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) 38079 (Completion Date 03/11/2024) and 34645 (Completion Date 01/03/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/11/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2600-2-a, WAC 388-78A-2600-2-f, WAC 388-78A-2600-2-j, WAC 388-78A-2600-2-j-i, WAC 388-78A-2600-2-j-ii, WAC 388-78A-2600-2-j-iii, WAC 388-78A-2600-2, WAC 388-78A-2600

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

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: HAMPTON SPECIAL CARE - TUMWATER **Provider Type:** Assisted Living Facility
License/Cert.#: 1579
Intake ID: 108990
Compliance Determination #: 34645
Region/Unit #: RCS Region 3 / Unit E
Investigator: Paul Aube
Investigation Date(s): 01/03/2024 through 01/03/2024
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/Treatment – Public report of resident falling in the facility and family being notified late.
2. Resident/Patient/Client Rights – Public report of resident fall in the facility not being reported to state.
3. Dietary Services – Public report of facility being unable provide foods to manage a diabetic diet.

Investigation Methods:

Sample:	Total residents: 46 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Family members Management
Record Reviews:	Facility policies Incident Log Incident investigation Progress Notes/Alert Charting Care Plans

Investigation Summary:

1. Quality of Care/Treatment – Facility investigated incident, and reported to appropriate parties. Facility failed to follow policy to send resident to be evaluated after resident was discovered to have a head injury. Failed practice identified.
2. Resident/Patient/Client Rights – Facility reported incident to appropriate parties. After review of progress notes, unable to substantiate claims of delay in notification to family.

3. Dietary Services – Per signed Disclosure of Services, facility does not provide "Calorie controlled diets for people with diabetes." No failed practice.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: HAMPTON SPECIAL CARE - TUMWATER **Provider Type:** Assisted Living Facility
License/Cert.#: 1579
Intake ID: 111980
Compliance Determination #: 34645
Region/Unit #: RCS Region 3 / Unit E
Investigator: Paul Aube
Investigation Date(s): 01/03/2024 through 01/03/2024
Complainant Contact Date(s):

Allegation(s):
Quality of Care/Treatment: Facility report of a resident-to-resident altercation in the community.

Investigation Methods:

Sample:	Total residents: 46 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Family members Management
Record Reviews:	Facility policies Incident Log Incident investigation Progress Notes/Alert Charting Care Plans

Investigation Summary:
Quality of Care/Treatment: Facility investigated incident, and monitored residents per policy. Facility failed to follow policy and notify law enforcement after one resident physically assaulted another resident. 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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800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 1579	Compliance Determination # 34645
Plan of Correction	HAMPTON SPECIAL CARE - TUMWATER	Completion Date
Page 1 of 6	Licensee: TROSPER ROAD LIMITED PARTNERSHIP	01/03/2024

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 01/03/2024 and 01/03/2024 of:

HAMPTON SPECIAL CARE - TUMWATER
1400 Trosper Rd SW
Tumwater, WA 98512

This document references the following complaint number(s): 108990, 111980

The following sample was selected for review during the unannounced on-site visit: 3 of 46 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI

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

01/10/2024
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.

Administrator (or Representative) 1-19-2024 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;

(f) In response to medical emergencies;

(j) To appropriately respond to aggressive or assaultive residents, including, but not limited to:

(i) Actions to take if a resident becomes violent;

(ii) Actions to take to protect other residents; and

(iii) When and how to seek outside intervention.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to implement and train staff on policies and procedures to address what staff persons must do in response to medical emergencies, and how to appropriately respond to aggressive or assaultive residents, for 3 of 3 residents (Resident 1 [R1], Resident 2 [R2], and Resident 3 [R3]) reviewed. These failures resulted in R1 experiencing a delay of care during a medical emergency, and R2 and other residents in the building being subject to further potential ongoing abuse from R3.

Findings included...

Review of a facility policy titled, "Fall Reduction Plan," last reviewed on 05/20/2022, stated, "If resident falls and strikes their head, there is a risk for a closed-head injury and, therefore, need to be sent to ER [Emergency Room] or seen by MD [Medical Doctor] for evaluation of the injury."

