STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

RiverRock Canyon Adult Family Home LLC
RiverRock Canyon Adult Family Home
3502 71st Ave W
University Place, WA 98466

RE: RiverRock Canyon Adult Family Home License # 754238

Dear Provider:

This letter addresses Compliance Determination(s) 67954 (Completion Date 10/30/2025) and 59971 (Completion Date 07/29/2025).

The Department completed a follow-up inspection of your Adult Family Home on 10/30/2025 and found that you have corrected the violations listed in the Complaint report dated 07/29/2025. Your home is back in compliance as of 05/02/2025 with the cited requirements of the Washington Administrative Code or the Revised Code of Washington or both.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-76-10400-3-c, WAC 388-76-10250-1, WAC 388-76-10250-1-a, WAC 388-76-10250-1-b, WAC 388-76-10250-1-b-i, WAC 388-76-10250-1-b-ii, WAC 388-76-10250-1-b-iii, WAC 388-76-10250-3

The Department staff who did the on-site verification:
Lisa Charette, NCI AFH Complaint Investigator
Rathana Duong, AFH Field Manager

If you have any questions, please contact me at (253)208-3090.

Sincerely,

Rathana Duong, AFH Field Manager
Region 3, Unit A
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Adult Family Home license.

The department completed data collection for an unannounced on-site complaint investigation on 05/29/2025 of:

RiverRock Canyon Adult Family Home
3502 71st Ave W
University Place, WA 98466

This document references the following complaint number(s): 177844, 179937

The following sample was selected for review during the unannounced on-site visit: 0 of 8 current residents and 1 former residents.

The department staff that investigated the Adult Family Home:

Lisa Charette, NCI AFH Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit A
PO Box 99250
Lakewood, WA 98496

Statement of Deficiencies	License #: 754238	Compliance Determination # 59971
Plan of Correction	RiverRock Canyon Adult Family Home	Completion Date
Page 2 of 9	Licensee: RiverRock Canyon Adult Family Home LLC	07/29/2025

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 Adult Family Home license, I must be in compliance with all the licensing laws and regulations at all times.

Provider (or Representative) — 08/08/2025 Date

WAC 388-76-10400 Care and services. The adult family home must ensure each resident receives:

(3) The care and services in a manner and in an environment that:

(c) Reasonably accommodates each resident's individual needs and preferences except when the accommodation endangers the health or safety of the individual or another resident.

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Adult Family Home (AFH) failed to ensure that 1 of 8 residents (Former Resident 8) received care and services in a manner did not endanger their health and safety. This failure resulted in Former Resident 8 (FR 8) having a fall with multiple fractures that required hospitalization.

Findings included...

On 05/29/2025 a record review of FR 8 's medical record showed that they were admitted to the AFH on [redacted]/2023. FR 8 's Annual Assessments dated 08/30/2024 and [redacted]/2023 showed that they had medical diagnoses of [redacted]

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 Adult Family Home license, I must be in compliance with all the licensing laws and regulations at all times.

Provider (or Representative) _____ Date _____

WAC 388-76-10400 Care and services. The adult family home must ensure each resident receives:

(3) The care and services in a manner and in an environment that:

(c) Reasonably accommodates each resident's individual needs and preferences except when the accommodation endangers the health or safety of the individual or another resident.

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Adult Family Home (AFH) failed to ensure that 1 of 8 residents (Former Resident 8) received care and services in a manner did not endanger their health and safety. This failure resulted in Former Resident 8 (FR 8) having a fall with multiple fractures that required hospitalization.

Findings included…

On 05/29/2025 a record review of FR 8 's medical record showed that they were admitted to the AFH on [redacted]/2023. FR 8 's Annual Assessments dated 08/30/2024 and [redacted]/2023 showed that they had medical diagnoses of [redacted]

[redacted], and [redacted]. The assessment showed FR 8 was a fall risk, had short term memory loss, moderately impaired decision-making, needed frequent reminders to use the call light, needed hands on assistance of one person for showering. The assessment further showed FR 8 would forget their limitations, benefited from frequent supervision and the use of bed/chair alarm.

On 05/29/2025 a record review of FR 8's Negotiated Care Plan (NCP) dated 09/30/2024 showed that FR 8 was a "medium fall risk", that they should be frequently reminded to use their call button for assistance and used a bed and chair alarm to alert staff to attempts of them trying to get up without assistance. The NCP included in red writing with no date or initials, a statement under bathing that FR 8 "likes to masturbate occasionally in the shower, staff is to make sure they are safe and comfortable and give them time to themselves in the shower until they have completed the act." The NCP was signed by FR 8's representative, the Provider (Staff F) and the Resident Care Coordinator (RCC) (Staff B) on 09/30/2024.

