STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

This document was prepared by Residential Care Services for the Locator website.

First Class Luxury LLC

First Class Luxury LLC
3818 104th St NE
Marysville, WA 98271

RE: First Class Luxury LLC License # 756858

Dear Provider:

This letter addresses Compliance Determination(s) 66996 (Completion Date 10/09/2025) and 66639 (Completion Date 10/03/2025).

The Department completed a follow-up inspection of your Adult Family Home on 10/09/2025 and found that you have corrected the violations listed in the Follow up report dated 10/03/2025. Your home is back in compliance as of 10/07/2025 with the cited requirements of the Washington Administrative Code or the Revised Code of Washington or both.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-76-10198-4

The Department staff who did the off-site verification:
Kimberly Rush, Long Term Care Surveyor

If you have any questions, please contact me at (206)914-5042.

Sincerely,

Renee Bourque, Field Manager
Region 2, Unit B
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

3906-172nd St NE, Suite #100, Arlington, WA 98223

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Adult Family Home license.

The department completed data collection for an unannounced on-site follow-up on 10/03/2025 of:

First Class Luxury LLC
3818 104th St NE
Marysville, WA 98271

This document references the following SOD dated: 10/03/2025

The following sample was selected for review during the unannounced on-site visit: 6 of 6 current residents and 0 former residents.

The department staff that inspected the Adult Family Home:

Kimberly Rush, Long Term Care Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit B
3906-172nd St NE, Suite #100
Arlington, WA 98223

This document was prepared by Residential Care Services for the Locator website.

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 Adult Family Home license, I must be in compliance with all the licensing laws and regulations at all times.

Provider (or Representative) | Date

WAC 388-76-10198 Adult family home Personnel records. The adult family home must keep documents related to staff in a place readily accessible to authorized department staff. These documents must be available during the staff's employment, and for at least two years following employment. The documents must include but are not limited to:

(4) Criminal history disclosure and background check results as required.

This requirement was not met as evidenced by:

Based on record review and interview, the Adult Family Home (AFH) failed to ensure 1 of 2 staff (Staff A, Entity Representative) had a current Washington state name and date of birth (WNDOB) background check available for review by the Department. This failure resulted in residents being cared for by someone with unverified background check results.

Findings included...

Record review of Staff A’s personnel records on 10/03/2025, showed that Staff A had a WNDOB background check that expired on 08/25/2025. Staff A’s personnel record did not contain a current WNDOB background check as required.

Interview on 10/03/2025 at 1:03 PM, Staff A stated that they submitted a request to the Background Check Central Unit (BCCU) to renew their WNDOB background check but had not received it back. Staff A could not recall the date the request was made.

This is an uncorrected citation previously cited on 08/06/2025.

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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, First Class Luxury LLC 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.

Provider (or Representative) Date

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STATE OF WASHINGTON
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Statement of Deficiencies	License #: 756858	Compliance Determination # 61138
Plan of Correction	First Class Luxury LLC	Completion Date
Page 1 of 12	Licensee: First Class Luxury LLC	08/06/2025

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Adult Family Home license.

The department completed data collection for an unannounced on-site complaint investigation on 06/20/2025 of:

First Class Luxury LLC
3818 104th St NE
Marysville, WA 98271

This document references the following complaint number(s): 181947, 183883, 184141

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

The department staff that investigated the Adult Family Home:

Kimberly Rush, Long Term Care Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit B
3906-172nd St NE, Suite #100
Arlington, WA 98223

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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 Adult Family Home license, I must be in compliance with all the licensing laws and regulations at all times.

Provider (or Representative) | Date

WAC 388-76-10225 Reporting requirement.

(1) The adult family home must ensure all staff:

(a) Report suspected abuse, neglect, exploitation, or abandonment of a resident:

(i) As required by chapter 74.34 RCW;

(ii) To the department by calling the complaint toll-free hotline number or completing an online report; and

(b) Report the following to the department by calling the complaint toll-free hotline number or completing an online report:

(iii) A missing resident.

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to report to the Department's centralized toll-free telephone number or online incident report when 1 of 4 residents (Resident 2) went missing from the AFH. Additionally, the AFH failed to ensure that allegations of abuse for 1 of 4 residents (Resident 4) were immediately reported to the Department’s centralized toll-free telephone number. These failures resulted in delayed management and investigation of Resident 2 missing from the AFH and the delayed investigation of the allegation of abuse resulting in the risk of further abuse to AFH residents.

Findings included…

Record review of the AFH’s undated policy titled, “Abuse Neglect and Exploitation” showed it is the responsibility of each staff member to immediately contact the Department’s toll-free telephone number directly regarding suspected or alleged abuse

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or other improprieties.

