STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

03/12/2025

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) 55670 (Completion Date 03/03/2025) and 50179 (Completion Date 01/07/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/03/2025 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-2410-8-a-iii, WAC 388-78A-2410-8-a-ii, WAC 388-78A-2410-8-a-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: 153899
Compliance Determination #: 50179
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 11/13/2024 through 01/07/2025
Complainant Contact Date(s):

Allegation(s):

1. Residents reports missing narcotics in their apartment.
2. Some residents missed their medications at admission due to inadequate documentation and accountability.
3. The Assisted Living Facility (ALF) was not completing timely assessments, which affected the resident's quality of care.
4. The ALF retaliated by firing staff for making reports against the ALF.

Investigation Methods:

Sample:	Total residents: 89 Resident sample size: 5 Closed records sample size: 1
Observations:	Identified resident Residents Medication administration Staff to resident interactions Resident to resident interactions Resident rooms
Interviews:	Identified resident Nursing staff Residents Family members Administrator
Record Reviews:	Medical records Incident investigation Facility policies Narcotic logs Progress notes Care plans Assessments

Investigation Summary:

1. The Assisted Living Facility (ALF) investigated an incident involving missing

narcotics but was unable to determine how the drugs went missing. On 10/31/2024, the Named Resident (NR) reported the incident to ALF staff more than a month after it occurred. The ALF staff notified law enforcement and all relevant parties. Following surgery on 09/23/2024, the NR requested assistance from ALF staff to administer Oxycodone for approximately three days. Afterwards the NR was independent in administering their medications again. The staff confirmed that they assisted the NR with Oxycodone and noted that they kept the medication in their medication cart briefly then returned the medications to the NR. However, as per ALF policy, they could not provide documentation or records related to the administration of narcotics, including those in the Medication Administration Records and the Narcotics Log Book. A citation was issued for noncompliance with WAC 388-78A-2410(8)(a)(i)(ii)(iii)(iv) Content of records.
2. The Licensed Nurse was responsible for requesting and reviewing medication records and orders. When a resident was admitted, the ALF faxed all medication orders to their contracted pharmacy so that the pharmacy could enter the resident's information into the computer, specifically in the medication administration records. The ALF requests refills for the resident's medications to be delivered to the facility. If the resident arrives with their medication supplies, the ALF staff would place these in the medication cart and administer them according to the doctor's orders. In cases where there were concerns about medication availability, the ALF staff would contact the resident's family or primary care physician or follow up with the pharmacy to ensure that the necessary medications were sent to the ALF. Interviews and record reviews of sampled residents indicated no concerns regarding medication availability at admission. No failed practices were identified.
3. The Caregivers report any changes in the residents' conditions or any deviations from their baseline to the Medication Technicians or the Memory Care Director for residents in the memory care unit and the licensed nurse (LN). If caregivers notice something unusual, they would document it in alert charting. The LN would then check on the resident and conduct an assessment. The LN would notify the family and the resident's primary care physician if there were issues. Interviews with selected residents (SR) and their families indicated no concerns. A review of the records showed that the Assisted Living Facility (ALF) conducts assessments every six months or when a resident's condition changes significantly. Evaluations from the SR demonstrated that assessments were conducted on time per their policy. No instances of failed practice were identified.
4. Interview with the ALF's sampled staff (SS) showed they felt they were able to speak with their supervisors for any concerns without fear of retaliation. The SS stated they were not aware of any staff that were fired due to retaliation.

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 11/13/2024 and 11/14/2024 of:

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

This document references the following complaint number(s): 153899

The following sample was selected for review during the unannounced on-site visit: 5 of 89 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.

