binders. At 3:48 PM, on the counter by some binders in the unattended area and unlocked, was an orange spray bottle that had a label that showed, "clean on the go HDQ c2 cleanser disinfectant detergent and fungicide" on it (a chemical that deodorized odors).

In an observation on 01/15/2025 at 3:31 PM, the nurse's station had a spray bottle with an orange liquid that sat on the counter next to binders that had been identified as a detergent and fungicide.

In an observation on 01/16/2025 at 12:32 PM, the nurse's station had a spray bottle with an orange liquid that sat on the counter next to binders that had been identified as a detergent and fungicide.

R3's Bathroom

Record review of R3's, "The [Facility] Service Agreement", dated 01/03/2025, under the section titled, "behavior management/redirect", showed R3 was determined to have behaviors (disturbing hallucinations [thoughts and beliefs that were not real] and delusional thinking). R3 experienced paranoia, severe sun-downing (a period of confusion and behavioral changes that can occur with people with dementia typically in the late afternoon and evening) and a shift in behavior that began at 6:00 PM. R3 was unable to determine danger to themselves and required line-of-sight supervision always.

In an observation on 01/16/2025 at 11:53 AM, inside R3's bathroom on the counter, not

locked up, was a 2.6-ounce white container with a label of "DOVE" deodorant original clean. Under the bathroom sink in the top unlocked drawer was a four fluid ounce bottle that was full of blue liquid of fresh mint mouthwash, and a three-ounce tube of ultra sheer Neutrogena dry-touch sunscreen broad spectrum. The label showed "warning only for external use. When using the product keep out of eyes. If swallowed get medical help or contact poison control center right away". There was a two fluid ounce bottle of moisturize skin cream and a 2.75 fluid ounce tube of fresh mint anticavity fluoride toothpaste.

R6's Bathroom and Room

Record review of R6's, "The [Facility] Service Agreement", dated 01/03/2025, under the section titled, "behavior management/redirect", showed R6 was at risk of being exposed to or displaying high risk behavior.

In an interview and observation on 01/16/2025 at 11:41 AM, Staff J, stated no chemicals were to be left out unlocked in any of the resident's rooms or accessible areas. Staff J stated the chemicals included toothpaste, shampoo, conditioner, lotion, and mouthwash. Staff J stated they have seen in the past a memory care resident use toothpaste as if it was lotion. Staff J unlocked and entered R6's room and inside the bathroom on the top counter, unlocked inside a yellow cady, was a tube of crest plus toothpaste and a bottle that was three quarters full of green liquid with a label that showed "lectric shave" after shave liquid. Staff J stated these should not be stored there. Staff J stated the toothpaste and the after shave liquid should be locked in the cabinet and pointed to the cabinet door that was under the sink that had a pad lock on it. At 11:47 AM in the unlocked shower on the shelves there was a 28 fluid ounce bottle of tresemme rich moisture hyaluronic conditions, another black 28 fluid ounce bottle of equate beauty moisture rich shampoo, and a white 22 fluid ounce bottle of equate beaty of sensitive skin body wash. At 11:50 AM on the shelves in the closet that was near R6's bed, not locked up, was a bottle of no-rinse cleanser, and a tube of peri guard ointment. The no-rinse cleaner label showed, "warning, for external use. In case of accidental ingestion seek professional physician or contact poison control center immediately." The label for the peri guard showed "warning: for external use only. Avoid contact with eyes in case of contact flush thoroughly with water, keep out of reach of children. In case of accidental ingestion contact a physician or poison control center right away."

R5's Room and Bathroom

Record review of R5's, "The [Facility] Service Agreement", dated 08/21/2024, under the behavior management/redirect section showed R5 was at risk of being exposed to or displaying high risk behavior.

In an observation on 01/14/2024 at 2:24 PM, R5's room inside of their closet had a container of dimethicone protect (skin protectant), and two bottles of PeriGuard ointment (skin protectant). Inside of R5's bathroom on the counter showed there had

been a container of fresh mint (toothpaste). In an unlocked cabinet showed a bottle of Remedy moisture body lotion, two bottles of four fluid ounces of fresh mint mouthwash, and 2.75 ounces of fresh mint toothpaste.

