STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Tierra Village
Coyote House
11864 Sunitsch Canyon Road
Leavenworth, WA 98826

RE: Coyote House License # 752600

Dear Provider:

This letter addresses Compliance Determination(s) 79895 (Completion Date 07/07/2026) and 71628 (Completion Date 05/12/2026).

The Department completed a follow-up inspection of your Adult Family Home on 07/07/2026 and found that you have corrected the violations listed in the Complaint report dated 05/12/2026. Your home is back in compliance as of 06/25/2026 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 388-76-10670, WAC 388-76-10670-1, WAC 388-76-10670-2, WAC 388-76-10670-3, WAC 388-76-10670-4, WAC 388-76-101631-1, WAC 388-76-10400-1, WAC 388-76-10400-2, WAC 388-76-10400-3, WAC 388-76-10400-3-a, WAC 388-76-10400-3-b, WAC 388-76-10400-3-c, WAC 388-76-10161-3, WAC 388-76-10205, WAC 388-76-10198-2-a, WAC 388-76-10673-1-b, WAC 388-76-10673-2-b, WAC 388-76-10375-1

The Department staff who did the on-site verification:
Brittney Shull, Community Complaint Investigator

If you have any questions, please contact me at (509)572-7394.

Sincerely,

Michelle Ann Yarbrough

Michelle Yarbrough, Adult Family Home Field Manager

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

Region 1, Unit C
Residential Care Services

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

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 01/20/2026, 02/06/2026, 02/27/2026, 03/23/2026, 04/15/2026, 04/24/2026, 04/30/2026 and 05/08/2026 of:

Coyote House
11864 Sunitsch Canyon Road
Leavenworth, WA 98826

This document references the following complaint number(s): 209175, 209089, 209156, 213637, 212249, 211223, 213473, 217607

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

The department staff that investigated the Adult Family Home:

Brittney Shull, Community Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit C
1200 Alder Street
Union Gap, WA 98903

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Statement of Deficiencies
Plan of Correction
Page 2 of 34

License #: 752600
Coyote House
Licensee: Tierra Village

Compliance Determination # 71628
Completion Date
05/12/2026

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.

Michelle Ann Yarbrough
Residential Care Services

05/26/2026
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)

6/4/2026
Date

WAC 388-76-10670 Prevention of abuse. The adult family home must:

(1) Meet the requirements of chapter 74.34 RCW;

(2) Ensure each resident's right to be free from abandonment, verbal, sexual, physical and mental abuse, exploitation, financial exploitation, neglect, and involuntary seclusion;

(3) Protect each resident who is an alleged victim of abandonment, verbal, sexual, physical and mental abuse, exploitation, financial exploitation, neglect, and involuntary seclusion; and

(4) Prevent future potential abandonment, verbal, sexual, physical and mental abuse, exploitation, financial exploitation, neglect, and involuntary seclusion from occurring.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to protect, prevent, and ensure 3 of 6 residents (Resident 1, 3, and 4) were free from sexual abuse, and 1 of 6 (Resident 2) was free from neglect. These failures resulted in harm for Residen1 and Resident 3, contributed to Resident 4 feeling unsafe in the AFH, and resulted in staff being unable to implement Resident 2's negotiated care plan to protect and prevent inappropriate sexual behaviors.

Findings included...

RCW 74.34.020
Definitions.
The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.
(2) "Abuse" means the intentional, willful, or reckless action or inaction that inflicts

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Residential Care Services | Date

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Provider (or Representative) | Date

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injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult which have the following meanings:
(a) "Sexual abuse" means any form of nonconsensual sexual conduct, including but not limited to unwanted or inappropriate touching, rape, molestation, indecent liberties, sexual coercion, sexually explicit photographing or recording, voyeurism, indecent exposure, and sexual harassment. Sexual abuse also includes any sexual conduct between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under chapter 71A.12 RCW, and a vulnerable adult living in that facility or receiving service from a program authorized under chapter 71A.12 RCW, whether or not it is consensual.
(13) "Mandated reporter" is an employee of the department or the department of children, youth, and families; law enforcement officer; social worker; professional school personnel; individual provider; an operator of a facility or a certified residential services and supports agency under chapter 71A.12 RCW; an employee of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, hospice, or certified residential services and supports agency; county coroner or medical examiner; Christian Science practitioner; or health care provider subject to chapter 18.130 RCW.
(15) "Neglect" means (a) a pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or (b) an act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100.

Record review of the facility Employee Handbook, dated 2025, showed that the AFH belonged to an educational center that shared a common property with additional residential homes and retreat centers to provide services for AFH residents and community members. The handbook showed that the AFH and educational center was governed by a board of directors. The handbook showed that the AFH's "Abandonment, Abuse, Neglect and Mandatory Reporting" policy required all incidents of suspected abuse to be reported as required by RCW 74.34. The handbook showed that there would be no interference with the requirement regarding employees or mandated reporters to file reports directly with the Department or law enforcement if they suspect sexual or physical abuse have occurred. The handbook showed that sexual abuse was defined as any form of nonconsensual sexual contact, including but not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. The handbook further stated in instances of when a vulnerable adult was unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish.

<Resident 2>

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Review of the AFH's October 2025 Staff Meeting minutes showed that Resident 2 needed to be in eyesight of staff at all outings and due to an incident on 09/17/2025, staff were to monitor Resident 2 in all communal spaces and not rely on Resident 2 to be appropriate with all residents, especially Resident 1.

Review of the Department Assessment, dated 10/15/2025, showed that Resident 2:
-Had a diagnosis of [redacted], and [redacted].
-Was to always have someone with them, whether at home or in the community, to coach them with safety and appropriate behaviors with others, required constant redirection and proximity supervision, had a tough time learning and understanding social boundaries, and required verbal support to be appropriate in socializing with others.
-Required full support and someone with them at all times to avoid health and safety hazards due to being unaware of them and was not safe to walk outside alone.
-Had significant short-term memory loss and long-term memory problems.
-Wandered and had a history of entering resident rooms while residents were sleeping.
-Had a motion alarm on their bedroom door to alert night staff to exiting the bedroom at night and required someone with them at all awake times to monitor and coach them for safety and appropriate behaviors and redirect back to bed.
-Was easily irritable/agitated, had extreme/rapid mood swings, was resistive to care with words/gestures.
-Was "sexually curious and focused on sex," had counseling to address sexual appropriateness, required supervision and verbal support for this need, would stand too close to others and say suggestive things, had tried to touch others inappropriately and required caregivers to provide proximity supervision and verbal support to be socially appropriate, and staff should be aware of where Resident 2 was and what they were doing at all times around other vulnerable adults.
-Sexually acted out, invited others to have a sleepover, would make "sexually suggestive," "forward, provocative, and intense," comments, and touched without permission. The assessment showed that the behavior was not easily altered and Resident 2 required consistent and constant supervision.

Record review of Resident 2's Negotiated Care Plan (NCP), dated 11/05/2025, showed that Resident 2:
-Had a sleep disturbance, wandered into other resident rooms and staff were required to know where Resident 2 was at, at all times.
-Had a history of abuse and neglect as a child that caused confusion with aspects of relationships and what type of physical contact was appropriate with others. Staff were to monitor Resident 2 at all times to support decision making, social interactions, and social boundaries.
-Had a recent incident of entering fellow resident rooms and attempting inappropriate contact, required a door alarm, and other residents to lock their door to prevent further occurrences. The NCP directed staff to refer to Resident 2's Safety Plan.

Review of Resident 2's Safety Plan, dated 10/17/2025, showed that Resident 2:
-Had a pattern of wandering into other resident rooms, primarily Resident 1's room, and sought or initiated inappropriate physical contact without staff supervision which

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presented privacy, boundary and safety concerns for residents of the household.
-Would awaken early before staff, desired attention or companionship, misunderstood social or personal boundaries, and acted impulsively/had limited awareness of other's privacy needs.
-Had cognitive/developmental limitations that impacted their judgement and had inconsistent redirection or supervision during early hours and required staff awake at 6:00 am to increase supervision of Resident 2, and required other resident doors to be closed and locked, a door alarm would notify premises staff and management when the door was opened, and Resident 2 to ride in the front seat during vehicle trips, in clear sight of the driver unless other staff were present in the vehicle as passengers, and morning activities to prevent wandering.
-Required staff to respond immediately and calmly to redirect Resident 2 out of other's rooms, ensure safety and privacy of all residents, escort Resident 2 to a supervised area and calming activity, notify the AFH manager and document the incident, and if physical contact occurred, notify guardians, case managers, and file an incident report with the Department.
-Required staff to supervise Resident 2 while they were awake from 6:00am to 8:00pm, confirm Resident 2's location every 15 minutes and ensure Resident 2 did not enter rooms without permission or supervision.

Record review of the facility's Incident Log showed:
-On 09/25/2025, and "approximately 10/17/2025," there were inappropriate sexual advances and touching in the morning between Resident 1 and Resident 2. The incident was reported to a representative (does not specify which), and the AFH Resident Manager. It did not show that the incident was reported to law enforcement. The outcome showed that staff were to never allow one-on-one unsupervised time between Resident 1 and Resident 2.
-On 10/08/2025, Resident 1 and Resident 2, "refused attempts to enter the bedroom," and a resident asked to touch the other resident in a facility van. The outcome showed a door alarm would be installed, staff would be up at 6am and Resident 1 and Resident 2 would no longer be unsupervised together. It showed that reports were made to the AFH resident manager, unspecified representatives, and to the Department. It did not show that law enforcement was notified.
- On 11/04/2025 and 12/04/2025, Resident 2 had a long hug and kiss from a community member while walking home from the day program. It showed that the AFH resident manager, unspecified resident representatives, and the Department had been notified. It did not show that law enforcement had been notified.
-On 01/15/2026, Resident 2 was observed touching Resident 1's groin in the day program after lunch. It showed that the AFH resident manager, unspecified resident representatives, the Department, and day program staff had been notified. It did not show that law enforcement had been notified.
-On [redacted]/2026, a report of a sexual encounter between Resident 1, Resident 2, and Resident 3 on 01/10/2026 or 01/11/2026 was made. It showed that the AFH resident manager, "all guardians," day program staff, and the Department had been notified. It did not show that law enforcement had been notified. It showed that Resident 2 was removed from the AFH on [redacted]/2026.