On 05/29/2025 a record review of the Incident Log dated [redacted]/2025 showed FR 8 had a fall on [redacted]/2025 from the shower chair and that FR 8 had injuries including a "lump on their right forehead, right shoulder pain and a skin tear to the right shoulder."

On 05/29/2025 a record review of a statement written by Staff C (caregiver) and dated [redacted]/2025, stated that they were giving FR 8 a shower on [redacted]/2025 and "during the shower, as they are allowed to per their care plan, FR 8 used the showerhead to masturbate. They do this every time I give them a shower and every time, they do this, I step outside of the bathroom for a couple of moments to give them privacy." The statement said, "approximately 10 seconds after Staff C stepped outside of the bathroom, they heard a loud thud in the bathroom, they immediately re-entered the bathroom and FR 8 had tipped over in the shower chair and was on the floor". Staff C said in the statement that they called Staff D (caregiver) to assist them, and they got FR 8 back into their wheelchair.

Review of hospital records dated [redacted]/2025 at 11:21 AM, showed that FR 8 arrived in the Emergency Room for evaluation after a fall in the shower. The record showed that FR 8 had a large right-sided hematoma (a collection of blood, typically formed as a result of trauma or injury that causes a rupture or tear in the blood vessel, that may appear as a bulge, swelling or bruise) to their head, multiple hematomas to the right arm which was in a sling and tenderness to the right shoulder. X-rays of FR 8's shoulder showed osteopenia (a condition with lower-than-normal bone density that can increase the risk of a fracture), and a right collar bone fracture. A CT scan showed fractures of the right second, third and fourth ribs, fractures of vertebrae (chest spinal cord bones) T6 and T7. A physician's note dated [redacted]/2025 at 5:33 PM stated that the physician spoke to the Power of Attorney (POA) for FR 8 , that the POA felt that FR 8 was not a surgical candidate and for the purpose of pain control the decision was made to transition FR 8 to end of life care/comfort care.

On 05/29/2025 at 10:36 AM in an interview with Staff B, they said that on [redacted]/2025 when FR 8 fell, they received a call to assist the caregivers (Staff C and Staff D) with assessing FR 8 due to a fall in the shower. Staff B said that FR 8 was wrapped in a towel, in their wheelchair and had skin tears to their right shoulder and forearm and a goose egg (raised area of swelling under the skin) on their right forehead that was bleeding. Staff B said that they contacted FR 8's family who wanted them assessed by the AFH nurse before calling Emergency Medical Services (EMS). Staff B said that the nurse came and assessed FR 8 and called EMS to transport FR 8 to the hospital. When Staff B was asked what they thought happened to cause the fall, Staff B said, "When FR 8 is done getting a shower, they request the caregiver to give them the handheld showerhead to masturbate. If the caregiver is male, FR 8 would ask them to step outside the room. Staff C stepped out of the room and, within a few seconds, heard a thud in the bathroom. When Staff C opened the door, they saw FR 8 tipped over in the shower chair to FR 8 's right side." Staff B said that when FR 8 arrived at the hospital, they discovered FR 8 had several broken ribs and a broken clavicle (collar bone) and that they were not a surgical candidate due to her multiple health conditions and for pain control, the family chose to start comfort care due to the AFH not being able to administer IV pain medication. Staff B said that FR 8 was transferred to a hospice facility and passed away on [redacted]/2025.

On 06/04/2025 at 1:32 PM in an interview with Staff A (Registered Nurse for the AFH) Staff A stated, "I actually wasn't aware that FR 8 was masturbating in the shower or that staff were leaving them alone for privacy, no one shared this information with me." Staff A reported that they complete all residents' annual assessments and that this information about FR 8 masturbating was not included in their assessment because they were unaware of the behavior. Staff A reported that Staff B is responsible for creating and updating all NCPs.

