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

11/26/2024

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

RE: Lynden Manor # 2641

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 50506 (Completion Date 11/26/2024) and 44357 (Completion Date 09/26/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/26/2024 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2371 Investigations. The assisted living facility must:

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

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,

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 #: 44357
Intake ID: 137107
Investigator: Helen Fisher
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 07/19/2024 through 09/26/2024
Complainant Contact Date(s):

Allegation(s):
The Named Resident (NR) went outside the Assisted Living Facility's secured memory care undetected.

Investigation Methods:

Sample:	Total residents: 88 Resident sample size: 3 Closed records sample size: 0
Observations:	NR's appearance and demeanor, environment, living quarter, exit doors, social interaction.
Interviews:	NR, resident care coordinator, med tech, caregiver, resident representative.
Record Reviews:	NR's negotiated service agreement, progress notes, incident investigation.

Investigation Summary:
Interviews indicated that the NR was assumed to use the door by the stairway of the ALF's memory care unit. The staff was not aware the NR was outside until they were seen by another staff standing outside the ALF front entrance. The staff stated that the NR was found approximately 10 minutes after the alarm went off. The ALF assumed the NR went out through the alarmed door adjacent to the lobby. The NR had a history of elopement and the ALF's preventative measures were ineffective. Failed practice was identified. A citation was written for noncompliance with Washington Administrative Code 288-78A (2371) Investigation.

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 #: 44357
Intake ID: 138359
Investigator: Helen Fisher
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 07/19/2024 through 09/26/2024
Complainant Contact Date(s): 07/18/2024

Allegation(s):

1. The Named Resident (NR) was involved in an altercation with another resident.
2. The NR had left the Assisted Living Facility (ALF) secured memory care undetected and was found by the police 5 miles away from the ALF.

Investigation Methods:

Sample:	Total residents: 88 Resident sample size: 3 Closed records sample size: 0
Observations:	The NR appearance, demeanor, exit doors, environment, the NR social interaction, living quarter.
Interviews:	NR, other not associated with ALF, med tech, resident care coordinator, caregiver, director of nursing (DNS).
Record Reviews:	NR's negotiated service agreement, progress notes, electronic medication administration record, incident investigation. Missing resident policy and procedures.

Investigation Summary:

1. The staff intervened and separated both residents. The NR was unharmed and was redirected. No failed facility practice was identified.
2. The staff stated that they did not know that the NR had left the memory care unit until the police officers were knocking on the door with the NR at midnight. The staff stated that the NR was last seen at 10:10 PM sleeping in their chair. The NR was observed as upset following an incident with another resident. The NR had no recollection of what happened when asked. The DNS stated that the NR must have followed someone out the memory care door and went outside through the silent alarm door. The ALF did not make a determination on how the NR got out of the ALF aside from assumptions. Failed practice was identified. A citation was written for noncompliance with Washington Administrative Code 288-78A (2371) Investigation.

Conclusion / Action:

☐ 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 07/19/2024 and 07/19/2024 of:

Lynden Manor
905 Aaron Dr
Lynden, WA 98264

This document references the following complaint number(s): 137107, 138359, 138398, 138648

The following sample was selected for review during the unannounced on-site visit: 3 of 88 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.

Kim Ripley
Residential Care Services

10/01/2024
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-2371 Investigations. The assisted living facility must:

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to ensure measures were in place to prevent 2 of 2 residents (Resident 1 and 2) from leaving the secured memory care unit unsupervised. These failures resulted in Resident 1 and Resident 2 exiting the building without detection, Resident 2 missing for approximately 2 hours and found walking 4-5 miles away from the ALF late at night, and placed all memory care residents at risk of leaving the ALF undetected.

Findings included…

Review of the ALF's "Elopement- Missing Resident" policy and procedures, with an effective date of 10/07/2020 showed elopement was defined as: The process of leaving protected and safe surroundings with no focused designation, or the inability to return safely after exiting facility. For residents assessed as unable to leave facility without supervision: Any/All Staff, upon noticing resident is missing: Verify whether resident has signed out on social leave, had an appointment outside the facility, etc., if the resident is past estimated time of return, contact resident's responsible party. If the resident is not located, continue search, include all areas or resident room such as bathroom, closets, etc. With in 5 minutes, Notify the ED/LN if on site. Notify Med Tech on duty to initiate building search (common areas, outside areas, other resident rooms, etc. The Med-Tech will gather the following information from the staff member that last saw the resident. Approximately what time was the resident last seen what they were wearing, what was their physical, mental and emotional status, notify LN if after hours. Search complete in 10-15 minutes. Executive Director, LN, Med Tech in maximum of 15 minutes Once staff have reported back to Manager/Med Tech on site, and the resident is still missing, call 911 and report a missing resident. Provide all information required for a police search.