Review of Resident 2's progress notes showed:
-On 09/25/2025, Resident 1's Representative reported to the AFH that Resident 1 told

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them that Resident 2 had made sexual advances on 09/24/2026 and a week or so previously. The notes showed that law enforcement was not notified until 9/29/2025.
-On 10/02/2025 a door alarm was ordered for Resident 2's bedroom.
-On 10/08/2025, the AFH learned Resident 2 and Resident 1 had an incident in the van on 09/27/2025 and Resident 2 had entered Resident 1's room on 3 different occasions for inappropriate reasons.
-On 12/04/2025, Resident 2 walked from the day program to the AFH and was approached by a community member who hugged and kissed Resident 2 on the cheek and Resident 2 was upset by the interaction.
-01/15/2026, a day program participant reported seeing Resident 2 rub the top of Resident 1's pants in which Resident 1 and Resident 2 and day program staff did not have direct line of vision of Resident 1 and Resident 1.

Review of the facility's door alarm documentation for Resident 2 showed Resident 2's door alarm triggered:
-On 1/11/2026 at 11:15pm and 11:30pm. (Staff B, Caregiver, working per January 2026 staff schedule)
-On 01/12/2026 at 5:50am and 11:39pm. (Staff C, Caregiver working)
-On 01/13/2026 at 11:46pm. (Staff C working)
-On 01/14/2026 at 12:25am, 12:26am, 12:32am, 12:33am, 12:39am, 1:03am, 1:07am, and 1:14am. (Staff C working)
-On 01/15/2026 at 12:29am, 12:30am, and 12:45am. (Staff C working)

Resident 1

Review of Resident 1's NCP, dated 05/27/2025, showed that Resident 1 was admitted to the facility on [redacted]/2025 and had trouble with decision making and required staff to assist with all decisions that had an impact on their life.

Review of Resident 1's Department Assessment, dated 10/06/2025, showed Resident 1:
-Had a diagnosis o[redacted] and [redacted].
-Had no deficits in memory. Resident 1 required assistance with decision making, daily problem solving daily, and did not understand consequences or responsibilities with choices.
-Required assistance with communication translation to others not familiar with Resident 1's speech pattern.
-Required support to manage and resolve conflicts.
-Would often not recognize the need to advocate for themselves and would not recognize if someone tried to take advantage of them.

Review of Resident 1's Emergency Room Medical Records, dated 01/18/2026, showed that Resident 1 had been taken to the emergency room for a sexual assault examination. The record showed that Resident 1 and Resident 1's Representative had reported Resident 2 sexually assaulted Resident 1, including one episode of anal

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penetration, on 01/11/2026 and 01/15/2026, at the AFH and associated day program building. The record showed that Resident 1 had complained of rectal discomfort, a bruise to their buttocks, 4 centimeters (cm) by 3cm, a linear abrasion (superficial injury to the skin caused by rubbing, scraping, or friction, resulting in partial removal of the outer layers) to right buttocks, 4cm in length, clustered abrasions to medial right knee, 1.5cm by 1.5cm, and clustered abrasions to left knee, 3cm by 3cm. The record showed that Resident 1 did not feel safe at the AFH, and appeared fearful and nervous, would speak in 1–2-word replies, avoided eye contact, and looked to Resident 1's Representative to speak for them. The record showed that Resident 1's Representative stated they had been notified in September 2025 that Resident 2 got in bed with Resident 1, which alarmed Resident 1 who ran out of their room and notified staff. The record further showed that Resident 1's Representative, was notified on 01/15/2026 via text message from Staff A, Resident Manager, that "something happened again," and they had "caught Resident 2 with their hand on Resident 1's crotch/leg area." The record showed that Resident 1's Representative, took Resident 1 to their home and Resident 1 told them that Resident 1 and Resident 3 had been sexually assaulted by Resident 2, and Resident 2 had entered Resident 3's room and began masturbating in front of Resident 2 and Resident 3. The record showed that Resident 1's Representative reported that Resident 2 had put their penis in Resident 1's buttocks, their hands on Resident 1's penis and buttocks, their mouth on Resident 1's mouth, neck, and penis. The record showed that Resident 1's Representative reported that Resident 1 told them that Resident 2 had done this before and would not stop.

On 01/20/2026 at 2:08pm, Staff A, Resident Manager, stated that Resident 1 had difficulty expressing boundaries consistently and Staff A had a responsibility to protect Resident 1. Staff A stated that in September of 2025, Resident 1's representative reported that Resident 1 had told Resident 1's Representative that Resident 2 had entered Resident 1's room and tried to get in Resident 1's bed. Staff A stated that Resident 1 told Staff A, Resident 1 did not want Resident 2 in their room. Staff A stated that a couple weeks later, Resident 2 had entered Resident 1's room early in the morning before staff were awake and Resident 1 had reported it had happened again. Staff A stated that following the September 2025 incident, Staff were supposed to be awake by 6:00am, Resident 1 and all residents were supposed to be encouraged to lock their door in the evening when staff were asleep, Resident 1 and Resident 2 were not to sit next to one another in the van, Resident 2 had to ride in the front of the van away from the other residents, Resident 1 and Resident 2 were not to be in each other's rooms and not to sit next to one another on the sofa. Staff A stated they informed all AFH staff of the new interventions. Staff A stated that Staff B, Caregiver, told Staff A that Resident 1 and Resident 2 had not followed the recommendations and Resident 1 and Resident 2 were still interacting in Resident 1's room. When asked if there was a consensual relationship between Resident 1 and Resident 2, Staff A stated they would be guessing and Staff A further stated that Resident 1 had told Staff A directly that they did not want Resident 2 in their room after the first incident and Resident 1 had difficulty enforcing boundaries at times. Staff A stated they had told Resident 2 they were not to touch Resident 1. Staff A stated the door alarm they initially installed beeped and staff were unable to sleep so they changed the door alarm to a phone application notification system that alerted to the phone(s) with the application installed. Staff A stated the door alarm did not always work and did not function without internet and therefore did not function during a power outage for 4 days in December 2025 due to a windstorm. Staff A did not state any additional interventions were added

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when the door alarm was not functioning.

Staff A continued to state that on 01/15/2026, a day program participant had witnessed Resident 2 touching Resident 1's crotch after lunch around 12:30pm-1:00pm when they were sitting next to each other watching a video. Staff A stated that Resident 1 confirmed that Resident 2 had touched Resident 1's crotch. Staff A stated that Resident 1 was fearful of not having access to the program. Staff A stated that Resident 2 also confirmed that Resident 2 had touched Resident 1's crotch. Staff A stated they were notified on 01/18/2026 of another incident involving intimate relations with Resident 1, Resident 2, and Resident 3. Staff A stated Resident 3 told Staff A that they thought they were in trouble and denied anything more than a hug. Staff A stated that they told Resident 3 that no one could touch them except doctors.

In an observation on 01/20/2026 at 3:04pm, the door alarm application on Staff A's phone was reviewed. The settings showed that the door alarm alerted only after it was open for 20 seconds. There was no alarm history for 12/11/2025 through 12/15/2025. It showed that the door opened frequently at night.

Review of the facility document titled, "Resident Out of Home Tracking 2025," showed Resident 1 was in the facility from 12/11/2025 through 12/15/2025 during the power outage and consequent door alarm failure.

In an interview on 01/21/2026 at 2:36pm, Collateral Contact 2 (CC2), Resident 1's Representative, stated that Resident 2 had a history of being "hypersexual," that they had personally witnessed. CC2 stated that Resident 1 told CC2 in September 2025 that Resident 2 had jumped in their bed and was "gross." CC2 stated that Staff A told CC2 that no residents should be going into anyone else's room, facility staff would encourage residents to lock their door at night, Resident 1 and Resident 2 would not be allowed to be alone together, and Resident 2 would not be allowed to sit next to Resident 1 in the van. CC2 stated they were notified on 01/15/2026 that Resident 2 touched Resident 1 in the crotch at the day program. CC2 stated they told Staff A they did not think Resident 1 was safe in the AFH with Resident 2 also residing there and requested that Staff A discharge Resident 2 and Staff A replied that it was complicated as Resident 2's representative was a significant financial donor to the AFH and day program. CC2 stated that on 01/16/2026, Resident 1 told CC2 that Resident 2 constantly made sexual suggestions to Resident 1, even through a closed bedroom door. CC2 stated that on 01/16/2026, Resident 1 told CC2 that Resident 2 was masturbating in front of Resident 1 and Resident 3 and Resident 2 requested that Resident 1 and Resident 3 touch their penis with a glove for their birthday. CC2 stated they notified Staff A that Resident 2 had constantly harassed Resident 1 for sexual interaction. CC2 stated that on 01/18/2026, Resident 1 told CC2 that on 01/15/2026, Resident 2 took Resident 1 to the bathroom, kissed Resident 1 on the neck, cheek, and penis and preformed anal sex and it had happened earlier that week as well in Resident 3's room. CC2 stated that Resident 1 was embarrassed and teary eyed when they told CC2 about the incident. CC2 stated they requested that Collateral Contact 3 (CC3), Executive Director, remove Resident 2 from the AFH for the protection of Resident 1 and CC3 asked CC2 if they knew who Resident 2's representative was. CC2 stated that they felt

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that CC3 was blaming the incidents on Resident 1 and stated that the door alarm might have failed.

