STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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) 79568 (Completion Date 06/25/2026) and 76338 (Completion Date 05/13/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/25/2026 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, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2371-4, WAC 388-78A-2630-1-a, WAC 388-78A-2130-3-a, WAC 388-78A-2130-3-b, WAC 388-78A-2130-3

The Department staff who did the on-site verification:
Jennifer Lee, Assisted Living Facility 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

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

Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2175
Intake ID: 221202
Compliance Determination #: 76338
Region/Unit #: RCS Region 1 / Unit B
Investigator: Tethra Wales
Investigation Date(s): 04/24/2026 through 05/13/2026
Complainant Contact Date(s):

Allegation(s):
Resident struck another resident on the head with a stick

Investigation Methods:

Sample:	Total residents: 17 Resident sample size: 4 Closed records sample size: 0
Observations:	Staff and resident interactions Staff presence and availability to residents Staff response to residents Resident emergency button system Hotline posted and available to residents and staff
Interviews:	Caregivers Alleged victim Resident Care Coordinator Current residents Resident representatives Resident case managers Administrator
Record Reviews:	Characteristic roster Staff roster Staff schedule Abuse and Neglect Policy Resident face sheets Resident care plans Temporary care plans Resident facility and state assessments Incident Report and Investigations Progress notes Staff background checks, specialty trainings and facility orientation

Investigation Summary:

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The facility failed to investigate and report allegations of physical abuse by a resident. The facility also failed to update the resident's care plan to reflect known behaviors and outline preventative actions and interventions. Failed facility practice cited under WAC 388-78A-2371 (1)(2)(3)(4), WAC 388-78A-2630 (1)(a), and WAC 388-78A-2130 (3)(a)(b)(5)(a)(d).

Conclusion / Action:

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

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Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2175
Intake ID: 222828
Compliance Determination #: 76338
Region/Unit #: RCS Region 1 / Unit B
Investigator: Tethra Wales
Investigation Date(s): 04/24/2026 through 05/13/2026
Complainant Contact Date(s):

Allegation(s):
Staff kicked a resident.

Investigation Methods:

Sample:
Total residents: 17
Resident sample size: 4
Closed records sample size: 0

Observations:
Staff and resident interactions
Staff presence and availability to residents
Staff response to residents
Resident emergency button system
Hotline posted and available to residents and staff

Interviews:
Caregivers
Alleged victim
Resident Care Coordinator
Current residents
Administrator

Record Reviews:
Characteristic roster
Staff roster
Staff schedule
Abuse and Neglect Policy
Resident face sheets
Resident care plans
Resident facility and state assessments
Incident Report and Investigations
Progress notes
Staff background checks, specialty trainings and facility orientation

Investigation Summary:
The facility failed to investigate and report allegations of physical abuse by a staff member. Failed facility practice cited under WAC 388-78A-2371 (1)(2)(3)(4) and 388-78A-2630 (1)(a).

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Conclusion / Action:

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

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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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 04/24/2026 and 05/04/2026 of:

Allegiance Supported Living
N 413 Kruger St
Chewelah, WA 99109

This document references the following complaint number(s): 221202, 222828

The following sample was selected for review during the unannounced on-site visit: 4 of 17 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Tethra Wales, Assisted Living Facility Licensor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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

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: 05/21/2026

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.

JOHN SACA — Administrator (or Representative) — Date: 6-1-26

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;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to investigate, determine the circumstances of incidents, document their investigative actions, and provide protection during investigations for allegations of abuse perpetrated by a resident and a staff person for 1 of 4 residents (Resident 1). These failures contributed to ongoing injury and harm to Resident 1 and placed them at risk for a decreased quality of life.

Findings included...

Review of the facility's undated policy titled, "Reporting Abuse, Neglect, and Exploitation," showed that an incident report would be prepared for any abuse, neglect, or exploitation to determine the circumstances of the event and to determine appropriate measures to prevent similar future situations.

