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) 36605 (Completion Date 04/08/2024) and 24741 (Completion Date 09/21/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/08/2024 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-2210-2-a

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,

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

Residential Care Services
Investigation Summary Report

Provider/Facility: The Rivers at Puyallup, Independent Living & Assisted Living
License/Cert.#: 2483
Compliance Determination #: 24741
Investigator: Carol Gijima
Investigation Date(s): 04/13/2023 through 09/21/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 72992
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):

1. Resident not taking medications correctly
2. Previous pharmacy keeps sending resident medications
3. Resident had a fall not reported to representative

Investigation Methods:

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

Investigation Summary:

1. Per record review, interviews with resident's representative and staff, the facility failed to ensure that resident received medications as ordered. Failed facility practice identified. See Statement of deficiency dated 09/21/2023.
2. Per record review, interviews with resident's representative, collateral contacts, and staff, there was not sufficient information to support failed practice.
3. Per record review, interviews with resident's representative and staff, there was not sufficient information to support failed practice.

Conclusion / Action:

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

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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Statement of Deficiencies License #: 2483 Compliance Determination # 24741
Plan of Correction The Rivers at Puyallup, Independent Living & Assisted Living Completion Date
Page 1 of 3 Licensee: PSL Associates, LLC 09/21/2023

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): 72992

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:

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) 10/3/2023 Date

WAC 388-78A-2210 Medication services.

(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 interviews and record reviews, the Assisted Living Facility (ALF) failed to ensure that 1 of 3 sampled residents received their medications as prescribed (Resident 1, R1). This failure placed Resident 1 at risk for potential negative health outcomes and a decline in quality of life.

Findings Included...

Record review on 04/13/2023 showed that R1 was admitted to the ALF on [redacted] 2021 with diagnoses to include [redacted] and [redacted]. A Resident Functional Needs Service plan dated 12/14/2022 showed that R1 required staff assistance with her medications

Review of the Medication Administration Records (MAR) for February, March and April 2023 showed that R1 did not receive her medications as ordered for February and April. There was no documentation in the progress notes noting any follow up with the doctor or pharmacy for medications not delivered.

February 2023 MAR
Celecoxib 50mg, one capsule by mouth two times daily, at 8:00am and 8:00pm - medication for pain was not administered for the following 8:00am and 8:00pm times on 02/08/2023, 02/09/2023, 02/10/2023 and 02/13/2023. The 8:00am dose was not administered on 02/12/2023, and 02/14/2023, and the 8:00pm on 02/11/2023.

April 2023 MAR
Celecoxib 50mg, one capsule by mouth two times daily, at 8:00am and 8:00pm- medication for pain was not administered for both administration times on 04/20/2023, 04/23/2023, 04/25/2023, 04/27/2023, and 04/28/2023. Medication was not administered at 8:00am on 04/21/2023, and 04/24/2023, and 8:00pm on 04/22/2023 and 04/26/2023.

During an interview on 06/05/2023 at 11:40am, Resident 1's Representative (RR1) stated that the facility had stated they were taking over managing her medications. RR1 stated she was informed by R1's doctor that R1 was not receiving her medications

During an interview on 06/27/2023 at 2:45pm, Staff B, Health and Wellness Director stated that the facility managed R1's medications. Staff B stated that there was no reason a resident would not receive their medications as ordered. When asked about what staff were supposed to do when medications have not been delivered, Staff B stated it should be documented on the MAR and the provider should be notified. Staff B did not provide an answer when asked why R1 did not receive her medications as ordered or why there was no documentation about follow up on medications not being delivered.

During an interview on 09/18/2023 at 2:11pm, Staff A, Administrator stated that medication technicians were responsible for following up with the pharmacy for medications not available or follow up with family if they were responsible for the medications. Administrator stated she didn't know why there was no documentation of follow ups regarding medications not being available. Administrator stated there was no reason a resident should not receive their medications as ordered.

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) 11/1/2023

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

Administrator (or Representative) [signature] Date 10/31/2023