STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

11/14/2023

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

RE: Lynden Manor License # 2641

Dear Administrator:

This letter addresses Compliance Determination(s) 32073 (Completion Date 11/02/2023) and 24699 (Completion Date 08/16/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/02/2023 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-2930-1-a, WAC 388-78A-2930-1-a-i, WAC 388-78A-2160

The Department staff who did the on-site verification:
Cristina Gonzalez, ALF 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 #: 24699
Intake ID: 84093
Investigator: Helen Fisher
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 05/31/2023 through 08/16/2023
Complainant Contact Date(s): 06/29/2023, 07/03/2023

Allegation(s):
The Named Resident was found unresponsive.

Investigation Methods:

Sample:	Total residents: 96 Resident sample size: 3 Closed records sample size: 1
Observations:	Resident was out of the facility Resident's apartment Emergency call in the apartment
Interviews:	Collateral contact, Other not associated with the facility, Med Tech, Caregiver, Resident Care Coordinator.
Record Reviews:	NR records Facility records Emergency response

Investigation Summary:
The facility staff stated that they went to the NR's apartment to give the NR's 7:00 AM medications around 10:20 AM and found the NR sideways on the floor in between the bed and the nightstand unresponsive. The facility provided 2 May 2023 medication administration records with contradictory information but the facility could not be cited under plan of correction with WAC-388-78A-2210 Medication Services. The facility staff stated that on 05/28/2023 the NR was not checked since the beginning of their shift at 6:00 AM to see if NR needed help for the bathroom or an escort to breakfast. Review of the care plan showed NR's needed a safety check, escort for meals and maximum assistance with toileting 1-2x per shift. The Executive Director stated that there were no specific time or log for staff monitoring. A citation was issued for noncompliance with WAC 388-78A-2160 Implementation of negotiated services agreement.

Conclusion / Action:

☒ 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: Lynden Manor
Provider Type: Assisted Living Facility
License/Cert.#: 2641
Compliance Determination #: 24699
Intake ID: 84153
Investigator: Helen Fisher
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 05/31/2023 through 08/16/2023
Complainant Contact Date(s): 06/29/2023, 07/03/2023

Allegation(s):
The Name Resident (NR) was found on the floor in the living room of their apartment with bloody big toe abrasions, smeared dried feces on NR's thighs and hands, and on the floor around NR. It appeared that the NR struggled for a long time on the floor.

Investigation Methods:

Sample:	Total residents: 96 Resident sample size: 3 Closed records sample size: 1
Observations:	NR was not observed (NR was deceased). Apartment emergency pull cord.
Interviews:	Collateral contacts, Director of Nursing, Resident Care Coordinator, Executive Director, Med Techs, Caregiver.
Record Reviews:	NR records Facility records Hospital record

Investigation Summary:
The facility staff called 911 when they found the NR on the living room floor with some blood on the NR and on the carpeting. The facility staff noted the emergency pull cord in the bathroom was pulled down. In an interview the staff stated that the call light had a glitch, and it was going on and off on the system. Review of the alert response report dated 05/28/2028 showed no report from the emergency pull cord. A citation was issued for noncompliance with WAC 388-78A-2930 Communication systems.

Conclusion / Action:

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

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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 # 24699
Plan of Correction	Lynden Manor	Completion Date
Page 1 of 5	Licensee: Lynden ALC LLC	08/16/2023

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 complaint investigation on 05/31/2023, 07/17/2023 and 07/17/2023 of:

Lynden Manor
905 Aaron Dr
Lynden, WA 98264

This document references the following complaint number(s): 84093, 84153, 82944, 84184

The following sample was selected for review during the unannounced on-site visit: 3 of 96 current residents and 1 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.

Jose Brito
Administrator (or Representative)

8/31/23
Date

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

(i) Bathrooms and toilet rooms;

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews the Assisted Living Facility (ALF) failed to provide a reliable way to call staff for 3 of 3 residents (Residents 1, 2 and 3) when the emergency call system was not functioning. This failure resulted in a delay in treatment and unmet care needs for Residents 1 and 2, and placed all residents needing assistance at risk for unmet care needs.

Findings included...

Resident 1
Resident 1 was admitted to the ALF on [redacted]/2023 with multiple medical diagnoses including [redacted] and [redacted]

A negotiated service agreement dated 03/27/2023, showed Resident 1 needed stand-by assistance with bathing, transfers, and needed maximum assistance with toileting 1-2 times per shift.

On 05/31/2023 at 12:15 PM observations of Resident 1 and Resident 2's bathrooms showed an emergency call light pull-cord by the toilet next to the shower stall.

In an interview on 07/06/2023 at 07:39 AM, Staff D, Med Tech, stated that the call system had glitches. They were going on and off and so it kept coming up on the system, so we went up there to go check on it thought maybe the resident was messing with it". Staff D stated that they found Resident 1 on the floor at 12:00 AM with quite some blood on the Resident 1 and on the carpeting.

In an interview on 07/11/2023 at 11:39 AM, Collateral Contact, (CC1) stated that they found Resident 1 on the living room floor with dried blood and dried feces on the Resident 1's hands and legs and on the floor which appeared that Resident 1 had struggled for a long time on the floor. CC1 stated that the emergency call cord in the bathroom was pulled down and activated. CC1 stated that they were told by some of the staff that the buttons were no longer operating.

