STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Grandview WA Management LLC
The Orchards at Grandview
2001 W 5th St
Grandview, WA 98930

RE: The Orchards at Grandview License # 2503

Dear Administrator:

This letter addresses Compliance Determination(s) 71459 (Completion Date 01/15/2026) and 68992 (Completion Date 12/18/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/15/2026 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-2640-1-a, WAC 388-78A-2640-1-b

The Department staff who did the on-site verification:
Melissa Milanez, Community Complaint Investigator

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, ALF Field Manager
Region 1, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: The Orchards at Grandview **Provider Type:** Assisted Living Facility

License/Cert.#: 2503
Intake ID: 201403
Compliance Determination #: 68992
Region/Unit #: RCS Region 1 / Unit G
Investigator: Melissa Milanez
Investigation Date(s): 11/19/2025 through 12/18/2025
Complainant Contact Date(s):

Allegation(s):
A resident had a fall with injury.

Investigation Methods:

Sample:	Total residents: 52 Resident sample size: 7 Closed records sample size:
Observations:	Residents Activities Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Family members
Record Reviews:	State reporting log Incident investigation Facility policies Staff training records Staff patterns

Investigation Summary:
Interview with the Administrator showed that staff had not notified the residents representative when the resident was sent to the hospital following a fall that resulted in a fractured hip. Record review of the incident investigation report failed to show documentation of the notification to the resident representative. Deficient practice identified and the facility was cited for WAC 388-78A-2640 (1)(a)(b).

Conclusion / Action:

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

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1200 Alder Street, Union Gap, WA 98903

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 11/19/2025 of:

The Orchards at Grandview
2001 W 5th St
Grandview, WA 98930

This document references the following complaint number(s): 201139, 201403

The following sample was selected for review during the unannounced on-site visit: 7 of 52 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Melissa Milanez, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

Statement of Deficiencies	License # 2503	Compliance Determination # 68992
Plan of Correction	The Orchards at Grandview	Completion Date
Page 2 of 4	Licensee: Grandview WA Management LLC	12/18/2025

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.

Laura Williams-Davis
Residential Care Services

12/30/2025
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)

12/30/2025
Date

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(b) The resident is relocated to a hospital or other health care facility; or

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to notify the resident's family member when resident had gone to the local hospital/emergency room (ER) for evaluation and treatment for 1 of 1 resident (Resident 1). This failed practice limited the representative's ability to participate in timely decision making, resident support, and advocacy related to the residents' care and treatment.

Findings included...

Record review of the ALF's policy titled, "Fall Procedure", undated, showed that if a transfer to the hospital has taken place, the care staff will contact the facility nurse, the resident's physician and responsible party.

Record review of Resident 4's Negotiated Service Agreement (NSA) undated, showed that they had a diagnosis of [redacted].

Record review of Resident 1's progress notes, dated [redacted]2025, showed that the resident had a fall in the dining room at 4:30 AM, and had complained of leg pain.

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-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(b) The resident is relocated to a hospital or other health care facility; or

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to notify the resident's family member when resident had gone to the local hospital/emergency room (ER) for evaluation and treatment for 1 of 1 resident (Resident 1). This failed practice limited the representative's ability to participate in timely decision making, resident support, and advocacy related to the residents' care and treatment.

Findings included…

Record review of the ALF's policy titled, "Fall Procedure", undated, showed that if a transfer to the hospital has taken place, the care staff will contact the facility nurse, the resident's physician and responsible party.

Record review of Resident 4's Negotiated Service Agreement (NSA), undated, showed that they had a diagnosis of [redacted].

Record review of Resident 1's progress notes, dated [redacted]/2025, showed that the resident had a fall in the dining room at 4:30 AM, and had complained of leg pain.

Emergency medical services were called, and the resident was taken to the hospital.

Record review of Resident 1's Incident investigation report, dated [redacted]/2025, showed that the resident was admitted to the hospital for a fractured hip.

Record review of Resident 1's Incident report, dated [redacted]/2025, showed documented dates and times of notifications made to the Administrator, nurse, and physician following a fall and emergency room transfer; however, the family notification section listed the resident's representatives name with no documented date, time, or method of contact.

In an interview on 12/11/2025 at 3:28 PM, Collateral Contact 1 (CC1), Resident Representative, stated that they had not been notified by the facility that Resident 1 had experienced a fall and had been sent to the hospital. Additionally, they stated that it was around 11:30 AM on [redacted]/2025 (7 hours later) that they had received a phone call from the hospital requesting information. It was during that call; the hospital nurse informed them that their mother was in the hospital due to a fall and had sustained a fractured hip which required surgery. They stated they were upset to learn that their mother had been at the hospital without family present, as they were confused and had Dementia. CC1 stated they were concerned about their ability to communicate their needs and advocate for themselves while alone in the hospital. Additionally, CC1 stated that later on that day they had spoken with someone at the facility and was told that the reason why they had not been notified was due to the night shift staff member not knowing the notification process.

In an interview on 12/11/2025 at 3:58 PM, Staff A, Administrator, stated that it was the facility's policy to notify family when a resident is sent to the hospital and that they were not sure why this did not occur in this case.

Statement of Deficiencies	License # 2503	Compliance Determination # 68952
Plan of Correction	The Orchards at Grandview	Completion Date
Page 4 of 4	Licensee: Grandview WA Management LLC	12/18/2025

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, The Orchards at Grandview is or will be in compliance with this law and / or regulation on (Date) 12/30/25

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

Administrator (or Representative) — Date: 12/30/25

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, The Orchards at Grandview 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