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) 57751 (Completion Date 04/09/2025) and 50598 (Completion Date 12/16/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/09/2025 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2305-1, WAC 246-215-02305-1, WAC 246-215-02310-4, WAC 246-215-02310-8, WAC 246-215-03525-1-a, WAC 246-215-02310-9, WAC 388-78A-3090-1-a, WAC 388-78A-2240

The Department staff who did the on-site verification:
Kathy Heinz, Long Term Care Surveyor
Susan Carmichael, Nursing Consultant Institutional

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

Sincerely,

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Arbor Assisted Living
Provider Type: Assisted Living Facility
License/Cert.#: 2663
Compliance Determination #: 50598
Intake ID: 150300
Investigator: Kathy Heinz
Region/Unit #: RCS Region 3 / Unit D
Investigation Date(s): 11/20/2024 through 12/16/2024
Complainant Contact Date(s): 11/20/2024

Allegation(s):

1. Medications are missing, left unsecured, not available or administered late
2. Meals are not provided at regular intervals, utensils, drinking glasses and napkins are not provided, condiments are not available
3. Facility and resident rooms are not clean and the facility is not in good repair
4. Residents are not provided privacy during Resident Council meetings
5. Care plans are not updated annually
6. Laundry is not completed in a timely manner

Investigation Methods:

Sample:	Total residents: 56 Resident sample size: 4 Closed records sample size:
Observations:	Resident rooms Staff to resident interactions Food preparation Kitchen Dining Residents Identified resident
Interviews:	Identified resident Residents Kitchen staff Executive Director
Record Reviews:	personnel files care plans Facility policies

Investigation Summary:

1. Medication carts were observed locked, in a locked room on 11/20/2024 . On 11/22/2024, one medication cart was observed on the second floor of the facility and it was locked. Record review showed medications were unavailable and a citation was written under 388-78A-2240
2. Condiments, utensils, napkins and drinking glasses were observed available for

the the lunch service on 11/20/2024 and 11/22/2024, and the breakfast service on 11/22/2024. The trash cans were not overflowing for the three meal services observed. Breakfast and the lunch services were started fifteen minutes after the scheduled time. A citation was written under 388-78A- 2305 for food sanitation.
3. A citation was written under 388-78A-3090 for maintenance and housekeeping.
4. Care pans were reviewed and they were current and signed by the residents
5. Under RCW 70.129 (Resident Rights) the facility must provide a space, if one exists, for residents and resident family groups to gather. Currently the residents gather in the dining room.
6. There was not enough evidence to support the allegation.

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

PO Box 99250, Lakewood, WA 98496

Statement of Deficiencies	License #: 2663	Compliance Determination # 50598
Plan of Correction	Arbor Assisted Living	Completion Date
Page 1 of 8	Licensee: Cypress Gardens ALC LLC	12/16/2024

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 11/20/2024, 11/20/2024, 11/22/2024, 12/03/2024, 12/16/2024 and 12/16/2024 of:

Arbor Assisted Living
3500 9TH ST
BREMERTON, WA 98312

This document references the following complaint number(s): 150300, 154616

The following sample was selected for review during the unannounced on-site visit: 4 of 56 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Kathy Heinz, Long Term Care Surveyor
Susan Carmichael, Nursing Consultant Institutional

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

12/27/2024

Date

Statement of Deficiencies	License #: 2663	Compliance Determination # 50598
Plan of Correction	Arbor Assisted Living	Completion Date
Page 2 of 6	Licensee: Cypress Gardens ALC LLC	12/16/2024

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) 1/2/2025 Date

WAC 246-215-02305 Hands and arms Cleaning procedure (FDA Food Code 2-301.12).

(1) Except as specified in subsection (4) of this section, foodemployees shall clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands or arms for at least 20 seconds, using a cleaning compound in a handwashing sink that is equipped as specified under WAC 246-215-05210 and Part 6, Subpart C of this chapter.

WAC 246-215-02310 Hands and arms When to wash (FDA Food Code 2-301.14). foodemployees shall clean their hands and exposed portions of their arms as specified under WAC 246-215-02305 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and:

(4) Except as specified under WAC 246-215-02400 (2), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking;

(8) Before donning gloves for working with ready-to-eatfood unless a glove change is not the result of contamination: and

(9) After engaging in other activities that contaminate the hands or gloves.

WAC 246-215-03525 Temperature and time control Time/temperature control for safety food, hot and cold holding (FDA Food Code 3-501.16).

