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

09/23/2025

Grandview Assited Living LLC
Magnolia Assisted Living
912 Hillcrest St
Grandview, WA 98930

RE: Magnolia Assisted Living # 2750

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 65686 (Completion Date 09/23/2025) and 62056 (Completion Date 08/04/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/23/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

(2) Within reasonable facility rules designed to protect the rights and quality of life of residents, the resident has the right to:

(a) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;

(5) A resident has the right to:

(a) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

(6) Reasonably accommodate residents consistent with applicable state and/or federal

law; and

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 :

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

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: Magnolia Assisted Living
Provider Type: Assisted Living Facility

License/Cert.#: 2750
Intake ID: 182110
Compliance Determination #: 62056
Region/Unit #: RCS Region 1 / Unit G
Investigator: Melissa Milanez
Investigation Date(s): 07/03/2025 through 08/04/2025
Complainant Contact Date(s): 08/05/2025

Allegation(s):

1. Identified resident with medication concerns.
2. Identified resident is not allowed to walk the hallways without assistance.

Investigation Methods:

Sample:	Total residents: 52 Resident sample size: 3 Closed records sample size:
Observations:	Identified resident Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents
Record Reviews:	Characteristic roster Resident records Medication Administration Records (MARS) Physican orders State reporting log Incident investigation Facility policies Staff patterns

Investigation Summary:

1. The Identified resident stated that the facility assisted them with their medications. The facility staff interview confirmed the resident had missed several dosages of prescribed medications due to not being available. Record review of facility Medication Administration Records showed the facility administered all of the resident's medications. Record review of the Negotiated service agreement failed

to show the current needs of the resident's medication management. Failed practice identified. See Statement of Deficiency dated 08/04/2025 under Washington Administrative Code 388-78A-2210 Medication services and WAC 388-78A-2130 Service agreement planning.

2. The identified resident stated that they are independent with walking and use a 4WW for mobility. They stated that when moving into the facility they were not allowed to bring any personal items from home due to having bed bugs. The facility provided them with a cane for a short amount of time while their new walker was being ordered. The resident stated it was difficult for them to walk in the hallways with the cane and would need to hold onto the handrails for safety. A 4WW was observed in the resident's room. Other sampled resident interviews showed that they felt safe, staff talk to them in a respectful manner and are allowed to move freely within the facility with no concerns. No failed practice identified.

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: Magnolia Assisted Living
Provider Type: Assisted Living Facility

License/Cert.#: 2750
Intake ID: 182047
Compliance Determination #: 62056
Region/Unit #: RCS Region 1 / Unit G
Investigator: Melissa Milanez
Investigation Date(s): 07/03/2025 through 08/04/2025
Complainant Contact Date(s): 08/05/2025

Allegation(s):
Identified residents who resided together at the facility were separated.

Investigation Methods:

Sample:	Total residents: 52 Resident sample size: 3 Closed records sample size:
Observations:	Identified resident Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Residents Social services staff Others not associated with the facility
Record Reviews:	Medical records State reporting log Incident investigation Facility policies Staff patterns Characteristic roster Resident records

Investigation Summary:
By separating the residents without appropriate justification or adequate involvement of the resident and their representative, and by imposing inconsistent visitation restrictions, the facility failed to ensure the resident's right to quality of life and personal relationships as required under WAC 388-78A-2660 and RCA 70.129.140. Failed practice 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
1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 2750	Compliance Determination # 62056
Plan of Correction	Magnolia Assisted Living	Completion Date
Page 1 of 14	Licensee: Grandview Assited Living LLC	08/04/2025

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 07/03/2025, 07/15/2025 and 07/17/2025 of:

Magnolia Assisted Living
912 Hillcrest St
Grandview, WA 98930

This document references the following complaint number(s): 182110, 184706, 182047

The following sample was selected for review during the unannounced on-site visit: 3 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 #: 2750	Compliance Determination # 62056
Plan of Correction	Magnolia Assisted Living	Completion Date
Page 2 of 14	Licensee: Grandview Assited Living LLC	08/04/2025

