STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Greenlake Senior Services LLC
Greenlake Emerald City
9001 Lake City Way NE
Seattle, WA 98115

RE: Greenlake Emerald City License # 2696

Dear Administrator:

This letter addresses Compliance Determination(s) 70215 (Completion Date 12/17/2025) and 65114 (Completion Date 10/31/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/17/2025 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-2600-1-a, WAC 388-78A-2600-2-f, WAC 388-78A-2600-2-g, WAC 388-78A-2600-2-p, WAC 388-78A-2600-1-b, WAC 388-78A-2660-1, WAC 388-78A-2660-4

The Department staff who did the on-site verification:
Cathy Prentice, Complaint Investigator

If you have any questions, please contact me at (253)312-1446.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Greenlake Emerald City
Provider Type: Assisted Living Facility

License/Cert.#: 2696
Intake ID: 194164
Compliance Determination #: 65114
Region/Unit #: RCS Region 2 / Unit J
Investigator: Cathy Prentice
Investigation Date(s): 09/04/2025 through 10/31/2025
Complainant Contact Date(s):

Allegation(s):

1. The Named Resident (NR) made a homicidal threat to the Administrator.
2. The NR screamed at a resident, pulled the fire alarm, and displayed erratic and aggressive behaviors.
3. The NR was given an eviction notice by the facility for being a danger to others.

Investigation Methods:

Sample:	Total residents: 99 Resident sample size: 14 Closed records sample size: 4
Observations:	Observed ALF residents, delivery of care and services; staff interactions with residents; residents' appearance; environment.
Interviews:	Named Resident not available: closed record review, other residents, staff, administration, collateral contacts.
Record Reviews:	Resident care records, Assessment, Negotiated Service Agreement (NSA), investigations, grievances, facility policies, other pertinent records.

Investigation Summary:

According to interview and record review:

1. The facility investigation showed the NR had [redacted] diagnoses and unsafe behaviors toward other residents as well as staff. The NR discharged to a different care setting on [redacted]/2025. No failed practice identified.
2. The facility investigation showed the NR had [redacted] diagnoses and unsafe behaviors toward other residents as well as staff. The NR discharged to a different care setting on [redacted]/2025.No failed practice identified.
3. The facility gave the NR a discharge notice that did not meet the requirements: Failed to record information regarding the notice and the discharge in the medical record and the notice did not include mental health advocacy information as required. See Statement of Deficiencies dated 10/29/2025.

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: Greenlake Emerald City
Provider Type: Assisted Living Facility

License/Cert.#: 2696
Intake ID: 193217
Compliance Determination #: 65114
Region/Unit #: RCS Region 2 / Unit J
Investigator: Cathy Prentice
Investigation Date(s): 09/04/2025 through 10/31/2025
Complainant Contact Date(s):

Allegation(s):

1. The Named Resident (NR) had a bruise on the forehead that was self inflicted with a hammer in an attempt to harm self.
2. The NR was found on the floor with a self inflicted injury to the head with an axe.
3. The NR had stopped eating, gave away possessions before harming himself.

Investigation Methods:

Sample:	Total residents: 99 Resident sample size: 14 Closed records sample size: 4
Observations:	Observed ALF residents, delivery of care and services; staff interactions with residents; residents' appearance; environment.
Interviews:	Named Resident not available: closed record review, other residents, staff, administration, collateral contacts.
Record Reviews:	Resident care records, Assessment, Negotiated Service Agreement (NSA), investigations, grievances, facility policies, other pertinent records.

Investigation Summary:

According to interview and record review:

1. The NR hit his head with a hammer in a suicide attempt. The facility failed to implement their Accidents, Incidents, and Unusual Occurrences, Ambulance (Emergency) Transport, Emergencies-Major Medical Emergency and Documentation, Mental Health Deterioration, Mental Health/Psychiatric Crisis, and Suicide Precautions policies. See Statement of Deficiency dated 10/31/2025.
2. The NR had suicidal ideation and plans from 10/27/2025 to [redacted]/2025 when he self inflicted injuries in a suicide attempt with an axe. The facility failed to implement their Accidents, Incidents, and Unusual Occurrences, Ambulance (Emergency) Transport, Emergencies-Major Medical Emergency and Documentation, Mental Health Deterioration, Mental Health/Psychiatric Crisis, and Suicide Precautions policies. See Statement of Deficiency dated 10/31/2025.
3. The NR had suicidal ideation with behaviors and plans from 10/27/2025 to

[redacted]/2025 including a suicide attempt on 09/02/2025. The facility failed to implement their Accidents, Incidents, and Unusual Occurrences, Ambulance (Emergency) Transport, Emergencies-Major Medical Emergency and Documentation, Mental Health Deterioration, Mental Health/Psychiatric Crisis, and Suicide Precautions policies. See Statement of Deficiency dated 10/31/2025.

