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

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) 69144 (Completion Date 11/21/2025) and 65348 (Completion Date 09/15/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/21/2025 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-2160

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

If you have any questions, please contact me at (206)305-3489.

Sincerely,

Jim Sherman

James Sherman, Field Manager
Region 2, Unit D
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: 192397
Compliance Determination #: 65348
Region/Unit #: RCS Region 2 / Unit D
Investigator: Wesler Dumecquias
Investigation Date(s): 09/09/2025 through 09/15/2025
Complainant Contact Date(s): 09/05/2025

Allegation(s):

1. The Named Resident (NR) eloped from the facility, fell and sustained an injury.
2. The facility increased the NRs level of services without consulting with the NR's Power of Attorney.

Investigation Methods:

Sample:	Total residents: 90 Resident sample size: 2 Closed records sample size: 0
Observations:	Identified resident Residents Activities Dining
Interviews:	Identified resident Identified staff Nursing staff Activity staff Administrator Residents Family members
Record Reviews:	Staff patterns Facility policies Incident investigation Activity schedule Care plan Assessment Progress Notes

Investigation Summary:

1. The Named Resident (NR) left the facility unnoticed and unsupervised after they were escorted out by the staff from the secured unit of the facility to attend an activity in the Assisted Living dining area. The NR was later discovered missing and

was found by a stranger outside on the street and had fallen to the ground, resulting in an injury. Failed practice was identified. A citation was issued for non compliance with WAC 388-78A-2160. Implementation of negotiated service agreement.
2. Interview indicated that the facility Licensed Nurse made the changes, resigned and left the facility without informing the NR's family. The facility corrected the issue and had a care conference with the NR's family regarding changes in the level of care. The issue was resolved and the NR was not charged of the amount.

Conclusion / Action:

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

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

Statement of Deficiencies	License #: 2362	Compliance Determination # 65348
Plan of Correction	Harbour Pointe Retirement & Assisted Living Center	Completion Date
Page 1 of 4	Licensee: CSH Harbour Pointe Lessee LLC	09/15/2025

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 09/09/2025 of:

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

This document references the following complaint number(s): 192397

The following sample was selected for review during the unannounced on-site visit: 2 of 90 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Wesler Dumecqulas, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

Statement of Deficiencies	License #: 2382	Compliance Determination # 65348
Plan of Correction	Harbour Pointe Retirement & Assisted Living Center	Completion Date
Page 2 of 4	Licensee: CSH Harbour Pointe Lessee LLC	09/15/2025

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.

James Sherman
Residential Care Services

09-24-2025
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)

09/29/2025
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 record review, the facility failed to supervise and provide safety oversight for 1 of 2 Residents (Resident 1) who had cognitive impairment and history of elopement when staff brought them out of the secured unit. This failure resulted in harm to Resident 1 when they left the facility unsupervised and had a fall with injury.

Review of the facility Disclosure of services dated January 2023 showed the facility would have the following security service to help protect residents with cognitive impairments and wandering behaviors:

A. Restricted use of exit doors in a designated portion of the building designed to serve residents with dementia.
B. Restricted use of exit doors throughout the building.

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

Review of an Incident Report (IR) dated 08/25/2025 showed Resident 1 was escorted by

staff outside of the secured memory care unit to attend a scheduled Music Therapy event in the assisted living dining room. The IR showed Resident 1 walked out of the facility alone. The IR showed a stranger informed the facility that Resident 1 was found outside on the street and had fallen to the ground, resulting in an injury. The staff returned Resident 1 to the facility in a wheelchair.

Review of a Change of Condition assessment dated 08/14/2025 showed Resident could not leave the facility unsupervised.

Review of Care Plan dated 08/14/2025 showed Resident 1 had current or history of occasional disorientation to person, place, time or situation even in familiar surroundings and required supervision and oversight for their safety. The Care plan showed Resident 1 needed to be monitored by staff for their safety due to exit-seeking behaviors. The Care plan showed Resident 1 could not leave the facility unsupervised.

On 09/09/2025 at 2:04 PM, Staff B, Memory Care Resident Care Coordinator, stated that a Music Therapy session took place in the assisted living dining room located on the facility's ground level floor. Residents from both the assisted living and memory Care units attended the activity. Staff B stated that the memory care residents were taken by the life enrichment staff and by a caregiver in two batches to join the session in the dining room of the Assisted Living unit and outside of the secured Memory Care unit. Staff B stated that Resident 1 was escorted by Staff C, Life Enrichment Director, to the dining room for the Music Therapy session, which ran from 1:20 to 2:30 PM. Staff B stated that Memory Care residents were only accompanied by their life enrichment director during all activities, whether the activity occurred inside or outside the memory care unit. Staff B stated that Staff C stepped out and left the residents to help another resident use the bathroom. Staff B stated that there should have been a care staff with the Memory Care units.

On 09/09/2025 at 2:58 PM, Staff D, caregiver, stated that they came in for their evening shift at 2:00 PM when they noticed that Resident 1 was not in the Memory Care unit. Staff D alerted Staff C who went back to the Assisted Living area to look for Resident 1.

On 09/09/2025 at 3:27 PM, Staff E, Activity Assistant, stated that there were no care staff that would stay with residents of the Memory Care unit every time they conduct activities.

On 09/09/2025 at 3:27 PM, Staff C stated that during the Music Therapy session, they took Resident 1 to the bathroom. Staff C stated that they returned Resident 1 to their seat and left them unsupervised. Staff C stated that they only realized Resident 1 was missing when a caregiver brought it to their attention. Staff C stated that they had been alone and did not have any care staff present to supervise the residents of the memory care unit during the activity. Staff C stated they were unaware Resident 's prior history of elopement from the facility.

Statement of Deficiencies	License #: 2362	Compliance Determination # 65348
Plan of Correction	Harbour Pointe Retirement & Assisted Living Center	Completion Date
Page 4 of 4	Licensee: CSH Harbour Pointe Lessee LLC	09/15/2025

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) ~~11/03/2025~~ SW 10/30/2025

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

Administrator (or Representative) 9/29/2025 Date