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

03/29/2024

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) 38736 (Completion Date 03/22/2024) and 32435 (Completion Date 12/20/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/22/2024 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-2950-6

The Department staff who did the on-site verification:
Cristina Gonzalez, ALF Licensor

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: 106037
Compliance Determination #: 32435
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 11/13/2023 through 12/20/2023
Complainant Contact Date(s): 11/13/2023

Allegation(s):
The Alleged Victim (AV) was found on the floor at the Assisted Living Facility with second degree burns to her left hand, wrist, forearm, and left shoulder with blisters.

Investigation Methods:

Sample:	Total residents: 54 Resident sample size: 4 Closed records sample size: 3
Observations:	Identified resident injuries Residents Resident rooms Resident care equipment Room sink and bathroom with faucet Water temperature
Interviews:	Identified resident Identified staff Nursing staff Residents Family members Hospital staff- Providence
Record Reviews:	Hospital records Medical records Incident investigation Facility policies Assessment Care plans Photos Email communications

Investigation Summary:
The Assisted Living Facility (ALF) investigated the fall incident and ruled out abuse and neglect. The ALF investigated the allegations for the AV's burn injuries but was not able to determine the cause for the burns. The AV was cognitively impaired. Interview

indicated that the AV had signs of blisters and skin shearing on their left hands as well as arms at the time 911 came and took the AV to the hospital. Interview and Record review from hospital records showed the AV sustained a second degree burns which were consistent with thermal or liquid burns. Observation showed the ALF's hot water temperature in the NR's sink and shower exceeded the acceptable range of 105 and 120 by up to 16 degrees Fahrenheit (F). The water temperature in the AV's sink measured as high as 136 degrees F. Failed practice was identified. A citations was issued for non compliance with WAC 388-78A-2950 (6) Water supply.

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 #: 2362	Compliance Determination # 32435
Plan of Correction	Harbour Pointe Retirement & Assisted Living Center	Completion Date
Page 1 of 5	Licensee: CSH Harbour Pointe Lessee LLC	12/20/2023

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 11/13/2023 and 11/20/2023 of:

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

This document references the following complaint number(s): 106037

The following sample was selected for review during the unannounced on-site visit: 4 of 54 current residents and 3 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

01/04/2024
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)

02-29-2024
Date

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to ensure the hot water temperature in the sink and bathroom was between 105 degrees and 120 degrees Fahrenheit (F) for 1 of 1 Resident (Resident 1). This failure resulted in Resident 1's water temperature readings ranging from 132 to 136 °F and Resident 1 being found with a second degree burn and all Residents at risk for burns or harm and compromised safety.

Findings included...

On 11/20/2023 at 09:57 AM, Staff F, Caregiver, stated that the water in Resident 1's faucet was hot.

On 11/20/2023 at 10:16 AM, the water temperature in Resident 1's sink faucet was 136 °F and in their shower was 123 °F using the state issued digital thermometer. Staff F was present.

On 11/20/2023 at 10:20 AM, the water temperature in Resident 1's faucet was 133.2 °F using the state issued thermometer. Staff G, Med Tech, was present.

On 11/20/2023 at 10:43 AM, Staff H, Maintenance Director, stated that they do not measure all the hot water temperatures in all the sinks and bathrooms of resident rooms. Staff H stated that the hot water supply was centralized that was why they do not measure all of them. Staff H stated that they never measured Resident 1's hot water supply in their sink and bathroom. Staff H stated that he checks his sampled rooms which were in the middle of the building and in each wing of their building. Staff H stated that the hot water temperature ranged from 112-118 °F.

On 11/20/2023 at 10:53 AM, the following readings of Resident 1's hot water supply was taken from Resident 1's sink faucet with Staff H:

1. At 10:53 AM using the ALF's non digital water thermometer, the reading was 132 °F.

2. At 10:56 AM using a state issued digital thermometer, the reading was at 133 °F.

On 11/20/2023 at 10:50 AM, Staff H stated that they do not know why the water temperature was still hot and he would go check and readjust the water temperature.

Resident 1 was admitted to the ALF on [redacted]/2023 with multiple diagnoses including [redacted].

Review of the ALF's Master Assessment dated 08/02/2023 showed Resident 1 required a 2-person assistance with transfers, 1 person for ambulation, 2 persons for toileting and 2 persons for bathing 2 times a week.

Review of Service Agreement dated 11/21/2023 showed effective 02/03/2023, Staff were to monitor Residents "day-to-day" for health changes. Staff were to visually check Resident 1 in the morning, afternoon, and during the night for safety and meeting their needs. Resident 1 needed a wheelchair with one person assistance for mobility and a walker for transfers with 1-person assistance.

On 11/20/2023 at 9:55 AM, Staff F, Caregiver, stated that Resident 1 could not stand or ambulate on their own. Staff F stated that Resident 1 only used a walker to help them stand up during transfers. Two staff were required to assist Resident 1 during transfers. Staff F stated that Resident 1 needed a wheelchair for mobility, and they had to push the wheelchair because Resident 1 could not do it themselves. Staff F stated that Resident 1 did not drink hot coffee or tea and liked only juice and water. Staff F stated they had to help Resident 1 when they drink. Staff F stated that Resident one did not have any hot drinks served to them during mealtimes. Staff F stated that they had to help Resident 1 eat during mealtimes because she did not know what she was doing.

Review of the ALF's Resident Incident/Unusual Occurrence Report dated 11/10/2023 showed Resident 1 was found at 5:15 AM lying on the floor on their left side and near their bed. Resident 1 appeared to have rolled from their bed. Resident 1 was observed with a swelling and a skin tear in their lower left arm. Staff called 911 and Resident 1 was transported to the hospital.

On 11/13/2023 at 3:07 PM, Staff C, Caregiver, stated that Resident 1 did not have a skin tear but there were signs of ruptured blisters and Resident 1's hand was wet from the blisters. Staff C stated that the Emergency Medical Services said it was a burn. Staff C stated that she did not have knowledge of Resident 1 being burned.

On 11/13/2023 at 4:39 PM, Staff A, Executive Director, stated that Resident 1 had a skin tear. Staff A stated that Emergency Medical Services (EMS) told their staff that Resident 1 had a burn. Staff A stated that the EMS cannot diagnose if it was a burn.

On 11/15/2023 at 2:48 PM, Collateral Contact 5 (CC5), hospital's Wound Care Registered Nurse, stated that the wounds were second degree burns. CC5 stated that the wounds were scattered, they were progressing like a burn and so they were not consistent with a pressure injury. CC5 stated that the wounds were consistent with a thermal type of injury with the greater probability that it was from hot water or hot liquid.

On 11/15/2023 at 3:11 PM, Collateral Contact 6 (CC6), Advanced Registered Nurse Practitioner, stated that there were blisters showing Resident 1's skin seemed newly burned or was a recent burn versus a pressure injury. CC6 stated that the injury could not be from a pressure injury because the skin was still blanchable (is visible skin redness that becomes white when pressure is applied and reddens when pressure is relieved).

Review of Providence Health and Services Wound Care dated 11/14/2023 showed an assessment from a wound consult related to Resident 1's left hand and forearm burn injury signed by CC5, "Wound 11/10/2023, Burn second degree (deep partial thickness); first degree (superficial partial thickness); other left lower anterior (in front of or the front surface of); dorsal (refers to the back). Wound base comment: partial thickness burn injury, scattered blisters that have ruptured, posterior (refers to the back side) aspect of the hand from the thumb to elbow".

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) 02-08-2024

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

Administrator (or Representative) — 02-29-2024 Date