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

PSL Associates, LLC
The Rivers at Puyallup, Independent Living & Assisted Living
611 S Main St Ste 400
Grapevine, TX 76051

RE: The Rivers at Puyallup, Independent Living & Assisted Living License # 2483

Dear Administrator:

This letter addresses Compliance Determination(s) 40288 (Completion Date 05/31/2024) and 31122 (Completion Date 12/01/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/31/2024 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-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3

The Department staff who did the on-site verification:
Carol Gijima, Community Compaint Investigator (NCI)

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

Sincerely,

Jody Just Region 3 Field Services Administrator signing for Manfay Chan

Manfay Chan, Field Manager
Region 3, Unit D
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT 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 follow-up on 10/16/2023 and 10/16/2023 of:
The Rivers at Puyallup, Independent Living & Assisted Living
123 4th Ave NW
Puyallup, WA 98371

This document references the following SOD dated: 12/01/2023

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 inspected the Assisted Living Facility:

Carol Gijima, Community Compaint Investigator (NCI)

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

12/11/2023
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.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT 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 follow-up on 10/16/2023 and 10/16/2023 of:
The Rivers at Puyallup, Independent Living & Assisted Living
123 4th Ave NW
Puyallup, WA 98371

This document references the following SOD dated: 12/01/2023

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 inspected the Assisted Living Facility:

Carol Gijima, Community Compaint Investigator (NCI)

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

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) — 12/14/23 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

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to conduct thorough investigations to determine the circumstances for resident – to - resident altercations and missing money for 3 of 3 sample residents (Residents 1, 2 & 3). This failure placed Residents 1 & 2 at risk for continued physical assaults and delayed interventions, and Resident 3 at risk for potential theft and misappropriation of residents' funds.

Findings included...

Record review on 10/16/2023 of the facility's incident reports showed that on 09/21/2023, Resident 2 (R2) was hit by Resident 1 (R1), the investigation outcome was pending. Another incident report dated 10/20/2023 showed that R3's spouse reported to the complaint investigator that they were missing $600, the outcome of the investigation was pending. There were no investigations on file to review both incidents.

Record review on 10/16/2023 of R1's documents showed that R1 was admitted to the facility on [redacted]/2023 with diagnoses to include [redacted]. The Negotiated Service Agreement (NSA) dated [redacted]2023 did not show that R1 had any physical aggression towards others.

Record review on 10/16/2023 of R2's documents showed that R2 was admitted to the facility on [redacted]/2023 with diagnoses to include [redacted]. The NSA dated [redacted]/2023 did not show that R2 had any wandering behaviors or physical aggression towards others. There was no documentation of protection measures for R2.

Record review of R3's records showed that R3 was admitted to the facility on [redacted]/2022. The NSA dated 02/03/2023 showed that R3 did not have cognitive concerns.

Administrator (or Representative) 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

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to conduct thorough investigations to determine the circumstances for resident – to - resident altercations and missing money for 3 of 3 sample residents (Residents 1, 2 & 3). This failure placed Residents 1 & 2 at risk for continued physical assaults and delayed interventions, and Resident 3 at risk for potential theft and misappropriation of residents' funds.

Findings Included…

Record review on 10/16/2023 of the facility's incident reports showed that on 09/21/2023, Resident 2 (R2) was hit by Resident 1 (R1), the investigation outcome was pending. Another incident report dated 10/20/2023 showed that R3's spouse reported to the complaint investigator that they were missing $600, the outcome of the investigation was pending. There were no investigations on file to review both incidents.

Record review on 10/16/2023 of R1's documents showed that R1 was admitted to the facility on [redacted]/2023 with diagnoses to include [redacted]. The Negotiated Service Agreement (NSA) dated [redacted]/2023 did not show that R1 had any physical aggression towards others.

Record review on 10/16/2023 of R2's documents showed that R2 was admitted to the facility on [redacted]/2023 with diagnoses to include [redacted]. The NSA dated [redacted]/2023 did not show that R2 had any wandering behaviors or physical aggression towards others. There was no documentation of protection measures for R2.

Record review of R3's records showed that R3 was admitted to the facility on [redacted]/2022. The NSA dated 02/03/2023 showed that R3 did not have cognitive concerns.