In an interview on 01/22/2026 at 2:34pm, Collateral Contact 1 (CC1), Day Program Staff, stated they had witnessed Resident 2 acting inappropriately with caregivers and had sexual aggression. CC1 stated they did not believe Resident 2 was an appropriate candidate to live in a group home setting due to needing constant supervision. CC1 stated that Resident 1 told CC1 and Staff B, Caregiver, that they thought Resident 2 was “under a spell,” and wanted to be “a doctor;” to touch and explore inappropriately. CC1 stated that they did not believe any intimate relations between Resident 1 and Resident 2 were consensual. CC1 stated that Resident 2 had told CC1 they had a crush on Resident 1. CC1 stated that Resident 1 told CC1 that Resident 2 had pulled down Resident 1’s pants at the day program and touched Resident 1 inappropriately. CC1 stated that a day program participant told CC1 they had witnessed Resident 2 touching Resident 1’s “privates,” and apologized: not wanting to get anyone in trouble. CC1 stated that Staff A never communicated to the day program staff that Resident 2 required strict constant one-on-one supervision. CC1 stated they observed that Resident 1 had a change in their normal routine; had not showered in days, and Resident 1 normally showered multiple times a day and shaved their body extensively. CC1 stated they were concerned and alerted Staff A on 01/15/2026 that something was not right and that they believed Resident 1 did not feel safe getting naked in the house to shower. CC1 stated that in a meeting on 01/15/2026, Collateral Contact 3 (CC3), Executive Director of both the AFH and the Day Program, discouraged staff from reporting allegations of abuse and directed that there should only be one reporter, and there was a confidentiality requirement in their employee handbook that required them not to report, that “wording was important.” CC1 stated CC3 and Staff A told meeting attendants that Resident 1 and Resident 2 had a consensual relationship. CC1 stated CC3 and Staff A’s reaction to the incident was wrong and they believed they were being intimated into not reporting, and they were fearful of losing their job. CC1 stated that CC3 stated they did not want the incident to be “leaked to donors,” and directed staff to not leave a “paper trail,” of emails or text messages about the incident. CC1 stated that Resident 2’s Representative was a founder of the program and had donated the property that the facilities resided on. CC1 stated that on 01/18/2026, CC3 told CC1 that they did not want Adult Protective Services (APS) “knocking at their door,” that CC1 “had no proof that Resident 2 was abused, and CC1 should not believe everything people with intellectual disabilities say,” and if CC1 needed to report anything, they should, “go through CC3.” CC 1 stated that Staff B told CC1 on 01/18/2026 that Staff A did not set up Resident 2’s door alarm on Staff B’s phone, that the door was only alerting the system, not their phone. CC1 stated that Staff B appeared “triggered,” was crying, and told CC1 they were worried. CC1 stated they had originally thought an incident between Resident 1 and Resident 2 had happened on 01/11/2026 as the door alarm system showed that Resident 2 had left their room at 11:30pm on 01/11/2026 when Staff B was working and Staff B did not have access to the door alarm application or alerts. CC1 further stated that Staff C, Caregiver, regularly went to their bedroom at 7:00pm and did not monitor residents after that time.

On 02/02/2026 at 10:17am, Resident 1 stated that Resident 2 asked Resident 1 to come into Resident 2’s room and to take their clothes off. Resident 1 stated that Resident 2 tried to have sex with Resident 1 on Resident 2’s bed. Resident 1 stated that Resident 2

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touched Resident 1's penis and touched their butt with a glove and penetrated their anus. Resident 1 stated that Resident 2 "grossed them out." Resident 1 stated in the living room Resident 2 touched Resident 1's penis over their clothes. Resident 1 stated that on another occasion Resident 2 had kissed Resident 1's neck and nose. Resident 1 stated on another occasion, they had gone to the was inappropriate. Resident 1 stated that Resident 1 and Resident 2 were supposed to take turns riding in the front seat of the van, not that Resident 2 was to always be in the front seat. Resident 1 stated that Resident 2 had tried to touch Resident 1 in the van. Resident 1 stated that Resident 2 also tried to touch Resident 6.

On 02/27/2026 at 1:23pm, Staff B, stated that one time when all the residents were sitting in the living room, Resident 1 gestured at Resident 2 by pointing to their "private area," and asked Resident 2 if they "wanted to uh…" Staff B stated that a month and a half ago after the alleged incident of a community member inappropriately touching Resident 2 at the day program, Resident 2 began leaving their room before staff had woken up for the day, at 6:00am, so staff were required to wake up earlier to ensure "nothing would happen." Staff B also stated that staff were required to ensure Resident 2 did not go into anyone's room. Staff B stated that they had learned about a month or so ago that Resident 2 had been up around 11:30pm at night during their shift and they had not "caught," them awake. Staff B stated Staff A did not alert Staff B about Resident 2 being up at night until a week later. Staff B stated they did not have the door alarm application connected to their phone until after the incident in January 2026. When asked about mandatory reporting requirements, Staff B indicated that they only recently learned about when to report incidents to the police. Staff B stated they had not made any reports and "let Staff A handle" reporting.

Resident 3

Review of Resident 3's Department Assessment dated 03/14/2025, showed Resident 3:
-Had an intellectual disability
-Had difficulty communicating with others
-Required assistance with complex decision making and understanding consequences of their actions
-Had short term memory problems requiring repetitive task cues and reminders, and difficulty remembering events from the same day or the day before.

Review of Resident 3's Negotiated Care Plan (NCP), dated 04/28/2025, showed Resident 3: -Had short term memory loss requiring staff to cue that Resident 3 had already asked questions/made comments and give choices with positive outcomes to assist with decision making.
-Had feelings of abandonment and required staff to remind Resident 3 of what was true in the moment; for example, asking Resident 3, "Is Resident 2 your friend? Do they like you? Are they happy to see you?"
-Did not have a care planned reason not to provide a lock on their bedroom door.

On 01/20/2026 at 4:06pm, Resident 3 stated they did not always feel safe at the AFH.

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On 02/02/2026 at 10:17am, Resident 1 stated that Resident 2 came into Resident 3's room while Resident 1 and Resident 3 were playing video games. Resident 1 stated that Resident 2 took off all their clothes, and touched Resident 3 on the penis, testicles, and butt, and kissed Resident 3's lips. Resident 1 stated that Resident 3 told Resident 2 to stop. Resident 1 stated Resident 2 told Resident 1 to leave Resident 3's room so Resident 1 left the room. Resident 1 stated they returned to Resident 3's room and Resident 3 also had their clothes off. Resident 1 stated that Resident 2 was "being gross," and asked Resident 1 to take their clothes off.

On 02/05/2026 at 2:55pm, Resident 3 stated that Resident 1 and Resident 3 were playing video games in their room. Resident 3 stated Resident 2 kissed Resident 3 on the cheek and Resident 3 gave Resident 2 a hug and Resident 2 tried to kiss them. Resident 3 put their hand on their face, expressing embarrassment. When asked if Resident 2 did anything with their clothes, Resident 3 stated, "Uh oh, I don't remember that," and smiled with an open mouth. Resident 3 stated they did not feel safe with Resident 2 and shook their head. Resident 3 smiled when asked to tell more about not feeling safe with Resident 2. Resident 3 stated they were afraid of Resident 2 "doing stuff." Resident 3 confirmed they did not have a lock on their door.

On 02/05/2026 at 3:32pm, Collateral Contact 4 (CC4), Resident 3 Representative, stated they were first notified of the incident by staff on 01/18/2026 by CC3, Executive Director. CC4 stated that CC3 told CC4 that Resident 1, Resident 2, and Resident 3 were in Resident 3's room and Resident 2 had exposed themselves and there was some kind of masturbation. CC4 stated Resident 2 was not removed from the facility until [redacted]/2026. CC4 stated that CC3 told CC4 that the intimate interactions between Resident 1 and Resident 2 were consensual. CC4 stated they wondered how CC3 knew if the relationship was consensual. CC4 stated Resident 3 did not have words for what happened so CC4 prompted and Resident 3 confirmed something sexual happened between Resident 2 and Resident 3 and then explained hugging and a kiss on the cheek and was no big deal. CC4 stated that a few days ago at a doctor's appointment, Resident 3 was in a "posture of maturity," (a moment of clarity) and told CC4 that they were scared of the AFH. When CC4 asked Resident 3 if they were "scared of having to do with Resident 1, and Resident 2," Resident 3 stated yes; that "they loved Resident 2" and were also "afraid of Resident 2." CC4 stated they had been warned in the past that Resident 2 had a history of sexual abuse and needed a lot of supervision. CC4 stated that CC4 was advised by the AFH staff to "just tell Resident 2 no, and you'll be fine."

On 02/06/2026 at 7:59am, observation showed that Resident 3's room did not have a lock in the door handle.

On 02/11/2026 at 3:55pm, CC4 stated they recalled that Resident 3 would call them upset and when CC4 tried to understand why, Resident 3 would say they didn't know. CC4 stated that Resident 3 had a history of being abused and Post Traumatic Stress Disorder (PTSD) and would shut down when they had a fear of people being mean to Resident 3. CC4 stated they believed that if Resident 3 felt threatened by Resident 2,

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they would have “given in.” CC4 stated they had looked at Resident 3’s door after the interview on 02/05/2026 and noticed they did not have a lock on their door like the other residents. CC4 stated the lock had been present when Resident 3 moved in. CC4 stated the lack of a lock was not in Resident 3’s care plan and they were not informed of it.

On 02/17/2026 at 3:58pm, CC4 stated Resident 3 was expressing deep sadness, anger, and fear as they approached the date that Resident 2 was supposed to return to the AFH, [redacted]/2026, and Resident 3 was unable to express where the emotions were coming from.

On 02/27/2026 at 1:23pm, Staff B stated they did not know Resident 3 did not have a lock on their door.

On 04/15/2026 at 2:45pm, Staff D, Caregiver, stated they did not have access to Resident 2’s door alarm application until after the application was added to their phone after the reported incidents in January 2026 (3 months after the door alarm intervention was determined to be needed).

Review of the January 2026 Staff Scheduled showed:
-Staff A did not have a scheduled caregiving shift for the month.
-Staff B worked 01/07/2026-01/11/2026 (did not have access to the phone alarm application).
-Staff C worked 01/03/2026-01/06/2026 and 01/12/2026-01/15/2026.
-Staff D worked 01/01/2026-01/02/2026 (did not have access to the phone alarm application).

Resident 4

Review of Resident 4’s Department Assessment dated 10/20/2025, showed Resident 4:
-Had an intellectual disability and required assistance with avoiding health and safety hazards.
-Had difficulty expressing themselves emotionally with maladaptive coping mechanisms (unhealthy strategies used to reduce short-term stress or emotional pain) and required assistance with complex decision making.
-Had no memory deficits.

Review of Resident 4’s NCP dated 11/18/2025, showed Resident 4
-Required staff assistance with all decisions that impact their life.
-Required staff to be aware of Resident 4’s mental health status each hour due to maladaptive coping mechanisms from anxiety and feelings of alienation.

On 01/20/2026 at 3:44pm, Resident 4 stated they were inappropriately touched twice

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by Resident 2. Resident 4 stated that on 01/18/2026, Resident 1 touched Resident 4's buttocks with their hands while they were sitting next to one another in the van. Resident 4 gestured with her own hand moving across her lateral buttocks/hip region. Resident 4 stated they told Collateral Contact 1 (CC1), Day Program Staff, who was driving the van.

