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

South Pointe Operations LLC
South Pointe Assisted Living
10330 4th Ave W
Everett, WA 98204

RE: South Pointe Assisted Living License # 2610

Dear Administrator:

This letter addresses Compliance Determination(s) 42702 (Completion Date 06/13/2024) and 37606 (Completion Date 03/14/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/13/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2240

The Department staff who did the on-site verification:
Jodi Condyles, ALF Licensor

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

Sincerely,

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

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 follow-up on 02/29/2024 and 02/29/2024 of:

South Pointe Assisted Living
10330 4th Ave W
Everett, WA 98204

This document references the following SOD dated: 03/14/2024

The following sample was selected for review during the unannounced on-site visit: 3 of 41 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Allison Nunn, Long Term Care Surveyor

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

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

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 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 interview and record review the Assisted Living Facility (ALF) failed to ensure the prescribed medications were obtained in a timely manner for 2 of 3 Residents (Residents 2 and 3) who received medication assistance. This failure resulted in Resident 2 missing 22 doses and Resident 3 missing 5 doses of prescribed medications and placed both residents at risk for medical complications due to untreated medical issues.

Findings included…

Review of the ALF's undated policy, "Medication/Treatment Management" showed it is the responsibility of the Administrator to maintain adequate professional oversight of the medications and treatment administration system.

Review of the "Medication Reordering" in-service dated 12/14/2023 showed if a medication has not arrived, staff must notify the Executive Director and the Wellness Director. The Executive Director and Wellness Director will work together to obtain the medication or to ask the doctor to change the order to a medication that is available.

Review of the Department of Social and Health Services' (DSHS) Secure Tracking and Reporting System (STARS) showed that on 12/13/2023, the ALF received an initial citation for this regulation. The ALF signed an attestation statement that showed the ALF would have a system in place and the deficiency corrected by 02/04/2024.

Resident 2

Resident 2 was admitted on [redacted]/2023 with multiple medical diagnoses including [redacted] and [redacted].

A Negotiated Service Agreement (NSA) dated 10/24/2023 showed Resident 2 was on

medication assistance and the ALF staff would dispense all medications to the resident.

A Medication Assistance Record (MAR) dated February 2024 showed Resident 2 was prescribed D-Mannose (prevents certain kinds of bacteria from sticking to the walls of the urinary tract and causing infection) 8000mg daily.

A MAR dated February 2024 showed Resident 2 did not receive 22 doses of D-Mannose on the following dates: February 5-8, 11-15, 17-29. The MAR showed “med on hold” and “absent” as reasons the medication was not given.

On 02/29/2024 at 12:56 PM Staff B, Med Tech, stated that Resident 2 purchased two bottles of D-Mannose, 500 MG pills, and provided them to the ALF on 02/28/2024. Staff B stated that Resident 2’s prescription for D-Mannose was written for a different dose and therefore Staff B did not administer the D-Mannose.

Resident 3

Resident 3 was admitted on [redacted]/2023 with multiple medical diagnoses including [redacted] and [redacted].

A NSA dated 02/06/2024 showed Resident 3 was on medication assistance. The NSA showed the ALF would dispense all medications.

A MAR dated February 2024 showed Resident 3 was prescribed Cholecalciferol oral tablet (a dietary supplement that is used to treat vitamin D deficiency) 50 MCG 2,000-unit gummy daily.

A MAR dated February 2024 showed Resident 3 did not receive 5 doses of Cholecalciferol on the following dates: February 20, 22, 27-29. The MAR showed “med on hold” and “other” as reasons the medication was not given.

On 02/29/2024 at 1:48 PM, Staff B stated that the ALF does not have Cholecalciferol gummies available for Resident 3.

On 02/29/2024 at 1:55 PM, Staff A, Executive Director, stated that the Med Tech should have told them about the issue that prevented the medications from being delivered. Staff A agreed that the ALF is responsible for ensuring that residents do not run out of medication.

This is an uncorrected deficiency previous cited on 12/13/2023.

