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

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

RE: Magnolia Assisted Living License # 2750

Dear Administrator:

This letter addresses Compliance Determination(s) 71374 (Completion Date 01/13/2026) and 68255 (Completion Date 11/17/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/13/2026 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-2350-1, WAC 388-78A-2350-7-a, WAC 388-78A-2350-7-b, WAC 388-78A-2350-7

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: 199610
Compliance Determination #: 68255
Region/Unit #: RCS Region 1 / Unit G
Investigator: Melissa Milanez
Investigation Date(s): 11/05/2025 through 11/17/2025
Complainant Contact Date(s): 11/24/2025

Allegation(s):
The facility failed to coordinate the named resident's appointments, resulting in missed and delayed specialty appointments.

Investigation Methods:

Sample:	Total residents: 50 Resident sample size: 3 Closed records sample size:
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Receptionist Others not associated with the facility (hospital staff, doctors office) Residents
Record Reviews:	Medical records Hospital records State reporting log Incident investigation Facility policies Staff patterns Characteristic roster Resident rental agreement

Investigation Summary:
Interviews, and record review showed that multiple specialty appointments were missed or significantly delayed, and the facility did not ensure timely scheduling or

communication with the named resident or providers. Deficient practice identified and the facility was cited for WAC 388-78A-2350 (1)(7)(a)(b) reference Statement of Deficiencies dated 11/17/2025.

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 11/05/2025 of:

Magnolia Assisted Living
912 Hillcrest St
Grandview, WA 98930

This document references the following complaint number(s): 199610

The following sample was selected for review during the unannounced on-site visit: 3 of 50 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

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

11/26/2025
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)

12/16/25
Date

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

(7) When coordinating care or services, the assisted living facility must:

(a) Integrate relevant information from the external provider into the resident's preadmission assessment and reassessment, and when appropriate, negotiated service agreement; and

(b) Respond appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning.

This requirement was not met as evidenced by:

Based on interviews and record review the facility failed to coordinate necessary health care services by not ensuring timely transportation was arranged and coordinated to medical appointments for 1 of 1 resident (Resident 1). This failure resulted in a delayed diagnosis and treatment of a potentially life-threatening condition for the resident.

Findings included... ...

Review of a facility policy titled, "Transportation," dated 01/01/2022, showed that the facility would assist in scheduling transportation to and from medical, dental and specialty appointments (in and out of town) through a community transportation agency.

Review of Resident 1's department annual assessment details, dated 10/28/2025,

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.

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

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(a) Integrate relevant information from the external provider into the resident's preadmission assessment and reassessment, and when appropriate, negotiated service agreement; and

(b) Respond appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning.

This requirement was not met as evidenced by:

Based on interviews and record review the facility failed to coordinate necessary health care services by not ensuring timely transportation was arranged and coordinated to medical appointments for 1 of 1 resident (Resident 1). This failure resulted in a delayed diagnosis and treatment of a potentially life-threatening condition for the resident.

Findings included……

Review of a facility policy titled, “Transportation,” dated 01/01/2022, showed that the facility would assist in scheduling transportation to and from medical, dental and specialty appointments (in and out of town) through a community transportation agency.

Review of Resident 1’s department annual assessment details, dated 10/28/2025,

showed that the facility was responsible for arranging medical transportation.

Review of Resident 1's face sheet printed on 11/06/2025, showed that the resident moved into the facility on [redacted]/2020.

Review of Resident 1's Negotiated Service Agreement, dated 03/15/2025, showed that all medical, dental, vision and specialty appointments would be scheduled by the facility receptionist/coordinator and that all transportation would be arranged for medical purposes to and from appointments.

Review of Resident 1's admission agreement signed by Resident 1 and a facility designee on 05/21/2025, showed that the facility was responsible for scheduling and coordinating medical appointments to ensure continuity of care.

Review of Resident 1's hospital records, dated [redacted]/2025, showed that the resident was brought into the emergency room with complaints of vaginal bleeding and pain while sitting down. Additionally, records showed that a pelvic ultrasound was performed, and Resident 1 was found to have a left ovarian mass, and that findings were concerning for malignancy (a harmful, cancerous tumor or growth that can invade nearby tissues and spread to other parts of the body) which would need further outpatient workup.

Review of Resident 1's ultrasound result reading and discharge summary notes, dated [redacted]/2025, showed a left ovarian 6.9cm x 3.6cm x 5.1cm internal mass, and that a Magnetic Resonance Imaging (MRI) test of the pelvis was recommended for further evaluation.

Review of Resident 1's Obstetrics and Gynecology (OB-GYN) office visit notes, dated 08/06/2025, showed that the provider recommended tumor markers (bloodwork that can show signs of certain types of cancer or abnormal growths) to be performed and requested a pelvic MRI for gynecologic evaluation, as further evaluation was needed to better understand and evaluate the residents' mass. Additionally, a referral had been sent to oncology for a specialty consultation.

In an interview on 11/17/2025 at 10:54 AM, Collateral Contact 1 (CC1), Hospital Scheduler, stated that hospital staff attempted multiple times to contact the facility to schedule Resident 1's MRI appointment. CC1 stated that the facility's phone line would ring with no answer and that and there was no voicemail or alternate option to leave a message. As a result, the hospital was unable to schedule Resident 1's MRI appointment with the facility despite repeated attempts.

