STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

Cypress Gardens ALC LLC
Arbor Assisted Living
3500 9TH ST
BREMERTON, WA 98312

RE: Arbor Assisted Living License # 2663

Dear Administrator:

This letter addresses Compliance Determination(s) 40752 (Completion Date 05/20/2024) and 35762 (Completion Date 03/12/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/20/2024 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-2040-1, WAC 388-78A-2980-2, WAC 388-78A-2660-1, WAC 388-78A-2660-2, WAC 388-78A-3040-7-a-iii, WAC 388-78A-2730-2-b-iii, WAC 388-78A-2150, WAC 388-78A-2150-1, WAC 388-78A-2150-2, WAC 388-78A-2150-3, WAC 388-78A-2350-1, WAC 388-78A-3090-1-c, WAC 388-78A-3090-1-b, WAC 388-78A-3090-1-a, WAC 388-78A-2440-1, WAC 388-78A-2610-2-c, WAC 388-78A-2610-2-a, WAC 388-78A-2710-2, WAC 388-78A-2480, WAC 388-78A-2480-1, WAC 388-78A-2480-2, WAC 388-78A-2500, WAC 388-78A-2500-1, WAC 388-78A-2500-2, WAC 388-78A-2500-2-a, WAC 388-78A-2500-2-b, WAC 388-78A-2500-2-c, WAC 388-78A-2500-2-d, WAC 388-78A-2510, WAC 388-78A-2540, WAC 388-78A-2540-1, WAC 388-78A-2540-2, WAC 388-78A-2540-3, WAC 388-78A-2305, WAC 388-78A-2305-1, WAC 388-78A-2474, WAC 388-78A-2474-2, WAC 388-78A-2474-2-b, WAC 388-78A-2474-2-e, WAC 388-78A-2474-4, WAC 388-78A-2474-6

The Department staff who did the on-site verification:
Melisa Moran, Assisted Living Facility Nursing Consultant Institutional
Cathleen Davis, ALF Licensor

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

Sincerely,

Manfay Chan, 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

Statement of Deficiencies	License #: 2663	Compliance Determination #: 35762
Plan of Correction	Arbor Assisted Living	Completion Date
Page 1 of 27	Licensee: Cypress Gardens ALC LLC	03/12/2024

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 the unannounced on-site full inspection on 01/24/2024 and 01/30/2024 of:
Arbor Assisted Living
3500 9TH ST
BREMERTON, WA 98312

The following sample was selected for review during the unannounced on-site visit: 12 of 55 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Cathleen Davis, ALF Licensor
Melisa Moran, Assisted Living Facility Nursing Consultant Institutional
Cory Myers, ALF Complaint Investigator

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 — 03/19/2024 (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.

Lisa Caulck
Administrator (or Representative)

4/1/24
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 observation and interviews the Assisted Living Facility (ALF) failed to ensure 13 of 13 fire extinguishers were inspected and signed on the attached monthly inspection tag for the month of December 2023 and January 2024. This failure placed 55 of 55 residents and staff at risk of potential harm due to not inspecting fire extinguishers in the event of an emergency.

Findings included...

"Code 906.2 General Requirements. 906.2 General requirements.
Portable fire extinguishers shall be selected, installed, and maintained in accordance with this section and NFPA 10.
Exceptions:
1.The distance of travel to reach an extinguisher shall not apply to the spectator seating portions of Group A-5 occupancies.
2.Thirty-day inspections shall not be required, and maintenance shall be allowed to be once every 3 years for dry-chemical or halogenated agent portable fire extinguishers that are supervised by a listed and approved electronic monitoring device, provided that all of the following conditions are met:
2.1. Electronic monitoring shall confirm that extinguishers are properly positioned, properly charged and unobstructed.
2.2. Loss of power or circuit continuity to the electronic monitoring device shall initiate a trouble signal.
2.3. The extinguishers shall be installed inside of a building or cabinet in a noncorrosive environment.
2.4. Electronic monitoring devices and supervisory circuits shall be tested every 3 years when extinguisher maintenance is performed.
2.5. A written log of required hydrostatic test dates for extinguishers shall be maintained by the owner to verify that hydrostatic tests are conducted at the frequency required by NFPA 10.
3. In Group I-3, portable fire extinguishers shall be permitted to be located at staff locations."

An observation on 01/24/2024 at 11:39 AM showed November 2023 as the last date of attached inspection tag signed off on fire extinguishers located throughout the facility.

During an interview on 01/24/2024 at 11:50 AM, Staff F, Maintenance Director, said that the fire extinguishers inspection is done monthly and signed in a separate log. Staff F said the inspection is done by picking the fire extinguisher up, then shaking to determine if sediment has settled to the bottom of the extinguisher.

During an interview on 01/25/2024 at 10:15 AM, Staff A, Regional Director, said that Staff F signed a fire extinguisher log rather than the required tag on each fire extinguisher. Staff A submitted a piece of paper with initials, dated 12/28/2023 and a line through December. The form titled "Monthly Fire Extinguisher Inspection Log" had Memory Care typed and AL handwritten beside the Memory Care title.

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, Arbor Assisted Living is or will be in compliance with this law and / or regulation on (Date) 4/13/24

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

Administrator (or Representative) — Date: 4/1/24

WAC 388-78A-2980 Lighting.

(2) The assisted living facility must maintain electric light fixtures and lighting necessary for the comfort and safety of residents and for the activities of residents and staff.

