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) 40146 (Completion Date 04/23/2024) and 24742 (Completion Date 10/10/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/23/2024 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-2160, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-3, WAC 388-78A-2120-4, WAC 388-78A-2600-1-a, WAC 388-78A-2600-1-b, WAC 388-78A-2640-1-a, WAC 388-78A-2640-1-b, WAC 388-78A-2640-3-a, WAC 388-78A-2640-3-b, WAC 388-78A-2640-3

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,

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 #: 24742
Investigator: Carol Gijima
Investigation Date(s): 04/13/2023 through 10/10/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 77308
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):

1. Weight loss
2. Facility didn't follow doctor orders for weekly weights
3. Did not receive showers
4. Ants in room

Investigation Methods:

Sample:	Total residents: Resident sample size: 4 Closed records sample size:
Observations:	General environment Residents in their rooms Staff-to-resident interactions
Interviews:	Resident representatives Collateral contacts Staff
Record Reviews:	Resident Characteristic Roster List of Residents Resident assessments and negotiated service agreements including the discharged records of the named resident Medication administration records (MAR) Staff progress notes Medical records (lab reports, H & P summary)' Incident log / reports, Facility P & P - Physicians orders

Investigation Summary:

1. Per record review, interviews with resident representative and staff, there was not sufficient information to either support or refute this allegation.
2. Per record review, interviews with the resident representative, collateral contact, and staff, the facility failed to follow the doctor's orders. Facility failed practice identified. See Statement of Deficiency dated 10/10/2023.
3. Per record review, interviews with the resident representative and staff, the facility

failed to give the resident showers per agreement. Facility failed practice identified. See Statement of Deficiency dated 10/10/2023.
4. 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 # 24742
Plan of Correction | The Rivers at Puyallup, Independent Living & Assisted Living | Completion Date
Page 1 of 9 | Licensee: PSL Associates, LLC | 10/10/2023

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): 77308

The following sample was selected for review during the unannounced on-site visit: 4 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) Date 10/24/2023

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on record reviews and interviews, the Assisted Living Facility (ALF) failed to provide showers as agreed upon in the Negotiated Service Plan (NSA) for 2 of 5 sampled residents (Residents 1, and 2). This failure placed Residents 1 and 2 at risk for developing skin infections, decreased skin integrity and poor quality of life.

Findings Included ..

Resident 1
Record review on 04/13/2023 showed that Resident 1 (R1) was admitted to the facility on [redacted]/2023 with diagnoses to include [redacted] and was sent to the hospital on [redacted]/2023. Review of the "Needs Service Plan (Negotiated Service Agreement, NSA)" showed that R1 was to receive one shower per week with staff assistance. Review of January 2023 to April 2023 shower logs showed that R1 did not receive a shower. Review of R1's progress notes did not show that R1 was given a shower. The facility did not have any documentation to show that R1 received showers since admission.

Review of progress notes showed that R1 developed redness to her buttocks on 03/25/2023.

Resident 2
Record review on 04/13/2023 showed that Resident 2 (R2) was admitted to the facility on [redacted]/2021 with diagnoses to include [redacted]. Review of the "Needs Service Plan" dated 12/14/2022 showed that R2 was to receive two showers a week with staff assisting her with set up and getting in and out of the shower. Review of January 2023 to April 2023 shower logs showed the following:

January 2023- R2 did not receive showers on the following scheduled days: 01/02/2023, 01/06/2023, 01/09/2023, 01/16/2023, 01/20/2023, 01/23/2023 and 01/30/2023. R2 received only two showers for the month. There was no documentation of showers being given or attempted on scheduled days.

February 2023- R2 did not receive showers on the following scheduled days: 02/03/2023, 02/10/2023, 02/13/2023, 02/17/2023, 02/20/2023, and 02/24/2023. Documentation showed that R2 refused a shower on 02/27/2023. R2 received one shower for the entire month.

March 2023- R2 did not receive showers on the following scheduled days: 03/13/2023, 03/20/2023, and 03/24/2023. Documentation showed R2 refused showers on 03/03/2023, and 03/06/2023.

During an interview on 04/12/2023 at 2:00pm, Resident 1's Representative (RR1) stated that R1 was supposed to have a weekly shower. RR1 stated she had several meetings with Staff B, Health and Wellness Director, but nothing was done.

During an interview on 04/13/2023 at 10:00am, Staff A, Administrator, stated there was no reason residents should not get their showers. When asked why R1 and R2 did not receive their showers, Staff A stated that nursing would know.

During an interview on 04/13/2023 at 11:05am, Anonymous Staff D (AS-D) stated that residents get a shower twice a week unless care planned otherwise. Staff stated that some residents did not get their showers. Staff stated that if a resident refused or was not given a shower per schedule, the staff were to document it.

