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) 68412 (Completion Date 11/06/2025) and 65361 (Completion Date 09/10/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/06/2025 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-2371-1, WAC 388-78A-2660-1, WAC 388-78A-2660-4, RCW 70.129.100.1, RCW 70.129.140.1

The Department staff who did the on-site verification:
Brian Zbylski, ALF Licensor

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

Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2175
Intake ID: 192753
Compliance Determination #: 65361
Region/Unit #: RCS Region 1 / Unit B
Investigator: Brian Zbylski
Investigation Date(s): 09/09/2025 through 09/10/2025
Complainant Contact Date(s): 09/10/2025, 09/11/2025

Allegation(s):

1. A named resident obtained objects in the facility.
2. A staff member shaved a named resident's head.
3. A named resident was not allowed to keep their cellphone overnight.

Investigation Methods:

Sample:	Total residents: 19 Resident sample size: 6 Closed records sample size: 0
Observations:	Resident appearance. Residents with cellphones. Activity room storage of craft supplies. Resident belongings in management office.
Interviews:	Current residents. Care staff. Resident Care Coordinator. Collateral contacts.
Record Reviews:	Resident Characteristic Roster. Staff List. Residents' Rights Policy. Resident face sheets, assessments, service agreements, progress notes, and safety plans. Activity schedule.

Investigation Summary:

1. The named resident found scissors and a razor that were unsecured in the facility. The facility did not document their investigative findings to show if interventions were implemented and to ensure the prevention of recurrence. Deficient practice identified. Washington Administrative Code (WAC) 388-78A-2371(1). Investigations.
2. The named resident had their head shaved by a named staff person. The resident reported that they consented to having their head shaved. Other residents in the facility did not have complaints or concerns about being forced or coerced into

actions against their desire. Deficient practice not identified.
3. The facility staff was requiring the named resident to turn their cellphone in to staff each night, and also removed another electronic device from the resident and had not returned it. Other residents reported that they were not required to turn in their cellphones to the staff. Deficient practice identified. WAC 388-78A-2660 (1); (4). Resident rights.

Conclusion / Action:

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

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

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 09/09/2025 and 09/10/2025 of:

Allegiance Supported Living
N 413 Kruger St
Chewelah, WA 99109

This document references the following complaint number(s): 192753

The following sample was selected for review during the unannounced on-site visit: 6 of 19 current residents and 0 former residents.

The department staff that investigated 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.

Stephanie Jones
Residential Care Services

09/17/2025
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.

Juan A. Saca
Administrator (or Representative)

9-24-25
Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that investigative actions were documented after 1 of 3 residents (Resident 3) obtained sharp cutting instruments. This failure placed the resident at risk of harm as the facility was not able to provide documentation that showed if interventions were implemented to avoid future occurrences.

Findings included...

Review of Resident 3's Face Sheet showed the resident was admitted to the facility on [redacted]2024 and had diagnoses of [redacted], and [redacted].

Review of Resident 3's Service Plan for Safety, dated 08/22/2024, showed that the resident had a history of threats to harm or kill themself. Further review showed that the resident's room would be checked by staff for sharp objects once a week.

In an interview on 09/09/2025 at 2:09 PM, Collateral Contact 1 stated that they told the facility staff upon admission that Resident 3 should not have access to scissors or razors and that the resident had a history of making suicidal comments.

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-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that investigative actions were documented after 1 of 3 residents (Resident 3) obtained sharp cutting instruments. This failure placed the resident at risk of harm as the facility was not able to provide documentation that showed if interventions were implemented to avoid future occurrences.

Findings included…

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

Review of Resident 3's Service Plan for Safety, dated 08/22/2024, showed that the resident had a history of threats to harm or kill themself. Further review showed that the resident's room would be checked by staff for sharp objects once a week.

In an interview on 09/09/2025 at 2:09 PM, Collateral Contact 1 stated that they told the facility staff upon admission that Resident 3 should not have access to scissors or razors and that the resident had a history of making suicidal comments.

In an interview on 09/10/2025 at 9:07 AM, Collateral Contact 2 stated that a caregiver at the facility reported that Resident 3 had found scissors in a craft box and used them to cut their hair.

In an interview on 09/10/2025 at 11:25 AM, Resident 3 stated that they had recently found scissors in the facility craft room and had cut their own hair, had "messed it up," and had to have Staff A, Resident Care Coordinator, shave their head. Observation at that time showed the resident with short hair.

In an interview on 09/10/2025 at 11:50 AM, Staff A stated that the facility did not let Resident 3 have scissors. Staff A stated that Resident 3 had recently located a pair of scissors in the craft room and determined that the resident found a razor that had been discarded by another resident. Staff A further stated that they did not document their investigative findings and did not talk to the staff person who was suspected of leaving the scissors unsecured.

