



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

Lynden ALC LLC
Lynden Manor
905 Aaron Dr
Lynden, WA 98264

RE: Lynden Manor License # 2641

Dear Administrator:

This letter addresses Compliance Determination(s) 34056 (Completion Date 12/18/2023) and 26813 (Completion Date 07/25/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/18/2023 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-2480-1, WAC 388-78A-2474-2-d, WAC 388-112A-0720-2-a

The Department staff who did the on-site verification:
Judith Mellon, RN, Licenser

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

Statement of Deficiencies

License #: 2641

Compliance Determination # 26813

Plan of Correction

Lynden Manor

Completion Date

Page 1 of 4

Licensee: Lynden ALC LLC

07/25/2023

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 07/14/2023, 07/25/2023, and 07/17/2023 of:

Lynden Manor

905 Aaron Dr

Lynden, WA 98264

This document references the following SOD dated: 07/25/2023

The following sample was selected for review during the unannounced on-site visit: 0 of 82 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Christine Banta, Community Complaint investigator

Cristina Gonzalez, ALF Licenser

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.

Kim Ripley
Residential Care Services

08/02/2023

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.

Statement of Deficiencies	License #: 2641	Compliance Determination # 26813
Plan of Correction	Lynden Manor	Completion Date
Page 2 of 4	Licensee: Lynden ALC LLC	07/25/2023


 Administrator (or Representative)

 8/15/23
 Date

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 2 sampled staff (Staff C) was screened for tuberculosis (TB) within three days of employment. This failure placed all residents at risk of exposure to a communicable disease.

Findings included...

Review of the ALF's staff files showed Staff C, Housekeeper, was hired on 06/21/2023. There was no documentation of TB testing in Staff C's employee files.

In an interview on 07/13/2023 at 9:14 AM, Staff A, Executive Director, stated that the nurse who usually administers TB testing had not been in facility due to injury and is physically unable to come to the ALF.

In an interview on 04/13/2023 at 10:37 AM, Staff B, Business Office Manager, stated that Staff C was recently hired at the end of last month. Staff B stated that the ALF's nurse has been unable to come to the ALF, so Staff C's TB tests are still waiting to be administered.

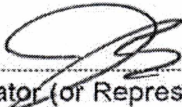
This is an uncorrected deficiency previously cited on 04/10/2023.

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, Lynden Manor is or will be in compliance with this law and / or regulation on (Date) 9/16/23.

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

Statement of Deficiencies	License #: 2641	Compliance Determination # 26813
Plan of Correction	Lynden Manor	Completion Date
Page 3 of 4	Licensee: Lynden ALC LLC	07/25/2023


 Administrator (or Representative)

 8/8/23
 Date

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:

(d) Cardiopulmonary resuscitation and first aid; and

WAC 388-112A-0720 What are the CPR and first-aid training requirements?

(2) Assisted living facilities.

(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to have confirmation of a completed CPR certification within 30 days of hire for 1 of 3 sampled staff (Staff D). This failure placed residents at risk for harm due to ALF staff not being certified to provide CPR.

Findings included...

Review of the ALF's staff files showed Staff D, Caregiver, was hired on 06/07/2023. There was no documentation of CPR certification in Staff D's employee files.

In an interview on 07/13/2023 at 10:32 AM, Staff A, Executive Director, stated that Staff D does not have a CPR card currently, but is scheduled for the next available class.

In an interview on 07/13/2023 at 3:02 PM, Staff B, Business Office Manager, stated that Staff D has not had CPR training yet and that it has been over the 30 days.

This is an uncorrected deficiency previously cited on 04/10/2023.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2641	Compliance Determination # 26813
Plan of Correction	Lynden Manor	Completion Date
Page 4 of 4	Licensee: Lynden ALC LLC	07/25/2023

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, Lynden Manor is or will be in compliance with this law and / or regulation on (Date) 9/16/23.

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



Administrator (or Representative)

8/8/23

Date

This document was prepared by Residential Care Services for the Locator website.



Residential Care Services Investigation Summary Report

Provider/Facility: Lynden Manor

Provider Type: Assisted Living Facility

License/Cert.#: 2641

Compliance Determination #: 22312

Intake ID: 77863

Investigator: Cristina Gonzalez

Region/Unit #: RCS Region 2 / Unit A

Investigation Date(s): 04/10/2023 through 04/20/2023

Complainant Contact Date(s): 04/20/2023

Allegation(s):

- 1) The Named Resident had a room change from a single resident room to a shared resident room.
- 2) The Named Resident did not receive anxiety medication for over a week, and there were inconsistencies having medications refilled timely.
- 3) The Named Resident was constantly out of toilet paper and bathroom was not clean.
- 4) The Named Resident was missing multiple clothing items, wearing clothes that do not belong to the Named Resident.
- 5) The Named Resident was not wearing socks and had skin loss from going without socks.
- 6) The Named Resident had an altercation with another Resident.
- 7) The Assisted Living Facility had frozen water pipes in December 2022 and has repairs needed to be made.
- 8) The Named Resident was not getting showers, baths, hair/teeth/hygiene care consistently. The Named Resident has foot fungus and has not had toenails trimmed in a long time.
- 9) Residents are left alone, unsupervised in the memory care while staff are smoking outside.

