STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

Puyallup Valley Enhanced Residential Care Inc

Puyallup Valley Enhanced Residential Care Inc
723 2nd St NW
Puyallup, WA 98371

RE: Puyallup Valley Enhanced Residential Care Inc License # 2490

Dear Administrator:

This letter addresses Compliance Determination(s) 78779 (Completion Date 06/17/2026) and 74298 (Completion Date 04/22/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/17/2026 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2371-4, WAC 388-78A-2371

The Department staff who did the on-site verification:
Carol Gijima, Community Compaint Investigator (NCI)

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Laurie Anderson

Laurie Anderson, Community Field Manager
Region 3, Unit D
Residential Care Services

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Residential Care Services
Investigation Summary Report

Provider/Facility: Puyallup Valley Enhanced Residential Care Inc
License/Cert.#: 2490
Compliance Determination #: 74298
Investigator: Carol Gijima
Investigation Date(s): 03/13/2026 through 04/22/2026
Complainant Contact Date(s): 04/22/2026

Provider Type: Assisted Living Facility

Intake ID: 220675
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
1. Allegation of sexual assault

Investigation Methods:

Sample:	Total residents: Resident sample size: 9 Closed records sample size:
Observations:	General environment Residents in their rooms & common areas Staff-to-resident interactions Resident behaviors
Interviews:	Named Resident X3 attempts Residents Staff
Record Reviews:	Resident Characteristic Roster Resident assessments and negotiated service agreements including the records of the named resident Staff progress notes Financial records Incident log / reports,

Investigation Summary:
1. Per record review and interviews with residents and staff, the facility failed to investigation allegations of sexual assault. Failed facility practice identified. The ALF demonstrated failed provider practice as documented in a Statement of Deficiencies dated 04/22/2026.

Conclusion / Action:

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

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☐ N/A

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You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 03/13/2026 of:

Puyallup Valley Enhanced Residential Care Inc
723 2nd St NW
Puyallup, WA 98371

This document references the following complaint number(s): 215064, 215336, 214619, 220675

The following sample was selected for review during the unannounced on-site visit: 9 of 0 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Carol Gijima, Community Compaint Investigator (NCI)

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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Statement of Deficiencies	License #: 2490	Compliance Determination # 74298
Plan of Correction	Puyallup Valley Enhanced Residential Care Inc	Completion Date
Page 2 of 6	Licensee: Puyallup Valley Enhanced Residential Care Inc	04/22/2026

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.

Clinton Fridley, RN
Residential Care Services

05/01/2026
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Anette M. Galindo
Administrator (or Representative)

5/25/2026
Date

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

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

(2) Determine the circumstances of the event;

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

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

This requirement was not met as evidenced by:

Based on record reviews and interviews, the Assisted Living Facility (ALF) failed to investigate and determine the circumstances and implement interventions to prevent recurrence of incidents related to 3 of 3 sample residents (Residents 1, Resident 2 and Resident 3) who were smoking, lighting fires, and had drug paraphernalia in their rooms; and when 1 of 2 sample residents (Resident 4) reported an allegation of sexual assault. These failures placed all 47 residents in the facility at risk of serious injury in case of a fire, and placed Resident 4 at risk of abuse and neglect.

Findings included...

Review of the facility incident report, dated 01/03/2026, showed that Resident 3 had drug paraphernalia in their room, wrapped in towels.

Review of the facility incident report, dated 01/18/2026, showed that at 9:00 PM, the fire alarm went off due to resident smoking in a room. Another incident report, dated

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As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Residential Care Services _____ Date _____

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) _____ Date _____

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01/18/2026, showed that the fire alarm went off again at 10:30 PM. The report showed Resident 1 was smoking in their room.

Review of the facility incident report dated 02/26/2026 showed that at 11:50 AM, staff heard a clicking noise. The report showed Resident 2 stated they were “filling up their torch lighter.”

Review of the facility incident report, dated 04/15/2026, showed that Resident 4 called 911 and reported that they had been assaulted. The report showed that Resident 4 was transported to the hospital.

The records showed no documentation that the facility staff completed any investigation related to Resident 1 smoking in their room which set off the smoke alarms. There was no documentation of any investigation related to Resident 2’s filling up of their torch lighter. There was no documentation of any investigation related to the discovery of drug paraphernalia found in Resident 3’s room. There was no documentation of any investigation related to Resident 4’s allegation of sexual assault.

Resident 1

Review of Resident 1’s negotiated service agreement, dated 01/19/2026, showed that Resident 1 smoked tobacco and some illicit substances. Resident 1 needed to be redirected on multiple occasions for smoking in room or upstairs restrooms. The agreement showed no documentation of any interventions used to prevent recurrence.

Resident 2

Review of Resident 2’s negotiated service agreement, signed 11/19/2025, showed no documentation that Resident 2 had behaviors related to smoking illicit substances or bringing drug paraphernalia into the building.

Review of Resident 2’s progress notes showed the following

- 01/19/2026 at 1:10 PM: resident was found in his room with another resident with paraphernalia. Resident 2 was reminded how unsafe it was for them and the rest of the residents.
- 01/27/2026 at 8:28 AM: resident found smoking behind the door and was redirected to the smoking area.
- 02/26/2026 at 11:52 AM: Staff heard “clicking of a lighter” and found resident with a torch and lighter in their room. Resident was reminded of the dangers of doing that in the building as well as it is dangerous for them.
- 02/26/2026 at 11:59 AM: resident was reminded of the importance of never

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lighting anything inside of the building. Explained the fire dangers. Resident stated understanding.