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to provide lighting in parts of the facility. The facility was dark in the common areas creating limited visibility. This failure created a potential safety hazard due to lack of lighting for 55 of 55 facility residents.

Findings included...

Observation on 01/24/2024 at 9:17 AM, showed dim lighting in the dining area. There were no lights turned on in the living room, directly next to the dining area. Dining room showed dim lighting from the one light turned on in this area. The activity room was dark with no lights turned on.

Observation on 01/24/2024 at 9:26 AM showed the activity room on second floor of the assisted living facility dark with no lights turned on. There were three lights located on the second floor with cracked white plastic covers. These lights were turned off and one was a halogen light with no cover.

Observation on 01/24/2024 at 11:00 AM showed a flickering, dim light in the west hallway shower room. This light continued to flicker and remain dim on 01/30/2024 at 9:30 AM.

Observation on 01/29/2024 at 2:15 PM showed the oxygen tank storage room with an unlit light inside the storage room but no control to turn the light on or off.

Observation on 01/30/2024 at 10:02 AM showed the dim light continued to flicker in the west hallway shower room.

In an interview on 01/25/2024 at 10:25 AM Resident 7 (R7) said, at times, the lighting in the dining area was often turned off making it difficult to see what we are eating.

In an interview on 01/29/2024 at 2:15 PM Staff H, Medication Technician, said they did not know how to turn on the lighting in the oxygen storage room after unlocking this area.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 4/1/24

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on record review and interviews the facility failed to provide keys to residents for mailboxes and their rooms for 2 of 12 sampled residents (Resident 9 and 10). This failure placed Residents 9 and 10 at risk of harm for the potential of property loss and invasion of privacy.

Findings included...

RCW 70.129.080
Mail and telephone—Privacy in communications.
The resident has the right to privacy in communications, including the right to:
(1) Send and promptly receive mail that is unopened;

RCW 70.129.100 Personal Property-Storage Space
(2) The facility shall, upon request, provide the resident with a lockable container or other lockable storage space for small items of personal property, unless the resident's individual room is lockable with a key issued to the resident.

During the Resident Group Meeting on 01/25/2024 at 10:00 AM, a record review of a flyer on the dining room tables. The letter stated in item numbered 4 " ... mailboxes will be renamed to match current staff and will be re-keyed so we can all have a mailbox key." The letter was signed by Staff B, Residential Care Coordinator Manager (RCCM).

In an interview on 01/26/2024 at 10:00 AM Resident 9 (R9) said they were not issued a key to either their room or mailbox. R9 said they are not comfortable receiving mail to the facility until they are issued a mailbox key. R9 said they can lock their door from the inside but must request staff to open their door to enter when leaving the facility.

In an interview on 01/28/2024 at 10:20 AM Resident 10 (R10) said they moved from a second-floor room to the downstairs room [redacted]. R10 said they moved from the second floor about a year ago and the facility has not provided a room key or mailbox key.

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, Arbor Assisted Living is or will be in compliance with this law and / or regulation on (Date) 4/13/24

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

Administrator (or Representative) — Date: 4/1/24

WAC 388-78A-3040 Laundry.

(7) The assisted living facility must provide a laundry area or develop and implement policy and procedure to ensure residents have access to an area where residents' may do their personal laundry that is:

(a) Equipped with:

(iii) At least one washing machine and one clothes dryer; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide access for laundry services to 1 of 12 sampled residents (Resident 5). This failure placed Resident 5 at risk of harm from wearing soiled clothing.

Findings included...

On 01/24/2024 at 10:15 AM the laundry room was observed with two loads of laundry in laundry baskets placed in front of the washers. The two washers were in use by housekeeping.

On 01/25/2024 at 10:25 AM in an interview, Resident 5 (R5) said they were wearing the cleanest of their dirty clothing. R5 said there was one housekeeping staff which worked very hard. R5 said with only one housekeeping staff for two buildings their laundry does not get done and they wear the cleanest of their dirty clothing. R5 said they want to wash their own clothing, but the facility changed the rules, and the residents can no longer wash their own clothing.

Review of a letter to residents and staff placed on dining room tables on 01/25/2024 states, "Independent Laundry Use - Since we have two days per week where we do not have housekeeping (who uses our washing machines during the day), we will be implementing times for residents that are able to do their own laundry. We will make an announcement when this is ready to be implemented."

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, Arbor Assisted Living is or will be in compliance with this law and / or regulation on (Date) 4/13/24

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

Administrator (or Representative) — Date: 4/1/24

WAC 388-78A-2730 Licensee's responsibilities.

(2) The licensee must:

(b) Maintain and post in a size and format that is easily read, in a conspicuous place on the assisted living facility premises:

(iii) A copy of the report, including the cover letter, and plan of correction of the most recent full inspection conducted by the department.

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to display and have available the recent copy of the last licensing inspection and complaint inspection results. This failure placed 55 of 55 residents at harm for not providing foreknowledge of identified failed facility practice concerns.

Findings included...

RCW 70.129.070
Examination of survey or inspection results—Contact with client advocates.
A resident has the right to:
(1) Examine the results of the most recent survey or inspection of the facility conducted by federal or state surveyors or inspectors and plans of correction in effect with respect to the facility. A notice that the results are available must be publicly posted with the facility's state license, and the results must be made available for examination by the facility in a place readily accessible to residents.

On 01/24/2024 at 9:00 AM an observation found there was no folder with the last full survey licensing inspection or complaint inspection results.