Investigation Methods:

Sample: Total residents: 97
Resident sample size: 9
Closed records sample size: 1

Observations: Identified resident
Residents
Activities
Dining
Resident rooms
Staff to resident interactions
Medications/Medication Cart

Interviews: Identified resident
Nursing staff
Residents
Family members
Maintenance staff
Executive Director, Director of Nursing, Resident Care

Coordinator, Nurse Delegator
Outside Agency

Record Reviews: Medical records
Facility policies
Staff training records
Facility policies
Nursing staff schedules
shower schedules

Investigation Summary:

- 1) The Named Resident had a room change from a single room to a shared room when flooding in the room occurred. A citation was written for noncompliance with WAC 388-78A-2665 Resident Rights-Notice-Policy on accepting Medicaid as a payment source.
- 2) The Named Resident had medication inconsistencies with medication orders. A citation was written for noncompliance with WAC 388-78A-2210 Medication Services.
- 3) The Named Resident's bathroom was clean and had toilet paper. No failed practice.
- 4 & 5) The Named Resident was wearing personal clothing, had socks and shoes on. The Named Resident's feet were observed to be dry and intact. The Named Resident had a Podiatry appointment scheduled. No failed practice.
- 6) The Named Resident had an altercation with another Resident, was previously investigated. No failed practice.
- 7) The Assisted Living Facility had frozen water pipes that burst during a severe weather ice storm. Previously investigated.
- 8) The Named Resident was dressed appropriately, hygiene care and supplies were available. The Named Resident had shower documentation completed. No failed practice.
- 9) Residents were supervised and staff were present to provide Resident care services. Staffing schedules reviewed and met the minimum staffing guidelines. No failed practice.

Conclusion / Action:

- ☒ 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

05/02/2023

CERTIFIED MAIL

9489 0090 0027 6382 8333 93

Licensee: Lynden ALC LLC
Lynden Manor
905 Aaron Dr
Lynden, WA 98264

RE: Lynden Manor License # 2641

Dear Administrator:

The Department completed a full inspection and a complaint investigation of your Assisted Living Facility on 04/20/2023 and found that your facility does not meet the Assisted Living Facility licensing requirements.

The Department:

- Wrote the enclosed Statement of Deficiencies (SOD) report; and
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- May inspect the facility to determine if you have corrected all deficiencies.

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 Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
 - o Mail the Plan/Attestation Statement and report with original signatures to:

Lynden ALC LLC
Lynden Manor #2641
04/20/2023
Page 2 of 22

Kimberley Ripley, Field Manager
Residential Care Services
Region 2, Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

- 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.

You May:

- Receive a letter of enforcement action based on any deficiency listed on the enclosed report.

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 (360)651-6846.

Sincerely,



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

Enclosure



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

RECEIVED

MAY 15 REC'D

AL TSA/RCS ARLINGTON

Statement of Deficiencies	License # 2641	Compliance Determination #22312
Plan of Correction	Lynden Manor	Completion Date
Page 3 of 22	Licensee: Lynden ALC LLC	04/20/2023

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 and complaint investigation on 04/10/2023 and 04/13/2023 of:

Lynden Manor
905 Aaron Dr
Lynden, WA 98264

This document references the following complaint numbers: 75354, 75340, 77863, 76807.

The following sample was selected for review during the unannounced on-site visit: 9 of 97 current residents and 1 former residents.

The department staff that inspected the Assisted Living Facility:

Judith Mellon, RN, Licenser
Cristina Gonzalez, ALF Licenser
Christine Banta, Community Complaint investigator
Jodi Condyles, ALF Licenser
Judith Mellon, RN, Licenser
Yulia Bondarchuk, LTC 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

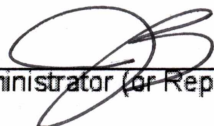
As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

This document was prepared by Residential Care Services for the Locator website.


Residential Care Services

5/2/23
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)


5/10/23
Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(c) Keep facilities, equipment and furnishings clean and in good repair; and

This requirement was not met as evidenced by:

Based on observations, interviews, and record review the Assisted Living Facility (ALF) failed to provide a safe, sanitary, well-maintained environment for residents living at the ALF. This failure resulted in residents living in an unsafe and unsanitary environment and placed all residents at risk for injury and a decreased quality of life.

Findings included...

During the initial tour of the ALF on 04/10/2022, the following was observed;

Observation on 04/10/2023 at 10:45 AM, in the first-floor dirty laundry room, behind the washer machine was a hole about the of a softball due to missing plaster board.

