STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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) 83334 (Completion Date 09/04/2026) and 79402 (Completion Date 08/04/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/04/2026 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-2120-2-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3, WAC 388-78A-2120-4

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

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Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2503
Intake ID: 229452
Compliance Determination #: 79402
Region/Unit #: RCS Region 1 / Unit G
Investigator: Melissa Milanez
Investigation Date(s): 06/24/2026 through 08/04/2026
Complainant Contact Date(s): 07/14/2026

Allegation(s):
The named resident was not being properly cared for and monitored at the facility.

Investigation Methods:

Sample:	Total residents: 49 Resident sample size: 3 Closed records sample size:
Observations:	Residents, Staff to resident interaction, Resident rooms, Resident cares and services.
Interviews:	Residents, Staff, Other's not associated with the facility.
Record Reviews:	Resident records, Medical records, Facility Policies

Investigation Summary:
Interviews, observations, and record review showed the facility failed to provide necessary care and services and failed to adequately monitor the resident's condition. Record review and hospital documentation showed the named resident was hospitalized with severe sepsis, anemia, and dehydration. Interviews and record review showed the named resident developed pressure injuries, required wound care, had oral care concerns, and experienced skin and hygiene issues that were not consistently identified, monitored, or addressed by the facility. Failed practice identified under WAC 388-78a-2120.

Conclusion / Action:

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

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STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

HOME AND COMMUNITY LIVING ADMINISTRATION

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 06/24/2026 and 07/14/2026 of:

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

This document references the following complaint number(s): 229452

The following sample was selected for review during the unannounced on-site visit: 3 of 49 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Melissa Milanez, Community Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

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Statement of Deficiencies	License #: 2503	Compliance Determination # 79402
Plan of Correction	The Orchards at Grandview	Completion Date
Page 2 of 6	Licensee: Grandview WA Management LLC	08/04/2026

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

08/05/2026
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.

Janet Wallner
Administrator (or Representative)

8/7/26
Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to identify, evaluate, monitor, and take appropriate action to a resident's significant change in condition for 1 of 3 residents (Resident 1). This failed practice delayed timely evaluation and treatment and contributed to the resident's hospitalization and progression of serious health conditions.

Findings included....

Review of the facility's policy titled, "Change of Condition," dated 05/2025, showed that the purpose of the policy was to acknowledge changes in condition, which were a variation from the residents established baseline. The policy showed that if a care staff

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questioned the nature of the change in condition they would refer to and follow their, "Medical Incident," policy. Additionally, the policy showed that staff would utilize the facility's stop and watch form and would notify the licensed nurse and place resident on "alert charting" [when there is a change in condition a resident will be monitored on alert charting for at least 72 hours and care staff would chart on the selected resident every shift on their facility progress notes.]

Review of the facility's policy titled, "Medical Incident Policy," dated 05/2024, showed that the ALF is to provide a safe environment for all residents and staff would respond with appropriate procedures when minor or major medical emergencies occurred to provide the best care for the residents. The care staff would be able to identify an emergency situation and determine if the situation was a minor or major emergency. A minor or major incident could include skin tears, scrapes, or abrasions. The staff are to summon the administrator to evaluate the medical emergency if they are in the facility. If the administrator is not in the facility, upon the discovery of a minor medical emergency, immediately assess the discovery using first aid skills and employment orientation to decide which action should be taken. After evaluating the discovery and using appropriate skills, notify the facility nurse, the residents responsible party and residents' physician as indicated by the nurses' instructions.

Review of Resident 1's Negotiated Service Agreement (NSA), dated 02/25/2026, showed that the resident had a diagnosis of [redacted], required total assist with oral care, dressing, eating, and mobility, and was dependent upon staff with transfers and/or position changes. Additionally, staff were to keep skin clean and dry, reposition the resident every two hours, and report reddened areas to the administrator and licensed nurse.

Review of Resident 1's hospital records showed the resident was transported by ambulance to the emergency department on 06/19/2026 at 2:31 PM. Upon arrival, the resident was unconscious and unresponsive to verbal commands, with a fever of 102.3 °F, a rapid heart rate, rapid breathing, and an oxygen saturation of 81 %, (normal levels 95%-100%). Laboratory findings demonstrated significant abnormalities, including high white blood count indicating infection, high sodium level, indicating significant dehydration, an elevated lactate, indicating severe sepsis (a life-threatening condition caused by the body's overwhelming response to an infection) and septic shock (most severe stage of sepsis), and acute kidney injury consistent with severe infection and dehydration. Additionally, hospital records documented that the resident was diagnosed with [redacted] and [redacted] and [redacted]. Due to the residents' poor prognosis, family elected to transition the resident to comfort care.

Review of Resident 1's hospital wound assessment completed on 06/19/2026 at 5:30 PM, showed a Stage 3 pressure (a deep open wound where the skin has broken down completely, extending into the fatty tissue beneath the skin) injury to the coccyx measuring 1.5 cm x 1.0 cm x 0.2 cm, with a wound bed described as yellow, moist, pink, and containing slough (dead or damaged tissue). Additionally, noted was an unstageable pressure injury to the right posterior heel measuring 1.5 cm x 2.0 cm,

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described as dry, and intact. A clinical assessment also documented a reddened, moist wound to the upper palate (roof of the mouth), and poor skin turgor (a clinical sign consistent with dehydration, when the skin has lost its normal elasticity).

Review of Resident 1's facility records from 05/11/2026 to 06/15/2026 showed no documentation of Resident 1's pressure area/wound to right heel and buttocks.