In an interview on 01/24/2024 at 11:15 AM Staff B, Residential Care Coordinator Manager, said they did not know where this survey binder was kept. Staff B said they were new to the position and still learning.

In an interview on 01/28/2024 at 10:14 AM Staff H, Medication Technician, said they looked for the survey binder but they were unable to locate 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, Arbor Assisted Living is or will be in compliance with this law and / or regulation on (Date) 4/12/24

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

Administrator (or Representative) — Date: 4/1/24

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign.

(2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and

(3) Any public or private case manager for the resident, if available.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to provide signed Negotiated Service Agreements (NSA) to 10 of 10 sampled residents (Resident 1, 2, 3, 4, 5, 6, 7, 8, 10, and 11). This failure placed residents in potential harm for not having an agreed upon care plan established for each resident.

Findings included...

In an interview on 01/25/2024 at 1:30 PM Staff B, Residential Care Coordinator Manager, said they did not have any signed Negotiated Service Agreements (NSAs). Staff B said none of the NSAs were signed by any of the residents.

In an interview on 01/25/2024 at 4:40 PM Resident 7 (R7) said they did not have a copy of a signed NSA in their possession. R7 said a request for the NSA was made to Staff B in November 2023 and again in January 2024 with no response. R7 said they did not know the contents of their NSA.

Review of Resident 1's (R1) Negotiated Service Agreement (NSA) showed a date of admittance of [redacted]/2017. R1's NSA was unsigned by R1 or a representative.

Review of Resident 2's (R2) NSA showed a date of admittance of [redacted]/2021. R2's NSA was unsigned by R2 or a representative.

Review of Resident 3's (R3) NSA showed a date of admittance of [redacted]/2019. R3's NSA was unsigned by R3 or a representative.

Review of Resident 4's (R4) NSA showed a date of admittance of [redacted]/2019. R1's NSA was unsigned by R4 or a representative.

Review of Resident 5's (R5) NSA showed a date of admittance of [redacted]/2024. R5's NSA was unsigned by R5 or a representative.

Review of Resident 6's (R6) NSA showed a date of admittance of [redacted]/2009. R6's NSA was unsigned by R6 or a representative.

Review of Resident 7's (R7) NSA showed a date of admittance of [redacted]/2023. R7's NSA was unsigned by R7 or a representative.

Review of Resident 8's (R8) NSA showed a date of admittance of [redacted]/2024. R8's NSA was unsigned by R8 or a representative.

Review of Resident 10's (R10) NSA showed a date of admittance of [redacted]/2017. R10's NSA was unsigned by R10 or a representative.

Review of Resident 11's (R11) NSA showed a date of admittance of [redacted]/2023. R11's NSA was unsigned by R11 or a representative.

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, Arbor Assisted Living is or will be in compliance with this law and / or regulation on (Date) 4/1/24

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

Administrator (or Representative) — Date: 4/1/24

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

This requirement was not met as evidenced by:

Based on interview and record review that facility failed to coordinate care for 1 of 12 sampled residents (Resident 5) by not scheduling medical appointments requested by the resident with a medical condition. This failure placed the resident at risk of potential medical decline by not being provided coordinated medical care.

Findings included...

Record Review of the facility's document titled "Disclosure of Services Required by RCW 18.20.300," undated, on page 2 of 9 in Section C stated, "Arranging Health Care Appointments: All Assisted Living Facilities must arrange health care appointments and remind you of them, as necessary." Section D states "Coordination of Health Care Services: All Assisted Living Facilities must coordinate services you receive from health care providers in the community with the services the assisted living facility provides to you, if you agree."

Record review of Resident 5 (R5) Negotiated Service Agreement (NSA) on page 10 of 13 listed a category titled "Coordination of Care" with a goal to "Maintain coordination of care with outside providers, maintain resident choice and maintain resident health and wellness" with an initiated date 01/08/2024. R5's NSA listed the goal of coordination of care as staff assist." R5's NSA states, "Resident requires staff assistance to coordinate care with physicians and outside providers."

Review of R5's progress notes showed R5 as not having a Primary Care Physician and having diarrhea. Progress Notes show no reference of facility staff attempting to coordinate a medical appointment for R5. Progress Note dated 01/12/2024 states, "At this time resident does not have a Primary Care Physician (PCP) because Power of Attorney (POA) had to change her insurance provider. POA is aware if any changes in condition resident will be transferred to the Emergency Room as needed."

In an interview on 01/29/2024 at 10:20 AM R5 said they have lived at the facility since [redacted]/2024. R5 said they have requested assistance with scheduling a medical appointment on multiple times with Staff B, Residential Care Coordinator Manager. Resident 5 said they are now "in the doghouse" with the facility administrative staff. R5 said they requested assistance with a scheduled medical appointment on multiple

occasions with Staff B to address the ongoing diarrhea. R5 said Staff B avoided and ignored the requests for help with scheduling the appointment to treat the medical condition.

In an interview on 02/15/2023 at 1:15PM Collateral Contact 3 (CC 3) said, R5 has both Kaiser and Apple Health medical insurance. CC3 said their spouse is R5's sibling and POA, and the siblings speak weekly. CC 3 said R5 has ongoing diarrhea and has not been provided a scheduled medical appointment with a medical provider.

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, Arbor Assisted Living is or will be in compliance with this law and / or regulation on (Date) 4/3/24

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

Administrator (or Representative) — Date: 4/1/24

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to provide a safe, sanitary, and well-maintained environment for 2 of 2 areas (interior and exterior grounds of the facility). These failures placed all residents at risk to have a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included...

