STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
***800 NE 136th Ave Ste 200, Vancouver, WA 98684***

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

RE: Trustwell Living at Sinclair Place License # 2728

Dear Administrator:

This letter addresses Compliance Determination(s) 79938 (Completion Date 06/30/2026) and 76798 (Completion Date 05/11/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/30/2026 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-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2640-1, WAC 388-78A-2640-1-a, WAC 388-78A-2640-1-b, WAC 388-78A-2640-1-c

The Department staff who did the on-site verification:
Phan Pham, Complaint Investigator

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

Sincerely,

Cory Cisneros

Cory Cisneros, Nursing Home Allied Health Field Manager
Region 3, Unit E
Residential Care Services

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# Residential Care Services
## Investigation Summary Report

**Provider/Facility:** Trustwell Living at Sinclair Place
**Provider Type:** Assisted Living Facility
**License/Cert.#:** 2728
**Intake ID:** 219899
**Compliance Determination #:** 76798
**Region/Unit #:** RCS Region 3 / Unit E
**Investigator:** Phan Pham
**Investigation Date(s):** 04/27/2026 through 05/11/2026
**Complainant Contact Date(s):**

**Allegation(s):**
Quality of care - Named resident had a pressure injury.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 51<br>Resident sample size: 2<br>Closed records sample size: 1 |
| **Observations:** | Residents, environment, staff interactions with residents, staff members providing care and services, and safety measures. |
| **Interviews:** | Residents, staff members, administrative and member not associated with the facility. |
| **Record Reviews:** | Sampled residents and incident reports. |

**Investigation Summary:**
An on-site investigation was conducted, and the concerns related pressure injury, quality of care and treatments were reviewed. The resident's care plan had interventions to ensure necessary care and services were being provided and kept the resident safe and were being implemented. Additional residents reviewed

**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

***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 04/27/2026 and 05/11/2026 of:

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

This document references the following complaint number(s): 220394, 219899

The following sample was selected for review during the unannounced on-site visit: 2 of 51 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Phan Pham, Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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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, RN
Residential Care Services

05/19/2026
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.

Kinley Adler
Administrator (or Representative)

5/19/26
Date

**WAC 388-78A-2371 Investigations. The assisted living facility must:**

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

**This requirement was not met as evidenced by:**

Based on observation, interview and record review, the facility failed to investigate an alleged fall with substantial injury while the resident was out of the community for 1 of 3 current sampled residents (Resident 1) reviewed. This failure placed residents at risk for repeated injuries.

Findings included...

Review of Resident 1's face sheet showed the resident was admitted to the facility on [redacted]/2026 with diagnoses including [redacted] and [redacted]. The resident's negotiated care plan dated 03/31/2026 documented the resident was dependent on staff members for assistance with their activities of daily living, transfers and ambulation.

Observation on 04/27/2026 at 2:46 PM, Resident 1 was observed in a wheelchair in their room, neatly groomed and dressed. Resident 1 had a dressing on their right forehead, dark redden skin discoloration around the right eye, cheek, and neck areas.

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In an interview at 2:46 PM, Resident 1 said they fell off the wheelchair while waiting for a ride at a community transit ride stop. Resident 1 stated they hit their forehead and elbow on the payment. Resident 1 said someone transported them to the hospital.

Review of the hospital record dated 04/21/2026, documented the resident fell of their wheelchair and sustained a hematoma (collection of clotted or partially clotted blood that pools outside of blood vessels) of the forehead and an abrasion of the face. The resident was discharged to the assisted living facility.

Review of Home Health, a third-party care charting form dated 04/22/2026, documented Resident 1 fell on 04/21/2026, sustained an abrasion on the right forehead and cheek from hitting the head on asphalt. The wound measured 12 centimeters (cm) in length, 13 cm in width and 0.1 cm in depth.

In an interview on 04/27/2026 at 2:48 PM, Staff A, Executive Director, stated Resident 1 fell and went to the hospital. Staff A said the assisted living facility did not complete an investigation because the incident happened off site.

In an interview on 05/11/2026 at 1:24 PM, Staff B, Resident Care Coordinator, stated the resident took the transit to the post office, fell off their wheelchair and was transported to the hospital. Staff B said it was difficult to investigate the incident when the resident got hurt while out of the facility.

In an interview on 05/11/2026 at 1:39 PM, Staff C, Regional Registered Nurse, stated staff members were responsible for investigating and completing incident reports for any injury to residents. Staff C said Resident 1's injury was substantial and the incident should have been investigated.

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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 Sinclair Place is or will be in compliance with this law and / or regulation on (Date) 6/24/26.

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

Administrator (or Representative) — Date: 5/19/26

**WAC 388-78A-2640 Reporting significant change in a resident's condition.**

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(b) The resident is relocated to a hospital or other health care facility; or

(c) The resident dies.

**This requirement was not met as evidenced by:**

Based on observation, interview and record review, the assisted living facility failed to ensure staff members notified the resident's physician when the resident fell and sustained injuries that required a hospital evaluation for 1 of 3 current sampled residents (Resident 1) reviewed for reporting. This failure placed the resident at risk of not receiving proper care and services.

Findings included...

Review of Resident 1's face sheet showed the resident was admitted to the facility on [redacted]/2026 with diagnoses including [redacted] and [redacted]. The resident's negotiated care plan dated 03/31/2026 documented the resident was dependent on staff members for assistance with their activities of daily living, transfers, and ambulation.

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Review of Home Health, a third-party care charting form dated 04/22/2026, documented Resident 1 fell on 04/21/2026, sustained an abrasion on the right forehead and cheek from hitting the head on asphalt. The wound measured 12 centimeters (cm) in length, 13 cm in width and 0.1 cm in depth.

In an interview on 04/27/2026 at 2:48 PM, Staff A, Executive Director, stated Resident 1 fell off site and went to the hospital before the assisted living facility staff knew it.

In an interview on 05/11/2026 at 1:24 PM, Staff B, Resident Care Coordinator, stated the resident took the transit to the post office, fell off their wheelchair and was transported to the hospital. Staff B said the assisted living facility's staff did not notify Resident 1's physician because the resident came back from the hospital.

In an interview on 05/11/2026 at 1:39 PM, Staff C, Regional Registered Nurse, stated staff members were responsible for reporting. Staff C said Resident 1's injury was substantial and their physician should have been notified.

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