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, South Pointe 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

Residential Care Services
Investigation Summary Report

Provider/Facility: South Pointe Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2610
Intake ID: 102258
Compliance Determination #: 31682
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 10/26/2023 through 12/13/2023
Complainant Contact Date(s): 10/25/2023, 12/20/2023

Allegation(s):

1. The Alleged Perpetrator (AP1) was not administering medications as prescribed and provided more pain medication to the alleged Victim (AV1) than was ordered.
2. The Alleged Victim 2 (AV2) was being given Haldol as a chemical restraint to manage behaviors. AV2 was missing meals due to being chemically restrained.
3. The AP1 yelled at residents due to incontinence. AP1 was observed throwing a laundry basket into AV3's room. Alleged Perpetrator 3 (AP3), an ALF staff was aggressive and forceful in their care particularly Alleged Victim 4 (AV4).
4. AP2 refused to change residents' briefs before their shift ends and opted to leave it for the next shift, leaving the residents in soiled for longer than 2 hours.
5. The ALF had a yellow book that showed incidents, care refusal, and events in the ALF, they keep private from the state and would not show the state. Staff were told to hide the book when the State showed up.
6. The ALF administrators engaged in bullying of staff and cut hours in retaliation to staff.
7. Call lights were typically not answered for anywhere from 15-40 minutes. Staff have purposefully shut off call lights by going to the resident's room but without providing care.

Investigation Methods:

Sample:	Total residents: 41 Resident sample size: 9 Closed records sample size: 2
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members Administrator
Record Reviews:	Incident investigation

Facility policies
Staff training records
Communication logs
Narcotic logs
Slower logs
MARS
Care plans
Assessments
Nursing notes
Email communications
Hospital records
Call light logs
Shower records
Communication logs
Call light Logs

Investigation Summary:

1. Record review showed the Assisted Living Facility (ALF) was following the physician's order in administering AV1's pain medications. Record showed AV1 had several medication order changes for their pain medications. Interview and record review showed the ALF failed to obtain medications timely for 2 residents resulting in 2 sampled residents not receiving their medications as prescribed. Failed practice was identified. A citation was issued for noncompliance of WAC 388-78A-2240 Non availability of medications.
2. The AV2 was on hospice services. The ALF was monitoring the AV2 and was following the care plan. Interview and record review showed the AV exhibited restlessness and combativeness. Record review showed the AV was ordered Haldol by hospice for restlessness and combativeness. The ALF was following the instructions and was administering the prescribed medication as ordered. The ALF staff were bringing AV2's meals in their room and feed them. No failed practice was identified.
3. Record showed AV3 was able to communicate, make needs known to staff, was cognitive and of sound mind. AV3 denied being yelled at by staff or having their laundry basket thrown into their room. Interview with 6 other sampled residents stated that there were no incidents where staff yelled at them or were rude. No failed practice was identified.
4. Interview with Staff and sampled resident (SR) indicated that care was being followed according to the service plan. Review of documents showed the ALF had a caregiver communication log which was a system the ALF put in place for staff to ensure that care was performed and care that needed follow up tasks were written and communicated. Interview with SR showed there were no incidents that they could recall where their briefs were not being changed. The SR stated that they were satisfied with the care they received from their caregivers.
5. Interview showed the yellow book being referred to was ALF’s caregiver communications logbook where staff would record showers, laundry, appointments, activities, health monitoring, service, and task as well as communication to Med-Tech. During an unannounced visit, the Executive Director and the Resident Care Coordinator showed and provided the state a copy of the “yellow book” when requested.
6. Sampled staff interviewed stated that they did not experience being bullied or being retaliated upon by their supervisor.
7. During an unannounced visit, staff were observed answering the call lights timely. Sampled residents stated that staff answered their call lights immediately and at times they waited from 5-10 minutes. Record review from 3 sampled residents showed the call lights were answered from 1 to 10 minutes. The ALF upgraded their internet connection to speed up their call system.

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: South Pointe Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2610
Compliance Determination #: 31682
Investigator: Wesler Dumecquias
Intake ID: 103308
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 10/26/2023 through 12/13/2023
Complainant Contact Date(s): 12/20/2023

Allegation(s):

1. The Assisted Living facility (ALF) discharged the Named Resident (NR) without a 30-day formal written notice and did not make an effort to assist the NR in seeking a new housing.
2. The ALF continued to charge the NR while their belongings and vehicle remain on the ALF's property.