During an interview on 04/13/2023 at 11:25am, Anonymous Staff E (AS-E) stated that showers were given according to the care plan. Staff stated that if a resident did not receive a shower or refused, it should be documented.

During an interview on 04/13/2023 at 11:55am, Staff B stated that R1 was given showers once or twice a week or as needed. Staff B stated that if residents refused, it would be documented in the progress notes and their representatives would be notified. When asked why R1 was not given her showers, Staff B stated that "she refused a lot." When asked if representative was aware, Staff B stated that she believed so. Staff B did not provide an answer when asked why the refusals were not documented. Staff B stated she did not know why R1 and R2 did not receive their showers.

During an interview on 06/05/2023 at 11:40am, R2's Representative (RR2) stated that R2 was not receiving her showers. RR2 stated that when she visited, R2 looked "disheveled and disgusting."

During an interview on 09/12/2023 at 12:25pm, Anonymous Staff F (AS-F) stated that residents did not receive their weekly showers due to staffing issues. Staff stated that R1 did not receive showers when she was at the facility.

This is a recurring deficiency previously cited on 09/16/2023.

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) 10/24/2023.

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

Administrator (or Representative) 10/24/2023 Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on record reviews and interviews, the Assisted Living Facility (ALF) failed to assess, evaluate, and take appropriate action when a change in a resident's condition was identified for 1 of 1 sampled resident (Resident 1). This failure contributed to the Resident 1's (R1) health declining and being hospitalized.

Findings Included...

Record review on 04/13/2023 showed that R1 was admitted to the ALF on [redacted]/2023 with diagnoses to include [redacted]. Review of the "Need Service Plan (Negotiated Service Agreement, NSA)" dated 01/24/2023 showed that R1 needed to be fed for all meals to "have adequate meal intake and maintain weight." Progress notes showed that R1 had a decrease in appetite

Review of the progress notes showed that R1's legs started draining fluid on 03/02/2023. On 03/06/2023, a progress note showed that R1's legs were still draining fluid and the nurse noted that she was going to wait for the doctor to assess R1 at the next visit which was the following week. There was no other documentation regarding the condition of the

legs or action taken until R1 went to the hospital on [redacted]/2023.

Further review of the progress notes showed that starting 03/21/2023 resident had a decreased intake, refused meals at times, and did not want to eat. There was no documentation of monitoring R1's nutritional status. Review of R1's medical record did not show a change in condition assessment, or any action being taken to address decreased appetite.

During an interview on 04/12/2023 at 2:00pm, Resident 1's Representative (RR1) stated that on [redacted]2023, family went to visit R1 and R1 appeared "dead sitting on the couch," "lips were dried and shriveled" and R1 was not able to speak. RR1 stated they immediately took her to the hospital. RR1 stated that R1 had not been eating and stated that the facility didn't know she was not eating.

During an interview on 10/04/2023 at 4:26pm, Staff C, Regional Nurse stated that when there was a change in resident's condition, the nurse would assess, notify the doctor and resident representative and place resident on alert. When asked why there was no assessment for R1 when she had a decrease in appetite, and in her overall health, Staff C stated she didn't know why an assessment was not done. Staff C stated their standard policy requires an assessment to be completed when a resident was not at baseline. Staff C stated she did not know the reason R1 went to the hospital on [redacted]2023.

This is a recurring deficiency previously cited on 05/23/2022 for subsections 388-78A-2120 (3)(a)(b)(4).

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) 11/24/2023.

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

Administrator (or Representative) 10/24/2023 Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(b) Provide the necessary care and services for residents, including those with special needs;

This requirement was not met as evidenced by:

Based on record reviews and interviews, the Assisted Living Facility (ALF) failed to follow their policy when a resident's physician's orders were not transcribed onto the Medication Administration Record (MAR) for 1 of 3 sampled residents (Resident 1). This failure contributed to Resident 1's decline in health and hospitalization.

Findings Included...

Record review of the facility's policy titled "Physician's Orders" dated 05/2022 showed that when new physician's orders were received, they were to be transcribed into the electronic medication administration record (MAR) by the nurse or their designee.

Review of R1's primary doctor's orders dated 03/09/2023 showed that the ALF was to monitor and weigh the resident weekly and send results to the doctor, R1 to use compression socks, and facility to elevate resident's legs when seated. There was no documentation of R1's doctor receiving the weight.

Record review of Resident 1's (R1) March 2023 MARs did not show physicians orders for weights, compression socks or elevation of legs.

