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

06/20/2024

PSL Associates, LLC
Cordata Court, Assisted Living & Memory Care
4415 Columbine Dr
Bellingham, WA 98226

RE: Cordata Court, Assisted Living & Memory Care License # 2481

Dear Administrator:

This letter addresses Compliance Determination(s) 42261 (Completion Date 06/05/2024) and 35901 (Completion Date 04/04/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/05/2024 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-2240, WAC 388-78A-2120-3-b, WAC 388-78A-2600-1-a, WAC 388-78A-2600-1-b

The Department staff who did the on-site verification:
Helen Fisher, Complaint Investigator

If you have any questions, please contact me at (360)651-6846.

Sincerely,

Kim Ripley

Kimberley Ripley, Field Manager
Region 2, Unit A
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Cordata Court, Assisted Living & Memory Care
License/Cert.#: 2481
Compliance Determination #: 35901
Investigator: Helen Fisher
Provider Type: Assisted Living Facility
Intake ID: 115462
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 01/29/2024 through 04/04/2024
Complainant Contact Date(s): 01/25/2024, 02/12/2024, 03/12/2024

Allegation(s):

1) The Assisted Living Facility (ALF) was not returning the Named Resident (NR's) family's call after a request for the med tech to check the Named Resident.
2) The ALF mismanaged the NR's diabetes and mixing up recordings in the medication administration record (MAR).
3) The medications were not given or reordered.
4) The blood pressure medication had been given outside the doctor's parameters and resulted multiple visits to the ER.
5) The medication list was not updated in the portal which contributed to the medication error.
6) The ALF financially exploited the NR.
7) The ALR had staffing concerns and was without a nurse on weekends.
8) The NR received a 30-day discharge notice, the ALF stated due to higher care than they can provide.
9) The NR had a toe amputation.
10) The NR's family had multiple meetings with management regarding concerns.

Investigation Methods:

Sample:	Total residents: 84 Resident sample size: 5 Closed records sample size: 0
Observations:	NR and sample residents' appearance, demeanor, living quarters, medication cart, medication assistance, medication set up, staff to resident interaction, staffing, pharmacy audits, environment, general cleanliness.
Interviews:	NR, Sample Residents, Executive Director, Health and Wellness Director, Med Tech, Caregiver, Collateral Contacts, Maintenance Director, Regional nurse.
Record Reviews:	NR, 12 months billing statements, negotiated service agreement, 3 months of medication administration agreement, 3 months chart notes, communication records, hospital discharge summary and physicians notes, medication list. NR and sampled residents records; incident report and investigation, care plan. progress notes, ledger, copies of

checks, policies and procedures (abuse and neglect, change in level of care, call response, incident reporting, fall, medication services) disclosure of services, residency agreement, call response report, training.

Investigation Summary:

1) Two sample resident's representatives denied having problem with calls to and from the facility staff. The staff stated that on evening of 01/21/2024 they were busy with the evening med pass when they received the message to check on the NR. The staff went to check on the NR about 30 to 45 minutes after the call was received from NR's family. They found that the NR's cell phone battery was drained. That was the reason why the NR's family could not reach the NR. The staff did not remember if they called the NR's family that evening. The Health and Wellness Director (HWD) provided the NR's family their cell phone number as an alternate contact in an event that the NR's representative was unable to connect with ALF. No facility failed practice was identified.

2) The NR stated that they were unaware of medications and blood glucose discrepancies during an unannounced visit at the ALF. Review of NR's electronic medication administration record (EMAR) showed discrepancies in documentation. Failed practice. WAC 388-78A-2210 (1)(b) Medication services. A citation was not written as the ALF was under a plan of correction.

3) Review of the NR's EMARs dated November 2023 and December 2023 showed the NR did not receive 3 different medications for up to 7 days as they were marked medications not available. Collateral contact stated that the family was not notified when the NR's medications ran out. The staff stated that they were reordering the medication 7 days in advance, but the NR's pharmacy was slow to send the NR's medication. There were no documents found that the ALF had been reordering the NR's medication from the pharmacy 7 days in advance. Failed practice. WAC 388-78A-2240 Nonavailability of medications.