Review of the facility's undated characteristic roster showed that Resident 1 had a

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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;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to investigate, determine the circumstances of incidents, document their investigative actions, and provide protection during investigations for allegations of abuse perpetrated by a resident and a staff person for 1 of 4 residents (Resident 1). These failures contributed to ongoing injury and harm to Resident 1 and placed them at risk for a decreased quality of life.

Findings included…

Review of the facility's undated policy titled, "Reporting Abuse, Neglect, and Exploitation," showed that an incident report would be prepared for any abuse, neglect, or exploitation to determine the circumstances of the event and to determine appropriate measures to prevent similar future situations.

Review of the facility's undated characteristic roster showed that Resident 1 had a

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developmental disability (condition causing physical, learning, language, or behavior impairments).

Review of Resident 1's negotiated service agreement, dated 12/13/2025, showed that Resident 1 had a diagnosis of [redacted]. Further review showed that Resident 1 was not always aware of outcomes associated with social interactions and could place themselves in danger.

Review of Resident 1's state prepared Person Centered Service Plan (PCSP), dated 12/02/2025 and completed by CC1, Resident 1's Developmental Disabilities Administration (DDA) Case Manager, showed that Resident 1 could disregard health and safety issues when focused on something, was in a known relationship with another resident at the facility, and required help from others to prevent them from being exploited, particularly in dating and intimacy. Further review showed that Resident 1 could have difficulty with personal boundaries and understanding what is appropriate physically and romantically.

Review of Resident 2's state prepared PCSP, dated 12/03/2025 and completed by CC2, Resident 2's DDA Case Manager, showed that a chaperon may be necessary in dating or romantic relationships and that Resident 2 may require reminders regarding appropriate behavior.

<Incident on 04/18/2026>

Review of Resident 1's Progress Note, dated 04/19/2026 and written by Staff C, Caregiver, dated 04/19/2026, showed that it indicated that Resident 1 informed the staff that on 04/18/2026, another resident had hit them with a stick on the head, that it hurt, and that it resulted in a headache. The progress note further showed that Resident 1 told Staff C that they asked the other resident to leave the room but they would not and continued to play rough. Review showed that Resident 1 indicated they were unable to reach their emergency call button.

Review of Resident 1's Progress Notes, dated 04/21/2026 and written by Staff B, Resident Care Coordinator, showed that it documented they talked to Resident 1 on 04/21/2026 about the incident that occurred on 04/18/2026 that involved Resident 2 hitting Resident 1 with a stick. The note showed that Staff B attempted to talk to Resident 2 about the incident but they had refused to speak about it.

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In an interview on 04/24/2026 at 11:25 AM, Resident 1 stated they didn't feel well last Saturday and that Resident 2, who they were dating, came to their room to cheer them up. Resident 1 further stated that they were "messing around" and Resident 2 hit them in the head with a stick and that it hurt. Resident 1 stated that Resident 2 got carried away and didn't realize how badly it would hurt them. Resident 1 stated that Resident 2 had brought the stick to their room and then described the stick as fat, short, and from a tree. Resident 1 stated that when Resident 2 hit them they were "super mad at [them] for doing that to me." Resident 1 stated they told Staff C about what happened.

In an interview on 04/24/2026 at 1:43 PM, Staff B stated that the investigation into the incident on 04/18/2026 was on-going. Staff B stated that they would have Staff C fill out the first part of the investigation. Staff B stated that they had spoken with Resident 1 but when they approached Resident 2, they refused to speak. Staff B stated that they let Resident 2 know where they could be found when Resident 2 was ready to talk. Staff B stated Resident 2 had not yet approached them to discuss it. When asked what steps they had taken to protect Resident 1 during the investigation, Staff B stated they had not taken any.

In an interview on 05/01/2026 at 2:52 PM, Staff D, Caregiver, stated that they informed Staff B about the incident between Resident 1 and Resident 2 on Monday morning, 04/20/2026. Staff D further stated that after they reported it, Staff B did not do anything about it, that nothing got done, and that it should have been important. Staff D stated that they did not believe Resident 2 intended to hurt Resident 1 but that Resident 2 was unaware of their strength. Staff D further stated that Resident 2 got a little out of control sometimes and that they had previously had a short temper when told what to do.