Record review of the facility's Disclosure of Services, undated, showed all assisted living facilities must maintain your living quarters and other areas you may use in a safe, clean, and comfortable condition.

Record review of the facility's policy titled, "Safe Storage and Handling of Supplies and Equipment," undated, showed the facility would ensure that all supplies and equipment, dirty and clean, were handled and stored in a safe manner, protecting residents from exposure and risk.

An observation on 01/24/2024 at 9:05 AM, showed three pipe wrenches sitting on the floor in the facility entrance doorway. Sheetrock and insulation chunks were scattered on a mat and on the concrete entrance to the facility.

An observation on 01/24/2024 at 9:49 AM, in the second-floor hallway, indicated there was a urine and fecal stench near Room 204.

An observation on 01/24/2024 at 10:08 AM, showed lights on the second floor with cracked white plastic covers. One halogen light was missing a cover.

An observation on 01/24/2024 at 10:17 AM, showed buckets with razors, hand sanitizer, dermal wound cleaner, and gauze placed by vending machines on the first-floor dining room.

An observation on 01/24/2024 at 10:36 AM, showed a mop bucket with soiled black water next to a working oxygen tank in the hallway. A housekeeping cart with a strong odor of urine was parked in the hallway.

An observation on 01/24/2024 at 10:54 AM, showed a shower chair with brown stains on the seat in the west hallway.

An observation on 01/24/2024 at 11:20 AM, presented an empty space for a non-working eye wash station in the east hallway.

An observation on 01/24/2024 at 3:09 PM, showed cobwebs on the second-floor sprinkler heads. The first-floor ceiling fans showed a thick coat of dust particles and cobwebs dangling from the ceiling. The vent system showed black dust on the metal framing.

An observation on 01/25/2024 at 9:30 AM, showed the three pipe wrenches remained in the front entrance of the facility. The sheet rock and insulation dust remained on the mat and concrete walkway into the facility.

An observation on 01/26/2024 at 10:15 AM, showed a dismantled ceiling fan with bent metal edges and exposed wires in Resident 7's (R7) bathroom.

An observation on 01/26/2024 at 4:26 PM, showed black mold down the length of the exterior vertical gutter by the east rear staircase. The front entrance sign had broken stone siding surrounding the ground beneath it.

An observation on 01/26/2024 at 4:29 PM, showed two plastic garbage bags and one dustpan outside of the east hallway entrance, sitting on the sidewalk.

An observation on 01/26/2024 at 4:31 PM, showed a pile of bent metal framing in front of a trash dumpster. Next to the metal pile was a broken wheelchair. Another pile of bed framing, miscellaneous metal pieces and a bent metal cart were observed on the opposite side of the dumpster.

An observation on 01/26/2024 at 4:33 PM, showed a laundry cart, two serving carts and a crumpled tarp were next to the perimeter chain link fence.

An observation on 01/26/2024 at 4:42 PM, showed a broken ice machine, along with a trash bag and plastic cups, on the outside walkway. On top of the broken ice machine was a bent cardboard box with plastic utensils inside. On the walkway outside the kitchen were two tall metal shelves, a food cart, and an electrical fan, sitting in the rain.

An observation on 01/26/2024 at 4:46 PM, showed three wet, molded wooden pallets propped against a shed on the perimeter of the building. The building showed chipped paint and dirt covering the east exterior wall. Near a planter was an area of lint debris in the dirt and on the pipes next to the vent. A west exterior window showed a screen on the ground near the window. Exterior of siding showed paint chipping and dirt throughout the building.

An observation on 01/26/2024 at 4:47 PM, showed a door labeled "Sprinkler Riser Room," was open with a light on inside the room. The courtyard showed a sheet rock platform ladder left near the facility entrance.

An observation on 01/26/2024 at 4:53 PM, outside the dining hall window, showed an open trash can labeled "Care Staff Only," overfilled with trash including open bags and discarded gloves.

An observation on 01/29/2024 at 3:30 PM, showed a temperature of 130 degrees Fahrenheit in the resident bathroom, closest to the kitchen. The 130-degree temperature was reported to Staff A, Regional Director, with a safety plan request. The ceiling fan in the resident bathroom was nonoperational.

In an interview on 01/24/2024 at 10:15 AM, Staff F, Maintenance Director, said pipes burst during freezing temperatures and inclement weather. Staff F said the broken pipes were in the process of repair, with open holes in the ceiling showing insulation-covered replaced

pipe.

In an interview on 01/24/2024 at 11:16 AM, Resident 1 (R1) said they had a hole in their ceiling where maintenance staff attempted to remove the fan. R1 said this hole has been there a long time with no resolution when they asked Staff B, Residential Care Coordinator Manager, or maintenance staff to repair this.

In an interview on 01/24/2024 at 3:10 PM, Resident 12 (R12) said there were so many cobwebs and dust on the ceiling fans in the television room, that they found it difficult to breath. R12 said they are on oxygen because of the amount of heavy dust on the fans and ventilation systems.

In an interview on 01/26/2024 at 10:15 AM, R7 said previous maintenance staff attempted to remove their bathroom ceiling fan and left behind a hole in their ceiling. R7 said the ceiling hole has been this way since the middle of December. R7 said the former maintenance staff never returned to cap the exposed wires. R7 said two plastic caps were left on the sink. R7 said many requests were made to Staff B for maintenance to repair the hole in the ceiling with no resolve.