Per WAC 388-76-10000, "Sexual abuse" means any form of nonconsensual sexual conduct, including but not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment."

Resident 4
Record review showed the AFH admitted Resident 4 on [redacted]/2024 with multiple diagnoses that included [redacted]. Review of Resident 4's assessment, dated 12/16/2024, showed that Resident 4 meets the criteria for dementia (impaired ability to remember, think, or make decisions) specialty placement and required caregiver assistance with activities of daily living.

Record review of Resident 4's NCP, dated 01/30/2025, showed that Resident 4 is "out of touch of reality," has hallucinations (thoughts of having seen, heard, touched, tasted, or smelled something that wasn't actually there) and delusions (having a false belief despite evidence of the contrary).

Record review of Staff B's (Caregiver) documentation titled "Note", dated 06/23/2025, showed that a cop arrived to the AFH and notified Staff B that Resident 4 alleged to being sexually abused.

Record review of the Department's electronic Secure Tracking and Reporting System (STARS), on 07/08/2025 at 8:00 AM, showed that the AFH did not report the allegation of abuse to the Department.

Phone Interview on, 07/10/2025 at 4:06 PM, Staff A (Entity Representative) stated that they found out about the allegation of abuse from the cop. Staff A stated that they called Resident 4's family and Resident 4 was taken to the hospital for evaluation. Staff A stated that they did not report the allegation of abuse to the Department because there was no suspicion that the abuse actually occurred. Staff A stated that Resident 4 hallucinates a lot, and they didn't know if they should report all of the hallucinations to the Department.

Resident 2
Record review showed the AFH admitted Resident 2 on [redacted]/2024 with multiple diagnoses that included [redacted]. Review of Resident 2's assessment, dated 04/02/2025, showed Resident 2 required caregiver assistance with activities of daily living.

Record review of a online social media post, dated [redacted]/2025, showed that Resident 4 was missing. The online social media post showed an update, with no date or time, that

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Resident 4 had been located.

Record review of STARS, on 06/16/2025 at 9:57 AM, showed that the AFH did not submit a report to the Department's centralized toll-free telephone number or online incident report that Resident 2 was missing.

Interview on, 06/20/2025 at 12:20 PM, Staff B stated that when Resident 2 left the AFH, Staff B immediately notified Staff A. Staff B stated that usually when Resident 2 leaves the AFH, Staff A tracks Resident 2 and brings them back to the AFH. Staff B stated that this time they discovered that Resident 2's tracker was left behind. Staff B stated that they did not contact anyone else because Staff A made the necessary contacts and reports.

Phone interview, on 06/20/2025 at 4:46PM, Staff A stated that they filed a missing person's police report, notified Resident 2's family and posted the missing person's report online to notify the local area. Staff A stated that they were planning to notify Resident 2's social worker but it was still early in the morning when the Resident was located and the social worker had already reached out to the AFH. Staff A stated that they did not know they were required to report Resident 2 was missing to the Department's centralized toll-free telephone number or online incident report.

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, First Class Luxury LLC 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.

_____ _____
Provider (or Representative) Date

WAC 388-76-10455 Medication Administration. For residents assessed with requiring the administration of medications, the adult family home must ensure medication administration is:

(2) By nurse delegation per WAC 246-840-910 through 246-840-970 ; unless

This requirement was not met as evidenced by:

Based on record review and interview, the Adult Family Home (AFH) failed to ensure that medications were administered by staff trained in nurse delegation for 2 of 4 residents (Residents 3 & 4). This failure placed Residents 3 and 4 at risk for medical

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complications and medication errors.

Findings included…

WAC 388-76-10000-defines nurse delegation as a registered nurse that transfers the performance of selected nursing tasks to competent nursing assistants, home care aides, or qualified long-term care workers in selected situations. The registered nurse delegating the task retains responsibility and accountability for the nursing care of the resident.

Resident 3
Record review showed the AFH admitted Resident 3 on [redacted]/2024 with multiple diagnoses that included [redacted]. Review of Resident 3's assessment, dated 01/31/2025, showed Resident 3 required medication administration by caregivers trained in nurse delegation.

