STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Avenue, Suite#220, Vancouver, WA 98684

March 21, 2019

The Hampton Salmon Creek LLC
The Hampton at Salmon Creek Memory Care Community
2305 NE 129th Street
Vancouver, WA 98686

RE: The Hampton at Salmon Creek Memory Care Community License #2227

Dear Administrator:

The Department completed a follow-up inspection of your assisted living facility on February 22, 2019 for the deficiency or deficiencies cited in the report/s dated November 7, 2018 and November 27, 2018 and found no deficiencies.

The Department staff who did the follow-up inspection:
Julie Erickson, ALF Licensor

If you have any questions please, contact me at (360) 397-9549.

Sincerely,

C Ramsey for:

Karyl Ramsey, Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services

Investigation Summary Report

Provider/Facility: The Hampton at Salmon Creek Memory Care Community (807063)
Intake ID(s): 3584651
License/Cert. #: AL2227
Investigator: Rain, Bryon
Region/Unit: RCS Region 3/Unit E
Investigation Date(s): 11/27/2018 through 11/27/2018
Complainant Contact Date(s): 11/27/2018

Allegations:

Quality of Care

Investigation Methods:

☒ **Sample:**	13 current residents and 1 former resident	☒ **Observations:**	General environment, residents rooms, staff-resident interactions, resident-resident, resident verbal/non-verbal behaviors, resident appearance
☒ **Interviews:**	Residents, Resident representative, staff, and administrative staff	☒ **Record Reviews:**	Resident records, Incident Reports, Policies and Procedures, Section 5 and 6 CG Flow.

Allegation Summary:

An on-site investigation was conducted and the allegation identified in the intake related to quality of care in the assisted living facility was reviewed. There was insufficient evidence to support failed practice. Additional residents were reviewed and interviewed with no concerns.

Unalleged Violation(s): ☒ **Yes** ☐ **No**

Deficiency not related to original allegation was identified see SOD written 11/28/2018.

Conclusion / Action: ☒ **Failed Provider Practice Identified / Citation(s) Written** ☐ **Failed Provider Practice Not Identified / No Citation Written**

WAC 388-78A-2160

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Avenue, Suite#220, Vancouver, WA 98684

Statement of Deficiencies	License #: 2227	Completion Date
Plan of Correction	The Hampton at Salmon Creek Memory Care Community	November 27, 2018
Page 1 of 3	Licensee: The Hampton Salmon Creek LLC	

You are required to be in compliance at all times with all licensing laws and regulations to maintain your assisted living facility license.

This document references the following complaint number: 3584651

The department has completed data collection for the unannounced on-site complaint investigation on 11/27/2018 of:

The Hampton at Salmon Creek Memory Care Community
2305 NE 129th Street
Vancouver, WA 98686

The following sample was selected for review during the unannounced on-site complaint investigation : 13 of 49 current residents and 1 former residents.

The department staff that inspected and investigated the assisted living facility:

Bryon Rain, BS RN, Assisted Living Facility Complaint Investigator
Desiree Jeschke, NCI ALF/AFH COMPLAINT INVESTIGATOR

From:

DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3, Unit E
800 NE 136th Avenue, Suite#220
Vancouver, WA 98684
(360)397-9549

RECEIVED
DEC 12 2018
DSHS RCS
REGION 3

As a result of the on-site complaint investigation 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.

C Berinsky for Karyl Ramsey
Residential Care Services

12/04/2018
Date

I understand that to maintain an assisted living facility license I must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative)

12-18-18
Date

01/11/19 BLR

01/11/19

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:
Based on interview and record review, the facility failed to ensure the Negotiated Service Agreement (NSA) was implemented for 9 of 9 sampled residents (Residents #1 - 9) who did not receive their showers or personal hygiene care as indicated on the NSA. This failure resulted in the residents not receiving adequate personal care and/or personal hygiene assistance when care staff did not follow the NSA.

Findings include:

Resident #5 moved into the facility on [redacted]2018. During an interview on 11/27/2018 at 03:14 PM, Resident #5's spouse stated shower aids have been sick and not showing up for work. Resident #5 had not had a shower or sponge bath for nine days.