(1) Except during active preparation for up to two hours, cooking, or cooling or when time is used as the public health control as specified under WAC 246-215-03530 , and except as specified in subsections (2) and (3) of this section, time/temperature control for safety food must be maintained:

(a) At 135 F (57 C) or above, except that roasts cooked to a temperature and for a time specified under WAC 246-215-03400 (2) or reheated as specified under WAC 246-215-03440 may be held at a temperature of 130 F (54 C) or above; or

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 observations and interview, the facility failed to ensure 1 of 1 kitchen staff (Staff B) washed their hands prior to putting on gloves and ensured food was held at proper temperatures prior to serving. This failure placed 56 of 56 residents at risk of eating food that was potentially contaminated by soiled gloves and served under

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) Date

WAC 246-215-02305 Hands and arms Cleaning procedure (FDA Food Code 2-301.12).

(1) Except as specified in subsection (4) of this section, foodemployees shall clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands or arms for at least 20 seconds, using a cleaning compound in a handwashing sink that is equipped as specified under WAC 246-215-05210 and Part 6, Subpart C of this chapter.

WAC 246-215-02310 Hands and arms When to wash (FDA Food Code 2-301.14). foodemployees shall clean their hands and exposed portions of their arms as specified under WAC 246-215-02305 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and:

(4) Except as specified under WAC 246-215-02400 (2), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking;

(8) Before donning gloves for working with ready-to-eatfood unless a glove change is not the result of contamination; and

(9) After engaging in other activities that contaminate the hands or gloves.

WAC 246-215-03525 Temperature and time control Time/temperature control for safety food, hot and cold holding (FDA Food Code 3-501.16).

(1) Except during active preparation for up to two hours, cooking, or cooling or when time is used as the public health control as specified under WAC 246-215-03530 , and except as specified in subsections (2) and (3) of this section, time/temperature control for safety food must be maintained:

(a) At 135 F (57 C) or above, except that roasts cooked to a temperature and for a time specified under WAC 246-215-03400 (2) or reheated as specified under WAC 246-215-03440 may be held at a temperature of 130 F (54 C) or above; or

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 observations and interview, the facility failed to ensure 1 of 1 kitchen staff (Staff B) washed their hands prior to putting on gloves and ensured food was held at proper temperatures prior to serving. This failure placed 56 of 56 residents at risk of eating food that was potentially contaminated by soiled gloves and served under

temperature.

Findings included...

Observation on 11/20/2024 at 12:15 PM showed a small sink located on the north wall of the kitchenette. There was no soap, soap dispenser, or paper towels available for staff use. Staff B, Cook, entered the kitchen through an exterior door. Staff B was observed wearing gloves. Staff B placed a pan of corn dogs, a pan of hot dogs and a pan of peas in a steam table. Staff B opened the refrigerator and pulled out a package of turkey lunch meat. Staff B open a bag of hot dog buns and placed a bun on a plate. Staff B pulled the turkey out of the package with his hands and placed the turkey on the hot dog bun. Staff B served the "sandwich" to a resident. Staff B opened a bag of salad mix and poured the salad mix on top of two plates. Staff B removed turkey meat from the package and tore the meat into pieces with his hands and placed the meat on top of the salad. Staff B did not wash his hands and put on new gloves prior to handling the ready to eat turkey meat and hot dog bun.

Staff B was asked to take a temperature of the hot food being held in the steam table. Staff B left the area and retrieved a thermometer. Staff B took the reading. The corn dog was 120 degrees Fahrenheit (F), and the hot dog was 117 degrees F. Staff B said, "that is not good."

Observation of the kitchen on 11/22/2024 at 8:15 AM showed the facility had installed a soap dispenser (at the request of the licensor on 11/20/2024) at the sink in the kitchen and tucked some paper towels between the water faucet and the wall. Staff B entered the kitchen through an exterior door. Staff B was wearing gloves. Staff B did not remove his gloves and wash his hands. Staff B plated the eggs and bacon onto individual plates and used his gloved hand to plate the biscuit. During the middle of the breakfast service, Staff B removed his gloves, pulled off his hooded sweatshirt and rubbed his hair. Staff B did not wash his hands prior to putting on gloves and plating more biscuits. Staff B stated he needed to get a drink and removed his gloves and left the area. Staff B returned with a drink. Staff B opened the can and took a drink. Staff B smoothed his hair with his bare hand. Staff B did not wash his hands prior to putting on new gloves and plated more biscuits.