During an interview on 10/16/2023 at 10:20am, Staff B, Memory Care Director stated that R1 was aggressive. When asked what the circumstances of the incident with R2 were, Staff B stated the licensed nurse would have more information. When asked what interventions were put in place to prevent similar incidents from happening again, Staff B stated that R1 was on a 1:1 for a while. There was no documentation provided of appropriate measures to prevent continued aggression.

During an interview on 10/16/2023 at 10:40am, R3's Resident Representative (RR1) stated that R3 had over $600 missing from his wallet. RR1 stated that R3 did not spend the money anywhere as she would have known about it.

During an interview on 10/16/2023 at 11:58am, Staff A, Administrator was asked about the incident between R1 and R2. Administrator stated that they were new to the community but would send the investigation report. When asked about R3's allegations of missing money, Staff A stated they were not aware of the complaint, stated that they would investigate and send the investigation report. In a separate interview on 11/30/2023 at 1:05pm, Staff A was asked about the outcomes of the investigations as well as the reports. Staff A stated that the police were notified about the missing money and the complaint had already been investigated in November 2022. Staff A stated that the investigations would be sent. No investigations were received.

During an interview on 12/01/2023 at 12:55pm, Staff C, Resident Care Coordinator stated that the licensed nurse was responsible for investigating resident incidents. When asked the circumstances surrounding R1 & R2's incident, Staff C stated that they were not aware of it as they did not work in the unit at the time. Staff C stated that the police were called, and the facility was going to send R1 to the hospital, but his family refused. Staff C stated that Staff D, Regional Nurse would know more about the incident.

During an interview on 12/01/2023 at 12:59pm, Staff D was asked what the circumstances of the incident between R1 & R2 were, Staff D stated that the police and family were called and R1 was placed on a 1:1 for about a week and given some medicine. When asked what interventions were put in place to prevent recurrence, Staff D stated that they were not in the building at the time but was made aware of the incident.

During an interview on 12/01/2023 at 1:13pm, Staff E, Assistant Executive Director stated that resident incidents were to be investigated to determine the causes, that other residents would be interviewed as well as staff. Executive Director stated that when the investigation is complete, they implement measures which would be documented on the care plan of progress notes. No documentation of appropriate prevention measures was provided.

This is an uncorrected deficiency previously cited on 07/26/2023.

During an interview on 10/16/2023 at 10:20am, Staff B, Memory Care Director stated that R1 was aggressive. When asked what the circumstances of the incident with R2 were, Staff B stated the licensed nurse would have more information. When asked what interventions were put in place to prevent similar incidents from happening again, Staff B stated that R1 was on a 1:1 for a while. There was no documentation provided of appropriate measures to prevent continued aggression.

During an interview on 10/16/2023 at 10:40am, R3's Resident Representative (RR1) stated that R3 had over $600 missing from his wallet. RR1 stated that R3 did not spend the money anywhere as she would have known about it.

During an interview on 10/16/2023 at 11:58am, Staff A, Administrator was asked about the incident between R1 and R2. Administrator stated that they were new to the community but would send the investigation report. When asked about R3's allegations of missing money, Staff A stated they were not aware of the complaint, stated that they would investigate and send the investigation report. In a separate interview on 11/30/2023 at 1:05pm, Staff A was asked about the outcomes of the investigations as well as the reports. Staff A stated that the police were notified about the missing money and the complaint had already been investigated in November 2022. Staff A stated that the investigations would be sent. No investigations were received.

During an interview on 12/01/2023 at 12:55pm, Staff C, Resident Care Coordinator stated that the licensed nurse was responsible for investigating resident incidents. When asked the circumstances surrounding R1 & R2's incident, Staff C stated that they were not aware of it as they did not work in the unit at the time. Staff C stated that the police were called, and the facility was going to send R1 to the hospital, but his family refused. Staff C stated that Staff D, Regional Nurse would know more about the incident.

During an interview on 12/01/2023 at 12:59pm, Staff D was asked what the circumstances of the incident between R1 & R2 were, Staff D stated that the police and family were called and R1 was placed on a 1:1 for about a week and given some medicine. When asked what interventions were put in place to prevent recurrence, Staff D stated that they were not in the building at the time but was made aware of the incident.