During an interview 11/27/2018 at 03:45 PM Staff D, a caregiver, stated showers are supposed to be given two times a week. The facility has been short care staff due to the holidays and people calling in sick. Staff C stated shower aides and caregivers will try to give showers when able, and residents can go one to two weeks without a shower sometimes. Some residents refuse shower services.

During an interview 11/27/2018 at 04:02 Staff C, a caregiver, stated showers are supposed to be given two times a week, and when residents receive their shower caregivers initial the date the shower was given in the shower log. When residents refuse a shower caregivers circle the box with the date of the offered shower in the shower log and either write a note on the back side of the shower log sheet or just a circle. Staff C stated a shower aide was recently sick and caregivers have quit. The facility has been pulling shower aides to fill in as caregivers.

During an interview 11/27/2018 at 05:08 Staff B, the Director of Resident Services, stated showers are given twice a week by shower aides unless the family requests showers be given once a week. Staff B stated the facility has had staffing issues, but the day shift shower aides are reliable and will stay over the end of their shift if they need to. The facility will schedule the shower aides into the next shift if necessary to provide showers.

Record review on 11/27/2018 of the Section 5 and 6 CG (Care Giver) Flow binder revealed nine residents who had not received twice weekly showers:

- Resident #9 last received a shower on 11/15/2018 with no refusals documented.
- Resident #1 last received a shower on 11/20/2018 with no refusals documented.
- Resident #2 last received a shower on 11/15/2018 with no refusals documented.
- Resident #6 last received a shower on 11/18/2018 with no refusals documented.
- Resident #5 last received a shower on 11/18/2018 with no refusals documented.
- Resident #3 last received a shower on 11/14/2018 with no refusals documented.
- Resident #4 last received a shower on 11/18/2018 with no refusals documented.

- Resident #7 last received a shower on 11/21/2018 with no refusals documented.
- Resident #8 last received a shower on 11/11/2018 with a refusal documented on 11/15/2018.

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, The Hampton at Salmon Creek Memory Care Community is or will be in compliance with this law and / or regulation on (Date) 1-11-19 . In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

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

Administrator (or Representative) — Date: 12-10-18

Residential Care Services

Investigation Summary Report

Provider/Facility: The Hampton at Salmon Creek Memory Care Community (807063)
Intake ID(s): 3579310
License/Cert. #: AL2227
Investigator: Rain, Bryon
Region/Unit: RCS Region 3/Unit E
Investigation Date(s): 11/06/2018 through 11/07/2018
Complainant Contact Date(s): 11/05/2018

Allegations:

1. Resident/patient/client neglect
2. Quality of care

Investigation Methods:

[X] **Sample:**	7 current residents	[X] **Observations:**	General environment, residents rooms, staff-resident interactions, resident-resident, resident verbal/non-verbal behaviors, resident appearance
[X] **Interviews:**	Residents, Resident representative, staff, and administrative staff	[X] **Record Reviews:**	Resident records, Incident Reports, Policies and Procedures, staff schedules, activities roster

Allegation Summary:

An on-site investigation was conducted and the allegations identified in the intake related to quality of care and neglect in the assisted living facility were reviewed. There was sufficient evidence to support failed practice for quality of care. Additional residents were reviewed and interviewed with no concerns.

Unalleged Violation(s): [X] **Yes** [ ] **No**

Consultation written

Conclusion / Action: [X] **Failed Provider Practice Identified / Citation(s) Written** [ ] **Failed Provider Practice Not Identified / No Citation Written**

One citation WAC 388-78A-2320 and one consultation WAC 388-78A-2630.

STATE OF WASHINGTON
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AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Avenue, Suite#220, Vancouver, WA 98684

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REGION 3

Statement of Deficiencies	License #: 2227	Completion Date
Plan of Correction	The Hampton at Salmon Creek Memory Care Community	November 7, 2018
Page 1 of 3	Licensee: The Hampton Salmon Creek LLC	

You are required to be in compliance at all times with all licensing laws and regulations to maintain your assisted living facility license.

This document references the following complaint number: 3579310

The department has completed data collection for the unannounced on-site complaint investigation on 11/6/2018 of:

The Hampton at Salmon Creek Memory Care Community
2305 NE 129th Street
Vancouver, WA 98686

The following sample was selected for review during the unannounced on-site complaint investigation : 7 of 50 current residents and 0 former residents.