Observation on 11/22/2024 at 12:15 PM showed Staff B entered the kitchen though an exterior door. Staff B was wearing gloves. Staff B did not take off his gloves and wash his hands. Staff B plated pasta, red sauce and carrots on residents' plates as they approached the serving window. Staff B pulled cheese from a bag with his gloved hand and sprinkled the cheese on top of the pasta. A resident asked for bread. Staff B opened the bread bag, pulled out a piece of bread and placed the piece of bread on the plate. Staff B removed his gloves and then removed his hooded sweatshirt. Staff B put on new gloves without washing his hands. Staff B proceeded to plate food including topping the pasta dish with cheese with his gloved hand.

Staff A, Administrator, stated during an interview on 12/03/2024 at 2:00 PM, she had

hired a new kitchen manager to help with concerns in the kitchen.

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) 1/30/2025.

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

Administrator (or Representative) 1/2/2025 Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

This requirement was not met as evidenced by:

Based on observations and interviews, the Assisted Living Facility (ALF) failed to ensure 3 of 3 resident shower rooms, kitchen, and laundry room were kept clean, sanitary, and in good repair. This failure resulted in 56 of 56 residents living in an environment in disrepair, with unclean and unsanitary conditions.

Findings included...

First Floor Shower room north side of the building:
Observations on 11/20/2024 at 10:00 AM, on 11/22/2024 at 7:40 AM, on 12/03/2024 at 12:15 PM, and on 12/16/2024 at 12:45 PM showed strands of dark hair and unidentifiable debris littered the tan colored tiles of the floor. The legs of the white plastic shower chair were covered with a pink and brown substance. The door jam and door showed multiple chips and gouges and missing paint. The shelves of the brown floor to ceiling shower caddy were rusted.

Second Floor Shower room north side of the building:
Observations on 11/20/2024 at 10:00 AM, on 11/22/2024 at 7:40 AM, on 12/03/24 at 12:15 PM, and 12/16/2024 at 12:45 PM showed the hem of the white shower curtain was brown. Brown and pink spots were observed on the shower curtain.

Shower room south side of the building:
Observations on 11/20/2024 at 10:00 AM, on 11/22/2024 at 7:40 AM, on 12/03/24 at 12:

hired a new kitchen manager to help with concerns in the kitchen.

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)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

This requirement was not met as evidenced by:

Based on observations and interviews, the Assisted Living Facility (ALF) failed to ensure 3 of 3 resident shower rooms, kitchen, and laundry room were kept clean, sanitary, and in good repair. This failure resulted in 56 of 56 residents living in an environment in disrepair, with unclean and unsanitary conditions.

Findings included...

First Floor Shower room north side of the building:
Observations on 11/20/2024 at 10:00 AM, on 11/22/2024 at 7:40 AM, on 12/03/2024 at 12:15 PM, and on 12/16/2024 at 12:45 PM showed strands of dark hair and unidentifiable debris littered the tan colored tiles of the floor. The legs of the white plastic shower chair were covered with a pink and brown substance. The door jam and door showed multiple chips and gouges and missing paint. The shelves of the brown floor to ceiling shower caddy were rusted.

Second Floor Shower room north side of the building:
Observations on 11/20/2024 at 10:00 AM, on 11/22/2024 at 7:40 AM, on 12/03/24 at 12:15 PM, and 12/16/2024 at 12:45 PM showed the hem of the white shower curtain was brown. Brown and pink spots were observed on the shower curtain.

Shower room south side of the building:
Observations on 11/20/2024 at 10:00 AM, on 11/22/2024 at 7:40 AM, on 12/03/24 at 12:

15 PM, and on 12/16/2024 at 12:45 PM showed the untiled north wall was chipped, gouged, and the paint was peeling. The seat of the white shower chair was speckled with brown and grey matter. The floor of the shower was littered with small pieces of unidentifiable debris. The shelves of the silver-colored floor to ceiling shower caddy were rusted. The wall-mounted silver colored soap tray was caked with a dried white substance. There was a grey matter along the edges of the floor on the dry side of the room. The licensor wiped the grey substance with a paper towel and the debris was grey dust. The cream-colored base tiles on the north wall of the room were marred with black marks and showed areas of unidentifiable substances.

