STATE OF WASHINGTON, DEPARTMENT OF SOCIAL AND HEALTH SERVICES

BOARD OF APPEALS

In Re:	)	Docket No. 01-2010-L-1224
[APPELLANT], **[FACILITY 1]**	)	**REVIEW DECISION AND FINAL ORDER**
Appellant	)	Adult Family Home License

I. NATURE OF ACTION

1. The Aging and Disability Services Administration (ADSA) within the Department of Social and Health Services (hereinafter referred to as the Department or DSHS) served [APPELLANT] (hereinafter referred to as the Appellant) with notice of its decision to Stop Placement of Admissions and Revocation of License regarding [FACILITY 1], an adult family home (AFH) regulated by ADSA. The Appellant objected to this decision and requested an administrative hearing.

2. Administrative Law Judge (ALJ) Erika Lim held an administrative hearing on May 3, 2010, through May 7, 2010, and mailed an *Initial Order* on August 3, 2010. In this decision, the ALJ disagreed with all of the multiple violations cited in the Department's notice and Statement of Deficiencies and thus reversed the Department's action to stop placement and revoke the license of [FACILITY 1] AFH.

3. This Final Order incorporates the Department's petition for review of the *Initial Order* and the Appellant's response for the easy reference of the reader.[1] The Department filed a petition for review of the *Initial Order* on August 24, 2010. The Department's petition and its attachment stated:

[1] The content of these documents is replicated herein without comment or correction, with the exception of the footnotes which are numbered consecutively throughout this *Review Decision and Final Order*.

The Department of Social and Health Services ("Department") petitions the Board of Appeals ("BOA") for review of the initial order in the case of *In re [APPELLANT], [FACILITY 1]*, Docket No. 01-2010-L-1224. A hearing was held in the above matter May 3-7, 2010, before Administrative Law Judge (ALJ) Erika Lim. [APPELLANT] was represented by attorney Thomas Grimm. The Department is appealing the initial order from this hearing which reversed the Department's revocation of [APPELLANT]'s adult family home license.

I. STANDARD OF REVIEW

This is an adult family home licensing case where the Department revoked one of [APPELLANT]'s two adult family home licenses. Pursuant to WAC 388-02-0600(2)(a), a review judge has the same decision-making authority as the ALJ when reviewing initial orders in licensing cases, but must consider the ALJ's opportunity to observe the witnesses.

A review of the record will reveal that the there were both errors in findings of fact and conclusions of law.

II. FINDINGS OF FACT

The Department takes exception to the following findings of fact which are clearly erroneous in light of the entire record: Findings of Fact 4.16, 4.24, 4.25, 4.27, 4.146, 4.149, 4.156, 4.161, and 4.221.

A reasonable review of the record leads to the following conclusions:

(A) Findings of Fact 4.16, 4.27, 4.221 stated that [APPELLANT] and her [RELATIVE 1] only went to church one at a time, or when the residents were at [ORGANIZATION], so that residents did not need to go to [FACILITY 1]. This is not supported by the statements of the residents or the testimony of the caregivers. *See Initial Decision,* FF 4.111, 4.119, 4.220.

(B) Finding of Fact 4.24 is counter to what [APPELLANT] told the complaint investigator during the complaint investigation. *Initial Decision,* FF 4.192.

(C) Finding of Fact 4.25 states that all residents attended [ORGANIZATION] events when [APPELLANT] and her [RELATIVE 1] were both at church. This is not supported by the record. Who attended [ORGANIZATION] events, and when they attended those events, was not clear on the record. One of the residents was not allowed to attend [ORGANIZATION] events for a period of time, and the

[ORGANIZATION] event calendar changed. *Testimony of [APPELLANT].* This finding of fact is also not consistent with the testimony of caregivers that they watched [FACILITY 2] residents at [FACILITY 1] on Saturdays.

(D) Finding of Fact 4.27 states that [FACILITY 2] residents have never been required to go to [FACILITY 1]. This finding is inconsistent with testimony of caregivers and statements of [FACILITY 2] residents. *See Initial Decision,* FF 4.111, 4.119, 4.123, 4.220.

(E) Finding of Fact 4.28 states that there are no licensing issues in [FACILITY 2]. This is not the case. Among other citations at [FACILITY 2], [APPELLANT] was cited for making residents from [FACILITY 2] go to [FACILITY 1]. *Testimony of Donna Andrews-Dennehy.* The Department agreed that the citations in [FACILITY 2] were not at issue in the present case.

(F) Finding of Fact 4.146 is counter to the *Testimony of Candace Corey* and *Initial Decision,* FF 4.195.

(G) Finding of Fact 4.149 is counter to *Testimony of Candace Corey* and *Initial Decision,* FF 4.194.

(H) Finding of Fact 4.161 is counter to the *Testimony of Candace Corey and Cheryl Everett* regarding the food citations. It also conflicts with *Initial Decision,* FF 4.202, 4.205.

III. CONCLUSIONS OF LAW

The ALJ made errors in the following conclusions of law: Conclusions of Law 5.2, 5.3, 5.4, 5.5, 5.6, 5.7, 5.8, 5.9, 5.10, 5.11, 5.12, 5.13, 5.14, and 5.15. These conclusions were premised upon a misapplication of the law to the facts.

IV. BACKGROUND

This matter is before the Office of Administrative Hearings (OAH) on an appeal by [APPELLANT] from the Department of Social and Health Services' (Department or DSHS) orders revoking one of her adult family home licenses. The provider has operated an adult family home since August 2006 at [ADDRESS 1], Washington (hereafter referred to as [FACILITY 1] or [FACILITY 1]). Ex. 4.[2] The adult family home license ([NUMBER]) is the second adult family home license issued to [APPELLANT], her first adult family home license was issued in 2002 for [FACILITY 2], which is located across the street from [FACILITY 1]. *Initial Decision*, Finding of Fact (FF) 4.1.

---

[2] Citations to exhibits refer to both the exhibit number and the page number (e.g., "Ex. 6.2," referring to the second page of Exhibit 6).

Adult family homes are inspected at the time of licensure and at least every 18 months thereafter. RCW 70.128.070(2)(a), (b). Unannounced inspections may be made at any time to ensure that the home and provider are in compliance with the regulations. RCW 70.128.070(2)(c).

On December 9, 2009, the Department completed an investigation and report of [FACILITY 1]. On December 16, 2009, the Department hand delivered to the provider a written “Statement of Deficiencies” along with a Notice of Stop Placement and Revocation. Ex. 1 and 2. Based on the violations cited in the Notice and the Statement of Deficiencies, the Department revoked the [FACILITY 1] license and imposed an immediate Stop Placement order pending any appeal.[3] The Notice and the Statement of Deficiencies cited a number of violations of the adult family home licensing regulations under WAC 388-76.

[APPELLANT] timely appealed the revocation of her adult family home license. A hearing was held in this matter on May 3-7, 2010. [APPELLANT] was represented by attorney Thomas H. Grimm. The ALJ reversed the Department’s revocation of the adult family home license and overturned every single citation in the Statement of Deficiencies. The Department now appeals to this tribunal because the ALJ’s conclusions of law were flawed and not based on the facts in the record.

V. THE CITATIONS ARE SUPPORTED

Individuals who reside in adult family homes are often totally dependent upon the adult family home. The extreme vulnerability of adult family home residents has led to the development of requirements that are designed to protect and promote the physical, mental, and emotional well-being of residents. The provider was cited for multiple violations based on the findings summarized in Exhibits 1 and 2.

A. Overcapacity

The provider operates two adult family homes, located across the street from each other. *Initial Decision*, FF 4.1. Each home is licensed for a maximum of six adults. *Id.* Typical staffing in both the provider’s homes is one caregiver per shift. *Initial Decision*, FF 4.108, 4.118, 4.130. Based on observations during the Department’s complaint investigation, and testimony at hearing, the provider repeatedly exceeded the licensed capacity of her second adult family home.

On November 2, 2009, Candace Corey, the Department’ complaint

---

[3] The stop placement of admissions is effective immediately and is not stayed pending an appeal. RCW 70.128.160(3); WAC 388-76-10980(2)-(3)

investigator, made an unannounced visit to [FACILITY 1]. When she arrived, there was one caregiver and eight adult family home residents in the home; six residents, who lived in [FACILITY 1], and two residents from the provider's other adult family home, [FACILITY 2]. The caregiver on duty told the complaint investigator that the two residents from the other home had been in [FACILITY 1] home since 7:00 AM. Ex. 2.15*; Initial Decision*, FF 4.185*.* The caregiver called the provider, who arrived approximately 30 minutes later. The provider spent the majority of her time with the investigator responding to questions. She offered infrequent assistance with residents. Ex 2.15; *Testimony of Candace Corey.*[4]

At 3:00 PM on November 2, 2009, two additional residents from the provider's other home entered the home. Both residents sat at the dining room table and had snacks. Also at 3:00 PM, a different caregiver arrived and the other caregiver soon left. At approximately 4:30 PM, an additional resident from the other home arrived. This meant that, at 4:30 PM on November 2, 2009, the caregiver in [FACILITY 1] was responsible for eleven residents with occasional help from the provider. This was the caregiver's second day of training and she was trying to prepare a supper meal. Ex 2.15*; Initial Decision*, FF 4.185*.*

The provider told the complaint investigator that having additional residents in the home was not usual. The provider also stated that the residents were in [FACILITY 1] when the complaint investigator was there because the caregiver from her other home and the new resident manager for [FACILITY 1] were taking adult family home classes in [LOCATION 1] and she did not have a caregiver in the other home. The provider stated as soon as the caregiver from the other adult family home returned the residents would go to their own home.[5] Ex 2.15; *Testimony of Candace Corey.*

It was a regular occurrence for there to be residents from the provider's other adult family home in [FACILITY 1]. *See Initial Decision,* FF 4.37, 4.47, 4.67, 4.61, 4.86, 4.173, 4.174 (various visitors to [FACILITY 1] saw [FACILITY 2] residents there). Caregivers who worked for the provider in [FACILITY 1] stated that it was a common occurrence, especially on Saturdays when [APPELLANT] and her [RELATIVE 1], the caregiver for the other home, went to Church. *Initial Decision,* FF 4.109-112, 4.119-123, 4.126*.* Caregivers did not necessarily know the care and supervisory needs of the residents of [FACILITY 2] because they were not familiar with

---

[4] [MANAGER 1] the current resident manager of [FACILITY 1], testified that it took the provider less than 30 minutes to arrive. However, he was not in the adult family home at the time the complaint investigator arrived, and his testimony was based on his assumptions that the provider called him right away and his knowledge of the roads in the area.

[5] The caregiver from the other home arrived at approximately 5:30PM. She left with the additional residents about 6 PM. Ex 2.15; *Testimony of Candace Corey.*

the care plans.[6] *Initial Decision,* FF 4.110. Sometimes, [APPELLANT] would send the residents over to the adult family home, even if the caregiver in [FACILITY 1] specifically asked her not to send them over. *Initial Decision,* FF 4.122. While the residents of [FACILITY 2] sometimes enjoyed being over at [FACILITY 1], those residents sometimes wanted to be in their own home. *Initial Decision,* FF 4.123. A caregiver described at least one instance where, when a resident from [FACILITY 2] tried to go home, she had to bring him back because there was no caregiver at the other home. *Id.*

The caregiver's statements and Ms. Corey's observations were further supported by the observations of Paul Tosch, the regional ombudsmen, who visited the home on November 21, 2009 and observed residents from the provider's other home in [FACILITY 1]. *Initial Decision,* FF 4.175-178. Only one caregiver was working in the home at the time of the visit. The caregiver was trying to feed one resident while another resident was trying to get out of her chair in the living room. The caregiver was running between the resident who was eating and the resident who was trying to get up. The caregiver then had to help a third who was walking to the table. *Id.* When Mr. Tosch contacted the provider to express concern regarding the residents from the other home being at [FACILITY 1], the provider stated that the residents were there because there was no caregiver at [FACILITY 2]. *Initial Decision,* FF 4.179.

It is undisputed that the licensed capacity for [FACILITY 1] is six people, which is also the maximum number of people allowed for any adult family home. *See* RCW 70.128.010(1). Therefore, based on what the Department knew at the time the license was issued, it was decided that [APPELLANT] could have six residents in her adult family home, for a total capacity of six. Adult family homes must not exceed licensed capacity. Exceeding the licensed capacity alone is enough to trigger a licensing remedy. Former WAC 388-76-10960(16). Capacity is defined as "the maximum number of persons in need of personal or special care permitted in an adult family home at a given time and includes related children or adults in the home who receive personal care or special care and services." Former WAC 388-76-1000 (definition of capacity).

The problem is not with the capacity number on her license (six), which is what is addressed in former WAC 388-76-10030, the problem is the actual number of people in need of personal or special care that were discovered in the adult family home when the complaint investigator, and others, were in the house. Testimony from multiple witnesses confirmed that there

---

[6] It is undisputed that all the residents of both [FACILITY 1] and [FACILITY 2] were residents of adult family homes who has personal and special care needs. *Testimony of [APPELLANT].* The residents of [FACILITY 1] had varied care needs. Some of them were fairly independent, others needed significantly more supervision because of behavioral issues. *Initial Decision,* FF 4219.

were more than six, and up to eleven, vulnerable adults in the home multiple times. The practical problem with this arrangement is that the combination of the residents from the provider's two homes can only be seen as insufficient staffing of her two homes, and blatant disregard for the limitations inherent to her adult family home licenses. Having so many people needing care or special care in one adult family home results in the risk that vulnerable adults in need of care and supervision will not get the attention they require.

The repetitive nature of [APPELLANT] exceeding the licensed capacity in [FACILITY 1] is especially egregious because she had every reason to know that she could not combine the residents of her two adult family homes without seeking Department permission in rare and special circumstance. Not only was [APPELLANT] an experienced adult family home operator, she had previously sought and obtained permission to combine her adult family homes during emergencies when her homes were flooded and evacuated. During those occasions, there was increased Department monitoring and an understanding that the arrangement was temporary because of the emergent circumstances. *Initial Decision,* FF 4.13-15. As such, [APPELLANT]'s continual combination of the residents of her two homes can only be seen as insufficient staffing of her two homes, and the blatant disregard for the limitations inherent to her adult family home licenses.

The ALJ concluded that the residents of [FACILITY 2] were "visitors" that did not count toward capacity because they did not need any care, were fairly independent, and the caregivers were not responsible for them. *Initial Decision,* CL 5.15. This determination completely ignores the fact that [FACILITY 2] residents are vulnerable adults, and by definition need care, the testimony of the [FACILITY 1] caregivers, and the testimony of [APPELLANT]. *See* RCW 74.34.020(15)(definition of vulnerable adult) and *Initial Decision,* FF 4.109-112, 4.119-123, 4.126, 219, *Testimony of [APPELLANT]* (testified [FACILITY 2] residents needed care and that she kept negotiated care plans for [FACILITY 2] residents at [FACILITY 1] for the caregivers).

B. Failure To Have A Resident Manager

It is undisputed that she did not have a resident manager for [FACILITY 1] from the time that [FORMER MANAGER 1], the former resident manger, quit until [MANAGER 1] became qualified. This violates the requirement to have a resident manager in the [FACILITY 1]. Ex. 2.2-3. The language of the requirement to have a resident manager is absolute: There is no language that indicates there is a grace period. When an adult family home provider has multiple adult family homes, each home must have one person responsible for managing the overall delivery of care to all

residents in the home. WAC 388-76-10036(1). The designated responsible person must be the provider, entity representative or a qualified resident manager. WAC 388-76-10036 (2). There is no exception to this rule. [APPELLANT] basically conceded that this was the case when she stated that she was training multiple resident managers "just in case" another situation like this occurs. *Initial Decision,* FF 4.19. No exception to this rule makes sense: The responsibility for managing the overall delivery of care to all residents is ongoing and continual, because the resident's care needs are also ongoing and continual.

The Initial Decision states that the requirement to have a resident manager, without a grace period, is unreasonable. *Initial Decision*, CL 5.4. However, the only reason a provider is allowed to have multiple adult family home is if there is designated responsible person, like a resident manager, to take responsibility for the residents' overall care. By committing to operate two homes, the provider has also committed to this requirement. Furthermore, if there was some emergent reason that she could not obtain a resident manager, she could have communicated with the Department that there was a problem and developed a plan to deal with the situation. The provider knows communication with the Department in emergent circumstances works; she requested an exception to the capacity requirement when one of her adult family homes was flood damaged. During those occasions, there was increased Department monitoring, and an understanding that the arrangement of combining of her two homes was temporary because of the emergent circumstances. *Initial Decision*, FF 4.13-15. When her resident manager quit, she did not attempt to communicate with the Department that there was a problem. Instead, the Department's complaint investigator caught the provider without a resident manager and, at the same time, the complaint investigator discovered that there were 11 vulnerable adults in one of the provider's adult family homes. *Initial Decision*, FF 4.185-4.188.

C. Failure To Have Qualified Staff

It is undisputed that [CAREGIVER 1], a caregiver in [FACILITY 1] who was sometimes responsible for 11 adult family home residents, did not have current CPR and first aid training. [APPELLANT] did not require her to show her current credentials when she was employed and only found out after she was cited that [CAREGIVER 1]'s credentials were expired. [APPELLANT] had been cited for having unqualified staff before. Ex. 2.3-4; *Initial Decision*, FF 4.103-105, 4.190. The initial decision claims that [APPELLANT]'s reliance on what [CAREGIVER 1] told her is enough to satisfy the regulation. *Initial Decision*, CL 5.5. This is not the case. WAC 388-76-10135 states that an adult family home must "ensure" that each caregiver has a "current valid" first aid and CPR card. [APPELLANT] did not ensure that this occurred--one of her staff did not have a current valid

CPR and first aid card. The citation was proper.

D. Failure To Have An Resident Assessment

It is undisputed that [APPELLANT] did not have a current assessment when she admitted [RESIDENT 1] as a new resident to [FACILITY 1]. The assessor could not come to the adult family home until after [APPELLANT] had already admitted the resident. *Initial Decision,* FF 4.76-83, 4.143. The minimum licensing requirement is that [APPELLANT] was required to get an assessment prior to admitting [RESIDENT 1], unless there was an emergency. Rather than follow the minimum licensing requirements, [APPELLANT] depended on her own experience as a nurse to admit [RESIDENT 1]. *Testimony of [APPELLANT].* This does not satisfy minimum licensing requirements. Ex. 2.4-5. *Testimony of Candace Corey, [APPELLANT], and David Robinson.*

[APPELLANT] appears to claim that this was an "emergency admission;" however, she does not establish that there was any true emergency. To establish that a true emergency exists, the home must verify that the resident's life, health or safety is at serious risk due to circumstances in the resident's current place of residence or harm to the resident has occurred. WAC 388-76-10395(2). The provider did not establish that such an emergency existed that would have allowed her to violate the minimum licensing requirements.

The Initial Decision mistakenly asserts that [APPELLANT] reasonably believed that an emergency existed because the resident's [RELATIVE 5] can no longer care for him. *Initial Decision,* CL 5.6. This is in error. There is no evidence that [RESIDENT 1] was forced to leave his home or the hospital. Furthermore, there was no showing that [APPELLANT] could not have obtained an assessment in the two weeks between when the [RELATIVE 5] viewed [FACILITY 1] and when he was placed there. There is also no showing that [APPELLANT] worked with the hospital discharge planner to manage [RESIDENT 1]'s discharge so that he could be assessed prior to admission. In sum, the Department established that the appellant violated the requirements for admission; the appellant did not establish that she had a legally valid reason for doing so.

E. Failure To Have Medication Labeled

It is undisputed that [APPELLANT] did not have the medication organizers properly labeled. When the complaint investigator told her that one was not labeled correctly, the provider stated she had the label in her office and forgot to put the label on the medication organizer. Ex. 2.11-12*; Initial Decision*, FF 4.198. The initial decision stated there was no violation of the labeling requirement because there was no rule regarding how long

after an emergency admission medicine needed to be labeled and the provider substantially complied because the label was printed in the office. *Initial Decision,* CL 5.11.

This interpretation of the labeling requirement is counter to common sense and the purpose of this rule. The medi-set lacked a proper label for two weeks after the resident was admitted to the adult family home. During that time period, multiple staff administered medication and the resident was at greater risk for a medication error. There is no authority that "substantial compliance" with this rule satisfies the requirement.

F. The Inspection Report Was Not Visible

While there is some dispute as to where the inspection results were posted, it is undisputed that the inspection report was obscured by papers and was not visible as required. Ex. 2.14*; Testimony of Cheryl Everett, [APPELLANT], and [MANAGER 1], Initial Decision*, FF 4.168. The initial decision overturned this citation stating that the requirement to have the inspection results in a visible location meant that the location had to be visible (i.e. the office), not the inspection results. *Initial Decision,* CL 5.13. This interpretation is nonsensical. The purpose of inspection results being in a visible location is so that visitors, family and residents can see the inspection results. To have them buried under paper completely defeats the purpose of the regulation.

G. There Was Expired Food In The House

It is undisputed that there was expired food in the emergency food supply. Further, the Department's contention that that there was not enough food <u>on the premises</u> was not challenged. Ex. 2.10-11; *Testimony of Candace Corey, and Cheryl Everett.* The ALJ overturned the citation because there was food at [FACILITY 2], and she took judicial notice that canned food has "use by dates", not expiration dates.[7] *Initial Decision,* CL 5.10. While there some testimony that there was plenty of food available for [FACILITY 2] because the food was stored at [FACILITY 1], this does not address the requirement that the emergency food supply be "on-site." *See* WAC 388-76-10840. Furthermore, the ALJ's revision of "expiration dates" to "use by" dates is not supported in the record. No one ever claimed that the food was not expired, at most, the provider claimed that a disgruntled caregiver had brought the beans into the home. *Testimony of [MANAGER 1] and [APPELLANT].*

H. There Was Not Sufficient Emergency Lighting

---

[7] This was never contended by the appellants and is an improper item for judicial notice because it is not necessarily true.

It is uncontested that the adult family home did not have sufficient lighting because there was only one working flashlight in the home. Ex. 2.14*; Initial Decision,* FF 4.207; *Testimony of Cheryl Everett.* The requirement states that there must be "flashlights" for emergency lighting.

The ALJ overturned this citation claiming that the provider could turn her headlights on and shine them into the house for emergency lighting. *Initial Decision,* CL 5.14. The provider did not raise the headlights of her car as an option for emergency lighting, it was strictly a reason given by the ALJ for why she was not sustaining the citation. This reasoning makes no sense for a variety of reasons. The provider, and the provider's car, were not always at [FACILITY 1]. Furthermore, in an emergency, the headlights of the car cannot be used within the rooms of the adult family home to illuminate the rooms for the residents.[8] The ALJ also notes that there is no evidence in the record of what other types of emergency lighting were available in [FACILITY 1]. *Id.* While the ALJ gives this as a reason for not sustaining the Department's citation, it is exactly the reason that the citation should be upheld: When looking for emergency lighting, the Department found one working flashlight and no other emergency lighting was apparent.

I. Negotiated Care Plans

The adult family home must use the resident assessment and preliminary care plan to develop a written negotiated care plan. The home must ensure each resident's negotiated care plan includes a list of the care and services to be provided, identification of who will provide the care and services, and when and how the care and services will be provided. WAC 388-76-10355(1)-(3).

When the Department's complaint investigator reviewed the resident records at the facility, four of the resident's records revealed no negotiated care plans. Printed on the top of each page of the residents' assessment were the questions: "When will assistance be provided?" and "Who will provide assistance?" The answers to these questions were omitted from all four residents' assessments which resulted in no plan of care to meet their identified needs. Ex. 2.6-5*; Testimony of Candace Corey.* Furthermore, [RESIDENT 2]'s care plan did not document a swallowing problem, even though his September 17, 2009 assessment documented he had a problem with choking and swallowing and needed supervision and assistance while eating. This omission was especially problematic because he was observed eating his dinner in the living room apart from the other residents who took their meals at the dining room table and he was observed to cough during the meal. The caregiver in the home could not see him while he ate, and apparently did not know that [RESIDENT 2]

[8] Under this rationale, a full moon could be considered emergency lighting.

needed supervision while eating.[9] Ex. 2.6; *Testimony of Candace Corey.*

At hearing, the provider produced care plans that were supposedly in the home at the time of the complaint investigation. *Appellant's* Ex. 16. However, at the time of the complaint investigation, the provider did not provide these documents to the complaint investigator to review. *Testimony of Candace Corey*. Because they were not provided to the complaint investigator, it is unknown whether the care plans were sufficient at the time of the investigation or whether they were later modified. Instead of providing the care plans to the complaint investigator when the issue was raised with her, the provider told the complaint investigator that, although she was first licensed for an adult family home in 2002, she did not know she had to add information regarding what care and services would be provided, who would provide the care and services, and when and how the care and services would be provided to the assessment tool in order to make it into a negotiated care plan. The provider further stated she would complete the negotiated care plans on each resident as soon as possible. Ex. 2.6-5*; Testimony of Candace Corey.* The provider further told the complaint investigator that she would revise and update the information on [RESIDENT 2]'s negotiated care plan to address his choking risk and need for supervision when eating. *Id.* At the very least, the provider's statements to the investigator acknowledges that there were deficiencies with the care plans, and her understanding of what should be in them was deficient as well.

J. Care And Services

There were several care and services issues with various residents in the home. Based on observation, interview and record review, the provider failed to ensure that blood glucose testing was done prior to meals, swallowing issues were properly evaluated, and one resident received needed assistance with brushing her teeth. Ex. 2.7-9. These citations were supported through testimony and documentation at hearing.

1. Teeth Care

[RESIDENT 3]'s assessment indicates she has many care needs related to Alzheimer's dementia, including substantial assistance with personal hygiene, which includes oral care. Ex. 6.11. There was no care plan observed during the complaint investigation that addressed [RESIDENT 3]'s needs for oral care. *Initial Decision*, FF 4.193.

---

[9] The provider explained to Ms. Corey that it was the caregiver's second day on the job and she was in training. Ex. 2.6; *Testimony of Candace Corey.* Regardless, the caregiver did not know how to properly care for [RESIDENT 2] and his eating needs. Furthermore, ignorance regarding [RESIDENT 2]'s swallowing problem was common, even [RESIDENT 2]'s [RELATIVE 2] was unaware and uninformed of his swallowing problem until shortly before the hearing. *Testimony of [RESIDENT 2'S RELATIVE]*

[RESIDENT 3]'s dentist, who has cared for her teeth since 2002, stated that, from 2007 to October 2009, dental visits showed a gradual decline in dental care, especially during the past six months. Records indicated she had moderate to heavy plaque build up identified during dental visits in 2007, 2008 and 2009. During her October 21, 2009 dental visit, [RESIDENT 3]'s had numerous issues with her teeth, heavy plaque build up, her gums were in poor condition, and there was food on her teeth. Ex. 8.3*; Initial Decision,* FF 4.54, 4.56, 4.58. [RESIDENT 3]'s dentist testified that a certain amount of dental decline is expected as people age, however, a few years ago the resident's teeth were not in this condition, and she needed better oral care. *Id.* He further stated that [RESIDENT 3]'s teeth were in such a condition, there was nothing he could do to address the breakdown of her teeth.

When asked about the condition of [RESIDENT 3]'s teeth, [APPELLANT] blamed [RESIDENT 3]'s [RELATIVE 4] for giving her sweets. However, numerous witnesses at hearing stated there were usually sweets of some kind in the adult family home, including ice cream, which adult family home staff gave to residents for snacks.[10] Regardless, eating sweets is not a problematic so long as [RESIDENT 3] receives proper oral care. Based on the appearance of her teeth during the October 21, 2009 visit to the dentist, she was apparently not receiving proper oral care in the adult family home prior to that visit.[11]

2. Blood Glucose Monitoring

[RESIDENT 2]'s record contained a physician's order to check his blood glucose level before each meal. On November 13, 2009, the Department's complaint investigator observed a caregiver check [RESIDENT 2]'s blood glucose during, not before, the lunch meal. Checking the blood glucose level after the resident started eating would result in a false high reading and would not provide the resident's physician with accurate information for managing the resident's diabetes. *Initial Decision*, FF 4.194.

In general, [RESIDENT 2]'s blood glucose levels were tempestuous; the blood glucose monitoring log showed that his blood glucose level were

[10] When the complaint investigator discussed [RESIDENT 3]'s dental problems with the provider, she blamed the issue on the resident's [RELATIVE 4] bringing her sweets. *Testimony of Candace Corey;* Ex. 2.7-8.

