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) 69623 (Completion Date 12/05/2025) and 65303 (Completion Date 10/07/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/05/2025 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 246-215-03525-1-a, WAC 388-78A-2300-1-d, WAC 388-78A-2210-1-b

The Department staff who did the on-site verification:
Nikolas Jennings, Community Nurse Complaint Investigator

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

Sincerely,

Laurie Anderson

Laurie Anderson, Community Field Manager
Region 3, Unit D
Residential Care Services

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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 #: 65303
Intake ID: 193535
Investigator: Nikolas Jennings
Region/Unit #: RCS Region 3 / Unit D
Investigation Date(s): 09/09/2025 through 10/07/2025
Complainant Contact Date(s):

Allegation(s):

1) Neglect- Resident not given their insulin.
2) Falsification of records- medication records showed medications that were not given.
3) Nursing services- Understaffed, specifically staff were not able to get resident to an appointment with a companion
4) Resident rights- Cigarettes stolen

Investigation Methods:

Sample:	Total residents: 57 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Dining Kitchen Food preparation Staff to resident interactions Resident rooms
Interviews:	Identified resident Nursing staff Identified staff Family members
Record Reviews:	Medical records State reporting log Facility policies Incident investigation

Investigation Summary:

1) Neglect- Resident not given their insulin. Facility records showed that the pharmacy failed to give the medication when they went to pick it up, and that upon finding the issue, the situation was addressed in a appropriate manner. Facility met regulatory requirements.

2) Falsification of records- medication records showed medications that were not given. Record review showed that multiple medications were not correctly documented leading to inconclusive evidence if the medication was given. Interview revealed that facility was aware of the issue and were working on correcting it. Failed practice identified.

3) Nursing services- Understaffed, specifically staff were unable to get resident to an appointment with a companion. Record review inconclusive on the need for additional help outside the facility and that the facility should provide resident with a companion. Facility met regulatory requirements.

4) Resident rights- Cigarettes stolen. Observation showed where resident cigarettes were held and that the cigarettes were locked up. Interview revealed that staff had not witnessed nor had concerns with cigarette theft. Facility met regulatory requirements.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Arbor Assisted Living
Provider Type: Assisted Living Facility
License/Cert.#: 2663
Compliance Determination #: 65303
Intake ID: 193224
Investigator: Nikolas Jennings
Region/Unit #: RCS Region 3 / Unit D
Investigation Date(s): 09/09/2025 through 10/07/2025
Complainant Contact Date(s):

Allegation(s):

1) Quality of care- Unqualified staff
2) Dietary services- Insufficient food
3) Physical Environment- Facility too hot
4) Resident rights- Preferences for additional food ignored.

Investigation Methods:

Sample:	Total residents: 57 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Dining Kitchen Food preparation Staff to resident interactions Resident rooms
Interviews:	Identified resident Nursing staff Identified staff Family members
Record Reviews:	Medical records State reporting log Facility policies Incident investigation

Investigation Summary:

1) Quality of care- Unqualified staff. Interview revealed that the new dietary group employed by the facility simply created menus for the facility, and was not a true dietician. Due to concerns from the residents of the facility, facility staff re-implemented their old menu at the building to alleviate resident concerns. Facility met regulatory requirements.

2) Dietary services- Insufficient food. Interview with staff and AV showed that the

facility consistently had additional food available in the event that the residents wished for more. Interview revealed that the food was frequently cold. Observation revealed that during meal service, one of the foods was consistently cold throughout and did not meet the hot holding temperature. Failed practice identified. Citation issued.

3) Physical Environment- Facility too hot. Observation revealed that facility was at a comfortable temperature during site visit. Regulatory requirement of air conditioners was not applicable for this side of the state due to not meeting the dry bulb temperature requirements. Facility met regulatory requirements.

4) Resident rights- Preferences for additional food were ignored. Interview with staff and AV showed that the facility consistently had additional food available in the event that the residents wished for more. Observation revealed that additional food was available following food service and that residents simply needed to ask for additional food. Facility met regulatory requirements.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Arbor Assisted Living
Provider Type: Assisted Living Facility
License/Cert.#: 2663
Compliance Determination #: 65303
Intake ID: 194656
Investigator: Nikolas Jennings
Region/Unit #: RCS Region 3 / Unit D
Investigation Date(s): 09/09/2025 through 10/07/2025
Complainant Contact Date(s):

Allegation(s):

1) Resident Assessment- Not updated following resident change in condition.
2) Quality of care- Medications done incorrectly.