In an interview on 05/04/2026 at 2:28 PM, Staff C stated that Resident 1 approached them on 04/19/2026 and told them that the previous day Resident 2 had gone to their room and hit them with a stick. Staff C stated they asked Resident 1 about the stick and Resident 1 replied that it was Resident 2's new one that they had recently stripped of bark to carve. Staff C stated that Resident 1 indicated that their head hurt. Staff C stated that Resident 1 shared that Resident 2 would not leave their room and that they were unable to get to their emergency button to press it. Staff C stated that they documented Resident 1's statement in Resident 1's Progress Notes, left a message for Staff B in the daily communication log directing them to check Resident 1's progress notes, and wrote Staff A, Administrator, a note about it. Staff C stated that they checked in with Staff A the following day and asked if anything had been done and was told it would be dealt with it the following day. Staff C stated nothing was done about the incident until law enforcement showed up on Tuesday 04/21/2026. When asked if they had any concerns for Resident 1's safety, Staff C stated that Resident 2 was kind of rough with Resident 1 and provoked them too much. Staff C further stated that "the hitting has gotten more frequent than it was." Staff C then stated that they had a photo of the stick that was used.

Observation on 05/04/2026 at 2:31 PM of a photo provided by Staff C, showed a piece of wood with the bark removed that was leaning up against a wall directly next to a

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door. Using the door for scale, the stick appeared to be 2 feet in length and 5 inches in diameter.

Review of the facility's investigation of the incident that occurred on 04/18/2026, showed that, "Phase 1 Part 1 Incident Report and Investigation," was completed and signed by Staff C on 04/24/2026, and included the circumstances as communicated by Resident 1 to Staff C. In response to whether there were any visible injuries, Staff C had noted "tiny bump on head." Further review showed, "Phase 1 Part 2 Administrative Review," was completed and signed by Staff B on 04/27/2026. Review of Part 2 showed that Staff B was made aware of the allegation on 04/20/2026, but did not complete the investigation until 04/27/2026, after the department had initiated their investigation.

< Incident on 01/18/2026>

In an interview on 04/24/2026 at 11:25 AM, Resident 1 stated that they were playing light sabers with Resident 2 when Resident 2 hit them with a light saber. Resident 1 further stated that they told Staff B and Staff E, Caregiver, about the incident.

Review of Resident 2's Progress Note, dated 01/18/2026 and written by Staff E, showed that another resident told Staff E that Resident 2 was playing too rough with their light saber swords. Further review showed that Staff E talked with Resident 2 and Staff B, and that Staff B asked that Resident 2's light sabers be kept in the office.

In an interview on 05/04/2026 at 12:05 PM, Staff B stated that they recalled asking that Resident 2's light sabers be kept in the office for a while. When asked by the department who Resident 2 got too rough with that necessitated the removal of the light sabers, Staff B stated that they did not know which resident. Staff B stated that they were not at the facility at the time of the incident and that staff called and told them about the incident. Staff B stated they spoke with Resident 2 by phone because they were upset about having to turn over the light sabers, and that they did not speak with Resident 2 about the incident itself.

In an interview on 05/04/2026 at 12:33 PM, Staff E stated that Resident 2 had a problem with hitting Resident 1 with the light saber. Staff E further stated that they did not fill out an incident report and instead contacted Staff B by phone and told them about it. Staff E stated that they were aware of other incidents of physical altercations between Resident 1 and Resident 2.

Review of Resident 1's Progress Notes showed no documentation of an incident that occurred on 01/18/2026.

Review of the incident reports and investigations involving Resident 1 or Resident 2, provided by the facility, showed no investigation or incident report related to Resident 2

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being too rough with Resident 1 on 01/18/2026.