[11] After the October visit and the subsequent revocation, [RESIDENT 3] apparently began receiving better oral care because her teeth improved. *Testimony of [DOCTOR 1].* This is consistent with the testimony of [CAREGIVER 2], who worked in the adult family home after the revocation, who said she brushed the resident's teeth every day and had minimal problems with [RESIDENT 3] being combative with tooth brushing. Any issues she had with [RESIDENT 3] being combative could be addressed by re-approaching [RESIDENT 3] later. *Testimony of [CAREGIVER 2], Initial Decision, FF 4.58.*

sometimes extremely high. *Initial Decision*, FF 4.194; Ex. 2.8. The high results could have been false highs based on when staff checked his blood, or they could have been symptomatic of problems with managing his diabetes. *Id.* Regardless of the high blood glucose levels in [RESIDENT 2]'s October 2009 monitoring log, the provider stated she had not contacted [RESIDENT 2]'s physician to report his blood glucose since September 11, 2009.[12] *Id.* As a licensed nurse, the provider knew that blood glucose results in the 200 and 300 ranges, in consideration of the fact that the resident's insulin had been discontinued, should have been reported to the physician. *Testimony of Candace Corey and [APPELLANT].* The high blood glucose levels could have resulted in diabetic complications such as heart, kidney, and vision problems. *Testimony of [RESIDENT 2'S RELATIVE], Initial Decision,* FF 4.71.

3. Swallowing Evaluation

[RESIDENT 1] was admitted to the adult family home on October 16, 2009. During the complaint investigation, he was observed coughing and having swallowing difficulties during the noon meal. *Initial Decision*, FF 4.195. Both the provider and another caregiver attempted to feed the resident and coax him to eat. The noon meal consisted of the type of food served that was difficult for a person with swallowing difficulties to eat. *Id.*

The provider was asked if she noticed [RESIDENT 1]'s difficulty swallowing, and if he had been evaluated for the problem or for dietary recommendations. The provider stated she noticed he seemed reluctant to eat but she had not contacted the resident's physician to discuss her observations of the resident's reluctance to eat. *Id.* After the resident's swallowing problem was pointed out by the investigator, the provider contacted the home health agency to request a swallowing evaluation. *Id*. The provider offered no explanation at hearing for why a swallowing evaluation or food recommendations were not requested earlier.

4. Resident Medication Was Not Accessible To Caregivers

The provider was cited for failing to ensure that residents had immediate access to narcotic and anti-anxiety medications. Ex. 2.9-10, *Initial Decision*, FF 4.196-197. This citation is supported in the record. Caregivers reported that the provider kept the narcotic and antianxiety medications separate from the other medications so that residents did not have immediate access to them. *Initial Decision*, FF 4.115. If a resident wanted or needed a narcotic or antianxiety medication, the caregiver had to call the provider on her cell phone and have the provider bring the medications to the home or retrieve them from another location in the

[12] At hearing, it was also discovered that [RESIDENT 2]'s problematic blood sugar levels had not been reported to his [RESIDENT 2'S RELATIVE]. *Testimony of [RESIDENT 2'S RELATIVE].*

home. This was especially problematic before November 2009. *Id.* Not having access to these medications delayed the administration of them to residents for up to an hour. *Testimony [FORMER MANAGER 1].* Caregivers had to deal with residents expressing pain. There was nothing caregivers could give them, even though there was a prescription drug that should have been available. *Testimony of [CAREGIVER 1].*

When the provider was questioned about why she limited access to these drugs, the provider stated she kept the narcotic and antianxiety medications separate because that was what they did in nursing homes. *Testimony of Candace Corey;* Ex. 2.10. The provider also stated she meant to have one of the narcotic medications discontinued, but had not done at the time of the complaint investigation. *Id.*

K. Activities

The provider was cited for failing to provide sufficient activities. Ex. 2.13. There were minimal activities for the residents of the adult family home. Furthermore, these activities were not consistent with the activities that were included in the resident's records. *Testimony of Candace Corey and Paul Tosch.* At most, the provider discussed offering bingo to the residents, and having them socialize with residents from her other adult family home. Rather than contest the assertion that enough activities were not provided, the current resident manager of [FACILITY 1] insinuated that the activities in the resident records were no longer accurate. *Testimony of [MANAGER 1].* Not only did this conflict with the testimony of other witnesses,[13] this is problematic because, to the extent activities need to be updated, it would be the responsibility of the provider to update them in the negotiated care plan. *See* WAC 388-76-10355(5) and WAC 388-76-10380(2). The ALJ did not address the obligation to change the care plans when she overturned the citation.

L. Failure To Understand

Based on observation, interview and record review the provider failed to understand the need to comply with minimal licensing requirements to ensure the physical and special care needs of vulnerable adults were met. The provider's failure to have qualified staff, negotiated care plans, and to not operate her home overcapacity resulted in a diminished quality of life and placed residents at risk of harm from unmet physical and supervision needs. [APPELLANT] chose to have adult family home licenses, in making that choice, she is obligated to follow all of the requirements, all of the time. Her failure to understand and carry out these obligations is one

[13] For example, [FRIEND 1] testified that [RESIDENT 4] wanted to be woken up from a nap in order to interact with people. *Testimony of [FRIEND 1].* The current resident manager insinuated that [RESIDENT 4] would not wish to be woken up from a nap and all she wants to do is sleep.

of the reasons her license is being revoked.

VI. UPHOLDING EVERY POSSIBLE CITATION IS NOT NECESSARY TO UPHOLD THE REMEDIES IMPOSED

A Decision-maker need not affirm all citations in the statement of deficiencies in order to uphold the Department's decision to revoke the Appellant's license. This position is supported through statute, rule, case law and policy.

DSHS licenses and regulates adult family homes under chapter 70.128 RCW, the rules adopted under chapter 388-76 WAC, and related statutes and regulations. The Department is authorized to suspend or revoke a license when an adult family home provider has failed or refused to comply with minimum licensing requirements. RCW 70.128.160(1)(a), (2)(d); WAC 388-76-10940(4)-(5), WAC 388-76-10960(14)(b), (16). DSHS may suspend admissions to the adult family home by imposing stop placement. RCW 70.128.160(2)(e). In this case, there are two different issues supporting revocation: Overcapacity and the failure to follow a litany of minimum licensing requirements.

A. Operating Overcapacity

Adult family homes are statutorily defined as "a residential home in which a person or persons provide personal care, special care, room, and board to more than one *but not more than six* adults who are not related by blood or marriage to the person or persons providing the services." RCW 70.128.010(1)(emphasis added). The sole act of operating an adult family home overcapacity is explicitly designated as justifying a licensing remedy, which includes revocation. WAC 388-76-10960(16). It makes sense that operating overcapacity is a stand alone reason for a licensing remedy. If a home operates above the six adult threshold, the home no longer qualifies as an adult family home. This limit on the amount of people that an adult family home can serve is inherent to the nature of an adult family home.

B. Failure To Follow Minimum Licensing Requirements

When a provider is cited for failing or refusing to comply with minimum licensing requirements, the Department may impose a licensing remedy. WAC 388-76-1040. A remedy <u>must</u> be imposed when the violations pose a serious risk, or are recurring or uncorrected. WAC 388-76-10945. These standards do not require DSHS to prove actual harm in order to impose any of the remedies available. The Department is expressly allowed to consider the severity of the potential harm and which remedy is likely to improve resident outcomes. The purpose of the adult family home

> regulations is to require that providers meet certain minimum licensing requirements to ensure that vulnerable adults have their care needs met. *Williams-Batchelder v. Quasim*, 103 Wn. App. 8, 16, 19 P.3d 421, 425 (2000). In balancing the needs of vulnerable adults and the interests of even well-meaning caregivers, DSHS must give priority to the safety of the residents. RCW 70.128.005; *Bond v. Dep't of Soc. & Health Servs.*, 111 Wn. App. 566, 575, 45 P.3d 1087, 1092 (2002). In doing this balancing test, and in looking at what other options the department had for remedies, the Department decided that the appropriate remedy was revocation. *Testimony of Pam Hildreth.*
>
> **VII. CONCLUSION**
>
> The ALJ should have upheld the Department's revocation of [APPELLANT]'s license. The record supports the Department's action in this case.

4. On August 31, 2010, the Appellant's representative requested and was granted a two-week extension of the original deadline for filing a response to the Department's petition for review of the *Initial Order*. On or about September 17, 2010, the Appellant filed a response, which stated:

> [APPELLANT] and [FACILITY 2] respond to the Department's Petition for Review. The license at issue is held by [FACILITY 2] but its owner, [APPELLANT], was also named in the licensing actions of DSHS, found in exhibits D-L and D-2. This response is timely, based upon the order extending time for filing a response, extending the date from September 3, 2010 to September 17, 2010 due to the vacation of the undersigned.
>
> This case involves the Department's attempt to revoke [FACILITY 1]'s adult family home license under the standards of WAC Chapter 388-76. Because the Department ordered that the Appellant's license be revoked, its burden was to establish violations sufficient to justify a license revocation by "clear, cogent and convincing" evidence. We discuss this standard below under Standard of Review. The Administrative Law Judge in her Initial Order did not rule on the Standard of Review, finding on the lower preponderance of evidence standard that the Department failed to prove any part of its case.
> On review, this same result must obtain.
>
> **I. STANDARD OF REVIEW**

The Department's recitation of WAC 388-02-0600(2)(a) as the standard of review is accurate as far as it *goes,* but it is incomplete as to the evidentiary standard. It is correct that the Review Judge must apply the same standards as the ALJ. However, it fails to discuss the higher evidentiary standard in a license revocation case. [14]

The Department has asserted that it has the burden of proving its case by a preponderance of the evidence, citing, WAC 388-02-0480. It is incorrect. The correct standard is that it must prove its case by clear, cogent and convincing evidence.

> WAC 388-02-0480 provides:
>
> **What does burden of proof mean?**
>
> The party who has the burden a proof is the party who has the responsibility to provide evidence to persuade the ALJ that a position is correct.

The following section, WAC 388-02-0485, specifies:

> **What is the standard of proof?**
>
> The standard of proof refers to the amount of evidence needed to prove a party's position. <u>Unless the rules or law states otherwise</u>, the standard of proof in a hearing is a preponderance of the evidence. The standard means that it is more likely than not something happened or exists.

(Emphasis added)

In a licensing case constitutional due process requires proof by a higher standard than mere preponderance of the evidence. Licensees have a constitutional right of due process in a license revocation hearing. *Nguyen* v. S*tate Department of Health Medical Quality Assurance*, 144 Wn.2d 516, 522, 29 P.3d 689 (2001)(physician). Due process requires that a professional disciplinary proceeding must be based upon findings that are on clear, cogent and convincing evidence. *Nguyen,* at 534; *Nims v, Washington Board of Registration,* 113 Wn. App. 499, 505, 24 53 P.3d 52 (2002) (professional engineer).

This higher standard of proof is required because, "the more important the interest, the less tolerant we are as a civilized society that it be erroneously deprived." *Nguyen,* at 524. Clear, cogent and convincing evidence exists when the ultimate fact in issue is shown to be "highly

[14] Appellant asserts the following standard to the Administrative Law Judge as well.

probable." *Id; Dependency of T.L.G.,* 126 Wn. App. 181, 197, 108 P.3d 156 (2005); *Dombrosky v, Farmers Ins. Co.,* 84 Wn. App. 240, 256, 928 P.2d 1127 (1996) (evidence of sufficient persuasive impact as to cause the trier-of-fact to believe that the fact at issue is highly probable).

Therefore, because this is a license revocation hearing, due process and the procedural standards in WAC 388-02-0485 require that the ALJ apply the higher burden of proof on the Department to establish a right to revoke, that is, the clear, cogent and convincing evidence standard. The ALJ did not rule on this point, because she determined that the Department had failed on even the less stringent standard of preponderance of the evidence. Initial Decision, CoL 5.2, p. 64.

II. FINDINGS OF FACT

The Department challenges nine of the 223 findings of fact in the initial decision. The Department does not address the remaining 214 findings of fact, which by themselves amply support the Conclusions of Law in the initial decision. Moreover, the Department is wrong in claiming that the nine findings, findings of fact 4.24,4.25,4.27,4.146,4.149,4.156,4.161 and 4.221 are clearly erroneous.

A. Findings of Fact 4.16, 4.27 and 4.21

The Department challenges as unsupported by the evidence. The first of these three findings states that [APPELLANT] and her [RELATIVE 1] only went to church together if there were no residents at home at House One. That is consistent with the testimony of [APPELLANT], as cited in the Finding. FF 4.16. Otherwise either [APPELLANT] or [APPELLANT'S RELATIVE 1], her [RELATIVE 1], would go to church and the other would be there for the residents of House One. [APPELLANT] testified that either she or her [RELATIVE 1] would go to church, so that there was someone at the House No. 1, if any residents of House No. 1 were to be there.

Not only is the challenge to 4.16 improperly taken, it does not matter. The ALJ found that the residents of House One were high functioning, independent and able to choose where they wanted to be. FF 4.21 and CoL 5.15. Further, whether or not there was a caregiver at House No. 1 is not at issue in this case which only involves allegations of claimed misconduct under the rules at House No. 2, as the Department has so stipulated. FF 4.28.

The challenge to Finding 4.27 is also unfounded or was resolved against the contentions of the Department. The Finding states that, "House One residents have never been required to go to House Two." This is

consistent with the testimony of [APPELLANT] and [MANAGER 1] that no House One resident was required to go to House No. 2 from House No, 1. It is also consistent with the other findings in 4.27 that the House One residents consider [APPELLANT] their [RELATIVE 1] (they have no families that pay attention to them), and they will go to House Two if they see her car there, and that [RESIDENT 5] liked to be with [RESIDENT 6] at House One. The testimony was uncontested on these points.

The challenge to FF 4.21 is puzzling. This finding summarizes [APPELLANT]'s testimony about 6 residents at House One. No one else testified as to the characteristics of these residents. The Finding is accurate.

Finding of Fact 4.24

Contrary to the statement on page 2 of the Petition for Review, Finding of Fact 4.24 is not contrary to what [APPELLANT] told the complaint investigator. This finding, in its entirety is:

> Each of the residents has a negotiated care plan. Testimony of [APPELLANT].

The finding could also cite to the care plans that were entered into evidence, Exhibit A-16, as well as testimony of [APPELLANT]. See, Finding 4.128. The Department's witnesses admitted that these were care plans as required by rule. [FORMER MANAGER 1] testified that she did them on her computer with [APPELLANT] and that they contain her handwriting, so they were done before October 23, 2009 and before the survey inspection on November 2. That the State's investigator did not look at them is not the fault of the Appellant. The finding is accurate and in accord with the testimony of the Department's own witness.

B. Finding of Fact 4.25.

Commencing in the middle of p. 26 of the Initial Decision is a discussion of the residents of House One. Challenged Finding 4.2 refers to and describes the activities of the residents of House One. The elderly residents of House Two did not attend [ORGANIZATION] events, and there was no unclarity in the record. Testimony that residents from House One were at House Two on Saturdays in not inconsistent with this finding. House One residents were high functioning and could choose to go to [ORGANIZATION], or not, and the Finding reflects that those who did choose would use the [BUS]. Every resident has the right to choose whether to engage in activities or not. This is consistent with the cited testimony.

The significance of the objection to Finding of Fact 4.25 in the Petition for Review is not clear. The burden is not on the Appellant to disprove the allegations of the Department on its license revocation. The burden is on the Department to establish each and every element of its claims. If there is unclarity, its claim must fail because it has not met its burden of proof.

C. Finding of Fact 4.27

The Department challenges this finding as being inconsistent with the testimony of caregivers, but [APPELLANT] testified exactly as the finding states. No House No. 1 resident was required to go to House No. 2. They were allowed to go to House No. 2 if they wanted to visit with residents at House No. 2 or they saw [APPELLANT]'s car and wanted to check in with her. [MANAGER 1] also testified to that effect. The Administrative Law Judge must not have credited testimony from caregivers who testified that residents of House No. 1 were required to come to House No. 2. This is justified. None of those caregivers was at House No. 1, nor was there any testimony that any of them witnessed resident from House No. 1 being told to go across the street to House No. 2. Thus, their testimony is simply speculation.

The Department cites four findings as supposedly in conflict with Finding 4.27: Findings 4.111, 4.119, 4.123, and 4.220. None is in conflict.

Finding of Fact 4.111 is not in conflict with Finding of Fact 4.27. The House No. 1 residents did cross the street, as is uncontested, because they wanted to visit with their friends that they got to know when [LOCATION 2] experienced the floods and they lived together at House No. 2 or wanted to see [APPELLANT] before heading out to other places for activities. In this, they had a right.

Finding of Fact 4.119 does not deal with the same topic as in Finding of Fact 4.27.

Finding of Fact 4.123 does not deal with whether House No. 1 residents were required to go to House No. 2. The same is true for Finding of Fact 4.220. Accordingly, none of cited Findings of Fact are in conflict, and the Department has no claim with regard to Finding of Fact 4.27.

D. Finding of Fact 4.28.

The Petition for Review misstates the finding, which reads:

> 4.28 The Department does not contend that there are any licensing issues regarding House One.

The Department agrees that any citations related to [FACILITY 2] were not at issue in the present case (Petition, page 3, lines 5-6).

E. Finding of Fact 4.146.

The Department complains that Finding of Fact 4.146 conflicts with Finding of Fact 4.195. Actually, there is nothing incorrect about either finding. Both [MANAGER 1] and [RESIDENT 1]'s [RELATIVE 5] denied that he had a swallowing problem. There was no question that [RESIDENT 1] occasionally did cough during his meals, or that he would refuse to swallow his food. Refusal to swallow one's food is not uncommon at end of life, as [RESIDENT 1] was, and was his right to refuse. These findings are correct.

F. Finding of Fact 4.149.

The Department claims that this finding is in conflict with Finding of Fact 4.194. These two findings reflect the slightly different testimony of [APPELLANT] and Ms. Corey with regard to resident [RESIDENT 2]'s meals and taking blood glucose readings. The only discrepancy between the two is resolved in the Finding. [APPELLANT], and [MANAGER 1] testified that [APPELLANT] rolled [RESIDENT 2] away from the lunch table before he started eating to measure the blood glucose level. This is consistent with the statements of two eyewitnesses, [MANAGER 1] ("checked [RESIDENT 2]'s blood glucose before he ate") and [CAREGIVER 3] ([APPELLANT] intervened "as I was placing his plate in front of him"), found in Exhibits A-3.2 and A-3.1, respectively. Finding of Fact 4.94 recites Ms. Corey's testimony that [RESIDENT 2] "was at the table and had started to eat when [APPELLANT] reminded [CAREGIVER 3] that his blood glucose level needed to be measured." This is not in conflict but just a different perspective from two different witnesses. [RESIDENT 2] had not actually started <u>eating</u> but was about to do so due to [CAREGIVER 3]'s nervous mistake in front of the surveyors, but [APPELLANT] rectified it before [RESIDENT 2] actually had something to eat. Thus, [APPELLANT] intervened and made sure that [RESIDENT 2]'s blood glucose level was measured before he began his meal. [RESIDENT 2] got care in accord with his care plan. The Finding is accurate and consistent with the evidence. Even if there was a conflict, it has been resolved by the ALJ against the Department's contentions.

G. Finding of Fact 4.161.

The Department claims in this challenge that Finding of Fact 4.161 is contrary to the testimony of Candace Corey and initial decision Finding of Fact 4.194. Finding of Fact 4.161 provides a detailed description of where food was stored for regular use and for emergency purposes. It also finds

that neither [APPELLANT] nor [MANAGER 1] ever bought refried beans, and they also testified that they never serve them at House No. 2. Because they were the only ones who did buy food for the houses, the appearance of the expired refried beans remained a mystery through the hearing. We do know that [FORMER MANAGER 1] did come into the facility on her day off at a time that she was in disagreement with management over her wages.

There is no conflict between the testimony of Ms. Corey and the finding. Ms. Corey did not look in the high closet where emergency rations were stored. She also did not look in the hallway. Ms. Everett did look in the high cabinet, and she did see food stored there. The testimony was that the cabinet was deep and Ms. Corey stopped looking when she saw the "use by" date on the mysterious refried beans. Finding of Fact 4.161. One can only conclude that (1) the Department investigators did not care whether there actually was adequate food to feed the residents and (2) that they were looking only for potential violations, no matter what the actual facts. As other witnesses testified, there was always adequate food for the people, and even family members enjoyed partaking of it.

II. CONCLUSION OF LAW

The Department challenges every Conclusion of Law but 5.1. It claims that the ALJ misapplied the law to facts. She did not.

III. THE DEPARTMENT FAILED TO CARRY ITS BURDEN OF PROOF

The Department commences its discussion with its main complaint which is its claim that the Licensee was "overcapacity." The Department contends that the residents of House No. 1 are residents of House No. 2. The Department is wrong as a matter of law.

The Department's Petition ignores the Findings of Fact 4.21-4.28, which describes the residents and other attributes of House No. 1. All of the residents at House No. 1 are capable of working and getting around the community by themselves. [RESIDENT 7] and [RESIDENT 8], two of those residents, work five days per week. Finding of Fact 4.21. On Saturdays, three of the House No. 1 residents, [RESIDENT 8], [RESIDENT 7] and [RESIDENT 9], might go to a movie. [RESIDENT 5] would ask if he can visit House No. 2. [RESIDENT 5] enjoys going to House No. 2 to have [RESIDENT 6] help him write. As the ALJ summarized in Conclusion 5.15,

> The residents of House No. 1 are high-functioning adults with developmental disabilities. Undisputed evidence

> establishes that they are mobile and that many have jobs, take quasi-public transportation, participate in activities through [ORGANIZATION] and have independent social lives that include activities such as going to movies and eating meals in restaurant, all without supervision or case aides.

The ALJ concluded that they were visitors and therefore not residents. There is no evidence that the House No. 1 residents ever lived at House No. 2, or that any stayed overnight at House No. 2, except during the flood when the Department approved moving residents from House No. 1 over to House No. 2 on at temporary basis.

The Department repeatedly claims that House No. 2 was “overcapacity,” without the regulation thoroughly to determine what they require. There is no dispute that the license for House No. 2 was for six residents, which is the maximum capacity under law.

There is no evidence that any number of residents greater than six ever lived at House No. 2. The Department contends that because of residents of House No. 1 would come over and visit with friends or check in with [APPELLANT] before going off on one of their ventures, this makes House No. 2 overcapacity. It does not.

A. License Capacity Claim

The Department addresses its claims about overcapacity commencing on page 5 of its memorandum. Though this is the cornerstone of its revocation action, it fails to discuss some of the most important aspects of license capacity, including the very regulation that says what is license capacity, WAC 388-76-10030. It also asserts that “six adults is a limit on “the amount of people that an adult family home can serve .... “ (Brief, page 3). This is not what the rules describe.

License capacity is defined in WAC 388-76-10030, which provides:

> (1) The Department will only issue an adult family home license for more than one but not more than six <u>residents</u>
> (2) In determining the home’s capacity, the Department must consider the:
>   (a) structural design of the house;
>   (b) number and qualifications of staff
>   (c) total number of <u>people living in the home</u> who require personal or special care, including:
>   (i) Children; and
>   (ii) other household members;

(d) The number of people for whom the home provides adult

day care; and

(e) The ability for the home to safely evacuate all people living in the home.

(Emphasis added.) License capacity is for residents in the home that are people other than staff, that is, those that are living in the home and receiving care. Prior to these proceedings the Department determined under this standard that 6 residents was the licensed capacity of the [FACILITY 2] home.

The term "resident" is defined in WAC 388-76-1000 to mean "any adult unrelated to the provider who lives in the adult family home and who is in need of care and for decision-making purposes, the term "resident" includes the resident's surrogate decision-maker following state law or at the resident's request." In short, the license capacity means not more than six persons living in the home, that is, residents at the home, who receive care. It does not include people who live elsewhere and happen to visit at the adult family home.

It is undisputed that [FACILITY 1] holds a license for six residents. The Department determined the factors in WAC 388-76-10030, including sub-section 2(d) and issued the license for the maximum number of 6. It has already had to consider in issuing the license the fact of people from House Two coming over, if there was in fact "adult day care" to be given to them. We submit that the House One residents did not receive adult day care, because they were independent, choosing where they wanted to go and merely visiting or hanging out at House Two. It is also undisputed that at no time did more than six people receiving care live in the home. The license capacity was never exceeded, nor could it.

[FACILITY 1] was set up so that only six persons could live in the home. However, it is undisputed that it is a large home designed specifically for the purpose of care in an adult family home. That includes visitors.

Residents at [FACILITY 2] would come across the street and visit with residents at [FACILITY 1]. The residents of each House were two different kinds of resident populations, with the Appellant's population being quite elderly and in need of geriatric care, and the people from House One being highly functional developmentally disabled persons. [APPELLANT] testified that House One residents came to House Two because they wanted to visit with people across the street, or if she happened to be over at House Two, they would check in with her before going on to other places. In each case, it was their choice.[15]

[15] Though both [FORMER MANAGER 1] and [CAREGIVER 1] testified, neither corroborated the alleged

There is no evidence that [APPELLANT] ever forced them to come across the street, despite the not credible testimony from former employees, [FORMER MANAGER 1] and [CAREGIVER 1]. Neither of them testified that they were at House One and in a position to make any judgments about the circumstances under which the House One residents decided to come over to visit across the street. [MANAGER 1], the then current residential care manager, testified to the voluntary nature of the visits, when he said that one of the residents at House One ([RESIDENT 5]) was very unhappy because [MANAGER 1] would not let him come in and visit at House Two following the Department's actions in this case. In summary, the Appellant honored the resident rights of House One residents and allowed them to come over and visit with their friends across the street, at least until prevented from doing so by the Department.

This does not make the House One residents also residents at House Two. There is no testimony that any House One resident spent the night at House Two, except during the period of time during the floods and when the combination of the two homes was sanctioned by the Department. Because there were no more than six residents at any time, the rules were completely met, as written. There is no evidence that the House One residents got any care other than getting meals at times, that is a factor that the Department had to take into account in issuing a license for six residents at [FACILITY 1]. We submit that getting meals or snacks, which is simply a part of basic hospitality, and interacting with the residents, as the [FACILITY 2] visitors did, is no different from when the family members came in.

Accordingly, the ALJ must determine that the Appellant never exceeded its license capacity, and it has never refused to comply with the regulations, nor failed with respect to WAC 388-76-10030.

Judge Lim summed up the discussion succinctly:

> I conclude that the residents of House No. 1 were visitors at House No. 2. The residents of House No. 1 lived across the street and were able to independently go to House No. 2, or any place else they chose. They were not driven to House No. 2 and left there with no way to return home or to go to another location of their choosing. Although the residents of House No. 1 have care needs, the caregivers at House No. 2 have no more responsible for them than they do the other persons who regularly come into contact with House No. 1

---

statement attributed to one of them that two [FACILITY 1] residents had been at [FACILITY 2] since 7 a.m. The [FACILITY 1] residents do not get up that early, much less go visiting. This is another of the inaccuracies and uncorroborated statements in the Statement of Deficiencies.

> residents during the course of their lives: coworkers, bus drivers, movie theatre attendants, food servers in restaurants. Nor do the caregivers at House No. 2 have any more responsibility to House No. 1 residents as visitors than they would to any other House No. 2 visitor-for example, if a resident's family member had a heart attack, or choked on a piece of food.

Because the residents of House No. 1 did not live at House No. 2 and were capable of independently going any place they chose as determined by Judge Lim, the Department's conclusions of overcapacity are simply wrong. The contentions must be rejected, and no remedy under WAC 388-70-10960 is available to be applied to justify revocation of the Appellant's license.

B. Resident Care Manager.

The Department claims that the licensee failed to have a resident care manager. Actually, this is not consistent with the facts. It is undisputed that [FORMER MANAGER 1], who was the resident manager in October 2009, quit and would not agree to stay at the home until the licensee could get a replacement manager for her. It is also undisputed that the licenses appointed [MANAGER 1] to be a backup resident care manager before [FORMER MANAGER 1] quit, in case the wage negotiations with [FORMER MANAGER 1] were to be unsuccessful. However, [MANAGER 1] needed to take some courses, but they were not immediately available. He arranged to take all of the necessary courses at one time during the first week of November 2009, the first availability. He successfully completed all of them and was certified as a resident care manager on November 7, 2009.

The Department urges a reading of WAC 388-76-10036(2) to say that when an event occurs outside the control of the licensee, such as the resident care manager quitting or dying, a violation of the regulation occurs and the licensee can lose its licensee.

The ALJ applied normal rules of statutory construction to hold that the regulation must be read in a sensible manner so as to avoid absurd results. The Department, on the other hand, urges that there is "no exception to this rule" (Petition, page 9).

Of course, the Department ignores its own reading of the rules to be flexible in the face of events out of the control of the licensee. For example, when floods occurred in [LOCATION 2] and flooded House One, the Department allowed 12 residents to be at House No. 2, because House No. 1 was uninhabitable. The Department does not explain why

using good sense to make sure that residents get care given emergent circumstances in the one instance justifies an exception to the rule but it urges no exception as the resident care manager, when events outside the control of the licensee have occurred.