In an interview on 11/04/2025 at 3:59 PM, Collateral Contact 2 (CC2), GYN Oncology Clinic Manager, stated that the oncology provider determined that Resident 1 required

an urgent evaluation and an MRI within two weeks [of office visit on 08/06/2025] due to concerns for a possible ovarian mass. They stated that they spoke with Staff A, Facility Receptionist, on 09/03/2025 and offered an appointment for the next day on 09/04/2025 due to urgency, but the facility stated they were unable to schedule transportation with such short notice. CC2 then scheduled and confirmed an appointment with Staff A for 09/15/2025 at 9:00 AM for Resident 1. CC2 stated that their office policy was to always call and confirm appointments the day before, so on 09/14/2025 they called and spoke to Staff A and were told that they had not been able to arrange transportation for Resident 1 and that the appointment would need to be rescheduled. The appointment was then rescheduled for 10/03/2025. On 10/02/2025 the doctor's office called the facility to confirm Resident 1's appointment for 10/03/2025 and was told by Staff A that they thought the appointment was on 10/05/2025 [this was a Sunday, they do not see patients in the clinic on Sundays] so transportation had not been scheduled for Resident 1 and the appointment had to be cancelled and would need to be rescheduled. The appointment had been rescheduled for 10/24/2025 at 1:00 PM. CC2 stated they again called the facility on 10/23/2025 to confirm Resident 1's appointment and spoke with Staff A, who confirmed that transportation was scheduled and that the resident would be showing up with a caregiver. CC2 stated that on 10/24/2025, Resident 1 never showed up to their appointment, and they had not received a call from the facility on why the resident had not made it. CC2 stated that they called the facility and spoke with someone who stated that they were not aware that Resident 1 had any missed appointments. They were later transferred to the nursing director who stated that they were not sure why Resident 1 had missed their appointments and assisted with rescheduling Resident 1's appointment for 10/30/2025. CC2 confirmed that Resident 1 was seen in the office on that day [a delay of 45 days from the originally scheduled appointment] but that there had been concerns due to Resident 1's mass nearly doubling in size compared to earlier findings. Additionally, CC2 stated that there had also been a delay in scheduling Resident 1's MRI appointment, which had been ordered on the residents first OBGYN appointment on 08/06/2025. CC2 confirmed that the MRI was completed on 10/28/2025.

Review of Resident 1's MRI results, dated 10/28/2025 [83 days from the order date], showed that the ovarian mass measured 10cm x 12cm x 9.7cm (nearly doubled in size).

Review of Resident 1's Gynecologic Oncology physician visit notes, dated 10/30/2025, showed that Resident 1 was referred to the office for a consult regarding an adnexal mass (a lump or growth) and a mild elevation of tumor markers (bloodwork that can show signs of certain types of cancer or abnormal growths). Additionally, it was noted that there had been a significant delay from initial referral to first appointment with them due to transportation issues. In that time, the mass had grown almost double in size (from August to October it went from 6cm to 10cm). Notes showed that the surgery should occur urgently without delay to avoid progressive increase size of the pelvic mass.

In an interview on 11/06/2025 at 10:48 AM, Resident 1 stated they had been taken to the emergency room for vaginal bleeding and pain while sitting. Resident 1 stated they were informed they had an ovarian cyst. They stated they had not been made aware by

facility staff that any of their follow-up appointments had been missed or rescheduled and stated that the facility did not communicate any changes in their appointments to them. Resident 1 stated they continued to experience pain when seated for extended periods of time.

In an interview on 11/06/2025 at 11:03 AM, Staff A stated that they were responsible for scheduling and arranging transportation for all residents. Staff A stated there had been multiple appointments that had to be rescheduled for Resident 1 due to not having all the paperwork filled out, the facility not arranging transportation, and not having the staff available to accompany Resident 1 to their appointment. Staff A acknowledged they were personally responsible for one of the cancellations stating they had "just forgot." They further stated that they did not notify their supervisor about the repeated need to reschedule Resident 1's appointments until the 3rd occurrence, despite recognizing the importance of timely coordination. Staff A stated that since then they had implemented a different internal process to address the flaws that contributed to missed and rescheduled appointments and stated they were working to correct the system so that it did not recur.

In an interview on 11/06/2025 at 12:26 PM, Staff B, Nursing Director, stated that they had not been aware that multiple oncology appointments had been cancelled or rescheduled until they received a call from the providers office on 10/27/2025. Staff B stated the facility had since hired a residential care coordinator to assist with obtaining paperwork for medical appointments and ensuring follow up tasks were completed. They stated this position would help prevent miscommunication and that moving forward, they would be the final person verifying that appointments and follow-up care were completed.

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) 01/01/2025 .

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

Administrator (or Representative) 12/16/25 Date

facility staff that any of their follow-up appointments had been missed or rescheduled and stated that the facility did not communicate any changes in their appointments to them. Resident 1 stated they continued to experience pain when seated for extended periods of time.

In an interview on 11/06/2025 at 11:03 AM, Staff A stated that they were responsible for scheduling and arranging transportation for all residents. Staff A stated there had been multiple appointments that had to be rescheduled for Resident 1 due to not having all the paperwork filled out, the facility not arranging transportation, and not having the staff available to accompany Resident 1 to their appointment. Staff A acknowledged they were personally responsible for one of the cancellations stating they had “just forgot.” They further stated that they did not notify their supervisor about the repeated need to reschedule Resident 1’s appointments until the 3rd occurrence, despite recognizing the importance of timely coordination. Staff A stated that since then they had implemented a different internal process to address the flaws that contributed to missed and rescheduled appointments and stated they were working to correct the system so that it did not recur.

In an interview on 11/06/2025 at 12:26 PM, Staff B, Nursing Director, stated that they had not been aware that multiple oncology appointments had been cancelled or rescheduled until they received a call from the providers office on 10/27/2025. Staff B stated the facility had since hired a residential care coordinator to assist with obtaining paperwork for medical appointments and ensuring follow up tasks were completed. They stated this position would help prevent miscommunication and that moving forward, they would be the final person verifying that appointments and follow-up care were completed.

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

_____ _____

Administrator (or Representative) Date