STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

08/25/2025

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) 64402 (Completion Date 08/25/2025) and 60045 (Completion Date 07/07/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/25/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(b) Chapter 18.88A RCW, Nursing assistants;

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

If you have any questions, please contact me at (253)312-1446.

Sincerely,
Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Lynden Manor
Provider Type: Assisted Living Facility
License/Cert.#: 2641
Compliance Determination #: 60045
Intake ID: 179331
Investigator: Helen Fisher
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 05/23/2025 through 07/07/2025
Complainant Contact Date(s):

Allegation(s):

The Director of Nursing was handling medications to the undelegated staff to give to the residents.

Investigation Methods:

Sample:	Total residents: 82 Resident sample size: 5 Closed records sample size:
Observations:	Environment.
Interviews:	Executive Director (ED)
Record Reviews:	N/A

Investigation Summary:

Interviews indicated that medications including insulin injections were handed over by the facility's nurse to the non-delegated staff to administer to the resident. The DNS confirmed that they were handing medication including insulin to non delegated staff to administer. Failed practice was identified. A citation was written for noncompliance with WAC 388-78A-2320 Intermittent nursing services system.

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 #: 60045
Intake ID: 179703
Investigator: Helen Fisher
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 05/23/2025 through 07/07/2025
Complainant Contact Date(s):

Allegation(s):

1) Medications were kept in the Named Staff 1 (NS1's) office to be used for other residents later. Medications were left by the residents who moved out.
2) Medications were left on the cart and the nurse's station unattended and accessible by staff and residents.
3) Medications were handed to the non-delegated staff to give to residents.
4) Three Named Residents (NR1, NR2 & NR3's) medications were placed on hold without an order.
5) Many medications were not available and medication errors.
6) NS1 did not like people with different ethnicities and wrongfully terminated staff. NS1 fired the Unnamed Staff (US) for not carrying a pager.
7) The med techs were asked to administer medications without an order.

Investigation Methods:

Sample:	Total residents: 82 Resident sample size: 5 Closed records sample size:
Observations:	Medication pass, medication storage. Residents, Environment.
Interviews:	Nursing staff. Residents. Collateral Contacts. Other not associated with the facility.
Record Reviews:	Residents' records, nurse delegation policy and procedures. Medication services policy and procedures.

Investigation Summary:

1) Interviews indicated that the medications being kept at NS1's office were to be destroyed and not for other residents' use. The leftover medications belonging to former residents were destroyed as per ALF's procedures. No failed practice was identified.
2) Medications were locked in the medication cart were observed during unannounced onsite visit at the Assisted Living Facility (ALF). The nursing staff denied seeing medications outside to the medication cart unattended. No failed

practice was identified.
3) Interviews indicated that medications including insulin injections were handed over by the facility's nurse to the non-delegated staff to administer to the resident. Failed practice was identified. A citation was written for noncompliance with WAC 388-78A-2320 Intermittent nursing services system.
4) The nursing staff indicated that they tried to place medication on hold when the medication had not arrived for 1 day. The practice was reversed the following day. No failed practice was identified.
5) According to the nursing staff the medications that were not available were new orders waiting to be filled and delivered by the pharmacy. Review of the sampled residents' medication administration records showed no medication discrepancies found. No failed practice was identified.
6) Employees were terminated due to noncompliance of the ALF policy and procedures. NS1 denied the report that they wrongfully terminated staff. No failed practice was identified.
7) Three med techs denied being asked to administer medications without an order. 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

Statement of Deficiencies	License #: 2641	Compliance Determination # 60045
Plan of Correction	Lynden Manor	Completion Date
Page 1 of 3	Licensee: Lynden ALC LLC	07/07/2025

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 05/23/2025 of:

Lynden Manor
905 Aaron Dr
Lynden, WA 98264

This document references the following complaint number(s): 179331, 179703

The following sample was selected for review during the unannounced on-site visit: 5 of 82 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 # 60045
Plan of Correction	Lynden Manor	Completion Date
Page 2 of 3	Licensee: Lynden ALC LLC	07/07/2025

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

07/07/2025
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.

Administrator (or Representative)

7/14/25
Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(b) Chapter 18.88A RCW, Nursing assistants;

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to ensure 1 of 1 staff (Staff A) was delegated to administer insulin injections. This failure resulted in residents being administered insulin injections without nursing oversight and placed all residents at risk for medication errors.

Findings included...

Reference:
WAC 246-840-930 The Nurse Delegation Program, under Washington State law, allows nursing assistants working in certain settings to perform certain tasks - such as administration of prescription medications including insulin injections - normally performed only by licensed nurses. A Registered Nurse (RN) must instruct the nursing

assistant regarding proper injection procedures and the use of insulin, demonstrate proper injection procedures, and must supervise and evaluate performance including return demonstration during the first four weeks of delegation of insulin injections and at least every ninety days thereafter. (8) Verify that the nursing assistant or home care aide: (a) Is currently registered or certified as a nursing assistant or home care aide in Washington state without restriction;(b) has completed both the basic caregiver training and core delegation training before performing any delegated task.

Review of the delegation log (undated) showed Staff A (caregiver) was not delegated to perform delegated tasks at the ALF.

In an interview on 05/23/2025 at 2:11 PM, Staff A stated that they previously completed delegation training and had a certificate dated 3/19/2011 and on 05/05/2012. Staff A stated that they were not assessed for medication administration tasks or delegated to administer insulin injections by the ALF's Nurse Delegator. Staff A stated that medications that included insulin would be handed to them for administration by Staff B (Director of Nursing- License Practical Nurse).

In an interview on 05/23/2025 at 2:32 PM, Staff B stated that they prepared the medications included insulin and handed them to Staff A to administer. Staff B stated that Staff A administered medications due to the ALF being short of medication technicians. Staff B stated that they worked on the first floor on 05/22/2025 and had Staff A help the medication pass on the second floor. Staff B stated that Staff A was the only undelegated staff that helped with the medications pass.

In an interview on 07/07/2025 at 2:45 PM, Staff C, Registered Nurse Delegator, stated that they were not aware that Staff A administered insulin injections to residents.

This is a recurrent deficiency previously cited on 04/20/2023.

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) 8/19/25.

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

Administrator (or Representative) Holander Date 7/14/25