STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

ALJOYA HOUSE AT MERCER ISLAND LLC
ALJOYA MERCER ISLAND
2430 76TH AVENUE SE
MERCER ISLAND, WA 98040

RE: ALJOYA MERCER ISLAND License # 2019

Dear Administrator:

This letter addresses Compliance Determination(s) 39792 (Completion Date 04/16/2024) and 37411 (Completion Date 03/08/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/16/2024 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-2474-2-c, WAC 388-112A-0400-3-a, WAC 388-78A-2620-2-a, WAC 388-78A-2620-2-b, WAC 388-78A-2950-6, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2484-1, WAC 388-78A-2484-2, WAC 388-78A-2484

The Department staff who did the on-site verification:
Jane Hermano, NCI
Kathy Young, Licensor

If you have any questions, please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

Laurie Anderson, Field Manager
Region 2, Unit D
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Statement of Deficiencies	License #: 2019	Compliance Determination #37411
Plan of Correction	ALJOYA MERCER ISLAND	Completion Date
Page 1 of 10	Licensee: ALJOYA HOUSE AT MERCER ISLAND LLC	03/08/2024

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 02/27/2024 and 03/04/2024 of:
ALJOYA MERCER ISLAND
2430 76TH AVENUE SE
MERCER ISLAND, WA 98040

The following sample was selected for review during the unannounced on-site visit: 7 of 32 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Jane Hermano, NCI
Kathy Young, Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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

03/14/2024 — Date

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

Administrator (or Representative) — 3-22-24 Date

WAC 388-112A-0400 What is specialty training and who is required to take it?

(3) Assisted living facility administrators or their designees, enhanced services facility administrators or their designees, adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that service residents who have special needs, including developmental disabilities, dementia, or mental health, must take one or more of the following specialty training curricula:

(a) Developmental disabilities specialty training as described in WAC 388-112A-0420 ;

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:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 4 caregivers (Staff D) sampled completed developmental disabilities (DD) specialty training. This failure placed Resident 6 at risk of receiving inadequate care and services to meet their specialized needs.

Findings included...

Review of the facility's Resident Characteristic Roster showed the facility admitted Resident 6 in the summer 2022. The roster showed Resident 6 was diagnosed with a [redacted].

Review of Resident 6's Negotiated Service Plan (NSP), dated 02/02/2024 and 06/01/2022, showed facility staff supported Resident 6 with cues and consistent communication related to health, wellness, well-being, and safety. The Activities of Daily Living section of the NSP showed Resident 6 needed verbal reminders to pick-up their apartment, remove trash, wash laundry, and shower.

Review of the facility's staff roster showed the facility hired Staff D on 01/11/2023 as a Resident Assistant to provide care and services to the residents. Review of Staff D's employee file showed no documentation that Staff D completed the DD specialty training.

Review of the facility's Resident Assistant job description, dated 09/2016, showed Resident Assistants needed to communicate effectively with residents with cognitive impairment.

Observation on 02/28/2024 at 11:15 AM, showed Resident 6 lived alone in their apartment within the facility.

During an interview on 03/04/2024 at 10:50 AM, Staff A, Executive Director, and Staff H, Administrative Services Director, confirmed that Staff D did not complete the DD specialty training.

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, ALJOYA MERCER ISLAND is or will be in compliance with this law and / or regulation on (Date) 3-22-24

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

Administrator (or Representative) — Date: 3-22-24

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(2) Ensure animals living on the assisted living facility premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

(b) Are certified by a veterinarian to be free of diseases transmittable to humans;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 5 of 5 sampled pets (Pet 1, Pet 2, Pet 3, Pet 4, and Pet 6) received regular examinations, vaccines, and were veterinarian certified to be free of diseases transmittable to humans. These failures placed all residents at risk of contracting illnesses spread by pets.

Findings included...

Review of the facility's policy titled, "Resident and Visiting Pets", dated 04/06/2024, showed that the facility only permitted pets to live on the premises that had a veterinary attested Health Certification and current vaccinations. Review of the facility's Disclosure of Services showed the pets must have regular examinations, vaccinations, and certification from a veterinarian that the pet was free of diseases transmittable to humans.

Observations between 02/27/2024 and 03/04/2024, showed pets resided in the facility.

PET 1
Review of Pet 1's veterinary records showed there was no documentation that showed a veterinarian certified Pet 1 to be free of diseases transmittable to humans.

PET 2
Review of Pet 2's veterinary records showed that as of 10/28/2023, Pet 2's Rabies vaccination was past due. The records showed that as of 08/13/2023, Pet 2's Bordetella and Leptospirosis vaccinations were past due. There was no documentation that showed a veterinarian certified Pet 2 to be free of diseases transmittable to humans. Record review showed there was no record of a current examination for Pet 2.