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

08/06/2025
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)

8.6.25
Date

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

(2) Within reasonable facility rules designed to protect the rights and quality of life of residents, the resident has the right to:

(a) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;

(5) A resident has the right to:

(a) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

(6) Reasonably accommodate residents consistent with applicable state and/or federal law; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to protect resident rights for 2 of 9 residents (Resident 1 and 2), when two residents were separated from their shared living arrangement. This failure contributed to a decline in the residents' emotional well-being, increased behavioral outbursts, and reduced overall quality of life, ultimately placing the resident at risk for further psychological and physical decline

during a critical stage of their care.

Findings included...

Per RCW 70.129.140 Quality of life-Rights-(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. (2) Within reasonable facility rules designed to protect the rights and quality of life of residents, the resident has the right to: (a) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; (c) Make choices about aspects of his or her life in the facility that are significant to the resident; (5) A resident has the right to: (a) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered;

Review of the facility's Resident Characteristic Roster, updated on 10/19/2023, showed that Resident 1 and 2 resided in the same apartment; apartment [redacted] and [redacted].

Review of Resident 1's Face Sheet, showed that the resident moved into the facility on [redacted]/2023. Review of the face sheet showed that the resident moved into the facility on [redacted]/2023 and that Resident 1's family member (Resident 1's son) resided in the same apartment with Resident 1 who was their durable power of attorney for finances, health care, and responsibilities. Additionally, the face sheet also showed that Resident 1 had a diagnosis of [redacted] and [redacted].

Review of the room change notifications given to both Resident's 1 and 2, signed and dated on 04/28/2025, stated, "The ALF would be welcoming a new resident to the facility. In order to attempt to maintain your comfort in your personal space, we will be placing you in a semi-private room with a neighbor who enjoys similar activities and needs. The transition to your new area will be performed 3 days from today's date."

Review of Resident 1's Department annual assessment details, dated 11/13/2024, showed that the resident expressed a clear desire to remain living with their family member [Resident 2]. Further review of the assessment showed the following statements:

- My relationships and interests: "My son."
- How to best support me: "Have my son involved. I will not proceed without consulting my son on any decisions."
- My perfect day: "Just being together with my son, being able to talk to each other."
- What's important to me: "To be with my son."
- In the next year, I really want to: "Be in the same place as my son."

Additionally, the care assessment showed that Resident 2 was the emergency contact for Resident 1 and that the resident was co-dependent on their son.

In an interview on 06/10/2025 at 3:47 PM, Staff A, Licensed Practical Nurse (LPN), stated that at the time of Resident 1 and 2's room change, the facility was making several room adjustments to accommodate new admissions. Staff A stated that Resident 1 and Resident 2 were separated to accommodate a new couple that was moving into the facility.

Observation on 07/03/2025 at 1:15 PM, showed Resident 1 laid in bed wearing a shirt and an incontinence brief, with a blanket draped over them. They were observed repeatedly rolling and twisting the blanket between their fingers. Despite multiple attempts to initiate conversation, Resident 1 did not respond to questions being asked.