During an interview on 12/01/2023 at 1:13pm, Staff E, Assistant Executive Director stated that resident incidents were to be investigated to determine the causes, that other residents would be interviewed as well as staff. Executive Director stated that when the investigation is complete, they implement measures which would be documented on the care plan of progress notes. No documentation of appropriate prevention measures was provided.

This is an uncorrected deficiency previously cited on 07/26/2023.

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, The Rivers at Puyallup, Independent Living & Assisted Living is or will be in compliance with this law and / or regulation on (Date) 12/31/2023 .

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

Administrator (or Representative) — Date: 12/14/2023

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, The Rivers at Puyallup, 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

Residential Care Services
Investigation Summary Report

Provider/Facility: The Rivers at Puyallup, Independent Living & Assisted Living
License/Cert.#: 2483
Compliance Determination #: 22500
Investigator: Carol Gijima
Investigation Date(s): 04/13/2023 through 07/26/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 77123
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
1. Resident to resident incident

Investigation Methods:

Sample:	Total residents: Resident sample size: 4 Closed records sample size: 3
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Residents Resident representatives Staff
Record Reviews:	Resident Characteristic Roster Resident assessments and negotiated service agreements including the records of the named resident Medication administration records (MAR) Staff records Staff progress notes Incident log / reports

Investigation Summary:
1. Per record review, interviews with collateral contacts and staff, the facility failed to investigate a resident to resident incident and implement interventions. The ALF demonstrated failed provider practice as documented in a Statement of Deficiencies dated 07/26/2023.

Conclusion / Action:

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

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: The Rivers at Puyallup, Independent Living & Assisted Living
License/Cert.#: 2483
Compliance Determination #: 22500
Investigator: Carol Gijima
Investigation Date(s): 04/13/2023 through 07/26/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 76948
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
Resident to resident incident

Investigation Methods:

Sample:	Total residents: Resident sample size: 4 Closed records sample size: 3
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Residents Resident representatives Staff
Record Reviews:	Resident Characteristic Roster Resident assessments and negotiated service agreements including the records of the named resident Medication administration records (MAR) Staff records Staff progress notes Incident log / reports

Investigation Summary:
1. Per record review, interviews with named resident, collateral contacts and staff, the facility failed to investigate a resident to resident incident, and failed to assess, evaluate and take appropriate action when a resident had a change in condition/behaviors. Failed facility practice identified. The ALF demonstrated failed provider practice as documented in a Statement of Deficiencies dated 07/26/2023.

Conclusion / Action:

[X] Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: The Rivers at Puyallup, Independent Living & Assisted Living
License/Cert.#: 2483
Compliance Determination #: 22500
Investigator: Carol Gijima
Investigation Date(s): 04/13/2023 through 07/26/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 86648
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
Resident to resident incident

Investigation Methods:

Sample:	Total residents: Resident sample size: 4 Closed records sample size: 3
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Residents Resident representatives Staff
Record Reviews:	Resident Characteristic Roster Resident assessments and negotiated service agreements including the records of the named resident Medication administration records (MAR) Staff records Staff progress notes Incident log / reports

Investigation Summary:
1. Per record review, interviews with resident representatives, collateral contacts and staff, the facility failed to investigate a resident to resident incident which resulted in significant injury. The ALF demonstrated failed provider practice as documented in a Statement of Deficiencies dated 07/26/2023.

Conclusion / Action:

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

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: The Rivers at Puyallup, Independent Living & Assisted Living
License/Cert.#: 2483
Compliance Determination #: 22500
Investigator: Carol Gijima
Investigation Date(s): 04/13/2023 through 07/26/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 80126
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
1. Resident sustained injury after a fall

Investigation Methods:

Sample:	Total residents: Resident sample size: 4 Closed records sample size: 3
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Residents Resident representatives Staff
Record Reviews:	Resident Characteristic Roster Resident assessments and negotiated service agreements including the records of the named resident Medication administration records (MAR) Staff records Staff progress notes Incident log / reports

Investigation Summary:
1. Per record review, interviews with staff, the facility failed to investigate the circumstances surrounding a resident fall with significant injury. The ALF demonstrated failed provider practice as documented in a Statement of Deficiencies dated 07/26/2023.

