STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Lynden ALC LLC
Lynden Manor
905 Aaron Dr
Lynden, WA 98264

RE: Lynden Manor License # 2641

Dear Administrator:

This letter addresses Compliance Determination(s) 72257 (Completion Date 02/12/2026) and 69718 (Completion Date 12/18/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/12/2026 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210-1-b, WAC 388-78A-2210-2-a, WAC 388-78A-2210-1, WAC 388-78A-2210-2

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

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 follow-up on 12/09/2025 of:

Lynden Manor
905 Aaron Dr
Lynden, WA 98264

This document references the following SOD dated: 12/18/2025

The following sample was selected for review during the unannounced on-site visit: 6 of 86 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Helen Fisher, Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(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 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to ensure 1 of 6 residents (Resident 4) received medication as prescribed by the physician. This failure resulted in Resident 4 missing an insulin dose and receiving twelve medications that belonged to another resident.

Findings included…

Record Review of an undated face sheet showed the ALF admitted Resident 4 on [redacted]/2025 with multiple diagnoses including [redacted] and [redacted].

Record review of a Negotiated Service Agreement, dated 11/09/2025, showed Resident 4 was to receive assistance with medication administration.

Record review of Physician Orders, dated 09/04/2025, showed Resident 4 was to receive a sliding scale dose of Humalog (Lispro) insulin (a medication used to lower blood sugar) based on their blood sugar level at bedtime.

Review of Resident 4's Medication Administration Record (MAR) dated 11/27/2025 at 8:00 PM, showed Resident 4's blood sugar was unchecked, and their Humalog insulin injection was not given to Resident 4.

Record review found no documentation as to why Resident 4's blood sugar was not checked and insulin was not given on 11/27/2025.

Review of a Progress Note (PN), dated 11/28/2025 at 7:23 AM, showed that Resident 4 received the following medications that belonged to another resident in error: celecoxib 50 mg (milligram) for pain and inflammation, duloxetine HCL (hydrochloride) 60 mg for depression, ferrous sulfate 325 mg for iron supplement, lisinopril 5 mg for high blood pressure, magnesium oxide 400 mg for dietary supplement, metformin HCL 500 mg for Type 2 diabetes, metoprolol 50 mg for high blood pressure, potassium chloride ER (extended-release) 10 MEQ (milliequivalent) for low potassium, vitamin D3 1,000 unit for supplement, pregabalin 50 mg for nerve pain and pramipexole 0.125 mg for restless legs syndrome.

Review of a PN, dated 11/28/2025 at 5:49 PM, showed Resident 4 was complaining of nausea, sleepiness and had refused a meal.

Interview, on 12/09/2025 at 2:19 PM, Staff A (Executive Director) stated that the two Medication Technicians (MT) had not followed the medication services policies. Staff A stated that one MTs was dispensing medications, while the second MT was delivering those dispensed medications. This resulted in Resident 4 receiving medications belonging to another resident.

This was an uncorrected previously cited on 10/06/2025 and a recurring deficiency previously cited on 04/20/2023, 05/02/2024, 06/20/2024, and 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)_____ .

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

_____ _____

Administrator (or Representative) Date

Residential Care Services
Investigation Summary Report

Provider/Facility: Lynden Manor
Provider Type: Assisted Living Facility
License/Cert.#: 2641
Compliance Determination #: 66299
Intake ID: 196304
Investigator: Helen Fisher
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 09/30/2025 through 10/06/2025
Complainant Contact Date(s):

Allegation(s):

1) The Named Resident (NR) international normalized ratio (INR) test was low.
2) The NR missed fourteen doses of warfarin 2.5 mg (milligram) (blood thinner) medication.

Investigation Methods:

Sample:	Total residents: 86 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents. Environment. Medication storage, Medication pass.
Interviews:	Executive Director (ED), Nursing Staff, Residents, Collateral Contact.
Record Reviews:	Resident's care plan, progress notes, medication administration records (MAR). ALF's medication management and assistance policy and procedures. Incident investigation.

Investigation Summary:

1) & 2) Interviews indicated that the NR missed fourteen doses of their blood thinner medication 2.5 mg dose resulted in low INR test result. The ED stated that the Resident 1's warfarin was mistakenly discontinued and was blocked out on the MAR for 14 days. Failed practice was identified. A citation was written for non compliance with Washington Administrative Code 388-78A-2210 Medication services.