In an interview on 07/03/2025 at 1:35 PM, Resident 2 stated they had been Resident 1's primary decision-maker since the death of their father in 1992. Resident 2 stated that they had resided in the same room with their loved one (Resident 1) since moving into the facility in the beginning of 2023. Resident 2 stated that they were separated from their loved one at the end of [redacted] 2025. Resident 2 stated that they were concerned about how the recent room change had negatively impacted their loved one's emotional well-being. Resident 2 stated the room change occurred abruptly. They stated they were given a form to sign, and stated, "They never really asked me if I wanted to move." Resident 2 described feeling pressured to agree to the move, explaining that although no threats were made, they got the sense that if they did not comply, there would be negative consequences, such as the risk of being asked to leave the facility. They recalled that Staff H, Administrator, stated that the change would be better for their mother, as that their new roommate would also be receiving hospice services. Resident 2 stated they were confused when they asked hospice staff about the move because the hospice nurse told them that they had nothing to do with the decision to separate Resident 1 and Resident 2. Resident 2 stated that since the move, their loved one had appeared frequently anxious, upset, and agitated; all behaviors that were not present prior to them being separated. Resident 2 stated that staff were now needing to medicate Resident 1 more often to calm them down, which was not necessary before. Resident 2 stated that when they signed Resident 1 up for hospice services, they were told by facility staff that 'nothing would change' and that they would still be allowed to visit and assist with care. Resident 2 stated that after the move, they were informed that they could only visit Resident 1 for 15 minutes following meals. Observation at the time of the interview showed that Resident 2 became emotional during the interview and stated that it was distressing to see Resident 1 so upset and described how each time they visited, Resident 1 would try to hold onto them and state they didn't want them [Resident 2] to leave. Resident 2 stated they would tell Resident 1 about how sorry they were to have to go. Resident 2 stated that it hurt them deeply to witness how this situation had affected Resident 1, and they wished that they could move back in with them to provide the comfort and support Resident 1 needs. Additionally, Resident 2 stated that the facility had never talked to them about interfering with Resident 1's care.

Observation on 07/03/2025 at 1:55 PM, showed Resident 2 entered Resident 1's room and upon entering, Resident 1 immediately reached out their arms and grasped Resident 2's hands. Resident 2 was observed to lean in to embrace Resident 1 and offered a hug and a kiss on the forehead. Observation showed the resident smiled during the interaction. Resident 1 pointed for water and Resident 2 assisted them with drinking and adjusted the head of the bed. Resident 2 stated that their loved one had not slept much, had received multiple medications and was not verbalizing much anymore. Further observation showed that as Resident 2 was left the room, Resident 1 held on tightly to Resident 2's hand and would not let go. Observations also showed that there was no chair in the room for Resident 2 to sit during the visits. When asked where they usually sit, they responded, "I either stand or sit on her walker."

In an interview on 07/03/2025 at 1:18 PM, Staff B, Caregiver, stated that after being off work for a period of time, they returned and noticed that Resident 1 and 2 had been separated. Staff B stated that the change appeared to affect Resident 1, describing them as being more aggressive and that they appeared sad when Resident 2 was not in their room. Staff B also stated that Resident 2 was no longer able to spend extended time in Resident 1's room due to Resident 1's roommate. Staff B explained that Resident 1 frequently became anxious, moved around in bed a lot, played with the call light cord and had even witnessed them wrapping it around their catheter tubing (a flexible hollow tube inserted into the body to drain urine). Staff B stated that if Resident 1 appeared to be in pain, Resident 2 would come out and ask staff for a pain pill. Staff B stated that before the move, Resident 2 would spend most of their time in their room, and that now they were only allowed when Resident 1's roommate was out of the room. The caregiver described Resident 2 as being helpful, often assisting the caregivers with turning Resident 1 or handing them supplies as they needed.

In an interview on 07/03/2025 at 2:10 PM, Staff C, Caregiver, stated that they were told that the reason why Residents 1 and 2 were separated was because they needed the room for someone else. Staff C stated that Resident 1 was nonverbal, unable to use their call light and that Resident 2 was their helper. Staff C stated that Resident 2 would often speak up for Resident 1 and would notify staff when they needed something. Additionally, Staff C stated that Resident 1 appeared sadder since the separation.

In an interview on 07/03/2025 at 2:29 PM, Staff D, Caregiver, stated that they were unsure why the residents were separated and stated that they had never witnessed Resident 2 interfering with Resident 1's care. Staff D stated that Resident 2 was helpful and would give staff an extra hand when needed. Staff D stated that they noticed Resident 1 was more anxious since the separation and that they began to refuse their medication. Additionally, Staff D stated that on several occasions they observed Resident 1 playing with their foley catheter (a flexible tube inserted into the body to drain urine from the bladder) by wrapping it up in their fingers. The caregiver stated that, initially when Residents 1 and 2 were separated, the facility limited Resident 2's visits to fifteen minutes at a time.