Review of a facility policy titled, "Incident Reports," last reviewed on 04/14/2021, stated, "All incidents related to physical abuse, neglect, sexual assault, or exploitation are reported to the ombudsman [an official appointed to investigate individuals' complaints against maladministration], state licensing agency, and in case of assault (physical or sexual) to law enforcement."

During an interview on 01/03/2024 at 10:45AM, Staff B, the Assistant Clinical Services

Director, was asked what staff were to do if a resident were to fall and hit their head. Staff B stated, "Caregivers are not to move the resident. They are to get the Med Tech [Medication Technician] right away. At that time, the Med Tech is supposed to ask the resident if they have any pain. If they have pain, [the staff] will notify the EMT's [Emergency Medical Technician]. If there is no pain, they will ask the resident if they hit their head. If the resident has no pain, and [says] they did not hit their head, they will help the resident off the floor." Staff B was then asked what staff persons should do if they suspected a head injury, or if there was a visual injury. Staff B stated, "[staff] would always notify the EMT's and not move the resident."

During an interview on 01/03/2024 at 11:55AM, Staff C, a Med Tech, was asked what they would do if a resident had fallen, and they suspected a head injury. Staff C stated, "For falls, I assess them on the floor for any injury, if they have a serious injury and it appears they hit their head, we will call 911. If it is something that is more serious, we would call immediately." Staff C was then asked who they would notify if there was a resident-to resident altercation where one resident physically assaulted another. Staff C stated, "For a resident-to-resident, we would do an incident report. It is what I believe to be called a sentinel event, so it gets reported to state. We would let [Staff A, the Clinical Services Director] know, and call family, and let doctors know." Staff C was then asked if anyone else would be notified. Staff C stated that they did not know who else would be notified. Staff C was informed that per facility policy, law enforcement should be notified for physical assault. Staff C was asked if they were familiar with this section in the policy. Staff C stated, "No, I did not know."

During an interview with on 01/03/2024 at 11:58AM, Staff D, a caregiver, was asked what they would do if a resident had fallen, and they suspected a head injury. Staff D stated, "You don't get them off the ground and call the med tech over to examine them. They will call the EMT's. If they are not bleeding, we would sit the resident up, but if bleeding or hurt, we would put a pillow under their head and wait for the EMT's to come and assess the resident before getting them up. Then at that point it will depend on the EMT's if they get sent out or not." Staff D was asked within what time frame the EMT's would be called, and Staff D stated, "Immediately. Situations like that we do not wait." Staff D was then asked who they would notify if there was a resident-to resident altercation where one resident physically assaulted another. Staff D stated, "I would report it to management. I would tell them what happened and what started it, and we would let the families know. We would also fax the doctor, but the Med Techs would do that." Staff D was asked if anyone else would be notified. Staff D stated, "I don't know." Staff D was informed that per facility policy, law enforcement should be notified for physical assault. Staff D was asked if they were familiar with this section in the policy. Staff D stated that they were not familiar.

<R1>
Review of R1's face sheet showed that R1 was admitted to the facility on [redacted]/2023.

Review of the facility incident log with dates ranging from 11/09/2023-01/02/2024, showed that R1 was involved in an incident on 12/02/2023 at 7:00AM.

Review of the Incident Report for R1, dated for 12/02/2023 at 7:00AM, under the "type of

Incident" it stated, "Skin Injury." Under section titled, "Describe what you saw and heard", it stated, "Resident came out of [their] bedroom and was going to the dining room. Resident stopped to have blood sugar taken and it was noticed that there was some bruising and a scrape on the upper left side of [their] forehead." Under the "Notifications" section of the incident report, "Emergency Services" was marked "No" as being notified.

Review of Progress notes for R1, dated 12/02/2023 at 7:25AM, stated, "Care staff brought resident out of [their] room after getting [them] dressed and [they] were brought to the writer before going into dining for breakfast to get [their] BS (Blood Sugar) taken. Care staff brought to writer's attention the bruising and skin abrasion to left side of forehead."

