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

02/14/2025

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) 54652 (Completion Date 02/14/2025) and 50452 (Completion Date 12/26/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/14/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

(7) When coordinating care or services, the assisted living facility must:

(a) Integrate relevant information from the external provider into the resident's preadmission assessment and reassessment, and when appropriate, negotiated service agreement; 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 #: 50452
Intake ID: 155944
Investigator: Helen Fisher
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 11/20/2024 through 12/26/2024
Complainant Contact Date(s): 11/19/2024

Allegation(s):

There were multiple concerns on the Named Resident (NR) not receiving care at the Assisted Living Facility (ALF).

1) The NR's family could not find the NR when they come for a visit. The NR had been found wandering inside the facility.
2) The NR had bruising with unknown source.
3) The NR had incontinence issues.
4) The ALF did not collect the NR's urine sample in a timely manner.
5) The NR developed pressure injuries on their heels after the NR moved to the ALF.

Investigation Methods:

Sample:	Total residents: 88 Resident sample size: 4 Closed records sample size: 0
Observations:	NR's appearance and mentation, living quarter, staff to resident interaction.
Interviews:	NR, collateral contacts, resident care coordinator (RCC), registered nurse (RN), director of nursing (DNS), caregiver.
Record Reviews:	NR's negotiated service agreement, progress notes, medication administration record. Physician's order, admission order.

Investigation Summary:

1) The staff stated that the NR liked to walk around the memory care unit and would wander into other residents room. The staff stated that they NR would get agitated when they were redirected constantly. The NR stated that they did not like to stay in their room. No failed practice was identified.
2) The NR was cognitively impaired and lived in the memory care unit. The NR stated that they did not like to stay in their room and liked to walk around. The NR stated that they liked to find out what's going on. The staff stated that the NR had a freedom of movement within the facility. No failed practice was identified.
3) The staff stated that the NR's knee bruising was the result of the fall 3 days prior. The staff stated that the incident was investigated and ruled out abuse and

neglect. Review of the progress notes showed the ALF was monitoring the NR's bruising. No failed practice was identified.

4) The NR stated that they were trying to get to the bathroom but sometimes they could not make it. The NR stated that they did not always tell the staff that they were wet. The NR stated that the staff were very helpful. The NR denied skin problem related to incontinence. The staff stated that the NR would use the trash cans to urinate. The staff stated that they reminded the NR to use the bathroom. Review of the progress notes showed the NR had urinary urgency when they had a urinary tract infection. The NR had a history of overactive balder. No failed practice was identified.

5) Interviews indicated that the NR urine sample was not collected and sent to the laboratory until 7 days after it was ordered collected by the physician. Failed practice was identified. A citation was written for non-compliance with Washington Administrative Code 388-78A-2350 Coordination of health care services.

6) The staff stated that they were not sure what caused the NR to develop pressure sores on their heels since the NR was walking constantly. The staff stated that NR was not turning when in bed and got agitated when asked to turn. The ALF did an investigation and found out the location of the pressure injuries may have been caused by the NR's footwear. The staff stated that since the NR had some ankle edema the NR's tennis shoes had gotten too tight and may have caused the pressure injuries to the NR's heels. 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

Residential Care Services
Investigation Summary Report

Provider/Facility: Lynden Manor
Provider Type: Assisted Living Facility
License/Cert.#: 2641
Compliance Determination #: 50452
Intake ID: 155026
Investigator: Helen Fisher
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 11/20/2024 through 12/26/2024
Complainant Contact Date(s): 11/19/2024

Allegation(s):

1) The Assisted Living Facility (ALF) was not providing nursing care to the Named Resident (NR).
2) The ALF was not following the doctor's order.
3) The NR had a pressure wound on their foot and the ALF asked the family to provide wound care.

Investigation Methods:

Sample:	Total residents: 88 Resident sample size: 4 Closed records sample size: 0
Observations:	NR's appearance and mentation, living quarter, staff to resident interaction.
Interviews:	NR, collateral contacts, resident care coordinator (RCC), registered nurse (RN), director of nursing (DNS).
Record Reviews:	NR's negotiated service agreement, progress notes, medication administration record. Physician's order, admission order.

Investigation Summary:

1) Interviews indicated that the NR was assessed and was placed on alert charting when the NR had signs and symptoms of illness. The RCC stated that the NR was monitored, and vital signs were taken when the NR had behavior changes and urinary frequency. The NR's Representative stated the No failed practice was identified.