On 06/02/2025 at 12:21 PM in an interview with Collateral Contact 1(CC 1, FR 8's Representative), they stated that FR 8 was known to be a fall risk to the staff at the AFH and that everyone was aware of this. CC 1 said that FR 8 had alarms in their chair and in their bed to alert staff of attempts to self-transfer because FR 8 didn't use the call light consistently, and that FR 8 had floor mats next to their bed and bed rails to prevent falls and injury. CC1 said, "Why would they think it was safe to leave FR 8 in the shower alone when they had all of these fall interventions in place to keep them safe?". CC 1 said that they received a call on [redacted]/2025 from Staff B stating that FR 8 was going to be transported to the hospital. CC1 stated that they wanted FR 8 to be assessed by the AFH nurse (Staff A) before the decision was made to send FR 8 to the hospital. CC 1 stated that they received a call a few minutes later from Staff A stating that FR 8 needed to go to the hospital, and it was only then that CC1 was made aware of the extent of FR 8's injuries. CC 1 stated that once FR 8 was at the hospital, it was determined that they had suffered from a right broken collar bone, 4 broken ribs on the right, and 3-4 broken vertebrae in their neck, as well as large goose egg on their right forehead and several skin tears on the right arm and shoulder. CC 1 said that FR 8 was not a surgical candidate and was in significant pain due to the injuries, and that the doctors recommended that FR 8 be transitioned to end of life care and started on a morphine drip (a pain medication administered by a needle in the vein to manage

moderate to severe pain). CC 1 stated that FR 8 was transferred to a facility for end-of-life care and passed away 5 days later. CC 1 stated that they were not given a clear explanation of how FR 8 fell in the shower room, and that they had been told two different stories; one story that FR 8 had been in the bathroom alone and one story that the caregiver had been in the bathroom when FR 8 fell. When asked if they were aware that the staff were leaving FR 8 in the shower alone to masturbate with the handheld shower wand, CC 1 said that they were not aware of this, that no one had discussed this behavior with them and that if they had, CC 1 would have told them that they needed to allow FR 8 to do this in a safer place, like their bed. CC 1 said that they would never have agreed to allow them to leave FR 8 in the shower alone due to them being a high fall risk. CC 1 stated that FR 8 would not have been able to ask for privacy due to their severe dementia. When asked if CC 1 recalled seeing this behavior listed on the NCP for FR 8 and written in red, they stated they had never seen this on the NCP.

On 06/04/2025 at 4:02 PM, in an interview with Collateral Contact 3 (CC 3), CC 3 stated that FR 8 was left alone in the shower when they fell. CC 3 said that Staff C gave multiple different versions of what happened when FR 8 fell. CC 3 said that the stories included Staff C stepping out of the shower room to place clothes in the dirty clothes hamper in FR 8's room; Staff C stepping out of the shower room to give FR 8 privacy while FR 8 masturbated; and Staff C being in the shower room when FR 8 fell. CC 3 stated that they had worked with FR 8 for longer than a year and had never heard of FR 8 having this behavior and had never known FR 8 to masturbate. CC 3 stated that FR 8 had itchy skin, would scratch themselves and would make non-sensual pleasurable sounds to the scratching. CC 3 stated that FR 8 was a known fall risk and should not have been left alone in the shower because they tried to stand on their own frequently.

On 06/11/2025 at 1:38 PM in an interview with Staff E (caregiver) they reported that they did showers for all the residents at both AFHs (two AFHs owned by the same owner and on the same property, with different addresses) and that their schedule alternated with Staff C's schedule. Staff E said that they had worked at the AFHs for 3 years. Staff E reported that there were two AFH's on the same property with different physical addresses and that they shared staff. They said that the caregivers who do showers for the residents are considered floats, and they do showers for both AFH's and that there was one shower aid each day. When asked if FR 8 had ever indicated they wanted privacy to masturbate in the shower or asked them to leave the room during a shower, Staff E said that they had not experienced this with FR 8. Staff E said that FR 8 had itchy skin and at the end of their shower, FR 8 would indicate they wanted their private area cleaned. Staff E said that they would give FR 8 the washcloth and encourage them to wash themselves or give them the shower wand to wash themselves. Staff E said, "When FR 8 washed themselves, it didn't seem sexual in any way, in fact, FR 8 didn't have the manual dexterity in their hands to really control where the water was going with the shower wand and needed encouragement from staff to wash this area." Staff E said that they had access to the NCPs for the residents, and they had not ever seen anything on FR 8's NCP that discussed masturbation in the shower or giving them privacy in the shower, prior to the fall. Staff E said that they were unaware of this behavior with FR 8.