In an interview on 07/15/2025 at 2:22 PM, Staff E, Caregiver, stated that they had never witnessed Resident 2 interfering with Resident 1's care. Staff E stated that they were very helpful and would assist in pulling Resident 1 up in bed when needed. Staff E stated that they felt that the separation had affected Resident 1 and that, "It was a big change for her, they spent a lot of time together, they were together 24-7."

In an interview on 07/15/2025 at 2:30 PM, Staff G, Medication Technician, stated that previously Resident 1 and 2 were separated several months ago, when a new couple moved into the facility and required that room.

In an interview on 07/03/2025 at 3:23 PM, Staff H, Administrator, stated that nowhere in the policy did it say that the residents had to be kept together. Staff H stated that hospice had reported concerns with Resident 2 interfering with Resident 1's care . Staff H stated they had a conversation with Resident 2 regarding these concerns and how they felt it would be a good idea for two hospice patients to be together in one room.

Review of Resident 2's 04/22/2025 through 06/11/2025 progress notes failed to show documentation of a clinical behavioral or safety reason for the room change.

Review of Resident 1's hospice records, dated 03/25/2025, showed that Resident 1 would frequently look at their loved one, Resident 2, for answers and guidance regarding care and condition.

Review of Resident 1's Medication Administration Records (MARs) from 03/2025 through 07/2025, showed an increase in the use and dosage of antianxiety medications following the resident's room change on 04/28/2025.

In an interview on 07/14/2025 at 2:06 PM, Collateral Contact 1 (CC1), Hospice Nurse, stated that they felt the facility's decision to separate the resident from their loved one coincided with a noticeable decline in the resident's condition. CC1 stated that shortly after the separation, Resident 1 began calling out for their son and exhibited increased agitation and behavioral outbursts, including yelling at staff, throwing items, and compulsively spilling drinks; all behaviors not previously observed. CC1 stated Resident 1's as needed, anxiety medication began to be administered more frequently following the room change. CC1 stated that hospice was not involved in the decision to separate Resident 1 and 2 and expressed concern that the move had caused the residents unnecessary emotional distress that contributed to a functional and cognitive decline. CC1 also reported that the loved one's visits to Resident 1 became increasingly restricted, and inconsistent after the move. CC1 stated that hospice promoted and valued family presence, particularly during end-of-life stages, and expressed concern that the facility's actions and limitations compromise that standard of care.

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, Magnolia Assisted Living is or will be in compliance with this law and / or regulation on (Date) 8.31.25 .

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

Administrator (or Representative) 8.6.25 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 :

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure a resident received prescribed medications as ordered for 1 of 3 residents (Resident 3). This failure contributed to the residents' blood pressure becoming elevated, which prevented a scheduled surgery from being performed, and placed Resident 3 at risk for a decline in their chronic health conditions.

Findings included.....

Review of a facility policy titled, "Medication Refills Policy," undated, showed that medication refills will be obtained in a timely manner to ensure residents have all physician ordered medication available and that medications are never allowed to run out unless directed to by the physician. The policy also stated that the facility has assumed responsibility for obtaining a resident's prescribed medications and the assisted living facility must obtain them in a correct and timely manner.

Review of Resident 3's Department annual assessment details, dated 05/01/2025, showed that due to the residents' limitations; including a complex medication regimen, failure to record blood sugars, inability to follow prescribed dosages or frequency, and frequent forgetfulness; the resident required assistance with administering, storing, and

re-ordering all medications.

Review of Resident 3's facility assessment, dated 05/21/2025, showed that staff store and provide medications to the resident as prescribed. The resident received medications through mail in pharmacy from the Veteran's Affairs (VA), and the resident needed reminders to provide medication to the staff to place in Medication Administration Record (MAR) and store properly. Additionally, the assessment showed that Resident 3 was advised to communicate with staff when they had 10 days left of medication to avoid interruption.

