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

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

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

RE: Trustwell Living at Highlander Place # 2731

Dear Administrator:

This document references Compliance Determination 67319 (12/05/2025), which included complaint number(s) 197404.

The Department completed a complaint investigation of your Assisted Living Facility on 12/05/2025 and found that your facility does not meet the Assisted Living Facility requirements.

The department staff who did the inspection and provided consultation:

Jacob Ubl, ALF NCI CI

Consultation:

WAC 388-78A-2690 Electronic monitoring equipment Resident requested use.

(1) Audio or video monitoring equipment may not be installed in the assisted living facility to monitor any resident apartment or sleeping area unless the resident or the residents' representative has requested and consents to the monitoring.

(5) The release of audio or video monitoring recordings by the facility is prohibited. Each person or organization with access to the electronic monitoring must be identified in the resident's negotiated service agreement.

(6) If the resident requests the assisted living facility to conduct audio or video monitoring of his or her apartment or sleeping area, before any electronic monitoring

occurs, the assisted living facility must ensure:

(a) That the electronic monitoring does not violate chapter 9.73 RCW;

(c) The resident and the assisted living facility have agreed upon a specific duration for the electronic monitoring and the agreement is documented in writing.

(8) The assisted living facility must immediately stop electronic monitoring if the:

(c) The resident becomes unable to give consent, unless consent has been provided by a resident's representative as described in this section.

(9) For the purpose of consenting to video electronic monitoring without an audio component, the term "resident" includes the resident's representative.

(12) If the assisted living facility determines that a resident, resident's family, or other third party is electronically monitoring a resident's room or apartment without complying with the requirements of this section, the assisted living facility must disconnect or remove such equipment until the appropriate consent is obtained and notice given as required by this section.

The Facility failed to have proper documentation and preparations in place before allowing video monitoring to take place in a resident apartment. The failure was resolved before complaint investigation took place. The Facility staff validated knowledge of video monitoring equipment regulatory requirements that they had educated themselves on.

You Must:
- Begin the process of correcting the deficiency or deficiencies immediately; and
- Complete correction as soon as possible.

You Are Not:
- Required to submit a plan-of-correction for the deficiency or deficiencies found.

The Department May:
- Inspect the facility to determine if you have corrected all deficiencies.

You May:
- Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:
- Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  - What specific deficiency or deficiencies you disagree with;
  - Why you disagree with each deficiency; and
  - Whether you want an IDR to occur in-person, by telephone or as a paper review.
  - You can make an IDR request and find directions on the IDR web page at: https://www.dshs.wa.gov/altsa/idr

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If You Have Any Questions:

- Please contact me at (360)450-1218.

Sincerely,

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: Trustwell Living at Highlander Place
License/Cert.#: 2731
Compliance Determination #: 67319
Investigator: Jacob Ubl
Investigation Date(s): 10/15/2025 through 12/05/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 197404
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
1. Death- General: Facility report of a residents death.

Investigation Methods:

Sample:	Total residents: 35 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	staff Residents Family members
Record Reviews:	Medical records Incident investigation Facility policies

Investigation Summary:
1. Death- General: Failed practice identified. Consultation as the Facility failed to have proper documentation and preparations in place before allowing video monitoring to take place in a resident apartment. The failure was resolved before complaint investigation took place. The Facility staff validated knowledge of video monitoring equipment regulatory requirements that they had educated themselves on.

Conclusion / Action:

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

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☐ N/A

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