The ALJ properly rejected the Department's position, because it "would bring about the type of strained or absurd result that the rules of statutory interpretation are meant to prevent." (Initial Order, page 66) The ALJ properly determined that the rule could not be interpreted to require a licensee to shut down its facility and kick out its residents in lieu of having its license revoked, which then results in the same shut down and removal of the residents. The rule is designed to have somebody in charge, and the Licensee did everything she could to make sure that the resident care manager was in place as soon as possible after [FORMER MANAGER 1] quit. There was no violation, and the interpretation of the rule by the ALJ is sensible, reasonable and consistent with the purposes of the licensing laws and regulations.

C. [CAREGIVER 1]'s CPR Card.

The Department characterizes this claim as a failure of the licensee to have qualified staff. It involves whether [CAREGIVER 1] had a valid and current CPR card and first aid training. As Judge Lim found, [CAREGIVER 1] had a valid CPR card at the time of her hire in May 2009, although [APPELLANT] was unable to obtain a copy of it (Initial Decision, page 67) When [CAREGIVER 1] was hired at House No. 2, [APPELLANT] asked her if she had a CPR card. Finding of Fact 4.104. [CAREGIVER 1] told her that it had been stolen when her purse was stolen in 2008 and she did not know the expiration date. She backed up the statement with a copy of the police report documenting that the purse was stolen.

[APPELLANT] attempted to get a copy of [CAREGIVER 1]'s CPR card. She eventually was successful, but when she did, she learned that it had expired in September 2009. The problem was that [CAREGIVER 1] did not take the classes to renew the CPR card. Finding of Fact 4.105.

WAC 388-76-10135 requires that the adult family home ensure that each caregiver has a current valid first aid and cardiopulmonary resuscitation card of certificate. The ALJ properly found that there was no violation of the regulation because [APPELLANT] verbally ensured that [CAREGIVER 1] had a current CPR card at the time of her hire in May 2009 and the rule does not say how the adult family home must ensure that the caregiver has a valid card. The ALJ also noted that WAC 380-112-0260(3)(b) puts the burden on caregivers to obtain and maintain a valid CPR and first aid card of certificate. Accordingly, there was no violation of either rule by the

licensee.

D. [RESIDENT 1]'s Assessment.

[RESIDENT 1] was already discharged from the hospital, and his [RELATIVE 5] needed to find a place for him in a hurry at the time she followed up on the initial inquiry to Home Two. She testified that she no longer could care for him. She sought to have him admitted to [FACILITY 1] late on a Friday afternoon. [MANAGER 1] and [APPELLANT], an LPN, were at the Home when the admission was sought. He attempted to get an assessment by David Robinson around 5:00 p.m. on that Friday. Finding of Fact 4.143. As the ALJ found, *id.,* Mr. Robinson was unable to do it because of the short notice and because it was so close to the weekend, but "he felt that House Two was adequate for [RESIDENT 1]'s needs." Mr. Robinson did the full assessment on Monday morning with the assessment results as expected. *Id* [MANAGER 1] testified, and the ALJ found, that [MANAGER 1] believed that [RESIDENT 1]'s situation was an emergency because [RESIDENT 1]' s [RELATIVE 5], who had been his care provider, was unable to continue doing so. [RESIDENT 1] had nowhere else to go.

WAC 388-76-10330 and 388-76-0395 allow admission of residents without an assessment in cases of genuine emergency. [MANAGER 1] believed that there was an emergency, as did [APPELLANT]. They felt that his life, health and safety were at risk because he would become homeless upon discharge from the hospital. Judge Lim properly credited [APPELLANT]'s belief as reasonably believed that [RESIDENT 1]'s admission was a "true emergency"." (Decision, page 68) Accordingly, there was no violation of the rule.

E. Medication Labels

This section of the Department's Petition for Review cites no regulation for its contentions. In conclusion, 5.11, page 74 of the Initial Decision, the ALJ finds that there was no violation of WAC 388-76-10480, because [APPELLANT] was in the process of organizing labels for [RESIDENT 1]'s medication organizer and that the labels had been printed but not stuck on. [CAREGIVER 1] testified that she verified every medication for [RESIDENT 1] from the original bottles, before giving them to him. As Judge Lim rules, properly, "the evidence in this case shows that [APPELLANT] was in the process of complying with this rule, so there has been no violation." Initial Decision, page 74.

F. Visibility of Inspection Report

WAC 388-76-10585 requires that the adult family home post a notice in a

visible location in the home indicating the Inspection Report is available for review. Conclusion 5.13 holds that there was a notice, it was in the office, and that is a part of the overall open floor plan of House No, 2, and the office is a visible location. Judge Lim properly applied the wording of the rule which requires that the notice be in a visible location. The bulletin board is in a visible location, and there is no violation of the rule.

G. Expired Food

Judge Lim quickly dealt with the contentions of the Department regarding food, because she determined that, "testimony in this case showed that there was ample food for both regular and emergency supplies in House No. 2 and also in House No. 1. There was emergency food at House No. 1 and at House No. 2, but the state investigator, Ms. Corey, did not look in the hallway cabinets, nor all of the kitchen cabinets. Consequently, she did not see much food. Initial Order, page 73. There was no evidence that any resident did not have his or her dietary needs met or that the ample food supplies would not last for a minimum of 72 hours for each resident. The big issue seemed to be the expiration date on the mystery refried beans, which was never served to any resident, nor brought by [MANAGER 1] or [APPELLANT], and vegenaise is non-perishable. Consequently, there was no spoiled food that could even begin to be an issue in this case. There was no violation of WAC 388-76-10840.

H. Emergency Lighting

The applicable regulation, WAC 388-76-10740, which provides that the adult family home must provide emergency lighting, such as working flashlights for staff and residents that are readily accessible. The Department contended that only one flashlight was working.

Judge Lim held that flashlights were only one example of emergency lighting, and headlights on [APPELLANT]'s car could also have been used as emergency lighting. However, the evidence also was that there were two other flashlights, one a rechargeable plugged into the wall (apparently not working at the time) and another with regular batteries and spares available. Testimony of [MANAGER 1]. Accordingly, there were flashlights, the plural of the word being the point of the Department's complaint. There were flashlights (plural), and the one that happened to be dead could be made working by changing the batteries, which were readily available in the office drawer. Plus, there was an alternative, the headlights of the [APPELLANT'S] car, to be used as emergency lighting if necessary. There was no violation of the regulation.

I. Negotiated Care Plans

In Finding of Fact 4.223 Judge Lim resolved conflicting evidence in the record from Ms. Corey and [APPELLANT] regarding the presence or absence of negotiated care plans for the residents of House 2. (Initial Order, p. 63) She did this by crediting the testimony of [FORMER MANAGER 1], who testified to having filled out the care plans before she left on October 23, 2009, roughly a week before the survey that led to the Department's findings. In addition, the Department witnesses admitted that Exhibit 16 contained negotiated care plans. In summary, the negotiated care plans were created before [FORMER MANAGER 1] left employment at [FACILITY 2], and the fact that Ms. Corey did not make copies of them or look at them is her own fault. [MANAGER 1] offered them to her. In Finding of Fact 4.223 Judge Lim found that there were current negotiated care plans for [RESIDENT 4], [RESIDENT 10], [RESIDENT 3], [RESIDENT 6], and [RESIDENT 2] in November 2009. [T]his was consistent with the testimony and Exhibit 16.

The Department's assertions about the care plans on page 14 of its Petition for Review have been resolved against the Department. There were negotiated care plans, and the fact that the investigator, Candace Corey, did not look at them "reflects more poorly on the Department than it does on [APPELLANT]." (Initial Order, p. 64.)

The Department also asserts that [RESIDENT 2]'s care plan did not document a swallowing problem. [RESIDENT 2]'s [RELATIVE 2], who visited him regularly, did not observe any swallowing problem at the time of the survey, though he had been observed by staff occasionally coughing while eating. See FF 4.73. The negotiated care plan documents that he could have an occasional swallowing problem if he ate too fast. FF 4.74; Ex. 6, p. 24.. The Department is wrong in its challenge.

J. Care and Services

In Conclusion 5.8, Initial Order page 70, the ALJ sets forth the relevant regulation related to three alleged violations related to care and services, WAC 388-76-10400. In summary, this regulation requires that the adult family home provide necessary care and services to help the resident reach the highest level of physical, mental and psycho-social well being consistent with resident choice, current functional status and potential for improvement or decline. Three allegations are raised, first with regard to [RESIDENT 3]'s dental care, second as to [RESIDENT 2]'s blood glucose testing, and third as to an alleged swallowing problem of resident [RESIDENT 1]. We deal with each in order, as did the ALJ on pages 70-71 of the Initial Decision.

1. <u>[RESIDENT 3]'s Dental Care</u>

The ALJ found no violation of WAC 388-76-10400 because [RESIDENT 3], who is in her [AGE 1], had a gradual decline in dental care and then suffered a setback, largely because of her weakness for sweet snacks, which her [RELATIVE 4] would bring to her and leave for her to eat at night. [RESIDENT 3] was also uncooperative with the caregivers' efforts to brush her teeth before the October 2009 checkup. [CAREGIVER 1] testified that [RESIDENT 3] threw and broke her toothbrush twice, as well as inflicting wounds and scars on [CAREGIVER 1] in her violent refusals. When she refused the offered dental care by throwing her toothbrush, rejecting help from [CAREGIVER 1] and eating sweets, she made choices about how she wanted to live her life. The regulation requires that the caregiver provide the care as necessary, but it must also be consistent with resident choice.

As Judge Lim noted, there is no evidence that caregivers did not provide dental care to [RESIDENT 3], or at least try to provide dental care to her. Thus, the Department has not demonstrated that the short-term decline in her dental condition was due to anything other than her own choices and uncooperativeness in her daily care. Certainly, the testimony of her dentist laid no blame on the facility at all for her conditions. There was no violation of WAC 388-76-10400.

2. <u>[RESIDENT 2]'s Blood Glucose Testing</u>

As noted on page 71 of the Initial Decision, [RESIDENT 2]'s blood sugar was to be checked on a rotating basis once a day, with breakfast being on the first day, lunch on the second day, and dinner on the third day, according to the negotiated care plan dated October 5, 2009. As noted above, there was conflicting evidence concerning <u>when</u> [APPELLANT] intervened to make sure that [RESIDENT 2] got his glucose tested before his lunch on the day the investigators were present. Judge Lim resolved this conflict in Conclusion 5.8 in favor of the testimony of [MANAGER 1] that [APPELLANT] intervened and did the blood glucose monitoring before [RESIDENT 2] began eating. The Review Judge should give deference to this determination of credibility, because Judge Lim was present at the hearing and able to observe the demeanor of the witnesses. The ALJ also found that there is no evidence of what is a normal range for [RESIDENT 2], though there was some testimony concerning his blood glucose levels being much higher than a normal person's because of his diabetes. Nevertheless, because of the good diet at [FACILITY 2], [RESIDENT 2] was able to be taken off insulin in early October 2009. There was no violation of this regulation.

3. <u>[RESIDENT 1]'s Alleged Swallowing Problems</u>

As found on page 71 of the Initial Order, the Department offered no

evidence for its conclusion that [RESIDENT 1] had a swallowing problem. [RESIDENT 1] was at the end of his life, as his [RELATIVE 5] testified, and he did refuse to eat. Thus, the ALJ properly found that the Department failed to prove that (a) [RESIDENT 1] actually had a swallowing problem and (b) that his refusal to eat was due to anything other than his own choice. Therefore, there was no violation of WAC 388-76-10400.

4. Resident Medications

The Petition for Review speaks generally to medications without reference to the actual allegations. Judge Lim on page 72 considered and rejected the three actual citations against the licensee.

The first citation had to do with [RESIDENT 4] not receiving hydrocodone for pain. However, [RESIDENT 4] was not prescribed hydrocodone. Accordingly, there was no violation.

The second such citation had to do with resident [RESIDENT 10] not being offered Ativan, a strong anti-anxiety medication. Again, [RESIDENT 10] was not prescribed Ativan, so there was no violation of the rule.

Finally, the Department alleged that [RESIDENT 1], did not get pain medications when [APPELLANT] was not available. The record is clear that [APPELLANT] did control access to pain medications that were narcotics, as she is required to do. Moreover, [CAREGIVER 1] testified that she provided diclofenac to [RESIDENT 1] for pain and that it was effective. She also said that [RESIDENT 1] did not need Vicodin, which is a narcotic. Accordingly, there was no violation of the rule, WAC 388-76-10400.

K. Activities

The Department's citations (allegations) for activities are quoted on pages 19-20 of the Initial Decision. [MANAGER 1] testified that to the extent that they were able to engage in the activities that they liked, [RESIDENTS 1, 4, 10, 3, 6, 2] did do them at House Two. The testimony about each of the residents at House Two is summarized in Findings of Fact 4.29 through 4.116. The allegation that all the provider did was offer bingo to the residents and having them socialize with residents from House One is incorrect. [MANAGER 1] testified to music, TV, [RESIDENT 6] interacting with [RESIDENT 5] and helping with writing, which she liked to do, and other activities consistent with the geriatric nature of the residents of House Two.

Conclusion 5.12 summarizes the evidence and the failure of the

Department to prove that the residents did not exercise the choices that they wanted, such as sleeping in a recliner ([RESIDENT 4]), going to a medical appointment and sitting in the front room while waiting to do so, commencing work on a puzzle and visiting with one's [RELATIVE 4]. Similarly, the conclusion on the top of page 76 of the Initial Order that the provider would not have both music going and the TV on is not a violation of the rules. The Department simply failed to carry its burden of proof with regard to its allegations concerning activities.

L. Failure to Understand

The Petition for Review sounds like a quote directly from the Statement of Deficiencies ("based on observation, interview and record review"). The allegations in this section of the Department's petition are based upon their previous allegations, which they failed to prove. Moreover, the ALJ in Conclusion of Law 5.3 held:

> Contrary to the Department's assertions, [APPELLANT] has amply demonstrated an understanding of all of these requirements by making great efforts to comply, or in fact by complying with all of them, as discussed below [later in the Initial Order].

Contrary to the assertion on page 19 of the Petition, her license was not being revoked by the Department because of an alleged "failure to understand and carry out ... obligations." The only reason given for the exercise of imposition of the revocation remedy was WAC 388-76-1096(16). Exhibit D-l. The regulation was cited only in connection with the alleged "overcapacity." The Department's contentions in this regard have been rejected by the ALJ and must be rejected by the Review Judge.

Furthermore, there is no evidence whatsoever of a "diminished quality of life" for the residents. To the contrary, the family members have testified uniformly to the good care, good food, and the superior quality of care compared to other settings. See Findings of Fact 4.65, 4.66, 4.67, 4.68, and 4.69, 4.84, for example. The residents were happy at House Two. Moreover, the family members uniformly testified to the good care given to their resident.

M. Minimum Licensing Requirements

In its Statement of Deficiencies and Revocation Letter, Exhibits D-1 and D-2, the Department did not cite WAC 388-76-10945 or WAC 388-76-10940 [mis-cited as 1040 on page 20 of the Department's petition]. As noted above, it cited WAC 388-76-10960(16) as the authority for imposing the revocation of license remedy. This was in connection solely with the

alleged overcapacity, which Judge Lim has rejected and this Reviewing Judge must reject as well. There was no serious risk to any resident, as is amply demonstrated in this record. The Department's reviewing officials went along with and based their revocation order on mistakes made by the investigators, and those mistakes cannot act as a basis for revocation of the appellant's license. We submit that the testimony of Ms. Hildreth and Ms. Corey about how they tried to find a lesser way to deal with the "over capacity" issue, by imposition of a condition, is clear evidence that the Licensee knows what to do and that license revocation is unjustified.

CONCLUSION

The ALJ properly reversed the license revocation order, because the cited basis for the revocation ("overcapacity") was not established and could not be established, because residents from House No. 1 were visitors at House No. 2. They were not residents, and it is uncontested that the number of actual residents at the home at any given time was only six or less. Accordingly, the licensed capacity of six was not exceeded, and no violation occurred.

Judge Lim properly rejected the allegations as being unfounded, because the Department failed to carry its burden of proof. She did not apply the proper standard of clear, cogent and convincing evidence as the burden of proof because she did not have to. The Department failed to carry its burden of proof even if the standard was a preponderance of the evidence.

[FACILITY 1] is a high quality, outstanding example of the best in adult family homes. [APPELLANT] cares for the residents at both of her houses, and they in turn care for her. As she testified, the House One residents treat her as their surrogate [RELATIVE 1]. The support of the families at the hearing and testimony of the good care to their loved ones is convincing that the Department has erred in issuing its revocation order. When residents no longer are fearful or shaking, as they were at other settings, or they can be taken off insulin because of the strict control on diet, this is good care. As Mr. Robinson, the person who did the assessments of the facility testified, House Two was home-like and nurturing. This is precisely what this entire state needs in long term care.

House Two has continued in operation with no problems since the draconian revocation. It must be allowed to continue to serve these elderly (up to [AGE 2]) residents and others in the community who want to come there.

Accordingly, the petition must be rejected and the initial decision affirmed.

II. FINDINGS OF FACT

To determine the adequacy and appropriateness of the ALJ's Findings of Fact in this matter and to make any necessary modifications to those findings, the undersigned reviewed the entire record of the hearing, including written transcripts, the documents admitted as exhibits, both parties' closing briefs and the Department's closing reply brief, the *Initial Order*, the Department's petition for review of the *Initial Order*, and the Appellant's response to the Department's petition. No ruling by the ALJ on the admissibility of proferred evidence is overruled or altered unless that is made explicit in this *Review Decision and Final Order.*

Some of the Findings of Facts from the *Initial Order* have been deleted, others modified, some added, and the order of many of them rearranged by chronology or by issue rather than by witness in this *Review Decision and Final Order*. These changes were made because many of the Findings of Fact in the *Initial Order* were merely recitations of each witness's testimony or the residents' assessments and care plans; were not supported by a preponderance of the evidence; or contradicted each other with no credibility determinations to indicate which of the contrary findings were relied upon to reach the initial decision. Where the evidence presented by the parties conflicted on certain points, the undersigned made detailed credibility findings that were not included in the *Initial Order*.

The Findings of Fact made herein are based upon a careful consideration of the record, including the demeanor and motivations of the witnesses as observed and recognized by the ALJ and the undersigned, respectively; the reasonableness of the testimony and exhibits; the amount of time that has elapsed between when any particular incident occurred and when various individuals provided statements or

evidence about that incident; and the totality of the evidence presented. Findings consistent with the testimony or exhibits of a particular witness or party indicate that the undersigned has found that evidence to be more credible than any contrary evidence unless otherwise noted.

The undersigned has determined the following facts are more probable than not, necessary, relevant, and supported by substantial evidence in the record:

Background

1. The Appellant, who is a licensed practical nurse (L.P.N.), owns and operates [FACILITY 1 & 2], which are AFHs in [COUNTY], Washington.[16] At issue in this matter is the Department's decision to stop placement and revoke the AFH license ([NUMBER], effective September 20, 2006) for [FACILITY 2] (hereinafter referred to as House 2), located at [ADDRESS 1], Washington.[17] [FACILITY 1] (hereinafter referred to as House 1), the license for which was issued in 2002, is an AFH located across the street from House 2; the full-time residents of House 1 are often at House 2.[18] Although the Department has also issued citations related to operations at House 1, they are not the focus of this particular matter.[19] The Appellant has other properties in [LOCATION 2], but it appears from the record that these are not AFHs.[20]

2. The AFH license for House 2 is to provide "…**24**-hour care for no more than **6** adults."[21]

3. House 2 is a large, two-story home.[22] It was built as a duplex so it has a

[16] Testimony of the Appellant.
[17] Department's exhibit 4.
[18] Testimony of the Appellant and testimony of [FORMER MANAGER 1].
[19] Statement of the Department's attorney during direct examination of Donna Andrews-Dennehy.
[20] Testimony of [MANAGER 1].
[21] Department's exhibit 4 (bolded emphasis in original).
[22] Testimony of [CAREGIVER 1], Candace Corey, [FORMER MANAGER 1], [CAREGIVER 2], and

left and a right side that are mirror images of one another, with no dividing wall between the two halves of the duplex, and there are two front entrances.[23] These front entrances open into a large living room that flows into a dining room, where there is also a double rear entrance to the house.[24] The living and dining rooms are large, open areas that constitute the middle or center section of House 2.[25] The dining room faces into the living room, backs up to the rear entrance, and is flanked on its left and right sides by the kitchen and the office, respectively.[26] In addition to staircases on both sides of the living room to allow access to the second-level, the living room has hallways off each side that lead to three bedrooms and bathrooms on the left and right sides of the house, respectively.[27]

4. The upstairs living space in this two-level home is believed to have a similar floor plan with six private bedrooms, for a total of 12 bedrooms in House 2.[28] The Appellant's living quarters are located on the second floor of House 2 and she keeps the residents' narcotic and anti-anxiety medications locked in a room up there or in her purse.[29]

5. There are closets in the first-floor hallways at House 2 where some emergency food and water may be stored.[30] Some emergency food is also stored in the

---

[MANAGER 1].

[23] Testimony of Candace Corey.

[24] *Id.*, Department's exhibit 2 at 14, and testimony of [MANAGER 1].

[25] Testimony of Candace Corey and Department's exhibit 2 at 14.

[26] Testimony of Candace Corey.

[27] Testimony of Candace Corey and Department's exhibit 2 at 14.

[28] Testimony of Candace Corey.

[29] Testimony of [CAREGIVER 1], [FORMER MANAGER 1], and [MANAGER 1]. *See also* Department's exhibit 2 at 9 (noting that "…if a resident wanted or needed a narcotic or anti-anxiety medication [the caregiver] had to call the provider on her cell phone and have the provider bring the medications to the home").

[30] Testimony of [MANAGER 1].

kitchen in a cabinet above the refrigerator.[31] There is no basement or garage at House 2.[32] House 1 has a garage where potatoes and onions are stored.[33] House 1 also has a bedroom that has been converted into a storeroom of food for both House 1 and House 2 residents.[34]

Residents

6. The full-time residents of House 2 on November 2, 2009, and November 13, 2009—the dates of the complaint investigation and full licensing inspection upon which the Department's actions were based—were [RESIDENT 4], [RESIDENT 10], [RESIDENT 3], [RESIDENT 6], [RESIDENT 2], and [RESIDENT 1].[35] These residents are referred to as Residents #1 through #6, respectively, in the Department's Statement of Deficiencies.[36] They all had some form of dementia and were generally frail and elderly.[37] All required 24-hour care and had high care needs.[38]

7. The full-time residents of House 1 in late-2009 included [RESIDENT 7], [RESIDENT 8], [RESIDENT 9], [RESIDENT 5], and [RESIDENT 11].[39] They all had developmental disabilities and were generally less frail and higher functioning than the House 2 residents.[40] However, all required 24-hour care and at least four of the House 1 residents had behaviors or care needs requiring a heightened level of supervision or

[31] *Id.*
[32] *Id.*
[33] *Id.*
[34] *Id. See also* testimony of [CAREGIVER 1], Candace Corey, [FORMER MANAGER 1], [CAREGIVER 2], and Pam Hildreth.
[35] Testimony of Candace Corey.
[36] Department's exhibit 2.
[37] Testimony of Donna Andrews-Dennehy.
[38] Testimony of [CAREGIVER 1], [FORMER MANAGER 1], [CAREGIVER 2], [MANAGER 1], and the Appellant. *See also* Appellant's exhibit 16.
[39] *Id.*
[40] *Id.*

assistance.[41]

8. An individual named [FORMER RESIDENT 1], who was once a full-time resident at House 2 for approximately one year from 2007 to 2008, but who now lives with his [RELATIVE 2], periodically returns to either House 1 or House 2 for a few days or weeks at a time for respite care.[42] [FORMER RESIDENT 1] requires 24-hour care.[43]

9. As a result of severe flooding in [COUNTY] during late 2007, the residents of both House 1 and House 2 at that time[44] were evacuated to a shelter.[45] They lived at the shelter together for approximately four days.[46] House 1 was flooded with four feet of water and was uninhabitable for at least three weeks.[47] During this time, the residents of House 1 stayed at House 2 with the House 2 residents.[48] The Department was aware of the situation and granted a temporary exception to the capacity limit at House 2 due to the emergency conditions.[49] However, the Department increased its monitoring of House 2 and was in constant communication with the Appellant, who kept the Department apprised of the progress on the House 1 repairs.[50] In addition, there were two caregivers, as well as the Appellant, present at all times to provide care and

---

[41] *Id.* (noting that [RESIDENT 11] tended to wander off and to become sexually aroused when he touched women's hair or the hair of animals and had to be redirected; [RESIDENT 5] had incontinence issues, was very hard of hearing, and had also developed dementia; [RESIDENT 9] had a seizure disorder; and [RESIDENT 7], who is married to [RESIDENT 8], was mute). *See also* the testimony of Paul Tosch (noting that because the residents of House 1 "…were assigned to… a licensed adult family home and being paid by the State, the assumption would be that they needed care") and the testimony of the Appellant (conveying her understanding that a caregiver had to be present at House 1 if any of the residents were there).
[42] Testimony of [FORMER RESIDENT 1'S RELATIVE].
[43] *Id.*
[44] [FORMER RESIDENT 1] was a resident of House 1 in 2007, but [RESIDENT 9] was not. Testimony of [FORMER RESIDENT 1'S RELATIVE] and Donna Andrews-Dennehy. [RESIDENT 1] did not become a resident of House 2 until late 2009. Testimony of David Robinson, [FRIEND 2], and the Appellant.
[45] Testimony of the Appellant and Pam Hildreth.
[46] Testimony of the Appellant.
[47] *Id.*
[48] Testimony of the Appellant and Pam Hildreth.
[49] *Id. See also* the testimony of [MANAGER 1].
[50] *Id.*

supervision for the residents of both House 1 and House 2 while they were all staying at House 2.[51]

Staff

10. The Appellant was the resident manager (RM) at House 1 at the time of the investigation and either she or [APPELLANT'S RELATIVE 1], was the RM at the time of the hearing in this matter.[52] [FORMER MANAGER 1] was the House 2 RM until October 23, 2009.[53] [MANAGER 1] reportedly completed the training necessary to be the RM at House 2 on November 7, 2009.[54] There was no RM at House 2 when the investigation began, but [MANAGER 1] was the House 2 RM at the time of the hearing.[55]

11. The caregivers at House 1 were the Appellant and [APPELLANT'S RELATIVE 1].[56] [APPELLANT'S RELATIVE 1] lives at House 1 and is scheduled to provide 24/7 care and supervision to the residents.[57] The Appellant noted in her testimony that House 1 "is the place to… relax" because the acuity of care is very low.[58] If [APPELLANT'S RELATIVE 1] needs time off, the Appellant generally covers her shift.[59]

12. The caregivers at House 2 at various times during the fall of 2009 were [FORMER MANAGER 1], [CAREGIVER 1], [CAREGIVER 3], [MANAGER 1], the

---

[51] Testimony of the Appellant.
[52] *Id. See also* Department's exhibit 2 at 3.
[53] Testimony of the Appellant, [MANAGER 1], and [FORMER MANAGER 1].
[54] Testimony of [MANAGER 1] and Appellant's exhibits 1-23 (Manager Mental Health Specialty Training) and 1-24 (Manager Dementia Specialty Training). [MANAGER 1] successfully completed the 48-hour Administrator Training on January 11, 2009. *See* Appellant's exhibit 1-22.
[55] Department's exhibit 2 at 2-3; testimony of Candace Corey; testimony of the Appellant; and testimony of [MANAGER 1].
[56] Testimony of the Appellant.
[57] *Id.*
[58] *Id.*
[59] *Id.*

Appellant, and [CAREGIVER 2].[60]

13. [MANAGER 1] was not a formal, paid caregiver at House 2 until October 6, 2009, when he agreed to take the necessary classes to become the RM at House 2.[61] However, he did not complete the required training and thus did not have the qualifications to be the House 2 RM until November 7, 2009.[62] He also owned an automotive repair business, which was his primary source of income, and performed work on the Appellant's rental homes.[63] Prior to October 2009, [MANAGER 1] helped remodel and construct Houses 1 and 2, respectively, and provided assistance to the Appellant with residents at House 2 when needed.[64] He was a nursing assistant registered (NAR) and had advanced first aid and advanced emergency care basic life support certification as well because he was also a volunteer fireman.[65] [MANAGER 1] and the Appellant have had a personal relationship and he referred in his testimony to House 2 as "home."[66]

14. [FORMER MANAGER 1], [CAREGIVER 1], and [CAREGIVER 4] are no longer employed by the Appellant.[67]