2) The nurse stated that the med techs were notifying the doctor via fax when the NR's blood sugar level was above 400. The staff stated that the NR's urine sampled was collected on 09/30/2024, 7 days after it was ordered to be collected. Failed practice was identified. A citation was written for non-compliance with Washington Administrative Code 388-78A- 2350 Coordination of health care services.

3) The staff stated that they were not delegated to do the pressure wound care tasks. The RCC stated that they asked the NR's daughter to do the wrapping until they received the doctor's order. The RCC stated that after they received the

doctor's order the DNS had been managing the NR's heels. The DNS stated that the med techs were not delegated to manage the NR’s heels’ pressure injuries wrapped dressing. The DNS stated that they managed the heels on weekdays but on weekends the family would rewrapped the NR's heels when the wrap became undone or when the NR removed them. The DNS stated that the NR's family was not obligated by the ALF to do any tasks. 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

Residential Care Services
Investigation Summary Report

Provider/Facility: Lynden Manor
Provider Type: Assisted Living Facility
License/Cert.#: 2641
Compliance Determination #: 50452
Intake ID: 154590
Investigator: Helen Fisher
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 11/20/2024 through 12/26/2024
Complainant Contact Date(s): 11/19/2024

Allegation(s):

1) The Assisted Living Facility (ALF) was not following the Named Resident (NR's) prescribed diabetic diet.
2) The NR's pressure injuries were not managed by the ALF. The ALF told the NR's daughter that they were not able to manage the NR's pressure injuries on heels.

Investigation Methods:

Sample:	Total residents: 88 Resident sample size: 4 Closed records sample size: 0
Observations:	NR's appearance and mentation, living quarter, staff to resident interaction.
Interviews:	NR, collateral contacts, resident care coordinator (RCC), registered nurse (RN), director of nursing (DNS), executive director (ED).
Record Reviews:	NR's negotiated service agreement, progress notes, medication administration record. Physician's order, admission order.

Investigation Summary:

1) Interviews indicated that the NR had been served a regular diet with sugar free dessert and juice. Review of the NR's signed doctor's diet order showed the NR to be on diabetic diet. Review of the NR's negotiated service agreement showed the NR was on a regular diet. Failed practice was identified. A citation was written for noncompliance with Washington Administrative Code 388-78A-2350 Coordination of health care services.
2) The staff stated that they were not sure what caused the NR to develop pressure sores on their heels since the NR was walking constantly. The staff stated that NR was not turning when in bed and got agitated when asked to turn. The ALF did an investigation and found out the location of the pressure injuries may have been caused by the NR's footwear. The staff stated that since the NR had some ankle edema the NR's tennis shoes had gotten too tight and may have caused the pressure injuries to the NR's heels. The DNS stated that the NR's heel wrap

supposed to stay in place, but the NR was removing them. The DNS stated that they were applying a lotion for moisture and wrapped the heels as per the doctor's order. The family would come and do the wrapping on weekend and when the NR removed the wrap. The DNS were managing the NR's heels pressure injuries, and they were doing better. The RCC stated that they told the NR's daughter to do the heels' wrapping until they received the doctor's order. The RCC stated that the DNS was in charged when it comes to skin issues. The staff stated that the NR's pressure sores were being managed by the family at first because they were not delegated for wound care. 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

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 11/20/2024 and 11/20/2024 of:

Lynden Manor
905 Aaron Dr
Lynden, WA 98264

This document references the following complaint number(s): 153091, 154590, 155026, 155944

The following sample was selected for review during the unannounced on-site visit: 4 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.

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-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

(7) When coordinating care or services, the assisted living facility must:

(a) Integrate relevant information from the external provider into the resident's preadmission assessment and reassessment, and when appropriate, negotiated service agreement; and

This requirement was not met as evidenced by:

Based on observation, interviews, and record reviews the Assisted Living Facility (ALF) failed to coordinate with the external health care provider, add the changed orders to the care plan, and respond appropriately when 1 of 3 residents (Resident 1's) blood sugar level exceeded the ordered parameters, when a doctor ordered to collect a urine sample for analysis, and a new diabetic diet was received. These failures resulted in Resident 1's doctor being unaware of Resident 1's high blood sugar level, a delayed in urine analysis, and being served a regular diet and placed Resident 1 at risk for untreated infection and diabetes complications.