Review of Resident 3's face sheet, printed on 07/07/2025 showed that the resident moved into the facility on [redacted]/2025 and had a diagnosis of [redacted].

Review of Resident 3's current physician order summary as of July 2025 showed that the resident was on several blood pressure medications: including Amlodipine (original order date 05/02/2025), Chlorthalidone (original order date 07/15/2025), Hydralazine (original order date 06/06/2025), Lisinopril (original order date 05/07/2025), Metoprolol (original order date 05/07/2025), and Terazosin (original order date 05/07/2025). Additionally, orders showed that Resident 3 was prescribed Gabapentin (used to treat nerve pain), and Trazadone (an antidepressant primarily prescribed to treat major depressive disorder or difficulty sleeping).

Review of Resident 3's May 2025 MAR showed that the resident missed 3 doses of Amlodipine, 1 dose of Lisinopril, and 1 dose of Loratadine, due to medications not found in medication cart and waiting on pharmacy. Additionally, MARs showed several documented high blood pressure readings including;

- 05/19/2025-196/101
- 05/20/2025-208/105
- 05/21/2025-196/95
- 05/22/205-201/97
- 05/23/2025-172/81
- 05/27/2025-185/87
- 05/28/2025-180/85
- 05/29/2025-191/88
- 05/30/2025-196/95
- 05/31/2025-188/90

Review of Resident 3's June 2025 MAR, showed that the resident missed twenty doses of Amlodipine, eight doses of Gabapentin, fourteen doses of Hydralazine, seventeen doses of Metoprolol, fourteen doses of Terazosin, and twenty doses of Trazadone due to medication not found in medication cart and waiting on pharmacy. Additionally, MARs showed several documented high blood pressure readings including;

- 06/01/2025-184/92
- 06/07/2025-196/95
- 06/08/2025-196/89
- 06/10/205-202/96
- 06/11/2025-198/98
- 06/12/2025-198/96
- 06/13/2025-198/80
- 06/14/2025-174/84
- 06/15/2025-196/78
- 06/16/2025-172/83
- 06/17/2025-216/91
- 06/18/2025-187/96
- 06/19/2025-190/85
- 06/20/2025-192/94
- 06/21/2025-201/94
- 06/22/2025-190/91
- 06/23/2025-200/86
- 06/24/2025-196/88
- 06/25/2025-206/104
- 06/26/2025-199/90
- 06/27/2025-202/101
- 06/28/2025-195/89
- 06/29/2025-206/90
- 06/30/2025-206/99

Review of Resident 3's July 2025 MAR, showed that the resident missed fourteen doses of Terazosin, and 14 doses of Trazadone due to physically unable to take, med not in cart and waiting on pharmacy. Additionally, MARs showed several documented high blood pressure readings including;

- 07/01/2025-214/102
- 07/02/2025-190/98
- 07/04/2025-204/93
- 07/05/2025-186/89
- 07/06/2025-209/95
- 07/07/2025-203/92
- 07/08/2025-211/98
- 07/09/2025-185/92
- 07/10/2025-191/90
- 07/11/2025-196/89
- 07/12/2025-208/87
- 07/13/2025-200/103
- 07/14/2025-200/96
- 07/15/2025-197/96

Review of Resident 3's progress note, dated 06/2/2025, showed the resident requested to go to the hospital for a high blood pressure of 230/105 (normal blood pressure is 120/80).

In an interview on 07/15/2025 at 1:39 PM, Resident 3 stated that they had been without several of their prescribed medications for approximately a month due to the facility running out. Resident 3 stated that some of their missing medications were for managing their blood pressure. They stated they were not happy that their scheduled surgery had to be postponed due to their blood pressure being too high. Resident 3 stated that the facility had been responsible for managing all their medications, including storing them, administering them, and reordering them. Resident 3 stated that they asked staff about their missing medications on several occasions and were told that the VA was too slow.

