STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Rural Resources Community Action
Allegiance Supported Living
N 413 Kruger St
Chewelah, WA 99109

RE: Allegiance Supported Living License # 2175

Dear Administrator:

This letter addresses Compliance Determination(s) 52046 (Completion Date 12/19/2024) and 49061 (Completion Date 10/22/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/19/2024 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-2100-2-a, WAC 388-78A-2484, WAC 388-78A-2484-1, WAC 388-78A-2484-2

The Department staff who did the on-site verification:
Veronica Jackson, Assisted Living Facility Licensor

If you have any questions, please contact me at (509)323-7315.

Sincerely,

JSalquist

Jessica Salquist, Field Manager
Region 1, Unit B
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

Statement of Deficiencies	License #: 2175	Compliance Determination # 49061
Plan of Correction	Allegiance Supported Living	Completion Date
Page 1 of 4	Licensee: Rural Resources Community Action	10/22/2024

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 follow-up on 10/21/2024 and 10/21/2024 of:

Allegiance Supported Living
N 413 Kruger St
Chewelah, WA 99109

This document references the following SOD dated: 10/22/2024

The following sample was selected for review during the unannounced on-site visit: 5 of 18 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Brian Zbylski, ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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

11/01/2024
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.

Lois Sacs — Administrator (or Representative)

11-18-24 — Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete annual assessments for 2 of 3 sampled residents (Residents 1 and 7). This failure resulted in residents not being assessed to ensure their care and service needs were being met.

Findings included...

Review of Resident 1's medical records showed an admission date of [redacted]/2015. Further review showed an outdated facility annual assessment dated 10/11/2022.

Review of Resident 7's medical records showed an admission date of [redacted]/2007. Further review showed an outdated facility annual assessment dated 09/02/2022.

In an interview on 10/21/2024 at 12:45 PM, Staff E, Resident Care Coordinator, stated that they were not aware that resident assessments needed to be completed annually. Staff E stated that updated assessments for Residents 1 and 7 had not been completed.

This is an uncorrected deficiency previously cited on 08/23/2024.

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, Allegiance Supported Living is or will be in compliance with this law and / or regulation on (Date) 11-30-24

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

LeHSACA
Administrator (or Representative)

11-18-24
Date

TB TEST

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff were tested for tuberculosis within three days of employment and failed to ensure a second tuberculosis test was completed within one to three weeks after the first test for 1 of 2 sampled staff (Staff B). This failure placed residents at risk of exposure to tuberculosis.

Findings included...

Review of the facility staff list showed that Staff B, Housekeeper/Caregiver, was hired on 04/01/2024.

In an interview on 10/21/2024 at 11:35 AM, Staff A, Administrator, stated that Staff B completed a single tuberculosis (TB, a respiratory disease) test after the facility's recent full inspection in August 2024. Staff A stated they misunderstood that the two-step process had to be restarted from the beginning.

Review of facility records showed no two step TB test was done.

This is an uncorrected deficiency previously cited on 08/23/2024.

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, Allegiance Supported Living is or will be in compliance with this law and / or regulation on (Date) 11-30-24.

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

Sonja Sacra
Administrator (or Representative)

11-18-24
Date

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

Statement of Deficiencies	License #: 2175	Compliance Determination # 46143
Plan of Correction	Allegiance Supported Living	Completion Date
Page 1 of 18	Licensee: Rural Resources Community Action	08/23/2024

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 the unannounced on-site full inspection on 08/20/2024, 08/21/2024, 08/22/2024 and 08/23/2024 of:

Allegiance Supported Living
N 413 Kruger St
Chewelah, WA 99109

The following sample was selected for review during the unannounced on-site visit: 6 of 18 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Brian Zbylski, ALF Licensor
Joy Pipgras, LTC Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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.

Stephanie Jones — 09/03/2024

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)

9-16-24
Date

WAC 388-78A-2060 Preadmission assessment. The assisted living facility must conduct a preadmission assessment for each prospective resident that includes the following information, unless unavailable despite the best efforts of the assisted living facility:

(1) Medical history;

(2) Necessary and contraindicated medications;

(3) A licensed medical or health professional's diagnosis, unless the prospective resident objects for religious reasons;

(4) Significant known behaviors or symptoms that may cause concern or require special care;

(5) Mental illness diagnosis, except where protected by confidentiality laws;

(6) Level of personal care needs;

(7) Activities and service preferences; and

(8) Preferences regarding other issues important to the prospective resident, such as food and daily routine.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a pre-admission assessment that provided the facility with the necessary information to care for 1 of 1 resident (Resident 5). This failure placed the resident at risk of unmet care needs and preferences.