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

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 04/13/2023 and 06/27/2023 of:

The Rivers at Puyallup, Independent Living & Assisted Living
123 4th Ave NW
Puyallup, WA 98371

This document references the following complaint number(s): 77123, 76948, 86648, 80126

The following sample was selected for review during the unannounced on-site visit: 4 of 0 current residents and 3 former residents.

The department staff that investigated the Assisted Living Facility:

Carol Gijima, Community Compaint Investigator (NCI)

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.

07/31/2023

Residential Care Services — 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) 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

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to conduct thorough investigations for resident-to-resident altercations for 5 of 7 sampled residents (Residents1,2,3,4 and 7), and 2 of 6 sampled residents (Resident 5 & 6) who fell and sustained significant fractures. This failure placed Residents 1,2 3, 4 and 7 at risk for continued physical assaults and delayed interventions, and Residents 5 & 6 at risk for decline in quality of life.

Findings Included...

Record review on 04/13/2023 and 06/27/2023 of the facility's incident reports showed no investigations for residents being physically assaulted by one resident, or the incidents involving residents' falls with serious injury.

Review of incident reports on 04/13/2023 showed the following resident-to-resident altercations:

04/03/2023 at 4:30pm - Resident 1 (R1) hit Resident 3 (R3) in the face with a closed fist.
04/03/2023 at 5:05pm - R3 hit Resident 2 (R2) in the face with his cane.
04/25/2023 at 3pm - R3 hit Resident 7 (R7) in the face with a closed fist.
05/12/2023 at 4:15pm - R3 hit R1 in the face with a closed fist.
06/20/2023 at 6:15am - R3 hit Resident 4 (R4) in the face with his cane.

Review of R1's progress notes on 04/13/2023 showed that on 03/22/2023, staff observed R1 being hit on the hands by R3 (there was no incident report).

Review of the incident report on 04/13/2023 showed that on 04/03/2023 staff heard R2

yelling. Upon entering the room, staff found R3 sitting on R2's bed. R2 reported to staff that R3 came into her room and hit her in the face with his cane.

Review of R3's progress notes on 04/13/2023 showed that on 04/03/2023, R3 was hit on the cheek with a closed fist by R1. Progress notes showed that the two residents had a verbal altercation earlier in the day.

Record review of R4's progress notes on 06/27/2023 showed that on 06/20/2023 staff heard R4 yelling. Upon entering the room, staff found R3 sitting on R4's bed. R4 stated that R3 hit him several times in the face with a cane.

Record review of R5's Functional Assessment dated 12/06/2022 showed that R5 was admitted to the ALF on [redacted]/2022 and required one person assistance with transfers and mobility. No care plan was provided. Further review of R5's progress notes showed that on 05/21/2023, R5 fell and sustained a hip fracture.

Record review on 07/25/2023 of Resident 6's (R6) Functional Assessment dated 01/02/2023 showed that R6 was admitted to the ALF on [redacted]/2021 with diagnoses which included [redacted]. Functional Assessment showed that R5 was independent with transfers and mobility. Further review of R6's progress notes showed that R6 was found sitting on the floor in his living room complaining of hip pain. Resident sustained a hip fracture and could not remember how he fell.

During an interview on 04/13/2023 at 11am, R2 stated that R3 hit R2's face with his cane. R2 stated she didn't know why he hit her. R2 stated she was afraid of R3 as he was able to get into her room.

During an interview on 04/13/2023 at 11:05am, Staff D, Caregiver stated that she heard that R2 was hit in the face by R3. Staff D stated the incident happened at night and she was not working at the time. Staff D was asked about interventions in place to prevent R3 from hitting other residents. Staff D stated she wasn't aware of any.

During an interview on 04/13/2023 at 11:25am, Staff E, Medication Technician stated that they kept an eye on R3 because of his physical aggression towards others. When asked what interventions were in place to keep others safe, Staff E stated that they redirected resident and checked on him frequently.

During an interview on 04/13/2023 at 11:42am Staff C, Memory Care Director was asked if resident-to-resident incidents were investigated. Staff C stated they were. When asked for the investigation, Staff C stated that Staff B (Health and Wellness Director) would have them. Staff C was asked what was done to ensure other residents' safety regarding R3's aggressive behavior, Staff C stated that they have one caregiver sit in the hallway and he was prescribed sleeping medicine.