On 06/12/2025 at 12:28 PM, in an interview with Staff A, they were told that there were

concerns about contradicting statements from staff regarding FR 8's fall in the shower. Staff A stated that they had the same concerns. Staff A said that initially, Staff C told them that they were in the bathroom with FR 8 and that water had sprayed on their pants, and that when Staff C bent down to wipe the water from their pants, FR 8 fell. Staff A said that about an hour after the fall, another staff member had come to them stating that they didn't think Staff C was telling the truth and that the story kept changing, so Staff A called a meeting with Staff B, Staff C, Staff D and Staff H (Operations Manager) to ensure that everyone had all the correct information since they were concerned about the differing stories about what happened. Staff A said that during this meeting they were told by Staff C that they had stepped out of the bathroom to take FR 8's dirty clothes to their hamper in their room and that on the way back to the shower, Staff C heard the thud from FR 8's fall. Staff A said, "Later, I saw the statement that Staff C wrote that said that FR 8 was pleasuring themselves and Staff C was standing outside the bathroom at the time of the fall." Staff A said that they were told by Staff B, Staff H and Staff I that Staff C had "help writing their statement. I am unsure of what that help was specifically." Staff A said that when they questioned Staff C about their statement not matching what was said about how the fall happened, Staff C told them that they were flustered by the paramedics being there. Staff A said that they reported their concerns about the differing statements to Staff F (the Provider) to follow up on.

On 06/12/2025 at 12:42 PM in an interview with Staff B, they were asked if it was common practice to date and initial changes made to the NCP after the annual NCP was generated. Staff B said that they make changes in red writing, but they don't usually date or initial those changes. When asked if they review the NCP or changes made to the NCP with the residents and/or their representatives, Staff B said that no one reviews the NCP with the family or the residents. Staff B said that the NCP is sent to the family member via email to sign and return or given to them to sign when they are visiting the facility. When asked if they ever had a conversation with FR 8's family member about their behavior of masturbating in the shower and being left alone, Staff B said that they did not, that they 'figured since they signed the care plan, that they were aware." When asked how the staff know to look for changes to the NCP, Staff B said, "The staff look at the care plans daily when providing care to residents."

On 06/16/2025 at 12:29 PM in an interview with Staff F (the Provider), they stated Staff C had told them that FR 8 had been receiving a shower, indicated that they wanted to pleasure themselves with the hand-held shower wand, and that Staff C stepped out to allow FR 8 privacy. Staff F said that they had heard varying accounts about what happened when FR 8 fell from multiple staff, so Staff F went to the facility to interview Staff C themselves and when asked about the differing accounts, Staff C told them that they were flustered when the paramedics were in the AFH, due to FR 8 being hurt and when the paramedics left, Staff C was finally able to calm down and recall what happened. Staff F stated that it was not standard practice to leave residents who were a known fall risk alone in the bathroom.

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, RiverRock Canyon Adult Family Home is or will be in compliance with this law and / or regulation on (Date) 08/02/2025.

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

Provider (or Representative) 8-15-25 Date

WAC 388-76-10250 Medical emergencies Contacting emergency medical services Required.

(1) The adult family home must develop and implement policies and procedures which require immediate contact of the local emergency medical services when a resident has a medical emergency. This requirement applies:

(a) Unless the caregiver, present at the time of the emergency, is a licensed physician or registered nurse acting within his or her scope of practice;

(b) Whether or not:

(i) Any order exists directing medical care for the resident;

(ii) The resident has provided an advance directive for medical care; or

(iii) The resident has expressed any wishes involving medical care.

(3) The home must inform the resident of the requirements in this section.

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Adult Family Home (AFH) failed to immediately contact emergency services when 1 of 8 residents (Former Resident 8) had a medical emergency. This failure resulted in delayed emergency services when the resident had a fall with multiple injuries.

Findings included...

In a record review of the AFH's Incident Log dated [redacted]/2025, it showed that FR 8 had a fall from the shower chair and had injuries including a "lump on their right forehead, right shoulder pain and a skin tear to the right shoulder." FR 8 was sent to the hospital.

In a record review of a statement dated [redacted]/2025 that was written and signed by Staff

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, RiverRock Canyon Adult Family Home 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.

Provider (or Representative) Date

WAC 388-76-10250 Medical emergencies Contacting emergency medical services Required.

(1) The adult family home must develop and implement policies and procedures which require immediate contact of the local emergency medical services when a resident has a medical emergency. This requirement applies:

(a) Unless the caregiver, present at the time of the emergency, is a licensed physician or registered nurse acting within his or her scope of practice;

(b) Whether or not:

(i) Any order exists directing medical care for the resident;

(ii) The resident has provided an advance directive for medical care; or

(iii) The resident has expressed any wishes involving medical care.