Investigation Methods:

Sample:	Total residents: 57 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Dining Kitchen Food preparation Staff to resident interactions Resident rooms
Interviews:	Identified resident Nursing staff Identified staff Family members
Record Reviews:	Medical records State reporting log Facility policies Incident investigation

Investigation Summary:

1) Resident Assessment- Not updated following resident change in condition. Interview with AV revealed that facility was in the process of updating their care plan. Record review showed that care plan was updated on 09/22/2025. Facility met regulatory requirements.

2) Quality of care- Medications done incorrectly. Record review showed that multiple medications were not correctly documented leading to inconclusive evidence if the medication was given. Interview revealed that facility was aware of the issue and were working on correcting it. Failed practice identified. Citation issued.

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

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 09/09/2025 of:

Arbor Assisted Living
3500 9TH ST
BREMERTON, WA 98312

This document references the following complaint number(s): 190345, 193737, 193535, 193224, 194656

The following sample was selected for review during the unannounced on-site visit: 3 of 57 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Nikolas Jennings, Community Nurse 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.

Laurie Anderson
Residential Care Services

10/08/2025
Date

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

Administrator (or Representative)

10/28/25
Date

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-2300 Food and nutrition services.

(1) The assisted living facility must:

(d) Prepare food on-site, or provide food through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC Food service;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to maintain food temperatures above 135 degrees Fahrenheit (F) for 1 of 2 sample dishes. This failure placed all 57 residents at risk for food borne illness.

Findings included...

On 09/09/2025 at 5:16 PM observation showed that when using the facility's food thermometer, the temperature of the chicken held in the middle warming tray measured 105 degrees F.

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Residential Care Services | Date

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

Administrator (or Representative) | Date

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

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(1) The assisted living facility must:

(d) Prepare food on-site, or provide food through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC Food service;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to maintain food temperatures above 135 degrees Fahrenheit (F) for 1 of 2 sample dishes. This failure placed all 57 residents at risk for food borne illness.

Findings included…

On 09/09/2025 at 5:16 PM observation showed that when using the facility's food thermometer, the temperature of the chicken held in the middle warming tray measured 105 degrees F.

In an interview on 09/09/2025 at 5:16 PM, Staff C, Cook, confirmed that the temperature of the chicken held in the warming tray was 105 degrees F.

In an interview on 09/15/2025 at 11:37 AM, Staff A, Executive Director, stated that the chicken should be held at 140 degrees F and it was not.

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) 11/21/25.

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

Administrator (or Representative) — Date: 10/20/25

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to properly provide medication services for 3 of 3 sampled residents (Resident 1, Resident 2, and Resident 3). This failure placed Resident 1, Resident 2 and Resident 3 at risk of medical complications due to unmet medication needs.

Findings included...

Record review of undated facility policy titled, "Medications", showed that staff followed a procedure when staff assisted residents to take medications or when medication administration was needed. The policy showed that staff would document the medication given or the refusal thereof.

Resident 1:

In an interview on 09/09/2025 at 5:16 PM, Staff C, Cook, confirmed that the temperature of the chicken held in the warming tray was 105 degrees F.

In an interview on 09/15/2025 at 11:37 AM, Staff A, Executive Director, stated that the chicken should be held at 140 degrees F and it was not.

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-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to properly provide medication services for 3 of 3 sampled residents (Resident 1, Resident 2, and Resident 3). This failure placed Resident 1, Resident 2 and Resident 3 at risk of medical complications due to unmet medication needs.

Findings included…

Record review of undated facility policy titled, “Medications”, showed that staff followed a procedure when staff assisted residents to take medications or when medication administration was needed. The policy showed that staff would document the medication given or the refusal thereof.

Resident 1:

Record review of negotiated service plan (NSP), dated 06/02/2025, showed that Resident 1 required modified assistance with their medications and that facility staff assisted with ordering and maintaining all medications and treatments. The NSP showed that facility staff assisted with medications and treatments per physician order and resident preferences.

Record review of Resident 1's July 2025 Medication Administration Record (MAR) showed Depakote (a medication used to regulate mood in certain mental disorders) was ordered for twice daily at 7:00 AM and 8:00 PM. Review of the MAR between the dates of 07/01/2025 and 07/15/2025 showed the following 7:00 AM doses were missed: 07/01/2025, 07/02/2025, 07/03/2025, 07/04/2025, 07/05/2025, 07/08/2025, 07/09/2025, 07/10/2025, 07/11/2025, 07/12/2025, and 07/15/2025. The MAR showed the following 8:00 PM doses were missed: 07/05/2025, 07/06/2025, 07/07/2025, 07/08/2025, 07/09/2025, and 07/10/2025.