On 01/22/2026 at 2:34pm, CC1 stated that on 01/18/2026, they had volunteered to drive the residents to dinner to alleviate Staff B. CC1 stated on the way home from dinner, CC1 overheard Resident 4 state, "[Resident 2], what are you doing?" CC1 stated that Resident 2 replied, "I'm sorry. I'm sorry. I'm sorry. I just can't help myself." CC1 stated that Resident 4 told CC1 that Resident 2 had touched their buttocks CC1 stated that later that night, Collateral Contact 8 (CC8), Community Member, told CC1 that Resident 2 had forcefully kissed CC8.

Record review of an email dated 02/23/2026 from Collateral Contact 6 (CC6), Healthcare Provider, to Staff A, showed that Resident 4 had sent a text message to CC6 at 4:00am that Resident 4 was scared, triggered, had nightmares of their roommate touching them inappropriately, and did not know what to do if the roommate returned home. The email showed that Resident 4 felt like isolating themselves from others and had urges to harm themselves.

On 02/27/2026 at 1:05pm, Resident 4 stated that they had not been eating due to stress because Resident 2 had touched their buttocks. Resident 4 stated that Staff B told Resident 4 that Resident 2 had been labeled a "pedophile," and was being sued.

On 02/27/2026 at 1:23pm, Staff B, Caregiver, stated that Resident 4 had a history of an eating disorder and stress. Staff B stated Resident 4 told Staff B that Resident 2 had touched Resident 4's buttocks while they were riding in the van. When asked if Resident 4 had any thoughts of self-harm recently, Staff B stated that they had received a call at 6:30am and Resident 4 had been texting their counselor in the night about harming themselves. Staff B stated Resident 4 told them that they were anxious about the "Resident 2 situation," and "everything being up in the air," not knowing when Resident 2 would return, and appeared worried.

On 03/12/2026 at 10:34am, CC6 stated that Resident 4 told CC6 that an unnamed resident who no longer resides in the AFH, had touched Resident 4's breasts and waist. CC6 stated that Resident 4 recently had thoughts of self-harm due to increased stress and anxiety.

Review of the AFH's Internal Investigation dated 4/28/2026, showed that the initial door alarm to supervise Resident 2, installed on 10/08/2025, "did not go smoothly," and was removed by Resident 2. The investigation showed that on 10/20/2025 the door alarm was replaced with another door "alarm" that was monitored by Staff A through a phone application, Staff A did not sleep at the AFH, and the "alarm" would not have woken up staff present in the AFH. The investigation showed that the alarm application was not

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installed on Staff B's phone, did not function on Staff D's phone, and that Staff C reported they had the application installed on their phone and "believed," they would have woken up to the alarm application. The investigation showed that the board was not aware of any of Resident 2's alleged incidents until 01/19/2026. The investigation showed that the alleged incidents were not reported to the Department directly by staff and the reports were instead filtered through Staff A, Resident Manager, and CC3, Executive Director which was a violation of the facility's "Abandonment, Abuse, Neglect and Mandatory Reporting" policy. The investigation showed that CC3 attempted to frame the incident and acted with a bias in favor of Resident 2. The investigation finally showed that Resident 2's Representative had donated $5000 per month up until April 2024 and prior to the $5000 donation, donated $1900 per month to cover facility costs.

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, Coyote House is or will be in compliance with this law and / or regulation on (Date) 6/25/2026

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

Provider (or Representative) 6/8/2026 Date

WAC 388-76-101631 Background checks Washington state name and date of birth background check. If the results of the Washington state name and date of birth background check indicate an individual has a disqualifying criminal conviction or a pending charge for a disqualifying crime under chapter 388-113 WAC, or a disqualifying negative action listed in WAC 388-76-10180 then:

(1) If the individual is a caregiver, entity representative or resident manager, the adult family home must not employ the individual, either directly or by contract; and

This requirement was not met as evidenced by:

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installed on Staff B's phone, did not function on Staff D's phone, and that Staff C reported they had the application installed on their phone and "believed," they would have woken up to the alarm application. The investigation showed that the board was not aware of any of Resident 2's alleged incidents until [redacted]/2026. The investigation showed that the alleged incidents were not reported to the Department directly by staff and the reports were instead filtered through Staff A, Resident Manager, and CC3, Executive Director which was a violation of the facility's "Abandonment, Abuse, Neglect and Mandatory Reporting" policy. The investigation showed that CC3 attempted to frame the incident and acted with a bias in favor of Resident 2. The investigation finally showed that Resident 2's Representative had donated $5000 per month up until April 2024 and prior to the $5000 donation, donated $1900 per month to cover facility costs.

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

_____ _____
Provider (or Representative) Date

WAC 388-76-101631 Background checks Washington state name and date of birth background check. If the results of the Washington state name and date of birth background check indicate an individual has a disqualifying criminal conviction or a pending charge for a disqualifying crime under chapter 388-113 WAC, or a disqualifying negative action listed in WAC 388-76-10180 then:

(1) If the individual is a caregiver, entity representative or resident manager, the adult family home must not employ the individual, either directly or by contract; and

This requirement was not met as evidenced by:

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Statement of Deficiencies	License #: 752800	Compliance Determination # 71628
Plan of Correction	Coyote House	Completion Date
Page 15 of 34	Licensee: Tierra Village	05/12/2026

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, Coyote House is or will be in compliance with this law and / or regulation on (Date) 6/25/2026

In addition, I will implement a system to monitor and ensure continued compliance with this requirement. THE REPORT SECTION IS BLANK

Provider (or Representative) Date 6/8/2026

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

(1) The care and services identified in the negotiated care plan.

(2) The necessary care and services to help the resident reach the highest level of physical, mental and psychosocial well-being consistent with resident choice, current functional status and potential for improvement or decline.

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

(a) Actively supports, maintains or improves each resident's quality of life;

(b) Actively supports the safety of each resident; and

(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 observation, interview, and record review, the Adult Family Home (AFH) failed to implement the negotiated care plan (NCP) and safety plan for 1 of 6 residents (Resident 2). These failures resulted in the AFH being unable to actively support the safety of 3 of 6 residents (Resident 1, 3, and 4) when Resident 2 displayed inappropriate sexual behaviors.

Findings included...

Resident 2 Assessment, Care Plan and Safety Plan:

Review of Resident 2's Department Assessment, dated 10/15/2025 showed Resident 2:
-Had a diagnosis of [redacted] and [redacted]

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

(1) The care and services identified in the negotiated care plan.

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

(a) Actively supports, maintains or improves each resident's quality of life;

(b) Actively supports the safety of each resident; and

(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 observation, interview, and record review, the Adult Family Home (AFH) failed to implement the negotiated care plan (NCP) and safety plan for 1 of 6 residents (Resident 2). These failures resulted in the AFH being unable to actively support the safety of 3 of 6 residents (Resident 1, 3, and 4) when Resident 2 displayed inappropriate sexual behaviors.

Findings included…

Resident 2 Assessment, Care Plan and Safety Plan:

Review of Resident 2's Department Assessment, dated 10/15/2025 showed Resident 2:
-Had a diagnosis of [redacted], and [redacted].

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-Was to always have someone with them, whether at home or in the community, to coach them with safety and appropriate behaviors with others, required constant redirection and proximity supervision, had a tough time learning and understanding social boundaries, and required verbal support to be appropriate in socializing with others.
-Required full support and to have someone with them at all times to avoid health and safety hazards due to being unaware of them and was not safe to walk outside alone.
-Had significant short-term memory loss and long-term memory problems.
-Wandered and had a history of entering resident rooms while they were sleeping.
-Had a motion alarm on their bedroom door to alert night staff to exiting the bedroom at night and required someone with them at all awake times to monitor and coach them for safety and appropriate behaviors and redirect back to bed.
-Was easily irritable/agitated, had extreme/rapid mood swings, was resistive to care with words/gestures.
-Was “sexually curious and focused on sex,” had counseling to address sexual appropriateness, required supervision and verbal support for this need, would stand too close to others and say suggestive things, had tried to touch others inappropriately and required caregivers to provide proximity supervision and verbal support to be socially appropriate, and staff should be aware of where Resident 2 was and what they were doing at all times around other vulnerable adults.
-Sexually acted out, invited others to have a sleepover, would make “sexually suggestive,” “forward, provocative, and intense,” comments, and touched without permission. The assessment showed that the behavior was not easily altered and Resident 2 required consistent and constant supervision.

Record review of Resident 2’s Negotiated Care Plan (NCP), dated 11/05/2025, showed that Resident 2:
-Had a sleep disturbance, wandered into other resident rooms and staff were required to know where Resident 2 was at, at all times.
-Had a history of abuse and neglect as a child that caused confusion with aspects of relationships and what type of physical contact was appropriate with others. Staff were to monitor Resident 2 at all times to support decision making, social interactions, and social boundaries.
-Had a recent incident of entering fellow resident rooms and attempting inappropriate contact, required a door alarm, and other residents to lock their door to prevent further occurrences. The NCP directed staff to refer to Resident 2’s Safety Plan.

Review of Resident 2’s Safety Plan, dated 10/17/2025 showed:
-Resident 2 had a pattern of wandering into other resident rooms, primarily Resident 1’s room, and sought or initiated inappropriate physical contact between the two residents without staff supervision which presented privacy, boundary and safety concerns for residents of the household.
-Resident 2 would awaken early before staff, desired attention or companionship, misunderstood social or personal boundaries, and acted impulsively/had limited awareness of other’s privacy needs.
-Resident 2 had cognitive/developmental limitations that impacted their judgement and had inconsistent redirection or supervision during early hours.
-For prevention of the behavior, there would be increased supervision with staff awake at 6:00am, other resident doors would be closed and locked, and a door alarm would

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notify staff on premises for management when the door was opened.
-Resident would ride in the front seat during vehicle trips, in clear sight of the driver unless other staff were present in the vehicle as passengers, and morning activities would be offered to prevent wandering.
-Staff were to respond immediately and calmly redirect Resident 2 out of other's rooms, ensure safety and privacy of all residents, escort Resident 2 to a supervised area and calming activity, notify the AFH manager and document the incident, and if physical contact occurred, notify guardians, case managers, and file an incident report with the Department.
-Staff were to supervise Resident 2 while they were awake from 6:00am to 8:00pm, confirm Resident 2's location every 15 minutes, and ensure Resident 2 did not enter rooms without permission or supervision.