Observation on 02/28/2024 at 11:55 AM, showed Pet 2 in the facility's Wellness Center with its owner.

PET 3
Review of Pet 3's veterinary records showed that there was no documentation that showed a veterinarian certified Pet 3 to be free of diseases transmittable to humans.

PET 4
Review of Pet 4's veterinary records showed there were no records that showed Pet 4 had a current examination or vaccinations.

Observation on 02/29/2024 at 2:00 PM, showed Pet 4 in the common areas with its owner. During an interview at that time, Pet 4's owner stated that Pet 4 was not people-friendly and could not be touched without snapping.

PET 5
Review of Pet 5's veterinary records showed there was no documentation that showed a veterinarian certified Pet 5 to be free of diseases transmittable to humans. Record review showed there no record of a current examination for Pet 5. The records showed Pet 5 only had a rabies vaccination and none of the other vaccinations appropriate for the species.

During an interview on 02/29/2024 at 2:24 PM, Staff H, Administrative Services Director, Staff H stated that they knew the residents in the community took proper care of their pets. Staff H stated that they did not have all the pet records on file, as required. Staff H stated that the residents were behind in providing their pet records to the facility.

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, ALJOYA MERCER ISLAND is or will be in compliance with this law and / or regulation on (Date) 3-22-24.

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

Marla O'Becker
Administrator (or Representative)

3-22-24
Date

WAC 388-78A-2950 Water supply. The assisted living facility must:

(8) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure the hot water temperature did not exceed 120 degrees Fahrenheit (F) in 18 apartments (Apartments 108, 130, 210, 223, 236, 311, 325, 327, 419, 436, 513, 530, 536, 601, 603, 604, 631, and 635), five common bathrooms (one on the first floor , two on the second floor, one on the third floor, one on the fourth floor and one on the sixth floor) and two other common areas (the art studio and the women's locker room). This failure placed all the residents at risk of burns from scalding water.

Findings included...
Review of the facility's policy titled, "Domestic Hot Water Temperature Monitoring", revised 06/05/2019, showed the facility maintained the water temperature for resident accessible fixtures between 105- and 120-degrees Fahrenheit.

RESIDENT APARTMENTS
Observations on 02/27/2024 showed the hot water temperature: at 10:24 AM in Apartment 601 measured 137.3 degrees F; at 10:31 AM in Apartment 604 measured 127.2 degrees F, at 10:35 AM in Apartment 603 measured 128.2 degrees F; at 10:47 AM in Apartment 631 measured 128.8 degrees F; at 10:52 AM in Apartment 635 measured 125.7 degrees F; at 10:56 AM in Apartment 536 measured 128.4 degrees F; at 11:02 AM in Apartment 530 measured 128.5 degrees F; at 11:23 AM in Apartment 513 measured 130.1 degrees F; at 11:31 AM in Apartment 419 measured 130.1 degrees F; at 11:53 AM in Apartment 436 measured 129.4 degrees F; at 12:58 PM in Apartment 311 measured 125.0 degrees F; at 1:07 PM in Apartment 325 measured 126.9 degrees F; at 1:10 PM in Apartment 327 measured 123.4 degrees F; at 1:17 PM in Apartment 236 measured 125.3 degrees F; at 1:32 PM in Apartment 223 measured 125.9 degrees F; at 1:36 PM in Apartment 210 measured 123.1 degrees F; at 1:45 PM in Apartment 108 measured 126.8 degrees F; and at 2:10 PM in Apartment 130 measured 125.9 degrees F.

COMMON BATHROOMS
Observations on 02/27/2024 showed: at 10:14 AM, the hot water temperature in the sixth-floor common bathroom measured at 129.5 degrees F; at 11:41 AM, the hot water temperature in the fourth-floor common bathroom measured 128.8 degree F; at 1:05 PM, the hot water temperature in the third-floor common bathroom measured at 126.5 degrees F; at 1:25 PM, the hot water temperature in the second-floor common bathroom, by the Wellness Center, measured 122.5 degrees F; at 1:37 PM, the hot water temperature in the second-floor common bathroom measured 127.7 degrees F; and at 1:48 PM, the hot

water temperature in the first-floor common bathroom measured 127.4 degrees F.

OTHER COMMON AREAS
Observations on 02/27/2024 showed: at 11:09 AM, the hot water temperature in the Art Studio measured 130.8 degrees F and at 1:48 PM, the hot water temperature in the Women's Locker Room measured 124.7 degrees F.

