STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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) 72543 (Completion Date 02/06/2026) and 68883 (Completion Date 12/11/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/06/2026 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-2210-1-b, WAC 388-78A-2210-1, WAC 388-78A-2210-2, WAC 388-78A-2210, WAC 388-78A-2120-1, WAC 388-78A-2120-2, WAC 388-78A-2120-2-a, WAC 388-78A-2120-2-b, WAC 388-78A-2120-3, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-4, WAC 388-78A-2120

The Department staff who did the on-site verification:
Celeste Vashey, ALF LTC Licensor
Pamela Horlick, NCI RN Complaint Investigator

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley RN

Clinton Fridley, Community Nurse 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: 201122
Compliance Determination #: 68883
Region/Unit #: RCS Region 3 / Unit E
Investigator: Pamela Horlick
Investigation Date(s): 11/18/2025 through 12/11/2025
Complainant Contact Date(s):

Allegation(s):

Quality of Care/Treatment: Facility failed to follow doctors orders by not obtaining and administering the medication as prescribed. Failed practice identified.

Investigation Methods:

Sample:	Total residents: 42 Resident sample size: 3 Closed records sample size: 1
Observations:	Identified resident Residents Activities Dining Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Family members Nursing staff Health care provider executive director
Record Reviews:	State reporting log Incident investigation Facility policies Medication Administration records Progress Notes Care Plan Medication Orders Resident Handbook Packing/delivery slip After visit summary Staff List

Investigation Summary:

Quality of Care/Treatment: Facility failed to follow doctors orders by not obtaining

and administering the medication as prescribed. Failed practice identified.

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: 200837
Compliance Determination #: 68883
Region/Unit #: RCS Region 3 / Unit E
Investigator: Pamela Horlick
Investigation Date(s): 11/18/2025 through 12/11/2025
Complainant Contact Date(s):

Allegation(s):

1. Resident/Patient/Client Neglect: Report of resident not getting their medication.
2. Pharmaceutical Services: Report of resident not getting their medication.

Investigation Methods:

Sample:	Total residents: 42 Resident sample size: 3 Closed records sample size: 1
Observations:	Identified resident Residents Activities Dining Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Family members Nursing staff Health care provider executive director
Record Reviews:	State reporting log Incident investigation Facility policies Medication Administration records Progress Notes Care Plan Medication Orders Resident Handbook Packing/delivery slip After visit summary Staff List

Investigation Summary:

1. Resident/Patient/Client Neglect: Facility failed to follow doctors orders by not

obtaining and administering the medication as prescribed. Failed practice identified.
2. Pharmaceutical Services: Facility failed to follow doctors orders by not obtaining and administering the medication as prescribed. Failed practice identified.

Conclusion / Action:

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

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

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 11/18/2025 and 11/24/2025 of:

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

This document references the following complaint number(s): 200837, 201122

The following sample was selected for review during the unannounced on-site visit: 3 of 42 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator
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

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.

Clinton Fridley RN
Residential Care Services

12/23/2025
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)

12/24/25
Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(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 interview and record review, the facility failed to ensure residents medications were administered as ordered for 2 of 3 sampled residents (Resident 1[R1] and Resident 3 [R3]). This failure resulted in residents not receiving medications as prescribed and contributed to R1 having altered mental status and being hospitalized and R3 for medical complications.

Findings included...

Record review of the facility policy titled, "Psychotropic Medications," updated 05/20/2022, showed psychotropic medications were to be given in a safe manner according to the physician orders. The community would minimize the use of psychotropic medications when possible. The clinical services director established routine psychotropic medication audits to ensure appropriate use and dosages of medications were being monitored.

Record review of the facility policy titled, "Medication Refills," dated 05/2022, showed

medication refills will be obtained in a timely manner to ensure residents will have all physician ordered medication available. The designated staff person contacts the dispensing pharmacy to obtain a refill at least seven (7) days prior to running out of a medication, unless medication is on a cycle fill with the pharmacy. When the medication is ordered it is entered in the eMAR (electronic medication administration record). Medications are never allowed to run out unless directed to by the physician.

Record review of the facility policy titled, "Medication refusal and/or Missed Doses," updated 05/20/2022, showed steps would be taken to avoid missed medications to prevent adverse reactions. Missed medications would be documented in the resident's medication record and the prescribing physician would be notified. The physician instructions related to the missed dose would be followed.

Record review of the facility document titled, "Disclosure of Services Required by RCW 18.20.300," revised 01/2023, showed there was an in-house pharmacy that followed the community's policy and procedure. All medications must arrive in a timely manner per state regulations, or the community would order from the in-house pharmacy, and the family would be billed for the cost.