Findings included...

Review of Resident 5's Face Sheet showed they admitted on [redacted]/2024. Further review of Resident 5's medical records showed no pre-admission assessment.

In an interview on 08/21/2024 at 2:08 PM, Staff A, Administrator, stated they did not know that a written pre-admission assessment was required.

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, Allegiance Supported Living is or will be in compliance with this law and / or regulation on (Date) 10/7/24.

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

[signature] 9-16-24

Administrator (or Representative) Date

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(1) Individual's recent medical history, including, but not limited to:

(a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons;

(b) Chronic, current, and potential skin conditions; or

(c) Known allergies to foods or medications, or other considerations for providing care or services.

(2) Currently necessary and contraindicated medications and treatments for the individual, including:

(a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and accurately direct others to administer to him/her;

(b) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to self-administer when he/she has the assistance of a caregiver; and

(c) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is not able to self-administer, and needs to have administered to him or her.

(3) The individual's nursing needs when the individual requires the services of a nurse on the assisted living facility premises.

(4) Individual's sensory abilities, including:

(a) Vision; and

(b) Hearing.

(5) Individual's communication abilities, including:

(a) Modes of expression;

(b) Ability to make self understood; and

(c) Ability to understand others.

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(a) History of substance abuse;

(b) History of harming self, others, or property; or

(c) Other conditions that may require behavioral intervention strategies;

(d) Individual's ability to leave the assisted living facility unsupervised; and

(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

(7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:

(a) Mental illness, or needs for psychological or mental health services, except where protected by confidentiality laws;

(b) Developmental disability;

(c) Dementia. While screening a resident for dementia, the assisted living facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(ii) Document the evidence in the resident's record.

(d) Other conditions affecting cognition, such as traumatic brain injury.

(8) Individual's level of personal care needs, including:

(a) Ability to perform activities of daily living;

(b) Medication management ability, including:

(i) The individual's ability to obtain and appropriately use over-the-counter medications; and

(ii) How the individual will obtain prescribed medications for use in the assisted living facility.

(9) Individual's activities, typical daily routines, habits and service preferences.

(10) Individual's personal identity and lifestyle, to the extent the individual is willing to share the information, and the manner in which they are expressed, including preferences regarding food, community contacts, hobbies, spiritual preferences, or other sources of pleasure and comfort.

(11) Who has decision-making authority for the individual, including:

(a) The presence of any advance directive, or other legal document that will establish a substitute decision maker in the future;

(b) The presence of any legal document that establishes a current substitute decision maker; and

(c) The scope of decision-making authority of any substitute decision maker.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a full assessment within 14 days of admission for 4 of 4 sampled residents (Residents 3, 4, 5, and 6), who had recently admitted to the facility. This failure placed residents at risk of unmet care needs due to not having a full assessment completed.

Findings included...

Review of Resident 3's Face Sheet showed an admission date of [redacted]/2024. Further review of the resident's medical records showed no facility assessment had been completed within 14 days of admission.

Review of Resident 4's medical records showed an admission date of [redacted]/2023. Further review showed a document titled "Assessment Form" which did not contain any resident identifying information, dates, assessor or signatures.

Review of Resident 5's Face Sheet showed an admission date of [redacted]/2024. Further review of the resident's medical records showed no facility assessment had been completed within 14 days of admission.

Review of Resident 6's Face Sheet showed an admission date of [redacted]/2024. Further review of the resident's medical records showed no facility assessment had been completed within 14 days of admission.

In an interview on 08/21/2024 at 9:45 AM, Staff E, Resident Care Coordinator, stated they were not aware that the facility needed to complete an assessment within 14 days of admission.

In an interview on 08/21/2024 at 10:40 AM, Staff A, Administrator, stated they did not know that the facility needed to complete an assessment within 14 days of admission.

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, Allegiance Supported Living is or will be in compliance with this law and / or regulation on (Date) 10-7-24.