During an interview 04/12/2023 at 2:00pm, Resident 1's Representative (RR1) stated that the doctor ordered a weekly weight on 03/09/2023 which the facility failed to obtain. RR1 stated that R1's legs were swollen and started draining fluid because the facility did not follow doctors' orders to elevate legs. RR1 stated that R1 had stopped eating and when they visited R1 on [redacted]/2023 she looked frail, dehydrated, had dry and cracked lips, and appeared as if no one had assisted her at all. R1 was taken to the hospital immediately by family.

During an interview on 04/12/2023 at 11:55Aam, Staff B, Health and Wellness director was asked why R1's orders received on 03/09/2023 were not on the MARs. Staff B was not able to provide an answer.

During an interview on 09/12/2023 at 9:35am, Collateral Contact 1 (CC1), Medial Assistant for R1's doctor stated that they received information from the family that R1 had decreased appetite. CC1 stated that the doctor ordered weekly weights to be sent to the office and to move R1 into memory care for increased supervision. CC1 stated that the office never received any weights from the facility.

During an interview on 10/04/2023 at 4:26pm, Staff C, Regional Nurse stated that when

orders were received from a resident's doctor, they would be verified by the nurse, and entered on the MAR. When asked why R1's orders received on 03/09/2023 were not entered into the MARs, Staff C stated she didn't know, and that the orders were found in a pile after Staff B was no longer employed.

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) 11/24/2023.

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

Administrator (or Representative) — Date: 10/24/2023

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(b) The resident is relocated to a hospital or other health care facility; or

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

This requirement was not met as evidenced by:

Based on record reviews and interviews, the Assisted Living Facility (ALF) failed to notify the resident's representative and physician when a resident had a change in condition for 1 of 1 sampled resident (Resident 1) Additionally, the resident's physician was not notified when the resident was sent to the hospital for 1 of 1 sampled resident (Resident 1). These failures resulted in Resident 1 receiving delayed care and hospitalization.

Findings Included...

Record review on 04/13/2023 showed that Resident 1 (R1) was admitted to ALF on [redacted]/2023 with diagnoses to include [redacted]. Review of R1's progress notes showed the following:

03/02/2023 - R1's legs started draining fluid and that R1's doctor was faxed asking for advice.
03/06/2023 - R1's legs were still draining fluid and staff decided to wait for the doctor to assess at the next visit, next week. There was no other documentation regarding the condition of the legs.
03/21/2023 - resident's mouth was dry.
03/24/2023 - resident did not want to eat much.
03/24/2023 - a second progress note stated resident was "eating some bites."
03/26/2023- resident refused meals and drank water for breakfast and lunch; note stated resident representative was notified.
03/28/2023 - Resident refused to eat dinner.
[redacted]/2023- resident did not eat much at breakfast and did not eat lunch.

Further review of records showed there was no documentation that the doctor was notified of R1's decrease in appetite or fluid drainage. Resident's representative was not notified of the decrease in appetite until 03/26/2023. R1 was taken to the hospital by family and admitted to the hospital on [redacted]/2023.

During an interview 04/12/2023 at 2:00pm, Resident 1's Representative (RR1) stated that the facility did not notify her of any changes in resident's condition until 03/26/2023 when a medication technician told her that R1 had a decreased appetite. RR1 stated that no one at the facility informed them of the fluid draining from her legs until she saw that her pant legs were wet during a visit.

During an interview on 04/13/2023 at 10am, Staff A, Administrator was asked who would be notified if residents had a change in condition or if they were transferred to the hospital. Staff A stated that the representative and resident's doctor would be notified. When asked if R1's representative and doctor were notified when she was transferred to the hospital, Administrator stated that nursing would know.

During an interview on 04/13/2023 at11:55am Staff B, Health and Wellness Director stated that the resident's representative and doctor would be notified for any change in condition and for hospital transfers. Staff B was asked who was responsible for notifying the resident's representative and doctor, Staff B stated that she made the calls. When asked who was notified when R1 had a change in condition and when she was transferred to the hospital, Staff B stated that there was no reason family and doctor was not notified.

During an interview on 09/12/2023 at 9:35am, Collateral Contact 1 (CC1), Medial Assistant for R1's doctor stated that the facility did not notify them when R1 was transferred to the hospital.

During an interview on 10/04/2023 at 4:26pm, Staff C, Regional Nurse stated that whenever there was a change in condition, the resident's representative and doctor would be notified. Staff C stated that notifications were made if resident was transferred to the

hospital. When asked who was notified when R1 experienced decrease in appetite, drainage of fluid from legs and when she was transferred to the hospital. Staff C stated that she was not aware of who was notified. When asked if that information should have been documented, Staff C stated it should have but it was not. Staff was asked why R1 was sent to the hospital, Staff C stated that she did not know.

This is a recurring deficiency previously cited on 05/23/2022.

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) 11/24/2023 .

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

Administrator (or Representative) Date 10/24/2023