Investigation Methods:

Sample:	Total residents: 41 Resident sample size: 9 Closed records sample size: 2
Observations:	Residents Resident to resident interactions Resident rooms
Interviews:	Residents Nursing staff Social services staff Family members Hospital staff
Record Reviews:	Hospital records Facility policies Assessment Care plan Email communications Billings

Investigation Summary:

1. Interview and record review showed the ALF did not issue a discharge notice to the NR. The NR was medically cleared to return to the ALF on 10/01/2023 but the ALF indicated that the NR can only return to their apartment if they pay their assessed rental, care and services fees at the time they were to return which resulted in the hospital needing to look for an alternative placement. The ALF was aware that the NR had not been paying their rent and services and owed the ALF 14,000 dollars. A

citation was issued for noncompliance of WAC 388-78A-2660 (1) Residents rights in relation to RCW 70.129(110) (3)(b-d), 70.129(110)(5)(a) (d) Disclosure, transfer, and discharge requirements.
2. The ALF indicated that the NR owed them unpaid rental and services in the amount of 14,000 dollars. The Executive director (ED) stated that they were billing the NR for a prorated special rental rate while at the hospital as well as their furniture being in their room. The ALF owner stated that the ALF waived the NR's unpaid back rent and services. No failed practice was identified.

Conclusion / Action:

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

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 10/26/2023 and 11/21/2023 of:

South Pointe Assisted Living
10330 4th Ave W
Everett, WA 98204

This document references the following complaint number(s): 102258, 103308

The following sample was selected for review during the unannounced on-site visit: 9 of 41 current residents and 2 former residents.

The department staff that investigated the Assisted Living Facility:

Wesler Dumecquias, Community Complaint Investigator

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

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

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 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 interview and record review, the Assisted Living Facility (ALF) failed to obtain the prescribed medications in a timely manner for 2 of 3 residents (Residents 1 and 4) who received medication assistance. This failure resulted in Residents 1 and 4 not having the prescribed medications available as ordered by their primary care physicians and placed all residents who receive medication assistance at risk for unmet needs.

Findings included…

Review of the ALF's undated Policy, "Medication/Treatment Management" showed it is the responsibility of the Administrator to maintain adequate professional oversight of the medications and treatment administration system. The administrator was responsible to provide a medication program in the form of assisting residents with the administration of their medications for residents who are unable to safely self-medicate and to ensure appropriate determination had been made for any resident to safely self-medicate.

Resident 1

Resident 1 was admitted on [redacted]/2022 with multiple diagnosis including [redacted] and [redacted].

Review of the Negotiated Service Plan (NSP) dated and signed on 07/11/2023 showed Resident 1 was on medication assistance. The NSP showed the ALF staff were to assist with medication ordering, dispensing, and getting new prescriptions from providers as needed.

Review of the signed 90-day physician's order dated 07/10/2023 showed Resident 1 was prescribed Hydrocodone- Acetaminophen oral tablet 5-325 MG, 3x a day for low back pain.

Review of the signed 90-day physician's order dated 10/18/2023 showed Resident 1 was prescribed the following medications:
1. Hydrocodone- Acetaminophen oral tablet 5-325 MG, 2x a day for low back pain.

2. Citalopram HBR 20 MG tablet, 1 tablet daily for major depressive disorder.
3. Hydralazine HCL oral 10 MG, 1 tablet 2x a day for hypertension.
4. Gabapentin oral capsule 100 MG, 1 capsule 3x a day for chronic pain syndrome.
5. Senna Oral Capsule 8.6 MG, 1 tablet once a day for constipation.

Review of Medication Administration Record (MAR) dated July 2023 showed Resident 1 was prescribed Hydrocodone- Acetaminophen oral tablet 5-325 MG, 3x a day for low back pain.