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

Administrator (or Representative) — Date: 9-16-24

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to complete annual assessments for 2 of 5 sampled residents (Residents 1 and 2) and annual smoking assessments for 2 of 2 residents (Residents 1 and 6). This failure resulted in residents not being assessed to ensure their needs were being met and to ensure they had the cognitive and physical abilities to safely smoke without harm to themselves or others.

Findings included...

<Resident 1>

Review of Resident 1's medical records showed an admission date of [redacted]/2015. Further review showed an outdated facility annual assessment dated 10/20/2022.

Review of Resident 1's Person Centered Service Plan, Current Annual DDA Assessment Details, dated 10/25/2023, showed the resident was diagnosed with [redacted], smoked cigarettes, made poor decisions, and was unaware of consequences.

Review of Resident 1's Smoking Assessment/Evaluation showed it was last reviewed on 11/24/2020.

Observation on 08/21/2024 at 3:20 PM, showed Resident 1 rolled a cigarette, lit it, and began to smoke.

<Resident 2>

Review of Resident 2's medical records showed an admission date of [redacted]/2011. Further review showed no facility annual assessment had been completed.

<Resident 6>

Review of Resident 6's negotiated service agreement, dated 01/31/2024, showed that the resident smoked cigarettes. Further review of the resident's medical record showed a smoking assessment had not been completed.

In an interview on 08/21/2024 at 10:40 AM, Staff A, Administrator, stated they used the Person-Centered Service Plan, Current Annual Assessment completed by the

Department of Social and Health Services case manager as the annual assessment and was not aware that the facility needed to complete their own annual assessment.

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, Allegiance Supported Living is or will be in compliance with this law and / or regulation on (Date) 10-7-24

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

Administrator (or Representative) — Date 9-16-24

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(3) The times services will be delivered, including frequency and approximate time of day, as appropriate;

(5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure negotiated service agreements included behaviors and interventions for 3 of 6 sampled residents (Residents 3, 4, and 6) and housekeeping and laundry services for 6 of 6 residents (Residents 1, 2, 3, 4, 5, and 6.) This failure placed residents at risk of harm to self and others, and unmet care and service needs.

Findings included...

<Behaviors and Interventions>

-Resident 3

Review of Resident 3's Face sheet showed the resident admitted on [redacted]/2024 and had diagnoses of [redacted], and [redacted].

Review of Resident 3's chart notes showed:

- On 03/29/2024 the resident told staff they wanted to hurt themself.

- On 03/21/2024 the resident wrote a note saying they were "going to end their life."

- On 04/07/2024 the resident told staff they wanted to be "with a guy in heaven," "hated their life," and were going to "overdose to be with him."

- On 06/03/2024 the resident wrote a note stating they were "going to end [their] life" and left the facility.

Review of Resident 3's Negotiated Service Agreement (NSA), dated 02/16/2024, showed it did not address any behaviors of suicidal ideation and did not include any interventions for staff to assist the resident when in crisis.

In an interview on 08/21/2024 at 3:23 PM, Staff E, Resident Care Coordinator, stated that the resident often said "things like this" when they wanted attention, did not feel the resident was a threat to themself, and that they did not include suicidal ideations in the resident's NSA.

-Resident 4

Review of Resident 4's Face sheet showed that the resident admitted on [redacted]/2023 with diagnoses of [redacted], and [redacted].

In an interview on 08/21/2024 at 9:16 AM, Resident 4 stated that they had forged a knife at a friend's house. Observation at that time showed that the resident retrieved a piece of steel about 14 inches long, fashioned into a knife with a sharp cutting edge, pointed tip and the blunt end was wrapped with a cord to create a handle.

During the daily status interview on 08/21/2024 at 3:21 PM, Staff A, Administrator, stated that residents were not permitted to have weapons in their rooms. Staff A stated that they kept Resident 4's carving tools locked in their office, and that the resident had to come to them when they wanted to use the tools.

During the daily status interview on 08/21/2024 at 3:21 PM, Staff E stated that Resident 4 "could possibly explode," but that they had not had anything occur.

Review of Resident 4's NSA, dated 12/27/2023, showed that the resident was easily irritable/agitated requiring interventions, had a mood disorder, and went from happy to angry very quickly. The NSA did not contain any documentation regarding the resident's carving tools and how the resident would be monitored for safety.

-Resident 6

Review of Resident 6's Face Sheet showed the resident admitted on [redacted]/2024 and had diagnoses of [redacted] ([redacted]), [redacted] ([redacted]) [redacted] and [redacted].

