STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

PSL Associates, LLC
Gig Harbor Court, Independent Living & Assisted Living
3213 45th Street Ct NW
Gig Harbor, WA 98335

RE: Gig Harbor Court, Independent Living & Assisted Living License # 2477

Dear Administrator:

This letter addresses Compliance Determination(s) 66344 (Completion Date 10/01/2025) and 62604 (Completion Date 07/25/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/01/2025 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-2210-1-b

The Department staff who did the on-site verification:
Michael Goulet, Complaint Investigator

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Laurie Anderson

Laurie Anderson, Community Field Manager
Region 3, Unit D
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Gig Harbor Court, Independent Living & Assisted Living
License/Cert.#: 2477
Compliance Determination #: 62604
Investigator: Michael Goulet
Provider Type: Assisted Living Facility
Intake ID: 185378
Region/Unit #: RCS Region 3 / Unit D
Investigation Date(s): 07/15/2025 through 07/25/2025
Complainant Contact Date(s): 07/09/2025, 07/25/2025

Allegation(s):

1) Incorrect eye drop medication delivered to resident on 6/10/25
2) Medication (Xarelto) missing (not administered) on 6/1/25, and facility med tech (Staff F) stated "nobody re-ordered the medication"
3) Medication (Xarelto, Metoprolol) missing (not administered) on [redacted]/25
4) "Unknown pill" missing (not administered) on 6/8/25
5) Medications administered late on most days in May and June 2025
6) Resident transferred to facility from skilled nursing facility with "buttsore" and "Tylnol" (sic, Tylenol/ Acetaminophen; unclear what allegation is meant to be inferred by this statement)

Investigation Methods:

Sample:	Total residents: Resident sample size: 5 Closed records sample size:
Observations:	General environment Resident Condition Residents in their rooms
Interviews:	Residents Staff
Record Reviews:	Medication Administration Records Email comunication between POA and facility

Investigation Summary:

1) Per interview, the complainant stated that Rocklatan eye drops (a combination of Latanoprost and Netardusil) was administered to the named resident instead of Xalatan (Latanorprost only). Per record review of facility medication administration records (MAR) for the named resident, there was no facility documentation of any Rocklatan eye drops being administered to the named resident. It is possible that the similarity in the medication names (Rocklatan, Xalatan) led to some confusion. In reviewing medication records for other facility residents who receive the administration of eye drops from facility med techs, no other resident was noted to have Rocklatan eye drops. No information available served to substantiate this