During an interview on 06/27/2023 at 11:40am, Staff F, Caregiver stated that R3 was aggressive to other residents and family. Staff F stated that R3 went into R4's room and "beat him with his cane." Staff F stated R4 had bruises to his right ear, eye, and cheek.

During an interview on 06/27/2023 at 11:58am, Staff G, Memory Care Director stated that she was not sure what interventions were in place prior to the last incident on 06/20/2023 when R3 hit R4. Staff G stated that R4 was heard yelling for help, and when staff entered R4's room, they found R3 sitting on R4's bed. R4 stated he was hit with a cane. When asked if an investigation was done, Staff G stated that Staff B would have it.

During an interview on 06/27/2023 at 2:45pm, Staff B was asked if resident incidents were investigated and who was responsible for investigations. Staff B stated that she was responsible for investigating resident incidents. When asked for investigations, Staff B was not able to provide them. When asked what interventions were in place to prevent R3 from hitting other residents and keeping them safe. Staff B stated they kept R3 separated from other residents and had a 1:1 sitter. Staff B was asked how R3 was able to continue hitting residents with a 1:1 sitter. Staff B did not provide an answer. When asked when the 1:1 was initiated, Staff B stated she would have to check. No date was provided. Staff B was asked why falls with serious injury for R5 and R6 were not investigated to rule out abuse or neglect. Staff B stated that it was because the residents were not in the facility, and she didn't investigate R5's fall because the family did not want to talk to her. Staff B was asked how she would know if staff followed the residents' care plan, or if there was abuse and/or neglect since she didn't investigate, Staff B did not provide an answer.

During an interview on 07/17/2023 at 12:12pm, Staff A, Administrator was asked why investigations were not conducted for resident-to-resident incident and for falls with significant injury. Staff A stated she could not answer why the nurse did not investigate at the time. Staff A stated Staff B was no longer employed at the facility. Staff A was asked if they failed to protect other residents as a result. Staff stated "yes."

During an interview on 07/19/2023 at 1:20pm R4's representative (RR1) stated that R4 told him that R3 had hit him in the head. RR1 stated that R4 sustained a large bruise inside his ear, a cut on his eyelid, cheek and around the neck and died a few days later. RR1 stated that R3 was supposed to have a motion detector but it was either turned off or it didn't sound. RR1 stated that R3 had assaulted 2 other people and he had witnessed him raising his cane and threatening people. RR1 stated he and his family had multiple conversations with the facility about their concerns with R3's aggressive behavior and nothing was done to protect other residents.

During an interview on 07/19/2023 at 1:35pm, R4's representative (RR2) stated that the facility knew about R3's behaviors as she had mentioned her concerns several times to Staff B. She stated that R3 had come at her with a fork in his hand and would have gotten her neck. RR2 stated she had witnessed R3 throwing items and yelling at residents during her visits. RR2 stated R4 was doing well, and family had been thinking of taking him off hospice services before he was assaulted by R3 and died a few days later from internal bleeding.

During an interview on 07/20/2023 at 11:16am, R2's representative (RR3) stated that R2 told her that she fell because the caregiver left her standing alone in the bathroom while she went to get her electric wheelchair from the living room. RR2 stated R2 was a 1 person stand by assist and was not to be left alone as she was not stable.

During an interview on 07/25/2023 at 10:39am, Collateral Contact (CC1) stated she had been aware of R3's aggressive behaviors for a long time and the facility did not do anything about it. CC1 stated other residents had been assaulted by R3 and when her client (R4) was hit she asked Staff B for the investigation. CC1 stated that Staff B did not have an investigation, and that she had no idea that she had to investigate the incident.

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, The Rivers at Puyallup, 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

WAC 388-78A-2100 On-going assessments. The assisted living facility must:

(2) Complete an assessment specifically focused on a resident's identified problems and related issues:

(a) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(b) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on interviews and record reviews the Assisted Living Facility (ALF) failed to reassess 1 of 1 sampled resident (Resident 3) when a problem with aggressive behaviors was identified. This failure placed all 13 residents in the memory care unit of the ALF at risk for being physically assaulted and to have a decrease in quality of life.