Resident 1

Resident 1 was admitted into the ALF's memory care unit on [redacted]/2021 with multiple

diagnoses including [redacted].

Review of the Resident 1 assessment dated 06/12/2024 showed Resident 1 requires supervision and monitoring to maintain Resident 1 dignity and safety. Access to the community at large without escort/supervision would put resident at risk of harm for abuse/neglect/exploitation/personal injury.

A negotiated service agreement dated 10/23/2023 showed Resident 1 had an exit seeking and wandering behavior that required redirection. No other preventative measures were identified.

Review of incident report dated 07/01/2024 around 5:30 PM showed a med tech heard the door alarm sound, when checked they did not see Resident 1 outside. Resident 1 was seen by the other staff standing outside at the front entrance door and was brought in.

Review of the investigation dated 07/01/2024 showed Resident 1 went out through the side door and had taken a walk around the ALF. Resident 1 was seen walking outside the ALF by another staff and was brought inside. Resident had dementia and thinks that they needed to get home. Resident was continuously disoriented to time, place, and others and was oriented to self only. Preventative measures showed service plan reviewed and updated, Resident 1 was placed on alert, when Resident 1 gets disoriented and thinks they got lost way home staff to assure Resident 1 had not wandered off.

Review of alarm log dated 07/01/2024 to 07/02/2024 showed there was no door alarm incidents found on 07/01/2024.

In an interview on 07/19/2024 at 9:20 AM, Staff A, Resident Care Coordinator, stated that on 07/01/2024 shortly after dinner, Resident 1 went outside through the alarmed door. The staff responded to the alarm, looked outside and second floor but did not see Resident 1. Staff A stated that Resident 1 may have gone out through the memory care unit front entrance. Staff A stated that Resident 1 was gone for about 10 minutes before they were seen at the ALF's front entrance.

In an interview on 07/19/2024 at 1:10 PM, Staff B, Executive Director, stated that they were not aware of the Resident 1 elopement incident.

Resident 2

Resident 2 was admitted into the ALF's memory care unit on [redacted]/2023 with multiple diagnoses including [redacted] ([redacted]).

Review of the Resident 2 assessment dated 06/12/2024 showed Resident 2 requires supervision and monitoring on to two times per shift to maintain Resident 2 dignity and safety. Access to the community at large without escort/supervision would put resident at risk of harm for abuse, neglect, exploitation, and personal injury. Monitor Resident 2 for any verbal aggression that may be initiated and separate resident from the situation.

A negotiated service agreement dated 09/22/2023 showed Resident 2 had an exit seeking and wandering behavior that required redirection. No other preventative measures were identified.

Review of incident report dated 07/11/2024 at 12:05 AM showed Resident 2 left the ALF without being detected by staff. The staff were unaware Resident 2 was missing until the police officers knocking on the ALF's door with Resident 2. Resident 2 was found approximately 4 to 5 miles walking towards the bridge over the river.

Review of the investigation dated 07/13/2024 showed that on the midnight of 07/11/2024. The med tech noted that Resident 2 was not on the chair where they usually sleep. The med tech then prompted other staff to search the building, five minutes into the search the med tech heard knocking on the memory care door, where two police officers with Resident 2 were standing. The police officers slated that they had found Resident 2, uninjured, walking pushing their walker, near the bridge that goes over the river approximately 4-5 miles away from the facility. Resident 2 had been in a previous incident with a female resident earlier in the evening and was still showing signs of feeling anger that they had to come back after being out on a trip with family for all most 2 weeks. Resident 2 went out through a silent alarm door, and no one heard it go off. The door adjacent to the front lobby had silent alarms and to outside doors at the assisted side and there were no alarms to the outside doors. The silent alarms to outside doors was added later as part of the call light system.