15. [FORMER MANAGER 1], a NAR with about eight years of experience as a caregiver, worked at House 2 from July 11, 2006, through October 23, 2009.[68] She served as the RM at House 2 for approximately her last year there and worked the

---

[60] Testimony of [FORMER MANAGER 1], [CAREGIVER 1], [CAREGIVER 2], [MANAGER 1], and the Appellant.
[61] Testimony of [MANAGER 1].
[62] *Id. See also* the Appellant's exhibits 1-15 through 1-25.
[63] Testimony of [MANAGER 1].
[64] *Id.*
[65] *Id. See also* the Appellant's exhibits 1-16, 1-18, 1-25
[66] *Id.* (testifying that their relationship is currently "…strictly employee-employer…," but also noting earlier in his testimony that he received a telephone call from the Appellant on November 2, 2009, when the investigator as at House 2, and that she "…needed me to come *home*…").
[67] Testimony of [FORMER MANAGER 1], [CAREGIVER 1], [CAREGIVER 2], and [MANAGER 1].
[68] Testimony of [FORMER MANAGER 1].

weekday shift of 7:30am until between 3 p.m. and 5 p.m., sometimes later and sometimes on Saturdays.[69] She asked the Appellant in late September or early October 2009 to increase her hourly wage from $11 to $14.[70] On October 6, 2009—shortly after the Appellant refused to grant her the raise she requested—[FORMER MANAGER 1] gave the Appellant more than two weeks' notice of her resignation to take another, lower-paying job.[71] She resigned because caring for both the House 1 and House 2 residents, cooking for all of them, and doing the laundry for both homes made it very difficult for her to give the House 2 residents all the attention she felt they required.[72] She also did not like to see [RESIDENT 10], one of the House 2 residents, in pain due to the inaccessibility of her pain medication.[73] [FORMER MANAGER 1] was highly praised and well-thought of by the Appellant, the Appellant's assessor, and family of the residents in her role as the RM at House 2.[74]

16. [CAREGIVER 1], a NAR, began her employment at House 2 in May 2009 and left in January 2010.[75] She worked the weekend day shift, 7:30 a.m. to about 4 p.m. on Saturdays and 7:30 a.m. until 2 p.m. on Sundays.[76] After [FORMER MANAGER 1] resigned in October 2009, [CAREGIVER 1] also helped the Appellant fill in with the

---

[69] *Id.*
[70] Testimony of [FORMER MANAGER 1], the Appellant, and [MANAGER 1].
[71] *Id.*
[72] Testimony of [FORMER MANAGER 1].
[73] *Id. See also* the testimony of [CAREGIVER 1] (stating that [RESIDENT 10] would wince and cry from the pain, but that [CAREGIVER 1] could not give her pain medications because the Appellant was not there and [CAREGIVER 1] did not have access to [RESIDENT 10]'s prescribed medication that the Appellant kept locked away in her room upstairs) and [MANAGER 1] (stating that the Appellant keeps the residents' narcotics in a locked room upstairs).
[74] Testimony of the Appellant (noting that she was an "excellent worker"), David Robinson (stating that she was "very affectionate" with the residents and "…was exemplary"), and [RESIDENT 2'S RELATIVE] (marveling over how a woman of her small stature could do the necessary lifting and transfer of clients by herself).
[75] Testimony of [CAREGIVER 1].
[76] *Id.* (explaining that Saturdays were normally long shifts because those were the Appellant's "…worship days, so she [the Appellant] liked to take that day off and go to church and relax and have, you know, time for herself").

weekday day shift, working until about 1 p.m. each day.[77] [CAREGIVER 1] left House 2 because her [RELATIVE 1] was very ill and she suspected she was pregnant and would be unable to perform the heavy lifting required with one of the House 2 residents.[78] It was also a very busy work environment.[79] Although [MANAGER 1] speculated in his testimony that [CAREGIVER 1] may have resigned for other reasons, the Appellant testified that [CAREGIVER 1] was very experienced, quick, and competent.[80]

17. [CAREGIVER 4], a Certified Nursing Assistant (CNA) with training in dementia and mental health issues, started as a caregiver at House 2 on November 16, 2009, and left in January 2010.[81] She worked the day shift of 7:30 a.m. to 5 p.m. each weekday.[82] [CAREGIVER 4]'s reported reason for resigning was her observation of a heated argument between the Appellant and [MANAGER 1] that [CAREGIVER 4] felt the Appellant was later dishonest about.[83] This argument incident was reportedly investigated by Ms. Corey and no deficiency was found.[84] [CAREGIVER 4] also stated that "…there wasn't enough staff available to do everything that needed to be done."[85]

18. There is generally one caregiver per shift in each of the Appellant's adult family homes.[86] In addition to providing general care and assistance, toileting, bathing, feeding, dental care, dressing, and supervision of the residents during each of their shifts, [FORMER MANAGER 1], [CAREGIVER 1], and [CAREGIVER 4] were each individually charged with sweeping, mopping, polishing the floors, and otherwise

---

[77] *Id.*
[78] *Id.*
[79] *Id.*
[80] Testimony of [MANAGER 1] and of the Appellant.
[81] Testimony of [CAREGIVER 2].
[82] *Id.*
[83] *Id.*
[84] Testimony of the Appellant.
[85] Testimony of [CAREGIVER 2].
[86] Testimony of [FORMER MANAGER 1], [CAREGIVER 1], [CAREGIVER 2], and the Appellant.

cleaning House 2 (including the upstairs area); doing laundry for both House 1 and House 2; occasionally engaging the residents in activities; baking cakes for the Appellant to take with her to church; and preparing home-cooked meals from scratch.[87] Meal preparation was sometimes done by these caregivers not only for the full-time residents of House 2, but also for their family members and for the full-time residents from House 1.[88]

19. In the Department's Statement of Deficiencies, [CAREGIVER 1] is Caregiver #1, [CAREGIVER 3] is Caregiver #2, [APPELLANT'S RELATIVE 1] is Caregiver #3, and [MANAGER 1] is Caregiver #4.[89]

Complaints and Past Violations

20. Four complaints from more than one individual were made to the Department's Complaint Resolution Unit (CRU) telephone call center about House 2 in the fall of 2009.[90] These complaints necessitated the investigation of 16 to 20 issues, including medications, care and services, staffing, capacity, and food.[91] Although the identities of the complainants who made the reports are confidential pursuant to RCW 74.39A.060(6), the Department's investigator, Candace Corey,[92] volunteered that she did not speak with [FORMER MANAGER 1], the former RM at House 2, as part of the complaint investigation and that none of the information included in the Department's

---

[87] Testimony of [FORMER MANAGER 1], [CAREGIVER 1], and [CAREGIVER 2]. *See also* the testimony of Paul Tosch and Candace Corey.
[88] *Id. See also* the testimony of [RESIDENT 2'S RELATIVE] and [FORMER RESIDENT 1'S RELATIVE].
[89] Department's exhibit 2.
[90] Testimony of Candace Corey.
[91] *Id.*
[92] Ms. Corey holds a B.S.N. and has been a registered nurse for 33 years. Testimony of Candace Corey. Prior to joining the Department as an investigator in 2000, she had worked at the Department of Corrections since 1981. *Id.*

Statement of Deficiencies came from [FORMER MANAGER 1].[93] Ms. Corey also noted that none of the persons referenced near the end of the Statement of Deficiencies "…who wish to remain anonymous…" and who provided information about their observations of House 2 were caregivers in House 2.[94]

21. The regional long-term care ombudsman, Paul Tosch, also received three complaints about House 2 in October 2009.[95] Although records kept by the long-term care ombudsman are generally confidential per WAC 365-18-110(1), Mr. Tosch was required by order of the ALJ and permitted by the State ombudsman to respond to questioning by the Appellant's attorney that these complaints were made by a beautician who did the hair of one of the House 2 residents, [CAREGIVER 1], and [FORMER MANAGER 1].[96] These complaints centered largely on the overcrowding/under-staffing at House 2 when individuals from House 1 were sent to House 2.[97]

22. Ms. Corey did five or six previous complaint investigations at House 2 over the years.[98] One such investigation in November 2007 resulted from a complaint about food at House 2.[99] During that investigation, the amount of unusable food, including food that was expired, food in cans that were rusted or dented, and improperly preserved food, that was found by the investigator and may have been served to the residents filled 11 garbage bags.[100] A citation was issued to the Appellant for this

---

[93] *Id.*
[94] Testimony of Candace Corey and Department's exhibit 2 at 15-16.
[95] Testimony of Paul Tosch.
[96] *Id.*
[97] *Id.*
[98] Testimony of Candace Corey.
[99] *Id.*
[100] *Id.*

violation in February 2008.[101] Citations were also previously issued to the Appellant, on February 1, 2008, and December 1, 2008, for failure of the Appellant to ensure the (1) residents had meaningful activities available to them and (2) caregivers had valid CPR/first-aid training, respectively.[102]

Investigation, Licensing Inspection, and Ombudsman Visit

23. On November 2, 2009, Ms. Corey went to House 2 in response to the four complaints received by the CRU in the fall of 2009.[103] She arrived at 1:30 or 2 p.m.[104] Ms. Corey saw one unsupervised caregiver, six House 2 residents, and two other people she later learned were full-time residents of House 1 who had been at House 2 since 7 a.m.[105] The TV was on, but no other activities were observed during the entire time Ms. Corey was there.[106] Some of the House 2 residents were eating snacks and one was in a wheelchair.[107] The Appellant was not at House 2 when Ms. Corey arrived, but the caregiver called her and the Appellant arrived about 30 to 40 minutes later.[108] Around 3 p.m., two more residents of House 1 arrived and another House 1 resident arrived around 3:30 or 4:00 p.m.[109] The Appellant could not send the House 1 residents back to their own home because there was no caregiver at House 1.[110] [MANAGER 1] arrived at approximately 5:30 p.m., left with the House 1 residents at about 6 p.m., and

---

[101] *Id.* and Department's exhibit 2 at 11.
[102] Department's exhibit 2 at 4 and at 13.
[103] Testimony of Candace Corey.
[104] *Id.*
[105] *Id.* and Department's exhibit 2 at 15. The Appellant's representative noted in footnote 14 of his response to the Department's petition for review of the *Initial Order* that the House 1 residents do not wake up by 7 a.m., much less go visiting, but there was no evidence to this effect in the hearing record.
[106] Testimony of Candace Corey and Department's exhibit 2 at 13.
[107] Testimony of Candace Corey.
[108] Department's exhibit 2 at 4.
[109] *Id.* at 2.
[110] Testimony of [MANAGER 1] and Department's exhibit 2 at 15 (noting that the Appellant told Ms. Corey that [APPELLANT'S RELATIVE 1] and [MANAGER 1] were in training classes in [LOCATION 1]).

took them over to [APPELLANT'S RELATIVE 1] at House 1.[111] Ms. Corey left House 2 sometime between 7 p.m. and 7:50 p.m.[112]

24. [CAREGIVER 1], who did not have current CPR certification, was the caregiver during the time between when Ms. Corey arrived on November 2, 2009, until 3:30 or 3:45 p.m. that day.[113] Ms. Corey observed her responding to residents, providing snacks, starting dinner, sweeping, mopping the floor, cleaning, doing dishes, and preparing the supper meal.[114] [CAREGIVER 3] was the caregiver who came on shift at 3 p.m.[115] Ms. Corey observed her continuing to make dinner and taking residents to the toilet.[116] [CAREGIVER 3] said that she was a brand-new caregiver.[117] The Appellant told Ms. Corey that it was [CAREGIVER 3]'s "…second day on the job and she was in training."[118]

25. Ms. Corey was unable to finish her investigation during the five to six hours that she was at House 2 on November 2, 2009.[119] Upon returning to the office, Ms. Corey conferred with her supervisor, Pam Hildreth,[120] who directed Ms. Corey to return to House 2 to complete her investigation and that a full licensing inspection

---

[111] *Id.* at 15.
[112] *Id.* at 13 and testimony of Candace Corey.
[113] *Id.*
[114] Department's exhibit 2 at 12 and testimony of Candace Corey.
[115] *Id.*
[116] *Id.*
[117] *Id.* [FORMER MANAGER 1] provided training to [CAREGIVER 3] on October 23, 2009, [FORMER MANAGER 1]'s last day at House 2. Testimony of [FORMER MANAGER 1].
[118] Department's exhibit 2 at 6.
[119] Testimony of Candace Corey and Department's exhibit 2 at 13.
[120] Ms. Hildreth is a Region 6 Field Manager for the Residential Care Services division of ADSA, who is responsible for AFH and boarding home licensing and complaint investigation as well as nursing home surveys and investigations. Testimony of Pam Hildreth. She is a registered nurse (R.N.), has a Master's degree in clinical medical/surgical nursing, and has roughly 40 years experience as a nurse. *Id.* Prior to assuming her current position with the Department in December 1999, she was a member of the Army Nurse Corps for 28 years in various nursing and supervisory roles. *Id.*

should also be done at that time.[121] A full licensing visit was called for because many of the issues Ms. Corey discovered during her November 2, 2009, visit to House 2 related to the minimum licensing requirements.[122]

26. On November 3, 2009, the Appellant called Ms. Corey to report that [CAREGIVER 1]'s first-aid and CPR card had been included in her purse when it was stolen in October 2008 and that the card had expired in September 2009.[123] The Appellant stated that [CAREGIVER 1] would get this training as soon as possible.[124] The Appellant also faxed a copy of [RESIDENT 3]'s assessment to Ms. Corey on November 3, 2009.[125]

27. According to the Department's Statement of Deficiencies, Ms. Corey was informed by a family member of "Resident #1" ([RESIDENT 4]) on November 9, 2009, that "…her [RELATIVE 1] used Hydrocodone on and off for chronic pain her entire life stemming from a diagnosis of [CONDITION 1] the resident had as a child."[126] This family member told Ms. Corey that she was not aware that the Appellant "…kept the pain medication separate from regular medications and caregivers had to call the provider[127] to access the medications."[128] The undersigned finds that Ms. Corey was actually referring to Resident #2 ([RESIDENT 10]) and [RESIDENT 10'S RELATIVE 1] when she referenced Resident #1 and her [RELATIVE 3] on the bottom of page 9 and

---

[121] *Id.* and testimony of Pam Hildreth.
[122] Testimony of Pam Hildreth.
[123] Department's exhibit 2 at 4, Appellant's exhibits 1-11 through 1-13, and testimony of [CAREGIVER 1].
[124] *Id. See also* Appellant's exhibit 1-30.
[125] Department's exhibit 6 and testimony of Candace Corey.
[126] Department's exhibit 2 at 9.
[127] The term "provider" is defined in WAC 388-76-10000 as "(1) [a]ny person who is licensed to operate an adult family home and meets the requirements of this chapter; or (2) [a]ny corporation, partnership, or limited liability company that is licensed under this chapter to operate an adult family home and meets the requirements of this chapter." Any use of this term in this *Review Decision and Final Order* refers to the Appellant.
[128] *Id.* at 10.

the top of page 10 in the Department's Statement of Deficiency.[129] This is because the information included in the Department's document is strikingly similar to testimony offered by [RESIDENT 10'S RELATIVE 1] at the hearing, there was no testimony or other evidence offered at the hearing that members of [RESIDENT 4]'s family had been contacted during the Department's investigation, and [RESIDENT 4]'s assessment and care plans[130] do not include hydrocodone whereas [RESIDENT 10]'s do.[131]

28. As part of her investigation, Ms. Corey also spoke with a collateral contact on November 9, 2009, who "…did not feel there were adequate activities for residents…," that they "…were not stimulated either mentally or socially at the adult family home…," and that "…there were not enough caregivers in the home to be actively involved in the residents' social wellbeing."[132]

29. On November 13, 2009, Ms. Corey returned to House 2 with Cheryl Everett, an adult family home licensor/surveyor for the Department, for four hours.[133] Ms. Everett has been a licensor for the Department since 1987 and holds a Bachelor's degree in sociology and psychology, but she is not the regular licensor of House 2.[134] Ms. Everett issued some of the citations related to minimum licensing requirements that are included in the Department's Statement of Deficiencies, including the citations regarding House 2's insufficient food supply and quality, improper posting of the inspection report, and lack of emergency lighting because there was only one working

[129] Department's exhibit 2 at 9-10.
[130] Appellant's exhibits 16-189 through 16-233, particularly 16-190, 16-191, 16-207, and 16-208.
[131] Appellant's exhibits 16-142 through 16-188, particularly 16-144 and 16-163.
[132] Department's exhibit 2 at 13.
[133] Testimony of Candace Corey and testimony of Cheryl Everett.
[134] Testimony of Cheryl Everett. Donna Andrews-Dennehy, another AFH licensor/surveyor for the Department, testified that House 2 is on her caseload.

flashlight.[135]

30. During her investigation visit on November 13, 2009, Ms. Corey observed the residents eating a meal at the dining room table that was served by [CAREGIVER 3].[136] [RESIDENT 2] started eating his meal before the Appellant reminded [CAREGIVER 3] that his blood glucose level needed to be measured prior to his meal.[137] Measuring blood glucose levels after one has eaten will result in inaccurate monitoring.[138] Other issues observed by Ms. Corey during this meal included [RESIDENT 1]'s coughing and difficulty with swallowing the food he was offered as well as [RESIDENT 2]'s unsupervised coughing while he was eating alone in the living room.[139]

31. After reviewing medication logs and the residents' medication organizer kits during her November 2, 2009, visit, Ms. Corey also reviewed the residents' assessments on November 13, 2009, and noted that three residents had been prescribed PRN (as needed) pain medications and anti-anxiety medication that were not readily available.[140] In the Department's Statement of Deficiencies and her testimony at the hearing, Ms. Corey again apparently confused Resident #1 ([RESIDENT 4]) with Resident #2 ([RESIDENT 10]), stating that "…Resident #2 took Ativan for anxiety."[141] In fact, it was [RESIDENT 4] who was prescribed Ativan/lorazepam for anxiety and

[135] *Id.* and Department's exhibit 2.
[136] Testimony of Candace Corey.
[137] *Id. See also* Department's exhibit 2 at 8.
[138] Testimony of Candace Corey and Department's exhibit 2 at 8.
[139] *Id. See also* Department's exhibit 2 at 6.
[140] Testimony of Candace Corey and Department's exhibit 2 at 9-10.
[141] *Id. See also* testimony of [RESIDENT 10'S RELATIVE 2] and the pharmacist who supplied House 2 with medications for the residents there, stating that he believed [RESIDENT 10] suffered from anxiety and was on Ativan.

[RESIDENT 10] who was prescribed Vicodin/hydrocodone for pain.[142] Nonetheless, neither medication was accessible to either resident when the Appellant was not home because they were locked in the Appellant's room upstairs or in her purse.[143] A collateral contact with whom Ms. Corey spoke as part of her investigation stated that the Appellant "…was frequently away from the home on Saturdays for more than 6 hours."[144]

32. On November 13, 2009, Ms. Corey was informed by anonymous persons that "…five residents from the other adult family home were at the adult family home every Saturday from 9:30AM until approximately 3PM while the provider was at church and shopping."[145] Ms. Corey was also told by an anonymous person during her investigation that "…it was annoying to their family members when the additional residents came to the home."[146]

33. In response to the complaints he received on October 16, 2009, and November 9, 2009, Mr. Tosch visited House 2 on Saturday, November 21, 2009.[147] He arrived around noon and stayed for about 30 minutes.[148] There were eight residents in House 2 during that time: the six full-time residents of House 2, two of whom were in

---

[142] Appellant's exhibits 16-144, 12-163, 16-191, and 16-208. *See also* testimony of [MANAGER 1].
[143] Department's exhibit 2 at 9; testimony of Candace Corey; testimony of [CAREGIVER 1]; testimony of [FORMER MANAGER 1]; testimony of [MANAGER 1]; and testimony of the Appellant. The Appellant also admitted to Ms. Corey that she kept the narcotic and anti-anxiety medications separate from the other medications, explaining that she had a narcotics log that the Appellant could not later produce. *See* Department's exhibit 2 at 10 and testimony of Candace Corey. *But cf.* Department's exhibit 5 at 1, in which the Appellant stated that the pain relief and anxiety medications were removed from use until they could be refilled because they were expired.
[144] Department's exhibit 2 at 10.
[145] *Id.* at 16.
[146] *Id.* at 15.
[147] Testimony of Paul Tosch. *See also* Department's exhibit 2 at 16 (Candace Corey identified the anonymous visitor to House 2 on November 24, 2009, who is referenced on page 16 of the Department's exhibit 2, as Mr. Tosch).
[148] Testimony of Paul Tosch.

their bedrooms sleeping, and two full-time residents of House 1.[149] The one caregiver on duty, [CAREGIVER 1], informed Mr. Tosch that two other House 1 residents had just left for a short walk and that she was uncomfortable caring for “that many” people.[150] Mr. Tosch observed [CAREGIVER 1] feeding one resident at the table, but this was interrupted at least three times when [CAREGIVER 1] had to “walk fast” and “with concern” and in a “helter skelter” manner to get from the table to the sofa in order to persuade a female resident of House 2 to sit down again because she kept trying to get up after [CAREGIVER 1] had led her from the table to the couch.[151] During his time there, Mr. Tosch observed one House 1 resident completing a crossword puzzle, but he did not observe any other activities.[152] He also spoke with the two House 1 residents present, noting that the one doing the crossword puzzle was “talkative.”[153] This House 1 resident said they [the House 1 residents] came over to House 2 “…all the time” and that there were times when they did not like coming over.[154]

34. On November 22, 2009, the Appellant called Mr. Tosch about his visit the day before.[155] The Appellant explained that the reason why House 1 residents had been at House 2 was because they were waiting for their bus and could not stay at House 1 because there was no caregiver there.[156] Neither [CAREGIVER 1] nor the House 1 residents with whom Mr. Tosch had spoken told him that they were at House 2 waiting to be picked up by their bus.[157] [MANAGER 1] called Mr. Tosch shortly after Mr. Tosch’s

---

[149] *Id.*
[150] *Id. See also* Department’s exhibit 2 at 16
[151] *Id.*
[152] Testimony of Paul Tosch.
[153] *Id.*
[154] *Id.*
[155] *Id.*
[156] *Id.*
[157] *Id.*

telephone conversation with the Appellant, identified himself as the new RM, and stated that he knew there were problems at House 2 but that he was going to ensure they did not happen again.[158]

35. [RESIDENT 1] was sent to the hospital on November 24, 2009.[159] He "…presented to the emergency room with a two day history of fatigue, weakness, shortness of breath, delirium, agitation and poor oral intake."[160] He was diagnosed with aspiration pneumonia and sepsis.[161] According to the ED physician notes, the caregiver said he was agitated and had struck staff twice that day.[162] [RESIDENT 1] did not return to the AFH and he died on December 1, 2009.[163]

36. On December 2, 2009, the Appellant informed Ms. Corey, as part of the latter's investigation, that [RESIDENT 3] was capable of brushing her own teeth and that she was cooperative about doing so.[164] The Appellant said caregivers had been doing the same thing regarding [RESIDENT 3]'s dental care as they had done since she was admitted to the AFH in 2007.[165] The Appellant blamed [RESIDENT 3]'s dental issues on the sweets that [RESIDENT 3]'s [RELATIVE 4] brought to her.[166]

37. On Saturday, December 5, 2009, Mr. Tosch again visited House 2.[167] This second visit was "to see how things were going."[168]

38. As part of her investigation, Ms. Corey contacted [RESIDENT 3]'s dentist

---

[158] *Id.*
[159] Department's exhibit 2 at 9. See also Department's exhibits 9 through 11.
[160] Department's exhibit 2 at 9 and Department's exhibit 9 a 1.
[161] *Id.*
[162] Department's exhibit 10 at 1.
[163] Department's exhibit 2 at 9 and Department's exhibit 12.
[164] Department's exhibit 2 at 7. *See also* testimony of Candace Corey.
[165] *Id.*
[166] *Id.*
[167] Testimony of Paul Tosch.
[168] *Id.*

on

December 7, 2009.[169] She spoke with [DOCTOR 1], who had been [RESIDENT 3]'s dentist since 2002, and also reviewed copies of [RESIDENT 3]'s dental records.[170] Ms. Corey learned that [RESIDENT 3]'s oral health had steadily deteriorated since 2007, when she first came to the Appellant's AFH, and that she could no longer brush her own teeth.[171] Following her regularly scheduled dental cleaning appointment in October 2009, [DOCTOR 1] wrote a letter to the Appellant stating that, based on the condition of [RESIDENT 3]'s teeth, it appeared that they were not being brushed and requesting that they be brushed twice per day.[172] By the time [RESIDENT 3] was next seen by [DOCTOR 1] in April 2010, he observed that her home care had noticeably improved although there was still moderate to heavy plaque.[173]

39. On December 8, 2009, Ms. Corey returned to House 2 for a complaint investigation visit and spoke with the Appellant about [RESIDENT 1]'s condition when he was taken to the hospital on November 24, 2009.[174] Ms. Corey was not aware at that time that [RESIDENT 1] had died on December 1, 2009, and it is not clear if the Appellant provided her with this information when Ms. Corey asked about [RESIDENT 1] during her visit on December 8, 2009.[175] The Appellant stated that [RESIDENT 1] "…had a trace of pneumonia, was fine in the morning and combative in the afternoon" when he left House 2 on November 24, 2009.[176] The Appellant told Ms. Corey "[h]is

[169] Department's exhibit 2 at 7 and testimony of Candace Corey.
[170] *Id. See also* Department's exhibits 7 and 8.
[171] Department's exhibit 2 at 7 and testimony of Candace Corey.
[172] Department's exhibit 7 and testimony of [DOCTOR 1].
[173] Testimony of [DOCTOR 1].
[174] Department's exhibit 2 at 9 and testimony of Candace Corey.
[175] Testimony of Candace Corey.
[176] *Id.* and Department's exhibit 2 at 9.

behavior changed from morning to afternoon."[177]

40. On December 9, 2009, Ms. Corey spoke with [RESIDENT 3]'s [RELATIVE 4].[178] He stated that although he no longer brought sweets to her, it was "…not unusual…" for [RESIDENT 3] to eat sweets at House 2 and that the two cans of Ensure given to her daily by her caregivers also contain a great deal of sugar.[179]

41. Upon conclusion of the investigation and inspection of House 2, Ms. Hildreth objectively reviewed Ms. Corey's draft of all the deficiencies cited and the rules violated and discussed Ms. Corey's and Ms. Everett's findings and observations with them.[180] These discussions focused on the overcapacity issue and [CAREGIVER 1]'s unsupervised care of AFH residents, especially so many of them, without CPR certification.[181] Not only were there concerns associated with having too many residents requiring care and services in an AFH with only one caregiver present, but requiring House 1 residents to go to House 2 and prohibiting them from returning to their own home because there was no caregiver at House 1 also impinged on their right to choose where they wanted to be.[182]

42. Ms. Corey and Ms. Hildreth explored the remedy options available for the cited violations and Ms. Hildreth's ultimate recommendation from the field was stop placement and revocation as the most appropriate remedies.[183] Ms. Hildreth, Ms. Corey, and Ms. Everett all acknowledged at the hearing that the Appellant's cited deficiencies with regard to the insufficient and expired food, inadequate emergency

---

[177] *Id.*
[178] Department's exhibit 2 at 8.
[179] *Id.*
[180] Testimony of Pam Hildreth and testimony of Candace Corey.
[181] *Id.*
[182] *Id.*
[183] *Id.*

lighting, or failure to properly post notice of the inspection reports likely would not have, in isolation, resulted in revocation of her AFH license, unless these violations were recurrent.[184] However, they also explained that these deficient practices informed the decision of whether to pursue enforcement or not because they were "…taken as part of the whole."[185] These types of violations reinforced the Department's finding that the Appellant was unable to meet or pay attention to minimum licensing requirements.[186] When combined together with the other cited violations, the food, emergency lighting, and notice violations provided an "…overview of the operation of the home and how the residents are cared for that would support revocation."[187]

43. Ms. Hildreth explained at the hearing that the array of Department enforcement options include consultations, plans of correction, limited civil fines, imposition of reasonable conditions, stop placement, revocation, and summary suspension.[188] She and Ms. Corey discussed possible conditions on the Appellant's AFH license at House 2, specifically to address the overcapacity issue, but requirements already mandated by statute or regulation cannot be imposed as conditions.[189] For example, because the Appellant is already required by law to limit the capacity of her AFH to no more than six residents and to have a qualified caregiver,[190] the Department could not condition the Appellant's license at House 2 on satisfying

[184] Testimony of Pam Hildreth; testimony of Candace Corey; and testimony of Cheryl Everett. Both Ms. Corey and Ms. Everett testified that the Appellant had previously been issued a Department citation for expired food thus making this a recurrent violation.
[185] Testimony of Pam Hildreth. *See also* testimony of Candace Corey and Cheryl Everett.
[186] *Id.*
[187] Testimony of Candace Corey.
[188] Testimony of Pam Hildreth. *See also* testimony of Candace Corey.
[189] *Id.*
[190] *See* RCW 70.128.010(1); RCW 70. 128.130(1); WAC 388-76-10015(1); and WAC 388-76-10135.

these requirements.[191] Examples given by Ms. Corey of appropriate conditions imposed in other situations included requiring a provider to hire a registered nurse, to take classes, or to re-take training.[192]

44. Conditions must be both measurable and enforceable.[193] As a result, the ability to compel consistent compliance and enforce a condition must be taken into consideration when deciding if imposition of conditions is an appropriate remedy for violation of the regulatory requirements.[194] In this case, Ms. Corey and Ms. Hildreth tried to craft a licensing condition for the Appellant to address the issue created by the difference between the number of residents allowed to be in House 2 and the number observed there, but they could not come up with one that would not require the Department to do "…pre-staffing monitoring visits…" and inspect House 2 at "…all hours of the day and night and every weekend to make sure that there was compliance with the condition."[195] Ms. Hildreth pointed out that the Department once tried to impose a condition on another AFH to prohibit a resident's family member who was a felon from being in the home, but it was "impossible" to monitor and ultimately led to revocation of that provider's AFH license.[196] Visitor logs to monitor compliance are "…only as good as people filling the logs" and determining the accuracy of the logs is dependent on residents who may not have good recall, particularly the residents at House 2 who all have dementia.[197] Ms. Hildreth did not know of other methods of monitoring visitors at

---

[191] Testimony of Pam Hildreth. *See also* testimony of Candace Corey.
[192] Testimony of Candace Corey.
[193] *Id.*
[194] Testimony of Pam Hildreth and testimony of Candace Corey.
[195] *Id.*
[196] Testimony of Pam Hildreth.
[197] *Id.*

House 2 that would be any more reliable.[198] Consequently, she determined there was no enforcement option other than revocation that would compel compliance.[199]

45. After putting forth her recommendation for revocation and stop placement, this matter was sent to Janice Schurman, a compliance specialist with RCS.[200] Ms. Schurman reviewed the evidence to determine whether it supported the field's recommendation, if the findings matched the citations, and whether the enforcement action was consistent with statewide application of the law in similar situations.[201] The matter was then sent to the RCS Assistant Director, Lori Melchiori, who also reviewed it for statewide consistency and to ensure the revocation recommendation was supported.[202] Upon approval by Ms. Melchiori, notice was received by the field that the recommendation was upheld.[203]

<u>Cited Violations</u>

46. The Department issued a Stop Placement of Admissions and Revocation of License notice to the Appellant on December 16, 2009, which incorporated by reference the Department's Statement of Deficiencies, completed on December 9, 2009.[204] The Stop Placement order was imposed immediately, pending any appeal.[205] The Notice and the Statement of Deficiencies cited a number of violations of the AFH licensing regulations under Chapter 388-76 WAC.[206] Pam Hildreth personally hand-

---

[198] *Id.*
[199] *Id.* and testimony of Candace Corey.
[200] *Id.*
[201] *Id.*
[202] Testimony of Pam Hildreth. *See also* Department's exhibit 1.
[203] *Id.*
[204] Department's exhibits 1 and 2.
[205] Department's exhibit 1 at 4.
[206] Department's exhibits 1 and 2.

delivered these two documents to the Appellant, who signed for them.[207] Ms. Hildreth explained their contents, including the Appellant's due process rights, to the Appellant and [MANAGER 1].[208] Each of the cited violations described in the Department's notice documents are summarized below, along with any additional[209] testimony or other evidence presented at the hearing related to each violation that the undersigned found credible and relevant.

