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

10/12/2023

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

RE: Lynden Manor License # 2641

Dear Administrator:

This letter addresses Compliance Determination(s) 30767 (Completion Date 10/09/2023) and 23931 (Completion Date 06/22/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/09/2023 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-2660-1, WAC 388-78A-2660-4, RCW 70.129.140.2, RCW 70.129.140.2.d

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

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

Sincerely,

Kim Ripley

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Lynden Manor
Provider Type: Assisted Living Facility
License/Cert.#: 2641
Compliance Determination #: 23931
Intake ID: 83020
Investigator: Helen Fisher
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 05/15/2023 through 06/22/2023
Complainant Contact Date(s):

Allegation(s):

1) The Named Resident (NR) had bruising on his left hip that extended up to his ribs and around both his abdomen and to his spine on his back. Another large bruise and skin tear were on his upper left arm.
2) There was an unwitnessed incident happened on 05/5/23 when NR refused stockings be removed but the Named Subject (NS) (caregiver) ignored NR's request. NR had a scuffle with a NS and fell off the bed.
3) NR becomes agitated when the NS cared for him.

Investigation Methods:

Sample:	Total residents: 98 Resident sample size: 4 Closed records sample size:
Observations:	NR appearance, skin condition and demeanor Equipment used Environment NS demeanor
Interviews:	NR, NS, Collateral Contact, Other not Associated with facility, Executive Director, Director of Nursing, Med Tech, Resident Care Coordinator (RCC), Med Techs (MT1 & MT2), Caregivers (Staff 1, Staff 2 & Staff 3)
Record Reviews:	Incident and Investigation report NR records NS Credentials Facility records

Investigation Summary:

The Director of Nursing did an investigation when they became aware of:
1) The NR's bruising on his left hip that extended up to his ribs and around both his abdomen, to his spine on his back and large bruise and skin tear were on his upper left arm. During an interview Collateral Contact 1 (CC1) denied being notified after NR fall. During an interview the NR denied falling and stated that they tussled with the NS which caused the injuries. During an interview the Staff D (Med Tech) stated that the NR had two unwitnessed falls on 05/01/2023. The NR sustained a skin tear on left

upper arm. The second fall took place on 05/04/2023 at 4:00 AM. The NR sustained a left upper arm injury. Staff D stated that the NR had been falling in the apartment and was able to get back up in the past. Review of the incident report dated 05/04/2023 at 4:00 AM, showed NR was found in bed with a large skin tear on left upper arm. Review of progress notes dated 05/05/2023 at 11:04 AM, showed NR's left upper arm skin tear reopened, left side of body, and left hip large bruising noted. Review of care showed NR was a high fall risk and had been checking NR 4 times per shift. No failed practice.
2) During an interview, the NR stated that they told the NS to leave their shoes, stockings, and bed clothing on, but NS ignored their request. During an interview the NS stated that they were told by Med Techs to remove and wash compression stocking at night. The NS stated that they did not receive training specifically on residents' rights prior to the incident. During an interview Staff B, Director of Nursing, stated that they were unsure if NS received the training on Resident rights prior to the incident with NR. During an interview Staff E, Caregiver, stated that the NR was very particular of how staff approach and would occasionally refuse to remove compression stocking and clothing at night. Failed Practice was found. A citation was issued for noncompliance with, WAC-388-78A-2660 Residents rights.
3) During an interview Collateral Contact 1 (CC1) stated that the NS was unkind to NR. During an interview CC1 stated that they believe the injuries were the results of an interactions between NR and NS. During an interview the NR stated that the NS was banned from going in their apartment, yet the NS stood at the door of their room and told them that they had the right to be there. During an interview the NS stated that they received conflicting instructions from their supervisors. NS stated that the Resident Care Coordinator (RCC) told them to not go in NR's apartment, the Director of Nursing (DNS) told them they can go in as long as they have another staff with them. During an interview the RCC stated that they completely removed the NS from caring for NR. No failed practice.

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 05/15/2023, 05/31/2023 and 05/31/2023 of:

Lynden Manor
905 Aaron Dr
Lynden, WA 98264

This document references the following complaint number(s): 81555, 81905, 81485, 83943, 83020

The following sample was selected for review during the unannounced on-site visit: 4 of 98 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Helen Fisher, 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

RCW 70.129.140 Quality of life -- Rights.

(2) Within reasonable facility rules designed to protect the rights and quality of life of residents, the resident has the right to:

(d) Wear his or her own clothing and determine his or her own dress, hair style, or other personal effects according to individual preference;

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 protect 1 of 4 resident's (Resident 1) rights to refuse to remove compression stockings at night. This failure prevented Resident 1 from being able to exercise their rights to refuse.

Findings included...

Review of RCW 70.129.1409(2)(d) showed (2) Within reasonable facility rules designed to protect the rights and quality of life of residents, the resident has the right to (d) Wear his or her own clothing and determine his or her own dress, hair style, or other personal effects according to individual preference;

Resident 1 was admitted to the ALF on [redacted]/2021 with multiple diagnoses including [redacted] and [redacted]

Review of an NSA dated 04/23/2023, showed Resident 1 did not have any identified guidance for staff when Resident 1 refused to have compression socks removed.

In an interview on 05/15/2023 at 8:16 AM, Collateral Contact 1 (CC1) stated that they brought in compression stockings for Resident 1. Resident 1 told CC1 that Resident 1 "tussled" with Staff A, Caregiver, and when Staff A tried to remove Resident 1's compression stockings on the night of 05/05/2023 Staff A was unkind to Resident 1.

In an interview on 05/15/2023 at 10:38 AM, Resident 1 stated that they told Staff A to leave their bed clothing and stockings alone, but Staff A insisted ignoring their request, so they "tussled" with the removal of the compression stockings. Staff A pulled the blankets off of Resident 1's feet and Resident 1 pulled the blankets back. Resident 1 stated they did not fall out of bed and the stocking were removed.

In an interview on 05/15/2023 at 11:47 AM, Staff E, Caregiver stated that they were aware that Resident 1 occasionally refused to remove compression stockings and clothing at night, so they would leave without taking clothing off.

In an interview on 05/15/2023 at 12:06PM, Staff B, Director of Nursing, (DNS) stated that Staff A had a "no-nonsense" approach and that may have been the reason why Resident 1 refused to cooperate. Staff B stated that Staff A should have walked away.

In an interview on 05/31/2023 at 3:30PM, Staff A stated that Resident 1 resisted having their stockings removed and told Staff A to get out. Staff A stated they were told by the Med Techs to remove stockings and wash at night.

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)_____ .

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

_____ _____

Administrator (or Representative) Date