In an interview on 08/04/2026 at 1:45 PM, Collateral Contact (CC1), Anonymous, stated that upon entering the hospital on 06/19/2026 they observed Resident 1 was unresponsive and cyanotic (having a bluish or purplish tint to the skin, lips, or fingernails due to deficient oxygenation of the blood) and in "poor condition". CC1 stated the facility had not informed them of any wounds prior to Resident 1's hospitalization. They stated they became aware of the wounds upon arriving to the hospital. CC1 stated they observed a wound on Resident 1's coccyx, and described it as being red, moist, and open. Additionally, they stated the hospital nurse showed them a second wound to Resident 1's right heel, which they observed to be black, dry, and appeared necrotic (dead tissue that appears black, hard, and dry).

Review of a non-emergency communication form dated 06/16/2026 sent to the resident's primary care physician stated "Resident had been a having a dry cough for a couple days now, since 06/12/2026. Is there anything they could get."

Review of Resident 1's Medication Administration Record (MAR) for the month of June 2026 showed that the resident received Tylenol 500mg tablet on 06/16/2026 at 12:17 PM for fever, and on 06/19/2026 at 12:59 AM for fever. Additionally, the MAR showed a PRN (as needed) order was received on 06/17/2026 for Benzonate (a prescription cough suppressant) to take by mouth three times daily as needed for cough, however, there was no documentation that the medication was administered prior to the resident's hospitalization on 06/19/2026.

Review of Resident 1's progress notes from 02/5/2026-6/22/2026 did not show the resident was placed on alert charting or monitored after staff identified a significant change in condition, including a fever and cough.

Review of Resident 1's vital records showed the last documented vital signs were recorded on 06/07/2026.

In an interview on 06/24/2026 at 11:30 AM Staff A, Licensed Practical Nurse, stated that staff had reported to them that Resident 1 had a cough and they had requested PRN cough medicine. Additionally, they stated that residents who experience a change in condition are typically placed on alert charting for ongoing monitoring. They confirmed Resident 1 was not an alert charting prior to the hospitalization.

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In an interview on 06/24/2026 at 11:36 PM, Staff B, Administrative Assistant, stated that Resident 1 required total assistance with all activities of daily living. They confirmed that the resident was not on alert charting prior to the hospitalization and stated they were unaware the resident had any wounds or fevers but stated that one day that week they heard the resident coughing in the dining room and stated it sounded like an "ugly, loud cough." Additionally, they stated that staff are to complete a skin assessment during each resident shower and document their findings on the shower/skin assessment form. Staff B confirmed the residents last documented shower and skin assessment occurred on 06/17/2026 (two days prior to hospital admission), and there were no reported skin issues or concerns.

In an interview on 06/24/2026 at 12:14 PM Staff C, Caregiver stated they entered Resident 1's room on 06/16/2026 to assist with cares and noticed the resident was hot to touch. Staff C stated they checked the resident's temperature and thought it was 99.9 degrees Fahrenheit (°F) and reported it to the Medication Technician. Additionally, they stated that the resident had not eaten much for two days.

In an interview on 06/24/2026 at 12:24 PM Staff D, Residential Care Coordinator (RCC) stated they had been employed at the facility since February 2026 and was responsible for reviewing and signing skin monitoring forms and putting residents on alert charting if needed. They stated they were unaware of any skin issues for Resident 1 prior to the hospitalization. Staff D stated Resident 1 experienced fevers on 2 separate occasions and a cough during the week before the hospitalization; however, the resident was not placed on alert charting, or they could not confirm if cough medicine was administered. When asked what the residents' temperatures were at those times, they stated they did not know because staff do not document temperatures when residents are not on alert charting. Additionally, Staff D stated that Resident 1 was nonverbal and unable to communicate.

In an interview on 07/14/2026 at 3:40 PM, Staff E, Medication Technician (MT) stated a caregiver informed them that Resident 1 had a temperature on 06/16/2026. Staff E stated they administered Tylenol but acknowledged they did not document the residents' temperature or felt the need to put the resident on alert charting.

In an interview on 07/14/2026 at 3:47 PM, Staff F, Caregiver/MT stated that during the early morning hours of 06/19/2026, they entered Resident 1's room to complete 2-hour checks and found the resident was hot to touch. They obtained a temporal temperature of 109.0 °F and stated they were concerned because the resident felt "very hot." When asked multiple times to confirm that the temperature was 109.0 °F rather than 100.0 °F, Staff F repeatedly confirmed the temperature was 109.0. Staff F then stated they administered Tylenol and applied a cold washcloth to the resident's forehead and under their arms. When asked whether they notified anyone of the resident's fever, the MT stated they wrote the residents temperature on a sticky note and gave it to the oncoming shift but could not recall who they gave the sticky note to.

In an interview on 07/14/2026 at 3:54 PM, Staff G, Administrator, stated that when a

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resident develops a fever and receives a PRN medication or has a change in condition, the resident should be placed on the alert charting, and the licensed nurse should be notified. They further stated that residents with skin breakdown or skin injuries should also be placed on alert charting to ensure ongoing monitoring and follow up. Staff G confirmed these procedures were not followed for Resident 1 and acknowledged staff failed to comply with the facilities policies. Staff G stated, "it looks like we have a fall down in our system."

This is a repeated deficiency previously cited on 12/04/2023.

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) 8/12/26 .

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

Janet Wallingford 8/7/26

Administrator (or Representative) Date

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