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) 41199 (Completion Date 05/13/2024) and 38922 (Completion Date 03/25/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/13/2024 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-2210-2, WAC 388-78A-2450-2-e

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

This document was prepared by Residential Care Services for the Locator website.

# Residential Care Services
## Investigation Summary Report

**Provider/Facility:** HAMPTON SPECIAL CARE - TUMWATER **Provider Type:** Assisted Living Facility
**License/Cert.#:** 1579
**Intake ID:** 122507
**Compliance Determination #:** 38922
**Region/Unit #:** RCS Region 3 / Unit E
**Investigator:** Phan Pham
**Investigation Date(s):** 03/25/2024 through 03/25/2024
**Complainant Contact Date(s):**

**Allegation(s):**
Quality of care - A staff administered a wrong insulin to Named resident.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 44<br>Resident sample size: 4<br>Closed records sample size: 0 |
| **Observations:** | Named resident, residents, environment, staff interactions with residents, staff members providing care and services, and safety measures. |
| **Interviews:** | Named resident, residents, and interdisciplinary team members. |
| **Record Reviews:** | Sampled residents and incident reports. |

**Investigation Summary:**
An investigation was conducted, and allegation identified in the intake related to medication services, care and services were reviewed. The assisted living facility failed to ensure insulin was being administered as ordered and the staff member followed professional standards of practice for medication administration to prevent medication error. Additional residents reviewed for care, services and safety had no concerns.

**Conclusion / Action:**

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

This document was prepared by Residential Care Services for the Locator website.

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 # 38922 |
| Plan of Correction | HAMPTON SPECIAL CARE - TUMWATER | Completion Date |
| Page 1 of 5 | Licensee: TROSPER ROAD LIMITED PARTNERSHIP | 03/25/2024 |

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 03/25/2024, 03/25/2024 and 03/25/2024 of:

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

This document references the following complaint number(s): 122507

The following sample was selected for review during the unannounced on-site visit: 4 of 44 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Phan Pham, Nurse Surveyor

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

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Cory Cisneros
Residential Care Services

04/01/2024
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.

This document was prepared by Residential Care Services for the Locator website.

| Statement of Deficiencies | License #: 1579 | Compliance Determination # 38922 |
|---|---|---|
| Plan of Correction | HAMPTON SPECIAL CARE - TUMWATER | Completion Date |
| Page 2 of 5 | Licensee: TROSPER ROAD LIMITED PARTNERSHIP | 03/25/2024 |

MMD 4-2-2024

Administrator (or Representative) 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 :

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

Based on observation, interview and record review, the assisted living facility failed to ensure insulin was being administered as ordered and the staff member followed professional standards of practice for medication administration to prevent medication error for 1 of 4 current sampled residents (Resident 1) reviewed for medication services. This failure placed Resident 1 at risk of harm from not receiving medications as ordered, and placed Resident 1 at risk of decreased quality of life.

Findings included...

Review of Resident 1's face sheet showed the resident admitted to the facility on [redacted]/2019 with diagnoses including [redacted].

Review of Resident 1's negotiated service plan, printed on 03/25/2024, documented Resident 1 required assistance with his activities of daily living and medication management.

Review of Resident 1's record showed on 11/16/2022 the resident had a physician order for Lantus (insulin) to be administered 30 units two times daily. On 10/12/2022 Resident 1's physician also ordered for Humalog (insulin) to be administered 6 units three times daily with meals.

Review of Resident 1's medication administration record, dated from 03/01/2024 to 03/25/2024, showed on 03/10/2024 at 7:30 PM, Resident 1 was given 30 units of Humalog insulin and Lantus insulin was not given.

Review of an incident investigation, dated 03/10/2024 at 7:00 PM, showed Staff B, Medication Tech, assisted the resident administering his insulin. Staff B gave the resident Humalog insulin 30 units instead of the Lantus and emergency medical services (EMS) were called. The EMS checked the resident's blood sugar upon arrival, and it was 280. The resident's blood sugar was rechecked within an hour, and it was 80. Staff summoned EMS

This document was prepared by Residential Care Services for the Locator website.

again for assistance and EMS gave the resident sugar tablets.

