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

Kelso AL, LLC
Trustwell Living at Highlander Place
114 Corduroy Rd
Kelso, WA 98626

RE: Trustwell Living at Highlander Place License # 2731

Dear Administrator:

This letter addresses Compliance Determination(s) 69073 (Completion Date 12/05/2025) and 64505 (Completion Date 10/01/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/05/2025 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-2160

The Department staff who did the on-site verification:
Jacob Ubl, ALF NCI CI

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley RN

Clinton Fridley, Adult Family Home Nurse Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Trustwell Living at Highlander Place
License/Cert.#: 2731
Compliance Determination #: 64505
Investigator: Jacob Ubl
Investigation Date(s): 08/20/2025 through 10/01/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 193720
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1. Quality of Life: Allegation that residents at the facility were not being treated with dignity and respect.

2. Quality of Care/Treatment: Allegation that resident needs were not being met at the facility.

Investigation Methods:

Sample:	Total residents: 33 Resident sample size: 9 Closed records sample size: 0
Observations:	Identified resident Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident staff Family members
Record Reviews:	Medical records State reporting log Incident investigation Facility policies

Investigation Summary:

1. Quality of Life: The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews, observations and records review, no failed facility practice was substantiated during the investigation. Additional residents reviewed for care, safety and services with no concerns.

2. Quality of Care/Treatment: Failed practice identified. The Facility failed to implement identified residents Negotiated Service Agreements.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Trustwell Living at Highlander Place
License/Cert.#: 2731
Compliance Determination #: 64505
Investigator: Jacob Ubl
Investigation Date(s): 08/20/2025 through 10/01/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 190697
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1. Resident/Patient/Client Rights: Allegation that residents were not being treated with dignity and respect.

2. Quality of Care/Treatment: Allegation that resident needs were not being met at the facility.

3. Administration/personnel: Allegation that staff were talking about residents private healthcare information where it could be heard in common areas.

Investigation Methods:

Sample:	Total residents: 33 Resident sample size: 9 Closed records sample size: 0
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions Kitchen
Interviews:	residents staff Family members
Record Reviews:	Medical records Incident investigation Facility policies

Investigation Summary:

1. Resident/Patient/Client Rights: The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews, observations and records review, no failed facility practice was substantiated during the investigation. Additional residents reviewed for care, safety and services with no concerns.

2. Quality of Care/Treatment: Failed practice identified. The Facility failed to implement identified residents Negotiated Service Agreements.

3. Administration/personnel: The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews, observations and records review, no failed facility practice was substantiated during the investigation. Additional residents reviewed for care, safety and services with no concerns.

Conclusion / Action:

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

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

Statement of Deficiencies	License #: 2731	Compliance Determination # 64505
Plan of Correction	Trustwell Living at Highlander Place	Completion Date
Page 1 of 5	Licensee: Kelso AL, LLC	10/01/2025

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 09/20/2025 and 10/01/2025 of:

Trustwell Living at Highlander Place
114 Corduroy Rd
Kelso, WA 98626

This document references the following complaint number(s): 190697, 190507, 190300, 188523, 193720

The following sample was selected for review during the unannounced on-site visit: 9 of 33 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Jacob Ubl, ALF NCI CI

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

Statement of Deficiencies	License #: 2731	Compliance Determination # 64505
Plan of Correction	Trustwell Living at Highlander Place	Completion Date
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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.

Clinton Fridley
Residential Care Services

10/09/2025
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)

11/15/2025
Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide care agreed upon in the needs and services plan (the facility's version of the negotiated service agreement [NSA]) for 3 of 9 sampled residents (Resident 1, Resident 2, and Resident 3). This failure resulted in the residents suffering a decreased quality of life by not having their care needs met.

Findings included...

In an interview on 08/14/2025 at 2:07 PM, Collateral Contact 1 (CC1), stated that they had witnessed observations that the facility was failing to adequality address residents' incontinence needs at the facility. CC1 stated that they saw and smelt urine while residents were at a meal.

<Resident 1>

Record review of an undated face sheet showed Resident 1 (R1) was admitted to the facility on [redacted]/2025 with a diagnosis of [redacted].

Record review of R1's NSA, dated 08/13/2025, showed R1 was incontinent of bladder and the facility was to keep the resident clean and dry by providing incontinent care.

