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) 51210 (Completion Date 12/04/2024) and 46165 (Completion Date 09/13/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/04/2024 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-2610-1, WAC 388-78A-2610-2-a, WAC 388-78A-2610-2-[redacted] WAC 388-78A-2610-2-d, WAC 388-78A-2610-2-f

The Department staff who did the on-site verification:
Anissa Bearden, 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

Residential Care Services
Investigation Summary Report

Provider/Facility: HAMPTON SPECIAL CARE - TUMWATER **Provider Type:** Assisted Living Facility
License/Cert.#: 1579
Intake ID: 142675
Compliance Determination #: 46165
Region/Unit #: RCS Region 3 / Unit E
Investigator: Anissa Bearden
Investigation Date(s): 08/26/2024 through 09/13/2024
Complainant Contact Date(s):

Allegation(s):
allegation facility had an infectious disease outbreak

Investigation Methods:

Sample:	Total residents: 38 Resident sample size: 6 Closed records sample size: 0
Observations:	Residents Dining Activities Resident care equipment Resident rooms Staff to resident interactions
Interviews:	Nursing staff Residents Housekeeping staff Laundry staff
Record Reviews:	Medical records Facility policies Staff training records

Investigation Summary:
after interview, observations, and record review, the facility failed to have PPE set up to ensure that it was not contaminated with infectious disease, they failed to ensure staff were protected and wore N95 respirators when they were providing care to infectious disease residents. The facility failed to have staff and implement proper hand hygiene during and infectious disease outbreak and the facility failed to report the infectious disease positive residents to the LHJ to get current guidance to minimize the spread of the infectious disease.

Conclusion / Action:

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

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Statement of Deficiencies	License #: 1579	Compliance Determination # 46165
Plan of Correction	HAMPTON SPECIAL CARE - TUMWATER	Completion Date
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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 08/26/2024 and 08/26/2024 of:

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

This document references the following complaint number(s): 142675

The following sample was selected for review during the unannounced on-site visit: 6 of 38 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Anissa Bearden, 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

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

09/25/2024
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Statement of Deficiencies	License #: 1579	Compliance Determination # 46165
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Administrator (or Representative) [signature] Date 9/26/2024

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;

(f) Report communicable diseases in accordance with the requirements in chapter 246-100 WAC.

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to implement infection control practices by staff not performing hand hygiene and not wearing correct personal protective equipment (PPE) in 2 of 2 areas (north and south side of memory care unit) during an infectious disease outbreak. The facility failed to report an infectious disease outbreak to the Local Health Jurisdiction (LHJ). The facility failed to follow and implement the Centers for Disease Control and Prevention (CDC) guidance for use and storage of PPE. These failures placed 38 of 38 residents and all staff members, and visitors at risk of being infected and continuing the spread of COVID-19 (Corona Virus Disease 2019-an infectious disease caused by a virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, sore throat, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death) during a COVID-19 outbreak.

Findings included...

"WAC 246-101-010 Definitions, abbreviations, and acronyms. The definitions, abbreviations, and acronyms in this section apply throughout this chapter unless the context clearly requires otherwise:... (26) "Local health jurisdiction" or "LHJ" means a county health department under chapter 70.05 RCW, city-county health department under chapter 70.08 RCW, or health district under chapter 70.46 RCW."

"WAC 246-101-101 Notifiable conditions- Health care providers and health care facilities... (2) The conditions identified in Table HC-1 are notifiable to public health authorities under this table and chapter." Table HC-1 showed that COVID 19 infections required notification to the Local Health Jurisdiction (LHJ).

Record review of the "Assisted Living Facility Guidebook, Partners in Protection", dated February 2018, under the section, "Appendix D other reporting requirements for assisted living facilities", showed communicable disease outbreak would be reported to the Department of Health and Social Services hotline. Under the section titled, "reporting guidelines for Assisted Living Facilities", showed communicable disease outbreak was required to be reported to the Local Health Department" and the Department of Social and Health Services Complaint Resolution Unit (CRU) hotline number.

Record review of the Department of Health's (DOH) document, titled, "COVID-19 Preparedness and Outbreak Control Checklist for Long Term Care Facilities," updated 04/24/2024, showed, "when to report...2 or more residents tested positive or probable for COVID-19 identified within 7 days." Under "Who to report to" it showed, "report to your LHJ (Local Health Jurisdiction) through established reporting processes."