Finding Included…

Record review on 04/13/2023 of the facility's incident reports showed that Resident 3 (R3)

had been involved in multiple resident-to-resident incidents, some of which were physical, others verbal. Incident reports showed that affected residents sustained injuries because of the physical aggression. Incidents showed the following:

04/03/2023 at 5:05pm - R3 hit Resident 2 (R2) in the face with his cane.
04/25/2023 at 3pm - R3 hit Resident 7 (R7) in the face with a closed fist.
05/12/2023 at 4:15pm - R3 hit Resident 1 (R1) in the face with a closed fist.
06/20/2023 at 6:15am - R3 hit Resident 4 (R4) in the face with his cane.

Record review on 04/13/2023 of R3's records showed that R3 was admitted to the ALF on [redacted]/2023 with diagnoses which included [redacted]. A service plan dated 01/30/2023 showed that R3 did not have physical aggression towards others. There was no updated assessment or care plan on file showing R3 was monitored or re-assessed for R3's behaviors towards other resident, their family members, and staff.

Progress notes did not show any assessments related to aggressive behaviors; some of R3' progress notes showed the following:

03/17/2023 at 7:43pm – R3 was observed destroying equipment, furniture in his room, and the next apartment.
03/18/2023 at 9:21pm – R3 was agitated, ripped a doll apart, was making loud noises and yelling, will continue to monitor (WCTM).
03/19/2023 at 1:44pm – R3 was verbally aggressive to another resident, and another resident's family member.
03/21/2023 at 1:58pm – R3 yelling at another resident.
03/21/2023 at 9:03pm – R3 clapping, making noises, and agitating other residents, WCTM.
03/22/2023 at 6:31pm – R3 slapped another resident who was in front of the door.
03/22/2023 at 10;48pm – R3 was observed to be agitated and verbally aggressive, WCTM.
03/24/2023 at 9:03pm – R3 continued with verbal aggression towards another resident, WCTM.
03/25/2023 at 8:53pm – R3 observed and reported to have aggressive behaviors, WCTM.
03/28/2023 at 9:04PM – R3 was observed with agitation, hitting tables and the med cart with his cane, and verbally aggressive towards another resident.
03/31/2023 at 2:16pm – R3's behavior "it's getting bad wants to fight everybody especially with his walking stick."
03/31/2023 at 9:23pm – R3 is physically aggressive and hitting table, and is difficult to redirect, WCTM.
04/01/2023 at 8:10pm – R3 was observed with increased agitation, physically and verbally towards staff and residents; hit his reflection while in bathroom and charged at the television in the activity area.

During an interview on 04/13/2023 at 11:42am Staff C, Memory Care Director stated that R3 did not have wandering or aggressive behaviors when he was admitted in [redacted] 2023. Staff C stated that behaviors started in March. When asked if R3 was reassessed to address the new behaviors, Staff C stated they had one caregiver sitting in the hallway. Staff C stated that Staff B (Health and Wellness Director) was responsible for assessments.

During an interview on 04/13/2023 at 11:55am, Staff B stated that when there was a change in resident's condition, she reassessed them and amended the care plan. Staff B did not provide a new assessment or amended care plan for R3 when asked. In a separate interview on 06/27/2023 at 2:45pm, Staff B was asked when R3's aggressive behaviors began. Staff B stated he didn't have any behaviors on admit and family did not mention any. When asked if R3 was reassessed for these new significant behaviors, Staff B did not provide an answer. Staff B did not provide an answer when asked how staff would be able to address these behaviors if resident was not assessed.

During an interview on 07/17/2023 at 12:12pm, Staff A, Administrator stated that whenever there was a change in condition, the nurse reassessed the resident, met with family and placed interventions in the care plan. Staff A stated that R3 did not have aggressive behaviors when he was admitted. When asked if the nurse reassessed the resident when the behaviors were observed. Staff A stated she did not know, and that Staff B was no longer employed at the facility.

During an interview on 07/25/2023 at 10:39am, Collateral Contact1 (CC1) stated that the facility did not address R3's aggressive behaviors. CC1 stated she was aware of multiple incidents with other residents in which R3 was the aggressor and nothing was being done to address the behaviors. CC1 stated that she talked to Staff B about what they were doing to protect other residents but stated that Staff B had no idea that she "seemed not to know what to do." CC1 stated that if the ALF had addressed R3's behaviors months ago, her client R4 would still be still alive.

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, The Rivers at Puyallup, 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