(3) The home must inform the resident of the requirements in this section.

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Adult Family Home (AFH) failed to immediately contact emergency services when 1 of 8 residents (Former Resident 8) had a medical emergency. This failure resulted in delayed emergency services when the resident had a fall with multiple injuries.

Findings included…

In a record review of the AFH's Incident Log dated [redacted] 2025, it showed that FR 8 had a fall from the shower chair and had injuries including a "lump on their right forehead, right shoulder pain and a skin tear to the right shoulder." FR 8 was sent to the hospital.

In a record review of a statement dated [redacted]/2025 that was written and signed by Staff

C (caregiver), it stated that FR 8 had fallen in the shower and was on the floor, and that they called a fellow caregiver to assist them with getting FR 8 into their wheelchair. Staff C then informed the Resident Care Coordinator (RCC, Staff B) and AFH Registered Nurse (Staff A) immediately. Staff C said that Staff A assessed FR 8 and Staff A "came to the conclusion to call emergency medical services (EMS)."

In a record review of hospital records for FR 8 dated [redacted]/2025 at 11:21 AM, it showed that FR 8 was brought in by EMS for evaluation after a fall in the shower which occurred at 10:30 AM. The record showed that FR 8 had a hematoma (a collection of blood under the skin caused by trauma) to their right forehead, multiple broken ribs, a broken collar bone and fractures of the vertebrae in their back.

On 05/29/2025 at 12:21 PM in an interview with Collateral Contact 1 [(CC 1) FR 8's Power of Attorney (POA)], they stated that they received a call on [redacted]/2025 from Staff B stating that "FR 8 had a fall in the bathroom and was being sent to the hospital." CC1 said that they asked Staff B to have Staff A, the Registered Nurse (RN) assess FR 8 before sending them to the hospital. CC1 said that they received another call shortly after this, stating that FR 8 was being sent to the hospital and it was not until the second call that was received from Staff A that they were made aware of how significant FR 8's injuries were.

On 06/04/2025 at 4:01 PM in an interview with Collateral Contact 2 (CC 2), they stated that they had been at the Provider's other AFH on the same property when they heard Staff B on the phone asking, "Why do we have a fall in the shower?", and then Staff B went to see what happened to FR 8. CC 2 said that Staff B didn't know if they should call 911 and it took 15 minutes for 911 to be called because Staff B didn't describe the severity of the fall accurately to CC1.

On 06/12/2025 at 12:28 PM in an interview with Staff A, they said that they were at home when FR 8 fell. Staff A said that they lived about 3 minutes away from the AFH. Staff A said that Staff B called them and reported that FR 8 had fallen in the shower and their POA wanted Staff A to assess FR 8 before deciding if hospitalization was warranted or if EMS should be called. Staff A said that they immediately went to the facility and found FR 8 in their wheelchair in the shower room and saw that FR 8 had a "goose egg [raised area of swelling under the skin] on their right forehead and was unable to tell Staff A what their name was." Staff A said that they felt like FR 8 needed to go to the hospital and they called 911.

On 06/12/2025 at 12:42 PM in an interview with Staff B, (RCC), when asked about what happened when Former Resident 8 (FR 8) fell, Staff B said, they were called by the caregiver to come from other house (another AFH on the same property, owned by the same owner, but with a different address) to see FR 8 due to a fall. Staff B said that FR 8 was still on the floor, that FR 8 had skin tears to their right shoulder and arm and a lump on their right forehead that was bleeding and FR 8 was crying in pain. Staff B called FR 8's family member/Power of Attorney (POA) to tell them what happened. The POA requested that Staff B call Staff A, the Registered Nurse (RN) to come and assess FR 8

before sending them to the hospital. Staff B said that they called Staff A to assess FR 8, they arrived in approximately 5 minutes and made the decision to call 911.

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, RiverRock Canyon Adult Family Home is or will be in compliance with this law and / or regulation on (Date) 09/02/2025

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

Carl Bohn — Provider (or Representative)

8-15-25 — Date

before sending them to the hospital. Staff B said that they called Staff A to assess FR 8, they arrived in approximately 5 minutes and made the decision to call 911.

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, RiverRock Canyon Adult Family Home 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.

Provider (or Representative) _____ Date _____