Observation on 04/10/2023 at 10:47 AM, in the first-floor dirty laundry room, there was stain patterns coming from above the exit door. The brown stained plaster board began at the top of the door frame, running down the right side of the door and was about 6 inches wide. The door frame was rusted along the right side from top to bottom.

Observation on 04/10/2023 at 11:10 AM, on the second-floor, dust covered multiple surfaces including furnishings, handrailing and the floor. The base boards were removed with bare plaster board exposed and nail heads showing.

Observation on 04/10/2023 at 11:21 AM, multiple doors to resident rooms, including Room 216, 220, 223, and 340, had scuff marks leaving streaks of black staining across the bottom of the doors.

Observation on 04/10/2023 at 11:26 AM, the spouts on the water fountains outside the elevators on the second floor were covered with a green-white chalky substance. There was several chewed food pieces on the basins of the water fountains.

Observation on 04/10/2023 at 11:30 AM, on the third floor gathering room, there was a cord from the wall socket to a lamp sitting on the table. The cord went across a walkway that ran from the entrance door to a chair. The cord was not covered.

Observation on 04/10/2023 at 11:35 AM, on the third-floor solid utility room, there was a pill located on the floor behind the door. There was oxygen tubing and masks under the sink with sponges and other cleaning supplies.

In an interview on 04/10/2023 at 11:36 PM, Staff G, Director of Nursing, said they have no idea why that stuff is in there, that's not where it should be. It's frustrating because the room where those supplies should be is right next door.

Observation on 04/10/2023 at 12:05 PM, on the third floor at the end of the hallway, there were nine ceiling tiles that had been removed due to a leak from the roof. There was no covering over the hole in the ceiling to prevent debris from falling through the hole.

Outside the facility:

Observation on 04/10/2023 at 12:05 PM, at the entrance of the facility, there were multiple cigarette butts on the ground.

Observation on 04/10/2022 at 12:24 PM, the garbage collection area on the southside of the building had two large dumpsters over following with recycle. Cardboard was around the base of the dumpster and the lid did not close. There were used gloves and other garbage and debris in the surrounding area. There were two dirty broken wheelchairs, two portable toilet lifts and several chairs near the dumpsters. There were eight opened/used oxygen tanks and six sealed tanks next to the recycle dumpster.

In an interview on 04/10/2023 at 12:24 PM, Staff G said that somebody is being lazy and not breaking it down, referring to the cardboard overfilling the dumpster.

Observation on 04/10/2023 at 12:31 PM, used surgical masks were located around the outside of the facility in several areas.

Observation on 04/10/2023 at 12:35 PM, a piece of the facilities gutter was located in the bushes at the entrance of the facility.

Review of the Assisted Living Facility (ALF) undated Disclosure of Services, a document given to residents and their representatives on admission, stated, "The facility must maintain your living quarters and other areas you may use in a safe, clean, and comfortable condition."

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, Lynden Manor is or will be in compliance with this law and / or regulation on (Date) 6/16/23.

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


Administrator (or Representative)

 5/10/23
Date

WAC 388-78A-2100 On-going assessments. The assisted living facility must:

(2) Complete an assessment specifically focused on a resident's identified problems and related issues:

(a) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(b) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to ensure 1 of 1 sampled resident's (Resident 7) assessments and negotiated service agreements (NSAs) were updated after an increased need for staff assistance in a manner consistent with their current change of condition. This failure placed Resident 7 at risk for unmet care needs.

Findings included...

Resident 7 was admitted to the ALF on [REDACTED]/2016 with multiple diagnoses including [REDACTED] and [REDACTED]

Review of Resident 7's assessment dated 04/07/2023 showed Resident 7 was independent

with toileting regardless of continence and able to maintain all continence care and clothing adjustment without assistance. The assessment showed Resident 7 required minimal staff assistance with ambulation when using their walker or wheelchair and had a history of 1-2 falls in the past three months.

Review of Resident 7's NSA dated 04/07/2023, showed Resident 7 was independent with toileting, continence care, and required minimal staff assistance with ambulation.

During an interview on 04/12/2023 at 11:59 AM, Staff O, Caregiver, stated that after Resident 7 had an unwitnessed fall in March 2023, Resident 7 required more assistance with their activities of daily living (ADLs) including toileting. Staff O stated that they assist Resident 7 with toileting including changing incontinence products. Staff O stated that Resident 7 does not help very much with their ADLs and that staff do most of the work. Staff O stated that Resident 7 had a new physical decline that make their ADLs hard to perform and this decline had resulted in Resident 7 falling several times.

