STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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) 83066 (Completion Date 09/03/2026) and 77875 (Completion Date 07/02/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/03/2026 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-2210-1-b, WAC 388-78A-2210-2-a

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: Harbour Pointe Retirement & Assisted Living Center
Provider Type: Assisted Living Facility
License/Cert.#: 2362
Intake ID: 224147
Compliance Determination #: 77875
Region/Unit #: RCS Region 2 / Unit D
Investigator: Wesler Dumecquias
Investigation Date(s): 05/22/2026 through 07/02/2026
Complainant Contact Date(s):

Allegation(s):

The facility staff administered the wrong dose of medication to the Named resident and there was a missing controlled medication of the NR.

Investigation Methods:

Sample:	Total residents: 95 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Medication administration medication cart
Interviews:	Identified resident Identified staff Nursing staff Residents Family members executive director
Record Reviews:	Incident investigation Facility policies Personnel files Staff training records Service plans eMARS Progress notes Assessments Staff trainings

Investigation Summary:

The facility failed to provide a safe medication assistance when it failed to implement their system resulting in medication errors. Failed practice was identified. A citation was issued.

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Conclusion / Action:

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

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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 05/22/2026 of:

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

This document references the following complaint number(s): 224147, 227742

The following sample was selected for review during the unannounced on-site visit: 4 of 95 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Wesler Dumecquias, Community Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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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: 07/14/2026

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: 7/21/2026

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 .

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement a safe medication delivery system and ensure 1 of 2 residents (Resident 1) who required medication assistance received their medication as ordered by their primary care physician. This failure resulted in Resident 1 receiving the wrong dose of a narcotic (controlled substance) medication and placed them at risk for worsening anxiety.

Findings included...

Review of facility policy dated 04/01/2017 titled, "Medication Error Reporting" showed a medication error is any preventable event that may cause or lead to inappropriate medication use or resident harm, while the medication is in the control of the wellness staff, resident or family. Such events may be related but not limited to identification, process, prescribing, communication, labeling, packaging, dispensing, administration/assistance, and omission. The policy showed when one of the above

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medication error occurred, the staff would notify the Wellness Director immediately; complete a Medication Error report, electronically or on paper; document the following in the resident's medical record; document the name of physician, family/representative; time notified and number called ; monitor resident's condition for seventy-two (72) hours or as directed; and, place the resident on alert charting. Additionally, the Wellness Director is responsible for the investigation of the error on the medication error form and identifying necessary follow-through. The day of or first day after the error occurred, the Wellness Director will complete an investigation of how the error occurred, will determine how to prevent future incidents and will recommend if any corrective action or retraining is required. All staff retraining will be attached to the medication error report and investigation.

Review of Resident 1's face sheet showed they admitted to the facility on [redacted] 2026 with multiple diagnoses including [redacted].

Review of progress notes dated 03/28/2026 showed Resident 1 required assistance with medication. The notes showed the facility started to provide medication assistance to Resident 1on the same date 03/28/2026.

Review of Medication Administration Record (eMAR) from 05/01/2026 to 05/31/2026 showed Resident 1 was prescribed Pregabalin 50 milligrams (MG) capsule to be taken by mouth every morning with breakfast and 75MG by mouth to be taken at bedtime on 04/23/2026 for an unspecified anxiety disorder. Staff initials showed doses given.

Review of a handwritten statement by Staff E, Registered Nurse dated 05/14/2026 showed they identified a narcotic medication count discrepancy on 05/02/2026 at approximately 6:00 AM during their handover shift report.

Medication error 1

Review of an Incident report (IR) dated 05/01/2026 showed Resident 1 reported they received an incorrect dosage of Pregabalin for their bedtime dose. The IR showed they took 50 mg of the medication instead of the 75 mg.