< Incident on 06/18/2025>

Review of Resident 1's June 2025 Progress Notes showed four notes, dated 06/18/2025, that showed the following:

Note 1, no time stamp- showed that CC1informed the facility that Resident 1 had told them that Resident 2 had been hitting them in the head to cause headaches and also biting them. Further review showed that the state case manager also called the police and that the police told the facility that Resident 1 and Resident 2 were playing too rough and that the police were closing the case. The progress note was signed by Staff B.

Note 2, no time stamp- showed that the facility asked both parties (Resident 1 and Resident 2) to stay away from each other for a while. The progress note was signed by Staff B.

Note 3, 7:00 PM- showed that Resident 1 continued to text Resident 2 and that Resident 2 gave the staff member a note that Resident 1 had given them. The progress note was signed by Staff F, Caregiver.

Note 4, 7:00 PM- showed a photocopy of a hand drawn heart with words written inside the heart. Further review showed that the written words included that they, Resident 1, was sorry, and that they still loved Resident 2.

In an interview on 04/30/2026 at 4:14 PM, CC1 stated that during a visit in June 2025 with Resident 1, they noticed a bruise on Resident 1's arm. CC1 further stated that when they asked Resident 1 what the bruise was from, Resident 1 stated that Resident 2 grabbed them. CC1 further stated that Resident 1 shared that they and Resident 2 had been playing around and that Resident 2 got rough. CC1 stated that they were not sure that Resident 2 picked up on the signals given by Resident 1 when they told Resident 2 to stop.

Review of Resident 1's Incident Report, dated 06/18/2026, showed that Resident 1 disclosed the incident to CC1, the police spoke with Resident 2, and that the police told Resident 2 not to hit, bite, or headbutt. Further review showed no documented communication between facility staff and Resident 1 or Resident 2 to determine the circumstances of the incident, no measures by the facility to prevent future occurrences listed, or plan to protect Resident 1 while an investigation was conducted.

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< Incident in May 2025>

Review of Resident 1‘s 2025 and 2026 Progress Notes showed an undated note, located between notes dated 05/08/2025 and 05/13/2025, written by Staff C, showed Resident 1 disclosed to Staff C that Resident 2 had bit them. Further review showed an observation of teeth marks on Resident 1’s arm. Review showed that when asked what Resident 1 and Resident 2 were doing when it happened, Resident 1 stated they thought Resident 2 was joking around. Further review showed that Resident 1 told Staff C that Resident 2 wouldn’t stop when Resident 1 said it hurt.

In an interview on 05/04/2026 at 1:24 PM, Resident 1 stated that Resident 2 had bitten them on the arm and neck, and that it had happened more than one time. Resident 1 further stated that “it seems like [they’re] playing around when [they] do it but [they’re] not playing around. I tell [them] to stop biting me but sometimes [they] don’t listen to me. It doesn’t feel like a game.”

In an interview on 05/04/2026 at 2:28 PM, Staff C confirmed they wrote the progress note located between the notes on 05/08/2025 and 05/13/2025, and that Resident 1 told them Resident 2 had bitten them. Staff C further stated that Staff B called it “rough housing,” but that they did not feel it was rough housing based on what Resident 1 told them.

In an interview on 05/04/2026 at 12:05 PM, Staff B stated that they were not aware of the May 2025 incident in which Resident 1 stated Resident 2 had bitten them and had not seen the progress note. Staff B further stated that they did not investigate the incident.

Review of the incident reports and investigations provided by the facility, involving Resident 1 or Resident 2, showed no investigation or incident report related to Resident 1’s disclosure to Staff C in May 2025 that Resident 2 had bitten them.

In an interview on 04/24/2026 at 1:43 PM Staff B confirmed that they conduct the investigations for the facility.

In an interview on 05/04/2026 at 12:05 PM, Staff B confirmed there was a known pattern of complaints by Resident 1 about physical injuries from Resident 2. When asked by the department how they determined if Resident 1’s complaints about being hit or bit by Resident 2 were rough play or physical abuse without an investigation, Staff B stated that it was not possible to determine.