R1

Record review of R1's Face Sheet, undated, showed R1 moved into the facility on [redacted]2025 with diagnoses including [redacted] and [redacted].

Record review of R1's service agreement, dated [redacted]/2025, showed that R1 suffered hallucinations and was unable to determine dangerous situations. Care staff and the nurse supported and monitored R1 and if any changes occurred, the clinical service director would be notified.

Record review of R1's physician orders showed on 09/17/2025 a new order for quetiapine (antipsychotic medication used to treat mental health conditions) 50 milligrams (mg) take one tablet by mouth daily for seven days, then two tablets daily for 30 days. On the bottom right hand corner of the order was a handwritten date of 09/17/2025 and Staff B, charge nurse, noted receipt of the order.

Record review of a facility provided packing slip, dated 09/17/2025, showed the facility only received R1's quetiapine for seven days. The order for R1's 30-day supply was not received by the facility.

Record review of R1's medication administration record (MAR), dated 09/2025, showed

from 09/18/2025 through 09/23/2025, R1 received one tablet of quetiapine daily. R1 did not receive the seventh dose, on 09/24/2025, to complete the seven-day part of the order.

Record review of R1's MAR, dated 09/2025, showed R1 did not receive quetiapine on 09/24/2025 or 09/25/2025. R1's MAR showed R1 received two 50 mg tablets of quetiapine on 09/26/2025 and 09/27/2025 to begin the 30-day part of the order. R1's MAR shows that they did not receive any further doses of quetiapine on 09/28/2025, 09/29/2025, 09/30/2025 and 10/01/2025.

Record review of a facility provided packing slip, dated 10/01/2025, showed the facility received R1's 30-day supply of quetiapine.

Record review of R1's MAR, dated 10/2025, showed R1 received two 50 mg tablets of quetiapine from 10/02/2025 through 10/24/2025 for a total of 23 days, not the full 30 days as ordered.

Record review of R1's progress notes, dated 11/04/2025 at 10:37 AM, showed R1 informed the medication technician that they had anxiety and felt "crazy". At breakfast R1 threw the silverware and their drinks and stated they could not help their behavior.

Record review of R1's progress notes, 11/04/2025 at 12:08 PM, showed that R1 threatened to hurt themself and others and was taken to the hospital.

In an interview on 11/24/2025 at 4:01 PM, Collateral Contact 1 (CC1), R1's power of attorney, stated they received a call from the facility on 11/04/2025 stating R1 was in crisis and talking about hurting themself. CC1 stated they arrived at the facility and observed R1 hitting the nurse. CC1 stated R1 stated they were nuts and they were having a nervous breakdown. CC1 stated while they took R1 to the hospital R1 opened the door of the moving car on the freeway and attempted to jump out. CC1 stated R1 then tried to take the keys out of the ignition and tried to put the car in "park" while they drove down the freeway. CC1 stated they were very scared that they could have swerved into another car while trying to prevent R1 from jumping from the moving car.

Record review of R1's "After Visit Summary," dated 11/04/2025, showed R1 was evaluated in the Emergency Room for suicidal thoughts and altered mental status.

In an interview on 11/18/2025 at 12:47 PM Staff B stated that they saw the order for R1's order containing two medications and that they dated and signed receipt of the order. Staff B stated they processed the order. Staff B stated they should have gotten both medications the next day. Staff B stated they did not receive both medications and that the med tech's should have contacted the pharmacy and let Staff B know that the order for the 30-day supply was not received. Staff B stated they were never informed by the

med tech's that it had not arrived. Staff B stated they relied on the med techs to relay information related to when a medication was not received from the pharmacy. Staff B stated it was not acceptable that R1 had a lapse between the two orders of medications. Staff B stated the 30-day supply of quetiapine should have started on 09/25/2025, immediately after the seven-day part of the order was completed, but the order was not started until 10/02/2025. Staff B stated the order was not adjusted to account for the delay in the start of the medication. Staff B stated they were responsible for adjusting the end date. Staff B stated R1 should have gotten their seven-day dose of quetiapine with the 30-day dose of quetiapine to immediately follow. Staff B stated they should have caught the mistake sooner. Staff B stated they should have extended the date to ensure the entire 30-day order was completed.

R3

Record review of R3's Face Sheet, undated, showed R3 moved into the facility on [redacted]/2022 with diagnoses including [redacted].

