STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

05/16/2025

Sequim AL, LLC
Trustwell Living at Sinclair Place
680 W Prairie St
Sequim, WA 98382

RE: Trustwell Living at Sinclair Place # 2728

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 59708 (Completion Date 05/16/2025) and 56347 (Completion Date 03/18/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/16/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

(iii) When the resident has an injury requiring the intervention of a practitioner.

The Department staff who did the On Site verification:
Paul Aube, ALF NCI

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Trustwell Living at Sinclair Place
Provider Type: Assisted Living Facility
License/Cert.#: 2728
Intake ID: 169752
Compliance Determination #: 56347
Region/Unit #: RCS Region 3 / Unit E
Investigator: Paul Aube
Investigation Date(s): 03/14/2025 through 03/18/2025
Complainant Contact Date(s):

Allegation(s):

1. Resident/Patient/Client Neglect: Public allegation of facility refusing to assist resident; leaving resident on floor after fall.
2. Pharmaceutical Services: Public allegation of issues receiving medications after transition to hospice services.

Investigation Methods:

Sample:	Total residents: 37 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Residents Nursing staff Management Family members
Record Reviews:	Incident investigation Facility policies Nursing Assessments Negotiated Service Agreements Progress Notes

Investigation Summary:

1. Resident/Patient/Client Neglect: Facility failed to conduct a new assessment after resident had change of condition, resulting in facility calling outside services to assist with getting resident back into bed after falls. Resident was no longer appropriate to remain in facility. Failed practice identified.
2. Pharmaceutical Services: Facility followed policies and procedures and sent resident back to hospital to receive medications as ordered when issue occurred. Resident remained in hospital until medications were obtained. No failed practice.

Conclusion / Action:

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

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800 NE 136th Ave Ste 200, Vancouver, WA 98684

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 03/14/2025 of:

Trustwell Living at Sinclair Place
680 W Prairie St
Sequim, WA 98382

This document references the following complaint number(s): 169752

The following sample was selected for review during the unannounced on-site visit: 3 of 37 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

(iii) When the resident has an injury requiring the intervention of a practitioner.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to complete a new assessment after a resident had a change of condition, for 1 of 2 residents (Resident 1 [R1]), reviewed. This failure resulted in R1 having repeated falls at the facility and placed R1 at risk for ongoing injury. This failure also delayed the facility in finding R1 placement to a facility with higher care and services and resulted in an overall decreased quality of life.

Findings included…

“WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must: (1) Observe each resident consistent with his or her assessed needs and negotiated service agreement; (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; (3) Evaluate, in order to determine if there is a need for further action: (4)

Take appropriate action in response to each resident's changing needs."

In an undated facility policy titled "Care Plan Policy" it stated, "Each resident should receive service and supervision based upon the resident's individual needs and preferences. These needs and preferences should be determined through the initial assessment and service planning process in the resident's Care Plan. The Care Plan will be developed through:
a.) Care Plan Discovery PRIOR to move-in, so that a determination can be made on appropriateness of the potential move-in and an accurate level of care can be established. Once a resident has moved in, the Care Plan should be reviewed for changes, especially if resident has been hospitalized… Subsequent care plans will be completed as follows:
i. At 30 days
ii. Every 90 days thereafter
iii. Significant Change in Condition."

Review of R1's Face Sheet show that the resident moved into the facility on [redacted] 2025.

Review of R1's "Functional Needs Service Plan" showed a completed date of 03/13/2025. Noted the Service Plan not signed by a facility representative, or a resident representative. Under "Transportation" it stated, "Independent. Resident travels independently on public transportation or drives own car." Under "Dining location" it stated, "resident will eat designated meal in dining room." Under "Mobility, Ambulation, and Transfer" it stated, "Resident uses Assistive Devices to aid with ambulation. Staff will assist with use of all assistive devices." The type of assistive device was not listed. Under "Does resident have a history of falls?" it stated, "Resident has a history of calls. Staff will determine steps to prevent falls. Frequent- 3 falls day of admit." No preventative fall interventions were listed.