In an interview on 01/26/2024 at 4:32 PM, Resident 2 (R2) and Resident 9 (R9) were sitting in the outdoor smoking area. R2 said the surrounding junk had been on the perimeter for a long time.

In an interview on 01/30/2024 at 10:35 AM, Staff A said the broken siding surrounding the exterior sign was from a vehicle accident. When asked, Staff A was uncertain of the date of the vehicle accident.

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: 4/1/24

WAC 388-78A-2440 Resident register.

(1) The assisted living facility must maintain in the assisted living facility a single current register of all assisted living facility residents, their roommates and identification of the

rooms in which such persons reside or sleep.

This requirement was not met as evidenced by:

Based on record reviews and interviews, the facility failed to maintain a current and accurate resident registry for 2 of 12 sampled residents (Resident5 and 11[R5 and 11]). This failure placed residents at risk and potential harm from the inability to be identified and evacuated in the event of an emergency or natural disaster.

Findings included...

A record review on 01/25/2024 at 12:20 pm of 2 of 12 sampled residents showed room [redacted] and [redacted], to have residents residing there and not to be listed on the resident register.

Record Review of Resident 5 (R5)'s face sheet showed an admit date of [redacted]/2024, but not listed on the resident register.

Record Reviews on 01/30/2024 showed R11as not being on the resident register. R11's face sheet showed a move in date of [redacted]/2023.

On 02/27/2024 a record review of R11's Annual Care Assessment Service Summary showed the Assessment date of 11/08/2023 and the facility as R11's address.

In an interview on 01/25/2024 at 10:00 AM Staff A, Regional Director, was asked what date Resident 5 (R5) was admitted to the facility. Staff B, Residential Care Coordinator Manager, reported, "Since [redacted] ([redacted]/2024)" then corrected herself saying "No, [redacted] ([redacted]/2024)."

In an interview on 01/29/2024 at 11:10 AM R5 stated they had been at the facility since the beginning of [redacted].

In an interview on 01/30/2024 at 11:15 AM Collateral Contact 1 (CC 1) said Resident 11 (R11) was residing in this facility and is currently in the hospital.

In an interview with Resident 7 (R7) on 01/30/2024 at 11:30 AM, R7 spoke of another resident at the facility. This other resident (R11) was later identified as not being on the resident register.

On 02/15/2024 at 06:38 PM an email request was made to Staff A and Staff B, for a resident registry, and this documentation was not provided as requested.

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, Arbor Assisted Living is or will be in compliance with this law and / or regulation on (Date) 4/13/24

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

Administrator (or Representative) — Date: 4/1/24

WAC 388-78A-2610 Infection control.

(2) The assisted living facility must:

(a) Develop and implement a system to identify and manage infections;

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections.

This requirement was not met as evidenced by:

Based on observation, interviews and record reviews, the Assisted Living Facility (ALF) failed to have 5 of 5 sampled staff (Staff C, J, K, L, & M) be fit tested for a N95 respirator (A device worn over the mouth and nose or entire face that prevents inhalation of dust, smoke, and other substances). This placed residents, as well as staff and visitors to the facility, at risk of potential harm if highly communicable pathogens were present.

Findings included...

Record review of the Dear Provider Letter (DPL) ALF# 2021-024, titled, "Employer Responsibilities for Respiratory Protection Program and Provision of Personal Protective Equipment (PPE)," dated 04/30/2021, directed Long Term Care Facilities (LTCF) under WAC 296-842-12005 to develop and maintain a respirator program which included initial fit testing and providing staff with their fit tested respirator.

Record review of the document titled, "L&I (Labor and Industries) and Department of Health (DOH) Respirator and Person Protection Equipment (PPE) guidance for Long Term Care: Employer responsibilities for respiratory protection program and provision of PPE," dated 03/30/2021, showed "The Long-term care facilities (LTCF) are required to provide initial fit tests for each Health Care Worker (HCW) with the same model, style, and size respirator (N-95) that the HCW will be required to wear for protection against the COVID-19 (Corona

Virus Disease 2019-an infectious disease caused by a virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, sore throat, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death and other airborne hazards). A 'fit test' is a procedure that tests the seal between the respirator's face piece and the HCW's face. It includes a medical evaluation and is completed by someone who is trained to fit test which takes a minimum of 15-20 minutes. The 'fit test' is to be completed every 12 months."

Record review of Washington State (WA) Department of Health (DOH) website document titled, "Respiratory Protection Program for Long-Term Care Facilities," undated, under the section titled, "fit testing," showed respirator fit testing was to be done before use of N95 respirator and then every year (within 12 months of the date of the last fit test).

Record review of the Department of Health document, titled, "Respiratory Protection Program for Long-Term Care Facilities," undated, showed "providing your workforce with respiratory protection against respiratory hazards, such as the virus that causes COVID-19, is a safety standard regulated and enforced by the Washington Department of Labor and Industries (L&I). Employers have an obligation to protect their employees from hazards in the workplace (General Duty WAC 296-126-094). In healthcare facilities, the tight-fitting disposable 'N95' respirator is a commonly used for respiratory protection. Respirator fit testing ensures that tight-fitting respirators seal properly and helps protect employees from exposure to airborne particles such as viruses and bacteria. Keep your employees safe and working by getting them fit tested and ready to properly use a respirator."

WAC 296-842-12010 Keep respirator program records. "(1) A written copy of the current respirator program must be kept by the employer. (2) Keep each employee's current fit test record, if fit testing is conducted, until the next fit test is administered. Fit test records must include: (a) Employee name; (b) Test date; (c) Type of fit test performed; (d) Description (type, manufacturer, model, style, and size) of the respirator tested; (e) Results of fit tests, for example, for quantitative fit tests include the overall fit factor AND a printout, or other recording of the test."