Review of the MAR dated June 2023 to September 2023 showed Resident 1 did not receive their prescribed medications because the medications were "Unavailable", "not in the cart", and the ALF was "waiting for pharmacy" on the following months and dates.
1. Hydrocodone- Acetaminophen was missed:
   - On 06/02/2023 at 5 AM for 1 dose.
   - On 07/29, 30, and 31 for 9 doses.
   - On 08/01 to 08/07/2023 for 14x for 5 AM and 2 PM doses.
   - On 08/01 to 08/06/2023 for 6x for the 10 PM doses.
   - On 09/6 1x for the 10 PM dose and 9/7/2023 1x for the 5 AM dose.
2. Hydralazine HCL oral 10 MG was missed:
   - On 7/7/2023 1x for 8 AM dose and 7/16/2023 1x for the 8 PM dose.
3. Citalopram HBR 20 MG tablet was missed:
   - On 8/2/2023 for 8 AM dose for 1 time.
4. Gabapentin oral capsule 100 MG was missed:
   - On 8/01 ,02,19, 23, 26, 28/2023 and 8/02/2023 for 18 doses.
   - On 9/03/2023 for 1x for 2 PM dose.
5. Senna Oral Capsule 8.6 MG was missed:
   - On 8/1,4,5,6,7,9,11,19,23,26,30 for 11 doses.

Resident 4

Resident 4 was admitted on [redacted]/2022 with multiple diagnoses including [redacted], and [redacted].

Review of the NSP dated and signed on 06/15/2023 showed Resident 4 was on medication assistance. The NSP showed the ALF staff would order, store, and dispense Resident 4's medications.

Review of the 90-day physician's order dated 10/17/2023 showed Resident 4 was ordered the following medications:
1. Mirtazapine 15 MG tab, 1 tablet by mouth nightly for generalized anxiety.
2. Risperidone .05 tablet, 1 tablet by mouth daily for cognitive impairment.
3. Psyllium husk powder oral 3.4 G, Mix 3.4 GM in 8 ounces of liquid or juice and drink 2x a day for diarrhea.

Review of Medication Administration Record (MAR) dated September 2023 showed Resident

4 was prescribed:
- Famotidine oral tablet 20 MG, 1 tablet 2 times a day for Gastro-esophageal reflux disease (a condition where the stomach acid repeatedly flows back into the tube connecting your mouth and stomach)
- Lidocaine pain Relieving External Patch 4%, apply 1 patch daily for chronic pain
- Melatonin oral 3 MG tablet, 1 tablet at bedtime for difficulty of sleeping.

Review of the MAR from June 2023 to October 2023 showed Resident 4 did not receive their prescribed medications because the medications were "medication unavailable" and "out of stock" as follows:
- On 06/06- 06/19/2023, 26 doses of Famotidine.
- On 06/06/2023 to 06/18/2023 for 14 doses and 09/01 to 09/07/2023, 6 doses of the Lidocaine patch.
- On 08/17/2023, 1 dose of Mirtazapine and 1 dose of Melatonin.
- On 08/6/2023 for 1 dose and 08/07/2023 for 1 dose of Risperidone.
- On 09/15 to 9/17/2023, 3 doses of Psyllium husk.

On 11/21/2023 at 1:53 PM, Staff A, Executive Director, stated that they were responsible for obtaining residents medications. They would have requested the medications and were waiting for the pharmacy to send it. Staff A stated that she does not know the reason why the medications were not available but said that it's possible the pharmacy did not refilled it timely. Staff A stated that they do not have a policy for non-availability of Medications but were responsible for obtaining residents medications.

On 12/05/2023 at 7:41 PM, Staff E, Med Tech, stated that 8-10 days before a resident who was using the ALF pharmacy runs out of medications, the Med Techs would call the ALF pharmacy. Staff E stated that while waiting for the order, they would request a 3-day emergency supply from their ALF pharmacy. Staff E stated that if the 3-day supply was consumed and the resident run out of medication, they would put on hold the medication, message the Doctor, and make an incident report. Staff E stated that she could not recall if Resident 1 had missed their medications and so she would not know if she called their Pharmacy for refill at that time.

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, South Pointe 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

RCW 70.129.110 Disclosure, transfer, and discharge requirements.

(3) Before a long-term care facility transfers or discharges a resident, the facility must:

(b) Notify the resident and representative and make a reasonable effort to notify, if known, an interested family member of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand;

(c) Record the reasons in the resident's record; and

(d) Include in the notice the items described in subsection (5) of this section.

