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

11/27/2025

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) 69305 (Completion Date 11/27/2025) and 65183 (Completion Date 10/02/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/27/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
**WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.**

**WAC 388-78A-2600 Policies and procedures.**

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(f) In response to medical emergencies;

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

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:** 192400
**Compliance Determination #:** 65183
**Region/Unit #:** RCS Region 1 / Unit G
**Investigator:** Melissa Milanez
**Investigation Date(s):** 09/05/2025 through 10/02/2025
**Complainant Contact Date(s):**

**Allegation(s):**
A named resident obtained a fall with injury.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 46<br>Resident sample size: 4<br>Closed records sample size: |
| **Observations:** | Identified resident<br>Residents<br>Activities<br>Resident care equipment<br>Resident rooms<br>Staff to resident interactions<br>Resident to resident interactions |
| **Interviews:** | Identified resident<br>Identified staff<br>Nursing staff<br>Residents<br>Social services staff<br>Therapy staff |
| **Record Reviews:** | Medical records<br>Hospital records<br>State reporting log<br>Incident investigation<br>Facility policies<br>Personnel files<br>Staff training records<br>Staff patterns<br>Resident records |

**Investigation Summary:**
Interviews and record reviews showed that the named resident obtained a fall after attempting to self-transfer back to bed. The facility failed to follow their policies and

procedures for safety checks, vitals, and alert charting for the Alleged Victim following the fall. Additionally, the facility failed to administer prescribed pain medication within a timely manner. Failed practice identified. Please see the Statement of Deficiency for Washington Administrative Code (WAC) 388-78A-2240 and WAC 388-78A-2660 (2)(f)(i).

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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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***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 09/05/2025 and 09/16/2025 of:

Magnolia Assisted Living
912 Hillcrest St
Grandview, WA 98930

This document references the following complaint number(s): 192400

The following sample was selected for review during the unannounced on-site visit: 4 of 46 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 #65183 |
|---|---|---|
| Plan of Correction | Magnolia Assisted Living | Completion Date |
| Page 2 of 7 | Licensee: Grandview Assited Living LLC | 10/02/2025 |

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

10/16/2025
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)

11.16.25
11.30.25
Date

**WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.**

**This requirement was not met as evidenced by:**

Based on interview and record review the Assisted Living Facility (ALF) failed to obtain and administer newly prescribed medication in a timely manner for a resident who required assistance with obtaining and administration of prescribed medications for 1 of 1 resident (Resident 1). This failure resulted in the delay of Resident 1 receiving their pain medication and contributed to ongoing and unmanaged pain.

Findings included...

Review of a facility policy titled, "Medication Refills Policy-Non-availability of medications," undated, showed 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 1's Negotiated Service Agreement, dated 08/19/2025, showed that staff were to assist with administering routine medications and as needed medications.

Review of Resident 1's emergency room after visit summary, dated [redacted]/2025, showed the resident was seen in the emergency room for an unwitnessed fall that occurred at the assisted living facility. Resident 1 was diagnosed with an [redacted]

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-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.**

**This requirement was not met as evidenced by:**

Based on interview and record review the Assisted Living Facility (ALF) failed to obtain and administer newly prescribed medication in a timely manner for a resident who required assistance with obtaining and administration of prescribed medications for 1 of 1 resident (Resident 1). This failure resulted in the delay of Resident 1 receiving their pain medication and contributed to ongoing and unmanaged pain.

Findings included...

Review of a facility policy titled, “Medication Refills Policy-Non-availability of medications,” undated, showed 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 1’s Negotiated Service Agreement, dated 08/19/2025, showed that staff were to assist with administering routine medications and as needed medications.

Review of Resident 1’s emergency room after visit summary, dated [redacted]/2025, showed the resident was seen in the emergency room for an unwitnessed fall that occurred at the assisted living facility. Resident 1 was diagnosed with an [redacted]

[redacted] The summary also showed that Resident 1 was discharged from the hospital later that day with instructions to follow up with the orthopedic doctor as soon as possible and was prescribed oxycodone for acute pain.

In an interview on 09/08/2025 at 10:06 AM, Resident 1 stated that they had a fall in their room at approximately 11:00 PM on [redacted]/2025 and was not discovered until 7:00 AM the following morning. They were transported to the emergency room where they were diagnosed with a [redacted]. Upon discharge from the hospital that same day, a prescription for oxycodone was sent to the pharmacy. Resident 1 stated that upon returning to the facility, they repeatedly asked staff for their prescribed pain medication. They stated staff told them that they did not have the medication available. The resident stated they had severe pain that rated 9 out of 10 throughout the day. Resident 1 stated, “I have been in a lot of pain every day since my fall. My ribs, my back, and my hip hurt really bad.”

