STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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) 80186 (Completion Date 07/13/2026) and 77752 (Completion Date 05/28/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/13/2026 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-2371, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2371-4, WAC 388-78A-2450-2-c, WAC 388-78A-2450-2-e, WAC 388-78A-2484, WAC 388-78A-2484-1, WAC 388-78A-2484-2, WAC 388-78A-2730-1-a, WAC 388-78A-2730-1-b, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-a-i, WAC 388-78A-2140-1-a, WAC 388-78A-2140-5

The Department staff who did the on-site verification:
Sunny Kent, Licensor
Scottie Sindora, ALF Licensor

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

This document was prepared by Residential Care Services for the Locator website.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies	License #: 2420	Compliance Determination # 77752
Plan of Correction	Mukilteo Memory Care	Completion Date
Page 1 of 12	Licensee: HSP - Harbour Point LLC	05/28/2026

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 the unannounced on-site full inspection and complaint investigation on 05/20/2026 and 05/22/2026 of:
Mukilteo Memory Care
4686 Pointes Dr
Mukilteo, WA 98275

This document references the following complaint numbers: 224783.

The following sample was selected for review during the unannounced on-site visit: 9 of 61 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Scottie Sindora, ALF Licensor
Sunny Kent, Licensor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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Statement of Deficiencies	License #: 2426	Compliance Determination # 77752
Plan of Correction	Mukilteo Memory Care	Completion Date
Page 2 of 12	Licensee: HSP - Harbour Point LLC	05/28/2026

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

6/2/2026
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.

Mirell
Administrator (or Representative)

6/5/2026
Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure resident incidents and injuries were investigated by the facility for 1 of 9 sampled residents (Resident 8). This left Resident 8 at risk for future concerns secondary to a lack of information about the event.

Findings included...

NOTE: The ALF's policy "Reporting Incidents", policy number 60.010, dated 2019, shows that, "the following occurrence types require the completion of an incident report..." Falls, both injury and non-injury, were the first item on the list.

Record review of a Face Sheet, printed on 05/20/2026 showed the ALF admitted Resident 8 on [redacted]/2024 with disabling diagnoses including [redacted] and [redacted]

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[redacted]

Record review of Progress Notes, dated 02/05/2026 at 9:56 PM, showed Resident 8 experienced an unwitnessed fall. Resident 8 was found by staff sitting beside their bed. When interviewed by staff, Resident 8 stated that they lost their balance and fell while making their bed.

Record review showed no documentation the ALF conducted an investigation that determined the circumstances of events, or whether further interventions were necessary in protection of the resident.

In an email, dated May 22, 2026 at 8:33 AM, the Department Representative emailed Staff F (Director of Wellness) and requested internal investigations for the unwitnessed fall on 02/05/2026. Staff F stated in the email that there was no internal investigation for the unwitnessed fall on 02/05/2026.

During an interview, on 05/22/2026 at 12:22 PM, Staff F confirmed there was no internal investigation for Resident 8's unwitnessed fall on 02/05/2026.

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) 6/30/2026 .

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

[redacted] 6/5/2026

Administrator (or Representative) Date

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(c) Verify prior to hiring that staff persons have the required licenses, certification, registrations, or other credentials for the position, and that such licenses, certifications, registrations, and credentials are current and in good standing;

(e) Ensure all resident care and services are provided only by staff persons who have the training, credentials, experience, and other qualifications necessary to provide the care and services;

This requirement was not met as evidenced by:

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Statement of Deficiencies	License #: 2426	Compliance Determination # 77752
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Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 5 staff (Staff B) held a valid caregiver certificate. This placed the ALF's 61 residents in the care of a staff person who did not have the level of training required by the Department to provide care and services to vulnerable adults.

Findings included...