Findings included…

Review of the ALF's undated title "Disclosure of Services" showed:
Food and Diets: All assisted living facilities must provide three meals per day, nutritious snacks, and prescribed general low sodium diets, general diabetic diets, and mechanical soft diets, Additionally, we are not required but have chosen to provide the following diets: Yes to puree diets, Yes, to no added salt no concentrated sweets at request, No, to calorie controlled diets for people with diabetes.

Resident 1

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

A negotiated service agreement dated 09/28/2024 showed Resident 1 would be

monitored and reported to the license nurse for signs and symptoms of hypoglycemia/hyperglycemia (low blood sugar/high blood sugar) such as excessive thirst, dizziness, confusion, excessive sweating and shaking.

On 11/20/2024 at 1:18 PM, Resident 1 was observed having lunch; barbeque meatballs, mashed potatoes with gravy, green beans and a glass of juice, served for lunch as shown in the regular menu.

Review of the Electronic medication administration record dated November 2024 showed Resident 1's blood sugar levels were 347, 308, 330, 386, 354, 270, 478,537, 145, 401, 425, 218, 233 from 11/01/2024 to 11/13/2024 at 7:00 AM.

Review of the physician's admit order dated [redacted]/2024 showed the doctor requested notification if Resident 1's blood sugar was below 60 and above 300.

In an interview on 11/20/2024 at 12:40 PM, Staff D, Medication Technician, stated that they faxed the doctor when Resident 1's blood sugar was above 400. Staff D stated that they were calling the nurse when Resident 1 blood sugar was above 400.

In an interview on 11/20/2024 at 12:57 PM, Staff B, Registered Nurse, stated that the med techs were notifying the doctor by fax when Resident 1's blood sugar was above 300. Staff B stated that the doctor did not provide a blood sugar parameter. Staff B stated that the staff were told to call the Emergency Services (EMS) when diabetic residents had over 400 blood sugar level and signs and symptoms of hypoglycemia/hyperglycemia (low blood sugar/high blood sugar) such as excessive thirst, dizziness, confusion, excessive sweating and shaking. Staff B stated the staff was to call Staff F (Director of Nursing) for instructions.

In an interview on 12/26/2024 at 9:09 AM, Staff F stated that the staff had been calling them when Resident 1's blood sugar was higher than 400. Staff F stated that they gave staff instructions on what to do. Staff F stated that the staff were instructed to call the doctor during business hours and fax when the doctor's office was closed.

In an interview on 12/17/2024 at 11:54 PM, Collateral Contact 2 (CC2), Office Staff stated that it was not appropriate to notify the doctor through fax when Resident 1's blood sugar was over 400. CC2 stated that the ALF was not calling the doctor when Resident 1 was having consistently high blood sugar levels. CC2 also stated that Resident 1's urinary tract infection was untreated for 10 days after the doctor ordered their urine to be tested on.

In an interview on 12/18/2024 at 11:32 AM, Staff E, Resident Care Coordinator, stated that Resident 1's urine sample was collected on 09/30/2024 and taken by Resident 1's daughter to the laboratory seven days later from the time it was ordered by the doctor. Staff E stated that Resident 1's urine test was positive for urinary tract infection and

was put on antibiotic treatment 10/04/2024.

Review of the physician's order dated 09/23/2024 showed to collect a urine sample from Resident 1 to test for urinary tract infection.

Review of the doctor’s order dated 11/07/2024 showed Resident 1 needed to be on a diabetic diet for all meals.

Review of the doctor’s order dated 11/12/2024 showed Resident 1 required a low carb, diabetic diet which entails a high protein, and low carbohydrate diet, absent of pie, cake, juice, and regular soda.

In an interview on 11/20/2024 at 2:36 PM Staff A, Caregiver, stated that they served Resident 1 a regular diet and adjusted to a smaller portion. Staff A stated that they served sugar free dessert and drinks for their diabetic residents including Resident 1.

In an interview on 11/20/2024 at 12:57 PM, Staff B, Registered Nurse, stated that they were serving Resident 1 diabetic diet which was no added sugar, sugar free dessert and juice.

In an interview on 12/16/2024 at 3:08 PM, Staff C, Executive Director, stated that Resident 1 had been served with regular diet and sugar free dessert and juices.

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