Review of R1's "Functional Needs Assessment" showed a completed date of 03/13/2025. Noted the Service Plan was not signed by a facility representative, or a resident representative. Under "Does resident require assistance with transportation?" it stated, "Resident is independent." Under "Does resident require assistance with meals?" it stated, "No." Under "Does resident have any limitations to mobility or transfers?" it stated, "No." Under "Does the resident require staff assistance with transfers?" it stated, "No – Resident is able to safely transfer independently. Under "Does the resident require frequent checks for safety?" it stated, "No." Under "Does the resident require assistance with dressing and grooming?" it stated, "No – Resident is independent."

Review of an Incident Log for February and March of 2025 showed that R1 had an incident on the following dates:
• 02/04/2025: Under the "Type of Incident Section" it stated, "Sent to ER (Emergency Room)."
• 02/23/2025: Under the "Type of Incident Section" it stated, "NIF (Non-Injury Fall)."
• 02/25/2025: Under the "Type of Incident Section" it stated, "NIF."
• 02/28/2025: Under the "Type of Incident Section" it stated, "Sent to ER."

• 03/01/2025: Under the “Type of Incident Section” it stated, “NIF.”
• 03/03/2025: Under the “Type of Incident Section” it stated, “EMS (Emergency Medical Services) Transport.”

Review of R1’s Incident Reports for the incidents which occurred in February and March of 2025 showed:
• 02/04/2025: Under “Statement of Person Injured or Involved,” it stated, “Resident stated [they] felt dizzy, then turned around and fell, hitting [their] head on the floor. Got up and got back into bed [themselves].” Review of the section “Emergency Care and Service” showed that “911 called and attended resident” was checked. Review of the section “Immediate prevention of Re-Occurrence” showed it was left blank. Review of the section “Summarize root-cause analysis and follow up intervention” showed it was also left blank.
• 02/23/2025: Under “Describe the Incident”,” it stated, “Resident was found kneeling on the floor next to bed.” Resident told staff [they] didn’t fall. Resident has skin tears on right knee.” Review of the section “Emergency Care and Service” showed that it was left blank. Review of the section “Immediate prevention of Re-Occurrence” showed, “Remind resident to use [their] call pendant.” Review of the section “summarize root-cause analysis and follow up intervention” showed, “[R1] is on hospice/comfort care. Hospice is aware resident continues to try and get out of bed.”
• 02/25/2025: Under “Describe the Incident”,” it stated, “Med Tech (Medication Technician) went to check on the resident. [R1] was found kneeling on the floor next to [their bed]. Review of the section “Emergency Care and Service” showed, “EMS here for another resident. Help get [R1] up off the floor.” Review of the section “summarize root-cause analysis and follow up intervention” showed, “Resident states [they] got out of bed to try and get [their] phone off the charger. Resident verbalizes [they] forgot [they were] non-weight bearing.”
• 02/28/2025: Under “Statement of Person Injured or Involved,” it stated, “Resident on frequent safety checks. Continued to call staff and stated repeatedly [they] felt ‘confined’ and wanted out of [their] room.” Under “Describe the Incident”,” it stated, “At [4:30AM] care staff went to check on resident and found [them] on the floor. [Hospice] called, and on-call RN (Registered Nurse) is on the way.” Review of the section “Was abuse ruled out and how?” showed, “Yes, resident is on hospice/non-weight bearing, comfort care.” Review of the section “summarize root-cause analysis and follow up intervention” showed, “Resident placed on frequent checks to ensure resident safety.”
• 03/01/2025: Under “Statement of Person Injured or Involved,” it stated, “Last seen at [4AM]. Found resident sitting upright in front of bed… No apparent injuries. Keeps repeating “help me,” however did not use pendant… Hospice called.” Review of the section “Immediate prevention of Re-Occurrence” showed, “Continue Safety Checks.”
• 03/03/2025: Under “Describe the Incident” it stated, “Private caregiver came in for resident. [They] came to me with questions… Caregiver called family member whom called EMS. They came and took [R1] to the ER per communication between EMS and POA (Power of Attorney). [Night] shift was informed as suggestion…by EMS and hospice to place mattress on floor for [R1’s] safety as well as staff’s… [R1] would reposition [themselves] frequently while on the mattress on the floor.”