R7's Bathroom

Record review of R7's, "The [Facility] Service Agreement", dated 04/15/2024, under the behavior management/redirect section showed R7 was at risk of being exposed to or displaying high risk behavior.

In an observation on 01/14/2025 at 2:46 PM, R7's bathroom on the counter showed there had been a container of crest toothpaste. In an unlocked cabinet there was a four fluid ounce bottle of Remedy body lotion, eight fluid ounces of bedside care spray, a container of full body wash, and 75 fluid ounces of peri cleanser (a product that helped clean the area between the genitals and anus).

In an interview on 01/16/2025 at 12:19 PM, Staff I, Medication Technician, said care items such as toothpaste, mouthwash, and shampoo should be locked under the residents' sinks or cabinets. Staff I said toothpaste and mouthwash supplied by resident's families could have fluoride in it which could hurt the resident if consumed.

In an interview on 01/16/2025 at 2:20 PM, Staff B, Nursing Director, said the facility staff knew they were supposed to lock up resident supplies after they were used. Staff B said items such as shaving cream, hair products, shampoo, and conditioner were supposed to be locked in the resident cupboards. Staff B said on one side of the facility, rooms had cabinets that had locks and keys while the other side of the facility cabinets had safety locks.

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, HAMPTON SPECIAL CARE - TUMWATER is or will be in compliance with this law and / or regulation on (Date) 2-28-2025.

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

Administrator (or Representative) [signature] Date 2/5/2025

WAC 388-78A-2400 Protection of resident records. The assisted living facility must:

(2) Maintain resident records and preserve their confidentiality in accordance with applicable state and federal statutes and rules, including chapters 70.02 and 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure confidentiality of resident records for 1 of 2 facility medication cart computers (North medication cart computer). These failures placed 44 of 44 residents at risk for exposure of confidential records.

Findings included...

Record review of the facility's policy titled, "Confidentiality", dated 05/20/2022, showed all residents data and information were treated as confidential. Resident charts, information, and preadmission documentation were kept inaccessible to visitors and individuals not involved in the direct care and admission of the resident. Care and administrative staff given access to resident related documentation were trained during orientation to maintain confidentiality.

In an observation on 01/15/2025 at 3:30 PM, in the hallway the North medication cart was sitting just outside the windows of the North dining room. Staff K, Medication Technician, was standing at the medication cart when they left to go to a residents' room. The North medication cart's computer was left open that displayed Resident 10, Resident 4 and three other resident's pictures, first and last names, and room numbers. Staff K returned to the medication cart and then dispensed another residents' medications. At 3:38 PM, Staff K left the North medication cart unattended to administer a resident their medication and left the top of the laptop slightly lowered, but able to see the screen illuminating light. Upon reviewing the screen that showed Resident 11's (R11) first and last name, room number, and their medication morphine sulfate (prescribed pain medications) 20 milligrams per liter. The unattended medication cart laptop computer displayed R11's person information until Staff K returned back to the medication cart at 3:43 PM.

In an observation on 01/16/2025 at 12:07 PM, the medication cart located on the north side of the facility outside of the dining rooms computer screen had been left ajar. On the screen showed Resident 3 [R3]'s picture, full name, and medications hydrocortisone (medication that treats skin conditions) and quetiapine (a medication that helps with mental health conditions).

In an interview and observation on 01/16/2025 at 12:11 PM, Staff M, Care Team, stated the medication technicians were expected to close the top of the computer laptop completely before they walk away from the medication cart. Staff M closed the computer top of the laptop and then opened it and showed that the screen was locked without any resident information displayed on the screen.

In an interview on 01/16/2025 at 12:21 PM, Staff J, Medication Technician, stated the medication technicians were to hit finish on the electronic record system or close the laptop computer entirely to ensure there were no residents personal information displayed when they left the computer on the medication cart left unattended.

In an interview on 01/16/2025 at 12:47 PM, Staff B, Nursing Director, stated all medication technicians were trained to close the laptop screen before they left the computer and medication cart unattended.

