STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

HSP - Harbour Point LLC
Mukilteo Memory Care
4686 Pointes Dr
Mukilteo, WA 98275

RE: Mukilteo Memory Care License # 2426

Dear Administrator:

This letter addresses Compliance Determination(s) 59683 (Completion Date 05/15/2025) and 54414 (Completion Date 03/17/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/15/2025 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-2600-1-a, WAC 388-78A-2600-1-b, WAC 388-78A-2600-2-f, WAC 388-78A-2640-1-a

The Department staff who did the on-site verification:
Michelle Mcglon, Nursing Consultant Institutional

If you have any questions, please contact me at (253)312-1446.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Mukilteo Memory Care
Provider Type: Assisted Living Facility

License/Cert.#: 2426
Intake ID: 164723
Compliance Determination #: 54414
Region/Unit #: RCS Region 2 / Unit J
Investigator: Michelle Mcglon
Investigation Date(s): 02/06/2025 through 03/17/2025
Complainant Contact Date(s):

Allegation(s):

1. The Named Resident (NR) had a witnessed fall, resulting in a fracture at the Assisted Living Facility (ALF).

Investigation Methods:

Sample:	Total residents: 60 Resident sample size: 2 Closed records sample size:
Observations:	Identified resident Residents Staff to resident interactions Resident rooms
Interviews:	Identified resident Nursing staff Residents Family members
Record Reviews:	State reporting log Incident investigation Resident Records

Investigation Summary:

1. Interview and record review showed the NR reported to the ALF staff, they had significant pain and difficulty ambulating . Record review showed the ALF staff assisted the NR with ambulation and transfers, but failed to follow their policy to have the resident evaluated by a physician for two days after the change of condition was reported. See Statement of Deficiency WAC 388-78A-2600 dated 03/17/2025.

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

20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

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 03/03/2025 and 02/06/2025 of:

Mukilteo Memory Care
4686 Pointes Dr
Mukilteo, WA 98275

This document references the following complaint number(s): 164723

The following sample was selected for review during the unannounced on-site visit: 2 of 60 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Michelle Mcglon, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

Statement of Deficiencies	License #: 2426	Compliance Determination # 54414
Plan of Correction	Mukilteo Memory Care	Completion Date
Page 2 of 6	Licensee: HSP - Harbour Point LLC	03/17/2025

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.

Jennie Singer
Residential Care Services

3/19/2025
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)

3/25/2025
Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(b) Provide the necessary care and services for residents, including those with special needs;

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(f) In response to medical emergencies;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement their Major and Minor Emergency Procedures Policy when 1 of 2 sampled residents (Resident 1) could no longer ambulate or transfer independently and was experiencing pain following a fall with injury. This failure resulted in Resident 1 having a delay in medical evaluation and not receiving medical care for five fractured ribs.

Findings included...

Record review of the ALF's policy, Major and Minor Emergency Procedures, dated 10/2017, showed if an injury was not life threatening, and the resident could not wait for a doctor's appointment then staff should call 911 for transport to the emergency department. or contact family or friends to take them, with prior authorization by family members. Provide basic first aid and make resident as comfortable as possible until transportation arrives.

Record review of an undated Face Sheet, showed the ALF admitted Resident 1 on [redacted]/2022 with multiple medical diagnoses including [redacted].

Record review of Resident 1's Service Plan (equivalent to a Negotiated Service Agreement), dated 09/17/2024, showed that Resident 1 was independent with mobility and transfers with the use of an assistive device.

Record review of a Resident Incident and Unusual Occurrence Report, dated 01/22/2025, showed Resident 1 lost their balance, resulting in a fall on to their right side resulting in a skin tear.

Record review of Wellness Progress Notes, showed on the evening shift (2:00 PM- 10:00 PM) of 01/23/2025, Resident 1 complained of pain. Record review showed the ALF staff notified the primary care physician by fax for Tylenol. On 01/24/2025 (no time or shift noted), the ALF staff documented Resident 1 reported "significant pain while ambulating. At this time, the resident requires assistance with ambulation. The resident does not currently have a PRN (as needed) order for pain management". On the night shift [10 PM- 6 AM] of 01/25/2025, the ALF staff documented Resident 1 complained of right arm pain. The ALF staff documented Resident 1 did not have a PRN pain medication to administer; therefore, the staff would continue to monitor.

