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 # 2175

Dear Administrator:

This document references Compliance Determination 29174 (09/22/2023), which included complaint number(s) 96250, 96188, 96395, 96988.
The Department completed a complaint investigation of your Assisted Living Facility on 09/22/2023 and found that your facility does not meet the Assisted Living Facility requirements.

The department staff who did the inspection and provided consultation:

Anne Sinclair, NCI Community Complaint Investigator
Sandra Fast, Community Complaint Investigator

Consultation:

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

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

The facility had provided the resident with a three day discharge notice due to the resident's behaviors. The facility agreed to extend the notice to a 30 day as required by regulation. The facility agreed to work with the resident's case manager to find safe housing for the resident.

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:
  - o What specific deficiency or deficiencies you disagree with;
  - o Why you disagree with each deficiency; and
  - o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  - o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

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: 96250
Compliance Determination #: 29174
Region/Unit #: RCS Region 1 / Unit B
Investigator: Anne Sinclair
Investigation Date(s): 09/12/2023 through 09/22/2023
Complainant Contact Date(s): 09/07/2023, 09/21/2023

Allegation(s):

1. Facility not providing requested documents in timely manner.
2. Concerns of Facility house rules violating resident rights.

Investigation Methods:

Sample:	Total residents: 17 Resident sample size: 4 Closed records sample size: 0
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions Dining
Interviews:	Identified resident Residents Administrator Caregiver Social worker Resident care coordinator Chief Operations Officer- AAA
Record Reviews:	Sample residents care plan/face sheet Named resident care plan/face sheet Sample resident Medication Administration Record (July-September) Disclosure of services Characteristic roster Staff roster Facility house rules Facility aggressive resident policy

Investigation Summary:

1. Staff interviewed reported they had provided resident information to resident state case managers at time of resident assessment. Facility had planned follow-up with

resident case manager to ensure timely information sharing. Record review showed named resident's care needs had been identified in negotiated service agreement. Residents interviewed had no concerns with care needs and felt safe in the facility. Findings do not support failed facility practice.
2. Facility staff interviewed reported recent updates to facility house rules that had been communicated within the past several weeks to residents. Residents interviewed stated they had been given a copy of new facility rules, and had discussed rules with staff. Review of updated house rules showed house rules needed correction and implementation in accordance with resident rights. Some residents denied discussing house rules with staff. Facility provided correction to house rules, including notification to appropriate parties after evaluation. Technical assistance provided for WAC 388-78A-2660 Resident Rights and RCW 70.129.140 Quality of Life-Resident rights.

Conclusion / Action:

- ☐ 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
Compliance Determination #: 29174
Investigator: Anne Sinclair
Intake ID: 96988
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 09/12/2023 through 09/22/2023
Complainant Contact Date(s): 09/07/2023, 09/21/2023

Allegation(s):
1. Resident discharge.
2. Facility withholding resident medications and food.

Investigation Methods:

Sample:	Total residents: 17 Resident sample size: 4 Closed records sample size: 0
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions Dining
Interviews:	Identified resident Residents Administrator Caregiver Social worker Resident care coordinator Chief Operations Officer- AAA
Record Reviews:	Sample residents care plan/face sheet Named resident care plan/face sheet Sample resident Medication Administration Record (July-September) Disclosure of services Characteristic roster Staff roster Facility house rules Facility aggressive resident policy Discharge notices Resident progress notes

Investigation Summary:

1. Named resident had received a discharge notice from facility. Interview and record review showed facility had been documenting resident behaviors that had contributed to discharge notice being issued. Staff interviewed had reported unfamiliarity with elements of resident discharge requirements. Staff reported update to resident discharge notice after evaluation, and had planned notification for appropriate parties, including resident, for updated discharge notice. Resident observed residing at facility during unannounced facility visit. Consultation provided under WAC 388-78A-2660 Resident Rights RCW 70.129.110 (5)(b)(c)(d) Disclosure, transfer, and discharge requirements om 09/22/2023.
2. Interviews and record review showed named resident was receiving food and meals by facility staff for duration of resident self isolation. Named resident interviewed reported staff had provided meals during self isolation period, along with medications. Residents were observed in dining room during unannounced facility visit, and named resident was able to ambulate independently and make their needs known. Staff interviews and record review showed Named resident history and pattern of refusal and non-compliance with medication assistance from facility staff. Staff interviewed reported resident deficit in understanding of medication assistance, and had discussed current provider orders and precautions with named resident for clarification, and had communicated with named resident's medication providers regarding resident non-compliance/refusal and apparent deficit in understanding of medication orders. Facility had a policy for medication assistance. Residents interviewed had no concerns with medication assistance at facility, or dining, and stated they can talk to staff about concerns. Findings do not support failed facility practice.

Conclusion / Action:

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