Plan/Attestation Statement

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

Administrator (or Representative) — Date: 2-5-2025

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 2 of 3 sampled new Staff (Staff C and Staff E) received their tuberculosis (TB) (a bacterial infection that typically affects the lungs but can also affect any part of the body) test within the required time frames. This failure placed 44 of 44 residents and staff at risk for exposure to TB.

Findings included...

Record review of the Centers of Disease Control (CDC) document titled, "Testing for Tuberculosis: skin test", dated 04/22/2024, showed a TB skin test required two visits with a healthcare provider. If a person received a TB skin test, they would have two visits with the healthcare provider. During the first visit, the healthcare provider would inject a small amount of TB solution just under the skin on the lower part of the inner arm. On the second visit after two or three days, the person would return to the healthcare provider and have the skin test that was injected on the inner arm observed

and determine if it was a positive or negative test result. Under the section titled, "two-step TB skin test", showed if someone was a healthcare worker they would have a two-step TB skin test. The two-step TB skin test could lower the chance that boosted reaction from an old TB infection would be misinterpreted as a recent infection. If the first-step TB skin test was classified as negative, a second-step TB skin test would be given one to three weeks after the first test was read.

Record review of a Dear Provider Letter, titled, "Reinstatement of tuberculosis testing requirements July 1, 2022," dated 05/17/2022 and amended on 05/26/2022, stated "Currently, tuberculosis (TB) testing requirements are suspended by the Department of Social and Health Services user WSR 22-07-004, which will expire July 1, 2022. To be prepared to meet the TB testing requirements on July 1, 2022, RCS (Residential Care Services) encourages all facilities and providers to immediately begin staff testing. This will allow time to meet the requirements once the emergency rules have expired and the permanent rules are reimplemented. The following rules will be reimplemented on July 1, 2022: For ALF (Assisted Living Facility) – WACs 388-78A-2484, -2480(1), and 2485(1)."

Record review of the untitled and undated facility document that was a list of employees showed Staff C, Care Team, was hired at the facility on 06/19/2024.

Record review of Staff C's "Employee TB test Documentation Form", dated 06/19/2024, showed Staff C received their first skin TB test on 06/19/2024 and read on 06/21/2024. Staff C's second step was administered on 07/15/2024 that was four days past the required time frame.

Record review of the untitled and undated facility document that was a list of employees showed Staff E, Maintenance Technician, was hired at the facility on 07/15/2024.

Record review of Staff E's "Employee TB test Documentation Form", dated 07/15/2024, showed Staff E received their first skin TB test on 07/15/2024 and read on 07/17/2024. Staff E's second step was administered on 08/16/2024 that was nine days past the required time frame.

In an interview on 01/16/2025 at 12:40 PM, Staff B, Nursing Director, said the facility did not have any policies related to TB testing. Staff B said the facility followed Washington state laws and regulations.

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, HAMPTON SPECIAL CARE - TUMWATER is or will be in compliance with this law and / or regulation on (Date) 2-28-2025.

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

Administrator (or Representative) MK Date 2-5-2025

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:

(l) To manage residents' medications, consistent with WAC 388-78A-2210 through 388-78A-2290 ; sending medications with a resident when the resident leaves the premises;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to notify the physician when 3 of 7 sampled residents (Resident 6 [R6], Resident 3 [R3]), and Resident 1 [R1]), refused their medication. The facility failed to notify the physician when 1 of 7 sampled residents (Resident 7 [R7]) missed their medications. This failure placed the residents at risk for medical complications due to the physician being unable to evaluate the significance of the resident not getting their medication and provide instructions.

Findings included...

Washington Administrative Code (WAC) 388-78A-2230 Medication refusal. "(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must: (c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person."

Record review of the facility's policy titled, "Medication refusal and/or Missed Doses", dated 05/20/2022, showed missed and refused medications were documented in the resident's medication record and the prescribing physician notified immediately or according to physician parameters. Physician parameters must be retained in writing and kept on file.

R6

Record review of R6's Face sheet, dated 01/14/2025, showed R6 moved into the facility

on [redacted]/2024 with multiple medical diagnoses that included [redacted].