NOTE: WAC 388-112A 0090 shows, Which long-term care workers are exempt from the 70-hour long-term care worker basic requirement?
The following long-term care workers are exempt from the 70-hour long-term care worker basic training requirement:
(1) An individual employed as a long-term care worker on January 6, 2012, who complied with the basic training requirements in effect on the date of hire;
(2) An individual previously employed as a long-term care worker who complied with the basic training requirements in effect on the date of hire and was employed as a long-term care worker at some time between January 1, 2011, and January 6, 2012;

Record review showed the ALF hired Staff B as a Wellness Coordinator on 11/25/2015. Further review showed Staff B held a Nursing Assistant Registration (NA-R) certificate, with an initial issuance date of 11/27/2013. Review of the Provider Credential Search showed no NA-C or HCA certification for Staff B.

In an email, on 05/21/2026 at 9:47 AM, Staff I (Business Office Manager) stated that, "I have talked to them (Staff B), and they have agreed to enroll in classes to take either the HCA or the CNA course/test".

During the exit interview on 05/22/2026 at 1:55 PM, Staff H (Executive Director) expressed understanding of the requirements.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 6/5/2026

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WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 5 sampled staff (Staff A) completed a two-step TB skin test. This placed 61 residents at risk for receiving care from a staff person whose TB history was incomplete.

Findings included...

Record review of an Employee List, dated 05/20/2026, showed the ALF hired Staff A on 03/12/2026 as a Resident Caregiver. Review of employee files showed Staff A received a Mantoux skin test (a type of skin test to determine if a person is infected with Mycobacterium tuberculosis) on 03/11/2026. The test was read 03/13/2026 and showed Staff A did not have active TB. The employee file also included lab results which showed Staff A underwent a QuantiFERON TB blood test (a blood test used to detect Mycobacterium tuberculosis) on 01/30/2025, with negative results. The blood test was completed 14 1/2 months before the date of hire and did not meet the criteria to be included as a first test.

Record review showed Staff A did not complete the two-step TB skin test.

During the exit interview on 05/22/2026 at 1:55 PM, Staff F (Director of Wellness) and Staff H (Executive Director) expressed understanding and confirmed Staff A had no other TB test results.

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Plan/Attestation Statement

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Administrator (or Representative) 6/5/2026 Date

WAC 388-78A-2730 Licensee's responsibilities.

(1) The assisted living facility licensee is responsible for:

(a) The operation of the assisted living facility;

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to renew the Medical Testing Site Waiver/Clinical Laboratory Improvement Amendments (MTSW/CLIA) waiver certificate by the expiration date of 09/30/2025. This placed 61 of 61 residents at risk for receiving waived tests, such as COVID tests and blood glucose monitoring, without the ALF having obtained the proper certificate.

Findings included...

Record review showed the ALF had a MTSW/CLIA certification with an expiration date of 09/25/2025. A search of the Center for Medicare & Medicaid Services – CLIA Laboratory search engine found no CLIA number for the ALF.

During the exit interview on May 22, 2026 at 1:55 PM, Staff H (Executive Director) confirmed the ALF did not have a current MTSW/CLIA waiver certificate.

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Plan/Attestation Statement

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Administrator (or Representative) 6/5/2026 Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure the Negotiated Service Agreement (NSA) contained relevant interventions or information to meet the care and service needs for 8 of 9 residents (Resident 1, 2, 3, 4, 5, 6, 7, and 8). This placed Residents 1, 2, 3, 4, 5, 6, 7, and 8 at risk of harm by not having their care needs met.

Findings included...

In an interview, on 05/21/2026 at 9:00 AM, Staff G (Medication Technician) stated that all information for the care of each resident would be found in their Service Plan (equivalent to NSA). Staff G stated that the service plans were updated regularly.

Resident 1

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Record review showed Resident 1 was admitted into the Memory Care Unit (MCU) on [redacted]/2025 with multiple medical diagnosis including [redacted] and [redacted].

Record review of Resident 1's assessment, dated 03/13/2026, showed [redacted] as a primary diagnosis. Further review showed the resident had "specific behaviors or symptoms that cause concerns" including resistance to care, hallucinations, episodes of frequent anxiety.