Preventative measures showed management went around and checked all the door alarms to assure they were all working, ad posted signs for staff to know what door is being opened when they see it on their computer monitor. staff to do 2-hour room checks in memory care, service plan reviewed, and resident was placed on alert.

Review of alarm log dated 07/01/2024 to 07/02/2024 showed there was no door alarm incidents found on 07/11/2024.

In an interview on 07/18/2024 at 12:09 PM, Collateral Contact (CC), stated that Resident 2 left the ALF, and nobody knew that Resident 2 was gone for more than 2 hours. CC stated that they were afraid for Resident 2's safety.

In an interview on 07/19/2024 at 9:20 PM, Staff A stated that when the night shift started at 10:00 PM they came and did their rounds, Resident 2 was in the tv room sleeping on the recliner. Staff A stated that night shift staff was not aware that Resident 2 was gone until the two police officers knocked on the door with Resident 2.

In an interview on 07/19/2024 at 1:23 PM, Staff C, Director of Nursing, stated that Resident 2 possibly went through door 5, which was the front door. Staff C stated that Resident 2 must have followed someone from the unit and then went out the front the reason why there was no alarm heard. Staff C updated Resident'2 care plan and placed signage by each exit doors after Resident 2 eloped.

Email on 09/23/2024 at 1:09 PM, Staff B wrote that the ALF's previous owner did not installed alarms to the outside doors. Only the loud alarms for the 4 exits out of memory care. When the old company put in the new call light system with pendants, they also added silent alarms to outside doors as part of the call light system.

Record review of Resident's 2 nursing notes dated 07/12/2024, showed the med tech went to check on Resident 2 at midnight of 07/11/2024 and found out that Resident 2 was not in their room which prompted the search. Five minutes into the search, two police officers were knocking on the memory care unit entrance door with Resident 2. Resident 2 was found approximately 4-5 miles away walking pushing their walker near the bridge over the river. Resident 2 complained of being cold but unharmed.

Review of the Department's Complaint Resolution Unit report showed there were eight other elopements reported by the ALF in the last 18 months:

On 07/22/2024 at 3:00 PM, a door alarm went off and found one of the residents was unaccounted for. The ALF received a call from a staff at the coffee shop 3 blocks away that they had the resident in their shop.

On 05/23/2024 at 9:00 AM, a resident was brought by the Police officer after leaving the ALF undetected. It was believed the resident to have had followed a visitor leaving the memory care unit.

On 04/29/2024 at 4:00 PM, a resident was brought back by the police officers after they were found wandering a street over. ALF did an investigation and concluded that the resident followed a visitor out the alarmed door.

On 02/15/2024 at 9:00 PM, during the staff rounds found out the resident was unaccounted, and their window was open. ALF did an investigation and concluded that the resident crawled out the window. The window clipped was removed. The resident's

family took them home.

On 12/15/2023 at 4:00 AM, during the staff rounds they found a resident's window opened, screen was on the floor and a chair next to the window. The resident was found outside the ALF standing behind a van. ALF did an investigation. Resident stated that they climbed out their window.

On 08/28/2023 at 11:30 AM, a resident left the ALF was brought back by the police officer. The ALF's memory care unit door alarms were being tested and the door by the stairway became unlocked.

On 05/19/2023 at 10:00 PM, a resident exited the memory care unit when the alarm door was opened by a staff member.

On 04/14/2023 at 3:00 PM, a resident was brought back to the ALF by a family member after finding the resident across the street from the ALF. ALF did an investigation and concluded that the resident followed a staff leaving the memory care unit through the secured door.

Review of the ALF's written interventions on each reported elopement incidents from prior investigations showed staff implemented 30-minute checks, management held an all-nursing meeting on elopements and how to be proactive and prepared on keeping residents out of harm's way, staff to monitor and to redirect when resident tries to get out of the door, new signage made at the doorway, so families were aware to watch for residents to make sure no one followed them out the door, maintenance placed an alarm and a clip on the window to limit the opening, in-serviced the staff to prevent the reoccurrence, battery operated alarms had been activated when the alarm system was down, alert charting for additional monitoring, staff watch for residents before leaving opening the door, staff to be reminded to watch the resident when there was an increase in activity in the memory care unit.

Review of prior interventions in preventing elopement reoccurrences were ineffective.

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