STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

06/07/2024

CSH Harbour Pointe Lessee LLC
Harbour Pointe Retirement & Assisted Living Center
10200 HARBOUR PLACE
MUKILTEO, WA 98275

RE: Harbour Pointe Retirement & Assisted Living Center License # 2362

Dear Administrator:

This letter addresses Compliance Determination(s) 42145 (Completion Date 06/03/2024) and 35893 (Completion Date 03/29/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/03/2024 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-2930-1-b-i

The Department staff who did the on-site verification:
Wesler Dumecquias, Community Complaint Investigator

If you have any questions, please contact me at (360)651-6846.

Sincerely,

Kim Ripley

Kimberley Ripley, Field Manager
Region 2, Unit A
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Harbour Pointe Retirement & Assisted Living Center
Provider Type: Assisted Living Facility
License/Cert.#: 2362
Intake ID: 114691
Compliance Determination #: 35893
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 01/26/2024 through 03/29/2024
Complainant Contact Date(s):

Allegation(s):

The Named Resident (NR) had a fall after attempting to use the bathroom on their own. The NR called for an hour while on the floor before the ALF staff arrived to help them.

Investigation Methods:

Sample:	Total residents: 41 Resident sample size: 5 Closed records sample size: 1
Observations:	Identified resident Residents Resident rooms Resident to resident interactions Staff to resident interactions
Interviews:	Identified resident Nursing staff Residents Administrator Family members
Record Reviews:	Hospital records Incident investigation Facility policies Call logs PCP notifications Progress notes Medication Administration records.

Investigation Summary:

The Assisted Living Facility (ALF) investigated the incident and determined that the NR attempted to use the bathroom and fell. Interview and record review showed there were issues of long waits and unreasonable response times by the ALF's staff when residents would call using their pendants and pull cords. Failed practice was identified. A citation was issued for noncompliance with WAC 388-78A-2930(1)(b)(i). Communication system in relation to RCW 18.20.184(1) Communication System-

Telephones and other equipment.

Conclusion / Action:

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

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3906-172nd St NE, Suite #100, Arlington, WA 98223

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 01/26/2024 and 03/05/2024 of:

Harbour Pointe Retirement & Assisted Living Center
10200 HARBOUR PLACE
MUKILTEO, WA 98275

This document references the following complaint number(s): 114691, 115190

The following sample was selected for review during the unannounced on-site visit: 5 of 41 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Wesler Dumecquias, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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.

Kim Ripley — Residential Care Services

04/05/2024 — 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.

Administrator (or Representative)

5/6/2024
Date

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(b) Provide the resident with personal wireless communication devices, such as pendants or wristbands, when a communication device is not installed in the resident's sleeping room, and when wireless communications are used:

(i) The system must be designed and installed consistent with industry standards and perform reliably throughout the facility; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to respond to residents' requests within a reasonable time when 2 of 3 sampled residents (Residents 1 and 4) were using their call pendants and pull cords. These failures resulted in a delay in Resident 1 receiving medical treatment for a head injury and wait times as long as 329 minutes for delivery of care and services for Residents 1 and 4 and placed all residents using the pendants at risk for long wait times and unmet care needs.

Findings included...

Review of Revised Code of Washington (RCW) 18.20.184 Communication system—Telephones and other equipment showed:
(1) Each assisted living facility shall be responsive to incoming communications and respond within a reasonable time to phone and electronic messages.

Review of the ALF's policy "Emergency Pendant System" dated 10/2017 showed each apartment and most common areas are equipped with an emergency pull cord. The pendant system is designed to alert the staff in the event a pendant is pushed.

Resident 1

Resident 1 was admitted on [redacted]/2020 with multiple diagnoses including [redacted].

On 01/26/2024 at 11:05 AM, Collateral Contact 1 (CC1), Emergency Services, stated that they responded to a call at the Assisted Living Facility (ALF) on 01/15/2024 at 7:00 AM. CC1 stated that Resident 1 was alert and oriented x 4 (to name, date, place and situation).

CC1 stated that they observed a laceration at the back of Resident 1's head. CC1 stated that Resident 1 informed them that they had a fall, hurt themselves and had been paging the staff all night but no one responded. CC1 stated that Resident 1 informed them that they tried to crawl to their door to ask for help but they could not reach their doorknob. CC1 stated that Resident 1's hair was mudded with blood indicating they had been there for some time.

On 01/26/2024 at 2:15 PM, Staff B, Med Tech stated that they were the Med tech working at that time. Staff B stated that Resident 1 was sleeping during rounds at 6:00 AM. Staff B stated that at around 6:45 AM, Resident 1's pendant's turned on and when the caregiver went to see them, Resident 1 was on the floor.