Resident 1 Assessment and Care Plan:

Review of Resident 1's NCP, dated 05/27/2025, showed that Resident 1 was admitted to the facility on [redacted]/2025 and had trouble with decision making and required staff to assist with all decisions that had an impact on their life.

Review of Resident 1's Department Assessment, dated 10/06/2025, showed that Resident 1 had a diagnosis of [redacted] and [redacted]. Resident 1 had no deficits in memory. Resident 1 required assistance with decision making, daily problem solving daily, and did not understand consequences or responsibilities with choices. Resident 1 required assistance with communication translation to others not familiar with Resident 1's speech pattern. Resident 1 required support to manage and resolve conflicts. Resident 1 would often not recognize the need to advocate for themselves and would not recognize if someone tried to take advantage of them.

Resident 3 Assessment and Care Plan:

Review of Resident 3's Department Assessment dated 03/14/2025, showed that Resident 3 had an intellectual disability, had difficulty communicating with others, required assistance with complex decision making and understanding consequences of their actions, short term memory problems requiring repetitive task cues and reminders, and difficulty remembering events from the same day or the day before.

Review of Resident 3's Negotiated Care Plan (NCP), dated 04/28/2025, showed that Resident 3 had short term memory loss and required staff to cue that Resident 3 had already asked questions/made comments, and required staff to give choices with positive outcomes to assist with decision making. The NCP showed that Resident 3 had feelings of abandonment and required staff to remind Resident 3 of what was true in the moment; for example, asking Resident 3, "Is Resident 2 your friend? Do they like you? Are they happy to see you?"

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Record Review, Observations and Interviews:

Record review of the facility's Incident Report showed:
-On 09/25/2025, and "approximately 10/17/2025," there were inappropriate sexual advances and touching in the morning between Resident 1 and Resident 2. The report notes that staff were to never allow one-on-one unsupervised time between Resident 1 and Resident 2.
-On 10/08/2025, Resident 1 and Resident 2, "refused attempts to enter the bedroom," and a resident asked to touch the other resident in a facility van. The outcome showed a door alarm would be installed, staff would be up at 6:00am and Resident 2 would no longer be unsupervised.
- On 11/04/2025 and 12/04/2025, Resident 2 had a long hug and kiss from a community member while walking home from the day program.
-On 01/15/2026, Resident 2 was observed touching Resident 1's groin in the day program after lunch.
-On [redacted]/2026, a report of a sexual encounter between Resident 1, Resident 2, and Resident 3 on 01/10/2026 or 01/11/2026 was made. The incident report showed that Resident 2 was not removed from the AFH until [redacted]/2026.

Review of the facility's door alarm documentation for Resident 2 showed Resident 2's door alarm triggered:
-On 1/11/2026 at 11:15pm and 11:30pm.
-On 01/12/2026 at 5:50am and 11:39pm.
-On 01/13/2026 at 11:46pm.
-On 01/14/2026 at 12:25am, 12:26am, 12:32am, 12:33am, 12:39am, 1:03am, 1:07am, and 1:14am.
-On 01/15/2026 at 12:29am, 12:30am, and 12:45am.

Review of Resident 1's Medical Records dated 01/18/2026 showed that Resident 1 had been taken to the emergency room for a sexual assault examination. The record showed that Resident 1 and Resident 1's Representative told hospital staff that Resident 2 sexually assaulted Resident 1 on 01/15/2026 and 01/11/2026 at the AFH and the associated day program building, which included at least one episode of anal penetration. The record showed that Resident 1 had complained of rectal discomfort, a bruise to their gluteal cleft, 4 centimeters (cm) by 3cm, a linear abrasion to right buttocks, 4cm in length, clustered abrasions to medial right knee, 1.5cm by 1.5cm, and clustered abrasions to left knee, 3cm by 3cm. The record showed that Resident 1 did not feel safe at the AFH, and appeared fearful and nervous, would speak in 1–2-word replies, avoided eye contact, and looked to Resident 1's Representative to speak for them. The record showed that Resident 1's Representative stated they had been notified in September 2025 that Resident 2 got in bed with Resident 1, which alarmed Resident 1 who ran out of their room and notified staff. The record further showed that Resident 1's Representative, was notified on 01/15/2026 via text message from Staff A, Resident Manager, that "something happened again," and they had "caught Resident 2 with their hand on Resident 1's crotch/leg area." The record showed that Resident 1's Representative, took Resident 1 to their home and Resident 1 told them that Resident 1

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and Resident 3 had been sexually assaulted by Resident 2, Resident 2 had come into Resident 3's room and began masturbating in front of Resident 2 and Resident 3. The record showed that Resident 1's Representative reported that Resident 2 had put their penis in Resident 1's buttocks, their hands on Resident 1's penis and buttocks, their mouth on Resident 1's mouth, neck, and penis. The record finally showed that Resident 1's Representative reported that Resident 1 told them that Resident 2 had done this before and would not stop.

On 01/20/2026 at 4:06pm, Resident 3 stated they did not always feel safe at the AFH.

On 01/20/2026 at 2:08pm, Staff A, Resident Manager, stated that Resident 1 had difficulty always expressing boundaries and Staff A had a responsibility to protect Resident 1. Staff A stated that in September of 2025, Resident 1's representative reported that Resident 1 had told Resident 1's representative that Resident 2 had entered Resident 1's room and tried to get in Resident 1's bed. Staff A stated that Resident 1 told Staff A, Resident 1 did not want Resident 2 in their room. Staff A stated that a couple weeks later, Resident 2 had entered Resident 1's room early in the morning before staff were awake and Resident 1 had reported it had happened again. Staff A stated that on 01/15/2026, a day program participant had witnessed Resident 2 touching Resident 1's crotch after lunch around 12:30pm-1:00pm when they were sitting next to each other watching a video. Staff A stated that Resident 1 confirmed that Resident 2 had touched Resident 1's crotch. Staff A stated that Resident 1 was fearful of not having access to the program. Staff A stated that Resident 2 also confirmed that Resident 2 had touched Resident 1's crotch. Staff A stated they were notified of another incident on 01/18/2026 involving intimate relations with Resident 1, Resident 2, and Resident 3. Staff A stated they asked Resident 3 about the incident and Resident 3 denied anything more than a hug. Staff A stated that Resident 3 thought they were in trouble. Staff A stated that they told Resident 3 that no one could touch them except doctors. Staff A stated that following the September 2025 incident, Staff were supposed to be awake by 6:00am, Resident 1 and all residents were encouraged to lock their door in the evening when staff were asleep, Resident 1 and Resident 2 were not to sit next to one another in the van, Resident 2 had to ride in the front of the van away from the other residents, Resident 1 and Resident 2 were not to be in each other's rooms and not to sit next to one another on the sofa. Staff A stated they informed all AFH staff of the new interventions. Staff A stated that Staff B, Caregiver, told Staff A that Resident 1 and Resident 2 had not followed the recommendations and Resident 1 and Resident 2 were still interacting in Resident 1's room. Staff A stated they could not confirm and Staff A further stated that Resident 1 had told Staff A directly that they did not want Resident 2 in their room after the first incident and Resident 1 had difficulty enforcing boundaries at times. Staff A stated they had told Resident 2 they were not to touch Resident 1. Staff A stated the door alarm they initially installed audibly alarmed and staff were unable to sleep so they changed the door alarm to a phone application which would only notify staff who had the application installed. Staff A stated the door alarm only worked when the internet was connected and there had been a power outage for 4 days in December due to a windstorm that disrupted internet service, and consequently the door alarm.

Review of the facility document titled, "Resident Out of Home Tracking 2025," showed

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Resident 1 was in the facility from 12/11/2025 through 12/15/2025 during the power outage and consequent door alarm failure.

In an observation on 01/20/2026 at 3:04pm, the door alarm application on Staff A's phone was reviewed. The settings showed that the door alarm alerted only after it was open for 20 seconds. There was no alarm history for 12/11/2025 through 12/15/2025.

In an interview on 01/21/2026 at 2:36pm, Collateral Contact 2 (CC2), Resident 1's Representative, stated that Resident 2 had a history of being "hypersexual," that they had witnessed. CC2 stated that Resident 1 told CC2 in September 2025 that Resident 2 had jumped in their bed and was "gross." CC2 stated that Staff A told CC2 that no residents should be going into anyone else's room, they would encourage residents to lock their door at night, Resident 1 and Resident 2 would not be allowed to be alone together, and Resident 2 would not be allowed to sit next to Resident 1 in the van. CC2 stated they were notified on 01/15/2026 that Resident 2 touched Resident 1 in the crotch at the day program. CC2 stated that on 01/16/2026, Resident 1 told CC2 that Resident 2 constantly pushed to get Resident 1 naked, and "get on their penis," even through a closed bedroom door. CC2 stated that on 01/16/2026, Resident 1 told CC2 that Resident 2 was masturbating in front of Resident 1 and Resident 3 and Resident 2 requested that Resident 1 and Resident 3 touch their penis with a glove for their birthday. CC2 stated that on 01/18/2026, Resident 1 told CC2 that on 01/15/2026, Resident 2 took Resident 1 to the bathroom, kissed Resident 1 on the neck, cheek, and penis and preformed anal sex and it had happened earlier that week as well in Resident 3's room. CC2 stated that Collateral Contact 3 (CC3), Executive Director, stated that the door alarm might have failed.