Overcapacity

47. The Department cited the Appellant for exceeding the licensed capacity of her AFH and placing the House 2 residents "…at risk of not having their care needs met and affected the residents' quality of life and safety."[210]

48. On November 2, 2009, there were eight AFH residents at House 2, two of whom were House 1 residents who had been there for many hours, and only one caregiver, [CAREGIVER 1], with many housekeeping duties.[211] Throughout the day, three additional residents from House 1 came to House 2, for a total of 11 residents, and [CAREGIVER 1] was relieved by [CAREGIVER 3], a new, inexperienced caregiver.[212] The Appellant was also at House 2 for a portion of the day, but her attention was focused on the investigator rather than assisting the sole caregiver with the residents.[213] During this time, the caregiver needed additional help from the Appellant, who interrupted her discussions with Ms. Corey to provide assistance.[214]

---

[207] Testimony of Pam Hildreth. Ms. Hildreth also provided copies of the notice documents to the family members of the House 2 residents.
[208] *Id.*
[209] In addition to the credible testimony and evidence already described in the foregoing Findings of Fact.
[210] Department's exhibit 2 at 15.
[211] *Id. See also* testimony of [CAREGIVER 1] and testimony of Candace Corey.
[212] *Id.*
[213] *Id.*
[214] *Id.*

49. During shifts when [FORMER MANAGER 1] was the only caregiver at House 2, the Appellant regularly sent residents from House 1 over to House 2 once or twice per week and then not at all for a couple weeks.[215] Although some of the House 1 residents worked, at least one or two House One residents usually went over to House 2 and sometimes all six were at House 2.[216] Sometimes the House 1 residents stopped briefly at House 2 to check in with the Appellant, sometimes they were there for an hour to an hour and a half until [APPELLANT'S RELATIVE 1] returned, and sometimes they were there much longer.[217] [FORMER MANAGER 1] cooked for these residents and occasionally helped them with toileting.[218] When both homes were full, [FORMER MANAGER 1] sometimes cared for all 12 residents at a time.[219]

50. Starting with [CAREGIVER 1]'s second weekend of work at House 2, the Appellant asked [CAREGIVER 1] whether it would be okay if some House 1 residents went over to House 2 while [CAREGIVER 1] was the only caregiver there.[220] From that point forward, the residents of House 1 were sent over to House 2 on Saturdays while the Appellant, [MANAGER 1], and [APPELLANT'S RELATIVE 1] went to church.[221] The most AFH residents [CAREGIVER 1] cared for at House 2 was 11, but more often it was a total of nine residents: six from House 2 and three from House 1 (i.e., [RESIDENT 11], [RESIDENT 5], and [RESIDENT 9]).[222] She would fix them meals and provide them with snacks.[223] [CAREGIVER 1] informed Mr. Tosch that she felt residents were "definitely"

---

[215] Testimony of [FORMER MANAGER 1].
[216] *Id.*
[217] *Id.*
[218] *Id.*
[219] *Id.*
[220] Testimony of [CAREGIVER 1].
[221] *Id.*
[222] *Id.*
[223] *Id.*

being neglected because of the overcrowding at House 2 when the House 1 residents were also there.[224]

51. During the week, the Appellant sent the House 1 residents to House 2 for respite time for [APPELLANT'S RELATIVE 1], or when [APPELLANT'S RELATIVE 1] had a medical appointment.[225] The Appellant would call [FORMER MANAGER 1] to let her know that she and [APPELLANT'S RELATIVE 1] were leaving and that the House 1 residents were on their way over to House 2.[226] The Appellant also told [FORMER MANAGER 1] to meet House 1 residents when they got off the [BUS].[227]

52. [FORMER MANAGER 1] told the Appellant that it was difficult to take care of House 2 residents and do the rest of her work when the House 1 residents were sent to House 2.[228] Sometimes [FORMER MANAGER 1] told the Appellant that she could not take care of House 1 residents, especially on Mondays, which were laundry days when [FORMER MANAGER 1] was doing the laundry for both House 1 and House 2.[229]

53. [FORMER MANAGER 1] had difficulty meeting the care and household needs of the House 2 residents when the House 1 residents were at House 2. She not only sometimes showered House 1 residents when they were at House 2 and washed the hair of a House 1 resident, but [RESIDENT 11], a House 1 resident, would also get into the drawers of the office at House 2 and had to be redirected to color pictures in one of the upstairs bedrooms of House 2.[230] In addition, [RESIDENT 11] would try to

[224] Testimony of Paul Tosch.
[225] Testimony of [FORMER MANAGER 1].
[226] *Id.*
[227] *Id.*
[228] *Id.*
[229] *Id.*
[230] *Id.*

leave House 2 to go back to House 1, but [FORMER MANAGER 1] could not let him do that because there was no caregiver at House 1.[231] She would sometimes have to leave the House 2 residents and go outside to bring [RESIDENT 11] back to House 2.[232] In addition to [RESIDENT 11]'s wandering and behavioral issues, other House 1 residents also had to be fed, cared for, and supervised while they were at House 2.[233] [RESIDENT 9] had a seizure disorder and [RESIDENT 5] had incontinence issues as well as a tendency to get angry and take others' things.[234] Although all the residents at House 2 "…had pretty high care needs…"[235] and "needed to be kept a close eye on,"[236] at least two of them, [RESIDENT 3] and [RESIDENT 10], required extra-vigilant supervision because they both had a history of running away from House 2 on their own[237] and also because "[RESIDENT 10] is a stand-by assist at all times…" whenever she was walking, which she sometimes tried to do on her own.[238] [RESIDENT 3] would also misbehave when her [RELATIVE 4] was not with her at House 2 by going through the drawers in the office, ripping up the couch, throwing food across the table at other residents, going into different areas of the house, and hitting or throwing things at her caregiver.[239]

54. [RESIDENT 5], a House 1 resident, told [FORMER MANAGER 1] that he

---

231 *Id.*
232 *Id.*
233 Testimony of [FORMER MANAGER 1] and testimony [CAREGIVER 1].
234 Testimony of [CAREGIVER 1] and testimony of Donna Andrews-Dennehy..
235 Testimony of [CAREGIVER 1].
236 Testimony of [CAREGIVER 2].
237 Appellant's exhibits 16-81 and 16-182; testimony of [RESIDENT 10'S RELATIVE 1]; testimony of [RESIDENT 10'S RELATIVE 2]; Appellant's exhibit 11-1; Department's exhibit 2 at 6; testimony of Donna Andrews-Dennehy; and testimony of Candace Corey.
238 Appellant's exhibits 16-153, 16-170, and 16-172.
239 Testimony of [CAREGIVER 1] and testimony of [CAREGIVER 2].

did not like being sent to House 2 by the Appellant.[240] His books were at House 1 as well as his other possessions and he wanted to be near them and have them accessible when he needed or wanted them.[241] [RESIDENT 5] told Donna Andrews-Dennehy, the regular Department licensor/surveyor for House 1 and House 2, in November 2009 that he liked to go to House 2 and that whoever the caregiver was there would take care of him [242] [RESIDENT 5] also liked to visit with [RESIDENT 6] at House 2, who helped him correct the letters he wrote to his family members, and to talk with [FORMER RESIDENT 1] when he was there.[243] One female resident from House 1 told Mr. Tosch on November 21, 2009, that the House 1 residents sometimes did not want to go to House 2 when they were sent there.[244]

55. [RESIDENT 7] and [RESIDENT 8] told Ms. Andrews-Dennehy that the Appellant and [APPELLANT'S RELATIVE 1] go to church on Saturdays from 10 a.m. to about 1 p.m.[245] [ORGANIZATION], an advocacy organization for people with developmental disabilities, offered activities one Saturday per month from 10:30 a.m. to 4 p.m. as well as vacation/traveling opportunities.[246] [RESIDENT 7] and [RESIDENT 8] regularly participated in [ORGANIZATION] and also sometimes went out into the community on Saturdays, watched a movie, or had a meal.[247] [RESIDENT 9] occasionally went with them or she went with [RESIDENT 5] and [RESIDENT 11] to House 2.[248]

---

[240] Testimony of [FORMER MANAGER 1].
[241] *Id.*
[242] Testimony of Donna Andrews-Dennehy.
[243] Testimony of [MANAGER 1] and testimony the Appellant. *See also* Appellant's exhibit 10-2.
[244] Testimony of Paul Tosch.
[245] Testimony of Donna Andrews-Dennehy.
[246] *Id. See also* testimony of [MANAGER 1] and the Appellant.
[247] *Id.*
[248] *Id. See also* testimony of [CAREGIVER 1].

56. As noted above, Mr. Tosch observed several residents from House 1 at House 2 during his Saturday, November 21, 2010, visit, which he described as somewhat chaotic.[249] He also noted that although some of the House 1 residents may work, this does not necessarily make them "high functioning" because they may still require "full care."[250]

57. Only one resident from House 1 sometimes came to House 2 to visit for about 15 minutes at a time during the two months when [CAREGIVER 4] was employed there for the Monday through Friday day shift from November 16, 2009, though January 2010.[251] House 1 residents are now told that they can no longer go to House 2.[252]

58. Many of the family members and the friend of House 2 residents testified at the hearing that they have seen House 1 residents at House 2.[253] House 1 residents also brought food over to House 2 regularly when the caregiver at House 2 notified the Appellant or the caregiver at House 1 that something was needed.[254] In addition, House 1 residents were picked up by the [BUS] at House 2 until the Department's enforcement action, when [MANAGER 1] instructed the bus driver to "[p]ick them up on the other side

---

[249] Testimony of Paul Tosch and Department's exhibit 2 at 16.
[250] *Id.*
[251] Testimony of [CAREGIVER 2].
[252] Testimony of [MANAGER 1].
[253] Testimony of [RESIDENT 10'S RELATIVE 1] (noting that she visits [RESIDENT 10] at House 2 twice per week and had seen House 1 residents at House 2 for birthday and holiday dinners as well as on the weekends); testimony of [FORMER RESIDENT 1'S RELATIVE] (stating that he stopped at House 2 every day, five days per week, for a full year while [FORMER RESIDENT 1] resided there on a full-time basis and that the residents of House 1 would come over for about an hour between lunch and dinner); testimony of [FRIEND 2] (stating that she visited [RESIDENT 1] nearly every day during the six weeks while he was at House 2 and saw the House 1 residents there "[m]ore than once, definitely") *but cf.* testimony of [RESIDENT 1'S RELATIVE] (testifying that she visited [RESIDENT 1] two to three times per week during the short time that he was at House 2 and never saw residents from House 1 at House 2); [RESIDENT 2'S RELATIVE] (stating that a "Latin-looking, rather swarthy and heavyset" female resident of House 1 came to House 2 when he visited his [RESIDENT 2'S RELATIVE], [RESIDENT 2], five to six times per year, that she would stay for a half hour to an hour, and that she would have dessert); and [FRIEND 1] (stating that she had seen the House 1 residents at House 2 a handful of times during her once to twice weekly visits to [RESIDENT 4] which have since become visits every two weeks or so).
[254] Testimony of [CAREGIVER 1]; testimony of [FORMER MANAGER 1]; testimony of [MANAGER 1]; and testimony of [CAREGIVER 2].

of the street."[255]

59. Following Ms. Andrews-Dennehy's conversations with the House 1 residents in November 2009, she spoke to the Appellant by telephone and was told that the Appellant and [APPELLANT'S RELATIVE 1] alternated going to church on Saturdays and that they would go together only during the holidays.[256] The Appellant and [MANAGER 1] testified to this effect as well.[257] They both also testified that although they attended church together, they did not make House 1 residents go to House 2 when there was no caregiver at House 1.[258] Further, the Appellant told both Ms. Corey, during her investigation on November 2, 2009, and Ms. Hildreth, when she delivered the revocation and stop placement notice on December 16, 2009, that having additional residents at House 2 was an uncommon occurrence and that it happened only because both [MANAGER 1] and [APPELLANT'S RELATIVE 1] were in [LOCATION 1] for training on November 2, 2009.[259] Because the Appellant's testimony and [MANAGER 1]'s testimony are inconsistent with the testimony of others on these points, credibility findings that were not made by the ALJ are required.

60. There was substantial evidence put forth by various individuals that the Appellant was often absent from House 1 and House 2 on Saturdays; that this was the Appellant's day of worship as a [RELIGION MEMBER] and she did attend church with [APPELLANT'S RELATIVE 1] and [MANAGER 1]; that House 1 residents were staying at House 2 on these days; that some House 1 residents did not always like being at House 2 but had no other choice; and that there was no caregiver at House 1 and only

---

[255] Testimony of [MANAGER 1].
[256] Testimony of Donna Andrews-Dennehy.
[257] Testimony of the Appellant and testimony of [MANAGER 1].
[258] *Id.*
[259] Department's exhibit 2 at 15; testimony of Candace Corey; and testimony of Pam Hildreth.

one caregiver at House 2 at these times. The sheer number of people of who provided this information coupled with their overall lack of motivation for fabricating such facts, [260] when weighed against the Appellant's and [MANAGER 1]'s reasons for disputing this information and in light of [MANAGER 1]'s tendency during his testimony to contradict many facts not favorable to the Appellant's case and to change his testimony while testifying, lead the undersigned to conclude that the Appellant's and [MANAGER 1]'s testimony are not credible. They often attended church with [APPELLANT'S RELATIVE 1], the House 1 caregiver, on Saturdays and required some House 1 residents to go to House 2 during this time.

61. Based on the foregoing facts and credibility determinations, the undersigned finds that there was no caregiver at House 1 on most Saturdays and some weekdays on a regular basis. During the House 1 caregiver's absence, some full-time residents of House 1 were required by the Appellant to go to House 2, where there was only one caregiver, and others to go out into the community until a caregiver returned to House 1. This resulted in there frequently being more than six AFH residents requiring care and supervision at House 2 for long periods of time.

Inadequate Care and Services

62. The Department cited the Appellant's AFH for failing to provide necessary care and services to residents or to do so in a way that supported their safety and quality of life.[261] These citations related to [RESIDENT 3]'s oral health; [RESIDENT 2]'s

[260] Although the Appellant's attorney attempted to illustrate that [FORMER MANAGER 1] and [CAREGIVER 1] were disgruntled former employees with an ax to grind against the Appellant, the evidence presented did not support this characterization and also did not explain why House 1 residents, the regional long-term care ombudsman, the beautician complainant, or Department staff would corroborate their testimony.

[261] Department's exhibit 2 at 7-10.

blood glucose levels and monitoring, as well as his need for supervision while eating; the unavailability of PRN medications for [RESIDENT 10], [RESIDENT 4], and [RESIDENT 1]; and [RESIDENT 1]'s swallowing difficulties and his final admission to the hospital with aspiration pneumonia.[262] The Appellant's failure to provide the necessary care and services contributed to [RESIDENT 3]'s poor oral health; may have resulted in inaccurate blood glucose readings to evaluate and appropriately manage [RESIDENT 2]'s diabetes; resulted in [RESIDENT 2]'s physician not being notified about his high and fluctuating blood glucose levels; subjected [RESIDENT 2] to a risk of unsupervised choking; denied [RESIDENT 10], [RESIDENT 4], and [RESIDENT 1] access to their PRN pain and anti-anxiety medications; and prevented [RESIDENT 1] from having a swallowing evaluation completed earlier.

63. As described above, [RESIDENT 3]'s oral health steadily declined from her admission to the AFH in 2007 until late 2009, but had improved by April 28, 2010,[263] from the poor status observed by [DOCTOR 1] in October 2009.[264] Many factors influenced [RESIDENT 3]'s oral health, including her advanced age, lack of saliva, ingestion of sugars and other food that were not cleaned from the teeth, and difficulty with providing adequate self-care when suffering from dementia.[265] [RESIDENT 3]'s [RELATIVE 4] regularly gave her chocolates and ice cream, as did staff at House 2, along with cookies, animal crackers, and hard candies.[266] As noted by Jeannie Johnson, a certified trainer for AFHs and a consultant for AFH providers who are issued

---

[262] *Id.*
[263] Chart notes for this visit, which took place less than one week before the administrative hearing, were not included as an evidentiary exhibit.
[264] *Id.* at 7; testimony of [DOCTOR 1]; testimony of Candace Corey;
[265] Testimony of [DOCTOR 1].
[266] Department's exhibit 2 at 7; testimony of [CAREGIVER 1]; testimony of [CAREGIVER 2]; testimony of [MANAGER 1]; and Appellant's exhibits 4-5 and 11-13.

Statements of Deficiencies, residents have the right to eat sweets but proper dental care must be provided to facilitate that choice.[267] The food and bacteria that cause decay must be removed by brushing, flossing, and rinsing.[268] If a resident is not compliant with brushing his or her own teeth, someone else must brush them.[269]

64. The Appellant told Ms. Corey in November 2009 that [RESIDENT 3] could brush her own teeth, if she was set up and encouraged, and had essentially been doing so since entering the AFH.[270] However, [DOCTOR 1] testified that [RESIDENT 3] was non-cooperative during her teeth cleanings and wrote a letter to the Appellant in October 2009 noting that because [RESIDENT 3] may be "…unable to care for her own teeth," to "[p]lease do whatever can be done to get [RESIDENT 3]'s teeth brushed regularly…"[271] [DOCTOR 1] also pointed out that there were food particles in [RESIDENT 3]'s mouth and teeth during her October 2009 cleaning and "…it appears that no one is brushing her teeth or at least not effectively."[272] In addition, [CAREGIVER 1] and [MANAGER 1] all testified that [RESIDENT 3] was sometimes very uncooperative with brushing her teeth and needed significant assistance.[273] This inconsistency between the Appellant's knowledge and the dentist's and caregivers' observations indicates that the Appellant was not aware that [RESIDENT 3] was not brushing her own teeth on a regular basis and that others were not doing so, either.

65. [CAREGIVER 2], who started working at House 2 on November 16, 2009, and left in January 2010, was able to successfully brush [RESIDENT 3]'s teeth, even

[267] Testimony of Jeannie Johnson.
[268] Testimony of [DOCTOR 1] and Appellant's Exhibit 4 at 1.
[269] *Id.* and Appellant's Exhibit 4 at 2.
[270] Testimony of Candace Corey and Department's exhibit 2 at 7.
[271] Testimony of [DOCTOR 1] and Department's exhibit 7.
[272] *Id.*
[273] Testimony of [CAREGIVER 1] and testimony of [MANAGER 1].

when [RESIDENT 3] was being difficult, by re-approaching her.[274] [RESIDENT 3]'s [RELATIVE 4] felt that the House 2 caregivers "…were taking better care of his [RELATIVE 5]'s teeth since her last dental appointment" in October 2009.[275] [DOCTOR 1] noted that when [RESIDENT 3] was again seen for a dental cleaning in April 2010 that her home care had obviously improved.[276]

66. Ms. Corey spoke with [RESIDENT 3]'s [RELATIVE 4] who pointed out that his [RELATIVE 5] was given foods containing high amounts of sugar by the House 2 staff.[277] Nonetheless and despite the poor dental care provided to [RESIDENT 3] at House 2 prior to November 2009, [RESIDENT 3]'s [RELATIVE 4] believed that House 2 could offer [RESIDENT 3] the care she needed.[278]

67. [RESIDENT 2] was diabetic and was previously prescribed insulin as part of his diabetes treatment.[279] His physician took him off insulin after review of [RESIDENT 2]'s blood glucose charts in August 2009.[280] However, his blood glucose levels were still monitored and were supposed to be measured prior to eating, on a daily basis but at alternating meals.[281] Measuring glucose levels during or after a meal will result in an inaccurate glucose reading.[282]

68. The Appellant checked [RESIDENT 2]'s blood sugar after he had already starting eating his meal on November 13, 2009, in contravention of his physician's

[274] Testimony of [CAREGIVER 2] and Appellant's exhibit 4 at 5.
[275] Department's exhibit 2 at 7.
[276] Testimony of [DOCTOR 1].
[277] Department's exhibit 2 at 8.
[278] Appellant's exhibit 11-13.
[279] Testimony of Candace Corey and testimony of [RESIDENT 2'S RELATIVE].
[280] Testimony of Candace Corey and Department's exhibit 2 at 8.
[281] Appellant's exhibit 3-4 and Appellant's exhibit 16-25. *See also* testimony of [MANAGER 1].
[282] Testimony of Candace Corey and Department's exhibit 2 at 8.

orders.[283] However, there is conflicting evidence on this point, requiring a credibility determination that the ALJ did not address in the *Initial Order*.[284] In a letter purportedly written by [CAREGIVER 3], she stated that the Appellant checked [RESIDENT 2]'s blood sugar before he had started eating his meal.[285] [CAREGIVER 3] did not testify and could not be questioned about her written statement, which was not signed under penalty of perjury. The Appellant and [MANAGER 1] had a self-interested motivation for contradicting Ms. Corey's relatively contemporaneous written observations and later live testimony based on those observations; months elapsed between this incident on November 13, 2009, [CAREGIVER 3]'s written statement, the Appellant's written statement, [MANAGER 1]'s written statement, and the Appellant's testimony on May 6, 2010; Ms. Corey had no motivation to fail to tell the truth; and Ms. Corey's training and experience as an R.N. may have alerted her to the failure to measure [RESIDENT 2]'s blood sugar at the appropriate time. For these reasons, the undersigned finds Ms. Corey's testimony about this incident more credible.

69. Ms. Corey's review of [RESIDENT 2]'s blood glucose levels revealed that they fluctuated between 133 and 381, with a normal range of 80-100.[286] Based on the blood sugar monitoring she observed, Ms. Corey did not know if the extremely high readings recorded were the result of truly elevated blood glucose levels or if they were "…false highs based on when staff checked his blood."[287] If the high glucose readings

---

[283] *Id.*
[284] The ALJ presumed in Conclusion of Law 5.8 at 70 that that because the Appellant is an L.P.N. she would not have performed the test after [RESIDENT 2] started eating, but there is no evidence in the record to support this presumption.
[285] Appellant's exhibit 3-1. *See also* Appellant's exhibit 3-2 (written statement of [MANAGER 1], dated December 18, 2009), Appellant's exhibit 3-3 (written statement of the Appellant, dated December 18, 2009), and testimony of the Appellant.
[286] Testimony of Candace Corey and Department's exhibit 2 at 8.
[287] *Id.*

were accurate, they could lead to "diabetic complications such as heart, kidney, and visions problems."[288]

70. Despite two months of [RESIDENT 2]'s fluctuating glucose levels that were not within the normal range, the Appellant told Ms. Corey that she had not contacted [RESIDENT 2]'s physician since September 2009, to discuss these fluctuations and high measurements.[289] [MANAGER 1] contends that he heard this conversation and that the Appellant told Ms. Corey she had notified [RESIDENT 2]'s physician, but that the physician did not wish to put [RESIDENT 2] back on insulin despite the high readings.[290] This presents another conflict in the evidence presented that must be addressed with a credibility determination, which the ALJ did not make in the *Initial Order*. Because there was no apparent motivation for Ms. Corey to lie about this exchange with the Appellant and since her recorded observation was more contemporaneous with the incident than [MANAGER 1]'s testimony, the undersigned finds Ms. Corey's testimony more credible on this point about whether the Appellant failed to notify [RESIDENT 2]'s physician about [RESIDENT 2]'s fluctuating and high blood glucose levels.