Review of Resident 6's chart notes showed:

- On 01/28/2024 the resident smelled of marijuana and was not acting per their baseline.

- On [redacted]/2024 the resident left the facility at 5:30 PM and did not return until [redacted]/2024 at 1:30 PM.

- On 02/23/2024 an empty alcohol bottle was found in the resident's laundry.

- On 5/11/2024 the resident fell, was hospitalized and diagnosed with [redacted] and [redacted].

-On 08/18/2024 the resident demanded pain medication from staff. When denied, due to not being the scheduled administration time, the resident became verbally abusive to staff.

Review of Resident 6's NSA, dated 01/31/2024, showed no interventions for staff to address any behaviors of drug or alcohol abuse, or verbal outbursts.

In an interview with 08/22/2024 at 10:01 AM, Staff E stated that Resident 6 did not like some of the staff and had been verbally aggressive with them. Staff E confirmed that the behaviors and interventions were not in the resident's NSA.

<Laundry and Housekeeping>

Review of the facility's undated Disclosure of Services showed that the facility would provide housekeeping and laundry services.

-Resident 1

Review of Resident 1's Person Centered Service Plan, Current Annual DDA Assessment Details (not a facility assessment), dated 10/25/2023, showed the resident had a diagnosis of [redacted] and required assistance with laundry and housekeeping.

Review of Resident 1's NSA, dated 11/20/2023, showed no frequency or times for housekeeping or laundry services, whether the resident required assistance, or were independent with the tasks.

In an interview on 08/21/2024 at 2:55 PM, Staff B, Housekeeper/Caregiver stated that the staff had to complete Resident 1's laundry.

-Resident 2

Review of Resident 2's NSA, dated 01/17/2024, showed no frequency or times for housekeeping or laundry services, whether the resident required assistance, or were independent with the tasks.

-Resident 3

Review of Resident 3's NSA, dated [redacted]/2024, showed no frequency or times for housekeeping or laundry services, whether the resident required assistance, or were independent with the tasks.

-Resident 4

Review of Resident 4's Person Centered Service Plan, Current Annual DDA Assessment Details, dated 12/07/2023, showed the resident required assistance using a washer and dryer and reminders to complete housekeeping tasks.

Review of Resident 4's NSA, dated 12/27/2023, showed no frequency or times for housekeeping or laundry services, whether the resident required assistance, or were independent with the tasks.

-Resident 5

Review of Resident 5's NSA, dated [redacted]/2024, showed no frequency or times for housekeeping or laundry services, whether the resident required assistance, or were independent with the tasks.

Observation on 08/23/2024 at 11:35 AM, showed that Resident 5 required assistance with using the clothes dryer.

-Resident 6

Review of Resident 6's NSA, dated 01/31/2024, showed no frequency or times for housekeeping or laundry services, whether the resident required assistance, or were independent with the tasks.

In an interview on 08/23/2024 at 11:45 AM, Staff E stated that they had a list with the days that residents needed to do their laundry and confirmed that laundry and housekeeping preferences were not included in the NSAs.

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, Allegiance Supported Living is or will be in compliance with this law and / or regulation on (Date) 10-7-24.

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

Administrator (or Representative) — 9-16-24 Date

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

(2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and

(3) Any public or private case manager for the resident, if available.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to obtain signatures from the resident or their representative for 2 of 6 sampled residents (Resident 2 and 6). This failure placed residents at risk of unmet care needs and receiving services that were not agreed upon.

Findings included...

<Resident 2>

Review of Resident 2's Negotiated Service Agreement (NSA), dated 01/17/2024, showed it did not contain a signature by the resident and/or their representative to show agreement to the plan.

<Resident 6>

Review of Resident 6's NSA, dated 01/31/2024, showed it did not contain a signature by the resident and/or their representative to show agreement to the plan.

In an interview on 08/21/2024 at 9:45 AM, Staff E, Resident Care Coordinator stated that obtaining the signatures had just been missed.

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, Allegiance Supported Living is or will be in compliance with this law and / or regulation on (Date) 10-7-24

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

Administrator (or Representative) 9-16-24 Date

WAC 388-78A-2450 Staff.