Record review of OSHA's Respiratory Protection standard 29 CFR 1910.134, undated, showed under section "1910.134(m) Recordkeeping. This section requires the employer to establish and retain written information regarding medical evaluations, fit testing, and the respirator program. This information will facilitate employee involvement in the respirator program, assist the employer in auditing the adequacy of the program, and provide a record for compliance determinations by OSHA."

Review of a facility policy titled "Respiratory Protection Program" showed on page one "Facility Administrator (Respiratory Protection Program) or designee will be responsible for appropriate record keeping regarding respirator fit testing.

In an interview on 01/26/2024 at 1:12 PM Staff A, Regional Director, said the previous Registered Nurse brought her dog to work. Staff A said the dog chewed up the records for

Respirator Protection Program fit testing.

An observation on 01/26/2024 at 1:12 PM showed a binder with chewed up marks on the exterior and no contents on the inside of the binder.

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, Arbor Assisted Living is or will be in compliance with this law and / or regulation on (Date) 4/13/24

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

Administrator (or Representative) — Date: 4/1/24

WAC 388-78A-2710 Disclosure of services.

(2) The assisted living facility must provide the services disclosed.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility staff failed to keep residents safe by abiding with the facilities disclosure of services of securing the exterior doors by 10:00 PM. This failure placed all residents in harm of a potential entry of an unknown person.

Findings included...

A review of a document provided by the facility titled "Disclosure of Services Required by RCW 18.20.300," undated, states on page 8 of 9 and labeled in bold letters "Security Services, Exit Doors will be locked from the outside from 10 PM to 6 AM."

In an interview on 01/28/2024 at 12:15 PM Resident 8 (R8) said they returned to the facility in the early hours of the morning at about 2:00 AM. R8 said the person transporting them and they were surprised to find the exterior doors unlocked at 2:00 AM in the morning. R8 said anyone could come into the facility at that hour and staff would not know.

An observation on 01/29/2024 at 10:30 PM showed the front door was left unlocked and open to the public. Staff were observed walking inside the facility, and no staff member

had locked the entry doorway.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 4/1/24

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

(2) For purposes of WAC 388-78A-2481 through 388-78A-2489 , "staff person" means any assisted living facility employee or temporary employee of the assisted living facility, excluding volunteers and contractors.

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to develop and implement a system to ensure 5 of 5 sampled staff (Staff C, J, K, L and M) had an initial tuberculosis (a communicable disease, TB) skin test within three days of employment. This failure placed 55 of 55 ALF residents at risk of TB infection.

Findings included...

Record review of Staff C, Administrator, personnel file on 01/26/2024 at 10:00 AM showed Staff C was hired by the ALF on 11/28/2022 as Administrator. Staff C's personnel file did not show an initial or a second TB test having been done.

Record review of Staff J, Medication Technician, personnel file on 01/26/2024 at 10:00 AM showed Staff J was hired by the ALF on 09/26/2023 as a Medication Technician. Staff J's personnel file did not show an initial or a second TB test having been done.

Record review of Staff K, Dietary Aide, personnel file on 01/26/2024 at 10:00 AM showed Staff K was hired by the ALF on 01/10/2024 as a Dietary Aide. Staff K's personnel file did not show an initial or a second TB test having been done.

Record review of Staff L, Caregiver, personnel file on 01/26/2024 at 10:00 AM showed Staff L was hired by the ALF on 10/10/2022 as a Caregiver. Staff L's personnel file did not show an initial or a second TB test having been done.

Record review of Staff M, Caregiver, personnel file on 01/26/2024 at 10:00 AM showed Staff M was hired by the ALF on 11/30/2023 as a Caregiver. Staff M's personnel file did not show an initial or a second TB test having been done.

In an interview on 01/26/2024 at 1:12 PM, Staff C said the previous Registered Nurse brought her dog to work. Staff C said the dog chewed up the records for TB testing.

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, Arbor Assisted Living is or will be in compliance with this law and / or regulation on (Date) 4/13/24

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

Administrator (or Representative) — Date: 4/1/24

WAC 388-78A-2500 Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, and:

(1) Who has received the diagnosis or treatment within the previous two years; and

(2) Whose diagnosis was made by, or treatment provided by, one of the following:

(a) A licensed physician;

(b) A mental health professional;

(c) A psychiatric advanced registered nurse practitioner; or

(d) A licensed psychologist.

This requirement was not met as evidenced by:

Based on record review and interviews, the Assisted Living Facility (ALF) failed to provide Mental Health training to 2 of 5 Long Term Care Staff. This failure placed 55 of 55 residents at risk of potential harm for abuse and/or neglect by untrained staff when responding to a resident's mental health crisis.

Findings included...

Record review of the facility's Disclosure of Services, undated, received on 01/24/2024 at 10:00 AM states that the facility does admit and provide services to residents with a [redacted] diagnosis. This Disclosure of Services states that they must provide their staff with specialized mental health training.

Record review of Staff C, Administrator, personnel file on 01/26/2024 at 10:00 AM showed Staff C was hired by the ALF on 11/28/2022 as Administrator. Staff C's personnel file did not show they completed the required specialized training for mental health.

Record review of Staff J, Medication Technician, personnel file on 01/26/2024 at 10:00 AM showed Staff J was hired by the ALF on 09/26/2023 as a Medication Technician. Staff J's personnel file did not show they completed the required specialized training for mental health.

