STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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) 76370 (Completion Date 04/23/2026) and 73245 (Completion Date 02/27/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/23/2026 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-2240

The Department staff who did the on-site verification:
Amy Wright, NCI Complain 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 B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Trustwell Living at Ridgeview Place
License/Cert.#: 2730
Compliance Determination #: 73245
Investigator: Amy Wright
Provider Type: Assisted Living Facility
Intake ID: 211696
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 02/20/2026 through 02/27/2026
Complainant Contact Date(s): 02/19/2026, 03/27/2026

Allegation(s):
Medications not administered as ordered.

Investigation Methods:

Sample:
Total residents: 48
Resident sample size: 3
Closed records sample size: 0

Observations:
Alleged Victim
Residents
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Reporter/Alleged Victim's Representative
Executive Director
Health Services Wellness Director
Alleged Victim
Resident

Record Reviews:
*Disclosure of Services
*Characteristic roster
*Staff roster
*Resident face sheets
*Resident care plan
*Progress notes
*Medication administration records
*Medication Assistance and Administration Policy

Investigation Summary:
Record review and interview showed that the Alleged Victim did not receive their medications as prescribed because they were unavailable. Failed facility practice identified and cited under WAC 388-78A-2240 Nonavailability of medications.

Conclusion / Action:

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

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8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

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 02/20/2026 of:

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

This document references the following complaint number(s): 211696

The following sample was selected for review during the unannounced on-site visit: 3 of 48 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Amy Wright, NCI Complain Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

Statement of Deficiencies	License #: 2730	Compliance Determination #73245
Plan of Correction	Trustwell Living at Ridgeview Place	Completion Date
Page 2 of 4	Licensee: Spokane Valley AL, LLC	02/27/2026

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.

Residential Care Services — 03/04/2026 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.

Administrator (or Representative) — 3/9/26 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. EB - 3/9/26

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to obtain a resident's prescribed medications in a timely manner for 1 of 3 residents (Resident 1). This failed practice resulted in missed medication for Resident 1 and placed them at risk for adverse health events.

Findings included...

Review of a Negotiated Service Agreement (NSA) for Resident 1, dated 01/28/2026, showed that the resident had diagnoses including [redacted], and [redacted]. Further review of the NSA showed that the facility was responsible for ordering Resident 1's medications.

In an interview on 02/19/2026 at 10:47 AM, Collateral Contact 1 (CC1), Resident Representative, stated that Resident 1 did not receive five of their medications for six days from 01/30/2026 through 02/05/2026. CC1 stated that the facility was supposed to be managing Resident 1's medications. CC1 stated they were concerned about Resident 1 missing those medications because the resident had atrial fibrillation, hypertension, and history of stroke and that missing the medications put Resident 1 at "beyond high risk." CC1 stated that they felt like they had to check in and keep an eye on Resident 1 to make sure they got their medications. CC1 stated they could have solved the

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 facility failed to obtain a resident's prescribed medications in a timely manner for 1 of 3 residents (Resident 1). This failed practice resulted in missed medication for Resident 1 and placed them at risk for adverse health events.

Findings included…

Review of a Negotiated Service Agreement (NSA) for Resident 1, dated 01/26/2026, showed that the resident had diagnoses including [redacted] and [redacted]. Further review of the NSA showed that the facility was responsible for ordering Resident 1's medications.

In an interview on 02/19/2026 at 10:47 AM, Collateral Contact 1 (CC1), Resident Representative, stated that Resident 1 did not receive five of their medications for six days from 01/30/2026 through 02/05/2026. CC1 stated that the facility was supposed to be managing Resident 1's medications. CC1 stated they were concerned about Resident 1 missing those medications because the resident had atrial fibrillation, hypertension, and history of stroke and that missing the medications put Resident 1 at "beyond high risk." CC1 stated that they felt like they had to check in and keep an eye on Resident 1 to make sure they got their medications. CC1 stated they could have solved the

problem right away because they had medications for Resident 1 at home.

Review of Medication Administration Records (MARs) for Resident 1, dated January 2026 and February of 2026, showed that Resident 1 did not receive their nightly atorvastatin (a medication used to lower bad cholesterol while raising good cholesterol to prevent heart attacks, stroke, and chest pain) from 01/29/2026 through 02/04/2026, because staff were waiting on a refill. The MARs showed that Resident 1 did not receive their morning flecainide (a medication used to prevent serious-life threatening irregular heartbeats like atrial fibrillation) from 01/30/2026 through 02/05/2026 and that they did not receive their bedtime dose of flecainide from 01/29/2026 through 02/04/2026, because the staff were waiting on refills. The MARs showed that Resident 1 did not receive their morning hydrochlorothiazide (a diuretic medication used to treat high blood pressure) from 01/30/2026 through 02/05/2026, because the staff were waiting on a refill. The MARs showed that Resident 1 did not receive their nightly rivaroxaban (a medication that reduces the risk of stroke) from 01/29/2026 through 02/05/2026, because the staff were waiting on a refill. Further review of the MARs showed that Resident 1 did not receive their nightly quetiapine (a medication used to treat major depressive disorder) from 01/29/2026 through 02/04/2026, because staff were waiting on a refill.

Review of a progress note for Resident 1, with an effective date of 01/29/2026 at 5:43 PM, and written by Staff A, Health Services Wellness Director, showed that on that day, the facility received notification from the pharmacy that Resident 1’s medications could not be filled because they were filled at another pharmacy. There was no documentation in the note to show that Resident 1’s family or doctor were contacted to notify them that Resident 1 was out of medication.

Review of a progress note for Resident 1, dated 02/05/2026 at 11:03 AM, and written by Staff A, showed that the facility again received notification from the pharmacy that some of Resident 1’s medications could not be filled. The progress note showed that Staff A then called the resident’s family to ask if they could bring in the needed medications, seven days after Resident 1 was first noted to be out of their medications.

Statement of Deficiencies	License #: 2730	Compliance Determination #73245
Plan of Correction	Trustwell Living at Ridgeview Place	Completion Date
Page 4 of 4	Licensee: Spokane Valley AL, LLC	02/27/2026

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) 4/10/26.

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

Ellyn Barndollar — Administrator (or Representative)

3/9/26 — 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