Record review of Resident 3's July 2025 medication log (ML), showed no caregiver initials as given for the following medications at 8:00 AM on 07/03/2025, 07/04/2025, 07/05/2025, 07/07/2025:

- Donepezil tablet (a medication used to treat memory loss and confusion)
- Finasteride tablet (a medication used to symptoms of an enlarged prostate and pattern hair loss)
- Vitamin D3 tablet (a vitamin used to supplement body nutrients)

Resident 4
Record review showed the AFH admitted Resident 4 on [redacted]/2024 with multiple diagnoses that included [redacted]. Review of Resident 4's assessment, dated 12/16/2024, showed that Resident 4 required caregivers trained in nurse delegation for medication administration.

Record review of Resident 4's July 2025 ML, showed Staff A's initial as given for all of Resident 4's 6 AM, 8 AM, and "AM" medications on 07/03/2025 and 07/04/2025. The July ML showed Staff B initialed as having given Resident 4's morning medications on 07/05/2025 and 07/07/2025.

Interview on, 07/08/2025 at 2:45 PM, Staff B (Caregiver) stated that Staff C (Caregiver) did not give residents medications because Staff C did not have nurse delegation training to give residents their medications. At 3:06 PM, Staff B stated that they (Staff B) did not work on the days the (Resident 3) ML was not initialed (07/03/2025, 07/04/2025, 07/05/2025, 07/07/2025).

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Interview on, 07/08/2025 at 3:07PM, Staff A (Entity Representative) stated that it was just Staff C working in the mornings on the days (Resident 3) MLs were not initialed (07/03/2025, 07/04/2025, 07/05/2025, 07/07/2025). Staff A stated that Staff C had given residents their morning medications those days. Staff A stated that they (Staff A) arrived to the AFH on those days around 10:00 AM – 11:00 AM. Staff A stated that Staff C previously did training with the nurse delegator but did not have all the required documents ready at the time of the nurse delegator's visit to the AFH. Staff A stated that Staff C was not nurse delegated to give residents their medications.

Phone interview on, 07/08/2025 at 3:15 PM, Collateral Contact 2 (CC2) stated that they were unable to delegate Staff C at the time of their last visit to the AFH. CC2 stated that they had done training with Staff C but Staff C was not yet nurse delegated to give resident's medications in the AFH.

Interview on, 07/08/2025 at 3:56 PM, Staff A stated that they give Resident 4 their Nourianz (used to treat Parkinsons disease symptoms) medication on 07/04/2025 at 9:00 AM. At 4:21 PM, Staff A stated that Staff B was off for three days. Staff A stated that they came to the AFH but arrived after breakfast and Staff C gave the residents their medications.

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, First Class Luxury LLC 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.

_____ _____
Provider (or Representative) Date

WAC 388-76-10475 Medication Log. The adult family home must:

(1) Keep an up-to-date daily medication log for each resident except for residents assessed as medication independent with self-administration.

(2) Include in each medication log the:

(e) Approximate time the resident must take each medication.

(3) Ensure the medication log includes:

(a) Initials of the staff who assisted or gave each resident medication(s);

(c) Documentation of any changes or new prescribed medications including:

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(i) The change;

(ii) The date of the change;

(iii) A logged call requesting written verification of the change; and

(iv) A copy of written verification of the change from the practitioner received by the home by mail, facsimile, or other electronic means, or on new original labeled container from the pharmacy.

This requirement was not met as evidenced by:

Based on record review and interview, the Adult Family Home (AFH) failed to have a system in place to ensure the medication logs (ML) were initialed, correct and contained all necessary information for 4 of 4 residents (Resident 1, 2, 3, 4). These failures placed residents at risk for harm from medication errors.

Findings Included...

Resident 1
Record review showed the AFH admitted Resident 1 on [redacted]/2024 with multiple diagnoses that included mixed [redacted]. Review of Resident 1's assessment, dated [redacted]/2024, showed Resident 1 required caregiver assistance with medications.

Record review of Resident 1's July 2025 ML, on 07/08/2025 at 3:01 PM, showed no caregiver initials as given for the following medications as noted below:

- Memantine tablet hydrochloride (a medication used to slow the progression of dementia associated with Alzheimer's disease) 5 milligrams (mg) missing 8:00 AM initials on 07/03/2025 - 07/05/2025 and 07/07/2025.
- Multivitamin Women tablet 50+ (a nutritional supplement) missing 8:00 AM initials on 07/03/2025 - 07/05/2025, 07/07/2025 and 07/08/2025.
- Atorvastatin tablet 40 mg (a medication that helps lower cholesterol) missing 8:00 AM initials on 07/03/2025 - 07/05/2025 and 07/07/2025.

Record review of Resident 1's July 2025 ML, showed handwritten "Atorvastatin Tab 40mg take one tab once daily" and handwritten "8 AM" doses. The ML did not include the date that Atorvastatin tablet was prescribed.