Review of Resident 1’s Medication Administration Record (MAR) for the month of September 2025, showed that the resident did not receive Oxycodone (prescribed pain medication) until [redacted]/2025 (12 days after it had been prescribed). The MAR further showed that the facility continued to administer Tramadol at bedtime, which had been the resident’s long term routine pain medication for chronic pain, and Tylenol as needed. The MAR failed to show documentation of pain scale assessments.

In an interview on 09/08/2025 at 10:39 AM, Staff A, Medication Technician (MT), stated that Resident 1 had complaints of pain that morning and was given Tylenol because their Oxycodone had run out. They stated that the hospital prescribed Oxycodone for 3 days, and the resident was to follow up with the orthopedic doctor. Staff A stated they did not know why the Oxycodone had not been given sooner. Additionally, Staff A stated that they had administered the Tylenol to Resident 1, and that Resident 1 continued to complain of pain.

In an interview on 09/24/2025 at 11:03 AM, Collateral Contact 1 (CC1), Emergency contact, stated that they had received multiple calls from Resident 1 after being discharged from the hospital [on [redacted]/2025] stating they were in pain and had not received their prescribed pain medication. CC1 stated that after receiving several phone calls from the resident stating they were in “a lot” of pain they went to the pharmacy (five days after Resident 1’s fall), to see if anyone from the facility had picked up the medication. CC1 confirmed the medication was still at the pharmacy, they picked it up and had taken it to the facility. Additionally, they stated they handed the medication to a staff member and were told that they could not administer the medication until consulting the facility doctor. CC1 informed the staff member that they had received multiple calls from Resident 1 and that they were experiencing a high level of pain and needed stronger pain management. CC1 stated they could not understand why the facility had not gone to get Resident 1’s pain medication as they oversaw administering all medications.

In an interview on 09/24/2025 at 1:47 PM, Collateral Contact 2 (CC2), Pharmacy

technician, confirmed that a prescription for oxycodone was sent to the pharmacy from the hospital on [redacted]2/2025 and was not picked up until five days later on [redacted]/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, Magnolia Assisted Living is or will be in compliance with this law and / or regulation on (Date) ~~11.30.25~~ 11.16.25.

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

Administrator (or Representative) — Date: ~~11.30.25~~ 11.16.25

**WAC 388-78A-2600 Policies and procedures.**

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(f) In response to medical emergencies;

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

**This requirement was not met as evidenced by:**

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure staff implemented policies and procedures for safety checks, vitals, and alert charting for 1 of 1 resident (Resident 1). These failures placed the resident at risk for undetected medical needs and risk for continued falls.

Findings included...

Review of a facility policy titled, "Monitoring," dated 01/01/2022, showed that residents who have any other diagnosis that causes [redacted], will require a 2-hour check for safety, whereabouts within the facility, and incontinent needs. Staff are to make visual contact with the residents at the 2-hour mark during the day and night.

Review of a facility policy titles, "Alert Charting Policy, Med-Tech Day & Night shift," undated, showed that the facility will monitor the resident with a fall with injury for complaints of pain, bruising, abrasions, skin tears, change in mobility, change in behavior, or inability to complete Activities of Daily Living (ADL's). In addition, the policy

technician, confirmed that a prescription for oxycodone was sent to the pharmacy from the hospital on [redacted]/2025 and was not picked up until five days later on [redacted]/2025.

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Administrator (or Representative) Date

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Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure staff implemented policies and procedures for safety checks, vitals, and alert charting for 1 of 1 resident (Resident 1). These failures placed the resident at risk for undetected medical needs and risk for continued falls.

Findings included…

Review of a facility policy titled, “Monitoring,” dated 01/01/2022, showed that residents who have any other diagnosis that causes [redacted], will require a 2-hour check for safety, whereabouts within the facility, and incontinent needs. Staff are to make visual contact with the residents at the 2-hour mark during the day and night.

Review of a facility policy titled, “Alert Charting Policy; Med-Tech Day & Night shift,” undated, showed that the facility will monitor the resident with a fall with injury for complaints of pain, bruising, abrasions, skin tears, change in mobility, change in behavior, or inability to complete Activities of Daily Living (ADL’s). In addition, the policy

showed that any resident who experiences a fall will be placed on alert charting once a day for three days and that all vital signs will be checked during this time. Further review of the alert charting policy showed examples of what should be included when staff chart on for a fall with injury:

- Current injury (make sure to see the injury prior to documenting) does the injury seem to be healing (if healing), ask pain level from a scale of 0-10
- After the fall- if not healing or worsening, notify the licensed nurse and provide a description of what you see
- Always ask pain level 0-10, if any pain, offer a PRN (as needed) medication
- If PRN is given, recheck after 30 minutes to see if it is effective
- Always document color of bruise as it heals

Alert charting examples for a non-injury fall:

- No new injuries after the incident
- No new pain after the incident
- Staff are to make sure to state documentation is being made after non-injury fall

Review of a facility policy titled, “Falls,” dated 01/01/2022, showed that the assisted living strives to keep residents safe and free from harm. Fall preventions are put in place for those who are at risk for falls. Additionally, the policy showed that upon a fall (injury or non-injury, witnessed or unwitnessed) all falls will be documented according to occurrence. Procedures for falls are as follows: Notify the Complaint Resolution for any unwitnessed or witnessed fall with injury; complete form entirely and record confirmation number, and place resident on alert charting.