In an interview on 08/20/2025 at 2:59 PM, R1 stated that they had pushed their call light about 10 minutes prior and had urinated themselves waiting for staff assistance with toileting. R1 stated that the facility was short staffed, so it took staff about 15 to 20 minutes, sometimes longer, to answer call lights and this was distressing and uncomfortable for them.

During an observation on 08/20/2025 at 3:01 PM in R1's room, while close to R1, there was a strong foul-smelling odor that was noted with R1's brief visually appearing damp and swollen with yellow liquid droplets dripping from R1's groin area.

During an observation on 08/20/2025 at 3:12 PM Staff B, caregiver, was observed entering R1s room to address R1s incontinence.

In an interview on 08/20/2025 at 3:16 PM, Collateral Contact 2 (CC2), stated they had observed the facility was failing to adequality address residents' incontinence needs at the facility. CC2 stated that the facility was short staffed, so it took staff about 15 to 20 minutes, sometimes longer, to answer call lights.

On 09/09/2025, in an interview, at 12:42 PM, Collateral Contact 3 (CC3) stated that the facility's expectation was that residents, who had incontinence, were to be kept free and dry of incontinence. CC3 stated that Resident 2 (R2), and Resident 3 (R3) were not getting their incontinence needs met as the residents would toilet themselves, risking a fall, or they would find the residents sitting in their own incontinence, for hours, and the incontinence was cold and partially dried.

<Resident 2>

Record review of an undated face sheet showed R2 was admitted to the facility on [redacted]/2023 with a diagnosis of [redacted].

Record review of R2's NSA, dated 08/25/2025, showed R2 was incontinent of bladder and the facility was to keep the resident clean and dry by providing incontinent care.

In an interview on 09/09/2025 at 12:58 PM, R2 stated that staff sometimes took a long time to respond to call lights causing them to urinate their brief while they were waiting for staff, have a bowel movement in their brief while they were waiting for staff, and sit in their incontinence, feeling disturbed, while they waited for staff to respond to their call light and assist them with a clean, dry, brief change.

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In an interview on 09/09/2025 at 1:17 PM, Collateral Contact 4 (CC4) stated that the facility's expectation was that residents, who had incontinence, were to be kept free and dry of incontinence. CC4 stated that R2 and R3 were not getting their incontinence needs met as the residents would toilet themselves, risking a fall, or they would find the residents sitting in their own incontinence, for hours, and the incontinence was cold and partially dried.

In an interview on 09/09/2025 at 2:55 PM, Collateral Contact 5 (CC5) stated that the facility's expectation was that residents, who had incontinence, were to be kept free and dry of incontinence. CC5 stated that R2 and R3 were not getting their incontinence needs met as the residents would toilet themselves, risking a fall, or they would find the residents sitting in their own incontinence and the incontinence was cold and partially dried.

In an interview on 09/09/2025 at 3:21 PM, Collateral Contact 6 (CC6) stated that the facility's expectation was that residents, who had incontinence, were to be kept free and dry of incontinence. CC6 stated that R2 and R3 were not getting their incontinence needs met as the residents would toilet themselves, risking a fall, or they would find the residents sitting in their own incontinence and the incontinence was cold and partially dried.

<Resident 3>

Record review of an undated face sheet showed R3 was admitted to the facility on [redacted]/2018 with a diagnosis of [redacted].

Record review of R3's NSA, dated 09/03/2025, showed R3 was incontinent of bladder and the facility was to keep the resident clean and dry by providing incontinent care.

In an interview on 09/09/2025 at 3:32 PM, R3 stated that staff sometimes took a long time to respond to their call lights causing them to urinate their brief while they were waiting for staff and sit in their incontinence while they waited for staff to respond to their call light to assist them with a clean, dry, brief change. R3 stated that they had given up on waiting for staff, out of frustration, and would rather risk falling, by attempting to transfer themselves to the toilet.

In an interview on 10/01/2025 at 1:53 PM, Staff A, executive director, stated it was unacceptable that residents had not been getting their incontinent needs met in a timely manner.

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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 Highlander Place is or will be in compliance with this law and / or regulation on (Date) 11/15/2025.

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

Administrator (or Representative) [signature] Date 11/15/2025