STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Spokane Valley AL, LLC
Trustwell Living at Ridgeview Place
12903 E Mission Ave
Spokane Valley, WA 99216

RE: Trustwell Living at Ridgeview Place License # 2730

Dear Administrator:

This letter addresses Compliance Determination(s) 71212 (Completion Date 01/09/2026) and 69148 (Completion Date 11/26/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/09/2026 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-2130-3-a, WAC 388-78A-2130-3-b, WAC 388-78A-2130-3

The Department staff who did the on-site verification:
Tethra Wales, Assisted Living Facility Licensor

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Community Field Manager
Region 1, Unit B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Trustwell Living at Ridgeview Place
License/Cert.#: 2730
Compliance Determination #: 69148
Investigator: Tethra Wales
Investigation Date(s): 11/25/2025 through 11/26/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 202101
Region/Unit #: RCS Region 1 / Unit B

Allegation(s):

1. Resident to resident altercation
2. Restricted access when entering and exiting the facility
3. Misrepresentation of Medicaid allowance by facility

Investigation Methods:

Sample:	Total residents: 48 Resident sample size: 5 Closed records sample size: 0
Observations:	Staff and resident interactions Staff presence and availability to residents Staff providing cares to residents Resident call pendant system Front entry to facility Dining Room
Interviews:	Caregivers Med Techs Alleged victim representative Administrator Housekeeping Current residents and staff Nursing Administration staff
Record Reviews:	Characteristic roster Staff roster Resident face sheets Resident care plans Incident Report and Investigation Progress notes Abuse and Neglect Policy Disclosure of Services

Investigation Summary:

1. A resident had a change of condition following a resident to resident altercation.

No updates were made to the resident's negotiated service plan to reflect the change or provide interventions for staff. Failed practice identified and cited under WAC 388-78A-2130 (3)(a)(b) Service agreement planning,
2. Resident access in and out of the front entry door to the facility was restricted and required staff to provide access. Restrictions were in place on a temporary basis while the facility found alternative interventions for a resident prone to elopement. Residents were able to access two side doors into the facility with their access code without staff assistance. No failed facility practice identified.
3. Complainant stated misinformation was provided at time of admission regarding Medicaid eligibility. Confirmed in facility's Disclosure of Services that the facility does not accept Medicaid. No failed facility practice identified.

Conclusion / Action:

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

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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 11/25/2025 and 11/26/2025 of:

Trustwell Living at Ridgeview Place
12903 E Mission Ave
Spokane Valley, WA 99216

This document references the following complaint number(s): 202101

The following sample was selected for review during the unannounced on-site visit: 5 of 48 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Tethra Wales, Assisted Living Facility Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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 — 12/04/2025 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.

Ellyn Randolph — Administrator (or Representative) — 12/5/25 Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must: EB - 12/31/25

(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 record review, the facility failed to update a resident's negotiated service agreement following a change in condition for 1 of 5 residents (Resident 3). This failure placed Resident 3 at risk of unmet care needs.

Findings included...

Review of a Resident Note (progress note) for Resident 3, dated 11/12/2025, showed that an incident occurred on 11/11/2025 between Resident 3 and Resident 2 in the facility dining room.

Review of a Resident Note for Resident 3 dated, 11/18/2025, showed that, "since this situation this resident has not left [their] room."

In an interview on 11/21/2025 at 9:50 AM, Collateral Contact 1 (CC1) ,Resident 3's Representative, stated that Resident 3 has struggled to get over the incident on

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-2130 Service agreement planning. The assisted living facility must:

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(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 record review, the facility failed to update a resident’s negotiated service agreement following a change in condition for 1 of 5 residents (Resident 3). This failure placed Resident 3 at risk of unmet care needs.

Findings included…

Review of a Resident Note (progress note) for Resident 3, dated 11/12/2025, showed that an incident occurred on 11/11/2025 between Resident 3 and Resident 2 in the facility dining room.

Review of a Resident Note for Resident 3 dated, 11/18/2025, showed that, “since this situation this resident has not left [their] room.”

In an interview on 11/21/2025 at 9:50 AM, Collateral Contact 1 (CC1) ,Resident 3’s Representative, stated that Resident 3 has struggled to get over the incident on

11/11/2025 and had not left their room to go to the dining room or step outside since the incident, because they were afraid. CC1 stated that prior to the incident Resident 3 participated in activities and spent a portion of their day in the lobby visiting with staff and residents.

In an interview on 11/21/2025 at 10:45 AM, CC2, Resident 3's Representative, stated that Resident 3 had not come out of their room because they were scared. CC2 further stated that Resident 3 has had all their meals delivered to their room since the incident.

In an interview on 11/26/2025 at 3:47 PM, Staff B, Health Services Director, stated that Resident 3 was "distraught" after the incident on 11/11/2025 and "is not able to get passed it." Staff B further stated that Resident 3 has stayed in their room since the incident, outside of one occasion when they came downstairs. Staff B stated that they offered to escort Resident 3 to meals but the resident declined. Staff B confirmed Resident 3 continued to receive meal trays to their room. Staff B further stated that prior to the incident Resident 3 did not confine to their room and ate in the dining room.

In an interview on 11/26/2025 at 1:01 PM, Staff A, Resident Care Coordinator, stated that prior to the incident on 11/11/2025 Resident 3 came downstairs for every meal and socialized on the couch in the lobby on a regular basis. Staff A confirmed that Resident 3 had not come out of their room since the incident and that all meals were delivered to their room.

Review of Resident 3's Resident Functional Needs Service Plan (the facility's titled negotiated service agreement), dated 05/30/2025, showed no documentation to address the change in Resident 3's condition following the altercation, their preference to eat their meals in their room, or interventions to address Resident 3's continued hesitation to leave their room.

Statement of Deficiencies	License #: 2730	Compliance Determination # 69148
Plan of Correction	Trustwell Living at Ridgeview Place	Completion Date
Page 4 of 4	Licensee: Spokane Valley AL, LLC	11/26/2025

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, Trustwell Living at Ridgeview Place is or will be in compliance with this law and / or regulation on (Date) 12/31/25 .

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

Ellyn Bourdon 12/5/25

Administrator (or Representative) Date

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 Ridgeview 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