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

20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies	License #: 2696	Compliance Determination #65114
Plan of Correction	Greenlake Emerald City	Completion Date
Page 1 of 10	Licensee: Greenlake Senior Services LLC	10/31/2025

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 09/04/2025 of:

Greenlake Emerald City
9001 Lake City Way NE
Seattle, WA 98115

This document references the following complaint number(s): 193217, 191657, 194164, 194321, 195584, 196668

The following sample was selected for review during the unannounced on-site visit: 14 of 99 current residents and 4 former residents.

The department staff that investigated the Assisted Living Facility:

Cathy Prentice, Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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.

Jamie Singer
Residential Care Services

11/13/2025
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)

11/25/2025
Date

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:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(f) In response to medical emergencies;

(g) When there are urgent situations in the assisted living facility requiring additional staff support;

(p) To coordinate services and share resident information with outside resources, consistent with WAC 388-78A-2350 ;

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;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement their Accidents, Incidents, and Unusual Occurrences, Ambulance (Emergency) Transport, Emergencies-Major Medical Emergency and Documentation, Mental Health Deterioration, Mental Health/Psychiatric Crisis, and Suicide Precautions policies for 1 of 1 resident (Resident 1) who exhibited suicidal ideations and plans, and a suicide attempt. This failure resulted in Resident 1 not receiving necessary mental

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Administrator (or Representative)

Date

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(g) When there are urgent situations in the assisted living facility requiring additional staff support;

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Based on interview and record review, the Assisted Living Facility (ALF) failed to implement their Accidents, Incidents, and Unusual Occurrences, Ambulance (Emergency) Transport, Emergencies-Major Medical Emergency and Documentation, Mental Health Deterioration, Mental Health/Psychiatric Crisis, and Suicide Precautions policies for 1 of 1 resident (Resident 1) who exhibited suicidal ideations and plans, and a suicide attempt. This failure resulted in Resident 1 not receiving necessary mental

health services and interventions which contributed to a second suicide attempt requiring hospitalization.

Findings included...

NOTE: Washington Administrative Code 388-78A-2120 -Monitoring residents' well-being. The assisted living facility must: (3) Evaluate, in order to determine if there is a need for further action: (b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons. (4) Take appropriate action in response to each resident's changing needs.

Review of the ALF policy, "Accidents, Incidents, and Unusual Occurrences", dated 02/15/2024, stated on page 22, for resident accidents or unusual occurrences the facility were to immediately provide for safety and administer first aide or call 911 if indicated.

Review of the ALF policy, "Ambulance (Emergency) Transport", dated 02/15/2024, stated on page 28, "When a resident displays symptoms of a potentially serious or life-threatening illness or sustains a potentially serious or life-threatening injury, the supervisor or designee will call 911.

Review of the ALF policy, "Emergencies-Major Medical Emergency and Documentation", dated 02/15/2024, stated on page 55, "When a resident shows any signs or symptoms of a medical crisis, 911 must be summoned immediately. Psychiatric crisis especially if accompanied by violent or dangerous behavior. Any change in stability or appearance of serious threat to health and well being do not hesitate to summon emergency medical services. Notify a licensed nurse if available to determine if emergency medical services are available, if a licensed nurse is not available immediately and you are unsure of extent of issue or injury call 911. For fracture or head trauma do not move resident." The policy lists examples of when to call 911 which included #10, "psychiatric crisis especially if accompanied by violent or dangerous behavior." The policy concluded the directive under section A, "anytime there is a change in the stability of the resident and there appears to be a serious threat to their health or well-being, do not hesitate to summon emergency medical services."

Review of the ALF policy, "Mental Health Deterioration", dated 02/15/2024, stated on page 158, "Each resident will receive care and intervention when there is concern with mental health. Contact MD or other mental health professional regarding the change in status. Update service plan to reflect any change in care needs. If the resident is a threat to himself, the MD or a psychiatric evaluation team is immediately contacted for placement or the resident may be sent to a local hospital for psychiatric evaluation."

Review of the ALF policy, "Mental Health/Psychiatric Crisis", dated 02/15/2024, stated on page 159, "Appropriate care will be arranged should a resident be in psychiatric

crisis-Any verbalization of suicidal ideation must be taken seriously by staff and reported to the manager-any resident verbalizing suicidal ideation is to be sent out for psychiatric evaluation."