In an interview on 01/22/2026 at 2:34 PM, Collateral Contact 1 (CC1), Day Program Staff, stated they had witnessed Resident 2 acting inappropriately with caregivers and had sexual aggression. CC1 stated they did not believe Resident 2 was an appropriate candidate to live in a group home setting due to needing constant supervision. CC1 stated that Resident 1 told CC1 and Staff B, Caregiver, that they thought Resident 2 was "under a spell," and wanted to be "a doctor;" to touch and explore inappropriately. CC1 stated that they did not believe any intimate relations between Resident 1 and Resident 2 were consensual. CC1 stated that Resident 2 had told CC1 they had a crush on Resident 1. CC1 stated that Resident 1 told CC1 that Resident 2 had pulled down Resident 1's pants at the day program and touched Resident 1 inappropriately. CC1 stated that a day program participant told CC1 they had witnessed Resident 2 touching Resident 1's "privates," and the day program participant apologized: not wanting to get anyone in trouble. CC1 stated that Staff A never communicated to the day program staff that Resident 2 required strict constant one-on-one supervision. CC1 stated they observed that Resident 1 had a change in their normal routine; had not showered in days, and Resident 1 normally showered multiple times a day and shaved their body extensively. CC1 stated they were concerned and alerted Staff A on 01/15/2026 that something was not right and that they believed Resident 1 did not feel safe getting naked in the house to shower. CC1 stated that Staff B, Caregiver, told CC1 on 01/18/2026 that Staff A did not set up Resident 2's door alarm on Staff B's phone, that the door was only alerting the system, not their phone. CC1 stated that Staff B appeared "triggered," was crying, and told CC1 they were worried. CC1 stated they had

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originally thought an incident between Resident 1 and Resident 2 had happened on 01/11/2026 as the door alarm system showed that Resident 2 had left their room at 11:30pm on 01/11/2026 when Staff B was working and Staff B did not have access to the door alarm application or alerts. CC1 further stated that they more recently believed that an incident happened on 01/12/2026 or 01/13/2026 due to the timing of Resident 1 not showering. CC1 stated that Staff C, Caregiver, had been working those nights and went to Staff C's bedroom at 7:00pm and did not monitor residents after that time. CC1 stated that on 01/18/2026, they had volunteered to drive the residents to dinner to alleviate Staff B. CC1 stated on the way home from dinner, CC1 overheard Resident 4 state, "Resident 2, what are you doing?" CC1 stated that Resident 2 replied, "I'm sorry. I'm sorry. I'm sorry. I just can't help myself." CC1 stated that Resident 4 told CC1 that Resident 2 had touched their buttocks." CC1 stated that later that night, Collateral Contact 8 (CC8), Community Member, asked CC1 what was going on between Resident 1 and Resident 2. CC1 stated that CC8 further told CC1 that Resident 2 had forcefully kissed CC8.

On 02/02/2026 at 10:17am, Resident 1 stated that Resident 2 came into Resident 3's room while Resident 1 and Resident 3 were playing video games. Resident 1 stated that Resident 2 took off all their clothes, and touched Resident 3 on the penis, testicles, and buttocks, and kissed Resident 3's lips. Resident 1 stated that Resident 3 told Resident 2 to stop. Resident 1 stated Resident 2 told Resident 1 to leave Resident 3's room so Resident 1 left the room. Resident 1 stated they returned to Resident 3's room and Resident 3 also had their clothes off. Resident 1 stated that Resident 2 was "being gross," and asked Resident 1 to take their clothes off. Resident 1 stated that Resident 2 asked Resident 1 to come into Resident 2's room, where Resident 2 touched Resident 1's penis and buttocks with a plastic glove and rubbed Resident 2's body on Resident 1. Resident 1 stated that Resident 2 "grossed them out." Resident 1 stated later in the living room, Resident 2 touched Resident 1's penis over their clothes. Resident 1 stated on another occasion, Resident 2 kissed Resident 1's neck and nose. Resident 1 stated they had gone to the bathroom and Resident 2 followed them into the bathroom and Resident 2 was inappropriate. Resident 1 stated that Resident 2 had tried to touch Resident 1 in the van. Resident 1 stated that Resident 2 also tried to touch Resident 6.

On 02/05/2026 at 2:55pm, Resident 3 stated that Resident 1 and Resident 3 were playing video games in their room. Resident 3 stated Resident 2 kissed Resident 3 on the cheek and Resident 3 gave Resident 2 a hug and Resident 2 tried to kiss them. Resident 3 put their hand on their face, expressing embarrassment. When asked if Resident 2 did anything with their clothes, Resident 3 stated, "Uh oh, I don't remember that" and smiled with an open mouth. Resident 3 stated they did not feel safe with Resident 3 and shook their head side to side indicating no. Resident 3 smiled when asked to tell more about not feeling safe with Resident 3. Resident 3 stated they were afraid of Resident 2 "doing stuff." Resident 3 stated they did not have a lock on their door.

On 02/05/2026 at 3:32pm, Collateral Contact 4 (CC4), Resident 3's Representative, stated that CC3, Executive Director, told CC4 that Resident 1, Resident 2, and Resident 3 were in Resident 3's room and Resident 2 had exposed themselves and there was some kind of masturbation. CC4 stated that on [redacted]/2026, Resident 2 was picked up

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by a family member. CC4 stated that CC3 told CC4 that the intimate interactions between Resident 1 and Resident 2 were consensual. CC4 stated they wondered how CC3 would know if the relationship was consensual. CC4 stated Resident 3 did not have words for what happened so CC4 prompted and Resident 3 confirmed something sexual happened between Resident 2 and Resident 3 and then explained hugging and a kiss on the cheek. CC4 stated that a few days ago at a doctor's appointment, Resident 3 was in a "posture of maturity," with clear conversation, and told CC4 that they were scared, scared of the AFH. When CC4 asked Resident 3 if they were "scared of having to do with Resident 1, and Resident 2," Resident 3 stated yes; that they were afraid of Resident 2." CC4 stated they had been warned that Resident 2 had a history of sexual abuse and needed a lot of supervision. CC4 stated that they were advised by the AFH staff to "just tell Resident 2 no, and you'll be fine."

On 02/06/2026 at 7:59am, observation showed that Resident 3's room did not have a lock in the door handle.

On 02/11/2026 at 3:55pm, CC4 stated they recalled that Resident 3 would call them upset and when CC4 tried to understand why, Resident 3 would say they didn't know. CC4 stated that Resident 3 had a history of being abused and Post Traumatic Stress Disorder (PTSD) and would shut down when they had a fear of people being mean to CC4. CC4 stated they believed that if Resident 3 felt threatened by Resident 2, they would have "given in." CC4 stated they had looked at Resident 3's door after the interview on 02/05/2026 and noticed Resident 3 did not have a lock on their door like the other residents. CC4 stated the lock had been present when Resident 3 moved in. CC4 stated the lack of a lock was not in Resident 3's care plan and they were not informed of it.

On 02/17/2026 at 3:58pm, CC4 stated Resident 3 was expressing deep sadness, anger, and fear as they approached the date that Resident 2 was supposed to return to the AFH, [redacted]/2026, and Resident 3 was unable to express where the emotions were coming from.

On 02/27/2026 at 1:05pm, Resident 4 stated that they had been stressed after Resident 2 had touched their buttocks. Resident 4 stated that Staff B told Resident 4 that Resident 2 had been labeled a "pedophile."

Record review of an email dated 02/23/2026 from Collateral Contact 6 (CC6), Healthcare Provider, to Staff A, showed that Resident 4 had sent a text message to CC6 at 4:00am that Resident 4 was scared, triggered, had nightmares of their roommate touching them inappropriately, and did not know what to do if the roommate returned home.

On 03/12/2026 at 10:34am, CC6 stated that Resident 4 told CC6 that an unnamed resident who no longer resides in the AFH, had touched Resident 4's breasts and waist and had related anxiety and stress from the incident.

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On 02/27/2026 at 1:23pm, Staff B, stated that one time when all the residents were sitting in the living room, Resident 1 gestured at Resident 2 by pointing to their "private area," and asked Resident 2 if they "wanted to uh…" Staff B stated that Resident 2 had been leaving their room before staff had woken up for the day, at 6:00am, so staff were required to wake up earlier to ensure "nothing would happen." Staff B did not indicate that there were any awake staff to monitor Resident 2 during staff sleeping hours. Staff B also stated that staff were required to ensure Resident 2 did not go into anyone's room. Staff B stated that Staff A told Staff B that Resident 2 had been up around 11:30pm at night and had not "caught," them (Resident 2) awake when they had been working. Staff B stated they did not have the door alarm application connected to their phone until a week after the incident in January 2026 and they therefore did not receive notifications of the door alarm while on duty.

On 04/15/2026 at 2:45pm, Staff D, Caregiver, stated they did not have access to Resident 2's door alarm application until after the application was added to their phone after the reported incidents in January, and they therefore did not receive notifications of the door alarm while on duty.

Refer to WAC 388-76-10670 Prevention of abuse.

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, Coyote House is or will be in compliance with this law and / or regulation on (Date) 6/25/2026

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

Provider (or Representative) [signature] Date 6/8/2026

WAC 388-76-10161 Background checks Who is required to have.

(3) All household members over the age of eleven, volunteers, students, and noncaregiving staff who may have unsupervised access to residents must have a Washington state name and date of birth background check. They are not required to have a national fingerprint background check.

This requirement was not met as evidenced by:

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On 02/27/2026 at 1:23pm, Staff B, stated that one time when all the residents were sitting in the living room, Resident 1 gestured at Resident 2 by pointing to their “private area,” and asked Resident 2 if they “wanted to uh…” Staff B stated that Resident 2 had been leaving their room before staff had woken up for the day, at 6:00am, so staff were required to wake up earlier to ensure “nothing would happen.” Staff B did not indicate that there were any awake staff to monitor Resident 2 during staff sleeping hours. Staff B also stated that staff were required to ensure Resident 2 did not go into anyone’s room. Staff B stated that Staff A told Staff B that Resident 2 had been up around 11:30pm at night and had not “caught,” them (Resident 2) awake when they had been working. Staff B stated they did not have the door alarm application connected to their phone until a week after the incident in January 2026 and they therefore did not receive notifications of the door alarm while on duty.

On 04/15/2026 at 2:45pm, Staff D, Caregiver, stated they did not have access to Resident 2’s door alarm application until after the application was added to their phone after the reported incidents in January, and they therefore did not receive notifications of the door alarm while on duty.

Refer to WAC 388-76-10670 Prevention of abuse.

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, Coyote House 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

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(3) All household members over the age of eleven, volunteers, students, and noncaregiving staff who may have unsupervised access to residents must have a Washington state name and date of birth background check. They are not required to have a national fingerprint background check.

This requirement was not met as evidenced by:

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Statement of Deficiencies	License #: 752600	Compliance Determination # 71628
Plan of Correction	Coyote House	Completion Date
Page 24 of 34	Licensee: Tierra Village	05/12/2026

Based on interview and record review, the Adult Family Home (AFH) failed to ensure that all household members had a Washington State name and date of birth background check for 1 of 1 household member (Household Member 1). This failure placed residents at risk of exposure to a household member with an unknown background history.

Findings included...

On 02/27/2026 at 1:23pm, Staff B, Caregiver, stated that Household Member 1 (HH1), lived downstairs in the facility, in their own apartment.

