STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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) 73243 (Completion Date 03/03/2026) and 65890 (Completion Date 01/13/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/03/2026 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-2410-9

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 #: 65890
Investigator: Michael Goulet
Provider Type: Assisted Living Facility
Intake ID: 194198
Region/Unit #: RCS Region 3 / Unit D
Investigation Date(s): 09/19/2025 through 01/13/2026
Complainant Contact Date(s): 09/11/2025, 10/15/2025

Allegation(s):

1) Neglect by facility staff led to amputation of resident's toe
2) No care plan revisions made related to change of condition
3) No showers for extended periods of time
4) No documentation that staff provided wound care for the resident's toe.
5) Fall in August which led to hospitalization and diagnosis of [redacted]
Additional allegations made on 11/14/2025:
6) Staff care checklist documented that named resident received care and services after they were out of the facility.

Investigation Methods:

Sample:	Total residents: Resident sample size: 3 Closed records sample size:
Observations:	General environment Residents in their rooms Condition of residents
Interviews:	other residents Staff
Record Reviews:	Podiatry visit note (07/21/2025) Admission agreement Resident evaluation Care Task checklist (with Temporary Service Plan documentation) Progress Notes

Investigation Summary:

1) Record review of after visit notes from the resident's podiatrist, dated 07/21/2025, showed that by [redacted] 2025, the infection related to ulceration of the Hallux (big toe) on the resident's left foot was resolved, and that the resident completed the course of antibiotic medication as prescribed three days prior to the facility admitting the resident. Per interview with staff at the named resident's Foot

and Ankle Clinic, no orders or recommendations for care were ever communicated to facility staff.
Per facility progress notes, the facility director of nursing services (DNS) contacted NR's family on 08/25/2025 related to a small, superficial open area to the underside of big toe. Ulceration of the same toe was noted in podiatry records dated 07/21/2025, prior to facility admitting the resident. Facility progress notes showed that the Director of Nursing Services (DNS) requested that the resident's Power of Attorney (POA) take the resident to their own physician or to an urgent care facility for further evaluation of this issue. The progress notes on 08/26/2025 showed that facility staff were still 'waiting for resident to be seen by physician asap' (as soon as possible).
Review of the named resident's care plan, dated 07/30/2025, showed the facility staff were aware of the condition of the resident's foot. The care plan showed staff were to report any skin concerns and observe feet during care.
Facility progress notes showed that the resident was taken out of the facility by their POA on [redacted] 2025, and per facility staff and review of facility records, the resident did not return to the facility after [redacted] 2025.
Based on the information available, there was insufficient information to support the allegation that the foot issues were ignored or neglected by the facility staff.
2) Per record review of the named resident's care task checklist, a temporary service plan was developed, labeled as 'TSP' (for temporary service plan), which included status checks and meal reminders. The TSP was initiated 08/04/2025 due to concerns related to a change in the resident's cognitive status.
3) Review of facility progress notes showed the named resident refused two of eight showers in August 2025. Review of the resident's care task checklist showed the named resident received shower assistance on 08/01/2025, 08/04/2025, 08/11/2025, 08/22/2025 and 08/29/2025, with showers noted as undocumented on 08/08/2025, 08/15/2025, 08/18/2025 and 08/25/2025. Per the facility DNS, some activities of daily living such as showers were not consistently documented at this time by all staff. Per interviews and observation of residents with significant care needs, this alone did not serve to substantiate a lack of appropriate care or constitute failed facility practice, as shower logs were not required by the department to be documented in resident records. Unable to substantiate failed practice related to this allegation.
4) Per interview, the facility DNS stated that the assisted living facility does not perform wound care, and that any such care would be contracted by an outside nursing agency (Home Health). Review of podiatry office orders showed there were no wound care orders for the named resident. Interview with podiatry clinic staff supported that no orders or suggestions for wound care regarding the named resident's foot were ever communicated to the facility.
Progress notes on 08/25/2025 showed staff reported an open area to the named resident's large toe. Facility staff contacted the resident's POA and requested the resident be seen be their own physician or an urgent care for evaluation as soon as possible. The notes dated [redacted] 2025 showed that staff documented that named resident left the facility with family on 2025. Named resident did not return to the facility after this date.
5) Review of facility progress notes showed Named Resident experienced an unwitnessed fall on 08/27/2025 while attempting to put their pants on over their shoes. The facility sent the resident to the hospital on 08/27/2025 to rule out head injury. Review of hospital records dated 08/27/2025, small laceration to the back of the head was noted. Records showed named resident was screened for infections and found unlikely. Records showed the hospital discharged the named resident back to the facility on 08/28/2025 without any issues noted.
Review of hospital medical records dated 08/31/2025 showed that family transported named resident to the hospital for a fall at the family’s home. The records showed a diagnosis of [redacted]