71. As a nurse, the Appellant should have known that such high readings that were consistently out of the normal range for a period of time warranted, at the minimum, calling [RESIDENT 2]'s physician to notify him, particularly since the physician had taken [RESIDENT 2] off insulin just a couple months before.[291]

72. [RESIDENT 2] had difficulties with swallowing, which presented a choking

---

[288] *Id.*
[289] *Id.*
[290] Testimony of [MANAGER 1].
[291] Testimony of Candace Corey and Department's exhibit 2 at 8.

hazard, and he required supervision and assistance while eating.[292] On November 13, 2009, [RESIDENT 2] was eating his meal in the living room, apart from the other residents who were eating at the dining room table, and out of sight of the caregiver in the kitchen.[293] He was heard and then seen coughing during his meal.[294]

73. Although [RESIDENT 2]'s blood glucose levels remained high and they may not have been appropriately monitored at House 2, [RESIDENT 2'S RELATIVE], believed [RESIDENT 2] improved while living at House 2.[295] However, [RESIDENT 2'S RELATIVE] was not made aware that [RESIDENT 2] had swallowing problems or that he was at-risk of choking until shortly before the hearing.[296] [RESIDENT 2'S RELATIVE] also had not been notified of [RESIDENT 2]'s problematic blood glucose levels.[297]

74. [RESIDENT 10], [RESIDENT 4], and [RESIDENT 1] were prescribed narcotic pain medication and anti-anxiety medication on an "as needed" (PRN) or at the request of the resident basis.[298] These medications were kept in the Appellant's locked private quarters or in her purse, accessible only to the Appellant, and not available when they may have been required.[299] The Appellant did not "…claim that it was her

---

[292] Testimony of Candace Corey and Department's exhibit 2 at 6. *See also* Appellant's exhibit 16-24 and 16-42.
[293] Testimony of Candace Corey and Department's exhibit 2 at 6.
[294] *Id.*
[295] Testimony of [RESIDENT 2'S RELATIVE] and Appellant's exhibit 11-15.
[296] Testimony of [RESIDENT 2'S RELATIVE].
[297] *Id.*
[298] Testimony of Candace Corey and Department's exhibit 2 at 9. *See also* Appellant's exhibits 16-144, 12-163, 16-191, and 16-208 and testimony of the Appellant (stating that [RESIDENT 1] was prescribed Vicodin for pain).
[299] *Id. See also* the testimony of [CAREGIVER 1] (stating that [RESIDENT 10] would wince and cry from the pain, but that [CAREGIVER 1] could not give her pain medications because the Appellant was not there and [CAREGIVER 1] did not have access to [RESIDENT 10]'s prescribed medication that the Appellant kept locked away in her room upstairs); testimony of [MANAGER 1] (stating that the Appellant keeps the residents' narcotics in a locked room upstairs); testimony of [FORMER MANAGER 1] (stating that the Appellant said [FORMER MANAGER 1] was giving [RESIDENT 10] her pain medicine too often—despite administering it as prescribed on the bottle and within her nurse-delegated role—so the Appellant locked the pain medicine away about four months before [FORMER MANAGER 1] left House 2 in October 2009); Department's exhibit 2 at 9 (noting that the caregiver on duty told Ms. Corey that she did

nursing judgment that caused her to… restrict access to these medications."[300]

75. [RESIDENT 10] was prescribed hydrocodone for pain.[301] There were at least two occasions when she expressed that she was in pain and requested it, the Appellant was not at home, [CAREGIVER 1] tried to contact the Appellant by phone while she was at church, the Appellant came after she got out of church, and [RESIDENT 10] did not get her medication.[302] The Appellant would not leave any of [RESIDENT 10]'s pain medication with [FORMER MANAGER 1], despite that [FORMER MANAGER 1] asked her to do so, when the Appellant left the premises.[303] Instead, [FORMER MANAGER 1] had to find or call the Appellant to obtain [RESIDENT 10]'s pain medication.[304] Sometimes there was a lengthy delay in obtaining and dispensing the pain medication, depending on where the Appellant was.[305] [FORMER MANAGER 1] had to call the Appellant "[e]very couple days" to get [RESIDENT 10]'s pain medication.[306] [RESIDENT 10] unnecessarily suffered pain. When someone is prescribed pain medication, it is important that he or she have timely access to it.[307] Testimony was presented at the hearing that withholding pain medication can be

---

not know where the medications were kept and that she had to call the Appellant to have her bring the narcotic and antianxiety medications home); and Department's exhibit 5 at 1 (the Appellant's and [MANAGER 1]'s request for informal dispute resolution in which they admitted that the pain and anxiety medications were removed from use).

[300] Testimony of Candace Corey.

[301] Appellant's exhibits 16-144 and 16-150.

[302] Testimony of [CAREGIVER 1] (stating that she called the Appellant at church but she did not come with the medication); testimony of [RESIDENT 10'S RELATIVE 1] (stating that her [RELATIVE 1], [RESIDENT 10], used hydrocodone on and off for chronic pain her entire life and had had [CONDITION 1] as a child); testimony of [RESIDENT 10'S RELATIVE 2] (stating that before [RESIDENT 10]'s [RELATIVE 4] died and she became a resident at House 2, she had a morbid sense of humor and would say her leg hurt so much that she was ready to be buried); and testimony of [FORMER MANAGER 1] (noting that there was a delay in getting [RESIDENT 10]'s pain medications if the Appellant was not at House 1 or House 2).

[303] Testimony of [FORMER MANAGER 1].

[304] *Id.*

[305] *Id.*

[306] *Id.*

[307] Testimony of Jeannie Johnson.

abusive.[308]

76. The Appellant reportedly did not like to give [RESIDENT 10] her narcotic pain medication because she felt it made [RESIDENT 10] drowsy.[309] However, the Appellant and [MANAGER 1] gave a different reason in their request for informal dispute resolution with the Department: that the prescriptions were removed from use because they were expired and that the Appellant was awaiting refill and delivery of the new prescriptions.[310] There is also some evidence that [RESIDENT 10] would obsess about her medication, ask for it inappropriately, and need to be redirected.[311] Further, [RESIDENT 10]'s Vicodin/hydrocodone prescription was discontinued by her physician on November 17, 2009, and replaced with Tylenol extra strength to address her pain although this new information and course of treatment were not added to her care plan until January 2010.[312] Regardless of the Appellant's inconsistent reasons for withholding [RESIDENT 10]'s hydrocodone and that it was later discontinued, the fact remains that when the medication was still being prescribed to [RESIDENT 10] and she needed it, it was not readily accessible and available to her when the Appellant was not at House 1 or House 2.

77. Although [RESIDENT 10] has stated to her [RELATIVE 3] and [RELATIVE

---

[308] Testimony of Candace Corey.

[309] Testimony of [CAREGIVER 1]. *But cf.* testimony of [FORMER MANAGER 1] (stating that the Appellant said [FORMER MANAGER 1] was giving [RESIDENT 10] her pain medicine too often—despite administering it as prescribed on the bottle and within her nurse-delegated role—so the Appellant locked the pain medicine away about four months before [FORMER MANAGER 1] left House 2 in October 2009).

[310] Department's exhibit 5 at 1. *But cf.* testimony of Candace Corey and Department's exhibit 2 at 10 (noting that the Appellant told her that she kept the narcotic and antianxiety medications separate because that is what was done in nursing homes).

[311] Appellant's exhibit 16-50. *See also* testimony of [CAREGIVER 1] (explaining that she would try to distract [RESIDENT 10] from her pain by giving her candy or having her talk to [RESIDENT 6], another female resident at House 2, until the Appellant could get to House 2).

[312] Appellant's exhibits 14-1 and 16-181; testimony of [RESIDENT 10'S RELATIVE 1]; and testimony of [RESIDENT 10'S RELATIVE 2].

6] that she was frightened while at House 2 and that she wanted to go home, along with her running away from House 2 and the need to coax her back, [RESIDENT 10]'s [RELATIVE 3] and [RELATIVE 6] appeared satisfied with the care she received there.[313]

78. [RESIDENT 4]'s Ativan/lorazepam medication was also prescribed on a PRN basis and was inaccessible and unavailable when the Appellant was away.[314] No evidence was presented at the hearing that she requested this medication, but it was established that her anxiety sometimes keeps her awake at night and that this, in turn, causes her to sleep during the day.[315] If her anti-anxiety medication was available and provided to her when needed, then she could calm down and sleep at night.[316] During Ms. Corey's investigation visit on November 2, 2009, [RESIDENT 4] was observed to be sleeping in a recliner for a long period of time.[317]

79. [RESIDENT 4]'s friend, [FRIEND 1], believed [RESIDENT 4] improved while at House 2.[318]

80. [RESIDENT 1] may have been prescribed Vicodin and diclofenac for pain on a PRN basis, but he did not request it and generally would not take it when offered.[319] The Appellant would leave two pills[320] with [CAREGIVER 1], just in case

---

[313] *See* testimony of [RESIDENT 10'S RELATIVE 1]; testimony of [RESIDENT 10'S RELATIVE 2]; and Appellant's exhibit 11-1.
[314] Testimony of [CAREGIVER 1]. See also Department's exhibits 2 at 9-10 and 5 at 1 and Appellant's exhibits 16-191 and 16-208.
[315] Testimony of [MANAGER 1]. *See also* Appellant's exhibits 16-204, 16-205, 16-209, and 16-227.
[316] *See* Appellant's exhibits 16-204, 16-205, 16-209, and 16-227.
[317] Department's exhibit 2 at 13.
[318] Appellant's exhibit 11-4 and testimony of [FRIEND 1].
[319] Testimony of [CAREGIVER 1] (noting that [RESIDENT 1] often refused his pain medication, but that he did ask for relief once and she gave him diclofenac 75mg); testimony of [MANAGER 1] (reiterating that [RESIDENT 1] often turned down pain medication when it was offered, but that he had accepted it from the Appellant once); Appellant's exhibit 5-5; and the Appellant. *But see* Department's exhibit 9 at 1 (listing [RESIDENT 1]'s medications, which do not include Vicodin or diclofenac, when he was taken to the hospital on November 24, 2009).

[RESIDENT 1] needed them while the Appellant was out.[321] Given that there was substantial evidence presented, some by the Appellant herself, that the Appellant kept narcotic and anti-anxiety medications separate from the residents' other medications, the undersigned finds that the Appellant kept [RESIDENT 1]'s narcotic medication with [RESIDENT 10]'s narcotic medication and [RESIDENT 4]'s anti-anxiety medication. As a result, [RESIDENT 1]'s narcotic medication was not available to him during the Appellant's absence.

81. [RESIDENT 1]'s assessment stated that he had swallowing difficulties, presented a choking risk, and had recently lost 20 pounds.[322] During a meal on November 13, 2009, [RESIDENT 1] coughed hard and had a lot of swallowing difficulties.[323] Although evidence was presented that [RESIDENT 1] often had to be coaxed to eat and sometimes held food in his mouth, which could also cause him to cough, the breaded chicken patty and green salad provided to him at the meal in question would make it even more challenging for someone with swallowing and choking problems to eat.[324]

82. Despite [RESIDENT 1]'s obvious swallowing difficulties and that the Appellant noticed his reluctance to eat, the Appellant told Ms. Corey that she had not contacted his physician or investigated whether a swallowing evaluation might be appropriate.[325] Following this conversation, [RESIDENT 1]'s physician's office faxed

---

[320] It is not clear from the record if these pills were Vicodin or diclofenac or one of each. The Appellant testified that Vicodin is a narcotic whereas diclofenac is not.
[321] Testimony of [CAREGIVER 1]. *See also* Appellant's exhibits 5-5 and 5-6.
[322] Department's exhibit 2 at 8. NOTE: [RESIDENT 1]'s assessment was not submitted as an evidentiary exhibit by either party.
[323] *Id.* at 8-9. *See also* testimony of Candace Corey.
[324] *Id. See also* testimony of [MANAGER 1] and testimony of [RESIDENT 1'S RELATIVE] (noting that [RESIDENT 1] often had to be persuaded to eat while he was at House 2).
[325] Department's exhibit 2 at 9 and testimony of Candace Corey.

orders for a swallowing evaluation to the Appellant on November 13, 2009, based on a diagnosis of loss of appetite.[326] A notation on this fax indicates that the Appellant then faxed [FACILITY 4] and was going to follow-up by phone on Monday, November 16, 2009.[327] On November 20, 2009, [RESIDENT 1]'s eating and swallowing were observed by someone, presumably from [FACILITY 4], with a "CCCSP" credential.[328] This evaluation noted that [RESIDENT 1] required certain foods "blended;" oral enteral nutrition in the form of five to six cans of Boost per day; cueing to chew; small bites; his head turned for thin liquids; his jaws massaged during oral care to increase jaw mobility; alternation of cold and hot liquids; increased oral care following meals; and his pills crushed in yogurt or pudding.[329] After this evaluation, [RESIDENT 1]'s physician was contacted on November 22, 2009, to approve orders for Boost to address [RESIDENT 1]'s poor appetite.[330] [RESIDENT 1]'s physician later wrote a note, dated December 23, 2009, about the Appellant's November 2009 request for a swallowing evaluation.[331] In this note, the physician stated that a swallowing evaluation was not needed because the physician had already reviewed issues related to [RESIDENT 1] falling out of bed, "PT/OT," and ordering Ensure due to his poor appetite on October 21, 2009,[332] and also because [RESIDENT 1] had been thoroughly examined while he was hospitalized in October 2009 prior to being admitted to House 2.[333] No evidence was presented about why [RESIDENT 1]'s physician wrote this note in December 2009, after his office had already ordered a swallowing evaluation and one had been conducted over a month

[326] Appellant's exhibit 5-9.
[327] *Id.*
[328] Appellant's exhibit 5-8.
[329] *Id.*
[330] Appellant's exhibit 5-7.
[331] Appellant's exhibit 5-3.
[332] *Id. See also* Appellant's exhibit 5-2.
[333] Appellant's exhibit 5-3.

before.[334] However, it may reveal that the Appellant had been apprised weeks earlier of [RESIDENT 1]'s swallowing difficulties by his physician and had not addressed them.

83. [MANAGER 1] stated at the hearing that [RESIDENT 1]'s swallowing difficulties had been raised by the Appellant with [RESIDENT 1]'s physician before Ms. Corey's November 2, 2009, visit.[335] This is in contrast to Ms. Corey's report that the Appellant told her she had not addressed [RESIDENT 1]'s swallowing issues with his physician, again requiring credibility findings that were not made by the ALJ on this issue. Because there was no apparent motivation for Ms. Corey to lie about her exchange with the Appellant on the matter; her recorded observation in the Department's Statement of Deficiencies was more contemporaneous with the incident three weeks after the conversation than was [MANAGER 1]'s testimony six months later; and a swallowing evaluation was conducted after Ms. Corey's conversation with the Appellant, the undersigned finds Ms. Corey's testimony more credible than [MANAGER 1]'s on this point about whether the Appellant failed to previously notify [RESIDENT 1]'s physician concerning [RESIDENT 1]'s swallowing problems.

84. [RESIDENT 1] went back to the hospital on November 24, 2009.[336] When Ms. Corey asked the Appellant about [RESIDENT 1] on December 8, 2009, the Appellant told her of his hospitalization, that he had a "trace of pneumonia" on November 24, 2009, and that his behavior had changed from fine in the morning to combative in the afternoon that day.[337] Ms. Corey indicated that this information was

---

[334] Appellant's exhibits 5-9 and 5-8.
[335] Testimony of [MANAGER 1].
[336] Department's exhibit 2 at 9.
[337] *Id.* and testimony of Candace Corey.

inconsistent with [RESIDENT 1]'s hospital admission history.[338] Ms. Corey pointed out that his diagnoses upon admission to the hospital were aspiration pneumonia and sepsis, rather than a "trace of pneumonia." [339] Aspiration pneumonia is defined as "…pneumonia due to the entrance of foreign matter, such as food particles into the respiratory passages…,"[340] which may be caused by "[d]isorders that affect normal swallowing" or "[o]ld age."[341] [RESIDENT 1] died on December 1, 2009 while he was an inpatient at the hospital.[342]

85. Although [RESIDENT 1] died six weeks after being admitted to House 2 on October 16, 2009, and his swallowing difficulties and choking risk were not addressed until after the Appellant was questioned by Ms. Corey on November 13, 2009, his [RELATIVE 5] and [RELATIVE 3] "…felt confident about the care [RESIDENT 1] was receiving at [FACILITY 2] and… would recommend the facility…"[343]

Lack of Resident Assessment and Inappropriate Emergency Placement

86. The Department cited the Appellant for admitting a resident to the AFH without an assessment and in the absence of a true emergency.[344] [RESIDENT 1] was admitted to House 2 from the hospital on October 16, 2009, but he did not have an assessment until October 19, 2009.[345]

87. The Appellant explained to Ms. Corey that she permitted [RESIDENT 1] to come to House 2 without an assessment because she felt there was an emergency that

---

[338] *Id.*
[339] *Id.* The record does not indicate how these two separate descriptions clinically differed, why the difference was significant, or whether it was somehow related to [RESIDENT 1]'s death a week later.
[340] *Dorland's Illustrated Medical Dictionary* 1185 (24th ed. 1965).
[341] http://www.nlm.nih.gov/medlineplus/ency/article/000121.htm.
[342] Department's exhibit 12.
[343] Appellant's exhibit 11-2. *See also* testimony of [FRIEND 2] and [RESIDENT 1'S RELATIVE].
[344] Department exhibit 2 at 4 and testimony of Candace Corey.
[345] Department's exhibit 2 at 5; testimony of Candace Corey; testimony of David Robinson; and testimony of the Appellant.

necessitated his immediate admission.[346] The Appellant stated at the hearing that although she knew she was required to have an assessment of [RESIDENT 1]'s needs completed before she admitted him to House 2, she relied on her nursing judgment and decided to admit him nonetheless.[347] The Appellant explained she did this because the hospital was planning to discharge [RESIDENT 1]; his [RELATIVE 5] felt she could no longer care for him on her own; and David Robinson, the Appellant's regular assessor, was not available to do an assessment that Friday afternoon on such short notice.[348] Although the evidence was unclear whether [RESIDENT 1] was actually admitted into the hospital in November 2009 or if he had had only an outpatient emergency department visit, hospitals may admit patients for social reasons rather than strictly medical ones and hospitals sometimes delay discharging a patient if suitable placement is not immediately available elsewhere.[349]

88. According to Ms. Corey, moving an individual who is safely in a hospital where his needs are being met into an AFH does not constitute an emergency.[350] There was no evidence in the record that [RESIDENT 1]'s life, health, or safety was at risk prior to his discharge or transfer from the hospital or that harm had occurred to him. Ms. Corey also explained that an assessment could have been done prior to [RESIDENT 1]'s discharge from the hospital, particularly since [RESIDENT 1]'s [RELATIVE 5] had already visited House 2 approximately two weeks prior and liked it.[351] An assessment

---

346 *Id.*; testimony of Candace Corey; and testimony of [MANAGER 1].
347 Testimony of the Appellant.
348 Testimony of the Appellant. *See also* testimony of [MANAGER 1]; testimony of [FRIEND 2]; testimony of David Robinson; and Appellant's exhibit 2-1.
349 Testimony of David Robinson. *See also* testimony of [FRIEND 2] and testimony of [RESIDENT 1'S RELATIVE].
350 Testimony of Candace Corey.
351 *Id.*; testimony of [FRIEND 2]; testimony of [RESIDENT 1'S RELATIVE]; and testimony of David Robinson.

prior to admission to an AFH is required to identify what the potential resident's needs are and determine whether the AFH can provide all the care the potential resident needs.[352] Although [RESIDENT 1]'s assessment on November 19, 2009, may have indicated that his needs could be met at House 2,[353] his admission took place before an assessment of his very substantial care needs was conducted.[354]

Unlabeled Medication Organizer

89. The Department cited the Appellant for not labeling [RESIDENT 1]'s medication organizer.[355] AFH medication organizers are required to have labels that include the name of the resident, a list of all prescribed and over-the-counter medications, the dosage of each medication, and the frequency at which the medications are given.[356] The failure to correctly label a resident's medication organizer could result in medication errors.[357]

90. [RESIDENT 1] was unable to identify his own medications or to indicate whether he was receiving the correct ones in the prescribed dosages.[358] He was prescribed at least six medications to be administered daily since his admission to House 2 on October 16, 2009.[359]

91. On November 2, 2009, [RESIDENT 1]'s organizer was filled with pills, but it is undisputed that there was no label on it to indicate to his caregivers that they were

---

[352] Testimony of Candace Corey.
[353] [RESIDENT 1]'s assessment was not submitted as an evidentiary exhibit by either party. As such and in light of the other evidence presented, it is not clear to the undersigned that his needs were met at House 2. Although [RESIDENT 1]'s swallowing and choking issues were addressed in his assessment, the Appellant did not acknowledge them until after she was questioned by Ms. Corey on November 13, 2009, and caregivers at House 2 may not have been aware of them.
[354] Department's exhibit 2 at 5; testimony of Candace Corey; testimony of David Robinson; and testimony of the Appellant.
[355] Department's exhibit 2 at 11.
[356] *Id.* and testimony of Candace Corey. *See also* WAC 388-76-10480(4).
[357] *Id.*
[358] Department's exhibit 2 at 11.
[359] *Id.* at 12.

his medications, what they were, how much of them he was supposed to take, or when he was supposed to take them.[360] When this deficiency was pointed out to the Appellant, she said the label was in her office upstairs and that she had forgotten to put it on the organizer.[361] [CAREGIVER 1] said the label had fallen off.[362] It is not clear from the record how long ago the label had fallen off or if it had actually ever been affixed to the organizer. If the latter, [RESIDENT 1]'s medication organizer was unlabeled for over two weeks since his admission to House 2 on October 16, 2009, and multiple staff administered his medications during that time.

92. The Appellant also told Ms. Corey that [CAREGIVER 1] "…checked each pill in the unmarked organizer with the pills in the prescription bottles before she gave them."[363] While this may have been an appropriate safeguard for [CAREGIVER 1] in addition to labeling the medication organizer, it is not sufficient in lieu of the required label.[364] Further, [CAREGIVER 1] was not the only caregiver at House 2 who administered medication to the residents.[365]

Failure to Ensure Caregiver CPR/First-Aid Certification

93. The Appellant was cited by the Department for failing to ensure that one of her caregivers had current, valid first aid and cardiopulmonary resuscitation (CPR) certification.[366] This failure resulted in the caregiver providing unsupervised care to residents without current CPR or first aid certification for over two months, which placed

---

[360] *Id.* and testimony of Candace Corey.
[361] *Id.*
[362] Testimony of [CAREGIVER 1].
[363] Department's exhibit 2 at 12; testimony of Candace Corey; testimony of [CAREGIVER 1]; Appellant's exhibit 12-1. It is unclear how [CAREGIVER 1] determined that the medications in the organizer matched up with the medications in the original prescription bottles or how she distinguished between different pills that might look similar.
[364] Testimony of Candace Corey.
[365] Testimony of [FORMER MANAGER 1] and testimony of Candace Corey.
[366] Department's exhibit 2 at 4.

those residents at risk.[367]

94. On November 2, 2009, inspection of the Appellant's employee records revealed that there was no documentation of [CAREGIVER 1]'s current CPR and first aid certification.[368] The explanations provided for this lack of documentation were (1) the Appellant assumed [CAREGIVER 1] was required by her other employer, [EMPLOYER 1], to have CPR and first aid certification and (2) [CAREGIVER 1]'s purse, which purportedly contained her most recent certification card, was stolen in October 2008.[369] However, [EMPLOYER 1] did not require [CAREGIVER 1] to be certified because [EMPLOYER 1] prohibited her from performing CPR on any of its clients.[370] [CAREGIVER 1]'s only employer, other than the Appellant, that required her to have current CPR and first aid certification was [EMPLOYER 2] in [LOCATION 2], Washington, where she worked from May 2006 through October 2006.[371]

95. The Appellant and [MANAGER 1] insisted at the hearing that [CAREGIVER 1] assured them that her certification was current, that the Appellant directed her to obtain a copy of the stolen card for the House 2 employee records, and that [CAREGIVER 1] agreed to provide the copy.[372] In contrast, [CAREGIVER 1] testified that she told the Appellant upon her hiring that she did not know when the stolen card expired, that she never told the Appellant she would give her a copy of the card, and that the Appellant would not give her a Saturday off work to complete the

---

[367] *Id.* and testimony of Candace Corey.
[368] Department's exhibit 2 at 4 and testimony of Candace Corey.
[369] *Id. See also* testimony of the Appellant; testimony of [MANAGER 1]; testimony of [CAREGIVER 1]; and Appellant's exhibits 1-11 through 1-14.
[370] Testimony of [CAREGIVER 1].
[371] *Id.* and Appellant's exhibit 11-10.
[372] Testimony of the Appellant and testimony of [MANAGER 1].

training and become re-certified because that was the Appellant's religious day.[373] Given this conflict in testimony; that the ALJ did not make a credibility determination in the *Initial Order* to address this conflict; and the Appellant's admission to Ms. Corey during the investigation[374] and in her testimony at the hearing that she assumed [CAREGIVER 1] was required by [EMPLOYER 1] to have current CPR and first aid certification and that it "…sounded like…" [CAREGIVER 1]'s card was current,[375] the undersigned finds it more credible that the Appellant did not ask [CAREGIVER 1] to provide her with a copy of her stolen certification card.

96. Some evidence was presented that the Appellant somehow obtained a copy of [CAREGIVER 1]'s stolen card and that it expired in September 2009, but no documentary evidence proving this assertion is included in the record and [CAREGIVER 1] stated that she did not know when it expired.[376] Before going to work for the Appellant in May 2009, the last time an employer required [CAREGIVER 1] to have certification was in 2006.[377] There is uncontroverted evidence that [CAREGIVER 1] was not re-certified to provide CPR and first aid until November 10, 2009.[378]

97. [CAREGIVER 1] was observed providing unsupervised care to House 1 and House 2 residents for 30 to 40 minutes on November 2, 2009, and testified that she was often the only caregiver during her shifts at House 2 since beginning employment there in May 2009.[379] Between at least September 2009—and possibly since her hiring at House 2 in May 2009—and November 10, 2009, [CAREGIVER 1] provided

---

[373] Testimony of [CAREGIVER 1].
[374] Department's exhibit 2 at 4 and testimony of Candace Corey.
[375] Testimony of the Appellant.
[376] Testimony of the Appellant; testimony of [MANAGER 1]; testimony of Jeannie Johnson; Department's exhibit 2 at 4; testimony of Candace Corey; and testimony of [CAREGIVER 1].
[377] Testimony of [CAREGIVER 1] and Appellant's exhibit 1-10.
[378] Appellant's exhibit 1-30.
[379] Department's exhibit 2 at 4; testimony of Candace Corey; and testimony of [CAREGIVER 1].

unsupervised care to a minimum of five elderly AFH residents (i.e., [RESIDENT 2], [RESIDENT 6], [RESIDENT 4], [RESIDENT 1], and [RESIDENT 10]) with documented heart problems[380] without having current CPR and first aid certification.

98. The Appellant was previously cited, in December 2008, for failing to ensure that she had current CPR and first aid certification.[381] Based on the evidence presented, it is unclear whether the Appellant was certified to provide CPR during the period when [CAREGIVER 1] did not have current certification.[382]

<u>Lack of a Resident Manager</u>

99. The Department cited the Appellant for failing to ensure House 2 had an RM responsible for managing the overall delivery of care at all times for the full-time residents of House 2 and ensuring that their needs were met.[383] This failure "…resulted in residents not receiving care and services in accordance with minimal licensing requirements."[384]

100. The Appellant operated two AFHs and, as the RM at House 1, she was the designated responsible person for managing House 1.[385]

101. The Appellant admitted that the previous RM at House 2, [FORMER MANAGER 1], resigned from the position on October 23, 2009.[386] [CAREGIVER 1] also said [FORMER MANAGER 1] no longer worked there at the time of the investigation on

---

[380] *See, e.g.,* Appellant's exhibits 16-12, 16-30, 16-96, 16-115, 16-190, 16-207, and Department's exhibit 2 at 5-6.
[381] Department's exhibit 1 at 2 and 2 at 4.
[382] *See* Appellant's exhibit 1-27 (indicating that the Appellant completed CPR training on May 31, 2008, and that the certification was valid for one year).
[383] Department's exhibit 2 at 2-3 and testimony of Candace Corey.
[384] *Id.*
[385] *Id.*; testimony of the Appellant; and testimony of [MANAGER 1].
[386] *Id.*

November 2, 2009.[387] On November 13, 2009, the Appellant told Ms. Corey that [MANAGER 1] would become the RM as soon as his successful completion of the necessary training was confirmed.[388]

102. There is no evidence in the record that the Appellant contacted the Department when [FORMER MANAGER 1] resigned or otherwise notified the Department that House 2 was without an RM and would be for several weeks until [MANAGER 1] successfully completed the RM training. Had she done so, the Appellant may have been able set up an enhanced monitoring plan with the Department for addressing this problem.[389] This could have been similar to the enhanced monitoring undertaken by the Department in 2007, when House 1 was uninhabitable due to flooding, following coordinated arrangements made between the Appellant and the Department for temporary housing of the House 1 residents at House 2.[390] Instead, the Appellant was without an RM when Ms. Corey started her investigation on November 2, 2009.[391]

103. Although the Appellant asked [MANAGER 1] on October 6, 2009, to complete the training to become an RM, he did not become qualified to become an RM until at least November 7, 2009.[392] The Appellant stated that she asked him to take the RM training because, as an owner of multiple AFHs, she wanted to have a back-up

---

[387] Department's exhibit 2 at 3 and testimony of Candace Corey.
[388] *Id. See also* testimony of the Appellant.
[389] Testimony of Pam Hildreth.
[390] *Id.* and testimony of the Appellant.
[391] Department's exhibit 2 at 2-3; testimony of Candace Corey; testimony of the Appellant; testimony of [CAREGIVER 1]; and testimony of [MANAGER 1].
[392] Testimony of the Appellant; testimony of [MANAGER 1] (testifying that he did not complete the 48-hour administrator training course until January 9, 2010; per WAC 388-112-0270, this is required training for providers who must complete it before operating or receiving a license to operate an AFH); and Appellant's exhibits 1-22 through 1-24.