Resident 3

Review of Resident 3's negotiated service agreement, dated 07/09/2025, showed that Resident 3 grows marijuana in room, and had a grow tent. Agreement showed Resident 3 huffs Seafoam motor oil and others. Agreement showed Resident 3 with unsafe smoking which was addressed with current intervention. No other interventions were included in the service agreement.

Review of progress note, dated 01/30/2026, showed that at 2:30 PM, Seafoam was found in resident's room. Note showed the resident understood that they were not allowed to keep these items in their room. Note showed they would call their mom to take them. Resident was given 48 hours.

A progress note, dated 01/30/2026, showed that at 3:51 PM glue, paint, thinners, caulking and other drug related chemicals were found in resident's room.

Resident 4

Review of Resident 4's negotiated service agreement, dated 11/01/2025, showed that Resident 4 had a history of accusatory behaviors and delusions.

Review of Resident 4's progress note, dated 04/15/2026, showed that at 3:38 AM, Resident 4 alleged sexual assault by Staff A, Administrator. The note showed Resident 4 called 911 and was taken to the hospital.

During an interview on 03/13/2026 at 10:30 AM, Staff B, Administrative Assistant, stated that Staff A conducted the investigations. Staff B stated that to keep other residents safe, Resident 1 was checked upon entering the building. Staff B stated that Resident 1 signed a contract to remove contraband. Staff B stated that housekeepers were to check Resident 1's room and the facility staff had local law enforcement on speed dial.

During an interview on 03/13/2026 at 11:43 AM, Staff A stated that Resident 1 set the fire alarm off. Staff A stated that paraphernalia was found in Resident 1's room. Staff A stated that they took a cooking stove, gas, and pipes out of Resident 1's room. Staff A stated that they were unsure how Resident 1 was able to start a fire twice on the same day. Staff A stated that they were unaware of any measures taken to prevent Resident 1 from setting fires. Staff A stated that they were unaware of the findings of the investigation and "missed that one."

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During an interview on 04/23/2026 at 12:50 PM, Staff A stated that they talked to residents as their investigation. Staff A stated that “we kinda call it our investigation.” Staff A stated that they were unaware of the measures taken to prevent Resident 2 from attempting to light their lighter or torch inside their room. Staff A stated that “it happens so much” when asked how they would ensure other residents’ safety in case of a fire. Staff A stated that they were unaware of any sexual allegations related to Resident 4. Staff A stated that “they (Resident 4) are fine…they (Resident 4) had no recent hospital visits.” Staff A stated that another government agency came to the facility to investigate the allegations of sexual assault. Staff A stated that Resident 4 had a history of accusatory behaviors and had accused them (Staff A) of “horrible things that I have never done.” Staff A stated that Resident 4 refused all exams at the hospital, that Resident 4 recanted their story at the hospital and when interviewed by the other government agency. Staff A stated, “I didn’t have any findings.”

In a separate interview on 04/23/2026 at 3:40 PM, Staff A stated that the other government agency investigated the allegations. Staff A stated they did not know who at the facility investigated the allegations.

During an interview on 04/10/2026 at 9:05 AM, Collateral Contact 1 (CC1), Anonymous Staff, stated that Resident 1 was caught smoking multiple times. CC1 stated that staff responded to fire alarms. CC1 stated that Resident 1 was moved downstairs to prevent recurrence and to keep the other residents safe.

During an interview on 04/10/2026 at 10:36 AM, Collateral Contact 2 (CC2), Anonymous staff, stated that Resident 1 used to start fires in their room. CC2 stated “I didn’t have to do anything” for prevention measures. CC2 stated that staff took things from Resident 1 and completed room searches. CC2 stated that Resident 1 brought things from outside. CC2 stated that to keep other residents safe, the facility tried to keep up on room searches.

In a separate interview on 04/23/2026 at 3:34 PM, Collateral Contact 2 (CC2), Anonymous staff, stated that Resident 4 was taken to the hospital for a sexual assault complaint. CC2 stated the allegation was against Staff A. CC2 stated that they were unsure if the allegation was investigated by the facility. CC2 stated that another agency had been in the building. CC2 stated they were unsure what interventions were in place. CC2 stated that if a resident made an allegation against management, they would call the hotline and law enforcement and not notify the accused.

During an interview on 04/22/2026 at 8:10 AM, Collateral Contact 3 (CC3), Anonymous staff, stated that Resident 1 just moved downstairs. CC3 stated that Resident 1 was setting smoking alarms off in their room and in the hallways. CC3 stated that Resident 1 set the smoking alarms off multiple times. CC3 stated “I wasn’t there, I am not sure what was done to stop him.”

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Statement of Deficiencies	License #: 2490	Compliance Determination # 74298
Plan of Correction	Puyallup Valley Enhanced Residential Care Inc	Completion Date
Page 6 of 6	Licensee: Puyallup Valley Enhanced Residential Care Inc	04/22/2026

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Puyallup Valley Enhanced Residential Care Inc is or will be in compliance with this law and / or regulation on (Date) 5/25/2026 .

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

Administrator (or Representative) Rosetta Gabriel Date 5/25/2026

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Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Puyallup Valley Enhanced Residential Care Inc is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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