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) 79531 (Completion Date 06/25/2026) and 76748 (Completion Date 05/01/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/25/2026 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-2630-1, WAC 388-78A-2630-1-a, WAC 388-78A-2630-1-b

The Department staff who did the on-site verification:
Paul Aube, ALF NCI

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Nursing Home Allied Health 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: 221163
Compliance Determination #: 76748
Region/Unit #: RCS Region 3 / Unit E
Investigator: Paul Aube
Investigation Date(s): 05/01/2026 through 05/01/2026
Complainant Contact Date(s):

Allegation(s):
Injury of Unknown Origin: Public report of resident injury of unknown origin.

Investigation Methods:

Sample:	Total residents: 50 Resident sample size: 2 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members Management
Record Reviews:	Incident investigation Facility policies Negotiated Service Agreements Temporary Service Agreements Alert Charting/Progress Notes

Investigation Summary:
Injury of Unknown Origin: Facility failed to notify the Department as per their policy, and failed to notify local authorities after they were unable to rule out possibility of abuse. Failed practice identified.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ]

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

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
HOME AND COMMUNITY LIVING 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 05/01/2026 of:

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

This document references the following complaint number(s): 221163, 219505, 221138

The following sample was selected for review during the unannounced on-site visit: 2 of 50 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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

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

05/18/2026
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)

5/21/26
Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review, the assisted living facility failed to make immediate notifications to the Department and notify local authorities after a resident sustained an injury of unknown origin in the facility for 1 of 2 residents reviewed (Resident 1 (R1)). This failure resulted in a delay in investigation by the Department and placed R1 at risk for ongoing/additional abuse.

Findings included...

RCW 74.34.035 Reports—Mandated and permissive—Contents— Confidentiality. (1) When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department... 4) A mandated reporter is not required to report to a law enforcement agency, unless requested by the injured vulnerable adult or his or her legal representative or family member, an incident of physical assault between vulnerable adults that causes minor bodily injury and does not require more than basic first aid, unless: (a) The injury appears on the back, face, head, neck, chest,

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

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.

Residential Care Services | 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) | Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review, the assisted living facility failed to make immediate notifications to the Department and notify local authorities after a resident sustained an injury of unknown origin in the facility for 1 of 2 residents reviewed (Resident 1 (R1)). This failure resulted in a delay in investigation by the Department and placed R1 at risk for ongoing/additional abuse.

Findings included…

RCW 74.34.035 Reports—Mandated and permissive—Contents— Confidentiality. (1) When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department… 4) A mandated reporter is not required to report to a law enforcement agency, unless requested by the injured vulnerable adult or his or her legal representative or family member, an incident of physical assault between vulnerable adults that causes minor bodily injury and does not require more than basic first aid, unless: (a) The injury appears on the back, face, head, neck, chest,

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

breasts, groin, inner thigh, buttock, genital, or anal area;

Review of an undated facility policy titled “Bruises and Injuries of Unknown Origin Investigation” stated that if the facility is unable to determine the cause and cannot rule out abuse, neglect, and mistreatment during the investigation of the injury, that this would make this incident immediately reportable to the Department, and proper licensing authorities. The policy also stated that the Executive Director (ED) would ensure that all required entities would be notified, such as the Department of Health, and the local authorities (Police).

Review of R1’s Face Sheet showed that the resident was admitted to the facility on [redacted]/2025. It showed that the R1 had a diagnosis of [redacted].

Review of an incident report for R1, dated 04/17/2026 at 7:30 AM, stated that R1 was found by facility staff with a “small reddish area to nose” and a “slightly bloody nose.” R1 was interviewed by staff but could not tell them what happened due to their dementia.

In an interview with CC1, R1’s representative, on 05/01/2026 at 11:10 AM, CC1 stated that the facility called them early the morning of the incident to inform them that R1 had a bloody nose. Later that day, CC1 stated that they visited R1 at the facility and found that R1 had substantial bruising to their nose and eyes. CC1 stated, “I looked at [R1] and saw across the bridge of [their] nose, it was a mess.”

Review of the investigation for the incident, which was conducted by Staff A, the Executive Director, showed that on 04/17/2026 at some time between 9:00 AM – 12:00 PM, bruising and swelling was observed to R1’s face by facility staff.

Review of R1’s progress notes showed a note dated 04/17/2026 at 4:48 PM which stated, “resident has been sent out to the hospital for nosebleed, swelling, bruise on face. Resident is current in the hospital for medical examination.” Further review of progress notes showed there was no documentation that the local authorities were called and notified.

Review of Department records showed that the facility made a notification of the incident to the department on 04/20/2026.

In an interview with Staff A on 05/01/2026 at 10:13 AM, Staff A was asked if they were able to determine the origin/cause of R1’s facial bruising after their investigation. Staff A stated that after interviewing all the floor staff that they were unable to confirm if R1 fell out of bed, or how the injury occurred. Staff A was asked why there was a three-day

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

delay in making the report/notification of the incident to the Department. Staff A stated that since the incident occurred on 04/17/2026, which was a Friday, and they thought that it needed to be reported within one business day. Staff A stated that in retrospect, that they felt the facility should have made the report/notification on the same day of the incident.

In another Interview with Staff A on 05/01/2026 at 1:44 PM, Staff A was asked if the local authorities were called after the facility became aware of R1's facial bruising. Staff A stated, "no, police were not called for that." When Staff A was asked why police were not called, they stated that they had no reason to believe that the injury was targeted abuse towards R1.

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) 6/15/2026.

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

Administrator (or Representative) — Date: 5/21/26

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

delay in making the report/notification of the incident to the Department. Staff A stated that since the incident occurred on 04/17/2026, which was a Friday, and they thought that it needed to be reported within one business day. Staff A stated that in retrospect, that they felt the facility should have made the report/notification on the same day of the incident.

In another interview with Staff A on 05/01/2026 at 1:44 PM, Staff A was asked if the local authorities were called after the facility became aware of R1's facial bruising. Staff A stated, "no, police were not called for that." When Staff A was asked why police were not called, they stated that they had no reason to believe that the injury was targeted abuse towards R1.

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)_____ .

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

_____ _____

Administrator (or Representative) Date

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