Record review of R6's Pre-Admission Medical Report, dated 11/27/2024, showed it was completed by R6's physician. The document showed all residents in the secured units were required to have staff administer all medications, including over-the-counter, prescription, and topical medications. There was no documentation as to when R6's physician wanted to be notified if R6 had refused or missed their medication.

Record review of R6's Level of Care Evaluation- Washington, dated 12/19/2024, showed staff assisted with all of R6's medications and treatments. R6 used the community pharmacy to get their medications dispensed from.

Record review of R6's Medication Administration Record (MAR), dated 01/01/2025 through 01/14/2025, showed on 01/06/2025 there was no documentation to show that R6 was administered their clopidogrel (a prescribed medication to help prevent blood clots in the blood), coenzyme (a supplement to help digest food and protect the heart and skeletal muscles), lisinopril (a prescribed medications to help lower high blood pressure), acetaminophen (a medications to help manage pain, discomfort, and lower high temperatures), memantine (a prescribed medications to help treat Alzheimer's disease), omega 3 (a supplement medication to treat and prevent heart disease, inflammation, and cognitive decline), turmeric (a supplement medication to help with inflammation), vitamin B12 (a supplement medication to help increase b12 levels in the blood), vitamin D3 (a supplemental medications to help increase vitamin D levels in the blood) in the AM. Review of the medication notes showed there was no documentation to show why the medications were not administered. Review of the MAR showed R6's acetaminophen for the afternoon dose was not administered on 01/01/2025, 01/05/2025, 01/06/2025, 01/12/2025, and 01/13/2025. Review of the medication notes showed R6 had refused their acetaminophen for every dose except on 01/12/2025 when they were asleep, and it was not administered. Review of R6's memantine 6:00 PM dose administration showed on 01/05/2025, 01/06/2025, and 01/07/2025, R6 was not administered their medications. Review of the medication notes showed R6 had refused the memantine. There was no documentation that the physician had been notified. Review of R6's acetaminophen, lovastatin (a prescribed medications to help lower high fat levels in the blood), and prazosin (a prescribed medication to help treat high blood pressure) administrations at bedtime showed for dates 01/05/2025, 01/06/2025, and 01/07/2025, R6 had not been given their medications. Review of the medication notes showed R6 had refused those medications on those documented dates.

Record review of R6's progress notes dated 01/01/2025 through 01/14/2025, showed there was no documentation to show that R6's medications were refused and R6's physician was notified.

On 01/16/2025 at 10:03 AM, R6's physician notifications were requested for 01/01/2025, 01/05/2025, 01/06/2025, 01/07/2025, 01/12/2026, and 01/13/2025 when R6 refused or missed their medications.

In an interview on 01/16/2025 at 12:47 PM, Staff B, Nursing Director, stated they were

unable to provide any physician notifications for R6 for review when they were missed or refused their medications that were documented on the MAR.

R3

Record review of R3's Face Sheet, dated 01/14/2025, showed R3 moved into the facility on [redacted]2024 with multiple medical diagnoses that included [redacted].

Record review of R3's Level of Care Evaluation- Washington, dated 11/28/2024, showed R3 required staff assist with all their medications and treatments. R3 received all their medications from the community pharmacy.

Record review of R3's MAR, dated 11/01/2024 through 11/30/2024, showed on 11/03/2024 for HS (hours of sleep or bedtime) medications that included divalproex sprinkle (a prescribed medication to help treat mental/mood conditions), lorazepam (a prescribed medications to help manage anxiousness and feeling or overwhelm), Metamucil (a medication supplement to help treat constipation and promote digestive health), mirtazapine (a prescribed medication to help treat mental/mood conditions), and olanzapine (a prescribed medications to help treat behaviors and mental/mood conditions) were all not administered. Review of the medication notes showed all the medications were refused by R3.

Record review of R3's MAR, dated 01/01/2025 through 01/14/2025, showed on 01/06/2025 for HS medications that included dicyclomine (a prescribed medications to help relax the stomachs muscles and bowels), lorazepam, Metamucil, mirtazapine, and quetiapine (a prescribed medications to help treat behaviors and mental/mood disorders) were all not administered. Review of the medication notes showed all the medications were refused by R3.