In an interview on 07/15/2025 at 2:24 PM, Staff I, Medication Technician (MT) stated that the procedure for reordering residents' medication was for the MT to notify the pharmacy and request the medication be delivered when the supply was down to about fourteen days remaining. Staff I stated that they were responsible for administering, storing, and reordering all of Resident 3's medications. Staff I stated that they had not notified the administrator or the nurse of the missing medications because the MT's are the ones that deal with the reordering of medications. Staff I stated that Resident 3 had arrived at the facility with all their prescribed medications in bottles and that they had run out at the facility. Additionally, Staff I stated that Resident 3's surgery had to be postponed due to their blood pressures being, "super elevated."

In an interview on 07/17/2025 at 3:16 PM, Staff H, Administrator, stated that they had not been made aware of missing medications for Resident 3. Staff H stated that Resident 3 was "very capable," of reordering their medications themselves from the VA, and that it was their responsibility to hand the medications to the staff when delivered. Staff H stated that staff administered and stored some of Resident 3's medications, but others were administered and stored by them and kept at bedside. Additionally, Staff H stated that staff needed to provide reminders to Resident 3 to take their medications. Staff H stated that there had been some confusion about who was responsible for reordering Resident 3's medications and that they needed to revamp some of their procedures.

In an interview on 07/18/2025 at 8:22 AM, Collateral Contact 2 (CC2), Case Manager, stated they completed Resident 3's current assessment and assisted with the resident's admission to the facility. They confirmed that, prior to moving in, Resident 3 had not been managing their medications safely at home. They further verified that the resident required assistance with administering, storing, and reordering all medications. They stated that these needs were clearly outlined in the care assessment, which specified that the facility would be responsible for managing all aspects of the residents' medications. They stated that if that had changed, they had not been made aware of that.

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, Magnolia Assisted Living is or will be in compliance with this law and / or regulation on (Date) 8/31/25 .

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

Administrator (or Representative) 8/6/25 Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on interview and recorded review, the facility failed to utilize the Department assessment information to develop the Negotiated Service Agreement (NSA) as the NSA did not address the current needs of the resident regarding medication management for 1 of 3 Residents (Resident 3). This failure contributed to the mismanagement of ordering and administration of blood pressure and pain medication, in addition to Resident 3 needing to reschedule surgery due to high blood pressures.

Findings included....

Review of Resident 3's face sheet, undated, printed on 07/07/2025, showed that the resident moved into the facility on [redacted]/2025 and had a diagnosis of [redacted].

Review of Resident 3's Department annual assessment details, dated 05/01/2025, showed that the resident had a diagnosis of [redacted]

[redacted] and [redacted]. The assessment also showed that due to the residents' limitations; including a complex medication regimen, failure to record blood sugars, inability to follow prescribed dosages or frequency, and frequent forgetfulness; the resident required assistance with administering, storing, and re-ordering all medications.

Review of Resident 3's Negotiated Service Agreement (NSA), dated 05/21/2025, showed that the resident had a diagnosis of [redacted], and staff were to monitor blood pressure daily and report any abnormalities to the licensed nurse. The NSA showed that the licensed nurse was to inform the provider of continued abnormal results, systolic (top number of the blood pressure reading) blood pressure under 100 and over 180 and diastolic (bottom number of the blood pressure reading) blood pressure under 60 and over 100. Additionally, the NSA showed that the resident was independent in re-ordering medication and was to notify the staff when they had ten days left of medications to avoid interruption.

Review of Resident 3's May 2025 Medication Administration Record (MAR), showed that the resident missed 2 doses of Amlodipine and 1 dose of Lisinopril (both treat high B/P) due to medications not found in medication cart and waiting on pharmacy.

Review of Resident 3's progress note, dated 06/02/2025, showed the resident requested to go to the hospital for a high blood pressure of 230/105 (this was outside of the systolic/diastolic parameters noted in the NSA).