and . Further test revealed osteomyelitis (bone infection) in the left foot and was related to the ulcer which was noted in podiatry records pre-dating the resident's admission to the facility and that this issue had not involved (spread to) the remainder of the resident's foot. Records showed toe amputation occurred on 09/09/2025. Multiple blood tests performed were negative for blood borne infection related to this issue. Treatment included antibiotics and transferred to inpatient hospice for end-of-life comfort measures as chosen by family.
6) Review of facility progress notes showed the named resident left the facility with their family on 2025 at 2:00 PM and did not return. Review of the named resident's care task checklist showed facility staff signed off on care for the named resident on the evening of 08/29/2025, on the morning of 08/30/2025 and throughout the day on 08/31/2025. Documentation showed staff signed of that they provided care and services, which included checking skin integrity and resident status, toileting assistance and escorting the resident to meals, on dates when the resident was known to be out of the facility. Citation issued.

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
HOME AND COMMUNITY LIVING ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

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 09/19/2025 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): 194198

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

The department staff that investigated the Assisted Living Facility:

Michael Goulet, Complaint Investigator

From:
DSHS, Home and Community Living 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.

Laurie Anderson
Residential Care Services

01/26/2026
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.

Administrator (or Representative)

1/27/26
Date

WAC 388-78A-2410-1 Content of resident records. The assisted living facility must organize and maintain resident records in a format that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

(9) Documentation consistent with WAC 388-78A-2120 monitoring resident well-being.

This requirement was not met as evidenced by:

Based on interview and record review, the assisted living facility (ALF) failed to ensure that staff accurately documented the care and services provided for one of 1 of 1 resident (Resident 1). This failure placed all facility residents at risk of not receiving care and services as documented.

Findings included...

Record review of Resident 1's (R1) facility Progress Notes, dated [redacted]2025, showed that on this date, R1 was taken out of the facility by family. The progress notes showed that R1 did not return to the facility after this date and time.

Record review of R1's Care Task Checklist, dated August 2025, showed that on the evening of 08/29/2025, on the morning of 08/30/2025 and throughout the day on 08/31/2025, staff documented that R1 received care and monitoring services from facility staff, three different times after R1 left from the facility.

During an interview on 01/12/2026 at 1:30 PM, Staff A, Director of Nursing Services (DNS), stated that entries of care on the Care Task Checklist required facility staff to manually enter their initials into the computer system to document completion of the tasks.

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.

Laurie Anderson
Residential Care Services

01/26/2026
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.

Administrator (or Representative)

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During an interview on 01/12/2026 at 1:30 PM, Staff A, Director of Nursing Services (DNS), stated that entries of care on the Care Task Checklist required facility staff to manually enter their initials into the computer system to document completion of the tasks.

During an interview on 01/13/2026 at 9:00 AM, Staff B, Facility Caregiver, confirmed that staff needed to manually enter their initials into the computer system to document when they completed any residents' care tasks.

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) 2/27/26 .

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

Administrator (or Representative) — Date: 1/27/26

During an interview on 01/13/2026 at 9:00 AM, Staff B, Facility Caregiver, confirmed that staff needed to manually enter their initials into the computer system to document when they completed any residents' care tasks.

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)_____ .

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

_____ _____

Administrator (or Representative) Date