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-2410 Content of resident records. The assisted living facility must organize and maintain resident records in a format that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

(8) Medical and nursing services provided by the assisted living facility for a resident, including:

(a) A record of providing medication assistance and medication administration, which contains:

(i) The medication name, dose, and route of administration;

(ii) The time and date of any medication assistance or administration;

(iii) The signature or initials of the person providing any medication assistance or administration; and

This requirement was not met as evidenced by:

Based on interviews and records review, the Assisted Living Facility (ALF) failed to document and maintain records for 1 of 1 Resident (Resident 1) who received assistance with narcotic medication administration. These failures resulted in Resident 1 lacking a record of the narcotic medications received, dispensed and accounted for, and having no records of medication administrations. These failures placed Resident 1 at risk for medication diversion and medications not being administered as ordered.

Findings included…

Review of the ALF's policy "Medication documentation" dated 04/01/2017, showed the safety of the Residents was the first priority in managing the administration of medications. Proper documentation of medications was imperative to ensure the safety of Residents. The Wellness Director had the primary responsibility for supervising all medication administration. The Staff member who administered or assisted the medication must document on the Medication Administration Record (MAR) that the medication was given. The staff would sign the MAR Signature Page in the front of the medication book or sign each MAR at the beginning of each month. Place initials in the box for the date and time the medication was given.

Review of the ALF's policy "Accountability of Controlled Substances" dated 04/01/2017, showed all scheduled medications [a way of sorting out which medicines or poisons need to be more tightly controlled, and which don't] must have a Controlled Substance

Record, either provided by the pharmacy or on the company form WELL60.9203 (narcotic logbook), which should contain: Resident's full name; Name of Dispensing pharmacy; Name of prescribing physician; Name, strength, and number of dosage units of the drug received; Method of administration; Date of dispensing.

Resident 1 was admitted to the ALF on [redacted]/2024 with diagnoses of [redacted] and [redacted].

A medical record review titled "After Visit Summary" (AVS) dated 09/23/2024 to 09/24/2024 showed Resident 1 had undergone a right hip replacement. The AVS showed Resident 1 was prescribed Oxycodone 5 milligrams (MG) tablet and 0.5 to 2 tablets were taken by mouth every six hours as needed for pain.

On 11/13/2024 at 2:05 PM, Resident 1 reported that they returned to the Assisted Living Facility (ALF) on 09/24/2024 following surgery at the hospital. Resident 1 stated that their doctor prescribed Oxycodone to manage their pain after surgery. According to Resident 1, there was an agreement with Staff C, the Director of Wellness, that the ALF staff would assist them by administering Oxycodone as needed. Resident 1 stated that the ALF staff provided the medication for about two to three days beginning on 09/24/2024 and that they received half a tablet each time. Resident 1 stated that the ALF staff returned the medications to them after the two to three days which they kept in their lock box.

On 11/13/2024, at 2:45 PM, Staff C, the Director of Wellness, reported that Resident 1 initially arrived for respite care and was managing their medications independently. Staff C mentioned that they assisted Resident 1 by administering Oxycodone 5 milligrams (mg) for only 36 hours after the resident returned to the assisted living facility (ALF) following surgery. Staff C also stated that they were unable to locate the narcotic log and the paper medication administration record but would continue searching for these documents.

On 11/14/2024 at 3:01 PM, Staff D, a medication technician, stated that there was no documentation for Resident 1's Oxycodone in the Assisted Living Facility's (ALF) narcotic count log.

On 11/14/2024 at 3:07 PM, Staff E, Medication technician, recalled that there had been Oxycodone in the ALF's medication cart. Staff E stated that they counted and administered the medication to Resident 1 but could not remember where they documented it. Staff E mentioned that they could not find a paper Medication Administration Record.

On 11/14/2024 at 3:06 PM, a review of the ALF's Narcotic Logbook, dated January 2024, confirmed no entry of records had been made for Resident 1's Oxycodone for

September 2024.

On 11/26/2024 at 3:58 PM, in an email, Staff B stated that narcotic medications were usually logged into their narcotic logbook. Staff B stated they do not have any progress notes for Resident 1.

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)_____ .

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

_____ _____

Administrator (or Representative) Date