Record review of R3's service agreement, dated 09/26/2025, documented that if R3 was agitated, care staff would support and monitor R3 and report changes or problems to the clinical services director. R3 could not safely administer their medications. R3's medications would be administered safely, correctly, and timely manner 100% of the time per the physician order to maintain therapeutic effectiveness. The nurse, RCC (resident care coordinator), medication technician, or the designee were to notify R3's power of attorney that medications should be re-ordered. If R3's personal supply was not available, the community would notify the pharmacy and request the medication, which would be billed to R3's power of attorney. R3 showed an increase in how much they slept and medications had been decreased in hopes to stop their lethargy (a state of unusual drowsiness, lack of energy, and mental sluggishness).

R3 Duplicated Medication

Record review of R3's, MAR, dated 10/01/2025 through 10/31/2025, showed R3 had two orders for quetiapine 25 mg tablet twice daily entered into the MAR. R3 received 50 mg of quetiapine twice daily between 10/28/2025 through 10/31/2025, for a total of four days.

Record review of R3's, MAR, dated 11/01/2025 through 11/18/2025, showed R3 had two orders for quetiapine 25 mg tablets twice daily. R3 received 50 mg of quetiapine twice daily between 11/01/2025 through 11/07/2025, for a total of seven days.

Record review of R3's Medication Incident Report, dated 11/21/2025, showed R3 had a wrong dosage of quetiapine administered with noted side effects observed including drowsiness and irritability. R3 received double dosage of quetiapine twice daily from

10/27/2025 through 11/07/2025 because there had been a duplicate order in the MAR.

On 11/24/2025 at 11:00 AM, Staff A stated they did not think the facility conducted psychotropic medication audits. Staff A said they would follow up.

On 11/24/2025 the Department requested all fax correspondence with R3's PCP from October 2025 through November 2025.

R3's records, as of 11/24/2025, showed no documentation that R3's PCP had been notified about the medication error involving the double dose of quetiapine.

As of 11/25/2025 there had been no fax documentation to review that R3's PCP had been notified when they received double doses of quetiapine medication.

In a joint interview on 11/18/2025 at 2:25 PM, Staff A stated that R3 received a double dose of their quetiapine order due to an error. Staff A stated a manual order was inputted in the system and the pharmacy inputted an order as well. Staff B stated the system should have flagged them that there were duplicate orders. Staff A stated they should have discontinued the manual order and that R3 should not have gotten the order from 10/24/2025 through 11/07/2025. Staff B was asked who should have noticed R3 was getting a double dose of quetiapine, they stated any of the med techs should have come to Staff B and told them that there was a duplicate order. Staff B stated they worked the cart on 11/07/2025 and saw that there was a duplicate order for the quetiapine. Staff B stated they discontinued the duplicate order thinking it was a misprint. Staff B stated they did not look back to see if R3 received a double dose of the quetiapine and they should have.

R3 Missed Medication

Record review of an untitled document, dated 10/31/2025, showed R3's PCP stated to encourage R3's fluid intake because they had two UTI (urinary tract infections) in October. R3's PCP ordered R3 to take one tablet of trimethoprim-sulfamethoxazole (an antibiotic medication that treats bacterial infections) medication twice daily by mouth for five days, cranberry pills, and vitamin C.

Record review of R3's MAR, dated 11/01/2025 through 11/18/2025, showed R3 had not started the trimethoprim-sulfamethoxazole medication. R3 started the cranberry pills and vitamin C on 11/13/2025.

Record review of R3's progress notes, as of 11/17/2025, showed no documentation that R3's PCP and power of attorney were notified that R3 received double dosages of quetiapine or missed the trimethoprim-sulfamethoxazole, cranberry pills and vitamin C.

medications.

In an interview on 11/18/2025 at 2:25 PM, Staff B stated there was an order written on 10/31/2025 for R3 to receive an antibiotic for a urinary tract infection (UTI). Staff B stated they were unable to administer the medication to R3 due to them having an allergy to the medication. Staff B was asked what was done to obtain a new medication, they stated nothing was done. Staff B stated the process was for our RCC's to go through the binder and make sure the faxes were answered. Staff B stated the fax was not answered. Staff B stated someone should have followed up to get the new medication sooner. Staff B was asked if waiting 18 days was entirely too long to wait to get an antibiotic, they stated yes. Staff B stated they should have gotten it within 3-4 days. Staff B stated as of today, R3 had not started a new medication for their UTI. Staff B stated nobody followed up with R3's POA to find out the status of the medication. Staff B stated the ball got dropped.

On 11/24/2025 at 12:17 PM, Staff C, Medication Technician/Caregiver, stated they were unsure when R3's UTI started.