(3) The assisted living facility must:

(d) Maintain the following documentation on the assisted living facility premises, during employment, and at least two years following termination of employment:

(i) Staff orientation and training or certification pertinent to duties, including, but not limited to:

(A) Training required by chapter 388-112A WAC;

(ii) Disclosure statements and background checks as required in WAC 388-78A-2461 through 388-78A-2471 ; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff records were maintained in the facility for 3 of 5 sampled staff (Staff B, D, and E), failed to ensure staff completed specialty training for 2 of 5 sampled staff (Staff A and B), and failed to complete background checks on 5 of 5 sampled staff (Staff A, B, C, D, and E). This failure placed residents at risk of receiving care from potentially untrained or unqualified staff.

Findings included...

<Staff records onsite>

Review of staff files showed that Staff B, Housekeeper/Caregiver, was hired on 04/01/2024, and that it did not contain documentation that they had completed facility orientation training.

Review of staff files showed that Staff D, Caregiver, was hired on 10/28/2021, and that it did not contain documentation that they had completed facility orientation training.

In an interview on 08/22/2024 at 1:25 PM, Staff A, Administrator, stated that Staff B and Staff D received facility orientation when they were hired but was unable to provide any documentation that it was completed.

Review of staff files showed Staff E, Resident Care Coordinator, was hired on 12/17/2017 and had a Nursing Assistant Registration (NAR) license.

In an interview on 08/22/2024 at 2:41 PM, Staff E stated that they had completed their continuing education requirements, but the records were not onsite.

<Specialty training>

Review of the facility's undated Disclosure of Services showed that the facility served residents with [redacted] diagnoses.

Review of staff files showed that Staff A was hired on 07/17/2023, and that there was no documentation on file showing they had completed mental health specialty training.

Review of staff files showed that Staff B was hired on 04/01/2024, and that there was no documentation on file showing they had completed mental health specialty training.

In an interview on 08/22/2024 at 1:25 PM, Staff A stated that they and Staff B had not completed mental health specialty training and were not aware of the requirement.

<Background checks>

Review of staff files showed Staff A did not have a current Washington state name and date of birth background check.

Review of staff files showed Staff B did not have a current Washington state name and date of birth background check.

Review of staff files showed that Staff C, Caregiver, was hired on 03/09/2024 and did not have a current Washington state name and date of birth background check.

Review of staff files showed that Staff D did not have a current Washington state name and date of birth background check.

Review of staff files showed that Staff E did not have a current Washington state name and date of birth background check.

In an interview on 08/22/2024 at 1:25 PM, Staff A shared an email from the facility's corporate office stating that ownership used private online companies to obtain background reports and not the department's Background Check Central Unit as required.

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, Allegiance Supported Living is or will be in compliance with this law and / or regulation on (Date) ~~10-17-2~~ 10-7-24.

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

[signature] 9-16-24

Administrator (or Representative) Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff were tested for tuberculosis within three days of employment and failed to ensure a second tuberculosis test was completed within one to three weeks after the first test for 1 of 5 sampled staff (Staff B). This failure placed residents at risk of exposure to tuberculosis.

Findings included...

Review of Staff B's, Housekeeper/Caregiver, personnel file showed they were hired on 04/01/2024. Further review showed the file contained a first step tuberculosis (TB, a respiratory disease) test dated 04/22/2024, 21 days after hire, and no documentation of a second step TB test.

In an interview on 08/22/2024 at 11:20 AM, Staff A, Administrator, stated they did not know that TB testing was to be completed within three days of employment and that a second test needed to be completed.

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, Allegiance Supported Living is or will be in compliance with this law and / or regulation on (Date) 10-7-24

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

Administrator (or Representative) — Date: 9-16-24

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(f) Report communicable diseases in accordance with the requirements in chapter 246-100 WAC.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement appropriate infection control measures and report to the local health jurisdiction when 3 of 18 residents (Residents 2, 3, and 4) tested positive for COVID-19. This failure placed residents at risk of contracting a contagious illness.

Findings included...

Review of the facility's undated policy titled, "Infection Control," showed that the facility was to report communicable (contagious) diseases to the local health jurisdiction (LHJ). Further review showed the policy did not contain any COVID-19 (contagious respiratory virus) specific information.

Review of a progress note, dated 07/17/2024, showed that Resident 4 tested positive for COVID-19.

Review of a progress note, dated 07/20/2024, showed that Resident 2 tested positive for COVID-19.