RM.[393]

104. House 2 did not have an RM between October 23, 2009, and, at the earliest, November 7, 2009.

Incomplete and Unavailable Negotiated Care Plans

105. The Appellant was cited by the Department for failing to complete negotiated care plans for five residents of House 2.[394] The failure to have care plans completed or available may have placed those residents at risk from unmet care, services, or supervision needs.[395]

106. Ms. Corey testified that only the assessments for [RESIDENT 4], [RESIDENT 10], [RESIDENT 3], and [RESIDENT 6] were included in the resident files made available to her during her investigation on November 2, 2009, and November 13, 2009, at House 2, and that there were no negotiated care plans for these individuals.[396] An assessment may serve as the basis for a negotiated care plan, but an assessment does not include information about who will provide the necessary care and services or details about when and how they will be provided.[397] The assessment documents that Ms. Corey reviewed did not include the information necessary to make them negotiated care plans.[398]

107. Ms. Corey also testified there was a care plan available for [RESIDENT 2], but it did not identify that he required supervision while eating or that he might choke

---

[393] Testimony of the Appellant.
[394] Department's exhibit 2 at 5-6 and testimony of Candace Corey.
[395] *Id.*
[396] Testimony of Candace Corey. Ms. Corey also noted in her testimony that a negotiated care plan was not required for [RESIDENT 1] at the time of her investigation because he was admitted to House 2 on October 16, 2009, and the Appellant had 30 days within which to complete his plan.
[397] *Id.*
[398] *Id. See also, e.g.,* Department's exhibit 6 and Appellant's exhibits 16-29 through 16-47, 16-189 through 16-206

although his assessment did specifically include this information.[399] After being reminded that [RESIDENT 2] had a risk of choking while eating, [CAREGIVER 3], the caregiver on duty during the observed meal, told Ms. Corey that his food needed to be cut up and that he sometimes required assistance with eating.[400] [CAREGIVER 3] did not note or appear to be aware that [RESIDENT 2] also required supervision during meals according to his assessment.[401]

108. The Appellant informed Ms. Corey on November 2, 2009, that she did not realize information had to be added to the assessments in order to make them negotiated care plans, but that she would complete the negotiated care plan for each resident as soon as possible.[402]

109. At the hearing, Ms. Corey was presented with documents about [RESIDENT 4], [RESIDENT 10], [RESIDENT 3], and [RESIDENT 6] that appeared to contain the elements necessary to make them negotiated care plans.[403] Some of these completed negotiated care plans contained at least some handwritten information provided by [FORMER MANAGER 1] prior to her resignation from House 2, indicating they did exist somewhere and in some form at the time Ms. Corey was conducting her investigation.[404] However, these were not the documents made available to Ms. Corey

---

[399] Department's exhibit 2 at 6; testimony of Candace Corey; and Appellant's exhibits 16-24 and 16-42.
[400] *Id.*
[401] *Id.*
[402] Department's exhibit 2 at 6 and testimony of Candace Corey.
[403] *Id. See also* Appellant's exhibit 16-11 through 16-28, 16-48 through 16-65, 16-114 through 16-131, 16-161 through 16-178, and 16-208 through 16-223.
[404] Testimony of [FORMER MANAGER 1] (noting that she completed negotiated care plans during her tenure at House 2 and that the handwriting on Appellant's exhibits 16-207 and 16-208 was [CAREGIVER 3]'s). *See also* Appellant's exhibits 16-48 ([FORMER MANAGER 1] noted that the handwriting that is not hers on this page may have been the Appellant's or [MANAGER 1]'s handwriting), 16-11, 16-114, 16-161, and 16-209.

while conducting to her investigation at House 2.[405] In addition, some of the documents Ms. Corey reviewed while at House 2 did not contain the handwritten notes that were included on them when presented as evidentiary exhibits at the hearing.[406] Such discrepancies undermine the Appellant's and [MANAGER 1]'s veracity as well as the reliability of the documents. The signature pages for many of these documents appear randomly attached, incomplete or undated, or as if the signatures have been erased or altered in some way.[407] Other documents purporting to be negotiated care plans were completed in 2010.[408]

110. In a faxed request from the Appellant to the Department for Informal Dispute Resolution (IDR), dated January 7, 2010, the Appellant stated that despite Ms. Corey's assertion that [RESIDENT 3]'s negotiated care plan could not be located, it was under a stack of new care plans, found by the provider (Appellant), and shown by the Appellant to Ms. Corey.[409] This does not address the negotiated care plans that were not made available to Ms. Corey for the other residents. In addition, if the "care plan" to which the Appellant refers in her January 7, 2010, IDR request is the same document for [RESIDENT 3] that she faxed to Ms. Corey on November 3, 2009, it was an

[405] Testimony of Candace Corey.
[406] *Id. See also, e.g.,* Department's exhibit 6 at 12 and Appellant's exhibit 16-77 (the version of [RESIDENT 3]'s assessment that was faxed to Ms. Corey by the Appellant on November 3, 2009, does not contain the handwritten alteration on page 12 that is included on page 12 of the Appellant's version of [RESIDENT 3]'s assessment, purportedly completed in September 2009, about the level of supervision needed for [RESIDENT 3] during an evacuation. This indicates to the undersigned that the assessments, and likely the care plans as well, were altered by the Appellant after they were provided to Ms. Corey but prior to the hearing or entirely different versions of the assessments were given to Ms. Corey. Either way, the discrepancies undermine the Appellant's and [MANAGER 1]'s veracity as well as the reliability of the documents).
[407] *See, e.g.,* Appellant's exhibits 16-28, 16-65, 16-112, 16-131, 16-159, 16-206
[408] Testimony of Candace Corey. *See also* 16-1 through 16-10, 16-85 through 16-94, 16-132 through 16-141, 16-179 through 16-188, and 16-224 through 233.
[409] Department's exhibit 5 at 2.

assessment rather than a completed care plan.[410]

111. [MANAGER 1] testified that he gave Ms. Corey the resident files, including the completed negotiated care plans, and they discussed them during her investigation at House 2 on November 13, 2009.[411] He claimed she asked for the care plans and he knew where they were located so he gave them to her.[412] [MANAGER 1] also stated that he had not looked at the residents' negotiated care plans before that day, despite being a formal caregiver at House 2 for over a month at that point.[413]

112. Because there was conflicting testimony about the negotiated care plans, the ALJ made the only credibility finding included in her *Initial Order*.[414] The ALJ found [FORMER MANAGER 1]'s and [MANAGER 1]'s testimony on this issue credible, but she did not explain why or how she made this credibility determination.[415] The ALJ also found that the Appellant was aware of the requirement to have negotiated care plans for the House 2 residents and that that there were current negotiated care plans for [RESIDENT 4], [RESIDENT 10], [RESIDENT 3], [RESIDENT 6] and [RESIDENT 2] in November 2009.[416]

113. After giving due regard to the ALJ's opportunity to observe the witnesses and their demeanor at the hearing, the undersigned cannot agree that [MANAGER 1]'s testimony on this point was more credible than Ms. Corey's. While [MANAGER 1] may very well have known where the resident files were located and may have provided them to Ms. Corey during the investigation, the totality of the evidence presented

---

[410] *Id.* and Department's exhibit 6. *See also* Appellant's exhibit 16-66 through 16-83 and testimony of Candace Corey.
[411] Testimony of [MANAGER 1].
[412] *Id.*
[413] *Id.*
[414] *Initial Order*, Finding of Fact 4.223 at 64-5.
[415] *Id.* (stating only that "[b]oth gave credible testimony").
[416] *Id.*

creates substantial doubt that those files contained all the residents' negotiated care plans and that the assessments and care plans presented at the hearing had not been altered.[417] This is not only because Ms. Corey testified that the resident files given to her by [MANAGER 1] did not contain the plans and that the assessments and plans presented at the hearing were not the same as those Ms. Corey reviewed during the investigation, but also because [MANAGER 1] freely admitted that he had never looked at the care plans prior to November 13, 2009, making it highly plausible that he may not have been able to identify them as such and may have mistaken the assessments for care plans. This is further supported by the Appellant's statement in her January 7, 2010, IDR request that the care plans were in a stack of papers on the counter (i.e., that they were not in the resident files given to Ms. Corey) or, conversely, that what the Appellant thought were care plans were actually assessments.[418] In addition, the Appellant noted in her IDR request that she, not [MANAGER 1], gave Ms. Corey the care plans.[419]

114. When taking these factors and inconsistencies into consideration, along with [MANAGER 1]'s motivation to contradict Ms. Corey and the amount of time that elapsed between his purported presentation of the care plans to Ms. Corey and the hearing, the undersigned finds that neither [MANAGER 1] nor the Appellant provided

---

[417] *See* testimony of Candace Corey. *See also, e.g.,* Department's exhibit 6 at 12 and Appellant's exhibit 16-77 (the version of [RESIDENT 3]'s assessment that was faxed to Ms. Corey by the Appellant on November 3, 2009, does not contain the handwritten alteration on page 12 that is included on page 12 of the Appellant's version of [RESIDENT 3]'s assessment, purportedly completed in September 2009, about the level of supervision needed for [RESIDENT 3] during an evacuation. This indicates to the undersigned that the assessments, and likely the care plans as well, were altered by the Appellant after they were provided to Ms. Corey but prior to the hearing or entirely different versions of the assessments were given to Ms. Corey. Either way, the discrepancies undermine the Appellant's and [MANAGER 1]'s veracity as well as the reliability of the documents).

[418] *See, e.g.,* Department's exhibits 5 at 2; Department's exhibit 6; and Appellant's exhibit 16-66 through 16-83.

[419] Department's exhibits 5 at 2.

Ms. Corey with the negotiated care plans for [RESIDENT 4], [RESIDENT 10], [RESIDENT 3], or [RESIDENT 6] during Ms. Corey's November 2009 investigation at House 2.

115. [FORMER MANAGER 1] appeared to be aware that negotiated care plans were required, but the evidence presented does not establish that the Appellant or [MANAGER 1] were likewise aware of the requirement, or elements necessary, to create negotiated care plans from the assessments or that the plans must be updated when the residents' needs change. Based on [FORMER MANAGER 1]'s understanding and completion of these plans prior to her resignation, the undersigned agrees with the ALJ's finding that there were negotiated care plans in place, in some form (although they may have been subsequently altered for the hearing), for [RESIDENT 4], [RESIDENT 10], [RESIDENT 3], and [RESIDENT 6] in November 2009. However, these plans were not made available to Ms. Corey upon request and the undersigned is not convinced that the individuals providing care to the residents at House 2 were aware of the location or contents of the residents' negotiated care plans. Further, [RESIDENT 2]'s negotiated care plan was incomplete because it did not contain necessary information that was included in his assessment about the risk of him choking while eating and the concomitant need to supervise him during meals.

Lack of Activities

116. The Department cited the Appellant for failing to provide the full-time residents of House 2 with the opportunity to engage in activities of their choice and for failing to choose activities consistent with their interests, assessments, and negotiated

care plans.[420] This alleged failure was purported to place the House 2 residents "…at risk for diminished mental, social and physical functioning and a decreased quality of life."[421]

117. The House 2 residents' assessments by David Robinson, completed in September 2009, stated that the following residents preferred the following activities:

- ***[RESIDENT 4]***: music, cards and games, reading newspapers, writing, exercise, sports on TV like baseball, helping others, shopping trips, time outdoors, and talking/conversing.
- ***[RESIDENT 10]***: music, talking, visiting, conversation, and TV.
- ***[RESIDENT 3]***: music, talking/conversing, reading/writing, likes to clean and help others.
- ***[RESIDENT 6]***: music, crafts, art, talking, helping others, trips, and time outdoors.
- ***[RESIDENT 2]***: music (especially Big Band), talking, and watching TV.[422]

[RESIDENT 1]'s assessment, also completed by David Robinson, but on October 19, 2009, indicated [RESIDENT 1] liked music, conversation, and TV.[423]

118. When Ms. Corey visited House 2 on November 2, 2009, [RESIDENT 4] was sleeping in a recliner with a newspaper in her lap; [RESIDENT 3] was visiting with her [RELATIVE 4]; [RESIDENT 6] was seated in a recliner with puzzle boxes stacked in front of her but none of the pieces had been taken out and she was not putting a puzzle together; [RESIDENT 10] was roaming around the AFH and talking continuously to nobody in particular; a House 1 resident was drawing or writing with a pencil and paper; one resident was waiting to go to a medical appointment; and the other residents were

---

[420] Department's exhibit 2 at 12 and testimony of Candace Corey.
[421] *Id.*
[422] Appellant's exhibits 16-69, 16-98, 16-145, and 16-192. *See also* Department's exhibit 2 at 13.
[423] Department's exhibit 2 at 13. NOTE: [RESIDENT 1]'s assessment was not submitted as an evidentiary exhibit by either party.

sitting in the living room while the TV was turned on.[424] On November 13, 2009, Ms. Corey observed none of the activities identified in the residents' assessments taking place, with the exception that the TV was on.[425]

119. [RESIDENT 3]'s and [RESIDENT 6]'s assessments did not indicate that either of them prefers TV as an activity.[426] Although [RESIDENT 4]'s assessment did not include a notation indicating that her usual sleep pattern includes napping, her negotiated care plan did include this information.[427] All of the residents' assessments stated that each one liked music and talking, but there was no music playing and there was no conversation between the residents or between the caregiver and the residents that was not related to care when Ms. Corey twice visited in November 2009.[428] The caregiver was very busy with housework, meal preparation, and attending to the care needs of the residents.[429]

120. The Appellant told Ms. Corey that the residents play Bingo, watch TV, and do puzzles.[430] When asked how residents who were unable to be interviewed and who had varying levels of dementia could play Bingo, the Appellant explained that a caregiver would assist them in playing the game.[431]

121. The Appellant testified that there was an activity whiteboard at House 2 on which she, [MANAGER 1], and [CAREGIVER 1] scheduled daily activities on a monthly basis.[432] Sometimes church would be held at House 2, with a preacher, musicians, and

---

[424] Department's exhibit 2 at 5-6 and 13, and testimony of Candace Corey.
[425] Department's exhibit 2 at 13 and testimony of Candace Corey.
[426] Appellant's exhibits 16-69 and 16-98.
[427] Appellant's exhibits 16-192 and 16-209.
[428] Department's exhibit 2 at 13 and testimony of Candace Corey.
[429] *Id.*
[430] *Id.*
[431] *Id.*
[432] Testimony of the Appellant.

singing.[433]

122. [MANAGER 1] testified that many of the items listed in [RESIDENT 4]'s assessment are no longer activities she enjoys doing.[434] Similarly, he stated that [RESIDENT 10] does not listen to music or watch TV.[435] [MANAGER 1] said that a preacher used to come to House 2 and there would be singing.[436] He also claimed that music was played for the residents a couple times per week, that [RESIDENT 2] no longer liked talking, and that [RESIDENT 6] did puzzles and colored, as well as played Bingo and helped [RESIDENT 5] write letters.[437] The September 2009 assessments did not reflect these updates.[438] [MANAGER 1] stated that Bingo was played at House 2 on an alternating schedule, but that not all of the residents took part.[439]

123. A collateral contact informed Ms. Corey on November 9, 2009, that he or she did not believe there were adequate activities for the House 2 residents.[440] The contact stated that this was because there were not enough caregivers at House to engage in activities.[441]

124. During Mr. Tosch's 30-minute visit on November 21, 2009, he observed no House 2 residents taking part in any activities and only two who were interacting with the caregiver.[442] One resident from House 1 was doing a crossword puzzle.[443] He also

---

[433] *Id.*
[434] Testimony of [MANAGER 1].
[435] *Id.*
[436] *Id.*
[437] *Id.*
[438] Appellant's exhibits 16-69, 16-98, 16-145, and 16-192
[439] Testimony of [MANAGER 1].
[440] Department's exhibit 2 at 13.
[441] *Id.*
[442] Testimony of Paul Tosch.
[443] *Id.*

observed that the caregiver, [CAREGIVER 1], was very busy.[444]

125. [CAREGIVER 4] testified that although there was a whiteboard that listed scheduled activities, there was only one occasion when one of the listed activities took place during the two to three months of her tenure at House 2.[445] On this particular day when the scheduled activity actually took place, a couple of the residents sat down and played Bingo.[446]

126. [CAREGIVER 1] testified that [RESIDENT 3] often interacted with her [RELATIVE 4], who visited daily.[447] They would sing, talk, watch TV together, and go through albums.[448]

127. Some family members and a friend of House 2 residents testified that the Appellant would have holiday dinners, birthday parties, or church with a preacher at House 2, and that the staff often interacted with the residents when family and friends were visiting.[449] Another testified that he had seen [RESIDENT 8], a House 1 resident, help [RESIDENT 6] with her puzzles.[450] [FRIEND 2] said she had also seen one of the residents do a lot of crossword puzzles and that another one, aged [AGE], slept a lot.[451] [RESIDENT 1'S RELATIVE] observed "…a lady doing puzzles…," other residents watching TV, and a "…102-year-old lady…" who "mostly slept."[452] [RESIDENT 2'S RELATIVE] also observed residents watching TV, doing puzzles, or playing games, and

---

[444] *Id.*
[445] Testimony of [CAREGIVER 2].
[446] *Id.*
[447] Testimony of [CAREGIVER 1].
[448] *Id.*
[449] Testimony of [RESIDENT 10'S RELATIVE 1]; testimony of [FORMER RESIDENT 1'S RELATIVE]; testimony of [FRIEND 2].
[450] Testimony of [FORMER RESIDENT 1'S RELATIVE].
[451] Testimony of [FRIEND 2].
[452] Testimony of [RESIDENT 1'S RELATIVE].

felt there was "…some interaction and socializing going on."[453] Many family members visited and talked with their relatives who were residents at House 2 as well as with the other residents there.[454]

128. The Appellant had previously been cited, in February 2008, by the Department for failing to ensure the residents had a right to choose activities consistent with their interests, assessments, and negotiated care plans.[455]

129. Despite the Department's previous citation; apparently isolated instances in 2009 when few, if any, activities were being offered to the residents at House 2; and the many tasks assigned to the caregivers at House 2, the undersigned finds on-balance and given the totality of the evidence presented that the Department did not show that the Appellant failed to ensure the residents either participated in or had the opportunity to participate in activities they enjoyed, whether it was watching television, doing puzzles, reading the newspaper, singing, listening to music, talking, playing Bingo, holiday dinners with family and friends, church services in the home, birthday parties, visiting, and otherwise interacting with staff, other residents, family, friends, or the family and friends of other residents.

Inadequate Meals/Food

130. The Department cited the Appellant for violating provisions of the Washington Administrative Code (WAC) that required her to "meet the nutritional needs of each resident" and to have emergency food on-site that meets the nutritional needs

---

[453] Testimony of [RESIDENT 2'S RELATIVE].
[454] Testimony of [RESIDENT 10'S RELATIVE 1]; testimony of [FORMER RESIDENT 1'S RELATIVE]; testimony of [FRIEND 2]; testimony of [RESIDENT 1'S RELATIVE]; and testimony of [FRIEND 1]. *See also* Appellant's exhibits 11-1, 11-3, 11-13, and 11-14.
[455] Department's exhibits 1 at 3 and 2 at 12.

of each resident.[456] Expired regular and emergency food items were observed in the home.[457] By failing "…to have food available in an emergency situation or for regular use that was not expired," the Appellant "…placed residents at risk for illness from consuming spoiled food."[458] Also, the Appellant's custom of storing much of House 2's regular and emergency food at House 1,[459] placed the residents of House 2 at risk of having insufficient food available if something happened to House 1—as it did during the floods of 2007—or the food stored there was otherwise inaccessible to House 2 residents.[460] Both Ms. Corey and Ms. Everett examined the food supply at House 2 and found it lacking in quantity and quality, but Ms. Everett issued the citation.[461]

131. During her visit to House 2 on November 2, 2009, Ms. Corey observed "…a minimal amount of food in the refrigerator which included leftovers and condiments."[462] Specifically, for the six House 2 residents and the many House 1 residents who frequently ate food at House 2, "[t]here were 8 bags of frozen potato products in the freezer (French fries, hash browns and frozen potatoes), one bag of frozen vegetables, 3 one pound packages ground beef, one pound package of ground turkey and one package of Canadian bacon."[463] Ms. Corey's examination of all the food cupboards in the kitchen, with the exception of the cupboard above the refrigerator,[464] revealed that they contained "…packages of jello pudding, an open box of crackers, half

---

[456] Department's exhibit 2 at 10; testimony of Candace Corey; and testimony of Cheryl Everett. See also WAC 388-76-10420(1)(c) and WAC 388-76-10840(2).
[457] *Id.*
[458] *Id.*
[459] Department's exhibit 5 at 1; testimony of the Appellant; testimony of [MANAGER 1]; testimony of [CAREGIVER 1]; testimony of [FORMER MANAGER 1]; testimony of [CAREGIVER 2]; testimony of Candace Corey; testimony of Cheryl Everett; and testimony of Pam Hildreth.
[460] Testimony of Pam Hildreth.
[461] Testimony of Candace Corey and testimony of Cheryl Everett.
[462] Department's exhibit 2 at 11 and testimony of Candace Corey.
[463] *Id.*
[464] Ms, Corey testified that she "…opened up all of the kitchen cupboards," but noted that she did not look in the "…cabinet above the refrigerator."

full packages of cereal, a jar of instant coffee, a jar of peanut butter approximately 1/8th full, small cans of peaches (sugar restricted) and tomato soup."[465] She did not "…look at any other cupboards elsewhere in the home," including the closets in the hallway, or in the food storage room at House 1.[466]

132. After reviewing the regular food supply, Ms. Corey conferred with the Appellant on November 2, 2009, about the lack of available food she observed in House 2 and was informed that the Appellant "…supplied the home with food from the pantry in her other adult family home located across the street."[467] However, there was not enough food available in House 2 and this paucity of food meant there were no choices for the residents although there is supposed to be.[468] No evidence was submitted or presented that the Appellant directed Ms. Corey to other areas in the home where more food might possibly be found, such as the cabinet above the refrigerator or the hallway closets, upon learning that Ms. Corey found the available food supply at House 2 to be insufficient.

133. Ms. Everett inspected the House 2 food supply—both regular and emergency—during her visit on November 13, 2009.[469] Ms. Everett knew where to look for the regular food supply because she asked the Appellant, the Appellant pointed out where it was located, and then Ms. Everett looked there.[470] Likewise, Ms. Everett knew

---

[465] *Id.*
[466] Testimony of Candace Corey.
[467] *Id.* and Department's exhibit 2 at 11.
[468] Testimony of Candace Corey (explaining that because there was only a total of one box of cereal, "…it would have barely… given a small bowl of cereal to each resident" and "[i]f the resident didn't want the cereal that was available in the one package or if they didn't want peanut butter, there wasn't anything available for them to substitute for that"). *See also, e.g.,* WAC 388-76-10510(4) (requiring the AFH to ensure each resident "[h]as the chance to exercise reasonable control over life decisions such as choice…").
[469] Testimony of Cheryl Everett.
[470] *Id.*

where the emergency food was located because "[t]he provider directed me to the emergency food supply" and "[i]t was high up in a cabinet and I had to stand on a chair to look at it."[471] No evidence was submitted or presented that the Appellant directed Ms. Everett to other areas in the home where more emergency food might possibly be found, such as the hallway closet, despite that Ms. Everett specifically asked where the food was located.[472]

134. During or after her inspection, Ms. Everett told Ms. Corey, the Appellant, and [MANAGER 1] that there was expired food in both the refrigerator and the cupboard above the refrigerator.[473] Specifically, there was a jar of Vegenaise, an egg-free sandwich spread, that expired on October 27, 2009, and there were two seven-pound cans of refried beans that expired on November 9, 2008.[474] When Ms. Everett brought the expired food items to the Appellant's attention, the Appellant told Ms. Everett that she checked the regular and emergency food supply on a weekly basis, but that she must have missed the expired items.[475]

135. Both the presence of the refried beans and the Vegenaise in House 2 on November 13, 2009, and their expiration dates were undisputed by the parties at the hearing. There was absolutely no evidence or argument set forth at the hearing by either party that even remotely suggested, much less established, that these expiration dates were actually "best by" dates or that these dates merely indicated the manufacturers' recommendations for best flavor and nutritional value.[476]

---

[471] *Id. See also* testimony of [MANAGER 1] (explaining that he saw Ms. Everett looking at the food in the cabinet above the refrigerator).
[472] Testimony of Cheryl Everett.
[473] *Id.* and testimony of Candace Corey; testimony of the Appellant; and testimony of [MANAGER 1].
[474] *Id.* and Department's exhibit 2 at 11.
[475] Testimony of Cheryl Everett and Department's exhibit 2 at 11.
[476] *See Initial Order*, Conclusion of Law 5.10 at 73.

136. [MANAGER 1] asserted at the hearing that there was more food at House 2 than either Ms. Corey or Ms. Everett observed in November 2009.[477] He alleged that Ms. Everett ceased her inspection of the cabinet above the refrigerator upon finding the expired refried beans, that there was more food in that cabinet and she did not see it, and that neither Ms. Corey nor Ms. Everett looked in the hallway closet for the food purportedly stored there.[478]

137. The Appellant had previously been cited by the Department, in February 2008, because the unusable food, the amount of which filled 11 garbage bags, found at House 2 in November 2007 constituted a failure to ensure the residents received the necessary care and services to reach the highest level of physical well-being or to actively support the residents' quality of life.[479]

138. Given that Ms. Everett specifically asked to be directed to where the food for House 2 was located and the Appellant told her, any failure by her or Ms. Corey to observe all the food that was purportedly located elsewhere at House 2 must be attributed to the Appellant. In light of Ms. Everett's request for direction and her subsequent search, the undersigned does not find credible [MANAGER 1]'s statement that Ms. Everett stopped her inspection immediately upon discovering the expired refried beans and therefore missed many of the other items purportedly located in the same cabinet. In addition, the lists of food allegedly available to the residents are undated, unsigned, and otherwise lack any indicia of reliability to establish that the

---

[477] Testimony of [MANAGER 1] (also noting that there was enough food in the storage room at House 1 "…for the whole neighborhood," but the undersigned does not find this point relevant to the citation for House 2).
[478] *Id.* and Appellant's exhibits 6-3 and 6-4.
[479] Department's exhibit 2 at 11 and testimony of Candace Corey. *See also* WAC 388-76-10400(2) and (3)(a).

identified food was truly located at House 2 on either November 2, 2009, or November 13, 2009.[480] Based on Ms. Corey's and Ms. Everett's observations, [MANAGER 1]'s lack of credibility, and the Appellant's previous citation for expired foods, the undersigned finds that the amount and quality of the food available at House 2 on November 2, 3009, and November 13, 2009, were insufficient to meet the residents' nutritional and dietary needs.

Insufficient Emergency Lighting

139. The Appellant was cited by the Department for failing to have more than one working flashlight in House 2.[481] Failure to have sufficient emergency lighting "…placed residents at risk of injury during an emergency."[482] Although Ms. Corey observed that the "plug-in type" of rechargeable flashlight located on the desk in the office did not work when she tried to turn it on while going through resident records, Ms. Everett issued this citation.[483]

140. During her inspection on November 13, 2009, Ms. Everett observed that there was one working flashlight on a counter in the office, along with a plug-in rechargeable flashlight that did not work.[484] There were also "…six flashlight batteries located in a drawer across from the flashlight."[485] [MANAGER 1] testified that there was a third flashlight, also in the office.[486] This purported additional flashlight "…needed a battery replaced…," but there were allegedly batteries nearby in a drawer in the

[480] Appellant's exhibits 6-3 and 6-4.
[481] Department's exhibit 2 at 14; testimony of Candace Corey; and testimony of Cheryl Everett.
[482] *Id.*
[483] *Id.*
[484] Department's exhibit 2 at 14 and testimony of Cheryl Everett.
[485] Department's exhibit 2 at 14.
[486] Testimony of [MANAGER 1].

office.[487]

141. There was no evidence or argument presented at the hearing to indicate that the Appellant may have had types of emergency lighting other than flashlights, such as candles or camping lanterns, available at House 2. Had such means of illumination been present, they presumably would have been observed by Ms. Corey or Ms. Everett during their investigation and inspection or pointed out to Department staff by the Appellant when the citation was issued. There was also no evidence or argument set forth at the hearing that even remotely suggested, much less established, that the Appellant's and [APPELLANT'S RELATIVE 1]'s car headlights could be used as emergency lighting if shone on House 2.[488]

142. Although there was a discrepancy between the testimony of Ms. Everett and [MANAGER 1] about whether there was a total of two or three flashlights in House 2, the relevant and undisputed fact is that only one of the flashlights was operable in November 2009.[489] The applicable regulation does not indicate a required number of working flashlights, but the plural form is stated.[490] In an emergency at House 2, there was only one flashlight that would work immediately upon turning it on and stay on.[491] The undersigned finds there was only one working flashlight in House 2 that was truly readily accessible as emergency lighting. There was no other apparent source of working, readily accessible emergency lighting available.