Record review of the Centers of Disease Control document, titled, "about handwashing", dated 02/16/2024, showed many diseases and conditions were spread by not washing hands with soap and clean, running water. Handwashing with soap was one of the best ways to stay healthy. Handwashing could keep a person healthy and prevent the spread of respiratory and diarrheal infections. Germs could spread from person to person or from surface to people when a person touches their eyes, nose, or mouth with unwashed hands, if a person touches surfaces or objects that have germs on them, blow their nose, cough, or sneeze into their hands and then touch other person's hands or common objects. Hands were to be washed often.

Record review of the CDC's 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 antiseptic hand rub. When a healthcare worker cleans their hands it reduces the potential spread of deadly germs to patients, spread of germs that include ones that were resistance to antibiotics, and reduces the risk of healthcare personnel from being infected from germs received from the patient. Healthcare workers were to clean their hands before touching a patient, before moving from work from soiled to clean, after touching a patient or patient's surrounding, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal. Healthcare works were to wash their hands with soap and water when their hands were visibly soiled.

Record review of the CDC document titled, "Transmission-based precautions", undated, showed standard precautions applied to all care activities regardless of suspected or confirmed infection status. Transmission based precautions were added measures to prevent the spread of disease from patients with known or suspected disease. PPE use for contact precautions include the gown and gloves available at entry point, before contact with a patient or patients' environment. All PPE would be removed at the point of exit with prompt hand hygiene. Under the section titled, "airborne infection isolation", showed it helped prevent transmission of infectious agents that were very small and remain viable and suspended in the air over long distances. Anyone that entered the room was to wear an N95 respirator or powered air purifying respirator before entry to the room or areas where they may be airborne infectious disease. Residents were to be limited to transport and movement outside of their room and the infectious area must be contained or covered. Indirect contact occurred when a health care worker was in the patient's environment or surroundings that may be

contaminated. Contact with a patient's surroundings may be overlooked as a means of spreading infection.

Record review of the facility provided document titled, "In service sign-in sheet", dated May 2024, showed it was an in-service (training) for staff that covered the sequence for putting on PPE and how to safely remove PPE. There were 22 staff members that had attended the in-service. Attached to the document was the CDC's document title, "Sequence for putting on PPE", undated, showed use safe work practices to protect yourself and limit the spread of contamination by limit surfaces touched and perform hand hygiene. The CDC document under the section titled, "how to safely remove PPE", showed all PPE was to be removed before exiting the infectious resident's room except a respirator, if worn. The respirator was to be removed after leaving the infectious resident's room and closing the door. Perform hand hygiene between steps if hands become contaminated and immediately after removing all PPE.

Record review of the facilities document title, "In-service sign-in sheet", dated May 2024, showed it was a staff in-service for "Infection control, what to do in COVID outbreak, hand washing". The in-service covered hand washing and use of hand sanitizer, when to use PPE, how to put on and take off PPE, what to do when entering a COVID positive room, and how to control the spread of infection. Attached to the in-service document there was a document that was titled "How to wash your hands", undated, showed hands were to be wet, soap applied, hands rubbed together on all parts of each hand then rinsed and thoroughly dried with a towel. There was a document that was titled, "definitions", undated showed hand hygiene was a general term that applied to either performing handwashing and alcohol-based handrub. Handwashing with soap and water remained a sensible strategy for hand hygiene in non-healthcare setting and was recommended by CDC and other experts.

Record review of the facility provided document titled, "indications for hand hygiene", undated, showed hand hygiene was to be performed when hands were visibly dirty, contaminated, or soiled. If a persons hands were not visibly soiled, then use an alcohol-based handrub for routinely decontaminating hands.

Record review of the facility provided document, titled, "specific indications for hand hygiene", undated, showed hand hygiene was indicated before patient contact, after contact with patient's intact skin, removing of gloves, and non-intact skin. Gloves should be worn when a health care worker had contact with blood or other body fluids in accordance with universal precautions.

Record review of the facility policy, titled, "COVID-19 policy and procedure", updated 11/01/2022, under the section titled "resident placement", showed employees entering the room of a resident with suspected or confirmed COVID-19 infection should adhere to Standard Precautions and use of a NIOSH- approved respirator with N95 filters or higher, gown, gloves, and eye protection. Respirators should be used in the context of a comprehensive respiratory protection program that was in accordance with the Occupational Safety and Health Administration (OSHA) respiratory protection standard.