Review of the ALF policy, "Suicide Precautions", dated 02/15/2024, stated on page 193, "All resident suicide threats or related comments (ideations) will be taken seriously and addressed promptly. Staff will immediately report any such comments to a nurse or supervisor-the nurse will assess the resident and implement a plan for safety monitoring." The policy defined, "Suicide threat: A statement made by the resident that directly indicates an intention to kill themselves e.g. I am going to kill myself or I am going to slit my wrists. Suicide Ideation or Related Comment: A statement that indicates a desire to be dead, but not specifically to kill themselves e.g. I wish I were dead or I have no reason to live." The policy stated the procedure to be followed to initiate suicide precautions included, "Upon learning of a suicidal threat or related comment made by a resident, the nurse or supervisor will initiate suicide precautions, complete a suicide risk assessment, document the reported threat or comment, the risk assessment results and the precautions that were implemented in the chart. Notify the MD and document. Suicide precautions will consist of: conducting a sweep of the resident's room, ensure no hazards, accessible. If the resident verbalized a suicidal thought or ideation monitor every 15 minutes. If the resident made a direct suicide threat 1:1 continuous monitoring will be initiated. If the suicide risk assessment indicates that the resident is actively suicidal, arrangement will be made for transfer to an acute care or psychiatric care setting. The resident will remain on continuous monitoring 1:1 until the transfer occurs."

Record review of a Face Sheet showed the ALF admitted Resident 1 on [redacted]/2024. Review of an Assessment, dated 04/03/2025, showed Resident 1 had no [redacted] or a history of suicidal ideations or attempts. Review of the Negotiated Service Agreement (NSA), dated 04/03/2025, showed Resident 1 was able to communicate effectively, had no mood or depression issues

Review of an email, sent on 08/27/2025 at 9:47 PM, from Staff D (Activity Director) to Staff A (Administrator), showed Resident 1 had a meeting on 08/27/2025 with Staff D where he discussed "he wanted to take his own life on September 2nd and he was inviting me to the funeral on September 6th. He wanted me to call a number and dictate to a coffin company for him, that he wanted them to come and pick up his body. I asked if there was anything I could say to change his mind. I asked him how he planned to do it and he gestured to his head. He was describing the funeral details."

In an interview, on 09/04/2025 at 10:30 AM, Staff A stated that on 08/27/2025 ALF staff had reported that that Resident 1, "wanted to take his life and asked for a coffin. Resident 1 was giving belongings to staff and planned to kill himself." Staff A stated that Resident 1 was place on "Alert Status" which meant safety checks were being conducted every 2 hours by care staff. Staff A confirmed that when he and other ALF staff became aware of Resident 1's suicidal ideation and plan the ALF did not call 911, did not contact mental health or crisis care professionals, did not notify Resident 1's physician, did not place Resident 1 on suicide precautions, did not initiate 1:1

monitoring, and did not update the NSA.

Record review of an email, sent on 08/30/2025 at 6:18 PM, from Staff B (Activity Assistant) to Staff A, showed Resident 1 was giving away his money. Staff A stated it may be related to the suicidal ideation.

In an interview, on 09/04/2025 at 11:50 AM, Staff A stated that on 08/30/2025 he became aware that Resident 1 continued to communicate to staff he had suicidal ideations with plans and was giving his things away to staff. Staff A confirmed, from 08/27/2025 through 08/30/2025, with continued suicidal ideations and plans ALF did not call 911, did not contact mental health or crisis care professionals, did not notify Resident 1's physician, did not place Resident 1 on suicide precautions, did not initiate 1:1 monitoring, and did not update the NSA.

Record review of an email, sent on 09/02/2025 at 5:53 PM, from Staff B to Staff A, stated that Staff B went to check on Resident 1 in his apartment on at 12:45 PM because he not shown up for lunch. The email stated that Staff B found Resident 1 lying in his bed in the dark. The email stated Staff B observed Resident 1 had a bruise on his forehead. The email stated Resident 1 told Staff B he had not eaten since the day before and was not hungry. The email stated that Resident 1 pointed to the bruise on his head and told Staff B, "it didn't work."