In an observation and interview on 02/27/2026 at 1:45pm, Staff A, Resident Manager, showed a door with a sign that read "Staff only." The door had a lock with a keyhole facing the facility side. Staff A stated that the door had a dead bolt lock on HH1's side. Staff A would not allow the Department Regulator to view the apartment and stated HH1 was not home.

On 02/27/2026 at 1:49pm, there was no background check record provided for HH1.

On 02/27/2026 at 1:49pm, Staff A stated that HH1 had lived in the apartment since August of 2025. Staff A did not refute that HH1 had access to the facility and residents. Staff A stated, "I knew this was a bad idea."

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, Coyote House is or will be in compliance with this law and / or regulation on (Date) 6/25/2026

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

Provider (or Representative) 6/6/2026 Date

WAC 388-76-10205 Medicaid or state funded residents. When the adult family home accepts medicaid or state funded residents, the home must follow the terms and conditions of the department contract and chapter 388-105 WAC.

This requirement was not met as evidenced by:

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Based on interview and record review, the Adult Family Home (AFH) failed to ensure that all household members had a Washington State name and date of birth background check for 1 of 1 household member (Household Member 1). This failure placed residents at risk of exposure to a household member with an unknown background history.

Findings included…

On 02/27/2026 at 1:23pm, Staff B, Caregiver, stated that Household Member 1 (HH1), lived downstairs in the facility, in their own apartment.

In an observation and interview on 02/27/2026 at 1:45pm, Staff A, Resident Manager, showed a door with a sign that read “Staff only.” The door had a lock with a keyhole facing the facility side. Staff A stated that the door had a dead bolt lock on HH1’s side. Staff A would not allow the Department Regulator to view the apartment and stated HH1 was not home.

On 02/27/2026 at 1:49pm, there was no background check record provided for HH1.

On 02/27/2026 at 1:49pm, Staff A stated that HH1 had lived in the apartment since August of 2025. Staff A did not refute that HH1 had access to the facility and residents. Staff A stated, “I knew this was a bad idea.”

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

_____ _____
Provider (or Representative) Date

WAC 388-76-10205 Medicaid or state funded residents. When the adult family home accepts medicaid or state funded residents, the home must follow the terms and conditions of the department contract and chapter 388-105 WAC.

This requirement was not met as evidenced by:

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Based on interview and record review, the Adult Family Home (AFH), failed to ensure that resident absences exceeding 72 hours in length or 18 days total in a calendar year were reported to the Department for 6 of 6 [redacted] receiving residents (Resident 1, 2, 3, 4, 5 & 6). This failure resulted in undocumented resident absences and did not allow the Department to determine whether social leave payment would be granted.

Findings included…

WAC 388-110-100
Discharge, social leave, and bed hold.
The contractor is not required to discharge (move out) and readmit a resident for absences of less than twenty-one consecutive days. The contractor must:
(1) Note an absence in a resident's record when a resident is absent from the assisted living facility for more than seventy-two consecutive hours;
(2) Obtain department approval for payment for social leave more than eighteen calendar days per year;

Record review of the AFH's Meaningful Day Contact (written agreement with the Department to provide meaningful activities to residents to assist with successful community living), signed on 10/31/2023 by Staff A, Resident Manager, showed a contract start date of 12/01/2023 and an end date of 11/30/2027. The Meaningful Day Contract required the AFH to report social leave (leave for recreational or socialization purposes) to the Department within one working day and must document written justification for absences more than 72 consecutive hours. The Meaningful Day Contract showed that payment for services was prorated for each month, and no payment was to be made for partial days or leaves more than 72 hours unless the absence was documented and payment or non-payment for social leave was approved. The contract showed that AFH may be paid for up to eighteen days of social leave per calendar year.

On 03/19/2026 at 3:48pm, Staff A stated they documented absences on a spreadsheet on their computer. Staff A stated that all residents leave for an extended winter holiday break in December each year for differing times frames. Staff A stated they did not notify anyone of the resident absences for December 2025 and asked if this was a requirement and who they should notify. Staff A confirmed they were not aware they were supposed to report social leave absences more than 72 hours in length.

Record review of the facility document titled, "Resident Out of Home Tracking 2025," showed:
-Resident 1 was absent from [redacted]/2025 through [redacted]/2025.
-Resident 2 was absent from [redacted]/2025 through [redacted]/2025, and [redacted]/2025 through [redacted]/2025. Resident 2 had a total of 32 absences for the calendar year.
-Resident 3 was absent from [redacted]/2025 through [redacted]/2025 and [redacted]/2025 through [redacted]/2025.
-Resident 4 was absent from [redacted]/2025 through [redacted]/2025.
-Resident 5 was absent from [redacted]/2025 through [redacted]/2025, [redacted]/2025 through [redacted]/2025, and [redacted]/2025 through [redacted]/2025. Resident 5 had a total of 28 absences for the calendar year.
-Resident 6 was absent from [redacted]/2025 through [redacted]/2025.

On 03/23/2026 at 11:46am, Staff A stated that Resident 2 and Resident 5 had more than 18 absences for the calendar year of 2025. Staff A stated they thought they had

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sent an email notification in January 2026 to the Department Case Manager for social leave absences for the calendar year of 2025 and they could not find the record of the notification. Staff A was observed to search for the e-mail on their computer. Staff A stated, "I guess I didn't send one this year."

On 03/24/2026 at 10:55am, Collateral Contact 7 (CC7), Department Case Manager, stated that social leave absences for Resident 1, 2, 3, 4, 5, & 6 had not been reported to the Department for 2025 and were not regularly reported to the Department Case Manager despite multiple requests to do so. CC7 stated that only Resident 2's social leave had been reported for January 2026 due to a current Department investigation.

Record review of Department Case Management notes on 03/24/2026 did not show any documented absences from 01/01/2025 through 03/24/2026 for Resident 1, 3, or 5.

Record review of Department Case Management notes on 03/25/2026 did not show any documented absences from 01/01/2025 through 03/24/2026 for Resident 4 or 6. The Case Management notes showed that Resident 2 had wanted to go to a summer camp in 2025, dates and duration were not provided. No other absences were documented for Resident 2 in 2025.

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, Coyote House is or will be in compliance with this law and / or regulation on (Date) 6/25/2026.

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

Provider (or Representative) Date 6/8/2026

WAC 388-76-10198 Adult family home Personnel records. The adult family home must keep documents related to staff in a place readily accessible to authorized department staff. These documents must be available during the staff's employment, and for at least two years following employment. The documents must include but are not limited to:

(2) Staff orientation and training records pertinent to duties, including, but not limited to:

(a) Training required by chapter 388-112A WAC, including as appropriate for each staff person, orientation, basic training or modified basic training, specialty training, nurse delegation core training, and continuing education;

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sent an email notification in January 2026 to the Department Case Manager for social leave absences for the calendar year of 2025 and they could not find the record of the notification. Staff A was observed to search for the e-mail on their computer. Staff A stated, “I guess I didn’t send one this year.”

On 03/24/2026 at 10:55am, Collateral Contact 7 (CC7), Department Case Manager, stated that social leave absences for Resident 1, 2, 3, 4, 5, & 6 had not been reported to the Department for 2025 and were not regularly reported to the Department Case Manager despite multiple requests to do so. CC7 stated that only Resident 2’s social leave had been reported for January 2026 due to a current Department investigation.

Record review of Department Case Management notes on 03/24/2026 did not show any documented absences from 01/01/2025 through 03/24/2026 for Resident 1, 3, or 5.

Record review of Department Case Management notes on 03/25/2026 did not show any documented absences from 01/01/2025 through 03/24/2026 for Resident 4 or 6. The Case Management notes showed that Resident 2 had wanted to go to a summer camp in 2025, dates and duration were not provided. No other absences were documented for Resident 2 in 2025.

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, Coyote House 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 388-76-10198 Adult family home Personnel records. The adult family home must keep documents related to staff in a place readily accessible to authorized department staff. These documents must be available during the staff's employment, and for at least two years following employment. The documents must include but are not limited to:

(2) Staff orientation and training records pertinent to duties, including, but not limited to:

(a) Training required by chapter 388-112A WAC, including as appropriate for each staff person, orientation, basic training or modified basic training, specialty training, nurse delegation core training, and continuing education;

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This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to ensure that a record of facility orientation was completed and retained for 3 of 4 staff (Staff A, B, F). This failure placed residents at risk of exposure to unqualified staff.

Findings included…

WAC 388-112A-0200
What is orientation training, who should complete it, and when should it be completed?
There are two types of orientation training: Facility orientation training and long-term care worker orientation training.
(1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation.

Staff A

Review of Staff A's (Resident Manager) facility orientation on 02/27/2026 was unable to be completed as no record was provided to review.

On 02/27/2026 at 11:21am, Staff A stated that they could not find their facility orientation and were hired in June of 2021.

Staff B

Review of Staff B's facility orientation titled, "Caregiver Orientation Checklist," dated 09/15/2017 had a section that was not initialed as reviewed titled, "Knowledge of resident's Negotiated Care Plans (NCPs). The facility orientation was not signed as completed.

On 02/27/2026 at 11:16am, Staff A stated the record was, "technically not the facility orientation," and they would need to request the record again. Staff A did not provide any alternate facility orientation records.

Staff E

Review of Staff E's facility orientation titled, "Caregiver Orientation Checklist," dated

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02/06/2026 showed that Staff E was hired on 02/06/2026. The facility orientation checklist was blank and not signed and completed.

On 02/27/2026 at 11:03am, Staff A stated Staff E was working unsupervised, and they had lost the copy of the facility orientation that Staff E had signed.

On 02/27/2026 at 11:35am, Staff E was observed to be in the AFH and asked Staff A what other tasks they could do.

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, Coyote House is or will be in compliance with this law and / or regulation on (Date) 6/25/2026.

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

Provider (or Representative)

6/8/2026
Date

WAC 388-76-10673 Abuse and neglect reporting Mandated reporting to department Required.

(1) In accordance with chapter 74.34 RCW, all providers, entity representatives, resident managers, owners, caregivers, staff, and students that provide care and services to residents, are mandated reporters and must immediately report to the department when there is:

(b) A reason to suspect that sexual assault of a vulnerable adult has occurred.

(2) Reports must be made to:

(b) The appropriate law enforcement agencies, as required under chapter 74.34 RCW.

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home failed to ensure that the department and law enforcement were immediately notified of sexual abuse incidents for 2 of 6 residents (Resident 1 & 2). This failure resulted in the delayed investigation of abuse and placed the residents at risk of ongoing sexual assault.