Review of Resident 7's progress notes dated 03/17/2023 through 04/10/2023 showed Resident 7 had fallen five times. A progress note (PN) dated 03/19/2023 showed that Resident 7 had difficulty ambulating and required extensive help getting ready for bed. A PN dated 03/21/2023 showed Resident 7 continued to have difficulty walking. On 04/06/2023, a PN showed Resident 7 required staff to help with toileting.

During an interview on 04/13/2023 at 09:46 AM, Staff M, Med Tech, stated that after Resident 7's falls in the month prior, Resident 7 had a decline in their condition. Staff M stated that staff assist Resident 7 to the bathroom and perform incontinence care for Resident 7. Staff M stated that Resident 7 is having difficulty walking without assistance despite staff help and use of assistive devices.

In an interview on 04/11/2023 at 02:25 PM, Resident 7 stated that staff help with toileting, changing incontinence products, and ambulation. Resident 7 stated that they have realized their health has declined with recent falls, loss of strength, and memory issues.

In an interview on 04/12/2023 at 11:59 AM, Staff O, stated that the ALF uses an online program called "Point of Care". Staff O stated that this program shows the care each resident needs and allows staff to document the ADLs that were performed. Staff O stated that in this program, the only services staff are required to help Resident 7 with was reminding Resident 7 of mealtimes and a weekly room clean. Staff O stated that this was not accurate to Resident 7's current level of care needs.

During an interview on 04/13/2023 at 10:49 AM, Staff I, Resident Care Coordinator, stated that Resident 7 was previously independent, but currently needs more help with ADLs than what was written in the assessment. Staff I stated that the assessment done on 04/07/2023 wasn't updated with these changes as family did not agree with Resident 7 having an increased level of staff assistance.

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, Lynden Manor is or will be in compliance with this law and / or regulation on (Date) 5/16/23.

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

X 
Administrator (or Representative)

X 5/16/23
Date

WAC 388-78A-2381 General design requirements for memory care.

(2) The facility must provide common areas, including at least one resident accessible common area outdoors. Such common areas should accommodate and offer the opportunity of social interaction, stimulate activity, contain areas with activity supplies and props to encourage engagement, and have safe outdoor paths to encourage exercise and movement.

(a) These areas must have a residential atmosphere and must accommodate and offer opportunities for individual or group activity including:

(iv) Ensuring residents have access to their own rooms at all times without staff assistance.

This requirement was not met as evidenced by:

Based on interview and observation, the Assisted Living Facility (ALF) did not ensure that residents in their memory care unit (MCU) had access to their own room without staff assistance. This failure placed all 24 residents living in the MCU at risk for a decreased quality of life.

Findings included...

In an interview on 04/13/2023 at 10:27 AM, Staff C, Med Tech, stated that on the Assisted Living part of the building, residents have their own keys to their rooms, but in MCU, staff lock the resident rooms and residents are required to ask staff for keys if they want to go back into their rooms. Staff C stated that when staff get residents get up, their room doors are locked, and the residents are placed in a common area.

In an observation on 04/13/2023 at 10:42 AM, a MCU resident was seen lying down on a couch with their eyes closed in the MCU common area. A second resident stood by the couch and asked to sit down. A staff member approached the couch and asked the first resident to sit up. The first resident stated that, "I'm very tired and my room isn't open. Can I go lay down in my bed?" The staff member was observed using a key to unlock and open the first resident's room door.

In an interview on 04/13/2023 at 10:46 AM, a third MCU resident stated that usually their room is locked and that they weren't sure how to open it. This resident denied having their own key or any way to access to their room during the day without staff permission.

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, Lynden Manor is or will be in compliance with this law and / or regulation on (Date) X 6/16/23.

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

X
Administrator (or Representative)X5/10/23

Date

WAC 388-78A-2665 Resident rights Notice Policy on accepting medicaid as a payment source. The assisted living facility must fully disclose the facility's policy on accepting medicaid payments. The policy must:

(6) Be signed and dated by the resident and be kept in the resident record after signature.

This requirement was not met as evidenced by:

Based on interviews and record reviews the Assisted Living Facility (ALF) failed to ensure 1 of 1 sampled Resident (Resident 5) had a signed copy of the ALF's policy regarding Medicaid as a payment source. This failure placed Resident 5 at risk of being discharged and unable to reside in the ALF.

Findings included...

Record review of the ALF's "Disclosure of Services" undated, showed that the ALF accepted Medicaid as a payment source.

Review of the Department's Secure Tracking and Reporting System Database, on 04/19/2023 at 4:16 PM, showed the ALF's contracts included Assisted Living Services (ALS), Adult Residential Care Services (ARC), and Enhanced Adult Residential Care Services (EARC).

RESIDENT 5

Resident 5 was admitted to the ALF on [REDACTED] 2018 with multiple medical diagnoses including [REDACTED]

During an interview on 04/13/2023 at 8:44 AM, Collateral Contact 1 (CC1) stated that the new company did not have me sign any Medicaid paperwork.