Record review of Wellness Progress Notes, showed Resident 1 was transported to the emergency department on the day shift [6 AM-2 PM] of 01/25/2025 by their family representative. The ALF did not seek emergency medical evaluation for Resident 1's complaints of pain, following a fall with injury for three days.

Record review of hospital records, dated 01/25/2025, showed Resident 1 sustained fractured five ribs from the fall.
In an interview, on 03/03/2025 at 4:22 PM, Staff A (Director of Wellness) stated that the ALF staff had not notified her of Resident 1's was experiencing pain. Staff A stated the ALF staff should have done more.

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, Mukilteo Memory Care is or will be in compliance with this law and / or regulation on (Date) 4/18/2025.

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

Administrator (or Representative) — Date: 3/25/25

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to notify the resident representative, call the resident's physician, and Wellness Director, when 1 of 3 sampled residents (Resident 1) experience a significant change of condition. This failure resulted in a delay in medical evaluation and treatment.

Findings included...

Record review of the ALF's policy, Major and Minor Emergency Procedures, dated 10/2017, showed if an injury was not life threatening, and the resident could not wait for a doctor's appointment then staff should call 911 for transport to the emergency department. or contact family or friends to take them, with prior authorization by family members. Provide basic first aid and make resident as comfortable as possible until transportation arrives. The policy stated to (a) Contact the responsible party listed as Emergency Contact on the front of the resident's wellness record. (b) Contact the resident's physician (leave a message with answering service or office. Fax should be the last option if an injury). (c) Notify the Executive Director, or Wellness Director.

Record review of an undated Face Sheet, showed the ALF admitted Resident 1 on [redacted]/2022 with multiple medical diagnoses including [redacted].

Record review of a Resident Incident and Unusual Occurrence Report, dated 01/22/2025, showed Resident 1 lost their balance, resulting in a fall on to their right side resulting in a skin tear.

Record review of Wellness Progress Notes, showed on the evening shift (2:00 PM- 10:00 PM) of 01/23/2025, Resident 1 complained of pain. Record review showed the ALF staff notified the primary care physician by fax for Tylenol. On 01/24/2025 (no time or shift noted), the ALF staff documented Resident 1 reported “significant pain while ambulating. At this time, the resident requires assistance with ambulation. The resident does not currently have a PRN (as needed) order for pain management”. On the night shift [10 PM- 6 AM] of 01/25/2025, the ALF staff documented Resident 1 complained of right arm pain. The ALF staff documented Resident 1 did not have a PRN pain medication to administer; therefore, the staff would continue to monitor.

Record review of Wellness Progress Notes, showed Resident 1 was transported to the emergency department on the day shift [6 AM-2 PM] of 01/25/2025 by their family representative.

Record review showed the ALF never contacted Resident 1’s physician via phone per their policy. Record review showed no documentation the ALF notified Resident 1’s representative when she started experiencing pain and had a change of condition in ability to ambulate.

In an interview, on 03/03/2025 at 4:22 PM, Staff A (Director of Wellness) stated that the ALF staff had not notified her of Resident 1’s change of condition.

In an interview, on 03/12/2025 at 9:25 AM, Collateral Contact 1 (CC1-family representative) stated that the ALF had not notified them about Resident 1’s pain issues after the fall, until they were at facility visiting. CC1 stated they then decided to transport Resident 1 to the emergency room. CC1 stated that they would have preferred the ALF to send Resident 1 to the hospital when she first complained of pain and difficulty ambulating.

Statement of Deficiencies	License #: 2426	Compliance Determination # 54414
Plan of Correction	Mukilteo Memory Care	Completion Date
Page 6 of 6	Licensee: HSP - Harbour Point LLC	03/17/2025

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, Mukilteo Memory Care is or will be in compliance with this law and / or regulation on (Date) 4/16/25 .

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

Administrator (or Representative) — Date: 3/25/2025