Review of WebMD website article, titled, "How Sugar Affects Diabetes", published date 01/18/2024, stated a normal blood sugar level was around 140 to 180 milligrams per deciliter (mg/dL) 1 to 2 hours after eating.

On 03/25/2024 at 09:34 AM, Resident 1 was observed in his bed and covered with blankets. Resident 1 stated he took medications and received injections daily and staff members assisted. Resident 1 was not able to provide additional information related to medication services and the incident.

In an interview on 03/25/2024 at 10:11 AM, Staff C, Medication Tech, stated she had gone through a nurse delegation process and demonstrated safe medication administration prior to independently providing medication assistance for residents. Staff C said she had been trained to check the physician's orders and ensure she had the right resident, medication, dosage, route, and time before administering a medication. Staff C stated she had been instructed to clarify with the Licensed Nurse when she had questions about an order and/or a medication.

In an interview on 03/25/2024 at 10:56 AM Staff A, Health Services Director, said the Medication Technicians have been taught to follow the five rights every time they gave residents medications. Staff A stated the Medication Technicians had completed the medication delegation training, met the medication administration requirements and had been observed for safe medication administration. Staff A she did medication observation routinely to ensure staff members followed the professional standards of practice and safe medication administration.

**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) ~~5-13-2024~~ 5-9-2024 MA

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

MA — 4-2-2024

Administrator (or Representative) — Date

**WAC 388-78A-2450 Staff.**

(2) The assisted living facility must:

(e) Ensure all resident care and services are provided only by staff persons who have the training, credentials, experience and other qualifications necessary to provide the care and services;

This document was prepared by Residential Care Services for the Locator website.

| Statement of Deficiencies | License #: 1579 | Compliance Determination # 38922 |
|---|---|---|
| Plan of Correction | HAMPTON SPECIAL CARE - TUMWATER | Completion Date |
| Page 4 of 5 | Licensee: TROSPER ROAD LIMITED PARTNERSHIP | 03/25/2024 |

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

Based on interview and record review, the assisted living facility failed to ensure staff person had current credential to provide care and services for one of one staff (Staff B) reviewed. This failure placed the residents at risk for care provided by unlicensed staff and services not being met.

Findings included...

Review of Resident 1's face sheet showed the resident admitted to the facility on [redacted]/2019 with diagnoses including [redacted].

Record review of Resident 1's negotiated service plan, printed on 03/25/2024, documented the resident required assistance with his activities of daily living and medication management.

Review of Resident 1's record showed on 11/16/2022 the resident had a physician order for Lantus (insulin) to be administered 30 units two times daily. On 10/12/2022 Resident 1's physician also ordered for Humalog (insulin) to be administered 6 units three times daily with meals.

Review of an incident investigation, dated 03/10/2024 at 7:00 PM, showed Staff B, Medication Technician, assisted Resident 1 with administering his insulin. Staff B gave Resident 1Humalog insulin 30 units instead of the Lantus insulin.

Review of Staff B's, personnel file on 03/25/2024 showed Staff B was hired on 04/05/2023 and had a Nurse Assistant Registered license that had expired 02/09/2024.

In an interview on 03/25/2024 at 10:11 AM, Staff C, Medication Tech, stated she received a renewal notification annually and it was her responsibility to maintain her credentials.

In an interview on 03/25/2024 at 10:56 AM Staff A, Health Services Director, said the assisted living facility's human resources office sent notifications to staff members who were due for their credential's renewal. Staff A stated staff members were responsible for maintaining their credentials and keeping them current.

**Plan/Attestation Statement**

This document was prepared by Residential Care Services for the Locator website.

| Statement of Deficiencies | License #: 1579 | Compliance Determination # 38922 |
|---|---|---|
| Plan of Correction | HAMPTON SPECIAL CARE - TUMWATER | Completion Date |
| Page 5 of 5 | Licensee: TROSPER ROAD LIMITED PARTNERSHIP | 03/25/2024 |

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) ~~5-15-2024~~ 5-9-2024

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

Administrator (or Representative) Date 4-2-2024

This document was prepared by Residential Care Services for the Locator website.