In an interview on 11/24/2025 at 11:00 AM, Staff A stated if residents used the in-house pharmacy, then the facility would be responsible for obtaining and administer the residents medication. Staff A referenced the facility disclosure of services and stated if a resident used a different pharmacy, then their family would be responsible to bring the facility the residents medication. Staff A said all attempts to coordinate medication pick up from the family would be documented in resident progress notes.

In an interview on 11/24/2025 at 12:17 PM, Staff C stated if a resident missed a medication facility staff would follow up with the residents PCP. Staff C stated if a resident missed their medication the facility staff would contact the resident's family to inform them. Staff C stated all contacts with resident families should be documented in progress notes. Staff C said some residents' families were responsible for picking up and providing the facility with the residents medications. Staff C stated that if the facility received a medication order that the resident was allergic to then they should contact the PCP within a day to obtain another medication.

This is a recurring deficiency previously cited on 01/24/2025 and 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) 1/23/2025 .

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

Administrator (or Representative) [signature] Date 12/24/2025

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

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

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

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to monitor and take appropriate actions for 2 of 3 sampled residents (Resident 1 [R1] and Resident 3 [R3]). This failure resulted in residents not receiving medications as prescribed and contributed to R1 having altered mental status and being hospitalized and R3 for medical complications.

Findings included...

Record review of the facility policy titled, "Alert Charting," undated, showed alert charting would be implemented when a resident condition required increased monitoring and observation for a limited time until the condition was resolved. The

licensed nurse would be responsible for initiating alert charting and maintaining it for 72 hours when a resident presented with the condition below and entered the information on the alert charting log. The Health Services Director was accountable to ensure documentation occurred and the physician was notified. Conditions or events that required alert charting included but were not limited to behavioral changes, infections or illnesses, and changes in level of consciousness.

R1

Record review of R1's Face Sheet, undated, showed R1 moved into the facility on [redacted]/2025 with diagnoses including [redacted] and [redacted].

Record review of R1's service agreement, dated [redacted]2025, showed that R1 suffered hallucinations and was unable to determine danger to self. Care staff and the nurse supported and monitored R1 and if any changes occurred, the clinical service director would be notified.

Record review of R1's physician orders showed on 09/17/2025 a new order for quetiapine (antipsychotic medication used to treat mental health conditions) 50 milligrams (mg) take one tablet by mouth daily for seven days, then two tablets daily for 30 days. On the bottom right hand corner of the order was a handwritten date of 09/17/2025 and Staff B, charge nurse, noted receipt of the order.

Record review of R1's MAR, dated 09/2025, showed R1 did not receive quetiapine on 09/24/2025, 09/25/2025, 09/28/2025, 09/29/2025, 09/30/2025 and 10/01/2025.

Record review of R1's MAR, dated 10/2025, showed R1 received two 50 mg tablets of quetiapine from 10/02/2025 through 10/24/2025 for a total of 23 days, not the full 30 days as ordered.

Record review of R1's progress notes, dated 09/18/2025 through 11/17/2025, showed no documentation related to when R1 missed the seventh dose of quetiapine on 09/24/2025 and from 09/28/2025 through 10/01/2025 when they should have received doses from the 30 day order of quetiapine. Additionally, there were no notes after 10/23/2025 when R1 should have gotten their quetiapine.

Record review of R1's progress notes, dated 11/04/2025 at 10:37 AM, showed R1 informed the medication technician that they had anxiety and felt "crazy". At breakfast R1 threw the silverware and their drinks and stated they could not help their behavior.

Record review of R1's progress notes, 11/04/2025 at 12:08 PM, showed that R1 threatened to hurt themself and others and was taken to the hospital.

In an interview on 11/24/2025 at 4:01PM, Collateral Contact 1 (CC1), R1's power of attorney, stated they received a call from the facility on 11/04/2025 stating R1 was in crisis and talking about hurting themself. CC1 stated they arrived at the facility and observed R1 hitting the nurse. CC1 stated R1 stated they were nuts and they were having a nervous breakdown. CC1 stated while they took R1 to the hospital R1 opened the door of the moving car on the freeway and attempted to jump out. CC1 stated R1 then tried to take the keys out of the ignition and tried to put the car in "park" while they drove down the freeway. CC1 stated they were very scared that they could have swerved into another car while trying to prevent R1 from jumping from the moving car.

Record review of R1's "After Visit Summary," dated 11/04/2025, showed R1 was evaluated in the Emergency Room for suicidal thoughts and altered mental status.