Review of Resident 1’s Negotiated Service Agreement (NSA), dated 08/19/2025, showed that Resident 1 had memory loss and may forget their whereabouts, and that staff were required to check on the resident’s whereabouts and safety regularly during the night. However, the NSA failed to identify that Resident 1 was at risk for falls and failed to include any fall prevention measures or interventions to reduce that risk.

Review of Resident 1’s progress notes, dated [redacted]/2025 at 7:15 AM, showed that Resident 1 was sent to the hospital for an unwitnessed fall with complaints of pain in their right hip, and back. Progress notes showed Resident 1 returned back to the facility the same day. No further documentation was noted until [redacted]/2025 (four days after the fall). Further review of the progress notes failed to show any documentation related to the fall, or any monitoring after the incident.

Review of Resident 1’s Emergency Room (ER) after visit summary note, dated [redacted]/2025, showed that the resident was brought into the ER by Emergency Medical Services (EMS) with reports of an unwitnessed fall. The summary note showed that the resident reported a fall at around 11:00 PM on [redacted]/2022 as they were trying to get from their wheelchair to the bed and were not found until around 7:00 AM the following morning on [redacted]/2025. Additionally, the summary note showed that Resident 1 had stated they landed on the ground, hitting their head, had complained of pain to the back of the head, upper neck, and right hip, and had not been able to move since the fall.

Review of Resident 1's Discharge summary visit notes, dated [redacted]/2025, provided by the facility showed a discharge diagnosis of a [redacted]

Review of Resident 1's weekly vital sign record for the month of August 2025, failed to show documented vital signs after the [redacted]/2025 fall incident.

In an interview on 09/08/2025 at 10:06 AM, Resident 1 stated that they had fallen late at night on [redacted]/2025 around 11:00 PM after attempting to use the bathroom. They stated that they had turned on their call light for assistance, but no staff responded. They stated they urgently needed to use the restroom and after waiting for a long time without help, they decided to get up on their own. Resident 1 stated as they were attempting to get back into bed, they fell to the floor and were unable to get up or reach their call light. Resident 1 stated they yelled and screamed for help, but no one came. They stated that they remained on the floor all night, from approximately 11:00 PM until 7:00 AM, when staff found them the following morning. Resident 1 expressed frustration that no one wanted to help them and stated it was very difficult to receive assistance at night because there was no one around. Resident 1 stated they wanted to move out of the facility because they did not feel safe or cared for.

In an interview on 09/16/2025 at 1:30 PM, Staff B, Lead Medication Technician (MT), confirmed Resident 1 was not placed on alert charting after the fall on [redacted]/2025.

Record review of the facility's as worked schedule for the month of August 2025, showed that Staff D, Medication Technician worked the night of the incident on [redacted]/2025.

In an interview on 09/16/2025 at 4:49 PM, Staff D, Medication Technician stated that they were expected to conduct 2-hour checks on residents during the night shift. They stated that even for residents who are not formally on 2-hour checks, staff typically should be checking on all residents periodically to ensure their safety. Staff D stated they did not recall checking on Resident 1 the night of the fall on [redacted]/2025. They stated they believed the resident was able to care for themselves, and if the resident did not activate their call light, they may not have visually checked on them. Staff D further stated that if the resident had been calling out for help, the staff may not have heard them because the resident in the adjoining room "always has their TV at 100," and the noise may have overpowered the resident's call for assistance.

In an interview on 09/22/2025 at 12:34 PM, Staff F, Licensed Practical Nurse (LPN) stated that they have worked at the ALF since January 2025 and they do not have access to the facility's electronic health record (EHR). Staff E stated that the process when a resident experiences a fall is for staff to place the residents on alert for monitoring, complete vital signs, and document progress notes daily. They stated that tasks have been "falling through the cracks "and that some monitoring and documentation have been missed. Staff F stated that the staff needed to improve their

charting practices, so a whiteboard was implemented to provide a visual reference of which residents were on alert charting. Additionally, they stated that they had a lot going on at the facility and had been performing many of the duties typically completed by a Residential Care Coordinator (RCC). Additionally, they stated to better manage these responsibilities, they had just hired an RCC to assist them with those tasks so that they can focus more on nursing responsibilities.

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Administrator (or Representative)

Date 11.16.25 ~~11-30-25~~

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