Review of the Progress Notes for R1 showed no documentation that EMT's were called, and no documentation that R1 was sent to the Emergency Room for the evaluation of R1's head injury.

Review of the Progress notes for R1, dated [redacted]/2023 at 1:35PM , showed, "[R1's POA, (Power of Attorney)] will be coming to the facility at [approximately] 3PM to take the resident to Urgent Care."

Review of Progress Notes for R1, dated [redacted]/2024 at 12:45PM, showed that the "Hospital reported that the resident had a hematoma (bleeding in the brain) ..."

During an interview with Staff B, the Assistant Clinical Services Director, on 01/03/2024 at 10:45AM, when asked to explain the circumstances behind R1's injury, Staff B stated, "[R1] went to the hospital for high blood sugars and came back to the facility. Later that morning, [staff] noticed the bruise [to R1's head]. [Staff E, (a Medication Technician)] was so concerned about the blood sugars and didn't really pay much attention to the bruise [on R1's head] at that moment. [Staff E] said [they] didn't notice it right away." Staff B was then asked why R1 was not sent out to the hospital immediately after the injury was discovered. Staff B stated, "[They] should have been."

<R2 and R3>

Review of R2's face sheet showed that R2 was admitted to the facility on [redacted]/2023.

Review of R3's face sheet showed that R3 was admitted to the facility on [redacted]/2023.

Review of the facility incident log with dates ranging from 11/09/2023-01/02/2024, showed that R2 and R3 were involved in an incident on 12/24/2023 at 4:50PM.

Review of Progress Notes for R2, dated 12/24/2023 at 5:08PM, showed, "Resident was in

the dining room when staff asked [R2] to move to different table. When [R2] stood up and bumped into another resident whom stabbed [R2] in the leg with a fork 2 to 3 times. Striking [R2's] right leg. Resident was moved away from other resident and sat down with staff. There is a small [puncture] wound with blood and redness." Further review of the progress notes showed no notation made regarding a report to law enforcement regarding the assault.

Review of the Incident Report for R2, dated for 12/24/2023 at 4:50PM, under "Type of Incident" it stated, "Resident to Resident altercation." Under the section titled, "What did you do?" it stated, "Resident was checked over and has a cut to [their] upper right thigh. Vitals taken and resident was moved away from another resident." Review of incident report did not list law enforcement notification under the "Notifications" section of the report.

Review of the Incident Report for R3, dated for 12/24/2023 at 4:50PM, under "Type of Incident" it stated, "Resident to Resident altercation." Under the section titled, "Describe what you saw and heard" it stated, "Resident was in the dining room when another resident walked by [them] and bumped into [their] right arm. Other resident stated sorry, and this resident stabbed other resident in the leg 2 to 3 times with a fork. When resident was asked why [they] stabbed the other resident [they] just mumbled and continued to eat dinner." Review of incident report did not list law enforcement notification under the "Notifications" section of the report.

Review of Progress Notes for R3 showed no documentation made regarding a report/notification to law enforcement regarding the assault.

During an interview with Staff B, the Assistant Clinical Services Director, on 01/03/2024 at 10:45AM, when asked to explain the circumstances behind R2 and R3's resident-to-resident alteration, Staff B stated, "My understanding is [R3] was already sitting at the table and [R2] bumped either [their] chair or [them], and [R3] got upset and as [R2] sat down, [R3] stabbed [R2] in the leg a couple of times with a fork. There was a puncture wound." Staff B was asked if law enforcement was called. Staff B stated, "No, law enforcement was not called, I didn't think we needed to do that." Notified Staff B that per facility policy, all physical assault should be notified to law enforcement. Staff B was asked if they would classify this as a physical assault. Staff B replied, "I guess I didn't look at it that way, but I see it now."

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) [redacted] 2-16-2024

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

Statement of Deficiencies	License #: 1579	Compliance Determination # 34645
Plan of Correction	HAMPTON SPECIAL CARE - TUMWATER	Completion Date
Page 6 of 6	Licensee: TROSPER ROAD LIMITED PARTNERSHIP	01/03/2024

Administrator (or Representative)

1-19-2024
Date