Review of Resident 3's June 2025 MAR, showed that the resident missed multiple doses of medication to treat high B/P:
-twenty doses of Amlodipine
-fourteen doses of Hydralazine
-seventeen doses of Metoprolol
-fourteen doses of Terazosin

The June 2025 MAR showed Resident 3 missed eight doses of Gabapentin (used to treat pain), and twenty doses of Trazadone (for insomnia) due to medication not found in medication cart and waiting on pharmacy.

Review of Resident 3's July 2025 MAR, showed that the resident missed fourteen doses of Terazosin, and 14 doses of Trazadone due to physically unable to take, medication not in cart and waiting on pharmacy.

Review of Resident 3's last six months of progress notes showed that the first communication made to the Veterans Affair (VA) clinic regarding medications was on 07/11/2025.

In an interview on 07/15/2025 at 1:39 PM, Resident 3 stated that they had been without several of their prescribed medications for approximately a month due to the facility running out. Resident 3 stated that some of their missing medications were for managing their blood pressure. They stated they were not happy that their scheduled surgery had to be postponed due to their blood pressure being too high. Resident 3 stated that the facility had been responsible for managing all their medications, including storing them, administering them, and reordering them. Resident 3 stated that they asked staff about their missing medications on several occasions and were told that the VA was too slow.

In an interview on 07/15/2025 at 2:24 PM, Staff I, Medication Technician (MT), stated that the procedure for reordering residents' medication was for the MT to notify the pharmacy and request the medication be delivered when the supply was down to about fourteen days remaining. Staff I stated that they were responsible for administering, storing, and reordering all of Resident 3's medications. Staff I stated that Resident 3 had arrived at the facility with all their prescribed medications in bottles and that they had run out at the facility. Additionally, Staff I stated that Resident 3's surgery had to be postponed due to their blood pressures being, "super elevated."

In an interview on 07/17/2025 at 3:16 PM, Staff H, Administrator, stated that they had not been made aware of missing medications for Resident 3. Staff H stated that Resident 3 was "very capable," of reordering their medications themselves from the VA, and that it was their responsibility to hand the medications to the staff when delivered. Staff H stated that staff administered and stored some of Resident 3's medications, but others were administered and stored by them and kept at bedside. Additionally, Staff H stated that staff needed to provide reminders to Resident 3 to take their medications. Staff H stated that there had been some confusion about who was responsible for reordering Resident 3's medications and that they needed to revamp some of their procedures. Staff H stated that the Department assessment and NSA does not always match, and they had conducted their own assessment and had not had time to contact the Social Worker to update them.

In an interview on 07/18/2025 at 8:22 AM, Collateral Contact 2 (CC2), Case Manager, stated they completed Resident 3's current assessment and assisted with the resident's admission to the facility. They confirmed that, prior to moving in, Resident 3 had not been managing their medications safely at home. They further verified that the resident required assistance with administering, storing, and reordering all medications. They stated that these needs were clearly outlined in the care assessment, which specified that the facility would be responsible for managing all aspects of the residents' medications. They stated that if that had changed, they had not been made aware of that.

In an interview on 07/30/2025 at 3:56 PM, Resident 3 stated that the staff were responsible for administering, storing, and re-ordering all medications. Resident 3 stated they had never been asked to re-order their own medications from their pharmacy. They stated that ever since they moved into the facility, the facility took over all their medications and began to administer them. They stated that staff would check

their blood pressure daily and would inform them of the high readings. Resident 3 stated, "The nurses never came to talk to me about my high blood pressures." They stated that on one occasion a staff member checked their blood pressure, and it was 250/105, they contacted the 24-hour nurse triage line at the VA clinic due to concerns and stated that the nurse instructed them to go to the emergency room immediately. The resident stated they called a caregiver to their room and said, "I'm going to the ER, this is ridiculous." They stated that the facility had run out of their pain medication and blood pressure medication, causing them pain and stress.

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, Magnolia Assisted Living is or will be in compliance with this law and / or regulation on (Date) 8.31.25 .

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

Administrator (or Representative) Date 8.6.25