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

06/23/2025

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) 61199 (Completion Date 06/23/2025) and 56787 (Completion Date 04/28/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/23/2025 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 #: 56787
Intake ID: 169050
Investigator: Helen Fisher
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 03/24/2025 through 04/28/2025
Complainant Contact Date(s):

Allegation(s):
The Named Resident (NR) left the Assisted Living Facility (ALF's) memory care unit undetected.

Investigation Methods:

Sample:	Total residents: 86 Resident sample size: 5 Closed records sample size:
Observations:	NR, Environment.
Interviews:	NR, Collateral contact, Staff.
Record Reviews:	NR's care plan, incident investigation and preventative measures.

Investigation Summary:
Review of the nursing records showed the NR went missing through the bed room widow undetected. Interviews with staff showed the NR was found 1.1 miles from the ALF. The incident was the NR's second time leaving the ALF through the window. Failed practice was identified. WAC 388-78A- 2371 Investigation.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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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 03/24/2025 of:

Lynden Manor
905 Aaron Dr
Lynden, WA 98264

This document references the following complaint number(s): 169050, 171872, 171918, 172533

The following sample was selected for review during the unannounced on-site visit: 5 of 86 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-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 1 of 3 residents (Resident 1) from leaving the secured memory care unit unsupervised. This failure resulted in Resident 1 leaving the building without detection, walking 1.1 miles away from the ALF 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.

An undated face sheet showed Resident 1 was admitted into the ALF's memory care unit on [redacted]/2016 with multiple diagnoses including [redacted]

A negotiated service agreement dated 12/20/2024 showed Resident 1 had an exit seeking and wandering behavior that required redirection. ALF's preventative measures were to check and monitor the latch in Resident 1's room to assure the window was secured.

Review of the investigation dated 02/26/2025 at 10:52 AM showed Resident 1 removed the screen, window's latch and exited through the window.

Review of incident report dated 02/26/2025 showed that Resident 1 had exit seeking behavior since 6:00 AM that morning. Resident 1 was seen walking near the middle school about 1.1 mile away from the ALF by a staff member who informed their supervisor Staff A (Executive Director).

Review of the previous elopement incidents showed Resident 1 had previously left the ALF through the window on 12/15/2023.

In an interview on 03/24/2025 at 11:20 AM, Staff A, Executive Director, stated that on 02/26/2025 they received a call from a staff member that Resident 1 was found walking near the middle school. Staff A stated that they investigated the incident and they instructed the maintenance staff to replace the broken window opening restrictor and placed a window alarm.

In an interview on 03/24/2025 at 1:10 PM, Staff B, Resident Care Coordinator, stated that Resident 1 had been actively exit seeking to try to find their wife and dog the morning before they were found.

In an interview on 04/25/2025 at 12:21 PM, Collateral Contact (CC) stated that they were concerned that there were not enough staff to check on residents who were trying to leave the ALF.

Review of the previous elopement incident showed that Resident 1 left the ALF undetected two times, first was on 12/15/2023 when they left the ALF through the window and the second time was on 04/29/2024 when they followed a visitor out and was found law enforcement a few streets over.

Review of prior interventions in preventing elopement reoccurrences were ineffective.
- On 04/29/2024 a new signage was made at the doorway for visitors to watch that a resident would not follow them out.
- On 12/15/2023 the maintenance added a clip on the window to limit the opening.

This is a reoccurring deficiency previously cited on 09/26/2024.

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