Record review of R3's progress notes, dated 11/01/2024 through 11/16/2024, showed there was no documentation that R3's physician was notified that R3 refused their medications on 11/03/2024 at HS.

In an interview on 01/16/2025 at 12:47 PM, Staff B stated they were unable to provide any physician notifications for R3 for review when they refused their medications.

R1

Record review of R1's, Face Sheet, dated 01/14/2025, showed R1 moved into the facility on [redacted]2024 with multiple medical diagnoses that included [redacted].

Record review of R1's, "The [Facility] Level of Care Evaluation Washington", dated 12/27/2024 showed R1 required staff assist with all their medications and treatments. R1 received all their medications from the community pharmacy.

Record review of R1's, MAR, dated 11/01/2024 through 11/30/2024, showed R3 had an order for Estradiol (medication that reduced the number and severity of hot flashes), Metoprolol (medication that treats high blood pressure), and Torsemide (medication that treats high blood pressure). On 11/17/2024 R3's medications were not all administered. Review of medication notes showed all the medications were refused by R1.
Record review of R1's progress notes, dated, 11/05/2024 through 11/27/2024, showed

there was no documentation that R1's physician was notified that R1 refused their medications on 11/17/2024.

Record review of an email sent to the Department on 01/22/2025, showed Staff B said the facility could not provide documentation to show that R1's physician had been notified of their refused medication on 11/17/2024.

R7

Record review of R7's, Face Sheet, dated 01/14/2025, showed R7 moved into the facility on [redacted]/2020 with multiple medical diagnosis which included [redacted] and [redacted]

Record review of R7's, "[Facility] Level of Care Evaluation Washington", dated 12/22/2024 showed R7 required staff assist with all their medications and treatments. R7 received their medications crushed. R7 received all their medications from the community pharmacy.

Record review of R7's, MAR, dated 01/01/2025 - 01/14/2025, showed R7 had orders for antiacid (medication that relieves indigestion and heartburn), baclofen (muscle relaxer), and quetiapine (medication that treats mental health disorders). On 01/05/2025 R7 missed their antiacid and baclofen medication, on 01/06/2025 R7 missed their antiacid, baclofen, and quetiapine medication, on 01/07/2025 R7 missed their antiacid and baclofen medication, and on 01/14/2025 R7 missed their quetiapine medication.
Review of medication notes showed all medications were missed because R7 had been asleep.

Record review of R7's progress notes, dated 01/02/2025 - 01/14/2025, showed there was no documentation that R7's physician was notified they missed their medication on 01/05/2025, 01/06/2025, 01/07/2025, and 01/14/2025.
The facility had been unable to provide any documentation to show that R7's physician had been notified R7's missed medication prior to 01/22/2025.

In an interview on 01/15/2025 at 1:49 PM, Staff B said it was the facility protocol that if a resident refused their medication three times, then they would notify the residents physician.

In an interview on 01/15/2025 at 3:16 PM, Staff K, Medication Technician, stated the medication technicians were expected to redirect and reoffer the resident's medications at least three different times if they had refused to take the medication. Staff K stated if the resident did refuse their medications, they would document it on the MAR as refused. Staff K stated they would not contact the physician if a resident refused their medications.

In an interview on 01/16/2025 at 3:52 PM, Staff I, Medication Technician, said if a resident refused a medication, then the facility staff would make a chart note about the refusal. Staff I said the resident's physician would not be notified about the refused medication unless it had been an ongoing concern. Staff I said the facility staff were not required to notify the residents physician every time they refused a medication.

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, HAMPTON SPECIAL CARE - TUMWATER is or will be in compliance with this law and / or regulation on (Date) 2-28-2025

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

Administrator (or Representative) MLA Date 2-5-2025

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 2 of 2 sampled staff (Staff F and Staff G) completed their continued education units (CEU). This failure placed all 44 of 44 residents at risk of receiving care and services from untrained and unqualified staff.