Record review of the facility policy, titled, "preventing transmission of infection", dated 03/26/2021, showed handwashing was the most important infection control measure in the community. The letter showed that full personal protective equipment (PPE) was to be used when caring for residents known to be positive for COVID-19 that included appropriate respiratory protection, eye protection, gown, and gloves.

LHJ

Record review of the public health and social services department document, titled, "initial COVID-19 guidance letter for long-term care facilities", dated 08/23/2024, showed it was sent to Staff B, Health Services Director. The document showed the facility was declared in an outbreak status for COVID-19.

Record review of the Departments database, showed on 08/13/2024 at 3:26 PM, the facility reported there were four residents that tested positive with COVID-19. The facility reported that they notified the physician and families. There was no documentation that the local LHJ was notified.

In an interview on 08/23/2024 at 1:29 PM, Collateral Contact 1 (CC1), County's Local Health Jurisdiction, stated they were unaware that the facility had COVID-19 positive residents. CC1 stated the facility did not have any guidance provided to them for the COVID-19 positive residents and current guidance to prevent further spread of contagious virus.

In an observation on 08/26/2024 at 9:45 AM, on the entry doors to the facility was a sign that showed that the facility had COVID-19 positive residents.

Record review of the facility provided untitled and undated document that was a list of residents, showed there were 15 residents that had tested positive for COVID-19.

In an interview on 08/26/2024 at 9:51 AM, Staff B stated they had faxed a document titled, "Washington state COVID-19 Point of Care Test Result Report Form", submit dated 08/14/2024, to the Washington state Department of Health. Staff B stated they received a call from the LHJ on 08/23/2024 and received guidance for the COVID-19 outbreak that day.

Hand Hygiene

In an observation on 08/26/2024 at 10:19 AM, Staff C, Caregiver, entered the hallway with a rolling cart with cups that had food inside. Staff C was observed to pass out the cups of food to the residents that sat in the hallways that were positive with COVID-19. Staff C wore a surgical mask when they were less than three feet from the residents. Staff C was observed to grab R1's wheelchair and move them to the table in the hallway by their bedroom door and handed them a cup of food to eat. Staff C walked back to the rolling cart with the cups of food. Staff C was not observed to wash their hands or use hand sanitizer after they touched R1's wheelchair. Staff C passed out other cups of food to three other residents that sat in the hallway. Staff C was not observed to wash their hands or use hand sanitizer during the entire observation. At 10:23 AM, Staff C walked into the dining room where many residents that were not infected with COVID-19 sat and ate a snack. Staff C dropped off the rolling cart and walked to the medication cart. Staff C picked up a pair of pants and looked at them. An unknown named female resident walked up to Staff C and were talking about the pants. Staff C was less than a foot from the female resident while they were talking about the pants. As of 10:27 AM Staff C had not washed their hands or used hand sanitizer.

In an observation and interview on 08/26/2024 at 10:27 AM, upon entering the left side

of the facility, there were two residents, Resident 2 (R2) and Resident 3 (R3), that were sitting at a table together eating a snack. R2 was heard to sniff and cough at times. R3's apartment door had a sign that was posted that showed R3 was in quarantine and required use of PPE to enter the room. At 10:28 AM, Staff D, Licensed Practical Nurse, walked down the hallway with a full PPE cart. Staff D unlocked R3's apartment door. Staff D opened the door and walked inside with the PPE cart and placed it inside the room to the right of the door. Staff D reached behind the door and locked the door handle. Staff D shut the apartment door and walked down the hallway back into the dining room. Staff D was not observed to wash their hands or use hand sanitizer after they left R3's room. At 10:38 AM, Staff D stated they put the PPE cart in R3's room as R3 had just tested positive in the hospital on 08/19/2024 with COVID-19. During the interview at 10:55 AM, Staff D walked away to help an unknown named female resident that was done with their snack. Staff D grabbed the snack cup with one hand and placed their other hand on the unknown named female resident's shoulder. Staff D still had not washed their hands or used hand sanitizer since being in R3's COVID-19 positive room. Staff D stated they did not have any hand sanitizer on them to use. Staff D stated they would need to wash their hands when they left a resident's room, after touching or performing personal care for a resident, after returning from a break, before meals, and anytime they were soiled. Staff D at 10:52 AM, stated they needed to wash their hands.

