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) 61914 (Completion Date 07/01/2025) and 58309 (Completion Date 04/21/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/01/2025 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-2040-1

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

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

Sincerely,

Manfay Chan, Allied Health 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 04/21/2025 of:
The Rivers at Puyallup, Independent Living & Assisted Living
123 4th Ave NW
Puyallup, WA 98371

This document references the following SOD dated: 04/21/2025

The following sample was selected for review during the unannounced on-site visit: 0 of 81 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) | Date

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) failed to maintain compliance with the State Fire Marshal's codes for long-term care facilities. This failure placed all 81 residents and staff at risk of harm in the event of a fire.

Finding included…

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that on 09/30/2024 and 01/21/2025, the ALF received a citation for not maintaining compliance with the State Fire Marshal's codes for long-term care facilities. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 11/14/2024 and 03/07/2025.

Record review of the inspection report sent to the department from the State Fire Marshal dated 04/08/2025, showed that the ALF failed their 4th re-inspection for the following previously cited deficiencies:

"NFPA 80 Fire Door Inspection and Testing

5.2.1 Inspection and Testing. Upon completion of the installation, door, shutters, and

window assemblies shall be inspected and tested in accordance with 5.2.4.
5.2.4 Periodic Inspection and Testing
5.2.4.1 Periodic inspections and testing shall be performed not less than annually.
5.2.4.2
And the following hall be checked:
1. Labels are clearly visible and legible
2. No open holes or breaks exist in surfaces of with the door or frame
3. Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped
4. The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned and in working order with no visible, signs of damage
5. No parts are missing or broken
6. Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7
7. The self-closing device is operational,: that is, the active door completely closes when operated from the full open position
8. If a coordinator is installed, the inactive lead close before the active lead
9. Latching hardware operates and secures the door when it is in the closed position
10. Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame
11. No field modification to the floor assembly have been performed that void the label.
12. Meeting edge protection, gasketing and edge seals where required, are inspected to verify their presence and integrity
13. Signage affixed to a door meets the requirements listed in 4.1.4

Findings during the fourth re-inspection were:
Previously cited deficiencies remain.
- Multiple fire doors and fire door frames have open pilot holes/penetrations
- Faulty installations/door sizing found for resident activity room and staff lounge—doors had excessive door gaps, and found sagging
Davis Door Company Scheduled to complete repairs and replace failed fire door by end of August 2024, Contractor shall be required to provide the facility with acceptance test verification—fire door template may be used—for all new fire doors.
Facility failed to produce records of acceptance testing for ALL newly installed fire doors, as previously instructed on 7/30/2024."

In an email dated 04/09/2025 at 11:59am, Collateral Contact 1 (CC1), State Fire Marshal, stated that they had conducted a fourth re-inspection on 04/08/2025 and the facility had not corrected the deficiencies. CC1 stated that the facility told them that "they were very close" to correcting them.

During an interview on 04/21/2025 at 1:00pm, Staff A, Administrator, stated that they had a company come to fix the issues, but they didn't have the correct parts. Staff A stated that they had received multiple quotes but that they had been expensive. Staff A stated that the facility's maintenance director was going to fix the doors.

During an interview on 04/21/2025 at 1:15pm, Staff B, Maintenance Director, stated that the facility had received expensive quotes to fix the doors, and that they were in the process of fixing the doors themselves.

During an interview on 04/21/2025 at 1:20pm, Staff C, Regional Maintenance Director, was asked why the deficiencies had not been corrected and the doors fixed. Staff C stated that they had to order the parts and get approval, which took a long time.

This is an uncorrected and recurring deficiency previously cited on 01/21/2025 and 09/30/2024.

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

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 01/15/2025 of:
The Rivers at Puyallup, Independent Living & Assisted Living
123 4th Ave NW
Puyallup, WA 98371

This document references the following SOD dated: 01/21/2025

The following sample was selected for review during the unannounced on-site visit: 0 of 80 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)

Date

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) failed to ensure the violations for their third failed State Fire Marshal (SFM) inspections were corrected. This failure placed all 74 residents at risk for harm in case of an emergency.

Finding Included...

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that on 09/30/2024, the ALF received a citation for this regulation. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 11/14/2024.

Record review of an email sent to the department dated 01/16/2025 at 3:06pm from The State Fire Marshal, showed, the ALF failed their 3rd re-inspection for the following issues.