In an interview on 01/24/2024 at 9:15 AM with Staff B, Residential Care Coordinator Manager, a request was made for copies of Staff C's and J's specialized training for mental health records. A second request was made on 01/29/2024 at 4:26 PM, and on both requests the production of the specialized training for mental health documentation was not provided.

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, Arbor Assisted Living is or will be in compliance with this law and / or regulation on (Date) 4/13/24

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

Paulerk — Administrator (or Representative)

4/1/24 — Date

WAC 388-78A-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the

assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

This requirement was not met as evidenced by:

Based on record reviews and interview, the Assisted Living Facility (ALF) failed to ensure 2 of 5 sampled staff (Staff C and Staff J) had the required specialized training for dementia to serve residents with a [redacted] diagnosis. This failure placed 55 of 55 ALF residents at risk for staff not having an understanding on how to work with and manage residents with a [redacted] diagnosis.

Findings included...

Record review of the facility's Disclosure of Services, undated, received on 01/24/2024 at 10:00 AM states that the facility does admit and provide services to residents with a [redacted] diagnosis. This Disclosure of Services states that they must provide their staff with specialized dementia training.

Record review of Staff C, Administrator, personnel file on 01/26/2024 at 10:00 AM showed Staff C was hired by the ALF on 11/28/2022 as Administrator. Staff C's personnel file did not show they completed the required specialized training for dementia.

Record review of Staff J, Medication Technician, personnel file on 01/26/2024 at 10:00 AM showed Staff J was hired by the ALF on 09/26/2023 as a Medication Technician. Staff J's personnel file did not show they completed the required specialized training for dementia.

In an interview on 01/24/2024 at 09:15 AM with Staff B, Residential Care Coordinator Manager, a request was made for copies of Staff C's and Staff J's specialized training for dementia records. A second request was made on 01/29/2024 at 04:26 PM, and on both requests the production of the specialized training for dementia documentation was not provided.

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, Arbor Assisted Living is or will be in compliance with this law and / or regulation on (Date) 4/13/24

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

Administrator (or Representative) — Date: 4/1/24

WAC 388-78A-2540 Administrator requirements. The licensee must ensure the assisted living facility administrator:

(1) Meets the training requirements under chapter 388-112A WAC, and

(2) Knows and understands how to apply Washington state statutes and administrative rules related to the operation of an assisted living facility, and

(3) Meets the administrator qualification requirements referenced in WAC 388-78A-2520 through 388-78A-2527 .

This requirement was not met as evidenced by:

Based on record review and interview the facility failed to provide a copy of an active certification for the Administrator's license for Staff C, Administrator. This failure placed 55 of 55 residents at risk for a facility being operated with an unlicensed Administrator.

Findings included...

A review of personnel file of Staff C, Administrator, on 01/26/2024 at 10:30 AM did not find a current Administrator's license to operate the facility.

A review of the Department's crossmatch systems, both FMS and STARS, on 02/28/2024 at 02:45 pm found Staff C to be listed in both as the facility's Administrator in charge of operating the facility.

In an interview on 02/06/2024 at 05:15 PM via email, the Administrator training certificate for Staff C, Administrator, was requested and not provided. On 02/07/2024 at 10:23 AM via email Staff D, Assistant Executive Director, stated they did not have the requested documentation to provide and stated Staff C, Administrator was not certified.

In an interview on 02/07/2024 at 10:23 AM via email Staff D, Assistant Executive Director, stated that Staff C, Administrator, has not had Administrator training and is enrolled in the next LEAD class in April 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: 4/1/24

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:

Based on observation and record review, the Assisted Living Facility (ALF) failed to date mark/label and store food items in kitchen cold storage refrigerators. This failure placed 55 of 55 residents at risk of potential harm for exposure to food-borne illnesses.

Findings included...

WAC 246-215-03526
Temperature and time control—Ready-to-eat, time/temperature control for safety food, date marking (FDA Food Code 3-501.17).
(1) Except when packaging food using a reduced oxygen packaging method as specified under WAC 246-215-03540, and except as specified in subsections (5) and (6) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than twenty-four hours must be clearly marked to indicate the date or day by which the food must be consumed on the premises, sold, or discarded when held at a temperature of 41ºF (5ºC) or less for a maximum of seven days. The day of preparation must be counted as day one.
(2) Except as specified in subsections (5) through (7) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant must be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than twenty-four hours, to indicate the date or day by which the food must be consumed on the premises, sold, or discarded, based on the temperature and time requirements specified in subsection (1) of this section and:
(a) The day the original container is opened in the food establishment is counted as day one; and
(b) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety.
(3) A refrigerated, ready-to-eat, time/temperature control for safety food ingredient or a portion of a refrigerated, ready-to-eat, time/temperature control for safety food that is