4) Staff stated that they were instructed by the nurse to give or hold medications when the blood pressure reading was outside the parameters. The HWD was unsure if all medical technicians were calling the nurse when NR's blood pressure reading was out of parameters. Review of NR's EMAR showed the NR received three different blood pressure medications 49 times outside the physician's ordered parameters. NR's blood pressure medications that were given outside parameters; Amlodipine was administered 13 times, Metoprolol 25 times and Lisinopril 11 times. Failed practice. WAC 388-78A-2210 (1)(b) Medication services. A citation was not written as the ALF was under a stop placement and working on a plan of correction.

5) The ALF stated that they had a hard time getting a hold of the NR's pharmacy for medication refills and they had to emergency fill from ALF's preferred pharmacy on their cost. Progress notes dated 1/10/2024 at 6:18 PM showed the NR's physician was having difficulty connecting with the NR's pharmacy to reconcile the NR's medication list (med list). Med list dated 01/29/2024 did not match the January 2024 EMAR one of blood pressure medications was missing and eye drop for glaucoma had different number on the EMAR. Failed practice. WAC 388-78A-2210 (2) Medication services. A citation was not written as the ALF was under a plan of correction.

6) The Executive Director (ED) stated that in April 2023 the ALF's automatically withdrawn the amount the NR's owed which was more than the amount of the check written as payment. The ALF credited the NR's account as they became aware of the error. No facility failed practice was identified.

7) Three med techs and four caregivers including an outside agency staff were observed during an unannounced visit to the facility. The staff stated that they were calling the nurse on weekends when there was a need pertaining to residents. Review of the January 2024 schedule showed the ALF was fully staffed with agency covering call ins. No facility failed practice was identified.

8) Review of the 30-day eviction notice dated 01/18/2024 showed the NR's level of care was higher than the ALF could provide. The NR’s new placement was found. No facility failed practice identified.
9 The NR had a toe amputation while at the ALF. Previously investigated.
10) The ALF and the NR’s family confirmed about the meetings that took place between parties. The ED stated that the ALF’s home office eventually took over the meeting and was directly in contact with the NR’s family regarding concerns. No facility failed practice was identified.

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: Cordata Court, Assisted Living & Memory Care
License/Cert.#: 2481
Compliance Determination #: 35901
Investigator: Helen Fisher
Provider Type: Assisted Living Facility
Intake ID: 115911
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 01/29/2024 through 04/04/2024
Complainant Contact Date(s): 01/25/2024, 02/12/2024, 03/12/2024

Allegation(s):

1) The Named Resident (NR) had a fall with injury and the ALF did not notify the family and Emergency Services until 18 hours after.
2) The Name Staff (NS) was sleeping while at the medication cart.
3) The NR had bruises all up and down their arms. The NR's family and Emergency Services were not notified.
4) The NR's family was concerned about NR's swollen leg and the med tech did not understand what medication to give for the swollen leg.
5) The Named Staff (NS) was in the room while the NR was taking a shower. The NS did not provide NR the standby assistance during a shower.
6) The NR's family found documentation discrepancies in the EMAR.
7) The NR's weight recordings fluctuated between 120 to 220 lbs.
8) Medications were not given correctly.
9) The NR waited outside for 20 minutes for staff to open the door afterhours.
10) The NR had ongoing billing issues.

Investigation Methods:

Sample:	Total residents: 84 Resident sample size: 5 Closed records sample size: 0
Observations:	NR and sample residents' appearance, demeanor, living quarters, medication cart, medication assistance, medication set up, staff to resident interaction, staffing, pharmacy audits, environment, general cleanliness.
Interviews:	NR, Executive Director, Collateral Contact, Health and Wellness Director, Med Techs, Caregiver, other not associated with facility, Maintenance Director, Regional nurse.
Record Reviews:	NR, 12 months billing statements, negotiated service agreement, 3 months of medication administration agreement, 3 months chart notes, communication records, hospital discharge summary and physicians notes, medication list. NR and sampled residents records; incident report and investigation, care plan. progress notes, ledger, copies of checks, policies and procedures (abuse and neglect, change in

level of care, call response, incident reporting, fall, medication services) disclosure of services, residency agreement, call response report, training.

