STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

08/08/2025

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

RE: Harbour Pointe Retirement & Assisted Living Center # 2362

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 63846 (Completion Date 08/08/2025) and 57412 (Completion Date 05/01/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/08/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
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.

The Department staff who did the On Site verification:
Wesler Dumecquias, Community Complaint Investigator

If you have any questions, please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

Laurie Anderson, Community Field Manager
Region 2, Unit D

Residential Care Services
Investigation Summary Report

Provider/Facility: Harbour Pointe Retirement & Assisted Living Center
Provider Type: Assisted Living Facility
License/Cert.#: 2362
Intake ID: 172559
Compliance Determination #: 57412
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 04/03/2025 through 05/01/2025
Complainant Contact Date(s):

Allegation(s):

1. The Named Resident (NR) left the Assisted Living Facility (ALF) unsupervised.
2. The ALF did not give the NR's scheduled medication which contributed to the NR's leaving the ALF.

Investigation Methods:

Sample:	Total residents: 93 Resident sample size: 3 Closed records sample size: 1
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident care equipment
Interviews:	Identified resident Nursing staff Residents Family members Business office manager
Record Reviews:	Incident investigation Facility policies Service plans Assessments Investigation Email

Investigation Summary:

1. The Assisted Living Facility (ALF) failed to follow the Named Resident's (NR) service plan at the time of the incident. The NR was allowed by the ALF staff to leave the ALF unsupervised and go for a walk by themselves. Failed practice was identified. A citation was issued for noncompliance with WAC 388-78A-2160-Implementation of negotiated service agreement.
2. The ALF investigated the incident and determined that the Medication Technician

(MT) did not give the Named Residents (NR) medication because they failed to check the NR's medication supply in the ALF medication overstock room. The MT thought the NR run out of their medication. The ALF investigated the incident. The ALF Licensed Nurse conducted an in-service and the MT underwent a retraining regarding their protocol in ensuring residents medications were available, how to check and ensure to look at residents' extra medications in their overflow or medication stock room. The MT was issued a warning and removed as a MT. The MT failed to report to work and was terminated. All parties were informed.

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 # 57412
Plan of Correction	Harbour Pointe Retirement & Assisted Living Center	Completion Date
Page 1 of 4	Licensee: CSH Harbour Pointe Lessee LLC	05/01/2025

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 04/03/2025 and 05/01/2025 of:

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

This document references the following complaint number(s): 172559

The following sample was selected for review during the unannounced on-site visit: 3 of 93 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 Z
20425 72nd Avenue S, Suite 400
Kent, WA 98032

Statement of Deficiencies	License #: 2362	Compliance Determination # 57412
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Page 2 of 4	Licensee: CSH Harbour Pointe Lessee LLC	05/01/2025

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.

Anthony Devito
Residential Care Services

05/06/2025
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)

5/7/2025
Date

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 records review, The Assisted Living Facility (ALF) failed to follow the Negotiated Service Agreement (NSA) for 1 of 3 residents (Resident 1) who became lost after they left the ALF unsupervised. This failure placed Resident 1 risk for harm and compromised safety.

Findings included...

Resident 1

Review of an undated Face sheet showed Resident 1 was admitted to the ALF on [redacted]/2025 with multiple diagnoses including [redacted].

Review of an NSA dated 02/12/2025 showed Resident 1 had a history of poor judgment and needed protection and supervision. The NSA showed Resident 1 could not leave the ALF unsupervised.

Review of an incident report dated 03/23/2025 showed Resident 1 was found by the Police about 0.4 miles outside of the ALF wandering and alone at around 11:30 PM. The Police brought Resident 1 back to ALF.

On 04/03/2025 at 2:28 PM, Staff B, Wellness Director, stated that Resident 1 was allowed to go out on their own because Resident 1 was independent and could go walk outside of the ALF on their own unaccompanied. Staff B stated that Resident 1 would go for a walk as far as to a nearby hotel which was about 0.4 miles away from the ALF.

On 05/01/2025 at 2:02 PM, Staff B stated that they did not have have residents in their Assisted Living (AL) units that were assessed as, "cannot leave the ALF unsupervised". Staff B stated that they did not have a way of knowing who was assessed or who had in their NSA's as could not leave the ALF unsupervised.

On 04/03/2025 at 4:10 PM, Resident 1 stated that they felt cold when they were outside for about an hour.

On 05/01/2025 at 1:35 PM, Staff C, Business Office Manager, stated the care staff and the ALF's front desk monitors residents who were identified as, "cannot leave the ALF unsupervised". Staff C stated that Resident 1 goes outside of the ALF on their own for a walk unaccompanied. Staff C stated that it was their understanding that residents cannot live in the AL if they cannot leave the ALF unsupervised.

On 05/01/2025 at 1:52 PM, Staff D, Medication Technician (Med tech), stated that they did not know if Resident 1 could leave the ALF unsupervised. Staff D stated that they would look at residents service plans if residents were able to go outside unsupervised. Staff D added that they would know a resident was not able to go outside unsupervised if the resident was confused. Staff D stated that all their Assisted Living (AL) residents could leave the ALF on their own and they could not stop them.

On 05/01/2025 at 2:31 PM, Staff A, Executive Director, stated that they were not aware they had residents that were assessed that could leave the ALF unsupervised. Staff A stated they would not be comfortable if that was in the AL residents service plans.

Statement of Deficiencies	License #: 2362	Compliance Determination # 57412
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Page 4 of 4	Licensee: CSH Harbour Pointe Lessee LLC	05/01/2025

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) 6/15/2025.

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

Administrator (or Representative) _____ Date 5/1/2025