allegation.
2) Per record review of the named resident's MAR, the medication Xarelto (blood thinner) was not administered as ordered on 6/1/25, and was noted in the MAR exceptions as "will be delivered (by pharmacy) tonight" by facility med tech (Staff F). This medication was not available most likely due to facility staff not re-ordering the medication in a timely manner. Several other instances of medication not being available due to not being re-ordered in a timely manner or to not being located in the medication cart by staff were also noted for the named resident: Doxycycline, not available on 5/28/25 and noted by med tech Staff H as being "unavailable"; Citalopram (aka Celexa, anti-depressant medication) not available on 7/2/25 and noted as "re-ordered and coming tonight" by med tech Staff H; and Jardiance (diabetic medication) not available on 7/2/25 and noted as "re-ordered and coming tonight" by med tech Staff H). These issues were cited as per notation below.
3) Per record review of the named resident's MAR, the medications Xarelto (administered once daily at 5:00pm) and Metoprolol (blood pressure medication, administered twice daily at 10:00am and 5:00pm) were noted to have been administered at 5:00pm on [redacted]/25. Per interview with the facility Director of Nursing Services (DNS, Staff A), the named resident was admitted to the facility late in the day on [redacted]/25 (and therefore would not have received the 10:00am dose of Metoprolol from staff at this facility).
4) Per record review of the complainant's narrative, it was initially stated that on 6/8/25 the named resident "received two only pills, should have been four", and then later stated as "the med tech delivered three pills, should have been four", but with no statement of what pill or pills were not administered on this date. Per interview, the complainant stated, "I assumed it was Xarelto (that was not administered), because there were two other times that was not available". Per record review of the named resident's MAR, they were scheduled to be administered Xarelto, Famotidine (antacid), Metoprolol and Melatonin (sleep supplement) at 5:00pm on 6/8/25, and per this record all of these medications had been administered for the named resident at this time on 6/8/25.
5) Per record review of the MARs for multiple residents, including the named resident, no exact time of administration is noted in this record. Per interview, the named resident initially stated there had been no instances of late or missing medication administration, then later in the same interview stated medications have been "six hours late". The named resident also stated not receiving medications on a date (7/14/25) when all medication were noted as being administered. The named resident did show some signs of mild to moderate cognitive impairment, and did not present as a good historian. Per interviews with multiple peers in the facility who receive significant medication assistance/ administration from facility staff, none stated any significant issues related to medications being administered on time. Unable to substantiate this allegation.
6) Per complainant interview, the facility "did not have the cream for her (AV's) pressure ulcer" on admit to the facility ([redacted]/25). Per interview, the facility DNS stated that the named resident had been noted to have a blister (not a pressure ulcer) to their buttocks on admission, and that a note (not a written order) from the resident's former skilled nursing facility noted the suggested use of zinc oxide cream. Per the DNS, any topical medication for this issue would require an order form the resident's physician, and barrier cream (which does not require a physician's order) was used until the facility did receive orders for antibiotic ointment (Mupirocin) for the resident on 5/27/25.
Multiple issues were noted with medication availability for both the named resident and for other residents in the facility, likely due to both not re-ordering medications in a timely manner, and to not organizing medications in a manner where all staff were able to easily locate these medications, thus leading to lapses in medication administration.
These issues were cited as per WAC 388-78A-2210 (1b) Medication Services

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
PO Box 99250, Lakewood, WA 98496

Statement of Deficiencies	License #: 2477	Compliance Determination # 62604
Plan of Correction	Gig Harbor Court, Independent Living & Assisted Living	Completion Date
Page 1 of 4	Licensee: PSL Associates, LLC	07/25/2025

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 07/15/2025 of:

Gig Harbor Court, Independent Living & Assisted Living
3213 45th Street Ct NW
Gig Harbor, WA 98335

This document references the following complaint number(s): 185378

The following sample was selected for review during the unannounced on-site visit: 5 of 0 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Michael Goulet, Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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: 07/30/2025

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: 8/6/2025

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.

This requirement was not met as evidenced by:

Based on interviews and record review, the assisted living facility (ALF) failed to ensure that 3 of 5 residents (Resident 1, 2, & 3 [R1, 2, & 3) received medications as ordered. This failure placed all facility residents at potential risk of physical harm related to not receiving needed care and services.

Findings Included...

Record review of R1's Medication Administration Records (MAR) for June 2025 showed that R1 did not receive administration of Xarelto (medication used to reduce risk of stroke and blood clots) at 5:00pm on 06/01/2025 as ordered due to the medication not being available for administration. Per MAR exception notes, the medication was noted by Staff F, Med Tech, as "will be delivered tonight," supporting that this medication was not re-ordered in a timely manner.

Record review of R1's MAR for May 2025 showed that R1 did not receive administration of doxycycline (antibiotic medication to treat bacterial infections) at 8:00am on 05/28/2025 as ordered due to the medication being noted as "medication unavailable" by Staff H, Med Tech, although this medication was noted to have been administered at all other times due by facility staff.

Record review of R2's MAR for June 2025 showed that R2 did not receive administration of Bumetanide (medication used to treat swelling) at 8:00pm on 06/12/2205 as ordered due to the medication being noted as "not in (medication) cart" by Staff B, Med Tech, although this medication was noted to have been administered at all other times due by facility staff.

Record review of R2's MAR for June 2025 showed that R2 did not receive administration of Metoprolol at 8:00am and 8:00pm on 06/21/2025 as ordered due to the medication being noted as "not in (medication) cart" by Staff I, Med Tech, although this medication was noted to have been administered without issue at all other times due by other facility staff.