Investigation Summary:

1) The NR was observed to be groomed and had a pleasant demeanor. The NR's left arm and left leg were wrapped with bandage during an unannounced visit at the ALF. The NR stated that they had a bruised arm and a bruised lower leg from a fall in the bathroom. The NR did not recall when the fall happened. The NR's family was notified within 24 hours of the NR's fall. The Health and Wellness Director (HWD) stated that they instructed the staff that HWD was to call the NR's family for notification, but they forgot to call. The ALF did an investigation and ruled abuse and neglect. The HWD assessed the NR's and notified the NR's family when they noted the NR's left leg swelling had an increased. No failed practice.

2) The ALF stated that the NS2 was not sleeping while at the cart. The NS2 stated that they were not sleeping while at the cart. The NS 2 stated that they were sitting on a bench leaning on the cart to be relieve. No failed practice.

3) The NR told staff on what happened to their arms. The NR's arms bruising was reported by the NR's family to the ALF. Progress notes dated 01/25/2024 showed the NR told the HWD during the investigation how they injured arms. The ALF did not notify the family and emergency services when they became aware of the NR's arms bruising. The ALF failed to assess, document, and monitor the NR's bruising. Failed practice. A citation was written for noncompliant with WAC 388-78A-2120 Monitor residents wellbeing.

4) The staff stated that they knew what medication to give for the swollen leg but was confused on what the NR's family was asking because there was no order to give the medication as needed. The staff made a report to the nurse regarding NR's swollen leg. No failed facility practice.

5) The NR stated that they can take their own shower and did not like men spying on them. The NS2 stated that NR oftentimes declined to have a staff in the bathroom during showers. The NS2 stated that the NR closed the bathroom door and told NS2 that the NR would call them when the NR needed something. The NS2 stated that they were honoring the NR rights to refuse to have them in the bathroom during shower. No failed practice.

6) Duplicate allegation. The concern was reported multiple times and was under investigation by another Residential Care Services investigator.

7) The HWD stated that they instructed the staff to make sure to place the scale on the hard surface and to lock the wheelchair when weighing the NR. The NR's weight would read higher when the scale was placed on the carpet flooring, or the wheelchair was not locked, or the NR was wearing extra clothing. The HWD stated that they were monitoring the NR's lower extremities edema more so NR's left leg, vital signs, and for any signs of fluid retention. A day staff stated that they were calling the doctor as per physician's instruction when NR gained 3 lbs. The NR's weight was being monitored daily. No failed practice.

8) Duplicate allegation.

9) Review of the front door call response report showed staff responses were up to 100 minutes. The NR stated that they were cold and needed to use the bathroom. The NR waited outside for 20 minutes resulting in NR's incident. Failed practice. A citation was issued for non-compliant with WAC 388-78A- 2600 Policy and procedures.

10) The ALF stated that the NR statements may have been hard to understand because the NR's bill was not paid on time and paid in full in some months. The Executive Director stated that the NR received a monthly level of care discount as per the NR's family and the ALF's agreement. Review of the NR's billing statement from March 2023 to [redacted] 2024 showed billing inconsistencies due to the level care charges and credits. The NR's ledger showed the NR had an unpaid balance when they moved out

on [redacted], 2024. No failed practice.

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: Cordata Court, Assisted Living & Memory Care
License/Cert.#: 2481
Compliance Determination #: 35901
Investigator: Helen Fisher
Investigation Date(s): 01/29/2024 through 04/04/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 118006
Region/Unit #: RCS Region 2 / Unit A

Allegation(s):
The Named Resident (NR) bruises were not reported to the NR's family. The NR's family was not notified immediately nor was the Emergency Services.

Investigation Methods:

Sample:	Total residents: 84 Resident sample size: 5 Closed records sample size: 0
Observations:	NR and sample residents, appearance and demeanor,
Interviews:	Health Wellness Director, med tech, caregiver, NR, other not associated with facility.
Record Reviews:	NR and sample residents' records, incident investigation, abuse and neglect policy and procedure, reporting policy and procedure.

Investigation Summary:
The NR's bilateral arms bruising were observed wrapped with ace bandage during an unannounced visit to the ALF. The NR's left arm bruising was reported by the NR's family to the ALF on 01/22/2024. The ALF investigated the NR's left arm injury on 01/25/2024 and established the source as related to NR's fall on 01/21/2024 and the NR's bumping left arm against the doorknob. However, the ALF did not update the NR's care plan and monitor arms bruising. Failed practice. WAC 388-78A-2120 Monitoring residents' wellbeing.