Incident report dated 05/28/2023 at 12:00 AM, showed Resident 1 was found on the floor with wounds on left arm below the elbow, both first 2 toes, right calf with blood and feces around Resident 1.

Emergency pull cord response dated 5/28/2023 showed no calls were recorded as having been received from Resident 1's bathroom.

Resident 2
Resident 2 was admitted to the ALF on [redacted]/2023 with multiple diagnoses including [redacted] and [redacted]

A negotiated service agreement dated 03/31/2023 showed Resident 2 needed staff monitoring 1-2 times per shift for safety and needed partial assistance of 1 staff with bathing.

In an interview on 07/07/2023 at 11:52 AM, Collateral Contact 2 (CC2) stated that on 05/24/2023 at 8:00 PM they found Resident 2 on the bathroom floor with feces on the floor and on the toilet. CC2 stated that the emergency cord was pulled down and activated.

In an interview on 07/17/2023 at 11:52 PM, Resident 2 stated that they fell in shower and crawled out of the shower. Resident 2 pulled the bathroom emergency pull cord using their toes and laid on the floor for 7 hours. Resident 2 stated that they came up to their apartment at 1:52 PM due to bowel incontinence and decided to take a shower and fell.

In an interview on 05/31/2023 at 2:36 PM, Staff D, Med Tech stated that on 05/24/2023 at approximately 8:00 PM they found the Resident 2 on the bathroom floor near the shower stall. Staff D stated that the Resident 2 was not wearing a call pendant, but the emergency pull cord was pulled down.

Review of the emergency pull cord report dated 05/24/2023 showed no call was recorded as having been made from Resident 2's apartment.

Resident 3
Resident was admitted to the ALF on [redacted]/2022 with multiple diagnoses including [redacted] and [redacted]

A negotiated service agreement dated 01/04/2023, showed Resident 3 needed 2 staff assistance with transfer from seated to standing, and moderate assistance with mobility for safety.

In an interview on 05/31/2023 at 12:28 PM, Resident 3 stated that they had to wait for up to an hour for their call to be answered. Resident 3 stated that they had to called 911 several times to get someone to answer Resident 3's pendant, because Resident 3 was scared that no one was responding to their request for help.

In an interview on 06/26/2023 at 11:26 AM, Staff F, Caregiver, stated that Resident 1 was not aware that when they press the call pendant and then presses it again, it resets the call.

Review of the call pendant report from 05/15/2023 to 05/31/2023 showed Residents' wait time for call response was up to 1 hour.

In an interview on 05/31/2023 at 11:02, Staff A, Executive Director stated that when residents call for help it may only be for a few minutes wait but for the resident it may feel like hours.

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) 10/9/23 .

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

Administrator (or Representative) — Date: 8/31/23

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to ensure one of one resident (Resident 1) received care as stated in the negotiated service agreement when Resident 1 was not escorted to breakfast by staff. This failure resulted in Resident 1 being found on the floor unresponsive and placed Resident 1 and all residents at risk for unmet care needs.

Findings included...

Resident 1 was admitted to the ALF on [redacted]/2023 with multiple medical diagnoses including [redacted]

A signed negotiated service agreement (NSA) dated 11/17/2022 showed Resident 1 needed reminders for meals and escort to the dining room and back to their room, and

maximum assistance with toileting 1-2x per shift. Staff were to provide peri care and ensure Resident 1 was wearing incontinent briefs.

Review of chart notes dated 05/28/2023 at 1:51 PM, showed Resident 1 was found on the floor unresponsive with Resident 1's head in-between the bed and the nightstand.

In an interview 06/29/2023 at 11:43 AM, Collateral Contact (CC) stated that they called at 10:20 AM on 05/28/2023 to check on Resident 1 and was notified by Staff E, Med Tech, that Resident 1 was found unresponsive in Resident 1's apartment on 05/28/2023 at 10:02 AM when Staff E went to deliver Resident 1's medications. The CC stated that they signed a negotiated service agreement that the facility will provide Resident 1 assistance to the bathroom and reminder and an escort each meal.

In an interview on 07/17/2023 at 10:45 AM, Staff G, Caregiver, stated that on 05/28/2023 they worked the day shift from 6:00 AM to 2:00 PM. Staff G stated that they did not check if Resident 1 needed help to the bathroom or an escort to breakfast the morning of 05/28/2023. Staff G stated that around 10:00 in the morning was the first time they saw Resident 1. Staff E, Med Tech, had called for help because Resident 1 was on the floor.

In an interview on 07/18/2023 at 10:21 AM, Staff E stated that they went to bring Resident 1's medicine "between 9:00 and 11:00 AM" on 05/28/2023 and found Resident 1 on the floor. Staff E stated that normally about 8:00 to 8:30 Resident 1 goes to breakfast. When Resident 1 didn't show up, Staff E went to Resident's room. Resident 1 was found on the floor. Staff E stated that Resident 1 appeared to have been trying to sit up in bed and just fell over sideways in between the bed and the nightstand. Staff E called Emergency Services who transported Resident 1 to the hospital.

Review of staff schedule for day shift on 05/28/2023 showed Staff E and Staff G were working with one other new staff person. It was the staff person's first day at work.

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) 8/9/23 .

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

Administrator (or Representative) — Date: 8/31/23