Review of R1’s progress notes showed the following written notes:
• 02/02/2025 at 1:05PM: “On 02/02/2025 staff reports [R1] has not come down to the dining room for meals ‘in a few days.’ Staff did attempt to bring [R1] sandwiches. Staff

reports [R1] took one bite and stated [they weren't] able to eat."
• 02/03/2025 at 1:22PM: "This morning it was reported that [R1] was not coming out of [their] room or eating by staff. Two residents came to this writer requesting [R1] 'get some help.' This writer did to go [R1's] room where [they] were lying on [their] left side in bed 'moaning' in just a t-shirt. There was 'red' on [their bed]. I asked [them] where it was coming from. This writer did inform [R1] [they] appeared to be in distress and EMS would be called… This writer did call [R1's] [family] who informed [R1] had called [them] more than 25 times over the weekend and seemed very confused… EMS was called. [R1] told EMS [they] would not go to the hospital several times… Resident placed Frequent safety checks."
• 02/04/2025 at 5:35PM: "[R1] has had a rapid decline over the last 24 hours. [R1] has been calling for assistance excessively and when staff attempt to help, [R1] refuses care. [R1] has not been coming to meals and had refused meal trays. This RN responded to a call to [R1's] apartment where [they were] found laying in bed, moaning that [they] needed help and was in pain. [R1] reported that [they] had a fall in [their] bathroom, and [they] hit [their] head. This RN had staff to call [EMS] for hospital evaluation as [they were] moaning in pain but adamantly refused… Roughly 1 minute after [EMS] left the building, [R1] called for staff assistance. This RN responded and [R1] was crying out 'help me, help me' and stated [they] fell, hit [their] head and in pain. This RN had staff alert [EMS] who were still in the parking lot, and they determined it was appropriate to take [R1 to the hospital] against [their] will. Police arrived and were able to assist [EMS] to get [R1] in the ambulance."
• 02/21/2025 at 11:28AM: "Resident returned from ER comfort measures to be onboarded with [hospice] per resident/POA request."
• Review of progress notes show there was no note written for incident on 02/23/2025.
• Review of progress notes show there was no note written for incident on 02/25/2025.
• Review of progress notes show there was no note written for incident on 02/28/2025.
• 03/01/2025 at 4:33PM: "This resident was observed on the floor in [their] room no apparent injuries. This resident did verbalize to staff 'help me' resident did not use pendant and was unable to verbalize why [they were] attempting to get out of bed… Upon hospice evaluation, they did recommend resident mattress be placed on the floor to prevent future injuries."
• 03/03/2025 at 4:24PM: "Resident was on a mattress on the floor per EMS/hospice recommendation as resident continued to 'fall' out of bed. Private caregiver did come to the facility and ask why [R1] was on the floor… Private caregiver called [family] who called 911 requesting this resident be transported [to the hospital].
• Review of progress notes showed no documentation of any conversation with family, or any documentation of a plan to transfer R1 to a different setting with a higher level of care.

During an interview with Collateral Contact 1 (CC1), R1's representative, on 03/13/2025 at 10:30AM, CC1 stated, "In the very beginning [R1] was ok, and [they were] still ambulatory (able to walk on their own)." CC1 stated R1 could no longer do that now. CC1 stated, "Then [R1] had a trip to the hospital and then [they] took a nosedive. I was nervous to have [R1] go back (to the facility) then." CC1 stated that the facility assured them that they could handle R1's care, telling CC1 that they also have hospice services available, in addition to their normal services. CC1 stated that initially the facility was taking care of R1 appropriately, and felt they were trying to accommodate R1's changes. CC1 stated that after R1 started to decline further, the facility was not assisting them. CC1 stated that "[R1] was bedbound because [their] legs were weak…