Record review of R2's MAR for July 2025 showed that R2 did not receive administration of spironolactone (medication for high blood pressure) on 07/06/2025 as ordered due to the medication being noted as "not in cart" by Staff B as well as on 07/07/2025 and 07/08/2025 as noted by Staff C, Med Tech, and 07/10/2025 as noted by Staff B although this medication was noted to have been administered without issue at all other times due by facility staff.

Record review of R2's MAR for July 2025 showed that R 2 did not receive administration of baclofen (medication for muscle spasm) on 07/06/2025 as ordered due to the medication being noted as "waiting on refill" by Staff C, Med Tech, who also noted this medication as being administered as ordered on 07/07/2025, and then noted the same medication as "medication not available" on 07/08/2025. This medication was noted as "not in cart" on 07/09/2025 by Staff B and noted as "medication not available" on 07/10/2025 by Staff C, although this medication was noted to have been administered without issue at all other times due by facility staff.

Record review of R3's MAR for June 2025 showed that R3 did not receive administration of Miebo (eye drops) on 06/11/2025 at 8:00am and 12:00pm due to the medication being noted as "waiting for delivery" by Staff C, then this medication was noted to be administered at 4:00pm and 8:00pm by Staff B. The following day (06/12/2025) this medication was again noted to be unavailable and "coming from pharmacy" by Staff C but was again noted as being administered at 4:00pm and 8:00pm by Staff B. The following day (06/13/2025) the same medication was noted as being unavailable (due to being undelivered by pharmacy) by Staff C until being administered at 8:00pm by Staff G, Med Tech (Staff G).

Record review of R3's MAR for June 2025 and July 2025 showed that R3 did not receive administration of Miebo on 06/30/2025 at 8:00am and 12:00pm as ordered due to the medication being noted as "waiting on pharmacy" by Staff C, but the same medication was noted as being administered at 4:00pm the same day by Staff B, who also noted the same medication as being non-available at 8:00pm the same day. The following day (07/01/2025), the same medication (Miebo) was noted as "waiting for delivery" at 8:00am by Staff E, Med Tech, then as administered at 12:00pm by Staff G, then again as

"waiting for delivery" at 4:00pm by Staff F, and then again as administered at 8:00pm by Staff F. The following day (07/02/2025) the same medication (Miebo) was noted as being administered by facility med techs at 8:00am (Staff C), 12:00pm (Staff C) and 4:00pm (Staff G), but then this medication was again noted as "not in cart" by Staff G at 8:00pm. The same medication (Miebo) was also noted to be "not in cart" at 8:00pm on 07/05/2025, but was noted in the facility MAR to have been administered without issue at all other times due this month by facility staff.

Record review of R3's MAR for June 2025 showed that R3 did not receive administration of potassium chloride on 06/01/2025 due to the medication being noted as "not in cart" by Staff H, Med Tech. R3 was noted to have been administered this medication by Staff F on 06/02/2025 and 06/03/2025, then the medication was again noted as "not in cart" by Staff G on 06/04/2025 and 06/05/2025, only to be again noted as administered by Staff G on 06/06/2025, and then noted as "waiting on the pharmacy" by the same med tech (Staff G)on 06/07/2025. The same medication (potassium chloride) was noted as "not in cart" on 06/11/2025 by Staff B, but was noted in facility MAR to have been administered without issue at all other times due by facility staff.

During an interview on 07/25/2025 at 1140am, Staff F stated that facility med techs are required to check the overflow (extra medication reserve) prior to noting a medication as 'not available,' and stated that, "I've noticed that a lot of people don't look at that,...they don't do that," prior to listing medications as 'not available' in the medication record. Staff F also stated that the facility "process is to contact the pharmacy" (if a medication is not available), and that "It's a failure; they are not doing their due diligence, they just want to pass and go." Staff F also stated that, "I can train them, but if they don't listen it's like talking to a brick wall."

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, Gig Harbor Court, Independent Living & Assisted Living is or will be in compliance with this law and / or regulation on (Date) 9/12/2025 .

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

8/6/2025

Administrator (or Representative) Date