During an interview on 04/13/2023 at 12:00 PM, Staff A, Executive Director, stated that the ALF is required to notify every resident about the ALF's policy of accepting Medicaid as a payment source. Staff A stated that when the ALF changed ownership, in 07/2022, Resident 5's paperwork for Medicaid as a payment source was not provided to Resident 5's Representative and that Resident 5's paperwork was not completed.

No documentation was available to show the Responsible Party signed the disclosure to confirm their receipt of the Medicaid Policy.

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, Lynden Manor is or will be in compliance with this law and / or regulation on (Date) 6/16/23

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

X 
Administrator (or Representative)

X 5/10/23
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 prescribed medications in a timely manner for one of one resident (Resident 8). This failure resulted in Resident 8 not having a prescribed medication available and put Resident 8 at risk for medical complications.

Findings included...

Resident 8 was admitted to the ALF on [REDACTED] /2023 with multiple medical diagnoses including [REDACTED]

Record review of Resident 8's negotiated service agreement (NSA) dated 02/02/2023 showed that Resident 8 received staff administration for all medications, treatments as

prescribed by the physician, and blood thinner monitoring related to a recent stroke.

Review of Resident 8's Electronic Medical Administration Record (EMAR) for the month of February 2023, showed Resident 8's medications were marked as NA (not available) as follows:

Aspirin 81mg (milligrams - unit of measurement) tablets to be given once a day to reduce risk of stroke and was not available on 02/02/2023, 02/03/2023 and 02/05/23 through 02/07/2023 given.

Docusate Sodium 100mg to be given twice a day for constipation and was not available at 7:00 AM on 02/02/2023 through 02/07/2023 and at 5:00 PM on 02/02/2023, 02/03/2023, and 02/06/2023.

Senna Laxative 8.6 mg tablets to be given twice a day for constipation and were not available at 7:00 AM on 02/02/2023, 02/04/2023 through 02/07/2023 and at 5:00 PM on 02/02/2023, 02/03/2023 and 02/06/2023.

Levofloxacin 500mg (antibiotic) not available for final dose on 02/05/2023

Vitamin C 250mg tablets not available on 02/02/2023, 02/03/2023, 02/06/2023, and 02/07/2023

Lisinopril 5mg given for hypertension was not available for the 5:00 PM dose on 02/02/2023 and at 7:00 AM on 02/03/2023.

In an interview on 04/11/2023 at 2:16 PM, Staff M, Med Tech stated that NA on an EMAR means medication is not available and progress notes would have a description of the NA status. Staff M stated that medications aren't always ready when a resident moves in since the new company manages facility. Staff N, Marketing, obtains admission paperwork and talks to the family, then Staff H, Registered Nurse Delegator, takes over and Staff I, Resident Care Coordinator, and Staff G, Director of Nursing (DNS), would obtain medication from the pharmacy.

In an interview on 04/11/2023 at 2:46 PM, Staff G stated that upon admission to the ALF, residents bring their own medications and the resident's medications from the pharmacy are not always available. Staff G stated that reconciling medications is between the pharmacy and medical providers and stated, "I do not verify medications." Staff G stated that Med Techs would let Staff I know if medications are not available, and an emergency supply could be requested from the pharmacy.

In an interview on 04/13/2023 at 10:10 AM, Staff I, stated, "I work on the medication cart when needed and confirm medication orders when Staff G is not working." Staff I stated that for a newly admitted resident, Staff N would obtain physician orders and fax them to the pharmacy to have the medication delivered by the end of move-in day or ahead of time. Staff I stated that Med Techs would alert Staff I if the medications are not available on the med cart and medications could be ordered STAT (urgent order).

Plan/Attestation Statement

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

X 
Administrator (or Representative)

A 5/10/23
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 observation, interviews, and record reviews the Assisted Living Facility (ALF) failed to develop and implement systems that support and promote safe medication service for 3 of 3 residents (Resident 5, 6 and 10) when medications were not administered as prescribed. This failure placed Resident 5, 6 and 10 at risk for medication mismanagement, medication error and medical complications.

Findings included...

Resident 5

Resident 5 was admitted to the ALF on [REDACTED]/2018 with multiple medical diagnoses including [REDACTED] and [REDACTED]. Record review of Resident 5's unsigned and undated Negotiated Service Agreement (NSA) showed Resident 5 received staff administration for all medications and treatments as prescribed by the physician.

Review of Electronic Medical Administration Record (EMAR) for the month of January 2023 showed Resident 5 was prescribed Alprazolam (for Alzheimer's and Anxiety disorder) 1 MG (milligram) tablets three times a day. In January Resident 5 received more doses than was prescribed. On 01/01/2023 resident 5 received six doses, on 01/02/2023 received six doses, on 01/03/2023 received five doses and on 01/16/2023 received four doses.