First Floor laundry room:
Observations on 11/20/2024 at 10:15 AM and on 11/22/2024 at 7:50 AM of the laundry room showed frayed hallway carpet butted up against chipped and gouged vinyl flooring at the doorway. Inside the door, a triangular shaped piece of flooring was missing. The piece of flooring was 16 inches in length at the base and five inches at the widest part. The door jamb was chipped and gouged and showed peeling paint.

Kitchen:
Observations on 11/20/2024 at 10:20 AM, on 11/22/2024 at 7:45 AM, and on 12/03/2024 at 12:20 PM showed multiple empty cardboard boxes in various sizes lying on the ground in the pantry area of the kitchen.

Observations on 11/22/2024 at 7:45 AM showed a soiled blue cloth lying on top of a stainless-steel table used for food prep. On top of the soiled rag was a kitchen knife smeared with a substance. The table was spattered with a dried light brown substance. The shelving located under the steam table showed debris and matter caked to the shelf.

Observations on 12/03/2024 at 12:20 PM of the kitchen showed six large cardboard containers of various types of ready to eat juices sitting on a shelf under the coffee maker. Hoses connected the bags of juice inside the cardboard containers to a dispensing gun. A plastic bag of juice had spilled out of the opening of one of the boxes and was lying hose-down on the floor of the kitchen. Sitting on the floor next to the bag of juice, was part of a yellow commercial mop-style mop bucket. Debris littered the floor.

Observations on 12/16/2024 at 1:15 PM of the kitchen on a shelf located above the dishwasher showed a metal baking pan, a roll of toilet paper, a plastic tray, a bottle of cleanser, an orange rag, a dish sink stopper, a glass jar, a fluffy green dusting mitt, and a yellow sponge. Below the dishwasher, sitting on a shelf, was a large white plastic receptacle. The inside of the receptacle was covered with dirt and debris. A heavily soiled dry cloth was observed in a green bucket. Two-gallon size containers were observed, without caps, labeled glass cleaner and pan cleaner. A toilet bowl plunger was observed lying under the dishware machine. A box of apples was located under a shelf on the back wall of the kitchen. Lying next to box was a heavily soiled white cloth. A dark brown dried substance was caked on the front of the ice machine. A soiled blue rag was lying on the floor near the coffee machine. The surface under the steam table

was littered with debris. The door jamb of the kitchen door leading to the dining room showed splatters of different colors of matter. The transition strip was caked with debris and the vinyl floor near the transition piece showed a buildup of black colored matter.

Dining Room:
Observations on 11/22/2024 at 7:47 AM and on 12/16/2024 at 1:13 PM showed an area of carpeting approximately 10 feet by 14 inches in front of a half wall. The carpet was heavily soiled with dark stains and food debris littered the floor. The carpet seams did not line up in two areas exposing the wood floor. Multiple areas of dried matter were observed on the half wall and base board running the length of the half wall.

Staff A, Executive Director, was interviewed on 12/03/2024 at 1:30 PM about the observations made in the kitchen and the laundry room. Staff A said the facility had recently hired a new dining services manager to address the issues related to the kitchen. The transition molding in the laundry room had been removed and the floor was going to be replaced.

Staff D, Resident Care Coordinator, was interviewed about the cleaning schedule for the common shower on 12/16/2024 at 1:00 PM. Staff D stated that they were going to be reviewing and adjusting the housekeepers cleaning schedules.

This is a recurring deficiency previously cited on 3/12/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Arbor Assisted Living is or will be in compliance with this law and / or regulation on (Date) 1/30/2025.

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

Administrator (or Representative) 1/2/2025 Date

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 reviews, the facility failed to ensure medications were available to be given to 2 of 3 sampled residents (Resident 1 and 2 [R1 and 2]) as ordered by a physician. This failure resulted in the residents not receiving their

was littered with debris. The door jamb of the kitchen door leading to the dining room showed splatters of different colors of matter. The transition strip was caked with debris and the vinyl floor near the transition piece showed a buildup of black colored matter.

Dining Room:
Observations on 11/22/2024 at 7:47 AM and on 12/16/2024 at 1:13 PM showed an area of carpeting approximately 10 feet by 14 inches in front of a half wall. The carpet was heavily soiled with dark stains and food debris littered the floor. The carpet seams did not line up in two areas exposing the wood floor. Multiple areas of dried matter were observed on the half wall and base board running the length of the half wall.

