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

12/24/2024

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

RE: Lynden Manor License # 2641

Dear Administrator:

This letter addresses Compliance Determination(s) 51860 (Completion Date 12/23/2024) and 46039 (Completion Date 10/02/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/23/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2930-1-c

The Department staff who did the on-site verification:
Helen Fisher, Complaint Investigator

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 #: 46039
Intake ID: 142427
Investigator: Helen Fisher
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 08/22/2024 through 10/02/2024
Complainant Contact Date(s): 08/21/2024

Allegation(s):

1) The Assisted Living Facility (ALF) was not answering phone and messages were not returned.
2) The Named Staff (NS) did not process hospice order for the Named Resident (NR's) medication for pain.
3) ALF voicemail did not include ALF's information.
4) The NS had a bad attitude towards hospice nurse.
5) ALF staff did not know how to make call to outside.

Investigation Methods:

Sample:	Total residents: 71 Resident sample size: 3 Closed records sample size:
Observations:	NR and Sampled Resident's appearance, demeanor, living quarter, staff to residents interaction, environment.
Interviews:	NR's family, medication technician, resident care coordinator, executive director, concierge, collateral contacts.
Record Reviews:	NR's negotiated service agreement, electronic medication administration records, progress notes.

Investigation Summary:

1) Interviews indicated that the ALF was not answering the multiple phone calls made during afterhours which resulted in a delay in processing the NR's new pain medication order from hospice. The staff stated that they don't know how to check the afterhours phone messages during their shift. Failed practice was identified. A citation was written for noncompliance with Washington Administrative Code 388-78A (2930) Communication system. RCW 18.20.184 Communication system- Telephone and other equipment.
2) The NS stated that they were not at the ALF but was coordinating with staff when the medication order was sent by hospice. The NS stated that they were not a nurse and had to wait until they got a hold of the director of nursing to verify the narcotic order. The NS was off but was taking calls from staff at the ALF. The NS stated that they requested hospice to send the order to them and the DNS by email because

the order was for narcotics. The NS stated that they found out that the hospice nurse went to the ALF removed the NR's old pain patch and placed 2 patches on. The staff stated that they checked all the faxes and were not able to locate which fax the hospice order was sent to until late that evening of 08/10/2024. The staff stated that they did not hear the phone ring that evening.
3) The Executive Director (ED) stated that the voice mail was created by their former concierge and was not aware that the voice mail did not mention the named of the ALF. The ED stated that they would replace the message in their voice mail.
4) The NS denied having a bad attitude stated that the hospice nurse was the one who was yelling at them during a phone call. The staff denied hearing the NS and the hospice nurse phone conversation.
5) Three staff stated that they knew how to make a call to the outside line. Three staff demonstrated how to make a call. No failed practice was identified.

Conclusion / Action:

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

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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 08/22/2024 and 08/22/2024 of:

Lynden Manor
905 Aaron Dr
Lynden, WA 98264

This document references the following complaint number(s): 142427

The following sample was selected for review during the unannounced on-site visit: 3 of 71 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

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(c) Provide residents, families, and other visitors with a means to contact a staff person inside the building from outside the building after hours.

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews, the Assisted Living Facility (ALF) failed to respond to incoming communications during afterhours when 2 of 2 residents' (Resident 1 and 2) doctor's order were received and processed. This failure resulted in multiple calls not being answered, messages not being returned, and the delay in processing of Resident 1 and Resident 2's pain treatment orders.

Findings included...

Review of RCW 18.20.184. Communication system—Telephones and other equipment. (1) Each assisted living facility shall be responsive to incoming communications and respond within a reasonable time to phone and electronic messages.

Review of the ALF title "Communications Policy" dated 02/01/2015 showed: It is Care Partners Senior Living policy to ensure residents have a mechanism to summon on duty staff should they require assistance. The facility supports each resident's right to access contacts with friends, family and acquaintances who reside outside the facility, therefore non-pay telephones are made available for residents to use. These telephones afford residents privacy for their conversations if they do not have telephones in their apartments.

Resident 1

Resident 1 was admitted to the ALF on [redacted]/2024 with multiple diagnoses including [redacted] and [redacted] ([redacted]).

Review of the care plan dated 08/14/2024 showed, Resident 1 was under hospice care for pain management.

Interview on 08/22/2024 at 10:40 AM, Collateral Contact (CC 1), hospice stated that on the evening of 08/10/2024 they had been calling the ALF to check if the hospice order sent was received, processed and given to Resident 1 but the facility did not answer their 12 calls during afterhours. CC1 stated that they reached voicemail numerous times and left 5 messages. CC1 stated that they did not receive a call back from the ALF.

Interview on 08/22/2024 at 11:02 AM, Staff A, Resident Care Coordinator, stated that the hospice nurse was upset and had told them that they had been calling the ALF and nobody answered. Staff A stated they were not at the ALF and did not know which fax number the hospice sent the order to. Staff A stated that they finally received the order via email from hospice.

Resident 2

Resident 2 was admitted to the ALF on [redacted]/2019 with multiple diagnoses including [redacted] ([redacted]).

A negotiated service agreement dated 05/19/2024 showed, Resident 2 was under hospice care for pain management.

Interview on 08/22/2024 at 11:23 AM, Staff B, Medication Technician, stated that they did not know how to check the voicemail messages.

Interview on 08/22/2024 at 12:46 PM, Collateral Contact (CC 2), hospice stated that they placed at least 8 calls including 3 voice messages and did not get a hold of someone at the ALF over the phone during afterhours. CC2 stated that on 08/21/2024 the ALF was not answering their calls to ensure hospice orders for Resident 2 were processed in a timely manner.

Interview on 08/22/2024 at 1:03 PM, Staff C, Front desk staff, stated that they checked weekend and afterhours messages when they came in the following morning.

Interview on 08/22/2024 at 1:15 PM, Staff D, Executive Director, stated that they have a concierge who answers the phone 7 days a week from 9:00 to 5:00 PM, the staff were supposed to answer the phone afterhours from 5:00 AM to 8:00 AM. The staff and concierge were responsible to check the messages. Staff B showed the wireless phone with direction on how to check messages.

On 08/22/2024 at 1:15 PM a wireless phone with directions on how to check messages taped to the phone was observed with Staff D.

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