On 01/26/2024 at 2:36 PM, Resident 1 stated that they had a fall and hit the back of their head. Resident 1 stated that they had been calling after the fall and had been pressing their pendant many times, but there were no staff that came to help them. Resident 1 stated that they were calling for help to use the bathroom, but no one was coming so they decided to go to the bathroom on their own. Resident 1 stated that was the time when they fell and hit the back of their head on their dresser. Resident 1 stated that they had been on the floor for long hours and most of the time, they had to wait an hour or longer to be able to get help.

Review of Resident Incident/Unusual Occurrence Report dated 01/15/2024 showed Resident 1 was found at 6:45 AM bleeding from their head, seated on the floor of their living room with their wheelchair at their bathroom entrance.

Review of Resident Event Report dated 01/15/2024 showed on 01/15/2024 at the time of the incident, Resident 1 pressed their call button nine times from 1:32 AM and was only responded to at 6:52 AM for a wait of 320 minutes. The Report from 01/01/2024 to 01/31/2024 showed Resident 1 called 34 times with their pendant and the ALF staff took as long as 30 minutes to 320 minutes long to respond.

In an email on 02/02/2024 at 11:34 AM, Staff B, Resident Care Director, stated that their staff had difficulty resetting Resident 1's pendant. Staff B stated that she requested a new one as early as 02/01/2024 right after the incident. Staff B stated that Resident 1 had her new pendant on 03/05/2024 during an unannounced visit.

On 03/15/2024 at 10:53 AM. Collateral Contact 3 (CC3) stated that they had issues with Resident 1's pendant. CC3 stated that the ALF staff informed them it was a battery issue, and the ALF was waiting for the new battery to come. CC3 stated that they went to buy a new battery on their own and replaced it, but the pendant still would not work. CC3 stated that they were informed the ALF would buy a new pendant for Resident 1.

Review of the Resident Event Report call logs from 02/01/2024 to 02/29/2024 showed Resident 1 had called 247 times with an average response time of 20 minutes and the

longest response time at 237 minutes. There were 16 times Resident 1 called with a response time from 30 minutes to 163 minutes.

Review of the "Resident Event Report" call logs from 03/01/2024 to 03/27/2024 after Staff B stated they changed Resident 1's pendant showed Resident 1 had called 110 times. There were 17 times Resident 1 called with a response time from 30 minutes to 237 minutes.

Resident 4

Resident 4 was admitted on [redacted]/2023 with multiple diagnoses including [redacted] and [redacted].

On 03/05/2024 at 3:49 PM, Collateral Contact 2 (CC2) stated that Resident 4 uses a pendant. CC2 stated that they live with and were always with Resident 4, so they hold Resident 4's pendant. CC2 stated that when they call for help, the ALF staff would not come immediately, and the response time was very slow especially at night. CC2 stated they had to wait for more than 30 minutes.

On 03/05/2024 at 3:36 PM, Staff E, Caregiver stated that Resident 4 needed a two person assist to move them to and from their bed to their wheelchair and would take some time to do it. Staff E stated that it could take 30 minutes sometimes because they toilet and dress them.

Review of "Resident Event Report" dated 01/01/2024 to 01/31/2024 showed the Resident 4 had called 81 times with an average response time of 45 minutes and the longest response time recorded was 328 minutes. The report showed Resident 4's 31 calls were responded ranging from 30 minutes to 328 minutes. For the period from 02/01/2024 to 02/29/2024, Resident 4 had called 57 times which were responded from 30 minutes to 224 minutes and for the period from 03/01/2024 to 03/17/2024, Resident 4 had called 27 times which were responded from 30 minutes to 259 minutes.

On 03/05/2024 at 3:36 PM, Staff E, Caregiver stated that the reason why they would not be able to respond immediately to resident's call would be because they were helping other residents with toileting, dressing or showering. Staff E stated that as an example Resident 4 and 5 who would need 2 people assist with care. Staff E stated that Resident 5 would need an hour of care especially before bed from changing them to putting them to bed.

On 03/29/2024 at 1:18 PM, Staff B, Resident Care Director stated that they were now printing call logs on a daily basis which serves as a maintenance report for them to be able to monitor and track any issues in the use of pendants.

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, Harbour Pointe Retirement & Assisted Living Center is or will be in compliance with this law and / or regulation on (Date) 5/15/2024 .

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

Administrator (or Representative) — Date: 05/03/2024