combined with additional ingredients or portions of food must retain the date marking of the earliest-prepared or first-prepared ingredient.
(4) A date marking system that meets the criteria stated in subsections (1) and (2) of this section may include:
(a) Using a method approved by the regulatory authority for refrigerated, ready-to-eat, time/temperature control for safety food that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft-serve mix or milk in a dispensing machine;
(b) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under subsection (1) of this section;
(c) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under subsection (2) of this section; or
(d) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the regulatory authority upon request.
(5) Subsections (1) and (2) of this section do not apply to individual meal portions served or repackaged for sale from a bulk container upon a consumer's request.
(6) Subsections (1) and (2) of this section do not apply to shelf stock.
(7) Subsection (2) of this section does not apply to the following foods prepared and packaged by a food processing plant inspected by a regulatory authority:
(a) Deli salads, such as ham salad, seafood salad, chicken salad, egg salad, pasta salad, potato salad, and macaroni salad, manufactured in accordance with 21 C.F.R. 110 Current Good Manufacturing Practice in Manufacturing, Packing, or Holding Human Food;
(b) Hard cheeses containing not more than thirty-nine percent moisture as defined in 21 C.F.R. 133 Cheeses and Related Cheese Products, such as cheddar, gruyere, parmesan and Reggiano, and Romano;
(c) Semi-soft cheeses containing more than thirty-nine percent moisture, but not more than fifty percent moisture, as defined in 21 C.F.R. 133 Cheeses and Related Cheese Products, such as blue, edam, gorgonzola, gouda, and Monterey jack;
(d) Cultured dairy products as defined in 21 C.F.R. 131 Milk and Cream, such as yogurt, sour cream, and buttermilk;
(e) Preserved fish products, such as pickled herring and dried or salted cod, and other acidified fish products defined in 21 C.F.R. 114 Acidified Foods;
(f) Shelf stable, dry fermented sausages, such as pepperoni and genoa; and
(g) Shelf stable salt-cured products such as prosciutto and parma ham.

Record review of a policy titled, "Care Partners Senior Living to store and handle foods in order to promote health and safety," undated, stated food shall be protected at all times from potential or real contamination.

1. Food, whether raw or prepared, if removed from its original container, shall be stored in a clean, labeled, covered container except during necessary period of preparation or service. Once opened, any product remaining in the original container shall be covered. Container covers shall be nonabsorbent except that linens or napkins may be used for lining or covering bread or roll containers.

An observation on 01/24/2024 at 9:45 AM of the facility's second floor common area refrigerator found a container of ice cream with no date. It was opened and date to be used by was not marked, bags of frozen blue berries in bag smashed in door with white frost and freezer burned inside, an open box of corndogs - box soft to touch, not dated, bag of opened mild cheddar inside a pink bin with dirt and debris, not labeled and dated. A blender was observed in the refrigerator with a white substance not labeled or dated. The refrigerator shelves were observed to have a brown debris and dirt on the shelves.

An observation on 01/24/2024 at 10:22 AM of the dry storage area showed debris, trash, and orange, sticky spots across the floor and under racks.

An observation on 01/24/2024 at 10:25 am of the facility's main kitchen area's cold storage refrigerator had jello bowls covered with plastic covered over them not labeled or dated. Observed at the bottom of fridge covered in debris was a metal pot with some stew/soup, grease congealed on top of stuff, vegetable mix that was ¼ full not labeled or dated stored on top of the refrigerator hidden from site. 15 containers with orange, apple, juice, water, and red juice, Parmesan cheese in metal bowl with plastic wrap dated 12/20/2023, an open to air half package of sliced cheese not covered, labeled or dated.

An observation on 01/24/2024 at 10:36 am found a bucket of brown cookies in a clear bin with plastic wrap not labeled found on top of the refrigerator hidden from site.

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: 4/1/24

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(b) Basic;

(e) Continuing education.

(4) The assisted living facility must ensure all persons listed in subsection (2) of this

section, obtain the home-care aide certification.

WAC 388-78A-2474 Training and home care aide certification requirements.

(6) For the purpose of this section, the term "caregiver" has the same meaning as the term "long-term care worker" as defined in RCW 74.39A.009.

This requirement was not met as evidenced by:

Based on record review and interview the facility failed to provide a copy of an active nursing assistant registered and/or a home care aid certification for Staff L, Caregiver. This failure placed 55 of 55 residents at risk for having an unlicensed caregiver providing care to them.

Findings included...

A review of personnel file of Staff L, Caregiver, on 01/26/2024 at 10:30 AM did not find a current nursing assistant registered current license and/or home care aid certification.

A review of the Department of Health's healthcare providers credential verification crossmatch system on 03/08/2024 at 11:30 AM found Staff L to be last registered as a nursing assistant on 09/22/2021 with their nursing assistant registered credential to have expired on 05/18/2022.

In an interview on 03/08/2024 at 11:40 AM with Staff A, Regional Director, stated that they were unaware that Staff L's nursing assistant registered (NAR) credential was expired. Staff A reached out to Staff L and requested the reason for why their credential was expired. Staff L reported they were "grandfathered" into the system of being required to be registered as a NAR.

Plan/Attestation Statement

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

Jcaulder — Administrator (or Representative)

4/1/24 — Date

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

Cypress Gardens ALC LLC
Arbor Assisted Living
3500 9TH ST
BREMERTON, WA 98312

RE: Arbor Assisted Living # 2663

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 03/12/2024 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Manfay Chan, Field Manager
Residential Care Services
Region 3, Unit D
PO Box 99250

Lakewood, WA 98496

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-2730 Licensee's responsibilities.

(2) The licensee must:

(b) Maintain and post in a size and format that is easily read, in a conspicuous place on the assisted living facility premises:

(i) A current assisted living facility license, including any related conditions on the license;

Observation found that the facility did not have their current business license displayed and posted. The Regional Director (Staff A) confirmed that the facility does not currently have the facility's current business license posted. Staff A printed and posted the current business license for residents and visitors to view.

You Are Not:
• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:
• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:
• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (253)442-3013.

Sincerely,

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

Enclosure