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: Cordata Court, Assisted Living & Memory Care
License/Cert.#: 2481
Compliance Determination #: 35901
Investigator: Helen Fisher
Investigation Date(s): 01/29/2024 through 04/04/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 116572
Region/Unit #: RCS Region 2 / Unit A

Allegation(s):
The Named Resident (NR) had an injury with unknown source.

Investigation Methods:

Sample:	Total residents: 84 Resident sample size: 5 Closed records sample size: 0
Observations:	NR and sample residents appearance, living quarter, social interaction, staff to resident interaction, environment and equipment in use.
Interviews:	Executive Director, Heath and Wellness Director, med tech.
Record Reviews:	NR and sample residents' records, incident investigation, abuse and neglect policy and procedure, reporting policy and procedure.

Investigation Summary:
The NR's arms bruising was reported by the NR's family to the ALF on 01/22/2024. No incident report found, and care plan was not updated to address NR's substantial arms bruising. Failed practice. WAC 388-78A-2120 Monitor residents wellbeing.

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

Statement of Deficiencies	License #: 2481	Compliance Determination # 35901
Plan of Correction	Cordata Court, Assisted Living & Memory Care	Completion Date
Page 1 of 6	Licensee: PSL Associates, LLC	04/04/2024

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 01/29/2024, 01/29/2024 and 02/08/2024 of:

Cordata Court, Assisted Living & Memory Care
4415 Columbine Dr
Bellingham, WA 98226

This document references the following complaint number(s): 115462, 115911, 117426, 118006, 116572, 116636

The following sample was selected for review during the unannounced on-site visit: 5 of 84 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Helen Fisher, Complaint Investigator

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

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.

Jayne Hill
Residential Care Services

04/16/2024
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 4/2/24

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interviews, and record review the Assisted Living Facility (ALF) failed to obtain medications when 1 of 3 residents (Resident 1) ran out of three prescribed medications and were documented as not available. This failure resulted in Resident 1 missing 17 doses of the three medications in a two-month period and placed all residents at risk for missing medications and medical complications.

Findings included...

The ALF's "Nonavailability of Medication Policy and Procedures" dated 08/26/2021 showed:
If the Community is unable to obtain the medication or treatment in a timely manner, the Community should notify the responsible party, pharmacy and/or provider in order to obtain them.

Resident 1 was admitted to the ALF on [redacted]/2023 with multiple diagnoses including [redacted] and [redacted].

A negotiated service agreement dated 12/18/2023 showed Resident 1 had cognitive impairment and needed medication assistance. Review of Resident 1's electronic medication administration records (EMAR) for December 2023 and January 2024 showed Resident 1 had the following medications listed in the EMAR as medications not available. The following medication doses were not available for Resident 1:

Sertraline 50 mg (milligrams, a unit of measurement) daily, used for depression, total of 4 doses.
Aspirin EC 81 mg daily, anti-inflammatory and blood thinner, total of 7 doses.
Atorvastatin 40 mg daily, for cholesterol and triglycerides levels, total of 6 doses.

Interview on 01/29/2024 at 2:50 PM, Staff A, Executive Director, stated that Resident 1's pharmacy was slow to deliver but was unsure if Resident 1's medications were ordered on time.

Interview on 01/29/2024 at 3:00 PM, Staff B, Health and Wellness Director, stated that they were having a tough time connecting with Resident 1's pharmacy and there was no confirmation if the request for refills went through. Staff B stated that there were times the staff did not look for the medications further and would mark them as not available. Staff B stated that they call Resident 1's physician and the pharmacy when Resident 1's medication was not available. No documentation was found regarding the ALF's communication with Resident 1's physician.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 5/16/2024 .

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

Administrator (or Representative) 4/22/2025 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:

(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.

This requirement was not met as evidenced by:

Based on observation, interviews and record review, the Assisted Living Facility (ALF) failed to evaluate and observe for complications for 1 of 3 residents (Resident 1) with bruising to both arms. This failure resulted in the bruising to Resident 1's arms not being monitored and placed all residents at risk for injury, complications, and unmet care needs.

Findings included...

Resident 1 was admitted to the ALF on [redacted]/2023 with multiple diagnosis including [redacted] and [redacted].

Observation on 01/29/2024 at 10:50 AM showed Resident 1 had a large purple bruised area to their left arm wrapped with a bandage and a scattered light purple bruising on right upper and lower arm.

