STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

05/13/2025

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) 59255 (Completion Date 05/13/2025) and 52788 (Completion Date 02/14/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/13/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

The Department staff who did the On Site verification:
Helen Fisher, Complaint Investigator

If you have any questions, please contact me at (253)281-1245.

Sincerely,

Anthony Devito

Anthony Devito, Field Services Administrator
Region 2, Unit Z
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Lynden Manor
Provider Type: Assisted Living Facility
License/Cert.#: 2641
Compliance Determination #: 52788
Intake ID: 162136
Investigator: Helen Fisher
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 01/09/2025 through 02/14/2025
Complainant Contact Date(s): 01/07/2025

Allegation(s):

1) The Named Resident (NR) was left covered with feces while lying in bed for at least six hours. The NR, the NR's bedroom, bathroom floor, and toilet had feces on them.
2) The NR had not been taken to meals in a timely manner.

Investigation Methods:

Sample:	Total residents: 89 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents, environment, staff to resident interaction.
Interviews:	Residents, Collateral contact, Executive Director (ED), Director of Nursing, Medication Technician, Caregiver.
Record Reviews:	Residents' records. Abuse and neglect policy and procedure

Investigation Summary:

1) Interview indicated that the NR had urine and bowel incontinence and was left approximately five hours in feces. The staff stated that the floor all the way to the bathroom had tracts of feces. The staff stated that they were aware that the NR had a bowel incontinence and had asked another staff to attend to the NR but was ignored. The staff stated that the NR had feces all over them and on the floor and toilet. The ALF did an investigation and the NS was reprimanded. Failed practice was identified. A citation was written for noncompliance with Washington Administrative Code 388-78A-2660 Resident rights.
2) The staff stated that the NR refused to get cleaned up to attend breakfast when asked by the staff. The staff stated that they were aware at the time that the NR had bowel incontinence and would have cleaned the NR had the NR agreed to get up. The staff stated that the NR missed breakfast. The ALF did an investigation and the NS was reprimanded. Failed practice was identified. A citation was written for noncompliance with Washington Administrative Code 388-78A-2660 Resident rights.

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 #: 52788
Intake ID: 162370
Investigator: Helen Fisher
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 01/09/2025 through 02/14/2025
Complainant Contact Date(s): 01/10/2025

Allegation(s):

1) The Named Resident (NR) was left in feces for six plus hours.
2) The Assisted Living Facility (ALF) left the NR sitting on and standing in their own urine multiple times.
3) The NR was not taken to the dining room until an hour after.
4) The NR was tested and diagnosed for [redacted].
5) The management was ignoring a request for NR's care plan change.

Investigation Methods:

Sample:	Total residents: 89 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents, environment, staff to resident interaction.
Interviews:	Residents, Collateral contact, Executive Director, Director of Nursing, Medication Technician, Caregiver.
Record Reviews:	Residents' records. Abuse and neglect policy and procedure

Investigation Summary:

1) The NR was cognitively impaired and unable to make their needs known. Interview indicated that the NR had a bowel incontinence and was left in feces while lying in bed for approximately six hours. The staff stated that they were aware that the NR had a bowel incontinence and had asked another staff to attend to the NR but was ignored. The staff was unable to provide the other staff's name. The staff stated that the NR had feces all over them and on the floor and toilet. The ALF did an investigation and the NS was reprimanded Failed practice was identified. A citation was written for noncompliance with Washington Administrative Code 388-78A-2660 Resident rights.
2) The staff stated that they have been offering every 2-hour toileting. The staff stated that the NR would occasionally refuse to be toileted. It was unknown on how long the NR was left on wet brief and on how long the NR was standing on their own urine. The ALF did an investigation, additional training was provided to staff. Failed practice was identified. A citation was written for noncompliance with Washington

Administrative Code 388-78A-2660 Resident rights.
3) The staff stated that lunch is at 1:00 PM and they always made sure residents were taken to meals. No failed practice was identified.
4) The staff stated that the NR was taken by their family to the doctor and was tested for bladder infection due to behavior issues. The staff stated that the NR was prescribed an antibiotic. The staff stated that they encouraged the NR to increase their fluid intake during meals. No failed practice was identified.
5) The ALF denied ignoring request for NR care changes. The ALF stated that normally a care conference was warranted to update the care plan. The ALF stated the NR's care plan was updated during the care conference with the NR's family. Review of the recent care plan showed toileting supervision and monitoring was updated as requested by the NR’s family to address the NR's changing needs. 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 #: 52788
Intake ID: 162690
Investigator: Helen Fisher
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 01/09/2025 through 02/14/2025
Complainant Contact Date(s): 01/13/2025, 02/05/2025

Allegation(s):

1) The Named Resident (NR) went missing and was found in another resident's room.
2) The NR wandered out the memory care unit through the locked door.
3) The ALF was leaving the NR completely soaked in urine for hours.
4) The Named Resident (NR) was completely covered for at least six hours.
5) Request for additional services was ignored by the ALF.