Record review of Resident 1's Medication Administration Record (MAR) for May, 2026, showed Resident 1 took Mirtazapine 30 milligrams (mg) daily for depression, Risperdone 1.5 mg twice a day (an antipsychotic medication used to treat schizophrenia, bipolar disorder, and irritability), Sertraline 150 mg daily for depression, and Aspirin 81 mg daily as a blood thinner.

Record review of Resident 1's Service Plan, dated 05/20/2026 gave no information regarding the signs and symptoms, or how to monitor, for Resident 1's depression, anxiety, or hallucinations, and did not state any interventions to assist with the resident's health and safety. In addition, there was no mention Resident 1 was taking blood thinners, or the signs and symptoms to monitor, and report to the nurse.

Resident 2

Record review showed Resident 2 was admitted into the MCU on [redacted]/2025 with multiple medical diagnosis including [redacted] and [redacted].

Record review of Resident 2's assessment, dated 05/05/2026, showed [redacted] as a primary diagnosis. Further review stated that the resident had "current or history of occasional anxiety." Record review of Resident 2's progress notes, dated 02/20/2026, stated, "this nurse reached out to PCP [Primary Care Physician] to inform about increased behaviors. Behaviors being more pushy and irritated" and on 05/12/2025, the resident received new medication of Olanzapine for, "agitation or in situations to prevent agitation when it might be likely."

Record review of Resident 2's MAR, for May 2026, showed Resident 2 took Escitalopram 20 mg daily for generalized anxiety, and Droabinol 2.5 mg daily for neurocognitive disorder.

Record review of Resident 2's Service Plan, dated 05/05/2026 gave no information regarding the signs and symptoms, or how to monitor, for Resident 2's anxiety, and did not state any interventions to assist with the resident's health and safety.

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Resident 3

Record review showed Resident 3 was admitted into the MCU on [redacted]/2023 with multiple medical diagnosis including [redacted] and [redacted].

Record review of Resident 3's assessment, dated 12/03/2025, showed the resident took an anti-coagulant daily. Record review of Resident 3's MAR, for May 2026, showed Resident 3 took Apixaban 2.5 mg twice daily to prevent blood clots.

Record review of Resident 3's Service Plan, dated 12/03/2025 gave no information regarding the signs and symptoms, or what to monitor for adverse side effects of blood thinners including frequent nose bleeds, gastrointestinal distress, sudden severe headaches or internal bleeding.

Resident 4

Record review showed Resident 4 was admitted into the MCU on [redacted]/2023 with multiple medical diagnosis including [redacted] and [redacted].

Record review of Resident 4's assessment, dated 12/31/2025, stated the resident had, "occasional anxiety issues, occasional mood and depression issues" and, "occasional disruptive, aggressive or socially inappropriate behavior, either verbally or physically improper. May require special tolerance or staff training."

Record review of Resident 4's MAR, for May 2026, showed the resident took Escitalopram 5 mg daily, and Trazodone 100 mg daily, for depression.

Record review of Resident 4's Service Plan, dated 01/02/2026 gave no information regarding the signs and symptoms, or how to monitor, for Resident 4's anxiety, depression, or inappropriate behaviors. There were no interventions for staff to assist with the resident's health and safety.

Resident 5

Record review showed Resident 5 was admitted into the MCU on [redacted]/2024 with multiple medical diagnosis including [redacted] and [redacted]. Record review of the Resident Characteristic Roster (RCR), dated 05/20/2026, showed

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Resident 5 had a long term Foley urinary catheter (a thin, flexible, indwelling tube inserted through the urethra into the bladder to drain urine).

Record review of Resident 5's assessment, dated 01/02/2026, showed the resident was independent with catheter care and, "will ask for assistance if anything seems off about his catheter."

In an interview, on 05/22/2026 at 10:15 AM, Resident 5 stated that he is in charge of his catheter bag, but the staff checked on it every once in a while. Resident 5 stated that he wasn't sure what problems could arise, aside from the bag leaking.

Record review of Resident 5's progress notes, dated 04/27/2026 stated "resident was noted with slightly swollen feet, after being evaluated by the DOW [Director of Wellness], catheter found to be tied unto [sic] his leg too tight causing a restriction." On 05/01/2026, the progress notes stated "Resident's catheter bag was leaking, called HH [Home Health] and left a voicemail. HH returned the call, spoke with the nurse, but they are currently full capacity but will try to send a nurse."

