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

08/28/2024

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

RE: Lynden Manor License # 2641

Dear Administrator:

This letter addresses Compliance Determination(s) 45186 (Completion Date 08/07/2024) and 40067 (Completion Date 06/20/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/07/2024 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-2210-1-b

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 #: 40067
Intake ID: 126328
Investigator: Anthony Devito
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 04/23/2024 through 06/20/2024
Complainant Contact Date(s): 04/22/2024

Allegation(s):

1) The Named Resident (NR) was not getting their morning medications from the med tech for they were left on the NR's countertop. The ALF was documenting the medication as given but they could have been thrown away. The NR was paying for the medication service they were not properly receiving.
2) The Assisted Living Facility was not taking the NR's blood pressure before giving the NR's medication.
3) The NR was taken to the hospital for blacking out and was found to have a bladder infection and was very dehydrated.
4) The NR had a weight gain of 10 lbs. (pounds) in fluids due to the ALF not following the NR's medication discharge order from the hospital.
5) The ALF had been giving the NR their diuretic medication (fluid retention) late in the evening which made them to go to the bathroom all night.
6) The unnamed staff (US) was not truthful with the NR's family.

Investigation Methods:

Sample:	Total residents: 85 Resident sample size: 6 Closed records sample size: 1
Observations:	Medication delivery, NR's and sample residents receiving medications, NR's appearance and mentation, living quarters, activity, staff to resident interaction.
Interviews:	NR, collateral contact, director of nursing, medication technician, housekeeping staff, caregiver, registered nurse.
Record Reviews:	NR and sample resident's negotiated service agreement, electronic medication records, progress notes. Hospital discharge summary. ALF's medication services policy and procedures.

Investigation Summary:

1) Interview indicated that the NR's morning medications were being left on the counter for them to take when they got up in the morning. The NR stated that some of the medication technicians (Med Tech) would leave their medication when they were asleep to take later. The med tech stated that they did not leave the NR's medications.

The med tech stated that they were not aware that medications were being left unsupervised. Two of two sampled residents' medications were found in a medicine cup in their apartment. Failed practice. A citation was written for noncompliance with Washington Administrative Code 388-78A-2210 (1)(b). Medication services.
2) The staff stated that the NR's blood pressure medications had no parameters. The NR blood pressure was monitored due to the multiple blood pressure medications the NR was taken. The NR stated that the staff was taking their blood pressure every day. Electronic medication administration (EMAR) records showed the NR's blood pressure was being checked and recorded daily. No failed practice was found.
3) The Resident Care Coordinator (RCC) stated that they sent out the NR to the hospital due to an unresponsive episode while attending the activity and the staff was unable to get a reading of their low blood pressure. The RCC stated that the NR baseline was able to make needs known, independent with meals and had access to fluids. The RCC stated that the NR did not notify staff that they were not feeling well. The NR stated that they did not need much help aside from shower and stockings assistance. The staff reported that the NR was good about coming down for meals. No failed practice was found.
4) There were multiple discrepancies found in the EMAR pertaining to medication management and weight parameters to give a second dose when the NR's weight was above 158 lbs. (pounds). The NR's diuretic and supplement were given outside parameters. Failed practice was found. A citation was not written for non-compliance with Washington Administrative Code 388-78A-2210 (2) Medication Services. The ALF was under a plan of correction.
5) Review of the EMAR showed the NR's diuretic was scheduled at 5:00 PM. The NR stated there were times that the med tech would bring their diuretic later than 5:00 PM. There was no written time order from the physician on when the diuretic should have been given. The staff stated that the NR could request the diuretic be given at the different time. No failed practice was found.
6) Interview indicated that the US was blaming other staff when the NR's family asked questions regarding NR's medications. The NR's family had no recollection on which staff they spoke with. The staff stated that nursing questions were referred to the director of nursing. No failed practice found.

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 04/23/2024 and 04/23/2024 of:

Lynden Manor
905 Aaron Dr
Lynden, WA 98264

This document references the following complaint number(s): 126328, 126733

The following sample was selected for review during the unannounced on-site visit: 6 of 85 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Helen Fisher, Complaint Investigator
Anthony Devito, Field Services Administrator

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-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 provide safe medication delivery services to 3 of 3 residents (Resident 1, 2, and 3) when medications were left unattended in Residents' rooms. This failure resulted in the ALF being unable to confirm if the Residents took their medications and placed Resident 1, 2 and 3 at risk for missed medications and medical complications.

Findings included...

The ALF's policy "Procedure for medication Services Self-Medication with Assistance " undated showed:
Procedure:
1. Inform the resident of reason for coming.
2. Unlock medication cupboard.
3. Take out medication (blister pack or other pharmacy-prepared labeled container, or if over the counter medication, in original container with manufacturer's label) from cupboard and open, if needed.
4. Hand container to resident, checking to assure they are aware of which medication and amounts they are taking at this time, and enabler may be used.
5. Instruct observe resident. Check to assure prescribed amount was taken.
6. Provide water and observe clients swallow pills slash apply medication.
7. Return medication to cupboard, lock up and document.