In an interview on 12/03/2025 at 12:30PM, Staff A stated that it was not a part of the policy to add residents to alert charting when they missed medications, but they believed it should be. Staff A stated they were advocating for the policy to be changed. Staff A stated they spoke with the medication technicians and they stated they do put residents on alert when they miss a medication. Staff A stated R1's seventh dose of their seven-day order was inputted incorrectly which resulted in the order "falling off" the MAR. Staff A stated if they knew R1 missed a dose, they would have put R1 on alert. Staff A stated R1 should have been on alert when their 30-day order had not been started. Staff A stated we did not receive the order, it was marked as given but we did not have it. Staff A stated R1 should have been on alert for missing the quetiapine during that time to monitor. Staff A stated R1 should also have been placed on alert after the 30-day order had ended prematurely. Staff A states they did not know what happened and it completely fell through the cracks. Staff A stated Staff B should have followed up with R1's doctor when R1 had their follow up on 10/21/2025 regarding the effectiveness of the medication. Staff A stated Staff B forgot.

R3.

Record review of R3's Face Sheet, undated, showed R3 moved into the facility on [redacted] 2022 with diagnoses including [redacted].

Record review of R3's service agreement, dated 09/26/2025, showed R3 was at risk of being exposed to high-risk behavior. If R3 was agitated care staff would support and monitor R3 and report changes or problems to the clinical services director. R3 could not safely administer their medications. R3's medications would be administered safety, correctly, and timely manner 100% of the time per the physician order to maintain therapeutic effectiveness.

Record review of an untitled document, dated 10/31/2025, showed R3's medical provider stated to encourage R3's fluid intake because they had two UTI (urinary tract infections) in October. R3's primary care physician (PCP) ordered R3 to take one tablet of trimethoprim-sulfamethoxazole (medication that treated bacterial infections) medication twice daily by mouth for five days, cranberry pills, and vitamin C.

Record review of R3's MAR, dated 10/01/2025 through 10/31/2025, showed R3 had two orders for quetiapine (antipsychotic medication used to treat mental health conditions) 25 mg tablets twice daily. R3 received both orders of quetiapine from 10/28/2025 through 10/31/2025.

Record review of R3's MAR, dated 11/01/2025 through 11/18/2025, showed R3 had two orders for quetiapine 25 mg tablets twice daily. R3 received both orders of quetiapine from 11/01/2025 through 11/07/2025.

Record review of R3's MAR, dated 11/01/2025 through 11/18/2025, showed that trimethoprim-sulfamethoxazole medication was never started.

Record review of R3's MAR, dated 11/01/2025 through 11/18/2025, showed the cranberry pills and vitamin C was started on 11/13/2025.

Record review of the facility's Alert Charting Report, dated 10/14/2025 through 11/12/2025, showed no documentation related to R3 receiving double doses of quetiapine, nor about trimethoprim-sulfamethoxazole not being started, or about the cranberry pills and vitamin C medications starting late.

Record review of R3's progress notes, dated 10/01/2025 through 11/17/2025, showed no documentation related to R3 receiving double doses of quetiapine, nor about trimethoprim-sulfamethoxazole not being started, or about the cranberry pills and vitamin C medications starting late

In an observation and interview on 11/24/2025 at 12:02 PM, Staff B, Charge Nurse, stated the facility staff noticed R3 had unusual behaviors such as being more aggressive and R3 could not be redirected. Staff B stated the facility did an in-house urinalysis and sent the results to R3's PCP. Staff B stated R3's behaviors would be under behavior charting. Staff B stated behavior charting was charted by exception and not continuously completed. Staff B referenced their computer and stated they did not see any alert charting dated 10/22/2025 and onward related to R3's behaviors. At 12:15 PM Staff B went to the cafeteria to point out to the Department which resident R3 was. R3 had been observed to be at the dining table, and their head and shoulders were slouched downwards over their food. Staff B rubbed R3's back and asked them if they planned to wake up and eat lunch. R3's plate of food had been observed to be untouched while other residents nearby had finished their food. Staff B stated R3

sleeping like that was considered normal to them.

In an observation and interview on 11/24/2025 at 12:17 PM, Staff C, Medication Technician/Caregiver, stated if a resident missed a medication, then they would be placed on alert charting to make sure no changes occurred. Staff C stated they were unaware when R3's UTI started. Staff C observed R3 slouched over at the dining table and stated it was normal for R3 to sleep a lot. Staff C stated if a resident had a UTI, then they would be placed on alert charting. Staff C stated if residents had behaviors, then an in-house urinalysis would be completed, they would send the results to their PCP, and the PCP prescribed an antibiotic.

This is a recurring deficiency previously cited on 01/24/2025.

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) 1/23/2025.

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

Administrator (or Representative) [signature] Date 12/24/2025