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<Staff F, Caregiver>

In an interview on 05/01/2026 at 2:52 PM, Staff D stated that they witnessed an interaction between Resident 1 and Staff F that was “inappropriate.” Staff D further stated that they were standing outside with Resident 1 when Staff F approached Resident 1 from behind and “whacked [them] with the inside of their leg on the lower back.” Staff D stated they immediately reported the incident to Staff A and Staff B. Staff D stated the incident occurred four to six months ago. Staff D further stated that on a separate occasion, they were in the kitchen with Staff A and Resident 1 and observed Staff F hitting Resident 1 on the head with an object. Staff D stated Staff A witnessed the interaction.

In an interview on 05/04/2026 at 12:05 PM, Staff B stated that they had not witnessed an inappropriate interaction between Staff F and Resident 1. Staff B further stated that Staff D told them about an incident in the kitchen in which Staff F “bammed [Resident 1] on the head with something,” and that Staff A talked to Staff F about it. Staff B then stated that they had heard something about “Staff F kicking [Resident 1's] leg out from under [them] outside.” Staff B stated they did not investigate it, had no documentation related to either incident because it was Staff A’s responsibility to investigate matters related to staff members, and that “hopefully it was logged.” Staff B stated that Staff F was previously suspended twice for inappropriate behaviors.

In an interview on 05/04/2026 at 1:24 PM, Resident 1 stated that Staff F had made them uncomfortable sometimes. Resident 1 stated that Staff F had said “really gross things,” such as, “I can make it nice and juicy for you,” and has hit on/flirted with them. Resident 1 stated that Staff F touched them and put their hands on them. Resident 1 further stated that they were outside and Staff F came around the corner and started “play hitting me.” When asked by the department what “play hitting” looked like, Resident 1 demonstrated by lightly backhanding the department investigator on the upper arm. Resident 1 then stated Staff F had also done that to the top of their head. Resident 1 further stated that Staff F had tripped them more than once and demonstrated to the department investigator by moving their leg in front of the investigator’s shin. Resident 1 stated that they told Staff F to stop but Staff F did not listen.

In an interview on 05/04/2026 at 1:18 PM, Staff E stated that they did not like the way Staff F interacted with some of the residents. Staff E further stated that they witnessed Staff F slamming their fist on the stainless-steel countertop when a resident was standing next to it. Staff E stated that Staff F laughed when the residents jumped or startled from the loud noise and claimed to be joking. Staff E stated that they heard that Staff F kicked Resident 1 but did not witness the incident. Staff E stated that Resident 1 was often on the receiving end of Staff F’s inappropriate interactions.

Review of Resident 1’s 2025 and 2026 Progress Notes showed no documentation of any

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incidents related to Staff F.

In an interview on 05/04/2026 at 1:42 PM, Staff A stated they had no recollection of any concerns raised by staff members about Staff F and had not investigated any incidents involving Staff F. Staff A stated they were only aware of a single interaction where Staff F raised their leg in a reverse kick motion towards Resident 1 and "tapped [Resident 1] in passing" with their foot while restocking gloves in one of the buildings. Staff A further stated that they had not spoken with Resident 1 about Staff F. Staff A stated that they were unaware of any suspensions involving Staff F and that the suspensions must have occurred before they were the administrator.

This is a recurring deficiency previously cited on 09/10/2025 for subsection (1) and on 06/15/2023 for subsections (1) (2)

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) 6-1-26.

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

John Mack — Administrator (or Representative)

6-1-26 — Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to report incidents of alleged physical abuse to the department's Complaint Resolution Unit for 1 of 4 residents (Resident 1). This failure precluded the department from conducting a timely investigation, contributed to ongoing harm to Resident 1, and placed the resident at increased risk for mental, emotional and physical injury.

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incidents related to Staff F.

In an interview on 05/04/2026 at 1:42 PM, Staff A stated they had no recollection of any concerns raised by staff members about Staff F and had not investigated any incidents involving Staff F. Staff A stated they were only aware of a single interaction where Staff F raised their leg in a reverse kick motion towards Resident 1 and “tapped [Resident 1] in passing” with their foot while restocking gloves in one of the buildings. Staff A further stated that they had not spoken with Resident 1 about Staff F. Staff A stated that they were unaware of any suspensions involving Staff F and that the suspensions must have occurred before they were the administrator.

