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

07/03/2024

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

RE: Lynden Manor License # 2641

Dear Administrator:

This letter addresses Compliance Determination(s) 42921 (Completion Date 06/27/2024) and 38914 (Completion Date 05/02/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/27/2024 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-2210-2

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 #: 38914
Intake ID: 123087
Investigator: Helen Fisher
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 03/28/2024 through 05/02/2024
Complainant Contact Date(s):

Allegation(s):

1) Multiple medication errors have been made.
2) The Assisted Living Facility (ALF) was notified and did not do anything to address the medication error.
3) The Named Resident (NR) could've been saved if the emergency services were called.
4) The Director of Nursing (DNS) was telling the medication technicians (Med Tech) to combine all evening medications and chart them later.

Investigation Methods:

Sample:	Total residents: 83 Resident sample size: 3 Closed records sample size: 0
Observations:	NR and sampled residents' appearance and demeanor, living quarter, social interaction, staff to resident interaction, hallways, general cleanliness.
Interviews:	Resident care coordinator, executive director, director of nursing, med techs, other not associated with facility.
Record Reviews:	NR's electronic medication administration records for January and February 2024, negotiated service agreement, progress notes.

Investigation Summary:

1) Record review showed in January and February 2024 multiple medication errors were made due to incorrect doses being administered. Failed practice. A citation was written for noncompliance with WAC 388-78A-2210 Medication services.
2) The ALF did an investigation on the medication errors and terminated the Named Staff prior to the unannounced visit to the facility. No failed practice.
3) The NR was refusing to eat and drink for four days before they passed. The family was aware of the NR's change in condition. The family stated that they did not have any concerns about the NR's blood sugar because the NR was borderline diabetes and was "ready to go". The staff were following the NR's care plan and in communication with the DNS, NR's physician, and family. The ALF did an investigation of the NR's the death. Abuse and neglect were ruled out. No failed practice.
4) Three delegated staff stated that they were not aware of any instructions from the

DNS to combine medications and to chart later. The DNS stated that they did not give instructions to medication technicians to combine medication and backtrack for signature. The DNS stated that the electronic medication administration system would not allow staff to backtrack and chart a different date. No failed practice.

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

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 03/28/2024 and 03/28/2024 of:

Lynden Manor
905 Aaron Dr
Lynden, WA 98264

This document references the following complaint number(s): 123087, 123633, 124588

The following sample was selected for review during the unannounced on-site visit: 3 of 83 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-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to ensure 1 of 3 residents (Resident 1) received medication as prescribed by the physician. This failure resulted in Resident 1 receiving wrong dosages of their anti-anxiety medication for 26 days and placed Resident 1 at risk for medical complications.

Findings included…

Resident 1

Resident 1 was admitted to the Assisted Living Facility (ALF) on [redacted]/2022 with multiple diagnosis including [redacted].

A negotiated service agreement dated 01/22/2022 showed Resident 1 had a cognitive impairment and was to receive medication administration.

The physician's order dated 03/31/2023 showed Resident 1 was to receive:
Lorazepam 0.50 mg (milligram) 1 tablet by mouth at 8:00 PM daily for anxiety
Lorazepam 0.25 mg 1 tablet by mouth every 3 hours as an additional dose when needed for anxiety.

Review of the electronic medication administration records (EMAR) for January and February 2024 showed Resident 1 had a medication listed as:
Lorazepam 0.50 mg (milligram) 1 tablet by mouth at 8:00 PM daily. Medication was marked as given daily at 8:00 PM from 1/25/2024 through 02/29/2024.

Review of the narcotic book dated 01/19/2024 showed a PRN (as needed) (in addition to the 0.50 mg daily dose) sticker with Resident 1's full name, the number of tablets as 30 and the named of medication as Lorazepam ½ tablet 0.25 mg by mouth every 3 hours as needed for anxiety. There were 26 staff initials belonging to 3 medication technicians (Staff B, E & F).

Interview on 03/28/2024 at 11:00 AM, Staff A, Resident Care Coordinator, stated that they were unaware of the medication error until a medication audit was done and it was found that Resident 1 had been receiving 0.25 mg instead of 0.50 mg of the anti-anxiety medication for 26 days between January and February 2024. Staff A stated that three med techs (Staff B, E, and F) made the errors. Staff made one error and received counseling. Staff E and F were no longer employed at the ALF.

Interview on 03/28/2024 at 12:26 PM, Staff B, Med Tech, stated that they made one mistake by administering Lorazepam 0.25 mg instead of 0.50 mg to Resident 1 but did not realize the mistake until a few days later. Staff B stated that she did not make a report.

Interview on 03/28/2024 at 1:12 PM, Staff C, Director of Nursing, stated that they received a medication error report from a staff member and did an investigation which resulted to Staff F termination of employment for committing 18 medication errors on Resident 1’s antianxiety medication.

On 03/28/2024 at 1:36 PM, Staff D, Executive Director, stated that they were not aware that the medication errors were committed until it was reported to Staff C.

On 03/29/2024 at 8:51 AM, Collateral contact, (CC) stated that they noted Resident 1's condition had been declining in the last 3 months. CC stated that missing their full medication dosage was not helpful as the Resident condition continued to decline.

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