Resident 2
Record review showed the AFH admitted Resident 2 on [redacted]/2024 with multiple diagnoses that included [redacted]. Review of Resident 2's assessment, dated 04/02/2025, showed Resident 2 required caregiver assistance with medications. Record review of Resident 2's July 2025 ML, on 07/08/2025 at 3:01 PM, showed no

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caregiver initials as given for the following medications as noted below:

- Clopidogrel tablet 75mg (a medication that reduces the chance of blood clots, heart attack and stroke) missing 8:00 AM initials on 07/03/2025 - 07/05/2025 and 07/07/2025.
- Rosuvastatin tablet 10mg (a medication used to treat high cholesterol and prevent heart attacks and strokes) missing 8:00 AM initials on 07/03/2025 - 07/05/2025 and 07/07/2025.

Resident 3
Record review showed the AFH admitted Resident 3 on [redacted]/2024 with multiple diagnoses that included [redacted]. Review of Resident 3's assessment, dated 01/31/2025, showed Resident 3 required caregiver assistance with medication administration.

Record review of Resident 3's July 2025 ML, on 07/08/2025 at 3:01 PM, showed no caregiver initials as given for the following medications as noted below:

- Donepezil tablet 10mg (a medication used to treat memory loss and confusion) missing 8:00 AM initials on 07/03/2025 - 07/05/2025 and 07/07/2025.
- Finasteride tablet 5mg (a medication used to treat symptoms of an enlarged prostate and pattern hair loss) missing 8:00 AM initials on 07/03/2025 - 07/05/2025 and 07/07/2025.
- Vitamin D3 tablet 1000 unit (a vitamin used to supplement body nutrients) missing 8:00 AM initials on 07/03/2025 - 07/05/2025 and 07/07/2025.

Resident 4
Record review showed the AFH admitted Resident 4 on [redacted]/2024 with multiple diagnoses that included [redacted]. Review of Resident 4's assessment, dated 12/16/2024, showed that Resident 4 required caregiver assistance with medication administration.

Record review of Resident 4's July 2025 ML, on 07/08/2025 at 3:01 PM, showed no caregiver initials as given for Crexont capsule 70-280mg (a medication used to treat Parkinsons disease) at 2:00 PM on 07/07/2025.

Nourianz
Record review of Resident 4's June and July 2025 ML, showed three orders for Nourianz (a medication used to treat Parkinsons disease):

- June and July 2025 ML's showed, pharmacy printed orders for 8:00 AM doses of Istradefylline 20mg (Nourianz) take one tablet by mouth three times a week on Monday, Wednesday, Friday. The ML showed no initials as given at 8:00 AM for doses in June and July.
- June and July 2025 ML's showed, pharmacy printed orders for 9:00 AM doses of

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Nourianz 20mg tablet take one tablet by mouth three times weekly (9:00 AM) **MAR ONLY** (medication administration record). The ML showed no initials as given at 9:00 AM for doses in June and July.

- June 2025 ML showed, handwritten “Nourianz 20mg tab take one tab three times a week Monday, Wednesday and Friday taken at noon”. The ML did not include the date that Nourianz was prescribed.
- July 2025 ML showed, handwritten “Nourianz 20mg tab take one tab three times a week” and handwritten “AM” doses with “X” through Tuesday, Thursday, Saturday and Sunday dates. The ML did not include the date that Nourianz was prescribed. The ML showed no initials as given at “AM” on 07/07/2025.

Interview on, 07/08/2025 at 3:56 PM, Staff A (Entity Representative) stated that they did not realize that Resident 4’s Nourianz order was already printed by the pharmacy on the ML. Staff A stated that they hand wrote the orders for Nourainz on Resident 4’s ML and it was the same as what the pharmacy printed. Staff A stated that they give Resident 4 their Nourianz medication at 9:00 AM three times a week.

Interview on, 07/10/2025 at 3:29 PM, Collateral Contact 1 (CC1) stated that Resident 4’s Istradefylline (Nourianz) medication is to be given at 9:00 AM. CC1 stated that the 8:00 AM admin time that was printed by the pharmacy was likely a typo. CC1 stated that “MAR ONLY” means that the pharmacy does not have a written fillable prescription of the medication or the pharmacy does not supply the medication. CC1 stated that if Resident 4 is no longer taking a medication, the AFH would need to send the pharmacy the discontinuation order from the doctor to update the ML.

