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
PO Box 379
Chewelah, WA 99109

RE: Allegiance Supported Living License # 2175

Dear Administrator:

This letter addresses Compliance Determination(s) 27010 (Completion Date 07/21/2023) and 25863 (Completion Date 06/27/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/21/2023 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-2660-1, WAC 388-78A-2660-2, WAC 388-78A-2660-4, RCW 70.129.140.1

The Department staff who did the on-site verification:
Anne Sinclair, NCI Community Complaint Investigator
Sandra Fast, Community Complaint Investigator

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Field Manager
Region 1, Unit B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Allegiance Supported Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2175
Intake ID: 85640
Compliance Determination #: 25863
Region/Unit #: RCS Region 1 / Unit B
Investigator: Sylvia Shauvin
Investigation Date(s): 06/26/2023 through 06/27/2023
Complainant Contact Date(s): 06/26/2023

Allegation(s):
1 - Respect and dignity.

Investigation Methods:

Sample:	Total residents: 19 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents' safety and well-being Staff's care and treatment of residents (dignity, choices) Staff's response to residents' problem behaviors (eg. resistance, anxiety)
Interviews:	Five residents Two resident representatives Community support staff Manager/Administrator Designee
Record Reviews:	Sample residents' Face Sheets, assessments, and care plans Staffing schedule - June 2023 Facility policies - resident rights, abuse Staff orientation content

Investigation Summary:
1 - Interviews with named resident, two resident representatives, community support staff, and Manager/Administrator Designee showed staff recently did not wait for resident to give permission before staff entered apartment, instructed a resident in an abrupt tone-of-voice, and grabbed resident by the wrist. As observed, named resident cried while describing the incident, and stated they felt the staff hated them. Facility failed to ensure resident was treated with dignity and respect. Failed practice was documented in 06/27/2023 Statement of Deficiencies under Washington Administrative Code 388-78a-2660 (1)(2)(4) Resident rights; reference to Revised Code of Washington 70.129.140(1) Quality of life.

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: Allegiance Supported Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2175
Intake ID: 85616
Compliance Determination #: 25863
Region/Unit #: RCS Region 1 / Unit B
Investigator: Sylvia Shauvin
Investigation Date(s): 06/26/2023 through 06/27/2023
Complainant Contact Date(s): 06/26/2023

Allegation(s):
1 - Staff burst into resident's room without knocking.

Investigation Methods:

Sample:	Total residents: 19 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents' safety and well-being Staff's care and treatment of residents (dignity, choices) Staff's response to residents' problem behaviors (eg. resistance, anxiety)
Interviews:	Five residents Two resident representatives Community support staff Manager/Administrator Designee
Record Reviews:	Sample residents' Face Sheets, assessments, and care plans Staffing schedule - June 2023 Facility policies - resident rights, abuse Staff orientation content

Investigation Summary:
1 - Interviews with named resident, two resident representatives, community support staff, and Manager/Administrator Designee showed staff recently did not wait for resident to give permission before staff entered apartment, instructed a resident in an abrupt tone-of-voice, and grabbed resident by the wrist. As observed, named resident cried while describing the incident, and stated they felt the staff hated them. Facility failed to ensure resident was treated with dignity and respect. Failed practice was documented in 06/27/2023 Statement of Deficiencies under Washington Administrative Code 388-78a-2660 (1)(2)(4) Resident rights; reference to Revised Code of Washington 70.129.140(1) Quality of life.

Conclusion / Action:

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

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Statement of Deficiencies	License #: 2175	Compliance Determination # 25863
Plan of Correction	Allegiance Supported Living	Completion Date
Page 1 of 3	Licensee: Rural Resources Community Action	06/27/2023

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 06/26/2023, 06/26/2023 and 06/26/2023 of:

Allegiance Supported Living
N 413 Kruger St
Chewelah, WA 99109

This document references the following complaint number(s): 85640, 85616

The following sample was selected for review during the unannounced on-site visit: 3 of 19 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Sylvia Shauvin, Complaint Investigator

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

06/28/2023
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.

Statement of Deficiencies	License #: 2175	Compliance Determination # 25863
Plan of Correction	Allegiance Supported Living	Completion Date
Page 2 of 3	Licensee: Rural Resources Community Action	06/27/2023

Tracy L. Ferrell
Administrator (or Representative)

7-5-2023
Date

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide care and services in a dignified and respectful manner for 1 of 3 residents (Resident 1). This failure resulted in emotional distress for the resident.

Findings included...

Review of a staff orientation document, dated January 2012, showed staff were trained to treat residents with respect, support residents' choices, and provide them with privacy for phone calls and visits.

Review of Resident 1's Negotiated Service Agreement, dated November 2022, showed the resident had problems with anxiety and was easily offended if they were told rather than asked to do something.

In an interview on 06/22/2023 at 3:30 PM, Collateral Contact 1, stated they were on the phone with Resident 1 on 06/09/2023 at around 1:00 PM. Collateral Contact 1 stated while they were on speaker phone with the resident, they heard a knock on the resident's apartment door, and heard the resident say, "Hold on. I'm coming." Moments later, Collateral Contact 1 heard Resident 1 state loudly that Staff A came into their room without permission and then grabbed them by the wrist.

Statement of Deficiencies	License #: 2175	Compliance Determination # 25863
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Page 3 of 3	Licensee: Rural Resources Community Action	06/27/2023

In an interview on 06/22/2023 at 3:30 PM, Collateral Contact 2 stated that during a phone call, they heard the resident's apartment door open, and Staff A say to the resident "Come on!" in what Collateral Contact 2 described as an "aggressive" and "demanding" tone-of-voice. Collateral Contact 2 also stated hearing Resident 1 state in a "fearful" tone-of-voice, that Staff A was grabbing their wrist.

In an interview on 06/26/2023 at 8:00 AM, Collateral Contact 3 stated when they transported Resident 1 on the afternoon of 06/09/2023, the resident showed them how Staff A grabbed the resident firmly by the wrist earlier that afternoon. CC3 stated Resident 1 cried while describing the incident.

In an interview on 06/26/2023, Resident 1 stated that Staff A had recently knocked on their apartment door and did not wait for permission to enter the apartment. Resident 1 also stated while they were on a phone call with a family member, Staff A grabbed their right wrist. Resident 1 further stated the incident made them feel "stressed" and added, "It makes me feel I did something that makes Staff A hate me". Resident 1 was observed tearful while describing the incident.

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) June 30, 2023

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

Tracy L. Ferrell — Administrator (or Representative)

July 5, 2023 — Date