(5) The written notice specified in subsection (3) of this section must include the following:

(a) The reason for transfer or discharge;

(b) The effective date of transfer or discharge;

(c) The location to which the resident is transferred or discharged;

(d) The name, address, and telephone number of the state long-term care ombudsman;

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to provide a written transfer or discharge notice when 1 of 1 resident (Resident 9) was hospitalized and was not allowed to return to the ALF. This failure resulted in Resident 9 not being allowed to return to their home and the hospital finding an Adult Family Home for Resident 9. This failure placed all Residents at risk for violation of their Residents rights during a discharge/transfer.

Findings included…

Resident 9 was admitted on [redacted]/2022 with multiple diagnoses including [redacted].

Review of hospital records dated [redacted]/2023 showed Resident 9 was admitted due to body weakness.

Review of nursing notes dated 09/26/2023 from Staff B, Director of Nursing Services, stated in her nursing notes her concerns about Resident 9 being a resident in their ALF because Resident 9 chooses to make decisions that were not good or safe for themselves and for other Residents living in the ALF. Staff B stated in her notes that Resident 9 continually smoke outside the ALF and use their cars' console as ashtray which caused a fire, the ALF found cigarette butts in their toilet as well as in the employees bathroom. Staff B stated in her nursing notes that Resident 9 was not a good fit for the facility and that if

Resident fully recovers from the hospitalization and quit smoking, they might benefit from a home or facility that could better support their mental illness and behavior.

Review of Hospital records dated 11/22/2023 showed Resident 9 was admitted at the hospital on [redacted]/2023 and was medically stable to return to the ALF on [redacted]/2023. The record showed the Collateral contact 9 (CC9), Social Worker, received a message from the ALF stating that the ALF were unable to serve and take back Resident 9 due to them owing the ALF approximately 14,500 and would continue to add $5,600 monthly to the bill while Resident 9's belongings and car remained on the ALF's property. The record showed the hospital started to look for a possible placement on 10/10/2023. The Hospital record showed Resident 9 was discharged on [redacted]/2023 to an Adult Family Home arranged by the Hospital.

Review of hospital records dated 11/22/2023 showed Collateral contact 7 (CC7), Registered Nurse Manager, received a call from Staff B, on 10/04/2023 and informed CC7 that Resident 9 had not been paying their rent and several months of arrears and the ALF was not taking Resident 9 back due to behaviors such as smoking, peeking on female residents, spitting everywhere, and driving backwards their car into the ALF's parking lot.

On 11/22/2023 at 10:39 AM, Collateral contact 6 (CC6), Social Worker, stated that the ALF called the hospital on 10/09/2023 to do an assessment. CC6 stated that Staff B stated they were doing an assessment although they were not taking Resident 9 back because it was the ALF's protocol, and they must do it. CC6 stated that the ALF was not taking Resident 9 back because Resident 9 had not been paying their rent, had been smoking, urinating everywhere, and peaking on women residents.

Review of hospital records dated 11/22/2023 showed Collateral contact 7 (CC7), Registered nurse manager, called Staff B on 10/09/2023 and was informed that staff B would be doing an assessment because it was the ALF's "protocol" although CC7 was informed that the ALF were not taking resident 9 back.

On 11/21/2023 at 1:53 PM, Staff A, Executive Director, stated that Resident 9 was not returning to the ALF due to numerous complaints which includes peeing on the hallways, smoking, peaking on female residents, borrowing money from other residents and he was not driving safely. Staff A, stated that Resident 9 owed the ALF in back rental amounting to 14,000 dollars. Staff A, stated that they informed the hospital that they will go and do an assessment. If Resident 9 can pay, they would take them back but Resident 9 could not pay. Staff A, stated that they conducted an assessment on 10/10/2023. Staff A, stated that there was an increase in Resident 9's services and was assessed a total of 5,400 dollars which represented 4,500 dollars in rent and 900 dollars in care and services. Staff A, stated that they wanted and required Resident 9 to pay the assessed 5,400 dollars corresponding to their Rent and services before returning to the ALF. Staff A, stated that they did not discharged Resident 9 but were waiting for them to pay the assessed amount first.

In an email on 12/08/2023 at 4:43 PM, Staff A, ED stated that they did not send a discharge notice.

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, South Pointe 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