Record review of Resident 5's Service Plan, dated 01/02/2026 gave no information regarding what to monitor for Resident 5's catheter. There were no interventions for staff to assist with the resident's health and safety related to catheter care.

Resident 6

Record review of a Face Sheet, dated 05/20/2026, showed the ALF admitted Resident 6 on [redacted]/2025 with disabling diagnoses including [redacted] and [redacted].

Record review of a "HSE and Washington Results and Service Plan" (equivalent to an Assessment), completed on 04/03/2026, showed that under the category of "Transferring Level of Assistance", Resident 6 was assessed as "Independent". Under "Transferring Enabling Devices and Methods", the assessor documented, "None Apply".

During an interview and observation with Resident 6 on 05/21/2026 at 1:45 PM, observation showed a bed mobility device, commonly known as a bed cane, fastened to the right side (facing) of Resident 6's double bed. The bed cane measured 13 inches long by 19 inches tall, with the top of the cane shaped like an upside down 'U'. The lower portion was covered with black vinyl fabric to prevent entrapment. Manipulation of the bed cane by the Department Representative showed the bed cane was firmly fastened to the bed and was not easily moved. Resident 6 explained that they used the

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bed cane every day to get out of their bed and would not remain independent during transfers without it. Resident 6 also stated that the bed cane was firmly fastened to the bed frame and did not move or slide while they used it for transfers.

A Service Plan, dated 04/03/2026, did not show any reference to the bed cane, how it was used, or how staff would monitor the bed cane to ensure it remained safe for Resident 6 to use independently.

Resident 7

Record review of a Face Sheet, dated 05/20/2026, showed the ALF admitted Resident 7 on [redacted]/2025 with disabling diagnoses including [redacted] or [redacted]. Review of electronic Medication Administration Records for February, March, April and May 1-20, 2026 showed Resident 7 took a twice daily anticoagulant medication to treat the a-fib.

Record review of a "HSE and Washington Results and Service Plan," dated 12/01/2025, showed no documented side effects to address potential health risks of daily administration of an anticoagulant medication. Review of a Service Plan (equivalent to a Negotiated Service Agreement), dated 12/05/2025, did not show documented side effects to address potential health risks of daily administration of an anticoagulant medication.

During an interview on 05/22/2026 at 12:20 PM, Staff F (Director of Wellness) reviewed documents for Resident 7 and agreed there was no anticoagulant safety plan for staff to use as a resource if Resident 7 exhibited side effects from the medication.

Resident 8

Record review of a Face Sheet, dated 05/20/2026, showed the ALF admitted Resident 8 on [redacted]/2024 with disabling diagnoses including [redacted] and [redacted].

Record review of a "HSE and Washington Results and Service Plan," dated 04/10/2026, showed Resident 8 had current or a history of frequent disruptive, aggressive, or socially inappropriate behaviors, either physically or verbal improprieties that may require a professional consult or staff training. Review of a Service Plan (equivalent to a Negotiated Service Agreement), dated 04/10/2026, showed Resident 8 experienced frequent hallucination and delusion issues in addition to the behavior issues. The Service Plan did not show any documented interventions for the behavior issues or the

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hallucinations and delusions.

During an interview on 05/22/2026 at 12:20 PM, Staff F stated that Resident 8 would sometimes perseverate on a particular former relative during conversation and required redirection to bring him back to the topic of discussion. Staff F reviewed documents for Resident 8 and agreed there were no interventions developed for staff to manage Resident 8's behaviors, delusions and hallucinations.

During an interview on 05/22/2026 at 1:00 PM, Resident 8 exhibited the behaviors documented on the Service Plan and wanted to discuss the former relative. The Department Representative used distraction to bring the resident back to the topics outlined in the Resident interview.

This citation was previously cited on 11/07/2024.

Plan/Attestation Statement

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

[signature] 6/5/2026

Administrator (or Representative) Date

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