This is a recurring deficiency previously cited on 06/06/2023.

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) 9-10-25.

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

JUAN A. SACA — Administrator (or Representative)

9-24-25 — Date

RCW 70.129.100 Personal property -- Storage space.

(1) The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

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:

In an interview on 09/10/2025 at 9:07 AM, Collateral Contact 2 stated that a caregiver at the facility reported that Resident 3 had found scissors in a craft box and used them to cut their hair.

In an interview on 09/10/2025 at 11:25 AM, Resident 3 stated that they had recently found scissors in the facility craft room and had cut their own hair, had “messed it up,” and had to have Staff A, Resident Care Coordinator, shave their head. Observation at that time showed the resident with short hair.

In an interview on 09/10/2025 at 11:50 AM, Staff A stated that the facility did not let Resident 3 have scissors. Staff A stated that Resident 3 had recently located a pair of scissors in the craft room and determined that the resident found a razor that had been discarded by another resident. Staff A further stated that they did not document their investigative findings and did not talk to the staff person who was suspected of leaving the scissors unsecured.

This is a recurring deficiency previously cited on 06/06/2023.

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)_____ .

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

_____ _____

Administrator (or Representative) Date

RCW 70.129.100 Personal property -- Storage space.

(1) The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

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;

(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 promote and protect resident dignity and rights for 1 of 4 residents (Resident 3). This failure resulted in Resident 3's personal belongings being taken away from them for certain periods of time.

Findings included…

Review of the facility's undated policy titled, "Residents' Rights," showed that residents had the right to receive care which promoted, maintained, and enhanced respect for each person's dignity.

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

In an interview on 09/09/2025 at 9:40 AM, Resident 4 stated that they had a cell phone and that it was never taken away by staff. Observation at that time showed that the resident had their cell phone with them.

In an interview on 09/09/2025 at 9:55 AM, Resident 5 stated that they had a cell phone and that it was never taken away by staff.

In an interview on 09/09/2025 at 10:10 AM, Resident 6 stated that they had a cell phone and that it was never taken away by staff.

In an interview on 09/09/2025 at 2:09 PM, Collateral Contact 1 stated that the facility staff would take Resident 3's cell phone away at night because the resident would stay up late and not get enough sleep.

In an interview on 09/10/2025 at 9:07 AM, Collateral Contact 2 stated that Resident 3 had told them that they had to retrieve their cell phone from staff every morning.

In an interview on 09/10/2025 at 11:25 AM, Resident 3 stated staff did not allow them to keep their cellphone at night and had also taken away their computer. Resident 3 further stated that this had gone on for about a year and their computer had not been

returned to them. Resident 3 stated that they did not think it was right for staff to take the items, and that other residents had not had their cellphones taken away.

In an interview on 09/10/2025 at 11:50 AM, Staff A, Resident Care Coordinator, stated that facility staff had kept Resident 3's cellphone in the office overnight due to the resident staying up late, going online and making phone calls in the middle of the night. Staff A further stated that Resident 3's computer was taken by staff at the same time for the same reasons. Staff A stated that this first occurred when the resident moved into the facility in [redacted] 2024.

Review of staff Narrative Notes, dated 06/01/2025, showed that staff had found a note from Resident 3 in the facility hallway. Resident 3's handwritten note was attached and stated that the resident was not happy that they had to give up their phone at night and wanted it to be returned to them.

Observation on 09/10/2025 at 1:20 PM, showed Staff A removed Resident 3's personal computer from their desk drawer.

This is a recurring deficiency previously cited on 06/26/2023.

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) 9-10-25.

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

JUAN A-SACA
Administrator (or Representative)

9-24-25
Date

returned to them. Resident 3 stated that they did not think it was right for staff to take the items, and that other residents had not had their cellphones taken away.

In an interview on 09/10/2025 at 11:50 AM, Staff A, Resident Care Coordinator, stated that facility staff had kept Resident 3's cellphone in the office overnight due to the resident staying up late, going online and making phone calls in the middle of the night. Staff A further stated that Resident 3's computer was taken by staff at the same time for the same reasons. Staff A stated that this first occurred when the resident moved into the facility in [redacted] 2024.

Review of staff Narrative Notes, dated 06/01/2025, showed that staff had found a note from Resident 3 in the facility hallway. Resident 3's handwritten note was attached and stated that the resident was not happy that they had to give up their phone at night and wanted it to be returned to them.

Observation on 09/10/2025 at 1:20 PM, showed Staff A removed Resident 3's personal computer from their desk drawer.

This is a recurring deficiency previously cited on 06/26/2023.

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)_____ .

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

_____ _____

Administrator (or Representative) Date