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

07/29/2025

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) 63048 (Completion Date 07/29/2025) and 58785 (Completion Date 06/09/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/29/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
**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 :

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 A
Residential Care Services

# Residential Care Services
## Investigation Summary Report

**Provider/Facility:** Lynden Manor
**Provider Type:** Assisted Living Facility
**License/Cert.#:** 2641
**Compliance Determination #:** 58785
**Intake ID:** 176053
**Investigator:** Helen Fisher
**Region/Unit #:** RCS Region 2 / Unit A
**Investigation Date(s):** 04/30/2025 through 06/09/2025
**Complainant Contact Date(s):** 04/29/2025

**Allegation(s):**

1. The Assisted Living Facility (ALF's) had made medication errors every month for at least minimum of 17 insulin medication errors since the NR's admission.
2. The ALF had been given the NR's medication whole though the doctor ordered to crush in multiple occasions.
3. The ALF accused the NR as "drunk" from drinking two bottles of wine daily.
4. The NR's insulin was kept in the NR's refrigerator, so the NR had access.
5. The NR's bathroom was always dirty, and the shower chair had feces from December 2024 to April 19th, 2025.
6. The NR's last shower at the facility was December 2024.
7. The NR had a fall at the facility on 01/21/2025 resulting in a broken hip.
8. The NR had another fall after returning from the hospital when a staff member came to the NR's room to get the laundry and scared the NR and fell backwards.
9. The doctor's request for weekly vitals to be faxed to his office was not followed.
10. The NR did not receive shower assistance as per doctor's request.
11. The NR was left alone during meal though the doctor ordered to be monitored due to the NR's choking risk. The NR's family found dinner plates in NR's room from the night before.
12. The NR was sent out to the hospital in a T-shirt and a brief, no slippers or socks in three occasions when the temperature was thirty-four degrees outside.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 89<br>Resident sample size: 3<br>Closed records sample size: 1 |
| **Observations:** | Residents, Environment, Equipment. |
| **Interviews:** | Collateral Contact, Nursing Staff, Direct Care Staff |
| **Record Reviews:** | Resident's records.<br>Shower Log<br>Incident Report & Investigation |

**Investigation Summary:**

1) Review of the medication administration records showed that the NR's blood sugar was not check before administration of the insulin at 4:30 in the evening for 17 days. Failed practice was identified. A citation was written for non-compliance with WAC 388-78A-2210 Medication services.
2) Interviews indicated the nursing staff had been crushing the NR's medication aside from three medications that were not crushable.
3) The ALF staff stated that the NR was consuming alcohol in their apartment when they were residing at the assisted side approximately almost two years ago.
4) Interviews indicated that the NR had access to the insulin when living at the assisted side was addressed by the ALF in April 2024. The ALF instructed the nursing staff to remove and store the insulin in the nurses station.
5) The NR's and three other residents' bathrooms were clean and had no smear of feces were observed during the unannounced onsite visit at the ALF.
6) Review of the shower log showed the NR was assisted to the shower on January 13, 2025.
7) & 8) Review of the investigative records showed that on 01/21/2025 the NR had a witnessed fall. The NR fell backwards while having a conversation with the staff. Interviews indicated that the staff was collecting the NR's clothes to wash when the NR fell backward. Abuse and neglect were ruled out. The NR's fall was reported to Complaint Resolution Unit (CRU) and investigated by the department with no failed practice.
9) Review of the doctor's order dated [redacted]/2025 showed that the doctor requested to send 2 weeks' worth of blood sugar readings, vital signs and weights on Fridays. The NR was out of the ALF since [redacted]/2025 two days after the order was received by the facility. No failed practice was identified.
10) Interviews indicated that the NR had been receiving staff assistance during showers. The NR was lacking safety awareness and would occasionally shower without asking for assistance. Review of the care plan showed the NR required assistance to complete bathing task. No failed practice was identified.
11) Interviews of the direct care staff showed that there were times the NR refused to eat at the dining room. The NR was served in the room with supervision. No failed practice was identified.
12) The staff stated that the NR appeared comfortable when they were transported by Emergency Services (ES). The NR was wearing a long sleeping shirt for bed. The staff was instructed by the ES to not move the NR for safety. No failed practice was identified.

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**Conclusion / Action:**

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

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| | | |
|---|---|---|
| Statement of Deficiencies | License #: 2641 | Compliance Determination # 58785 |
| Plan of Correction | Lynden Manor | Completion Date |
| Page 1 of 4 | Licensee: Lynden ALC LLC | 06/09/2025 |

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 04/30/2025 of:

Lynden Manor
905 Aaron Dr
Lynden, WA 98264

This document references the following complaint number(s): 175698, 175703, 176053

The following sample was selected for review during the unannounced on-site visit: 3 of 89 current residents and 1 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 # 58785 |
|---|---|---|
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| Page 2 of 4 | Licensee: Lynden ALC LLC | 06/09/2025 |

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

06/12/2025
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.

[redacted]
Administrator (or Representative)

6/16/25
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 injectable medications for diabetes (insulin) without checking the blood sugar level and placed Resident 1 at risk for medical complications.

Findings included...

Resident 1

An undated face sheet showed Resident 1 was admitted to the Assisted Living Facility (ALF) on [redacted]/2023 with multiple diagnoses including [redacted] ([redacted]) and [redacted] ([redacted]).

A negotiated service agreement dated 01/20/2025 showed Resident 1 was to receive assistance with medication administration.

The physician's order dated 11/27/2024 showed Resident 1 was to receive:
Humalog 100 units/ml (milliliter) Kwik pen, inject 10 units subcutaneously two times a day at 7:00 AM and 4:30 PM. Hold for blood sugar lower than 100 related to Type 2 Diabetes Mellitus with hyperglycemia.

Review of the medication administration records (MAR) for January 2025 showed Resident 1 had a medication listed as:
Humalog 100 units/ml (milliliter) Kwik pen, inject 10 units subcutaneously two times a day at 7:00 AM and 4:30 PM. Hold for blood sugar lower than 100 related to Type 2 Diabetes Mellitus with hyperglycemia. The January MAR showed insulin was administered at 4:30 PM without blood sugar level recorded between January 1 & January 17, 2025, a total of 17 days.

Interview on 04/30/2025 at 1:43 PM, Staff A, Resident Care Coordinator, stated that they were unaware of the medication error committed on Resident 1 before they left the ALF. Staff A stated that they were checking Resident 1's blood sugar in the morning and before lunch but unsure on evenings. Staff A stated that if the blood sugar was not written on the MAR they were not done.

Interview on 04/30/2025 at 3:01 PM, Staff B, Med Tech, stated that they did not recall checking Resident 1's blood sugar prior to administering insulin before dinner at 4:30 PM on January 5, 2025.

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

This is a recurring deficiency previously cited on 05/20/2024.

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| Page 4 of 4 | Licensee: Lynden ALC LLC | 06/09/2025 |

**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) 7/23/25 .

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

Administrator (or Representative) [signature] Date 6/16/25