Observation of the Boiler Room on 02/27/2024 at 12:35 PM, showed the facility used multiple types of equipment to manage the hot water temperature. There were five displays of temperature readings that ranged from 137 degrees F to 144 degrees F.

During interviews on 02/27/2024 at the times of the resident accessible sinks were tested, both Staff F, Associate Executive Director, and Staff G, Facilities Director, stated that they were aware the water temperatures tested too high and should not measure more than 120 degrees F.

During an interview on 02/27/2024 at 12:30 PM, Staff A, Executive Director, stated Staff G needed to be trained to properly manage the facility's hot water temperatures.

During an interview on 02/27/2024 at 12:35 PM, both Staff F and Staff G stated that they did not know how to adjust the equipment. Staff F and Staff G stated that there were no staff within the facility who knew how to adjust the hot water temperatures. Staff F and Staff G stated that they did not know how the hot water heater thermostats became set between 137 degrees F and 140 degrees F.

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, ALJOYA MERCER ISLAND is or will be in compliance with this law and / or regulation on (Date) 3-22-24

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

Administrator (or Representative) — Date: 3-22-24

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the

resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to document in the Negotiated Service Agreement (NSA) the care needs and interventions for 4 of 7 sampled Residents (Resident 3, Resident 4, Resident 5, and Resident 7). This failure placed Resident 3, Resident 4, Resident 5, and Resident 7 at risk for unmet care needs and potential for worsening medical condition.

Findings included…

RESIDENT 3
Review of Resident 3's Resident Health Evaluation and NSA, dated 02/14/2024, showed Resident 3's diagnoses included a [redacted]. The NSA showed that Resident 3 received 250 milligrams (mg) Keppra (anti-seizure medication) tablet, in the morning and 500 mg in the afternoon. There was no documentation of the signs and symptoms of Resident 3's seizures. The NSA provided no staff instructions for staff to follow when Resident 3 experienced seizures.

RESIDENT 4
Review of Resident 4's December 2023, January 2024, and February 2024 Medication Administration Record (MAR) showed Resident 4 received 2.5 mg Eliquis tablet (medication used to prevent blood clots), one tablet, twice daily by mouth for atrial fibrillation (an irregular heart rate that can lead to blood clots in the heart).

Review of Resident 4's Resident Health Evaluation and NSA, dated 02/07/2024, showed no documentation that Resident 4 received daily blood thinners. There was no documentation about the possible side effects from the use of Eliquis, such as an increased risk of bleeding. There were no staff instructions about what actions were needed if Resident 4 experienced any side effects from the medication. There were no staff instructions about when to report any signs and symptoms of possible side effects to the nurse.

RESIDENT 5
Review of Resident 5's December 2023, January 2024, and February 2024 MAR showed Resident 5 received 81 mg of Enteric Coated Aspirin (a coating around the tablet to allow the medication to pass through the stomach to the small intestine before dissolving) daily, by mouth. There was no documentation on the MARs that explained the reason for the medication.

Review of Resident 5's Resident Health Evaluation and NSA, dated 02/13/2024, showed Resident 5's diagnoses included [redacted] and [redacted]

[redacted] There was no documentation that showed Resident 5 received daily blood thinners. There was no documentation about the possible side effects from daily use of Aspirin, such as an increased risk of bleeding. There were no staff instructions about what actions were needed if Resident 5 experienced any side effects. There were no staff instructions about when to report any signs and symptoms of possible side effects to the nurse.

RESIDENT 7
Review of Resident 7's December 2023 MAR showed in that month, Resident 7 received warfarin (a blood thinner medication). Review of Resident 7's January 2024 and February 2024 MARs showed Resident 7 received 5 mg Eliquis tablet, one tablet, twice daily by mouth to lower the risk of blood clots. The MARs showed Resident 7's diagnoses included [redacted].

Review of Resident 7's Resident Health Evaluation and NSA, dated 09/28/2023, showed Resident 7 received "coumadin (a drug is used to treat or prevent blood clots) management" (monitoring the blood clot level to administer the right dose of blood thinner medication). There was no documentation about the possible side effects from the daily use of Eliquis, such as an increased risk of bleeding. There were no staff instructions about what actions were needed if Resident 7 experienced any side effects. There were no instructions about when to report any signs and symptoms of possible side effects to the nurse.

During an interview on 02/28/2024 at 10:15 AM, Staff B, Community Health Director, informed the licensor the facility followed an anti-coagulant protocol. Staff B stated that they would provide a copy of the protocol to the licensor.