Findings included...

Washington Administrative Code (WAC) 388-112A-0611 "Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed (1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described in this section. (a) The following long-term care workers must complete 12 hours of continuing education by their birthday each year: (i) A certified home care aide; (ii) A long-term care worker who is exempt from the 70-hour home care aide basic training under WAC 388-112A-0090 (1) and (2); (iii) A certified nursing assistant"

WAC 388-110-220 "(3) In an assisted living facility with an enhanced adult residential care-specialized dementia care services contract, for residents served under that contract, the contractor must: (d) Ensure that each staff who works directly with residents has at least six hours of continuing education per year related to dementia, including Alzheimer's disease. This six hours of continuing education may be part of the ten hours of continuing education required by WAC 388-112[A]..."

Staff F

Record review of an untitled, and undated document, showed Staff F, Care Team, was hired at the facility on 11/22/2022 with their birthdate on November 29th.

Record review of Staff F's CEU's, dated 11/29/2023 - 11/29/2024, showed they had only completed nine hours with only two hours focused on dementia and Alzheimer's disease.

Staff G

Record review of an untitled, and undated document, showed Staff G, Care Team Medication Technician, was hired at the facility on 09/28/2022 with their birthdate on May 12th.

Record review of Staff G's CEU's, dated 05/12/2023-05/12/2024, showed they had only completed four hours with only one hour focused on dementia and Alzheimer's disease.

In an interview on 01/16/2025 at 3:46 PM, Staff B, Nursing Director, said they did not have any other CEU's to provide to review for Staff F and Staff G.

In an interview on 01/16/2025 at 3:10 PM, Staff B said they did not think Staff H, Business Office Director, had a system in place to track the facility staff CEU's.

Plan/Attestation Statement

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Administrator (or Representative) 2-5-2025 Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure all medications were stored and locked in a secure manner in 2 of 7 sampled resident rooms (Resident 1 [R1] and Resident 9 [R9]'s bathroom and room). The failure to secure

medications placed 44 of 44 residents at risk of access and potential ingestion of potentially harmful substances and presented risk for tampering with or misuse of medications by residents, staff, or visitors in the facility.

Findings included...

Record review of the facility's "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated showed 32 of 44 residents were labeled to have dementia (a condition that effects thinking, remembering, reasoning, and effects daily life)/Alzheimer's (condition causing memory loss and reduced functional abilities)/Cognitive Impairment (condition affecting thinking, memory, and decision-making).

Record review of the facility's policy titled, "Medication Storage", dated 05/20/2022, showed medications would be stored in a manner that ensured maintenance of both the integrity of the medication and the safety of all residents that resided in the community. Medication could not be administered to the resident unless there was a specific health care provider order from the physician and authorization from the pharmacy. The procedure section showed all medications which included over the counter medications would be kept in a locked storage at all times.

In an observation on 01/14/2025 at 2:14 PM, R1 and R9's bathroom showed in an unlocked cabinet was a box of Walgreens one ounce hydrocortisone cream with aloe (medication that treats skin conditions). On R9's side of the room on their nightstand next to their bed showed two packages of nine bubble pack circles that had a clear plastic film of them. One package had been completely empty. One package had three blue circular drops inside of the clear plastic film. The backside of the package read Biotene Lozenges (helped with dry mouth and freshens breath).

R1

Record review of R1's, "The [Facility] Level of Care Evaluation Washington", dated 12/27/2024, showed R1 had diagnosis of [redacted]. The facility staff assisted R1 with all medications and treatments. The document had been signed by Staff B, Nursing Director.

Record review of R1's, "Medication Administration Record (MAR)", dated 01/01/2025 - 01/14/2025, showed, R1 did not have an order for hydrocortisone cream with aloe or Biotene Lozenges.

R9

Record review of R9's, "The [Facility] Level of Care Evaluation Washington" dated, 01/11/2025, showed R1 had diagnosis of [redacted]. The facility staff assisted R9 with all medications and treatments. The document had been signed by Staff B.