Resident 1

Resident 1 was admitted to the ALF on [redacted]/2023 with multiple medical diagnoses including [redacted] ([redacted]). Assessment dated 11/07/2023 showed Resident 1 needed medication assistance.

Review of Electronic Medical Administration Record (EMAR) for the month of April showed

Resident 1 was prescribed to take in the morning Digoxin (for essential hypertension) 0.125 mg (milligram) tablet daily, Diltiazem ER (for essential hypertension) 360 mg capsule daily (for essential hypertension), Eliquis (anticoagulant) 2.5 mg tablet daily, Isosorbide dinitrate (for chest pain) 30 mg tablet daily, Potassium Chloride ER (cardiac health supplement) 20 meq. (milliequivalent) tablet daily, Torsemide (localized edema) 20 mg tablet for weight over 158 lbs. (pound), and Jardiance (heart failure) 10 mg tablet daily. All the medications listed on 04/01/2024 to 04/23/204 were signed as given.

Review of the hospital discharged summary dated 03/31/2024 showed the Resident 1 was to take medication for edema 20 mg daily.

Interview on 04/22/2024 at 9:47 AM, Collateral Contact (CC1), stated that Resident 1 morning medications were being left on the countertop every morning for Resident 1 to take. CC1 stated that they were concerned that Resident 1 may throw their medications away by mistake.

Interview on 04/23/2024 at 12:55 PM, Resident 1 stated that every morning between 7:00 to 7:30 AM the medication technician (med tech) would come in and left the medications on the countertop and most of the time they were still asleep. Resident 1 stated that when they told the staff to not leave their medications, they had to walk to the nurse's station when they were to take them.

Resident 2

Resident 2 was admitted to the ALF on [redacted]/2021 with multiple diagnoses including [redacted] ([redacted]). Assessment dated 12/19/2023 showed Resident 3 needed assistance with medications.

Review of EMAR for the month of April showed Resident 3 was prescribed to take Calcium antacid (for gastro-intestinal reflux) 500 mg tablet daily, Cephalexin (bladder infection) 250 mg 4 times a day, Famotidine (stomach upset) 20 mg daily, Eliquis (anticoagulant) 5 mg twice a day, Certavite Senior tablet (supplement) daily, Furosemide (fluid retention) 20 mg tablet daily, Lisinopril (high blood pressure) 40 mg tablet daily, Magnesium (supplement) 400 mg tablet daily, Metoprolol tartrate (high blood pressure) 100 mg daily, Potassium Chloride (supplement) 20 meq tablet daily, Sertraline Hydrochloride (for depression) 50 mg tablet daily and Vitamin E (supplement) 400 caplet daily. All the medications listed on 04/01/2024 to 04/23/204 were signed as given.

On 04/23/2024 at 11:45 AM, a small medication cup was observed on the countertop by the kitchen sink with twelve different medications identified by Staff B, medication technician, as morning medications doses for Resident 2.

Interview on 04/23/2024 at 12:03 PM, Staff B, Med Tech, stated that they did not leave medications in residents' rooms. Staff B stated they watched Residents take their medications.

Interview on 04/23/2024 at 01:18 PM, Resident 2 stated that they were taking their medications when they remember to take them. Resident 2 stated that the staff normally left their medications on the counter by the sink so they would see them. Resident 2 stated that they were taking their medication unsupervised.

Resident 3

Resident 3 was admitted to the ALF on [redacted]/2023 with multiple diagnoses including [redacted] ([redacted]). Assessment dated 12/29/2023 showed Resident 3 needed medication assistance.

Review of the EMAR for the month of April showed Resident 3 was prescribed to take in the evening Cephalexin (for bladder infection) 500 mg three times a day for 7 days, Atorvastatin (medication for cholesterol) 40 mg every evening and Acetaminophen (medication for pain) 500 mg twice a day. All the medications listed on 04/01/2024 to 04/23/204 were signed as given.

Interview on 04/23/2024 at 11:00 AM, Collateral contact (CC2) stated that they had been finding a cup of medications on Resident 3's countertop when they were in the room in the mornings about a dozen times.

On 04/23/2024 at 11: 45 AM a small medication cup containing three different medications was observed on the top of the coffee maker identified by Staff B as evening medication doses for Resident 3.

Interview on 04/23/2024 at 11:57 PM, Resident 3 stated that the evening med techs were leaving their medications on the counter and on the top of coffee maker all the time. Resident 3 stated that they could not remember to take them at night.

Interview on 04/23/2024 at 12:03 PM, Staff B, Med Tech, stated that they gave Resident 3 medications at 8:00 AM. Staff B stated that they were unaware on how long the Resident 3 medications in the cup had been on the coffee maker. Staff A stated that the Resident 3 medications found on the coffee maker were medications for the evening.

Interview on 04/23/2024 at 1:41 PM, Staff C, Director of Nursing, stated that they were unaware of medications being left in Resident 1, 2 and 3 apartments. Staff D stated that they were not supposed to leave in residents' room.

Interview on 04/23/2024 at 02:16 PM, Staff D, Executive Director, stated that they would investigate the medications left in Resident 2 and Resident 3 apartment.

This citation was previously cited on 04/20/2023.

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)_____ .

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

_____ _____

Administrator (or Representative) Date