Documentation on the March 2023 EMAR showed Resident 5's Alprazolam tablet doses were missed. On 03/21/2023 and 03/22/2023 five out of the six scheduled daily doses

were not provided.

In an interview on 04/13/2023 at 10:10 AM, Staff I, Resident Care Coordinator, stated that both she and Staff G, Director of Nursing (DNS), review and reconcile physician orders against medications physically in the medication carts and resident EMAR's. Staff I stated that they were aware of Resident 5 being out of medication in March as Xanax required new orders from the physician and that took a few days. Staff I stated that she was not sure about the January physician orders as they are not in the resident chart and "it looks like resident received a double dose".

In an interview on 04/13/2022 at 11:00 AM, Staff G stated that Xanax orders need to be renewed every 90 days and "it's an issue." Staff G stated that the previous DNS did all these orders that ran simultaneously, and it looks like they didn't remove old orders and started giving a new one.

Resident 6

Resident 6 was admitted to the ALF on [REDACTED]/2022 with multiple medical diagnoses including [REDACTED] and [REDACTED]

[REDACTED] Record review of Resident 6's negotiated service agreement (NSA) dated 12/02/2022 showed Resident 6 received staff administration of all medications, treatments as prescribed by the physician, and takes routine controlled substances (narcotics).

Review of Resident 6's EMAR for the month of April 2023, showed Resident 6 was to receive Potassium Chloride 20 MEQ's (milliequivalent, a unit of measurement) one time a day for a supplement and Polyethylene Glycol 3350 (Miralax) to receive twice a day for constipation.

In an interview on 04/12/2023 at 10:59 AM, Resident 6 stated that they cannot turn their head to the side due to pain in neck and back and cannot see what is on the side table next to the recliner. Resident 6 stated that the Potassium and Miralax were left on the side table for Resident 6 to sip on throughout the day.

Observation on 04/12/2023 at 10:59 AM showed there were three cups on a side table next to Resident 6's recliner; one cup was white; one blue and one was clear and halfway full of bright orange liquid. In addition to the cups Resident 6's side table had one open bottle of TheraTears (eye drops) and one new bottle in an unopened box, including an empty pill cup with Resident 6's room number.

In an interview on 04/12/2023 at 11:28 AM, Staff L, Med Tech, stated this morning there were three old cups of Potassium and Miralax left on the side table next to Resident 6's recliner. Staff L stated that they observed Resident 6 take morning medications and finish drinking the Potassium and Miralax they brought and left one 'old' cup of Potassium and

Miralax mix on resident 6's side table.

Record review of Resident 6's EMAR for the month of January 2023 showed that Resident 6 was prescribed Morphine Sulfate IR (immediate release) (narcotic) "three" times a day for Chronic Pain Syndrome. The EMAR then showed a second physician order for Morphine Sulfate ER (extended release) prescribed "four" times a day. Resident 6's Morphine Sulfate IR was not provided between 01/26/2023 and 01/30/2023 resulting in nine missed doses. The Morphine Sulfate "ER" showed two missed doses on 01/23/2023.

During an interview on 04/12/2023 at 10:50 AM, Staff L, Med Tech, stated that they felt bad for Resident 6; they were suffering. Staff L felt that Resident 6 had a lot of pain. Staff L stated that she was not aware of any narcotics for Resident 6 not being available.

During an interview on 04/13/2023 at 10:05 AM, Staff G, Director of Nursing stated they don't reconcile medication orders, that is between the physician and the pharmacy. Staff G stated that the Morphine orders were confusing and that it was a little haphazard. Staff G stated that he was unsure why the Morphine doses were unavailable intermittently and that he would review the EMAR. No other physician orders were available for review on Resident 6's medical record. Staff G stated that he was unsure what had happened to the missed doses, why the missed doses were not available, and why the two Morphine orders were both on the EMAR. No physician orders were available for review.

Resident 10

Resident 10 was admitted to the ALF on [REDACTED] /2021 with multiple medical diagnoses including [REDACTED] and [REDACTED]. Review of Resident 10's most recent NSA dated 11/02/2022 showed staff were to order and maintain all medications and treatments and assist Resident 10 with medications/treatments as per physician orders.

Review of Resident 10's EMARS from January 2023 through April 2023 showed Resident 10 was to receive three types of eye drops in the left eye for glaucoma; Dorzolamide HCl Solution 2% three times a day; Combigan Solution 0.2%-0.5% twice a day and Latanoprost 0.005% one time a day.

Review of Resident 10's April 2023 EMAR showed that there was no physician order for Dorzolamide HCl Solution 2% on the EMAR and no Dorzolamide eye drops were provided to Resident 10 in April 2023. No physician orders were available for review to show that the eye drops were discontinued by the physician.