Record review of R9's, "MAR", dated 01/01/2025 - 01/16/2025, showed R9 did not have and order for hydrocortisone cream with aloe or Biotene Lozenges.

In an observation and interview on 01/16/2025 at 12:09 PM, R1 and R9's bathroom showed in an unlocked cabinet was a box of Walgreens one ounce hydrocortisone cream with aloe. Staff J, Medication Technician, said the hydrocortisone cream was not on their medication pass. Staff J said they were unsure if the medication belonged to R1

or R9. Staff J said the facility would need an order for the hydrocortisone cream. On R9's side of the room on their nightstand next to their bed showed one package that had six of nine blue circular drops inside of the clear plastic film. Staff J said R9 had burning tongue (a condition where your tongue, roof of your mouth, or lips feel like they are burning) and R9's spouse brought them in. Staff J said they thought the lozenges were like cough drops but then noted a cough drop would be considered a medication that the facility would need an order for.

In an interview on 01/16/2025 at 12:19 PM, Staff I, Medication Technician, said hydrocortisone would be considered a medication because it was a topical cream that would be prescribed by a physician. Staff I said R1's spouse probably brought in the hydrocortisone cream. Staff I confirmed R1 did not have a current order to use hydrocortisone cream. Staff I said all medications within the facility should be stored in the medication carts. Staff I confirmed R9 did not have an order for lozenges. Staff I said R9's spouse brought in the medication. Staff I said if R9 wanted the lozenges at their bedside then their physician would have to provide an order that R9 could take the lozenges on their own.

In an interview on 01/16/2025 at 3:10 PM, Staff B, Nursing Director said R9's spouse brought in the lozenges for them.

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Administrator (or Representative) — Date: 2-5-2025

WAC 388-78A-2040 Other requirements.

(2) The assisted living facility must have its building approved by the Washington state fire marshal in order to be licensed.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to be in compliance with the Washington State Patrol Fire Protection Bureau for 1 of 1 kitchen review. This failure placed 44 of 44 residents' life and safety at risk in the event of a fire.

Findings included...

International Fire Code (IFC) 607.3.3 2018 "Hoods, grease-removal devices, fans, ducts and other appurtenances shall be cleaned at intervals as required by Sections 607.3.3.1 through 607.3.3.3."

Record review of the IFC table 607.3.3.1, "commercial cooking system inspection frequency showed all other cooking operations frequency of inspection was six months."

In an observation and interview on 01/14/2025 at 12:56 PM, in the kitchen, the service sticker on the kitchen's hood showed it was last services on 05/30/2024. Staff N, Dining Services Director, stated the kitchen's hood was to be services every six months. Staff N stated they noticed on 01/13/2025 that the hood was due to be serviced.

In an interview on 01/15/2025 at 11:55 AM, Staff E, Maintenance Technician, stated the hood cleaning was due in November 2024. Staff E stated they had not been aware the hood cleaning service had been their responsibility.

In an interview on 01/24/2025 at 12:02 PM, Staff A, Executive Director, stated when the facility changed management company the tracking process was no longer used causing the hood to be missed when it was due to be serviced. Staff A acknowledged that the kitchen's hood should have been serviced in November 2024.

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WAC 388-110-220 Enhanced adult residential care service standards.

(3) In an assisted living facility with an enhanced adult residential care-specialized dementia care services contract, for residents served under that contract, the contractor must:

(n) Ensure residents have access to their own rooms at all times without staff assistance; and

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to provide 7 of 7 sampled residents (Resident 1 [R1], Resident 8 [R8], Resident 5 [R5], Resident 7 [R7], Resident 2 [R2], Resident 10 [R10], Resident 6 [R6]) access to their room without staff assistance.

This failure impacted 44 of 44 residents' autonomy and quality of life.

Findings included...

R1

In an observation and interview on 01/14/2025 at 2:05 PM, R1's room door had been locked. At 2:10 PM, Staff E, Maintenance Technician, opened R1's room. Staff E said the resident doors at the facility had privacy locks. Staff E said the resident doors could be opened with any key. Staff E said the doors had privacy locks because some of the residents were wanderers and would wander into other resident rooms.