On 03/04/2024, Staff B provided the facility's anti-coagulant protocol for the residents via email. In the email, Staff B stated that Resident 4, Resident 5, and Resident 7's MARs had a separate sheet that contained the anti-coagulant protocol. In the email, Staff B stated that the resident NSAs did not document any safety plan related to the use of anti-coagulant medications and aspirin therapy. Staff B stated that they were unaware Resident 3's NSA did not document any information related to seizure activity and did not document any interventions for staff to follow.

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, ALJOYA MERCER ISLAND 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: 3-22-24

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that 4 of 8 staff (Staff B, Staff D, Staff I, and Staff J) initiated and completed Tuberculosis (TB) testing within the required timelines upon hire. This failure placed all residents at risk of exposure to a contagious illness.

Findings included...

Review of the facility's document, "DSHS Staff Roster" received on 02/27/2024, showed the facility hired Staff B, Community Health Director, on 11/06/2023; Staff D, Resident Assistant on 01/25/2021; Staff I, Dining Services, on 08/05/2023; and Staff J, Food Server, on 12/18/2023. Review of the amended staff roster, received on 02/29/2024, showed the facility initially hired Staff B on 06/01/2022, Staff D on 04/21/2021; Staff I on 05/19/2023, and Staff J on 09/27/2023. Review of the second staff roster showed the facility completed compliance rehires for a total of ten current staff members.

Review of Staff B's records showed on 03/14/2022, Staff B's first-step TB test was administered, 79 days prior to their initial hire date on 06/01/2022. Review of Staff D's records showed the document titled, "Tuberculosis (TB) Testing Dates" was signed and dated by Staff D and a licensed nurse on 01/25/2021. The testing form for Staff D showed there was no data entered in the boxes for the first and second steps of testing. Review of Staff I's records showed Staff I was only administered one of two TB skin tests. Review of Staff J's records showed Staff J was only administered one of two TB skin tests.

During an interview on 01/29/2024 at 1:16 PM, Staff A, Executive Director, stated that the amended hiring dates on the second roster resulted from staff not meeting their hiring requirements within the required timeframe from their date of employment. Staff A stated that to correct the deficiencies and return to compliance, the facility did a compliance rehire. The compliance rehire was effective on the date any noncompliant staff completed the missed requirements.

Observation during the full inspection between 02/27/2024 and 03/04/2024, showed Staff B was present in The Wellness Center and moved about throughout the facility and interacted with residents.

Statement of Deficiencies	License #: 2019	Compliance Determination #37411
Plan of Correction	ALJOYA MERCER ISLAND	Completion Date
Page of 10	Licensee: ALJOYA HOUSE AT MERCER ISLAND LLC	03/08/2024

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, ALJOYA MERCER ISLAND is or will be in compliance with this law and / or regulation on (Date) 3-22-24 .

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

Administrator (or Representative) — Date: 3-22-24

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

03/14/2024

ALJOYA HOUSE AT MERCER ISLAND LLC
ALJOYA MERCER ISLAND
2430 76TH AVENUE SE
MERCER ISLAND, WA 98040

RE: ALJOYA MERCER ISLAND # 2019

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 03/08/2024 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:

Laurie Anderson, Field Manager
Residential Care Services
Region 2, Unit D
20425 72nd Avenue S, Suite 400

Kent, WA 98032

• 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-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

Observation showed Resident 4 used two bed rails, each one attached to the sides of the bed. The bed rails were partially covered with pillowcases. The pillowcases were not securely attached to the rails which allowed the pillowcases to move and create a potential gap between the bed and the rails. During the inspection, the facility covered the bed rails with custom fit covers that were securely fit to each rail and did not move.

WAC 388-78A-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

Resident 3 required medication management assistance. Resident 3’s family provided the medication management assistance. Facility did not document alternative plan for Resident 3’s medication management assistance when family was unavailable. During the inspection, facility staff obtained a family assistance plan that documented both the family and the facility responsibility for Resident 3’s medication assistance when the primary family member was unavailable.

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(b) Provide the necessary care and services for residents, including those with special needs;

Observation showed Resident 1 used an oxygen concentrator to receive continuous oxygen through a nasal cannula (oxygen tubing with two prongs inserted in the nose). There was

no documentation in Resident 1's negotiated service plan that described the oxygen usage and monitoring requirements. During the inspection, the facility staff updated the service plan and included oxygen assessment and continuous oxygen equipment checks. The service plan showed documentation of the company who provided oxygen supplies and serviced the oxygen concentrator.

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)234-6020.

Sincerely,

Laurie Anderson

Laurie Anderson, Field Manager
Region 2, Unit D
Residential Care Services

Enclosure