IFC 903.5 2009, 2012,2015,2018
"1) No corrective report for last annual inspection deficiencies noted, the contractor performed only a partial annual inspection. The facility provided a service order to prove that unit inspection was performed on 08/09/2024; however, service only indicates that 15 deficiencies were discovered, and failed to indicate what all inspection findings were, or it the inspection was part of the facility's annual confidence test for

2024.
2) Multiple fire doors and fire door frames have open pilot holes/penetrations. - Faulty installations/door sizing found for resident activity room and staff lounge--doors had excessive door gaps and found sagging.
3) Davis Door Company scheduled to complete repairs and replace failed fire door by end of August 2024. Contractor shall be required to provide the facility with acceptance test verification--fire door template may be used--for all new fire doors.
4) Facility failed to produce records of acceptance testing for ALL newly installed fire doors, as previously instructed on 7/30/2024.
5) Multiple unprotected/open penetrations found throughout the building's ceilings and corridor walls; however, no plans were present to identify the construction's fire-resistance rating.
6) Facility shall provide an inventory of all fire-resistance-rated construction required during time of construction--as indicated on the building's as-built plans.
7) Unable to produce documentation showing that all fire-resistant-rated construction assemblies have received annual inspection in the past 12 months--last performed June 2, 2023.
8) Unable to produce corrective report for 10/15/23 hood suppression report - inspector notes indicate that system is not wired to fire alarm system.
9) Unable to produce corrective report for 10/15/23 hood suppression report - inspector notes indicate that system is not wired to fire alarm system.
10) Facility failed to maintain records of inspection, testing and maintenance for each smoke alarm in the building - no device inventory, device age, operational status, or corrective actions noted. Facility only tracks monthly task completion and installation date.
11) Facility failed to maintain records of inspection, testing and maintenance for each carbon monoxide alarm in the building - no device inventory, device age, operational status, or corrective actions noted. Facility only tracks monthly task completion.
12) Fire drill records fail to indicate the transmission of the fire alarm signal throughout the facility during simulation.
13) Unable to produce documentation showing that fire alarm system has been placed in test mode in the past 12 months showing compliance with fire alarm signal transmission."

During an interview on 01/21/2025 at 8:53am Staff B, Regional Maintenance Director stated that they were unable to produce records to show the facility had fixed the State Fire Marshal's re inspection, as the former employee who was responsible was unable to access the records from their system.

This is an uncorrected deficiency previously on 09/30/2024.

Plan/Attestation Statement

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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

Provider Type: Assisted Living Facility

License/Cert.#: 2483

Intake ID: 142636

Region/Unit #: RCS Region 3 / Unit D

Compliance Determination #: 47510

Investigator: Carol Gijima

Investigation Date(s): 09/20/2024 through 09/30/2024

Complainant Contact Date(s):

Allegation(s):

1. Facility out of compliance with fire and safety inspection

Investigation Methods:

Sample:	Total residents: 74 Resident sample size: Closed records sample size:
Observations:	General environment
Interviews:	Staff
Record Reviews:	Fire Marshall reports Policy- Maintenance, Fire drills, Facilities general policy

Investigation Summary:

Per record review and interviews with staff, the facility failed 3 fire and safety inspections. The ALF demonstrated failed provider practice as documented in a Statement of Deficiencies dated 09/30/2024.

Conclusion / Action:

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

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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 09/20/2024 and 09/20/2024 of:

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

This document references the following complaint number(s): 142636

The following sample was selected for review during the unannounced on-site visit: 0 of 74 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

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

This requirement was not met as evidenced by:

Based on record review and interviews, the Assisted Living Facility (ALF) failed to maintain their facility in compliance with fire and safety codes. This failure left staff without training on how to timely respond to emergencies, and placed all 74 residents at risk for serious injury in case of an emergency.

Finding Included...

Review of the ALF's records showed that the facility failed fire marshal inspections conducted on 02/14/2024, 05/14/2024 and 07/30/2024.

During an interview on 09/20/2024 at 9:45am, Staff C, Maintenance Director stated that the facility policy was to conduct fire and safety requirements per schedule as well as monthly fire drills. When asked why the safety inspections were not done, Staff C stated that the inspections started before being employed.

During an interview on 09/20/2024 at 9;55am, Staff B, Memory Care Director stated that they knew fire drills were conducted monthly. When asked why the facility had not been conducting fire and safety requirements as documented on their inspection report, Staff B stated that they were working to correct it.

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