Investigation Methods:

Sample:	Total residents: 89 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents, environment, staff to resident interaction.
Interviews:	Residents, Collateral contact, Executive Director, Director of Nursing, Medication Technician, Caregiver.
Record Reviews:	Residents' records. Abuse and neglect policy and procedure

Investigation Summary:

1) The NR was cognitively impaired. The staff stated that the NR wandered in the memory care unit and into another residents' room. The staff stated that since residents' doors were not locked, we often found the NR inside other residents' room. The staff stated that they redirected the NR without a problem. The staff stated the NR was adjusting to a new environment. No failed practice was identified.
2) The staff responded when exit door alarm was set off and found the NR at the second floor. The staff stated that the NR was unharmed and agreeable to return to the unit. The ALF stated that the exit doors when pushed it would open and alarmed for 15 seconds until it was reset by staff. The staff stated that after that event the NR's care plan was updated. No failed practice was identified.
3) The staff stated that they have been offering every 2-hour toileting. The staff stated that the NR would occasionally refuse to be toileted. It was unknown on how long the NR was left on wet brief and on how long the NR was standing on their own urine. The ED stated that they did an investigation as they became aware of the

event and retrained staff. Failed practice was identified. A citation was written for noncompliance with Washington Administrative Code 388-78A-2660 Resident rights.
4) Interview indicated that the NR had urine and bowel incontinence and was left covered in feces for approximately five hours. The staff stated that they were aware that the NR had a bowel incontinence and had asked another staff to attend to the NR but was ignored. The staff stated that the NR had feces all over them and on the floor and toilet. The ALF did an investigation and the NS was reprimanded. Failed practice identified. A citation was written for noncompliance with Washington Administrative Code 388-78A-2660 Resident rights.
5) The ALF denied ignoring request for NR care changes. The ALF stated that normally a care conference was warranted to update the care plan. Review of the care plan showed toileting supervision and monitoring was updated during the care conference between the ALF and the NR's family to address the NR's changing needs. 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 01/09/2025 of:

Lynden Manor
905 Aaron Dr
Lynden, WA 98264

This document references the following complaint number(s): 162136, 162370, 162690

The following sample was selected for review during the unannounced on-site visit: 3 of 89 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

Statement of Deficiencies	License #: 2641	Compliance Determination # 52788
Plan of Correction	Lynden Manor	Completion Date
Page 2 of 3	Licensee: Lynden ALC LLC	02/14/2025

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

02/24/2025
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.

Hollander
Administrator (or Representative)

2/25/25
Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to promote care to 1 of 3 residents (Residents 1) in a manner and in an environment that enhances Resident 1's dignity and respect when Resident 1 was left for at least four and a half hours covered in feces. These failures resulted in Resident 1 being unclean and placed Resident 1 at risk for unmet care needs and a diminished quality of life.

Findings included...

RCW 70.129.140 Quality of life—Rights. (1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

Resident 1

An undated face sheet showed Resident 1 was admitted to the ALF on [redacted]/2024 with multiple diagnoses including [redacted] and [redacted].

A Negotiated Service Agreement (NSA) dated 08/26/2024 showed Resident 1 was incontinent of urine and bowel and needed to receive assistance. The NSA showed the desired outcome was for Resident 1 to remained clean, dry, and odor free.

On 01/07/2025 at 4:34 PM, Collateral Contact (CC1) stated that on 01/06/2025 at approximately 12:00 PM, they found Resident 1 soaked in urine, covered with feces while lying in bed, and the floor all the way to the bathroom had tracts of feces. CC1 stated that Resident 1 had a bowel accident at around 7:00 AM. CC1 stated that Resident 1 was not cleaned from 7:00 AM until 12:00 PM.

In an interview on 01/09/2025 at 10:30 AM, Staff A, Medication Technician, stated that on 01/06/2025 they arrived at 7:30 AM, went to give Resident 1 their medications and found them in bed with feces all over, and noticed feces on the floor to the bathroom. Staff A stated they got busy and forgot to return to Resident 1's room until a family member came in.

In an interview on 01/10/2025 at 1:54 PM, Collateral Contact (CC2) stated that on 01/01/2025 at approximately 12:30 PM, they found Resident 1 standing in their urine in the bathroom with all wet clothes off. CC2 was unsure when they were last checked by the staff. CC2 stated that on 01/02/2025 at lunchtime, Resident 1 was also found sitting on the seat of their walker soaked with urine.

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) 3/31/25.

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

Administrator (or Representative) S Hollander Date 2/25/25