During an interview on 04/13/2023 at 2:00 PM, Staff C, Med Tech stated, "I am pretty sure Resident 10 had three eye drops, she has glaucoma but I'm not seeing the third eye drop on the EMAR." Staff C stated that she was unsure why Resident 10's April 2023 EMAR did not show a third eye drop and stated, "I know it was there on the March (2023) EMAR"

because I gave it." No physician orders were available for review to show Resident 10's eye drops were to be discontinued.

Review of Resident 10's March 2023 EMAR showed two different orders, both for Combigan Solution. One of the orders was written "Instill one drop in both eyes two times a day," and the other order was written "Install one drop in the left eye two times a day for glaucoma." One entry on the March 2023 EMAR dated 03/31/2023 showed Resident 10 received Combigan eye drops, one drop in "both" eyes at 8:00 PM. Resident 10 was diagnosed with [REDACTED]

During an interview on 04/19/2023 at 1:30 PM, Collateral Contact 1 (CC1) stated that they watched a Med Tech put the eye drops in Resident 10's right eye and Resident 10's glaucoma is only in her left eye. CC1 stated that the Med Tech said the eye drop was for both eyes. CC1 stated that they talked to Staff G about the eye drops, and Staff G stated that something didn't seem right, they were "giving it wrong." CC1 stated that they called the Doctor, and the Doctor said Resident 10 should still be getting the eye drops for her glaucoma."

Review of Resident 10's EMARs showed Resident 10 was to receive Melatonin 10 mg (unit of measurement) at bedtime for sleep disturbance. Resident 10's April 2023 EMAR showed Resident 10's Melatonin was discontinued on 04/06/2023.

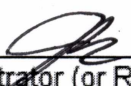
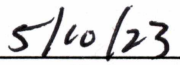
During an interview on 04/19/2023 at 1:30 PM, Collateral Contact 1 (CC1) stated that Resident 10 was not sleeping well and was anxious. That was why she was placed on Melatonin, to help her sleep at night. CC1 stated they talked to Staff G about the melatonin, because Resident 10 was getting it and all of a sudden she wasn't getting it anymore. CC1 stated that CC1 talked to Staff G about not receiving the Melatonin, and said there was something wrong on the EMAR.

In an interview on 04/13/2023 at 2:00 PM, Staff C stated that she was unsure why Resident 10 was not on Melatonin. There were no physician orders that came through or that she's seen to discontinue Resident 10's Melatonin. No physician orders were available for review to show Melatonin was to be discontinued for Resident 10.

Plan/Attestation Statement

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

 Administrator (or Representative)	 Date
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WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) did not ensure 4 of 6 sampled ALF staff (Staff A, C, D, & F) were screened for tuberculosis (TB) within three days of employment. This failure placed all residents at risk of exposure to a communicable disease.

Findings included...

Upon review of the ALF employee files, the following was shown:

Staff A, Executive Director, hired on 02/13/2023, showed no TB tests were completed.

Staff C, Med Tech, hired on 07/12/2022, showed an initial TB skin test completed on 01/31/2023, not within three days of hire.

Staff D, Med Tech, hired on 01/25/2023, showed an initial TB skin test completed on 01/31/2023, not within the required three days of hire.

Staff F, Med Tech, hired on 10/28/2022, showed an initial TB skin test completed on 03/20/2023, not within three days of hire. The second TB skin test was not completed.

In an interview on 04/11/2023 at 10:05 AM, Staff J, Business Office Manager, stated that Staff A did not have that done when [Staff A] was hired.

In an interview on 04/11/2023 at 10:42 AM, Staff J, stated, "Yeah, it doesn't look like we got [Staff F's] TB tests finished".

Plan/Attestation Statement

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X 
Administrator (or Representative)

X 5/16/23
Date

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(h) Provide staff orientation and appropriate training for expected duties, including:

(i) Organization of the assisted living facility;

(ii) Physical assisted living facility layout;

(iii) Specific duties and responsibilities;

(iv) How to report resident abuse and neglect consistent with chapter 74.34 RCW and assisted living facility policies and procedures;

(v) Policies, procedures, and equipment necessary to perform duties;

(vi) Needs and service preferences identified in the negotiated service agreements of residents with whom the staff persons will be working; and

(vii) Resident rights, including without limitation, those specified in 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 ensure that 6 of 6 sampled staff (Staff A, B, C, D, E, and F) had the required Facility Orientation documentation. This failure placed all staff and resident at risk of being unprepared and unfamiliar with the facility's daily operations

Findings included...

Review of the staff files with Staff J, Business Office Manager, showed Staff A (Executive Director), Staff B (Caregiver), Staff C (Medication Technician), Staff D (Medication Technician), Staff E (Caregiver) and Staff F (Medication Technician) were missing valid documentation that the Facility Orientation was completed.

In interview on 04/11/2023 at 10:05 AM, Staff J stated they did not have any of the Facility Orientation documents signed for all six sampled staff (Staff A, B, C, D, E, and F).