Findings included...

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02/06/2026 showed that Staff E was hired on 02/06/2026. The facility orientation checklist was blank and not signed and completed.

On 02/27/2026 at 11:03am, Staff A stated Staff E was working unsupervised, and they had lost the copy of the facility orientation that Staff E had signed.

On 02/27/2026 at 11:35am, Staff E was observed to be in the AFH and asked Staff A what other tasks they could do.

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, Coyote House 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

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(b) The appropriate law enforcement agencies, as required under chapter 74.34 RCW.

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home failed to ensure that the department and law enforcement were immediately notified of sexual abuse incidents for 2 of 6 residents (Resident 1 & 2). This failure resulted in the delayed investigation of abuse and placed the residents at risk of ongoing sexual assault.

Findings included…

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RCW 74.34.020
Definitions.
The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.
(13) "Mandated reporter" is an employee of the department or the department of children, youth, and families; law enforcement officer; social worker; professional school personnel; individual provider; an operator of a facility or a certified residential services and supports agency under chapter 71A.12 RCW; an employee of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, hospice, or certified residential services and supports agency; county coroner or medical examiner; Christian Science

Review of the facility policy titled, “Abandonment, Abuse, Neglect, and Mandatory Reporting,” dated 2025, showed that the all staff were mandated reporters and were required to report any reasonable cause to believe that sexual abuse had occurred to the Department and to law enforcement in accordance with RCW 74.34. The policy showed that sexual abuse was defined as any form of nonconsensual sexual contact, including but not limited to unwanted or inappropriate touching, rape, sodomy, or sexual coercion. The handbook further stated in instances of when a vulnerable adult is unable to verbally express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish.

<Resident 1>

Review of Resident 1’s Department Assessment, dated 10/06/2025, showed Resident 1:
-Had a diagnosis of [redacted] and [redacted].
-Had no deficits in memory.
-Required assistance with decision making, daily problem solving daily, and did not understand consequences or responsibilities with choices.
-Required assistance with communication translation to others not familiar with Resident 1’s speech pattern.
-Required support to manage and resolve conflicts.
-Would often not recognize the need to advocate for themselves and would not recognize if someone tried to take advantage of them.

<Resident 2>

Review of the Department Assessment, dated 10/15/2025 showed that Resident 2:
-Had a diagnosis of [redacted], and [redacted].

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-Required proximity supervision and constant redirection at home and in the community, to coach them with safety and appropriate behaviors with others, had a tough time learning and understanding social boundaries, and required verbal support to be appropriate in socializing with others.
-Had significant short-term memory loss and long-term memory problems.
-Wandered and had a history of entering resident rooms while they were sleeping.
-Had a motion alarm on their bedroom door to alert night staff of exiting the bedroom at night and required someone with them at all awake times to monitor and coach them for safety and appropriate behaviors and redirect back to bed.
-Was easily irritable/agitated, had extreme/rapid mood swings, was resistive to care with words/gestures.
-Was “sexually curious and focused on sex,” had counseling to address sexual appropriateness, required supervision and verbal support for this need, would stand too close to others and say suggestive things, had tried to touch others inappropriately and required caregivers to provide proximity supervision and verbal support to be socially appropriate, and staff should be aware of where Resident 2 was and what they were doing at all times around other vulnerable adults.
-Sexually acted out, invited others to have a sleepover, would make “sexually suggestive,” “forward, provocative, and intense,” comments, and touched without permission. The assessment showed that the behavior was not easily altered and Resident 2 required consistent and constant supervision.

<Incidents and reporting>

Review of the facility Incident Log showed that:
-On 09/25/2025, there was “inappropriate sexual touching,” with Resident 2 and Resident 1. The outcome was to “never allow one-on-one unsupervised,” time between the two residents. There was no documented notification to Law Enforcement on the Incident Log.
-On 10/08/2025, there was “refusal attempts to enter the bedroom,” with Resident 2 and Resident 1.
-On 10/08/2025, in the van, “asked to touch the resident,” with Resident 2 and Resident 1.
-On 12/04/2025, Resident 2 was kissed by a community member not associated with the AFH. There was no documented notification to Law Enforcement on the Incident Log.
-On 01/15/2026, “Resident 2 was observed to have touched Resident 1 in the groin.” There was no documented notification to Law Enforcement on the Incident Log.
-On [redacted] 2026, “Resident 1 reported a sexual encounter with Resident 2 on 1/10/2026 or 01/11/2026.” There was no documented notification to Law Enforcement on the Incident Log.

Review of a Law Enforcement Incident Report dated 09/30/2025 showed that Staff A, Resident Manager, reported an incident on 09/30/2025 that had occurred on 09/17/2025. The incident report showed that Staff A told Law Enforcement that on 09/17/2025 Resident 2 had allegedly entered Resident 1’s room and touched their genitals. Staff A further told Law Enforcement that a staff member had entered the room and advised Resident 2 to leave Resident 1’s room. Staff A told Law Enforcement

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that there were no victims and the facility needed to generate a case number for their records.

As of 04/13/2026, a Law Enforcement Incident Report of incident reported on 01/18/2026, could not be reviewed by the Department as it had not yet been completed.

Review of Department Records showed that the AFH:
-Did not report the sexual abuse incident from 12/4/2025 to the Department until 12/5/2025.
-Did not report the sexual abuse incident from 01/10/2026 to the Department until 01/20/26. (2 days after Staff A stated they had knowledge of the incident.)
-Did not report the sexual abuse incident from 01/15/2026 at 12:40pm to the Department until 01/16/2026 at 2:19pm.

On 01/20/2026 at 2:08pm, Staff A, Resident Manager, stated reports of interactions between Resident 2 and Resident 1 began in September 2025 and a few weeks later, Resident 2 began entering Resident 1's room in the early mornings before staff were awake. Staff A stated that on 01/15/2026, it was observed by a community member that Resident 2 had touched Resident 1 in the groin area. Staff A stated they spoke to Resident 2 who confirmed what had reportedly happened. Staff A stated that there was another allegation that Resident 1, Resident 2, and Resident 3 were involved in relations possibly on 01/10/2026 or 01/11/2026. Staff A stated that they could not determine if Resident 1 had consented to Resident 2's sexual touches without guessing. Staff A stated that Resident 1 had told Staff A and Resident 2 that sexual touches were unwanted after the first incident and that Resident 1 did not want Resident 2 in their room. Staff A stated they had made notifications to residents, staff, guardians and APS, and case managers. Staff A did not state that they had made notifications to law enforcement. Staff A stated they had learned about the incident on 01/15/2026 on that same date. Staff A stated they had learned about the allegation of the incident on 01/10/2026 or 01/11/2026 on 01/18/2026.

On 01/20/2026 at 1:27pm, Staff C, Caregiver, stated they had been told there was an incident on 01/15/2026 in which Resident 2 had inappropriately touched Resident 1. Staff C stated that Resident 1 had previously complained of being inappropriately touched in the past. Staff C stated they were uncomfortable calling the Department hotline to report abuse and in the event of suspecting abuse, they would tell their manager, Staff A whom they assumed would notify their superior, Collateral Contact 3 (CC3), Executive Director. Staff C asked if they should be reporting to the Department.

On 01/22/2026 at 2:34pm, Collateral Contact 1 (CC1), Day Program Staff, stated Staff A told other staff members that Resident 1 was "not as innocent as people think." CC1 stated that CC3 stated CC3 was to be the "only spokesperson," because it was important to carefully choose their words. CC1 stated that Resident 2 had a history of being sexually inappropriate and Resident 2 had displayed changes in their behavior that concerned CC1. CC1 stated that the topic of the meeting was confidentiality and

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they were discouraged from leaving a “paper trail” or reporting and that confidentiality in their employee handbook meant that there should only be one reporter. CC1 stated that CC3 told CC1 they did not need to legally report anything and was to go through CC3 alone. CC1 stated that they were intimidated not to report, that CC3 told CC1 they had no proof, and that they should not believe everything people with intellectual disabilities say.

On 02/27/2026 at 1:23pm, Staff B, Caregiver, stated that the person who reports on behalf of the AFH, was the person who witnesses or hears about abuse. Staff B stated they had only recently learned that they should make a report to law enforcement as well as the Department. Staff B stated they had not directly seen abuse, so they let Staff A handle the reporting.

Review of an email from local law enforcement dated 03/16/2026 showed that the AFH:
-Reported an incident of sexual offense on 09/30/2025 that had occurred on 09/17/2025.
-Did not show any reports for incident on 12/04/2026.
-Did not report an incident that was reported to law enforcement by another party on 01/18/2026.
-Did not show any reports for incident on 01/15/2026.

On 03/23/2026 at 1:16pm, Staff C, Caregiver, indicated that the named community member from the incident on 12/04/2026, had a history of being inappropriate with residents and giving unwanted hugs.

Review of the AFH’s Internal Investigation dated 4/28/2026, showed that there was a violation of the facility’s “Abandonment, Abuse, Neglect and Mandatory Reporting,” policy when staff notified Staff A of incidents between Resident 1 and Resident 2 and did not directly report the incidents to the Department.

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Statement of Deficiencies	License # 752600	Compliance Determination # 71628
Plan of Correction	Coyote House	Completion Date
Page 33 of 34	Licensee: Tierra Village	05/12/2026

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, Coyote House is or will be in compliance with this law and / or regulation on (Date) 6/25/2026.

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

Provider (or Representative) _____ Date 6/8/2026

WAC 388-76-10375 Negotiated care plan Signatures Required. The adult family home must ensure that the negotiated care plan is agreed to and signed and dated by the:

(1) Resident; and

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH), failed to ensure that the Negotiated Care Plan was signed by the resident for 1 of 4 residents (Resident 4). This failure placed the resident at risk for not agreeing with their care plan.

Findings included:

On 02/27/2026, review of Resident 4's Negotiated Care Plan (NCP) dated 11/18/2025 showed that Staff A, Resident Manager, had signed the NCP on 10/17/2025 and there were no other signatures on the NCP.

On 02/27/2026 at 12:24pm, Staff A stated that Resident 4's NCP was not signed as Resident 4's family had the copy and needed to sign it. Staff A further stated that they had identified it was not signed as they were preparing for their upcoming licensing inspection and Resident 4's NCP was due for an annual renewal on 11/18/2025.

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Provider (or Representative) [signature] Date 6/8/2026

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Provider (or Representative) Date

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