STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
***800 NE 136th Ave Ste 200, Vancouver, WA 98684***

Channel Point LLC
Channel Point Village
907 K St
Hoquiam, WA 98550

RE: Channel Point Village License # 2621

Dear Administrator:

This letter addresses Compliance Determination(s) 51507 (Completion Date 12/09/2024) and 48532 (Completion Date 10/09/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/09/2024 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-2610-1

The Department staff who did the on-site verification:
Phan Pham, Nurse Surveyor

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

# Residential Care Services
## Investigation Summary Report

**Provider/Facility:** Channel Point Village
**Provider Type:** Assisted Living Facility
**License/Cert.#:** 2621
**Compliance Determination #:** 48532
**Intake ID:** 147144
**Investigator:** Phan Pham
**Region/Unit #:** RCS Region 3 / Unit E
**Investigation Date(s):** 10/09/2024 through 10/09/2024
**Complainant Contact Date(s):**

**Allegation(s):**
Infection control - Residents were diagnosed with [redacted].

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 50<br>Resident sample size: 3<br>Closed records sample size: 0 |
| **Observations:** | Named residents, residents, environment, staff interactions with residents, staff members providing care and services, infection control, and safety measures. |
| **Interviews:** | Named residents, residents, staff members, administrative and member not associated with the facility. |
| **Record Reviews:** | Sampled residents and incident reports. |

**Investigation Summary:**
An investigation was conducted, and allegation identified in the intake related to infection control, care and services were reviewed. The facility failed to ensure staff members Personal Protection Equipment (PPE) was removed prior to exiting residents' rooms to prevent the spread of infection. Additional residents reviewed for care, services and safety had no concerns.

**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
***800 NE 136th Ave Ste 200, Vancouver, WA 98684***

| | | |
|---|---|---|
| Statement of Deficiencies | License #: 2621 | Compliance Determination # 48532 |
| Plan of Correction | Channel Point Village | Completion Date |
| Page 1 of 3 | Licensee: Channel Point LLC | 10/09/2024 |

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 10/09/2024, 10/09/2024 and 10/09/2024 of:

Channel Point Village
907 K St
Hoquiam, WA 98550

This document references the following complaint number(s): 147144, 147871

The following sample was selected for review during the unannounced on-site visit: 3 of 50 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Phan Pham, Nurse Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.

Cory Cisneros
Residential Care Services

10/14/2024
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.

| Statement of Deficiencies | License #: 2621 | Compliance Determination # 48532 |
|---|---|---|
| Plan of Correction | Channel Point Village | Completion Date |
| Page 2 of 3 | Licensee: Channel Point LLC | 10/09/2024 |

Administrator (or Representative) 10-23-24 Date

**WAC 388-78A-2610 Infection control.**

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

**This requirement was not met as evidenced by:**

Based on observation, interview and record review, the facility failed to ensure implementation of appropriate infection control practices when staff members Personal Protection Equipment (PPE) was removed prior to exiting residents' rooms for 1 of 1 facility reviewed. This failure placed the residents and staff at risk for contracting diseases and staff members spreading the infection.

Findings included...

Review of the Center for Disease Control and Prevention (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated 11/29/2022, documented to remove and discard PPE upon completing a task before leaving the patient's room or care area.

On 10/09/2024 at 12:41 PM, carts of clean PPE were observed in the hallway outside resident rooms [redacted], [redacted], [redacted] and [redacted], and garbage containers without lids were placed next to each cart. Soiled PPE was observed in the garbage containers. Residents and staff members were observed passing by room [redacted] hallway.

In an interview on 10/09/2024 at 12:44 PM, Staff B, Medication Tech, said she had been trained on infection control. Staff B stated she wore full PPE when assisted residents diagnosed with [redacted] ([redacted]) and PPE was to be removed right after she exited the residents' rooms.

On 10/09/2024 at 12:53 PM, Staff C, Caregivers, was observed put on gown, gloves, mask and eye protection and entered Resident 1's room (room [redacted]). Staff C assisted in repositioning Resident 1 in her chair. At 12:58 PM Staff C exited the resident's room, removed the PPE, and discarded the PPE in the garbage container outside of Resident 1's room.

In an interview at 12:58 PM, Staff C said Resident 1 had COVID-19 and was being

| Statement of Deficiencies | License #: 2621 | Compliance Determination # 48532 |
|---|---|---|
| Plan of Correction | Channel Point Village | Completion Date |
| Page 3 of 3 | Licensee: Channel Point LLC | 10/09/2024 |

isolated. Staff C stated she have been instructed to wear full PPE when entering Resident 1's room and remove the PPE after exiting the room.

In an interview on 10/09/2024 at 2:27 PM, Staff A, Director of Wellness, said the facility had five residents diagnosed with [redacted]. Staff A stated she had trained all staff members on infection control and steps to prevent the spread of infections. Staff A said staff were to put on gown, gloves, mask and eye protections before entering a COVID-19 infected rooms and remove the PPE after they had exited.

**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, Channel Point Village is or will be in compliance with this law and / or regulation on (Date) 10-14-24 .

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

Administrator (or Representative) — Date: 10-14-24