This is a recurring deficiency previously cited on 09/10/2025 for subsection (1) and on 06/15/2023 for subsections (1) (2)

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

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to report incidents of alleged physical abuse to the department’s Complaint Resolution Unit for 1 of 4 residents (Resident 1). This failure precluded the department from conducting a timely investigation, contributed to ongoing harm to Resident 1, and placed the resident at increased risk for mental, emotional and physical injury.

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Findings included…

Review of the facility's undated policy titled, "Reporting Abuse, Neglect, and Exploitation," showed that any staff member who had a reasonable cause to believe that an incident of abuse had occurred, would notify the Department of Social and Health Services Complaint Resolution Unit (CRU) hotline. Further review showed that if a staff member had reason to suspect an incident of physical assault had occurred, they would report it to the local law enforcement emergency services number.

Review of the facility's undated characteristic roster showed that Resident 1 had a developmental disability (condition causing physical, learning, language, or behavior impairments).

Review of Resident 1's negotiated service agreement, dated 12/13/2025, showed that Resident 1 had a diagnosis of [redacted].

< Incident on 04/18/26>

Review of Resident 1's Progress Notes showed a note written by Staff C, Caregiver, dated 4/19/2026, that documented that Resident 1 informed the staff that they had were hurt and had a headache as a result of another resident hitting them with a log stick on the head. The note further showed that Resident 1 told Staff C that they asked the resident to leave the room but they would not and continued to play rough.

In an interview on 04/24/2026 at 11:25 AM, Resident 1 stated that Resident 2 hit them in the head with a stick and that it hurt. Resident 1 stated they told Staff C about what happened.

In an interview on 04/24/2026 at 1:43 PM, Staff B, Resident Care Coordinator, stated that the investigation into the incident on 04/18/2026, when Resident 1 was hit on the head with a stick, was on-going and they did not yet have any findings. Staff B stated they did not report it to CRU and that CC1, Resident 1's Case Manager (not a facility employee), had reported it.

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In an interview on 05/01/2026 at 2:52 PM, Staff D, Caregiver, stated that they informed Staff B about the incident between Resident 1 and Resident 2 on Monday morning, 04/20/2026. Staff D further stated that after they reported it, Staff B did not do anything about it.

In an interview on 05/04/2026 at 2:28 PM, Staff C stated that Resident 1 approached them on 04/19/2026 to report that Resident 2 hit them with a stick the day before. Staff C stated that Resident 1 indicated that their head hurt. Staff C stated that they documented Resident 1's statement in Resident 1's progress notes, left a message for Staff B in the daily communication log directing them to check Resident 1's progress notes, and wrote Staff A a note about it. Staff C stated that they checked in with Staff A the following day and asked if anything had been done and was told Staff A would deal with it the following day. Staff C stated nothing was done about the incident until 04/21/2026. Staff C stated they did not report the incident to the CRU hotline.

Review of the CRU database on 05/05/2026 showed no facility reports related to an incident between Resident 1 and Resident 2 on 04/18/2026.

<Incident on 01/18/26>

In an interview on 04/24/2026 at 11:25 AM, Resident 1 stated Resident 2 hit them with a light saber. Resident 1 further stated that they told Staff B and Staff E, Caregiver, about the incident.

Review of Resident 2's Progress Notes showed a note, dated 01/18/2026 and written by Staff E, that indicated that another resident told Staff E that Resident 2 was playing too rough with their light saber swords. Further review showed that Staff E talked with Resident 2 and Staff B, and that Staff B asked that Resident 2's light sabers be kept in the office.

In an interview on 05/04/2026 at 12:33 PM, Staff E stated that Resident 2 had a problem with hitting Resident 1 with the light saber. Staff E further stated that they did not fill out an incident report but contacted Staff B by phone and told them about it.