Staff A, Executive Director, was interviewed on 12/03/2024 at 1:30 PM about the observations made in the kitchen and the laundry room. Staff A said the facility had recently hired a new dining services manager to address the issues related to the kitchen. The transition molding in the laundry room had been removed and the floor was going to be replaced.

Staff D, Resident Care Coordinator, was interviewed about the cleaning schedule for the common shower on 12/16/2024 at 1:00 PM. Staff D stated that they were going to be reviewing and adjusting the housekeepers cleaning schedules.

This is a recurring deficiency previously cited on 3/12/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Arbor Assisted Living is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

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 reviews, the facility failed to ensure medications were available to be given to 2 of 3 sampled residents (Resident 1 and 2 [R1 and 2]) as ordered by a physician. This failure resulted in the residents not receiving their

medications as ordered and placed the residents at risk for medical complications and/or increased pain associated with not receiving medications as ordered.

Findings included...

Record review of the facility's policy "Medication Unavailable" dated 06/22/2021 showed the facility was responsible to obtain medications for residents who received staff assistance with medications.

R1
Review of R1's September 2024 and November 2024 Medication Administration Records (MARs) showed an order for Stiolto Respimat, an inhaled medication (inhaler) for lung disease, which R1 self-administered two puffs daily.

Review of the September MAR showed R1 did not receive the medication on 09/16/2024, 09/23/2024, 09/24, 2024, 09/25/2024, 09/26, 2024, and 09/29/2024 because the medication was "not available."

Review of the November MAR showed R1 did not receive the medication on 11/02/2024, 11/06/2024, 11/08/2024, 11/09/2024, 11/10/2024, 11/12/2024, and 11/15/2024 because the medication was "not available."

Review of R1's November 2024 progress notes showed facility staff wrote the medication was on order on the dates it was not given, and additionally included a note on 11/07/2024 the inhaler was broken.

During an interview on 11/20/2024 at 12:16 PM about the inhaler, R1 stated, "there was a time I didn't get it, now it's okay. It's the kind you "cock" and they broke it. Now I get it every morning."

During a telephone interview on 11/22/2024 at 10:00 AM, Staff B, Director of Assisted Living, stated that facility staff broke R1's inhalers and the pharmacy would not send new ones.

R2
Review of R2's September 2024, October 2024, and November 2024 MARs showed an order for a narcotic pain medication Hydrocodone-Acetaminophen 10 milligrams (mg) - 325 mg, one tablet six times a day for chronic pain.

Review of the September MAR showed R2 did not receive the medication one time on 09/03/2024, 09/05/2024, 09/16/2024, and 09/27/2024, and two times on 09/29/2024 because the medication was "not available." Additionally, the MAR was left blank six

times without explanation as to why the medication was not given.

Review of the October MAR showed R2 did not receive the medication two times on 10/06/2024 and three times on 10/07/2024 because the medication was "not available." Additionally, the MAR was left blank 11 times without explanation as to why the medication was not given.

Review of the November MAR showed R2 did not receive the medication one time on 11/08/2024, and five times on each 11/09/2024, 11/10/2024, 11/11/2024, and 11/12/2024 because the medication was "not available." Additionally, the MAR was left blank one time on 11/10/2024, 11/11/2024 and 11/16/2024 without explanation as to why the medication was not given.

Review of R2's November 2024 progress notes showed facility staff wrote the medication was on order 11/8/2024 through 11/12/2024.

During a telephone interview on 11/22/2024 at 10:00 AM, Staff A stated they were not sure why the pain medication was not available to R2.

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) 11/30/2025.

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

Administrator (or Representative) — Date: 11/2/25

times without explanation as to why the medication was not given.

Review of the October MAR showed R2 did not receive the medication two times on 10/06/2024 and three times on 10/07/2024 because the medication was "not available." Additionally, the MAR was left blank 11 times without explanation as to why the medication was not given.

Review of the November MAR showed R2 did not receive the medication one time on 11/08/2024, and five times on each 11/09/2024, 11/10/2024, 11/11/2024, and 11/12/2024 because the medication was "not available." Additionally, the MAR was left blank one time on 11/10/2024, 11/11/2024 and 11/16/2024 without explanation as to why the medication was not given.

Review of R2's November 2024 progress notes showed facility staff wrote the medication was on order 11/8/2024 through 11/12/2024.

During a telephone interview on 11/22/2024 at 10:00 AM, Staff A stated they were not sure why the pain medication was not available to R2.

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)_____ .

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

_____ _____

Administrator (or Representative) Date