[R1] can't really do anything for [themselves… [R1] gets agitated and restless, scoots out of bed and ends up (falling) on the floor. The last two falls there were at 2AM and 5AM in the morning, and EMS would not come out anymore because it happened so many times. Staff would call them, and staff would say (to EMS) that they can't get [R1] up (off the floor). I talked to the hospice nurse, and they asked me if they could put the mattress on the floor to help minimize [R1] having an injury (because R1 was falling so often). I had concerns with that because I thought [R1] would scoot off that mattress and [they] would lay on the floor for a long time." CC1 stated they hesitantly agreed. CC1 then stated, "I hired [Collateral Contact 2, (CC2)], a private caregiver that took care of [R1] because I was worried about the care [they were] getting there. I wanted eyes on [them] to check on [them] and see what was going on. [CC2] reported to me that when [they] came in to see [R1], [R1] was on the off their mattress, on the cold floor. [R1] was in [their] depends (incontinence brief), and no pants. [CC2] stated [they] went to go get someone to help [them] get [R1] back on the bed, since they needed two people. [CC2] stated [they] got in touch with [office staff] and was told 'No [R1] is fine, and [R1] is safe' and [office staff] refused to [find someone to] come and help. CC2 called me and they sent me a picture [of R1 on the bare floor] and I was just appalled. I called the facility, and I also got [the office staff] and I told [them] again the situation and asked [them] to [find someone to] help [CC2] put [R1] back on [their] mattress and [they] told me the same thing. I was so angry, so I called 911. I asked them to go pick up [R1] and to take [them] to the hospital to be evaluated, and for new placement (to a new facility, with a higher level of care)."

During an interview with Staff B, the Resident Care Coordinator, on 03/14/2025 at 12:16PM, Staff B was asked to help clarify R1's decline of condition, as the progress notes were not clear. Staff B stated, "[R1] came in fairly independent, pretty social even. Then it started with [them] not wanting to wear pants to the dining room. That was when we noticed [they were] having a bit of a decline, spending a lot of time in bed… [R1] just quickly declined." Staff B was asked to give an approximate date as to when R1 started to decline. Staff B stated that R1's decline started on or around 02/04/2025. Staff B was asked to discuss R1's falls. Staff B stated, "There were lots of incidents when [R1] would fall. [R1] could not bear weight and every time [they] tried to get up, [they] would slide out of bed. [R1] was a 3-person transfer, sometimes 5 people; so, EMS had to be called to get him back into bed. They (EMS) were not happy about that." Staff B was asked if R1 was left on the floor on any occasions. Staff B stated, "Sometimes it wasn't even possible for 2 staff to get him back in the bed. If there is only 3 (staff) of us here, 3 of us cannot get him back into bed. We tried with 3 (staff), and we were not able." Staff B stated the facility would then call EMS to get R1 back into their bed. Staff B stated, "[EMS] informed us when they came (to help get R1 off the floor) that it was not a service that they provide; to help assist residents back in the bed multiple times a day. EMS told us to call hospice first before calling them, and it was hospice's responsibility to get [R1] in bed; and if hospice was unable, then we were supposed to call 911… At one point, EMS and hospice were present (after R1 had a fall), and they recommended to place the mattress on the floor to avoid injury." Staff B stated that R1 would often roll onto the floor. "On 03/03/2025, [R1] was rolling out [their] bed and was on the floor. A private caregiver came in and was upset with seeing [R1] on the floor. They notified [R1's] family. They (family) were upset and called us, and they requested [R1] be sent out. [R1] has been out of facility since this date." Staff B was asked if at any point they felt R1 had exceeded the facility's level of care. Staff B stated, "When [R1] started falling consistently and we were having to call hospice and EMS regularly." Staff B was

asked why R1's Service Plan and Assessment were dated for 03/13/2025, while R1 was out of the facility. Staff B stated, "It was pending. [R1] was due for an assessment, and by the time [R1's] was pending, we had not had the opportunity to have a care conference with [R1's family]." Staff B was asked if they felt that the current assessment accurately reflected R1's condition. Staff B stated, "No." Staff B was asked to provide a previous Assessment, and previous Service Plan for R1 for review. Staff B stated they were not able to locate the previous Assessment and Service Plan. Staff B was asked if a new Assessment and Service Plan should have been completed for R1 due to their decline/change in condition. Staff B stated, "Yes."

During an interview with Staff A, the Executive Director, on 03/14/2025 at 2:05PM, Staff A was asked if any conversations were had with R1's family to discuss R1 being transferred to a different setting with a higher level of care. Staff A stated, "[Staff B] has spoken with [R1's family] and hospice multiple times, stating that [R1] needed to go to a Skilled Nursing Facility." Staff A was asked if any of these conversations were documented. Staff A stated, "If [Staff B] did not document them, then no." Staff A was asked if a change of condition assessment should have been done for R1 after the facility recognized R1 had a decline of condition. Staff A stated, "Yes."

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, Trustwell Living at Sinclair Place is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date