In an interview on 05/04/2026 at 12:05 PM, Staff B stated that they recalled asking Resident 2 for the light sabers and kept them in the office for a while. Staff B further stated that they didn't know if the incident was reported to CRU. Staff B was unable to locate any documentation of the incident or a report.

Review of the CRU database on 05/05/2026 showed no facility reports related to an incident between Resident 1 and Resident 2 on 01/18/2026.

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<Incident on May 2025>

Review of Resident 1‘s 2025 and 2026 Progress Notes showed an undated note, located between notes dated 05/08/2025 and 05/13/2025, written by Staff C, that showed Resident 1 disclosed to Staff C that Resident 2 had bit them. Further review showed an observation of teeth marks on Resident 1’s arm. Further review showed that Resident 1 told Staff C that Resident 2 wouldn’t stop when Resident 1 said it hurt.

In an interview on 05/04/2026 at 1:24 PM, Resident 1 stated that Resident 2 had bitten them on the arm and neck, and that it had happened more than one time.

In an interview on 05/04/2026 at 2:28 PM, Staff C confirmed that Resident 1 told them Resident 2 had bitten them. Staff C stated that they had not reported the incident and that they had been told conflicting instructions regarding reporting, including being told not to report because the facility wanted to look into it first.

Review of the CRU database on 05/05/2026 showed no facility reports related to an incident between Resident 1 and Resident 2 in May 2025.

< Staff F, Caregiver>

In an interview on 05/01/2026 at 2:52 PM, Staff D stated that they witnessed an inappropriate interaction between Resident 1 and Staff F. Staff D stated that four to six months ago they witnessed Staff F approached Resident 1 from behind and whack them in the back. Staff D stated they immediately reported the incident to Staff A, Administrator, and Staff B. Staff D further stated that on a separate occasion, they along with Staff A, were in the kitchen with Resident 1 and that they both observed Staff F hit Resident 1 on the head with an object.

In an interview on 05/04/2026 at 12:05 PM, Staff B stated that Staff D told them about an incident in the kitchen in which Staff F hit Resident 1 on the head with something, and that Staff A talked to Staff F about it. Staff B then stated that they also had heard something about Staff F kicking Resident 1’s leg out from under them.

In an interview on 05/04/2026 at 1:24 PM, Resident 1 stated that Staff F had made them uncomfortable at times. Resident 1 stated that Staff F had made inappropriate sexual comments to them and had hit on/flirted with them. Resident 1 stated that Staff F

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touched them and put their hands on them. Resident 1 further stated that one time Staff F started play hitting them. Resident 1 further stated that Staff F tripped them more than once. Resident 1 stated that they told Staff F to stop but Staff F did not listen.

In an interview on 05/04/2026 at 1:42 PM, Staff A stated they were only aware of a single interaction where Staff F raised their leg in a reverse kick motion towards Resident 1 and "tapped" them with their foot in passing.

Review of the CRU database on 05/05/2026 showed no facility reports related to any incidents between Resident 1 and Staff F.

In an interview on 04/24/2026 at 1:43 PM, Staff B stated that they needed to hold a staff meeting about reporting abuse and neglect.

This is a recurring deficiency previously cited on 06/15/2023 for subsection (1)(a).

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) 6-1-26.

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

JOH JACA — Administrator (or Representative)

6-1-26 — Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120:

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

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touched them and put their hands on them. Resident 1 further stated that one time Staff F started play hitting them. Resident 1 further stated that Staff F tripped them more than once. Resident 1 stated that they told Staff F to stop but Staff F did not listen.

In an interview on 05/04/2026 at 1:42 PM, Staff A stated they were only aware of a single interaction where Staff F raised their leg in a reverse kick motion towards Resident 1 and “tapped” them with their foot in passing.

Review of the CRU database on 05/05/2026 showed no facility reports related to any incidents between Resident 1 and Staff F.

In an interview on 04/24/2026 at 1:43 PM, Staff B stated that they needed to hold a staff meeting about reporting abuse and neglect.

