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) 79565 (Completion Date 06/25/2026) and 77395 (Completion Date 05/19/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/25/2026 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-2170-1

The Department staff who did the on-site verification:
Amy Wright, NCI Complain Investigator

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

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: Trustwell Living at Ridgeview Place
License/Cert.#: 2730
Compliance Determination #: 77395
Investigator: Amy Wright
Investigation Date(s): 05/14/2026 through 05/19/2026
Complainant Contact Date(s): 05/13/2026, 05/20/2026

Provider Type: Assisted Living Facility

Intake ID: 222504
Region/Unit #: RCS Region 1 / Unit B

Allegation(s):
Memory care resident left alone in community after facility outing.

Investigation Methods:

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

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

Interviews:
Reporter
Executive Director
Business Office Director
Residents
Activities Director
Alleged Victim's Representative

Record Reviews:
*Disclosure of Services
*Characteristic roster
*Staff roster
*Utility invoice
*Resident face sheets
*Resident care plans
*Progress notes
*Transportation checklist
*Resident sign out log
*Utility disconnect notice
*Incident investigation
*Medication administration records
*Resident mini mental exam
*Elopement assessment

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Investigation Summary:

Interview and record review confirmed that a facility resident, who required supervision when outside the facility, was left alone in community after the facility van returned to the facility without them. Failed facility practice was identified and cited under WAC 388-78A-2170 Required assisted living facility services (1).

Conclusion / Action:

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

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
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 05/14/2026 of:

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

This document references the following complaint number(s): 223214, 222504

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

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Statement of Deficiencies	License #: 2730	Compliance Determination #77395
Plan of Correction	Trustwell Living at Ridgeview Place	Completion Date
Page 2 of 4	Licensee: Spokane Valley AL, LLC	06/19/2026

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 — 06/01/2026 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) — 6/5/26 Date

WAC 388-78A-2170 Required assisted living facility services. Ellyn Bardellon 6/2/26

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that a resident who left the facility on a group outing was provided supervision in the community according to their negotiated service agreement for 1 of 1 resident (Resident 1). This failed practice resulted in Resident 1 being left unsupervised and alone on a community group outing and placed them at risk for injury and becoming lost in the community.

Findings included...

Review of a face sheet for Resident 1, dated 12/31/2025, showed that the resident had a diagnosis of [redacted].

Review of a negotiated service agreement for Resident 1, dated 03/03/2026, showed that the resident required supervision when outside the facility.

In an interview on 05/13/2026 at 3:17 PM, Collateral Contact 1 (CC1), Member of the Public, stated that on 04/29/2026, they encountered Resident 1 around 10:30 AM or 11:00 AM walking around outside a store. CC1 stated that Resident 1 looked lost. CC1 stated that they went inside the store to shop and when they came back out approximately an hour later, Resident 1 was still outside. CC1 stated that they

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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.

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-2170 Required assisted living facility services.

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approached the resident who told them that someone was coming to pick them up. CC1 stated that they went into another store and shopped for about 20 to 30 minutes. CC1 stated that when they exited the second store, they approached Resident 1 again and Resident 1 told them that they lived at a nearby assisted living facility. CC1 stated that they went inside the store and spoke with an employee who told CC1 that they had seen a group of four to five elderly people come in on a bus earlier that day. CC1 stated that the store employee reported that the bus had already come back and picked the people up. CC1 stated that it was not until then that Resident 1 realized they had been left behind. CC1 stated that it had been hot that day and Resident 1 had not been dressed for the weather. CC1 stated that Resident 1 had no way to call anybody. CC1 stated that they called the facility number several times, they left multiple voicemails, and no one ever answered or called them back “to this day.” CC1 stated that they brought Resident 1 back to the facility themselves around 1:30 PM to 2:00 PM.

Review of a resident sign in/sign out log, showed that six residents were documented as having left the facility with two staff members on 04/29/2026 at 10:20 AM enroute to a store. The log showed that five of the residents returned to the facility at 11:30 AM.

In an interview on 05/14/2026 at 10:09 AM, Staff A, Executive Director, stated that Staff B, Activities Director, was new and thought that because all the residents were adults, a checklist had not been necessary. Staff A stated that Staff B felt horrible about Resident 1 being left behind.

In an interview on 05/14/2026 at 11:29 AM, Staff B stated there had not initially been a process for accounting for residents when on facility outings.

In an interview on 05/19/2026 at 2:37 PM, Collateral Contact 2 (CC2), Resident Representative, stated that Resident 1 had dementia and they were forgetful. CC2 stated that Resident 1 had no cell phone. CC2 stated that if someone told Resident 1 to be outside in half an hour, that may not have worked, especially if Resident 1 was shopping.

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Statement of Deficiencies	License #: 2730	Compliance Determination # 77395
Plan of Correction	Trustwell Living at Ridgeview Place	Completion Date
Page 4 of 4	Licensee: Spokane Valley AL, LLC	05/19/2026

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) 6/11/26.

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

Ellyn Brandellen - ED — Administrator (or Representative)

6/5/26 — Date

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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 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

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