Acetaminophen
Record review of Resident 4’s July 2025 ML, on 07/08/2025 at 3:01 PM, showed routine 9:00 AM and 6:00 PM Acetaminophen tablet 325mg (a medication to relieve pain and reduce fever). The order showed “**MAR ONLY**”. The ML showed no initials as given for 9:00 AM and 6:00 PM doses on 07/01/2025 – 07/07/2025, and 9:00 AM on 07/08/2025. The ML showed no date of discontinuation or order change.

Interview on, 07/08/2025 at 2:45 PM, Staff B (Caregiver) stated that Resident 4 no longer takes routine Acetaminophen. Staff B stated that they did not remember the date of the medication change.

Interview on, 07/08/2025 at 3:56 PM, Staff A stated that Resident 4’s routine Acetaminophen was discontinued on 02/05/2025. Staff A stated that they could not find the discontinuation order. Staff A stated that the pharmacy stated that they could not take discontinued medications off of the ML but put MAR ONLY for record keeping because it was not a prescription.

Interview on, 07/08/2025 at 3:06 PM, Staff B stated that the missing caregiver initials on the residents ML were an oversight. Staff B stated that they did not work those days. Staff B stated that Staff A would explain what happened when they arrived at AFH.

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Interview on, 07/08/2025 at 3:07PM, Staff A stated that the missing caregiver initials were an oversight and that residents were given all doses of their medications.

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, First Class Luxury LLC 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.

_____ _____
Provider (or Representative) Date

WAC 388-76-10198 Adult family home Personnel records. The adult family home must keep documents related to staff in a place readily accessible to authorized department staff. These documents must be available during the staff's employment, and for at least two years following employment. The documents must include but are not limited to:

(4) Criminal history disclosure and background check results as required.

This requirement was not met as evidenced by:

Based on record review and interview, the Adult Family Home (AFH) failed to ensure 1 of 3 staff (Staff A, Entity Representative) had a Washington state name and date of birth (WSNDOB) background check available for review by the Department. This failure placed the residents at risk of being cared for by someone with an unverified background.

Findings included...

Record review of Staff A’s undated personnel file showed that Staff A completed a national fingerprint background check on 10/09/2023. Staff A’s personnel file did not have a WSNDOB background check.

Interview on 07/08/2025 at 3:38 PM, Staff A stated that they had a WSNDOB BGI and would send it to the Department by 07/09/2025 at 5:00 PM.

Phone interview on 07/10/2025 at 4:06 PM, Staff A stated that they submitted a request to the Background Check Central Unit (BCCU) to obtain the record of their WSNDOB

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background check but have not received it back. Staff A stated that if they didn't have a WSNDOB background check then they couldn't have a final fingerprint background check done. As of 07/18/2025 the Department had not received Staff A's WSNDOB background check.

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, First Class Luxury LLC 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.

_____ _____
Provider (or Representative) Date

WAC 388-76-10220 Incident log. The adult family home must keep a log of:

(1) Alleged or suspected instances of abandonment, neglect, abuse or financial exploitation;

(2) Accidents or incidents affecting a resident's welfare; and

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to log incidents that occurred for 2 of 4 resident's (Resident 2 & 4). This failure placed the safety and well-being of residents at risk by not having data or incidents collected in one place for review.

Findings included…

Resident 2
Record review showed the AFH admitted Resident 2 on [redacted]/2024 with multiple diagnoses.

Record review of the AFH's incident log, on 06/20/2025 at 12:41PM, showed no documentation that Resident 2 went missing from the AFH.

Interview on 06/20/2025 at 12:20 PM, Staff B (caregiver) stated that when Resident 2 left the AFH, Staff B immediately notified Staff A (Entity Representative). Staff B stated that they did not document that Resident 2 was missing on the incident log because

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they communicated it with Staff A. Staff B stated that Staff A was usually able to track Resident 2 and bring them back to the AFH.

Phone interview, on 06/20/2025 at 4:46PM, Staff A stated that they did not record that Resident 2 was missing on the incident log because they had documentation of the chat conversations between them and Staff B showing that Resident 2 left the AFH.

Resident 4
Record review showed the AFH admitted Resident 4 on [redacted] 2024 with multiple diagnoses.

Phone Interview on, 07/10/2025 at 4:06 PM, Staff A stated that they found out about Resident 4's allegation of abuse from the cop and wrote an incident report. Staff A stated that they would send the Department the incident report.

Record review of the documentation sent to the Department on 07/10/2025 at 5:19 PM, showed a document titled "Note". The "Note" was dated 06/23/2025 and signed by Staff B. The "Note" showed that a cop arrived to the AFH and notified Staff B that Resident 4 alleged to being sexually abused.

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, First Class Luxury LLC 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.

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