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
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

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 09/30/2025 and 10/06/2025 of:

Lynden Manor
905 Aaron Dr
Lynden, WA 98264

This document references the following complaint number(s): 196304

The following sample was selected for review during the unannounced on-site visit: 3 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 J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

Statement of Deficiencies	License #: 2641	Compliance Determination # 66299
Plan of Correction	Lynden Manor	Completion Date
Page 2 of 4	Licensee: Lynden ALC LLC	10/06/2025

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.

Jamie Singer
Residential Care Services

10/13/2025
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)

10/17/25
Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(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 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

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 a double dose of blood thinning medication, and resulted in a sub-therapeutic lab result when they missed fourteen doses of blood thinning medication placing them at risk for medical complications.

Findings included..,

Review of the website Drugs.com showed warfarin was a blood thinning medication that was used to prevent blood clots. Take warfarin exactly as prescribed by your doctor. When taking warfarin, a frequent blood test called an international normalized ratio (INR) is conducted frequently to determine the dosage of warfarin. An INR test measures how well blood is able to clot and is particularly important for individuals taking medications such as warfarin.

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-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(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 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

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 a double dose of blood thinning medication, and resulted in a sub-therapeutic lab result when they missed fourteen doses of blood thinning medication placing them at risk for medical complications.

Findings included…

Review of the website Drugs.com showed warfarin was a blood thinning medication that was used to prevent blood clots. Take warfarin exactly as prescribed by your doctor. When taking warfarin, a frequent blood test called an international normalized ratio (INR) is conducted frequently to determine the dosage of warfarin. An INR test measures how well blood is able to clot and is particularly important for individuals taking medications such as warfarin.

Record Review of an undated face sheet showed the ALF admitted Resident 1 on [redacted] 2025 with multiple diagnoses including [redacted] and [redacted].

Record review of a Negotiated Service Agreement, dated 07/24/2025, showed Resident 1 was to receive assistance with medication administration.

Record review of Physician Orders, dated 09/04/2025, showed Resident 1 was to receive:
-Warfarin 2.5 mg (milligram) one tablet during the day on Mondays, Wednesdays, Thursdays, Saturdays and Sundays, 5 days a week.
-Warfarin 3.75 mg (one 2.5 mg and a half tablet) every Tuesdays and Fridays.

Review of Resident 1's Medication Administration Record (MAR) dated 09/01/2025 to 09/30/2025, showed the ALF incorrectly transcribed the warfarin order as: warfarin 2.5 mg one tablet during the day on Mondays, Wednesdays, Thursdays, Fridays, Saturdays and Sundays, 6 days a week.

Review of the MAR showed Resident 1 received both a 2.5mg and 3.75 mg dose on 09/05/2025. The MAR showed the 2.5 dose of warfarin was crossed out, indicating it was discontinued, on 09/06/2025 without a physician's order. Resident 1 did not receive warfarin from 09/06/2025 through 09/08/2025, on 09/10/2025, 09/11/2025, from 09/13/2025 through 09/15/2025, on 09/17/2025, 09/18/2025, from 09/20/2025 through 09/22/2024, and on 09/24/2025. Resident 1 missed a total of fourteen 2.5mg doses of warfarin.

Record review of an INR result, taken on 09/25/2025, showed Resident 1's result to be 1.0. The lab results stated a therapeutic INR goal was 2.0 to 3.0. Resident 1's INR was below therapeutic levels.

Interview, on 09/30/2025/2025 at 01:13 PM, Staff A (Executive Director) stated that they were unaware of the medication error until Resident 1 received their below therapeutic INR results. Staff A stated that they did an investigation and found out that Resident 1's 2.5 mg dose of warfarin was discontinued by error.

Interview, on 10/02/2025 at 1:16 PM, Staff B (Wellness Director) stated that they did not know that they made an error in transcribing the physician order, or discontinued the order in error, until they were told by Staff A.

This was a recurring deficiency previously cited on 04/20/2023,

Statement of Deficiencies	License #: 2641	Compliance Determination # 66299
Plan of Correction	Lynden Manor	Completion Date
Page 4 of 4	Licensee: Lynden ALC LLC	10/06/2025

05/02/2024, 06/20/2024, and 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) 11/18/25.

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

Administrator (or Representative) — Date: 10/17/25

05/02/2024, 06/20/2024, and 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)_____ .

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

_____ _____

Administrator (or Representative) Date