Review of a progress note, dated 07/20/2024, showed that Resident 3 tested positive for COVID-19.

In an interview on 08/20/2024 at 10:05 AM, Staff E, Resident Care Coordinator, stated that three recent positive COVID-19 test results among residents were not reported to the LHJ or the department hotline. Staff E stated they were not aware of the reporting requirements. Staff E further stated that care staff did not wear N95 respirators (protective face mask designed to achieve a close fit and efficient filtration of airborne particles), protective gowns, or eye protection when caring for the affected residents.

In an interview on 08/23/2024 at 10:50 AM, Staff A, Administrator, stated that the facility did not report the three recent positive COVID-19 cases to the LHJ or to the department hotline.

In an interview on 08/23/2024 at 10:52 AM, Staff F, Caregiver, stated that during the recent COVID-19 outbreak staff did not use N95 masks, gowns or eye protection. Staff F

further stated that the facility did not post precautionary signage on residents' doors and did not have personal protective equipment available outside of the positive Covid-19 resident's rooms.

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, Allegiance Supported Living is or will be in compliance with this law and / or regulation on (Date) 10-7-24

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

Administrator (or Representative) 9-16-24 Date

WAC 388-78A-2730 Licensee's responsibilities.

(1) The assisted living facility licensee is responsible for:

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to develop and implement a respiratory protection program as required and failed to ensure staff were fit tested annually for N95 respirators for 5 of 5 sampled staff (Staff A, B, C, D, and E). This failure placed residents at risk for respiratory infection.

Findings Included...

Per Chapter 296-842 WAC, Respirators, the facility must implement a program/policy, conduct medical evaluation and fit testing (test completed by specially trained personnel to ensure N95 masks (protective face mask designed to achieve a close fit and efficient filtration of airborne particles) seal effectively reducing chance of exposure to respiratory viruses), and provide effective training before employees are assigned duties that may require the use of respirators.

Per WAC 296-842-15005, facilities must conduct fit testing before employees are assigned duties that may require the use of respirators.

Review of a Department of Social and Health Services provider letter, dated 09/14/2023, showed that employers in long term care settings were responsible to "follow regulations pertaining to respiratory protection" including respirator fit testing for long term care workers.

Review of Staff A's, Administrator, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

Review of Staff B's, Housekeeper/Caregiver, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

Review of Staff C's, Caregiver, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

Review of Staff D's, Caregiver, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

Review of Staff E's, Resident Care Coordinator, undated personnel file showed it did not contain records for a medical evaluation or fit testing.

In an interview on 08/20/2024 at 10:05 AM, Staff E stated that the facility had not completed respirator fit testing for staff for a couple of years. Staff E stated there were three residents that tested positive for COVID-19 about one-month prior and that staff did not wear N95 respirator masks when caring for the residents.

In an interview on 08/23/2024 at 10:52 AM, Staff F, Caregiver, stated that during the COVID-19 outbreak "a few weeks ago" staff wore surgical masks and did not wear N95 respirator masks during cares for Residents 2, 3, and 4.

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, Allegiance Supported Living is or will be in compliance with this law and / or regulation on (Date) 10-7-24

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

Administrator (or Representative) — Date: 9-16-24

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to provide a sanitary and well-maintained environment in 3 of 3 facility areas (air vents, dining room, exterior grounds). This failure placed residents at risk of harm and a decreased quality of life.

Findings included...

During the environmental tour of the facility on 08/20/2024 at 9:45 AM, the following was observed:

> Eight of 19 dining room chairs had ripped or torn upholstery on the seats.

> Multiple ceiling exhaust vents had varied levels of dirt and debris build up on the covers.

> The exterior grounds had areas of dead leaves and debris scattered around the property.

> Weeds were growing out of cracks in the concrete walkways and in the rock beds.

> Overgrown bushes/shrubbery extended into the walkways in the garden area and the pathway to the parking lot and bicycle rack.

In an interview at that time, Staff E, Resident Care Coordinator, stated that they were responsible for the lawn and yard maintenance.

In an interview on 08/20/2024 at 3:26 PM, Staff E stated that they were aware of the damaged dining room chairs and intended to repair the seats.

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, Allegiance Supported Living is or will be in compliance with this law and / or regulation on (Date) 10-7-24

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

Administrator (or Representative) — Date: 9-16-24