Statement of Deficiencies	License #: 2481	Compliance Determination # 35901
Plan of Correction	Cordata Court, Assisted Living & Memory Care	Completion Date
Page 4 of 6	Licensee: PSL Associates, LLC	04/04/2024

Review of the progress notes dated 01/22/2024 at 10:06 AM showed the ALF was informed of bruising to both arms of Resident 1. Resident 1's negotiated service agreement dated 12/18/2023 had not been updated to address the bruising to both arms. Review of the electronic medication administration and treatment record dated January 2024 showed no monitoring was done on the bruising to Resident 1's arms.

Interview on 01/25/2024 at 4:26 PM, Collateral contact, (CC) stated that they found bruising up and down both of Resident 1's arms when they visited Resident 1 on 01/22/2024.

Interview on 01/29/2024 at 10:50 AM, Resident 1 stated that staff were wrapping their arm due to bruising. Resident 1 stated that their left arm was still sore, and they were unsure what happened.

Interview on 01/29/2024 at 2:50 PM, Staff A, Executive Director, stated that the bruising to Resident 1's arms was not monitored by staff.

Interview on 02/08/2024 at 1:27 PM, Staff B, Health and Wellness Director, stated that they did not update Resident 1's negotiated service agreement and did not instruct staff to monitor Resident 1's bilateral arm bruising. Staff B stated that they told staff to wrap it with an ace bandage. There was no documentation regarding monitoring and care management of the bruising to Resident 1's arms.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 5/16/2024 .

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

Administrator (or Representative) — Date: 4/22/2024

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 interviews and record review the Assisted Living Facility (ALF) failed to respond to an emergency call in a timely manner and failed to implement their policy and procedures in response to an emergency call when 1 of 3 residents (Resident 1) waited outside the front entrance door for assistance. This failure resulted in Resident 1 having an incontinent incident while waiting in the cold weather for entry into the facility and placed residents at risk for waiting longer during an emergency.

Findings included...

The ALF's "Emergency Call System Policy" dated 11/2020 showed:
Response Purpose: The use of an emergency call system is designed to contribute to ensuring resident safety and allows residents in the community to alert staff remotely of their need for assistance.

Response Time Monitoring: As part of the Pegasus Senior Living Quality Assurance program, response times will be monitored. Response times greater than 13 minutes will be reviewed to determine the root cause and changes implemented to improve response times.

Resident 1 was admitted to the ALF on [redacted]/2023 with multiple diagnosis including [redacted] and [redacted].

Interview on 01/29/2024 at 10:50 AM, Resident 1 stated that on 01/26/2024 they waited for so long at the front entrance door. Resident 1 stated that it was cold outside, they needed assistance to go to the bathroom and the delay resulted in Resident 1 losing bowel control from waiting.

Interview on 01/29/2024 at 11:32 AM, Collateral contact (CC) stated that they had issues related to staff response to calls in Resident 1's apartment and the front entrance door during afterhours (6:00 PM to 7:00 AM). CC stated that on 01/26/2024, Resident 1 waited for 20 minutes outside by the front entrance door before a staff opened the door which resulted in Resident 1 soiling their clothes on that occasion.

Review of the ALF's front entrance door call response records during afterhours (6:00 PM to 7:00 AM) dated 01/02/2024 to 01/29/2024 showed the response times were up to one hour and 40 minutes (100 minutes).

Review of Resident 1's apartment (pendant call) response records dated 12/30/2023 to 01/30/2024 showed the response times were up to 38 minutes.

Interview on 01/29/2024 at 12:00 PM, Staff D, caregiver, stated that they didn't recall the specifics on what happened on 01/26/2024. Staff D stated that they were told to answer call lights as soon as possible but there were times they may be helping another resident.

Interview on 01/29/2024 at 1:25 PM, Staff E, Maintenance Director, stated that the call pendants and all call responses including the front entrance door were being checked weekly. Staff E stated that the staff may be slow in answering calls.

Interview on 02/08/2024 at 2:05 PM, Staff A, Executive Director, stated that their policy and procedure on emergency response was for staff to answer alerts and calls within minutes after receiving alerts. Staff A stated that they had not reviewed the response time reports recently.

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, Cordata Court, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 5/14/2024.

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

Administrator (or Representative) — Date: 4/22/2024