In an interview, on 09/04/2025 at 11:50 AM, Staff A stated he became aware, from Staff B's email, that Resident 1's had a bruise on his forehead and was refusing to eat. Staff A stated he went to Resident 1's apartment, on 09/02/2025, and saw a bruise on Resident 1's forehead that was, "Red and three inches long and oval shaped." Staff A stated it looked like Resident 1's head was "bashed" into a wall. Staff A stated Resident 1 told him that his head hurt. Staff A stated that Resident 1 told him he hit himself on his forehead with a hammer in a suicide attempt. Staff A stated Resident 1 had been refusing meals for two days. Staff A confirmed, from 08/30/2025 through 09/02/2025, with continued suicidal ideations and now an actual suicide attempt the ALF did not call 911, did not contact mental health or crisis care professionals, did not notify Resident 1's physician, did not place Resident 1 on suicide precautions, did not initiate 1:1 monitoring, did not update the NSA, and did not search his apartment for a hammer or any other harmful objects.

Record review of Formal Investigation Report (FIR) documented by Staff A, dated 09/05/2025, stated that on [redacted]/2025 "between 8:30 and 9:30 AM" Staff E (Front Desk Concierge) assisted Resident 1 to call a taxi to go to a hardware store.

Review of an email sent from Staff E to Staff A, on 09/03/2025 at 5:09 PM, stated that Staff E had assisted Resident 1 in getting a taxi to a hardware store. The email showed Staff E printed out directions to the hardware store for Resident 1 and observed him leave for the hardware store and return to the ALF.

In an interview, on 10/28/2025 at 11:25 AM, Staff E confirmed that on the morning of [redacted]/2025 she assisted Resident 1 to get a taxi and provided him printed directions to a hardware store. Staff E stated she had not been notified that Resident 1 had attempted suicide via a hammer the [redacted].

Record review of the FIR, dated 09/05/2025, stated that at 10:45 on [redacted]/2025, when Resident 1 returned from the hardware store he had arranged a meeting with Staff F (Business Office Manager) to discuss funeral arrangements.

Review of an undated written statement, documented by Staff F, stated that on [redacted]/2025 at 10:45 AM, "[Resident 1] came to my office it was 10:45 am. He again tried to give me his keys and explain that his wallet was in his drawer. He would not be here, and I should give everything in the drawer to [Resident 1's son]. I asked him where he would be and his reply 'with my wife.' My reply to [Resident 1] was we need him to be here, that we all have loved ones that we miss and that God has plans for him and that he is very special person. He then asked me to come to his apartment at 11:30 AM. I told him I will come to your apartment. I got busy with my work, and it was a little after 12 pm that I remembered I needed to go to [Resident 1's] apartment."

Record review of the FIR, dated 09/05/2025, stated that at 12:15 PM on [redacted]/2025, Staff A received, "Urgent call: [Resident 1] in apartment with axe and head injury, found facedown, bleeding; [Staff B] applying pressure; EMS (emergency medical staff) and police contacted."

Review of a Progress Note (PN), dated [redacted]/2025, Staff A documented that Resident 1 purchased an axe that morning without staff knowledge. The PN stated that at noon, Resident 1 was found by Staff B in his apartment, "in a pool of blood with the axe nearby".

Review of a PN, dated 09/03/2025, Staff C (Wellness Director) documented that Resident 1 was, "Found face down with Staff B applying pressure to a bleeding wound on the back of the head. A bloodied axe was discovered nearby."

In an interview, on 09/04/2025 at 11:50 AM, Staff A confirmed that after Resident 1's suicide attempt on 09/02/2025 , the ALF did not call 911, did not contact mental health or crisis care professionals, did not notify Resident 1's physician, did not place Resident 1 on suicide precautions, did not initiate 1:1 monitoring, did not update the NSA, and did not search his apartment or put interventions in place to prevent Resident 1 from accessing harmful objects.

Review of the Washington State Health Care Authority website, on 09/09/2025, showed Designated Crisis Responders (DCR)s were available and dispatched through 9-1-1. DCR's can determine if a person presents a harm to self/others/property, is at imminent

risk, or is in need of assisted outpatient behavioral health treatment. The DCR would conduct an evaluation and investigation.

Review of the website www.seattle.gov, on 09/09/2025 showed Community Crisis Responders were available for facilities to contact when a resident had a mental health status change/crisis. The website stated, "when a person calls 9-1-1 for help, the City of Seattle aims to send resources immediately and intervene effectively, to meet the needs identified and achieve optimal outcomes for all parties involved. Community Crisis Responders (CCR) assist Seattle Police Department (SPD) officers in responding to 9-1-1 call events involving persons experiencing crisis or behavioral health challenges. CCRs are qualified behavioral health professionals, trained to provide support and resources to people experiencing crises and behavioral health challenges."