In an interview on 01/16/2025 at 8:36 AM, Collateral Contact 2 (CC2), R1's Power of Attorney, said R1's room door had been kept locked. CC2 said if R1 wanted to go in their room the facility staff helped R1 get in.

R8

In an observation and interview on 01/14/2025 at 2:08 PM, the Department knocked on R8's door. R8 answered to come in, but R8's door was locked. Staff C, Care Team, unlocked and opened R8's bedroom door. Staff C stated the facility kept all the resident's bedroom doors locked cause of other residents wandering into their rooms. R8 was unable to state if they preferred to have their door locked all the time.

R5

In an observation on 01/14/2025 at 2:24 PM, R5's room door had been locked. The facility staff had to open the door for the Department.

In an interview on 01/16/2025 at 10:15 AM, Collateral Contact 3 (CC3), R5's Power of Attorney, said R5's room door had been kept locked.

R7

In an observation on 01/14/2025 at 2:46 PM, R7's door had been locked. The facility staff had to open the door for the Department.

R2

In an interview on 01/15/2025 at 2:03 PM, Collateral Contact 4 (CC4), R2's Power of Attorney, said R2 did not have a key to their room. CC4 said all the doors at the facility had locks that could be unlocked with any key. CC4 said the facility staff gave R2 access to their room.

In an observation on 01/15/2025 at 3:35 PM, R2's door had been locked. The facility staff had to open the door for the Department.

R10

In an observation on 01/16/2025 at 12:24 PM, R10 asked the Department if they could open their door for them. The Department saw Staff E in the hallway nearby and asked Staff E to open R10's door. Staff E opened R10's door for R10.

R3

In an observation on 01/16/2025 at 11:53 AM, R3's bedroom door was locked. Staff O, Care Team, had to unlock and open the bedroom door to R3's room.

R6

In an observation and interview on 01/16/2025 at 11:41 AM, Staff J, Medication Technician, stated all the resident's bedroom doors were locked at all times. Staff J was observed to check R6's bedroom door handle that was locked. Staff J unlocked R6's bedroom door to enter the room.

In an interview on 01/16/2025 at 3:10 PM, Staff B, Nursing Director, acknowledged that the contract stated residents should be able to access their own rooms without staff assistance.

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WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 2 of 2 sampled staff (Staff F and Staff G) had submitted a new Washington state name and background check every two years. This failure placed 44 of 44 residents at risk for being cared for

by a staff member with a potentially disqualifying history.

Findings included...

Record review of the untitled and undated facility document that was a list of employees showed Staff F, Care Team, was hired at the facility on 11/22/2022.

Record review of Staff F's Interim Washington State Name and Date of Birth background check was completed on 11/21/2022.

Record review of Staff F's current Washington State Name and Date of Birth background check was completed on 01/14/2025. The background check was completed 64 days past the required time frame.

Record review of the untitled and undated facility document that was a list of employees showed Staff G, Care Team Maintenance Technician, was hired at the facility on 09/28/2022.

Record review of Staff G's Interim Washington State Name and Date of Birth background check was completed on 08/25/2022.

Record review of Staff F's current Washington State Name and Date of Birth background check was completed on 01/14/2025. The background check was completed 142 days past the required time frame.

In an interview on 01/16/2025 at 11:30 AM, Staff H, Business Office Director, stated they had a computer system that alerts them when a staff member was due to have an updated Washington State Name and Date of Birth background check completed. Staff H stated Staff G had been on leave of absence when their background check was required to be rechecked. Staff H stated Staff G's background check was not checked when Staff G returned to work.

In an interview on 01/16/2025 at 12:40 PM, Staff B, Nursing Director, said the facility did not have any policies related to background checks. Staff B said the facility followed Washington state laws and regulations.

Statement of Deficiencies	License #: 1579	Compliance Determination # 53078
Plan of Correction	HAMPTON SPECIAL CARE - TUMWATER	Completion Date
Page 36 of 36	Licensee: TROSPER ROAD LIMITED PARTNERSHIP	01/24/2025

Plan/Attestation Statement

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Administrator (or Representative) 2-5-2025 Date