Plan/Attestation Statement

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X 
Administrator (or Representative)

X 5/10/23
Date

WAC 388-78A-2468 Background checks Employment Conditional hire Pending results of Washington state name and date of birth background check. The assisted living facility may conditionally hire an administrator, caregiver, or staff person directly or by contract, pending the result of the Washington state name and date of birth background check, provided that the assisted living facility:

- (1) Submits the background authorization form for the person to the department no later than one business day after he or she starts working;
- (4) Does not allow the person to have unsupervised access to any resident;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to complete a background check for 1 of 6 sampled staff (Staff B) before allowing unsupervised access to the facility residents. This placed all residents at risk for being cared by a staff person with a potential disqualifying event.

Findings included...

Review of the ALF's staff record showed Staff B (Caregiver) was hired on 07/12/2022. There was no evidence of a background check completed in Staff B's employee file.

In an interview on 04/11/2023 at 10:06AM, Staff J, Business Office Manager, stated that they were unable to find a completed background check for Staff B.

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, Lynden Manor is or will be in compliance with this law and / or regulation on (Date) X 6/16/23.

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

X 

Administrator (or Representative)

X 5/10/23

Date

WAC 388-78A-24642 Background checks National fingerprint background check.

(1) Administrators and all caregivers who are hired after January 7, 2012 and are not disqualified by the Washington state name and date of birth background check, must complete a national fingerprint background check and follow department procedures.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to complete the required national fingerprint background check for 5 of 6 sampled staff (Staff A, C, D, E, and F). This failure placed the safety of all residents by allowing staff with possible disqualifications access to them.

Findings included...

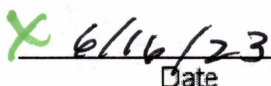
Review of staff files with Staff J, Business Office Manager, showed the files for Staff A (Executive Director), Staff C (Medication Technician), Staff D (Medication Technician), Staff E (Caregiver), and Staff F (Medication Technician) had no evidence of a national fingerprint background check done.

In interview on 04/11/2023 at 10:05 AM, Staff J stated they did not have any fingerprint background checks in the employee files for Staff A, B, C, D, E and F.

Plan/Attestation Statement

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Administrator (or Representative)	Date

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:

(d) Cardiopulmonary resuscitation and first aid; and

WAC 388-112A-0720 What are the CPR and first-aid training requirements?

(2) Assisted living facilities.

(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to have confirmation of a completed CPR certification for 2 of 6 sampled staff (Staff C, and Staff E). This failure placed the resident at risk for harm due to ALF staff not certified to provide CPR.

Findings included...

Review of the ALF's staff record showed Staff C, Med Tech, was hired on 07/22/2022. There was no documentation of a CPR certification in Staff C's employee file.

Review of the ALF's staff record showed Staff E, Caregiver, was hired on 06/17/2022. There was no documentation of a CPR certification in Staff E's employee file.

In an interview on 04/11/2023 at 10:06AM, Staff J, Business Officer Manager, stated that there was no CPR certification in Staff C or Staff E's employee files.

Plan/Attestation Statement

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

X [Signature]
Administrator (or Representative)

X 5/10/23
Date

WAC 388-78A-2320 Intermittent nursing services systems.

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(e) Chapter 246-888 WAC, Medication assistance.

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to have confirmation of completed Nurse Delegation Core and Diabetes training for 1 of 3 sampled staff (Staff F). This failure placed 24 residents in the secured memory care unit at risk of untrained staff administering medications.

Reference:

WAC 246-840-930 The Nurse Delegation Program, under Washington State law, allows nursing assistants working in certain settings to perform certain tasks - such as administration of prescription medications including insulin injections - normally performed only by licensed nurses. A Registered Nurse (RN) must instruct the nursing assistant regarding proper injection procedures and the use of insulin, demonstrate proper injection procedures, and must supervise and evaluate performance including return demonstration during the first four weeks of delegation of insulin injections and at least every ninety days thereafter. (8) Verify that the nursing assistant or home care aide: (a) Is currently registered or certified as a nursing assistant or home care aide in Washington state without restriction; (b) has completed both the basic caregiver training and core delegation training before performing any delegated task.

Findings included...

Review of an employee file showed Staff F, Med Tech, was hired 10/28/2022. No documentation of nurse delegation core or diabetes training or the required nursing assistant or home care aide credentials were in Staff F's employee file or nurse delegation binders.

In an interview on 04/11/2023 at 10:55 AM, Staff H, Registered Nurse Delegator, stated that Staff F did not have the delegation training for core and diabetes as required. Staff H stated that Staff F worked on the medication cart as a Med Tech in the memory care and administered medications.

During an interview on 04/12/2023 at 12:55 PM, Staff H stated that the only residents that are delegated in the ALF are the 24 memory care residents.

Plan/Attestation Statement

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

X
Administrator (or Representative)X5/10/23

Date