Review of the website KingCounty.gov, on 09/09/2025, showed, "If you or someone you know is experiencing a mental health related crisis, help is available for everyone in King County, 24 hours a day, 365 days a year. CCRs are dispatched by the Seattle 9-1-1 Communications Center or directly radioed to assist by Seattle Police Department patrol officers, who ensure the situation is safe and CCRs can spend sufficient time co-facilitating community members to the appropriate service providers."

In an interview, on 09/09/2025 at 12:00 PM, Collateral Contact 2 (CC2- Social Worker from Harborview Medical Center Psychiatric Unit) stated that Resident 1 had been admitted to the [redacted] at the hospital on [redacted]2025. CC2 stated Resident 1 was receiving psychiatric treatment for suicide attempts and medical care for self inflicted injuries to his head and neck. CC2 stated Resident 1 arrived through the hospital emergency room unresponsive. CC2 stated she wondered why the ALF did not call mental health professionals sooner, with all that Resident 1 was going through at the facility. CC2 stated that DCRs were available around the clock. CC2 stated Resident 1 communicated to the hospital that he tried to kill himself but it did not work.

In an interview on 09/09/2025 at 12:05 PM, CC3 (Social Worker Harborview Medical Center Emergency Room) stated that if a resident was in a mental crisis, an ALF can call 911 anytime for transport to the emergency room for an assessment or for ITA hospitalization. CC3 stated after seeing Resident 1 in the emergency room, she was surprised the ALF had not contacted mental health and health professionals sooner. CC3 stated mental health professionals, DCR's were available 24 hours seven days per week and would go to the facility if called.

In an interview, on 09/09/2025 at 1:50 PM, CC1 (911 Dispatcher for the City of Seattle) stated ALFs can call 911 at 24/7 if they need DCRs for resident with mental health problems. CC1 stated DCR's would visit ALFs onsite along with medics.

In a phone interview, on 09/08/2025 at 11:50 AM Staff A stated, "I see now that we should have followed our policy for suicide precautions, but we did monitor and check

on him a lot, but we did not call for medical attention and we did not call the doctor and we did not call 911 or the other things that it says in the policy because we didn't know about the policies until [Department Representative] pulled them from the policy book and table of contents and asked me to send them to you."

This is a recurring deficiency previously cited under subsection 1(b) on 02/12/2025 and 06/05/2025.

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, Greenlake Emerald City is or will be in compliance with this law and / or regulation on (Date) 12/15/2025 .12/15/2025

SB confirmed amended POC date with Provider on 12/1/2025.

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

Administrator or Representative

10/25/2025
Date

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

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

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to document reasons for the discharge or include required advocacy information for 1 of 3 residents (Resident 2) when a discharge notice was given. This failure led to a lack of information in the medical record for Resident 2's discharge and placed him and his legal representative at risk for not knowing advocacy resource information.

Findings included...

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Administrator (or Representative) Date

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Findings included...

NOTE: Revised Code of Washington (RCW) 70.129.110 Disclosure, transfer, and discharge requirements. (3) Before a long-term care facility transfers or discharges a resident, the facility must: (c) Record the reasons in the resident's record; (f) For residents with mental illness, the mailing address and telephone number of the agency responsible for the protection and Certified on 7/12/2024 RCW 70.129.110 Page 1 advocacy of individuals with mental illness established under the protection and advocacy for mentally ill individuals act.

Record review of a Face Sheet showed the ALF admitted Resident 2 on [redacted]/2024 with diagnoses of [redacted] and [redacted].

In an interview, on 09/11/2025 at 12:17 PM, Staff A (Administrator) stated the ALF gave Resident 2 a discharge notice on 09/09/2025 for behaviors unsafe to the health and safety of others, after accommodations and earlier warnings did not work. Staff A stated he did not enter any chart notes regarding the discharge notice or the reasons for the discharge notice in Resident 2's medical record.

Review of Resident 2's record showed no information was documented regarding Resident 2's discharge notice and discharge.

Review of the Discharge Notice, dated 09/09/2025 and issued to Resident 2, showed there was no information for the mailing address and telephone number of the agency responsible for the protection and advocacy of individuals with mental illness as required.

Statement of Deficiencies	License # 2696	Compliance Determination #55114
Plan of Correction	Greenlake Emerald City	Completion Date
Page 10 of 10	Licensee: Greenlake Senior Services LLC	10/31/2025

Plan/Attestation Statement

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~~Administrator (or Representative)~~

11/25/25
Date

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Administrator (or Representative) Date