This is a recurring deficiency previously cited on 06/15/2023 for subsection (1)(a).

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

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(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

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This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to update negotiated service agreements to reflect needs and functioning, and to include the required parties in the process of developing them for 1 of 4 residents (Resident 1). This failure contributed to ongoing physical harm to Resident 1 placed the resident at risk for unmet care needs and staff support.

Findings included…

Review of Resident 1's state prepared Person Centered Service Plan (PCSP), dated 12/02/2025 and completed by CC1, Resident 1's Developmental Disabilities Administration (DDA) Case Manager, showed that Resident 1 could demonstrate limited awareness of health and safety concerns when focused on a particular objective, was in a known relationship with another resident at the facility, and required help from others to prevent them from being exploited, particularly in dating and intimacy. Further review showed that Resident 1 could have difficulty with personal boundaries and understanding what was appropriate physically and romantically.

Review of Resident 1's 2025 and 2026 Progress Notes showed three separate allegations:

May 2025 (undated progress note located between a note dated 05/08/2025 and a note dated 05/13/2025) – Resident 1 reported Resident 2 bit them and did not stop when asked.

06/18/2025 – Resident 1 disclosed to community support provider that Resident 2 had a history of hitting and biting them.

04/18/2026 – Resident 1 disclosed that Resident 2 hit them on the head with a stick.

Review of Resident 2's January 2026 Progress Notes showed an incident on 01/18/2026 in which Resident 2 was noted as being too rough with a light saber.

In an interview on 05/04/2026 at 12:33 PM, Staff E, Caregiver, stated that Resident 1 was the resident struck by the light saber noted in the 01/18/2026 Progress Note.

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Review of Resident 1's Temporary Care Plans, dated 06/18/2025 and 06/26/2025, showed an allegation by Resident 1 about Resident 2 as the concern. Further review showed the entry on 06/18/2026 outlined the allegation, the individuals notified, and the police department's decision to close the case. Review showed that the 06/26/2025 entry noted that the residents could have together time in public areas but that no private time would be allowed. Further review showed that the interventions outlined were limited to restricting resident interactions in private spaces, and were not enacted until eight days after the incident occurred.

Review of Resident 1's 2025 Progress Notes showed a note, dated 11/04/2025, that indicated the restrictions related to Resident 1 and Resident 2 interacting in private spaces were lifted. Further review showed no replacement preventative measures or interventions.

Review of Resident 1's Service Plan for Safety and Prevention, dated 04/21/2026, showed a concern that Resident 1 was hit in the head with stick, with a one-sentence account of the incident. Further review showed a list of several responses Resident 1 and their counselor were working on together related to Resident 2, that included walking away from the situation if Resident 2 didn't listen and going to staff immediately with concerns. Review showed no interventions or preventative measures to be taken by facility staff preceding or after rough play or a physical altercation.

In an interview on 05/01/2026 at 2:52 PM, Staff D, Caregiver, stated that they were unaware of any plan or interventions specific to escalations or altercations between Resident 1 and Resident 2.

In an interview on 05/04/2026 at 1:18 PM, Staff E, Caregiver, stated that they had not been provided a plan or instructions on what to do in response to rough play or physical altercations between Resident 1 and Resident 2.

In an interview on 05/04/2026 at 2:28 PM, Staff C, Caregiver, stated that they were not provided with any instructions, interventions or plan related to rough play or physical altercations between Residents 1 and 2 or how staff were to respond if they observed similar behaviors or concerns. Staff C further stated that "the hitting has gotten more frequent than it was."

Review of Resident 1's negotiated service agreement, dated 12/13/2025, showed a lack of interventions specific to Resident 1's tendency to disregard safety, their long-term relationship with Resident 2 that often included rough play, their history of reporting injuries inflicted by Resident 2, or the need to monitor for exploitation, boundaries, and decision making in regard to dating and intimacy.

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

JOE JAES — 6-1-26

Administrator (or Representative) — Date

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Administrator (or Representative) Date

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