PPE

In an interview on 08/26/2024 at 9:51 AM, Staff B stated the staff wore surgical masks when they were out in the common areas and hallways of the facility. Staff B stated there were no COVID-19 positive residents that had any symptoms of coughing, stuffy or runny nose, no stomach issues, and no respiratory concerns, only experienced being extremely tired. Staff B stated on the doors there were signs posted that indicated the resident was positive with COVID-19.

In an observation on 08/26/2024 at 10:18 AM, Resident 1's room had a sign on the door that showed they were quarantined and required use of personal protective equipment (PPE). There were no PPE carts or PPE supplies available at R1's apartment door for use. In the same hallway there were three other resident rooms that showed they were quarantined and required use of PPE supplies to enter the room. All three rooms did not have PPE carts or supplies outside of the room for staff and visitors available for use.

In an observation on 08/26/2024 at 10:19 AM, Staff C was in the same hallway passing out snacks to the COVID-19 positive residents. Staff C was wearing a surgical mask when they were less than three feet from the residents. Staff C was observed to grab R1's wheelchair and move them to the table that was by their bedroom door and set them up with the snack.

In an observation and interview on 08/26/2024 at 10:27 AM, upon entering the left side of the facility in the back hallway by the kitchen door, there were two residents, R2 and R3, that were sitting at a table together eating a snack. R2 was heard to sniff and cough at times. R3's apartment door had a sign that was posted that showed R3 was in quarantine and required us of PPE to enter the room. At 10:28 AM, Staff D, Licensed Practical Nurse, walked down the hallway with a full PPE cart in their hands. Staff D unlocked R3's apartment door. Staff D opened the door and walked inside with the PPE cart and placed it inside the room to the right of the door. Staff D reached behind the door and locked the door handle. Staff D shut the apartment door and walked down the

hallway back into the dining room. Staff D was not observed to wash their hands or use hand sanitizer after they left R3's room. At 10:38 AM, Staff D stated they put the PPE cart in R3's room as R3 had just tested positive in the hospital on 08/19/2024 with COVID-19. Staff D stated they kept the PPE carts in the COVID-19 positive resident's rooms. Staff D stated other dementia residents in the community would get into the PPE carts and removed the PPE supplies and the reason to keep the PPE carts in the rooms. Staff D stated all the residents in the hallways were COVID-19 positive and all the residents that were in the dining room were negative for COVID-19. Staff D stated when they would need to enter the COVID-19 positive resident's room, they would open the door, open the PPE cart in the room and remove their gown, N95 respirator, gloves, and face shield. Staff D stated they would put the PPE on just outside the room. Staff D stated after they were done with their PPE, they would remove their gown, gloves, N95 respirator, and face shield while inside the resident's room at the door and discard in a red biohazard trash bag. Staff D stated they would grab a new surgical mask in the PPE cart, that was in the COVID-19 positive residents' room and put it on before returning to the hallway. Staff D stated they did this process in the room to ensure not to cross contaminate. Staff D stated they were required to wear a surgical mask when they were in the common and hallway areas of the facility. Staff D stated they were keeping the COVID-19 positive residents separated from the COVID-19 negative residents as much as possible. Staff D stated all the residents that tested positive with COVID-19 had signs posted on their doors that showed they were in quarantine and required use of PPE before entering the room.

In an interview on 08/26/2024 at 10:55 AM, Staff E, Caregiver, stated they wore surgical masks in the hallways and common areas of the facility. Staff E stated they would change into an N95 respirator before going into a COVID-19 positive resident's room. Staff E stated all the carts with the PPE supplies to put on to care for a COVID-19 positive resident were stored inside the resident's room by the door. Staff E stated they removed their gloves, gown, N95 respirator and face shield, when they were still inside the COVID-19 positive resident's room at the door. Staff E stated they would grab a new surgical mask that was stored in the PPE cart inside the COVID-19 resident's room and put it one before they exited the COVID-19 positive resident's room.

In an interview on 08/26/2024 at 11:05 AM, Staff F, Caregiver, stated all the PPE supplies to put on to care for a COVID-19 positive resident were located inside the resident's apartment door.