During an interview on 06/30/2026 at 2:21 PM Staff, E stated that they identified a discrepancy in the narcotic (controlled substance) count on 05/02/2026. Staff E stated that when they checked the narcotic logbook for Resident 1's Pregabalin 75 MG for 05/01/2026, they discovered that while it was dated, timed and had the initial of Staff G, Medication Technician (MT), there was no recorded quantity in the designated space provided for tracking the remaining medication after administration. Staff E stated that they counted the remaining Pregabalin 75 MG at 21 capsules which did not change from when it was last administered and counted, so this prompted them to document a "Missed Dose" in the narcotic logbook for the Pregabalin dose on 05/01/2026. Staff E

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stated that they communicated and reported their findings in person regarding the medication discrepancy on the same day on 05/02/2026 to Staff B, Wellness Director.

During an interview on 07/02/2026 at 1:37 PM, Staff G, MT stated that when they gave Resident 1's medication on 05/01/2026, they just selected the medication package that was labelled "PM". Staff G stated that they did not verify the dose of the medication when they took the medication from the bubble pack (single dose packaging) of the Pregabalin. Staff G stated that they relied on information recorded in Resident 1's individual records in the narcotic logbook that stated, Pregabalin 50 MG, "Take one capsule PO (by mouth) AM and PM".

Medication error 2

Review of Incident report (IR) dated 05/09/2026 showed Resident 1 received the incorrect dosage of their pregabalin medication. The IR showed Resident 1 received 50 MG of the medication instead of 75 MG for their bedtime dose. The IR showed the medication error was reported by Staff H, MT to Staff B.

Review of Resident 1's eMAR dated May 2026 showed Staff H initialed the Pregabalin 75 mg bedtime dose as given, when the medication error in the IR showed that the 50 mg dosage was given.

During an interview on 06/30/2026 at 2:30 PM and 3:05 PM, Staff B stated that Staff H, MT gave the incorrect dosage to Resident 1 on 05/09/2026 which was a separate medication error incident. Regarding the 05/01/2026 medication error incident, Staff B acknowledged that Staff G might have given the incorrect dosage to Resident 1 as the number of Pregabalin 75 MG doses recorded in the Narcotic logbook remained unchanged at 21 capsules on 05/01/2026. Staff B stated that they did not investigate the 05/01/2026 incident until an investigation was started for the 05/09/2026 incident on 05/12/2026 when Staff B conducted their random medication cart audit. Additionally, Staff B stated that their procedure involves updating and rewriting the individual narcotic record (logbook) whenever a new order for any controlled medication was received. Staff B stated that they failed to update page 29 of Resident 1's individual narcotic records after they received the new order on 04/21/2026, which increased the Pregabalin bedtime dose from 50 MG to 75 MG. Staff B added that the 75MG was not for PM but was for Bedtime. Staff B stated that their bedtime medication administration was 9:00 PM.

Review of the facility's Narcotic logbook titled "INDIVIDUAL NARCOTIC RECORD" for Resident 1 showed on page 29 that Pregabalin medication of 50 MG was prescribed as one capsule PO (by mouth) to be taken in "AM and PM". The record showed 59 capsules of the medication were received by the staff and logged on 03/29/2026. The record showed an entry for 05/01/2026 was dated, timed, and initialed by Staff G, with the medication quantity crossed out. Page 30 of the record showed that Resident 1's Pregabalin 75 MG capsule was to be taken one capsule by mouth nightly at bedtime,

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with 30 capsules logged as received by the staff on 04/20/2026. The record showed a missed dose was documented on 05/01/2026. Additionally, Pages 29, 30, and 32 of Resident 1's individual narcotic records for Pregabalin medications contained multiple alterations related to dates, times, and quantities of documented medications. The records on page 29 were not updated according to the current physician orders. Specifically, page 29 showed the Pregabalin dosage of 50 MG, instructions to "Take one capsule PO (by mouth) AM and PM," were not revised to reflect the instructions from the new prescription dated 04/23/2026, which increased the PM dosage from 50 MG to 75 MG at bedtime.

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) 08/17/2026.

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

Administrator (or Representative) — Date: 07/21/2026

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_____ _____

Administrator (or Representative) Date

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