Record review of progress notes dated 07/01/2025 through 07/31/2025 showed that on 07/01/2025, 07/02/2025, 07/03/2025, 07/04/2025, 07/05/2025, 07/06/2025, 07/07/2025, 07/08/2025, 07/09/2025, 07/10/2025, 07/11/2025, 07/12/2025, and 07/15/2025 that Depakote was "on order" or "awaiting pharmacy".

In an interview on 10/06/2025 at 3:19 PM, Staff B, Resident Care Coordinator, stated that the July 2025 MAR documentation was incorrect.

In an interview on 10/07/2025 at 11:08 AM, Staff A, Executive Director, stated that the documentation for Resident 1's Depakote was done incorrectly on the July 2025 MAR.

Resident 2:

Record review of Resident 2's July 2025 MAR showed chlorthalidone (a medication used to help with swelling and water retention), was marked as not available on 07/27/2025, 07/28/2025, and 07/29/2025.

Record review of Resident 2's July 2025 progress notes showed the medication was "on order" for 07/27/2025, 07/28/2025, and 07/29/2025.

In an interview on 10/06/2025 at 3:19 PM, Staff B, stated that the resident assessment showed Resident 2 as independent with their medications. Staff B stated that the MAR documentation was incorrect and that staff provided the medications for Resident 2, which included reordering. Staff B stated that they were not sure what happened with Resident 2's chlorthalidone and that the order never changed.

In an interview on 10/07/2025 at 11:08 AM, Staff A stated that the medication was not followed up upon or was not reordered on time.

Resident 3:

Record review of Resident 3's NSP, dated 02/25/2025, showed that Resident 3 required medication assistance, that the facility would order and maintain all medications and treatments, and that the facility would assist the resident with medications and treatments as per the order and resident preferences.

Record review of Resident 3's July 2025 MAR showed levothyroxine (a medication to assist with low thyroid hormone) was ordered once daily, every morning at 6:00 AM. The MAR showed that on 07/03/2025, 07/09/2025, and 07/26/2025, there was no documentation that confirmed the medication was given and no documentation of an exception for it not being given.

Record review of Resident 3's July 2025 progress notes showed no documentation on 07/03/2025, 07/09/2025, or 07/26/2025 related to the levothyroxine medication.

Record review of Resident 3's August 2025 MAR showed cephalexin (an antibiotic given for certain types of infections) was ordered for four times a day for five days. The MAR showed that it was given four times daily on 08/07/2025, 08/08/2025, 08/09/2025, 08/10/2025, 08/11/2025, and 08/12/2025 for a total of six days.

Record review of Resident 3's August 2025 progress notes showed no documentation related to the cephalexin on 08/12/2025.

Record review of Resident 3's August 2025 MAR showed furosemide (a medication to reduce excess water in the body) was ordered once daily for seven days. The MAR showed that it was given on 08/07/2025 through 08/11/2025 for a total of five days and was not given again after 08/11/2025.

Record review of Resident 3's August 2025 progress notes documented that a note written on 08/12/2025 related to furosemide showed that "medication is finished". This note occurred on day six of the seven-day order.

Record review of Resident 3's August 2025 MAR showed levothyroxine was ordered once daily every morning at 6:00 AM. The MAR showed that on 08/02/2025, 08/03/2025, 08/10/2025, 08/16/2025, 08/20/2025, 08/23/2025, and 08/30/2025, there was no documentation that confirmed the medication was given and no documentation of an exception for it not being given.

Record review of Resident 3's August 2025 progress notes showed no documentation on 08/02/2025, 08/03/2025, 08/10/2025, 08/16/2025, 08/20/2025, 08/23/2025, or 08/30/2025 related to the levothyroxine medication.

In an interview on 10/07/2025 at 11:08 AM, Staff A stated that the medication technicians did not follow the facility's protocol related to medication administration.

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) 11/21/25

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

Administrator (or Representative) — Date: 10/28/25

Record review of Resident 3's August 2025 progress notes showed no documentation on 08/02/2025, 08/03/2025, 08/10/2025, 08/16/2025, 08/20/2025, 08/23/2025, or 08/30/2025 related to the levothyroxine medication.

In an interview on 10/07/2025 at 11:08 AM, Staff A stated that the medication technicians did not follow the facility's protocol related to medication administration.

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Administrator (or Representative) Date