The department staff that inspected and investigated the assisted living facility:

Bryon Rain, BS RN, Assisted Living Facility Complaint Investigator

From:

DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3, Unit E
800 NE 136th Avenue, Suite#220
Vancouver, WA 98684
(360)397-9549

As a result of the on-site complaint investigation 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.

C Burinsky for Karyl Ramsey — Residential Care Services
11/08/2018 — Date

I understand that to maintain an assisted living facility license I must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative)
11.19.18 — Date

11/28/18 BLR

12/22/18

WAC 388-78A-2320 Intermittent nursing services systems.
(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:
(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and
(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:
(d) Development of, and necessary amendments to, the nursing component of the negotiated service agreement for each resident;
(e) Implementation of the nursing component of each resident's negotiated service agreement; and

This requirement was not met as evidenced by:
Based on interview and record review, the facility failed to provide an effective system for incorporating doctor's orders into a resident's medication administration record (MAR) for 1 of 7 residents (Resident #1). This failure led to unmet care needs for this resident.

Findings include:

All interviews and record reviews occurred on 11/06/2018 unless otherwise stated.

Resident #1 was admitted to the facility on [redacted] 2017 with a diagnosis of [redacted] and [redacted] Record review of Resident #1's chart revealed that Resident #1 fell at the facility on 08/28/2018 at 6:30 PM and sustained a skin tear to right temple (3 x 3cm) and swelling above the right eye with skin tear (1 x 1cm).

Review of Resident #1's progress notes read Resident #1 was taken to the hospital by his power of attorney (POA) for evaluation on 08/30/2018, where no issues were identified. A doctor's order dated 08/30/2018 from the visit to the hospital instructed the facility to apply ice for 20 minutes every hour during the day when the resident is not sleeping for the next 24 hours. There is no documentation of Resident #1 receiving ice for his head.

During an interview Staff C, a licensed practical nurse, stated the instructions for applying ice should have been added to the Medication Administration Record (MAR) when the resident returned from the hospital with the order. Staff C stated that the 24 hour time period should have been "blocked out" in the MAR by whoever received the order and placed the order in the chart. Staff B, the Director of Resident Services, was present for the interview and agreed the order should have been added to the MAR.

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, The Hampton at Salmon Creek Memory Care Community is or will be in compliance with this law and / or regulation on (Date) 12/22/18. In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

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

Administrator (or Representative) — Date: 11-19-18

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Avenue, Suite#220, Vancouver, WA 98684

November 8, 2018
CERTIFIED MAIL
7016 2070 0000 4687 4620

The Hampton Salmon Creek LLC
The Hampton at Salmon Creek Memory Care Community
2305 NE 129th Street
Vancouver, WA 98686

RE: The Hampton at Salmon Creek Memory Care Community License #2227

Dear Administrator:

The Department completed a complaint investigation of your assisted living facility on November 7, 2018 and found that your facility does not meet the assisted living facility licensing requirements.

The Department:
- Wrote the enclosed report;
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- May inspect the facility to determine if you have corrected all deficiencies.

You Must:
- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);
- Within 10 calendar days after you receive this letter, complete and return the enclosed "Plan/Attestation Statement";
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
  - o Mail the Plan/Attestation Statement with original signatures to:

Karyl Ramsey, Field Manager
Residential Care Services
Region 3, Unit E
800 NE 136th Avenue, Suite#220
Vancouver, WA 98684

- Complete correction within 45 days or sooner if directed by the department after review of your proposed correction dates.

- Contact me for clarification of the deficiency or deficiencies found.

Consultation:
In addition, the department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

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

The facility did not inform the department of an occurrence of resident-to-resident altercation documented in an incident report and the resident's chart. All assessments and monitoring for the resident were completed.

You Are Not:
- Required to submit a plan-of-correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:
- Receive a letter of enforcement action based on any deficiency deficiency listed on the enclosed report.

In Addition, You May:
- Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  - What specific deficiency or deficiencies you disagree with;
  - Why you disagree with each deficiency; and
  - Whether you want an IDR to occur in-person, by telephone or as a paper review.
  - Send your requests to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (360) 397-9549.

Sincerely,

C Burinsky for:

Karyl Ramsey, Field Manager
Region 3, Unit E
Residential Care Services

Enclosure