In an interview on 08/26/2024 at 11:14 AM, Staff B stated staff were to bring a PPE cart to resident rooms that were positive for an infectious disease. Staff B stated staff would get extra personal PPE supplies and restock the cart in the room. Staff B stated the staff do not remove the PPE cart until the resident was completed with their quarantine and no longer were positive for infectious disease. Staff B stated all PPE carts were stored inside of the positive resident's room by the door. Staff B stated all staff were required to wear N95 respirator, gown, gloves, and face shield when they entered a positive COVID-19 resident's room. Staff B stated staff would open the COVID-19 positive residents' door, retrieve all of their PPE supplies from the PPE cart inside the resident's room and put them on just outside the resident's door. Staff B stated all the staff were to remove all their PPE off that included their gowns, N95 respirators, gloves, and face shield inside the resident's room. Staff B stated staff would get a new surgical or KN95 mask from the PPE cart inside the COVID-19 positive resident's room before they left.

In an observation and interview on 08/26/2024 at 11:25 AM, Staff G, Housekeeping, was

observed to be pulling a rolling rack with clean clothes. Staff G wore a surgical mask. Staff G walked by R1 sitting in the hallway in their wheelchair. Resident 4's (R4) room that had a sign that showed R4 was quarantined and required anyone who entered the room to wear an N95 respirator, gown, gloves, and face shield upon entering the room. Staff G entered R4's room while only wearing a surgical mask and delivered the clothes. Staff G locked R4's inside door handle and exited R4's room. Staff G did not put on PPE before they entered R4's room. Staff G grabbed the clothing rack and pulled it further down the hallway. Staff G was not observed to wash their hands or use hand sanitizer after they left R4's room. Staff G grabbed more clothes from the rack, reached into their pocket and pulled their keys out. Staff G unlocked the door to Resident 5 (R5)'s room. R5's door had a sign posted that showed R5 was quarantined and required anyone who entered the room to wear an N95 respirator, gown, gloves, and face shield upon entering the room. Staff G unlocked R5's door and entered with the clean clothes. Staff G came out of R5's room reached to the inside, locked the door handle and shut the door. Staff G pulled the rolling clothing rack further down the hallway. Staff G did not put PPE before they entered R5's room. Staff G was not observed to wash their hands or use hand sanitizer they left R5's room. Staff G entered Resident 6's (R6) room and delivered clothes. There was no sign posted on R6's door. Staff G came out of R6's room and Staff G grabbed the rolling clothes rack to continue to deliver the resident clothes. Staff G was not observed to wash their hands or use hand sanitizer. Staff G stated they did not have any hand sanitizer on for them to use. Staff G stated they had left their hand sanitizer in the laundry room. Staff G stated they were unaware if they needed to wear PPE or an N95 respirator when they entered a COVID-19 positive residents' room. As of 11:33 AM, Staff G was not observed to wash their hands or use hand sanitizer. This was an uninterrupted observation.

In an observation on 08/26/2024 at 11:34 AM, Staff E, Caregiver, opened R4's room and walked in. Just inside of R4's room was a PPE cart. Staff E opened the top drawer of the PPE cart that had a bottle of hand sanitizer, a box of N95 respirators, foot/shoe coverings, and an open package of surgical masks. In the second drawer there was a package of face shields and in the third drawer there was an opened package or disposable gowns. Staff E stated the caregivers would get extra PPE supplies and restock the PPE carts when supplies were low. Staff E stated in some of the COVID-19 positive resident's rooms, they would keep extra PPE supplies in the bathroom under the sink cabinet.

In an interview on 08/28/2024 at 9:22 AM, CC1 stated their department was not the same as the Washington State Department of Health. CC1 stated all long-term care facilities were to report infectious disease cases to the local county's public health department or the local health jurisdiction so the facilities could get the most up to date guidance to minimize the spread of the infectious disease. CC1 stated PPE supplies were always to be stored outside of the room of a resident positive with an infectious disease that required use of PPE. CC1 stated residents were to remain in their rooms for isolation or staff would need to wear N95 respirators around the residents in the common areas to prevent the staff and other residents being contaminated with the infectious disease.

In an interview on 09/13/2024 at 12:35 PM, Staff B stated they only called the Washington State Department of Health (DOH) and followed the guidance on DOH's website. Staff B stated that care staff that wore a surgical mask around the COVID-19 positive residents that were in the hallways of the facility were not properly protected from the COVID-19 infectious virus.

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Plan of Correction	HAMPTON SPECIAL CARE - TUMWATER	Completion Date
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This is a recurring deficiency previously cited on 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) ~~11/7/2024~~ 10/28/2024

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

Administrator (or Representative) 9/26/2024 Date