Improperly Posted Inspection Report

---

[487] *Id.*
[488] *See Initial Order*, Conclusion of Law 5.14 at 77.
[489] Testimony of Cheryl Everett and [MANAGER 1]. *See also* testimony of Candace Corey (stating that the rechargeable flashlight did not work).
[490] WAC 388-76-10740(2).
[491] Testimony of Cheryl Everett and [MANAGER 1]. *See also* testimony of Candace Corey (stating that the rechargeable flashlight did not work).

143. The Department cited the Appellant for failing to post the notice of inspection results in a visible location in House 2.[492] This failure to make the inspection results readily available for review by residents, representatives, or visitors "…resulted in residents and resident representatives not having access to information regarding operation of the adult family home to enable them to make informed choices about continued residency."[493] Ms. Corey observed that the inspection results were obscured by other papers affixed to a bulletin board in House 2, but Ms. Everett issued the citation.[494] The Appellant's posting of the inspection report itself was apparently intended to function as the required notice that the inspection report was available and thus both the report and notice are referenced interchangeably in this *Review Decision and Final Order's* Findings of Fact and Conclusions of Law related to this violation.

144. On November 13, 2009, Ms. Everett observed that the Appellant had a bulletin board in the office of House 2 on which the inspection report was posted, but that the report was completely masked by papers tacked over it.[495] She found the inspection report was not visible because it was (a) on a bulletin board in the office, which was not a central location indicating the inspection report was available for review, and (b) covered up by other papers.[496] When Ms. Everett notified the Appellant of this deficiency, the Appellant responded that the caregivers must have placed the papers over the inspection report.[497] As noted by Ms. Everett, merely removing the papers that were covering the inspection report would not have corrected the deficiency

[492] Department's exhibit 2 at 14; testimony of Candace Corey; and testimony of Cheryl Everett.
[493] *Id.*
[494] Testimony of Candace Corey and testimony of Cheryl Everett.
[495] Testimony of Cheryl Everett and Department's exhibit 2 at 14.
[496] *Id.*
[497] *Id.*

because it was not in a conspicuous area available to the residents and their representatives for review.[498] Although Ms. Everett did not instruct the Appellant about where to post the inspection report, Ms. Everett did suggest the dining area or near the front door as a more conspicuous posting place.[499] That same day, the Appellant re-posted the report in a more central location, unobscured by other papers.[500] As noted by Ms. Corey and Ms. Everett, correcting the deficiency, however, does not relieve the Department of its duty to issue the citation.[501] Ms. Corey testified that the purpose of the regulation requiring the posting of notice about these inspection reports is to ensure it is visible so that those who may need or want to see the inspection reports have the opportunity to do so and may ask questions about the operation of the AFH.[502]

145. When questioned about where the inspection report currently hangs, [MANAGER 1] testified that the inspection report is posted on a bulletin board that hangs on a wall in the dining room, next to the door everyone uses to enter and exit House 2.[503] He did not indicate that this is where the bulletin board was hanging or where the inspection report was posted on November 13, 2009. However, [MANAGER 1] agreed that on November 13, 2009, the inspection report "…was not completely visible because it was being obstructed by the newspaper article," which "…had been pinned over the top of it" and was "…half [of a] page of a newspaper."[504]

146. The Appellant asserted at the hearing that the bulletin board on which the inspection report was posted has always hung in the dining room and that it was never

---

[498] Testimony of Cheryl Everett.
[499] *Id.*
[500] *Id.*
[501] Testimony of Candace Corey and testimony of Cheryl Everett.
[502] Testimony of Candace Corey.
[503] Testimony of [MANAGER 1].
[504] *Id.*

moved from the office to that location.[505] The Appellant agreed that at least a "…portion of the report was covered…" by a "…newspaper that somebody clipped."[506] Nonetheless, she insisted that the report was available for review because it was "bright yellow."[507]

147. It is stated in Conclusion of Law 5.13 of the *Initial Order* that "…the bulletin board with the notice was in the office…" and that the office was "…part of the overall open floor plan of House Two." However, (1) the evidence indicating that the living room and dining room were a combined large, open area with the kitchen and office as separate rooms off that large, open common area and (2) Ms. Everett's testimony and documentation that the office was not a visible location do not support this conclusion.[508] The ALJ made no findings about Ms. Everett's, the Appellant's, or [MANAGER 1]'s credibility on these issues.

148. Based on Ms. Everett's testimony, which the undersigned has no basis to disbelieve, that the bulletin board on which the inspection report was posted was located in the office, which was not a conspicuous location; the ALJ's conclusion that the bulletin board was in the office; and [MANAGER 1]'s lack of specificity about where the bulletin board was located on November 13, 2009, coupled with his and the Appellant's lack of credibility on other issues, the undersigned finds it more credible that the bulletin board on which the inspection report was posted was located in the office. This was not a visible location indicating the inspection report was available for review. Further, the inspection report was not itself visible because it was covered up with a

[505] Testimony of the Appellant.
[506] *Id.*
[507] *Id.*
[508] *Id.*

newspaper clipping.

Inability to Provide Care & Services/Lack of Understanding

149. The Appellant was cited by the Department for failing "…to understand the need to comply with minimal licensing requirements to ensure the physical and special care needs of vulnerable adults were met."[509] By failing to ensure the AFH was not over its capacity, a caregiver had current CPR certification, a negotiated care plan accurately reflected the assessment, and that several other regulatory requirements were met, the Appellant "…placed the residents at risk of harm from unmet physical and supervision needs" and diminished their quality of life.[510]

150. The Appellant's attorney contended at the hearing that the existence of undated House 2 policies,[511] which may have been created after the Department's investigation in November 2009, indicated that the Appellant does understand the minimum licensing requirements for AFHs and that she satisfied those requirements. While some of these policies could possibly serve as one indicator of the Appellant's current understanding necessary to meet the needs of vulnerable adults, they do not establish by a preponderance of the evidence that the Appellant possessed such an understanding at the time of the investigation and previously. Furthermore, the Appellant's continued insistence that House 2 was not overcapacity when there were 11 AFH residents present and only one caregiver; blaming [CAREGIVER 1] for the citation related to caregiver CPR certification requirements; and failing to include information in [RESIDENT 2]'s negotiated care plan about his risk of choking and the need to supervise him during meals, underscore for the undersigned that the Appellant does not

[509] Department's exhibit 2 at 2 and testimony of Candace Corey.
[510] *Id.*
[511] Appellant's exhibit 13.

possess the understanding and ability to provide the necessary care and services to these residents, regardless of whatever policies may currently be in place at House 2.

151. In response to the above-described cited violations, as set forth in the Department's hand-delivered December 16, 2009, notice, the Appellant request an IDR meeting on December 24, 2009, and January 7, 2010.[512] The Appellant also requested an administrative hearing on January 6, 2010.[513] At the conclusion of the five-day hearing on May 7, 2009, the ALJ asked the parties to provide briefing in their closing arguments about whether the ALJ was required to affirm all of the Department's citations in order to affirm the revocation; which specific citations must be affirmed in order to affirm the revocation; and if any authority gives an AFH provider a "grace period" to replace an RM.

III. CONCLUSIONS OF LAW

1. **General Authority.** The Department's petition for review of the *Initial Order* and the Appellant's response were timely filed and are otherwise proper.[514] The ALJ had jurisdiction to hear and determine whether the citations and remedies set forth in the Department's Stop Placement of Admissions and Revocation of License notice and its incorporated Statement of Deficiencies were correct.[515] Chapter 388-76 WAC implements Chapter 70.128 RCW, entitled "Adult family homes." The authority to promulgate rules "…with respect to adult family homes and the operators thereof to be licensed under this chapter to carry out the purposes and requirements of this chapter…" is granted to the Department in RCW 70.128.040(1). Administrative hearings

[512] Department's exhibit 5.
[513] Appellant's exhibit 17.
[514] WAC 388-02-0560 through WAC 388-02-0585.
[515] Chapter 34.12 RCW; Chapter 70.128 RCW; WAC 388-76-10995; and Chapter 388-02 WAC.

conducted pursuant to Chapter 388-76 WAC and subsequent administrative review of the ALJs' *Initial Orders* are subject to the statutes and regulations found at Chapter 34.05 RCW, Chapter 10-08 WAC, and Chapter 388-02 WAC. Jurisdiction exists to review the *Initial Order* and to enter the Department's *Review Decision and Final Order*.[516]

2. It may help to explain briefly at the outset the unique characteristics and specific limitations of the administrative hearing process. An administrative hearing is held under the auspices of the *executive branch of government* and neither the ALJ nor the Review Judge enjoy the broad equitable authority of a Superior Court Judge within the *judicial branch of government.* It is well settled that administrative agencies, such as the OAH and the Board of Appeals, are creatures of statute, without inherent or common law powers, and, consequently, they may exercise only those powers expressly granted in enabling statutes or necessarily implied therein.[517] It is also well settled that an ALJ's or a Review Judge's jurisdictional authority to render a decision in an administrative hearing is limited to that which is specifically provided for in the authorizing statute(s) or WAC provision(s).[518] This is because ALJs and Review Judges must first apply the Department rules adopted in the WAC to resolve an issue.[519] If there is no Department WAC governing the issue, the ALJ and the Review Judge must resolve the issue on the basis of the best legal authority and reasoning available, including that found in federal

---

[516] Chapter 34.05 RCW; WAC 388-02-0530(2); WAC 388-02-0570; and WAC 388-02-0600. *See also* Chapter 70.128 RCW and WAC 388-76-10995.
[517] *Skagit Surveyors & Eng'rs, L.L.C. v. Friends of Skagit County*, 135 Wn.2d 542, 558 (1998), and *Taylor v. Morris,* 88 Wn.2d 586, 588 (1977). *See also* WAC 388-02-0216 (limiting "[t]he authority of the ALJ and the review judge is limited to those powers conferred (granted) by statute or rule… [t]he ALJ and the review judge do not have any inherent or common law powers").
[518] *Id.*
[519] WAC 388-02-0220(1).

and Washington constitutions, statutes and regulations, and court decisions.[520] The ALJ and the Review Judge may not declare any rule invalid, and challenges to the legal validity of a rule must be brought *de novo* in a court of proper jurisdiction.[521]

3. "The power of an administrative tribunal to fashion a remedy is strictly limited by statute."[522] Again, the only discretionary authority afforded to ALJs and Review Judges is that which is set forth, either explicitly or implicitly, in statute or agency rule.[523] As a result, the ALJ and the undersigned have extremely limited authority to grant equitable relief in this administrative forum.[524] Equity within the administrative hearing process generally comes from equal application of the law to the supported facts for all who appear before the tribunal. ALJs and Review Judges do not have the same opportunity as Superior Court Judges to fashion an equitable remedy.

4. In an adjudicative proceeding regarding Department action against an AFH license, the undersigned has the same authority as the ALJ to enter Findings of Fact, Conclusions of Law, and Orders.[525] In this case, many of the Findings of Fact in the *Initial Order* were merely recitations of each witness's testimony or the residents' assessments and care plans; were not supported by a preponderance of the evidence; or contradicted each other with no credibility determinations to indicate which of the conflicting findings were relied upon to reach the initial decision.[526] For these reasons, some of the Findings of Facts from the *Initial Order* have been deleted, others modified,

---

[520] WAC 388-02-0220(2).
[521] WAC 388-02-0225(1).
[522] *Skagit Surveyors & Eng'rs v. Friends of Skagit County*, 135 Wn.2d 542, 558 (1998).
[523] WAC 388-02-0216.
[524] WAC 388-02-0495 (setting forth the only explicit equitable remedy of which the undersigned is aware in administrative hearings applying the Department's WAC provisions).
[525] WAC 388-02-0600(1). *See also* RCW 34.05.464(4); *Tapper v. Employment Security*, 122 Wn.2d 397 (1993); and *Northwest Steelhead and Salmon Council of Trout Unlimited v. Washington State Dept. of Fisheries,* 78 Wn. App 778 (1995).
[526] *See Initial Order*.

some added, and the order of many of them rearranged by chronology or by issue rather than by witness. As required by RCW 34.05.461(3) and WAC 388-02-0250(3), these final Findings of Fact have been set forth in this *Review Decision and Final Order*. Credibility findings have been made by the undersigned in instances when the evidence presented conflicted and the Findings of Fact were based substantially on those credibility determinations.[527]

5. The Washington Administrative Procedures Act broadly states that the undersigned Review Judge has precisely the same decision-making authority when deciding and entering the *Final Order* as the ALJ had while presiding over the hearing and deciding and entering the *Initial Order*, unless the Review Judge or a provision of law limits the issue subject to review.[528] RCW 34.05.464(4) grants the undersigned Review Judge the same decision-making authority as the ALJ and in the same manner as if the undersigned had presided over the hearing.[529] This includes the authority to make credibility determinations, weigh the evidence, and change or set aside the ALJ's findings of fact.[530] This is because "…administrative review is different from appellate review."[531] The undersigned Review Judge does not have the same relationship to the

---

[527] *See* RCW 34.05.461(3) (stating that "[a]ny findings based substantially on credibility of evidence or demeanor of witnesses shall be so identified…") and WAC 388-02-0520(3) and (4) (requiring inclusion of "…the facts used to resolve the dispute based on the hearing record… [and an explanation] why evidence is credible when the facts or conduct of a witness is in question").

[528] RCW 34.05.464(4). *See also* WAC 388-02-0600(1).

[529] *Kabbae v. Dep't of Soc. & Health Servs.*, 144 Wn. App. 432, 443 (2008) (citing RCW 34.05.464(4) as the basis for invalidating WAC 388-02-0600(2)(e)—now repealed—which purported to limit the scope of the undersigned's decision-making authority when reviewing certain types of cases).

[530] *See Hardee v. Dep't of Soc. & Health Servs.,* 152 Wn. App. 48, 59 (2009), *review granted,* 168 Wn.2d 1006 (2010) (referring to the court in *Regan v. Department of Licensing*, which "…held that a reviewing officer has the authority 'to modify or replace an ALJ's findings, including findings of witness credibility' and stated that the statute does not require a reviewing judge to defer to the ALJ's credibility determinations, but rather authorized the reviewing judge to make his or her own independent determinations based on the record"). *See also Regan v. Dep't of Licensing*, 130 Wn. App. 39, 59 (2005).

[531] *Kabbae*, 144 Wn. App. at 441 (explaining that this is because the final decision-making authority rests with the agency head). *See also Messer v. Snohomish County Bd. of Adjustment*, 19 Wn. App. 780, 787

ALJ as an Appellate Court Judge has to a Trial Court Judge or that a Trial Court Judge has to a Review Judge in terms of the level of deference owed by the Review Judge to the presiding ALJ's findings of fact.[532] The Review Judge's authority to substitute his or her judgment for that of the presiding ALJ on matters of fact as well as law is the difference.[533] However, if the ALJ specifically identifies any findings of fact in the *Initial Order* that are based substantially on the credibility of evidence or demeanor of the witnesses,[534] a Review Judge must give due regard to the ALJ's opportunity to observe the witnesses when reviewing those factual findings by the ALJ and making his or her own determinations.[535] This does not mean a Review Judge must defer to an ALJ's credibility findings, but it does require that they be considered.[536]

6. Review Judges must personally consider the entire hearing record or such portions of it as may be cited by the parties.[537] Consequently, the undersigned has considered the adequacy, appropriateness, and legal correctness of all initial Findings of Facts, Conclusions of Law, and admitted evidence, regardless of whether any party has asked that they be reviewed. Because the ALJ is directed to decide the issues *de novo* (as new),[538] the undersigned has also decided the issues *de novo*.[539] In accordance with RCW 34.05.464(4) and WAC 388-02-0600(1), the undersigned has

(1978) (stating that "[t]he general legal principles which apply to appeals from lower to higher courts do not apply to administrative review of administrative determinations").

[532] *See, e.g., Tapper v. Employment Sec. Dep't.,* 122 Wn.2d 397, 404-05 (1993), *overruled on other grounds by Markam Group, Inc. v. Employment Sec. Dep't,* 148 Wn. App. 555, 562 (2009), and Andersen, *The 1988 Washington Administrative Procedure Act – An Introduction,* 64 Wash. L. Rev. 781, 816 (1989).

[533] *Id.*

[534] RCW 34.05.461(3).

[535] RCW 34.05.464(4) and WAC 388-02-0600(1).

[536] *Hardee*, 152 Wn.App. at 59 (stating that RCW 34.05.464(4) permits a Review Judge to make his or her own independent credibility determinations and need not defer to the ALJ's as long as the ALJ's credibility findings are duly contemplated).

[537] RCW 34.05.464(5). *See also* WAC 388-02-0560(4).

[538] WAC 388-02-0215(1).

[539] RCW 34.05.464(4) and WAC 388-02-0600(1). *See also Hardee*, 152 Wn. App. at 59.

given due regard to the ALJ's opportunity to observe the witnesses, but has otherwise independently decided the case.

7. During the course of this particular case, some of the applicable WAC provisions were amended.[540] As clarified in WAC 388-02-0220(3) "[w]hen applying program rules regarding the substantive rights and responsibilities of the parties (such as eligibility for services, benefits, or a license), the ALJ and review judge must apply the program rules that were in effect on the date the department notice was sent, unless otherwise required by other rule or law…."[541] In this matter, this means the substantive rules set forth in Chapter 388-76 WAC—as opposed the procedural rules set forth primarily in Chapter 388-02 WAC—describing the Appellant's rights and responsibilities that were in effect at the time of the Department's action in December 2009 are the rules that must be applied. Where the undersigned analyzed the facts of this case based on WAC provisions that have been amended since the Department's action, the former WAC provisions are cited and noted.

8. "When applying program rules regarding the procedural rights and responsibilities of the parties, the ALJ and review judge must apply the rules that are in effect on the date the procedure is followed."[542] This generally means those procedural rules that were in place when the ALJ or the undersigned Review Judge followed them are those that have been applied rather than those procedural rules that were in effect

---

[540] *See* WSR 10-03-064; WSR 10-04-008; WSR 10-16-082; and WSR 11-04-074 (noting amendments to various provisions of Chapter 388-76 WAC, effective February 15, 2010; February 22, 2010; January 1, 2011; and
March 3, 2011, respectively)
[541] *See also Gersman v. Group Health Ass'n, Inc.*, 975 F.2d 886, 900 (D.C.Cir.1992), *cert. denied* 511 U.S. 1068 (1994) (holding that the rights and responsibilities of the parties must be adjudicated as they were under the law prevailing at the time of the Department's conduct that gave rise to the hearing because "[i]t is the general rule that substantive statutory amendments do not apply to pre-amendment conduct").
[542] WAC 388-02-0220(4).

at the time of the Department's action. The ALJ and Review Judge are required to apply the rules in Chapter 388-02 WAC on the date each rule is effective, including WAC 388-02-0220 (effective March 03, 2011).[543]

9. **Standard of Proof**. The standard of proof refers to the amount of evidence needed to prove a party's position. [544] A preponderance of the evidence means that it is more likely than not that something happened or exists.[545] The burden of proof is borne by the party attempting to persuade the ALJ that his or her position is correct.[546]

10. Unless a WAC provision, RCW provision, or published case law states otherwise, the standard of proof in a Department hearing is a preponderance of the evidence.[547] This is the standard applied in AFH licensing cases because there is no regulation, statute, or case specifically addressing the licensing of AFHs that requires a different standard. The Appellant asserts that the standard of proof in AFH licensing cases should be clear, cogent, and convincing evidence because published case law, namely, *Nguyen v. Dep't of Health*, 144 Wn.2d 516 (2001) and *Nims v. Bd. of Registration*, 113 Wn. App. 499 (2002), held that constitutional due process requires a higher standard than mere preponderance of the evidence when revoking the professional license of a physician and engineer, respectively.[548]

---

[543] WAC 388-02-0220(6).
[544] WAC 388-02-0485.
[545] *Id.*
[546] WAC 388-02-0480(2).
[547] WAC 388-76-10995(3) and WAC 388-02-0485.
[548] *See also Ongom v. Dep't of Health*, 159 Wn.2d 132 (2006) (nursing assistant). *But see Eidson v. Dep't of Licensing*, 108 Wn. App. 712, 721 (2001) (remanding for reconsideration of the sanction imposed on a real estate appraiser's license, but upholding application of a preponderance of the evidence standard because "the appraiser disciplinary proceedings involved… were all based on violations of… objective standards of conduct" so the less stringent "…preponderance of the evidence standard sufficiently protected both [the license holder's] interests and the interests of the public").

11. Although it may be correct that an AFH license is a constitutionally protected property right,[549] the revocation of which requires, at minimum, due process of notice and an opportunity to be heard, it does not necessarily follow that all licensees are entitled to a standard of proof higher than a preponderance of the evidence when faced with possible revocation of their licenses.[550] As also found by the Court of Appeals of Washington, Division One, in *Islam v. Dep't of Early Learning*, 157 Wn. App. 600, 609 (2010) and *Hardee v. Dep't of Soc. & Health Servs.,* 152 Wn. App. 48, 56 (2009), "…professional licenses issued to individuals under the Uniform Disciplinary Act, *chapter 18.130 RCW*…" in *Nguyen* and *Ongom* differ, in terms of the level of due process required, from those that are "…more in the nature of a site license…" restricted to a certain location.

12. Like the child care center license in *Islam* and the family child care home license in *Hardee*, the requirements for obtaining an AFH license are relatively minimal.[551] In addition, an AFH license is not transferable and, like a child care license, is valid only for the licensee and address listed on the license.[552] A particular professional license is not required to obtain either a child care license or an AFH license.[553] As a result, the undersigned concludes that the Appellant's AFH license is

---

[549] *Conway v. DSHS*, 131 Wn. App. 406, 418 (2005) (noting that "…the parties do not dispute that Conway has a protected property interest in her AFH license").
[550] *See id.* (remanding for modification of the Department's revocation of last remaining AFH license, but taking no issue with the preponderance of the evidence standard applied in that matter); *Eidson,* 108 Wn. App. at 721 (upholding application of the preponderance of evidence standard to revocation of a real estate appraiser's license); *Islam v. Dep't of Early Learning*, 157 Wn. App. 600, 613 (2010) (holding that the state's interest in the safety of children in state-licensed child care centers supports the enforcement of child care licensing standards by a preponderance of the evidence); and *Hardee*, 152 Wn. App. at 51 (holding that "[d]ue process is satisfied by application of the preponderance of the evidence standard to the revocation of a home child care license").
[551] *See* WAC 388-76-10055 through WAC 388-76-10110. *See also Islam*, 157 Wn. App. at 609; *Hardee*, 152 Wn. App. at 56; Chapter 170-295 WAC; and Chapter 170-296 WAC.
[552] WAC 388-76-10010(3). *See also* RCW 43.215.260 and *Islam*, 157 Wn. App. at 609.
[553] *See, e.g.,* RCW 70.128.128; *Islam*, 157 Wn. App. at 609; Chapter 170-295 WAC; Chapter 170-296

more in the nature of a site license than a professional license of an individual; the reasoning and holdings applied in *Islam* and *Hardee* are likewise applicable to AFH licenses; and due process is satisfied by application of the preponderance of the evidence standard to the revocation of the Appellant's AFH license.

13. It is also important to note that the Washington State Legislature has statutorily found the State has a "compelling interest" to protect and promote the well-being of vulnerable adults[554] residing in AFHs.[555] Also, as held by the Court of Appeals of Washington, Division Two, in *Bond v. Dep't of Soc. & Health Servs.*, 111 Wn. App. 566, 575 (2002),

> One of our government's most sacred duties is to protect those unable to care for themselves. When balancing the needs of vulnerable adults entrusted to state care and the interests of even well-meaning caregivers who fail to provide necessary and adequate supervision over their charges, DSHS must give priority to the safety of these vulnerable adults.

Requiring the Department to satisfy a more stringent standard of proof in AFH licensing matters may provide greater due process protection to AFH licensees like the Appellant, but it also increases the likelihood that AFHs not meeting minimum licensing requirements will continue operating and placing vulnerable adult residents at risk of harm. This is not consistent with the legislative mandate or Division Two case law

---

WAC; and Chapter 388-76 WAC. *See also Kraft v. Dep't of Soc. & Health Servs*., 145 Wn. App.708 (2008) (rejecting the petitioner's argument that application of the clear, cogent, and convincing standard of proof was required because a finding of mental abuse of a vulnerable adult pursuant to RCW 74.34.020 might result in the loss of her teaching credential and thus was comparable to a license revocation under RCW 18.120.050(1)). Similarly, although the Appellant is a licensed practical nurse (L.P.N.), this is not a requirement for AFH licensure and there was no evidence presented that revocation of her license to operate House 2 will affect her status as an L.P.N.

[554] According to RCW 74.34.020(16)(d), the full-time residents of both House 1 and House 2 were vulnerable adults by virtue of their admission to an AFH, a "facility" as that term is defined at RCW 74.34.020(5). Each resident of House 1 also met the definition of a vulnerable adult because they have developmental disabilities; each resident of House 2 met the definition as well because they were all over the age of sixty and were functionally, mentally, or physically unable to care for themselves. RCW 74.34.020(16)(a) and (c). *See also* WAC 388-76-10000.

[555] RCW 70.128.005(4) (further noting that "[t]he health, safety, and well-being of vulnerable adults must be the paramount concern…").

establishing that "[t]he health, safety, and well-being of vulnerable adults must be the paramount concern in determining whether to issue a license to an applicant, whether to suspend or revoke a license, or whether to take other licensing actions."[556]

14. As noted previously, administrative tribunals are creatures of statute and thus their authority when rendering decisions is limited; this power is further restricted in Department matters by the requirement that presiding and reviewing officers apply the WAC as the first source of law.[557] Only when no WAC provision applies may an ALJ or Review Judge rely on other available legal authorities.[558] In Department hearings, the default standard of proof is a preponderance of the evidence.[559] An ALJ or Review Judge may apply a different standard of proof only if "…the rules or law states otherwise."[560] There are no rules or law stating otherwise. The preponderance of the evidence standard in AFH licensing cases is supported by the analogous case law cited in Conclusions of Law 11 and 12 and the legislative findings and case law described in Conclusion of Law 13 of this *Review Decision and Final Order*. As such, neither the ALJ nor the undersigned have the power to extend the holdings in *Nguyen*, *Ongom*, and *Nims* to the present case. Absent rules or law establishing that the clear, cogent, and convincing standard of proof applies to AFH licensing matters, the standard of proof remains a preponderance of the evidence.

15. **Capacity**. RCW 70.128.010 defines capacity, in relevant part, as "…the

[556] *Id. See also Bond*, 111 Wn. App. at 575 (determining that the licensee placed her five developmentally disabled residents at imminent risk of harm by failing to ensure the very vulnerable residents were cared for by a fully qualified caregiver when the licensee was absent for a six-hour period due to a family emergency).
[557] WAC 388-02-0220(1); *Skagit Surveyors & Eng'rs, L.L.C. v. Friends of Skagit County*, 135 Wn.2d 542, 558 (1998); and *Taylor v. Morris,* 88 Wn.2d 586, 588 (1977)
[558] WAC 388-02-0220(2).
[559] WAC 388-02-0485.
[560] *Id.*

maximum number of persons in need of personal or special care permitted in an adult family home at a given time…" Similarly, the WAC provision in effect at the time of the Department's December 2009 citation of the Appellant for operating an AFH over its licensed capacity defined capacity as "the maximum number of persons in need of personal or special care permitted in an adult family home at a given time and includes related children or adults in the home who receive personal care or special care and services."[561] An "adult family home" is statutorily defined as "a residential home in which a person or persons provide personal care, special care, room, and board to more than one but not more than six adults who are not related by blood or marriage to the person or persons providing the services."[562] The evidence presented at the hearing in this matter established that (1) the Appellant's license for House 2 is limited to the maximum AFH capacity of six adults, (2) there were at least nine, and as many as eleven or twelve, "…persons in need of personal or special care…" from both House 1 and House 2 at House 2 on a regular basis, sometimes for many hours at a time, and (3) the full-time residents of House 1 who were at House 2 often could not return to House 1 because there was no caregiver present there. In addition, the House 2 caregiver provided, and was obliged to provide, the care and services that House 1 residents might need while they were at House 2.[563]

---

[561] Former WAC 388-76-10000, amended effective February 15, 2010. *See* WSR 10-03-064 at 17.
[562] RCW 70.128.010(1). *See also* WAC 388-76-10000 (mirroring the statutory definition of an AFH, but also adding at subsection (2) that "…the term 'adult family home' includes the person or entity that is licensed to operate an adult family home").
[563] Contrary to the Appellant's argument that the House 1 residents were merely visitors at House 2 and thus the caregiver had no responsibility to them if they choked on food or had a heart attack, RCW 74.34.020(12)(b) —in contrast to RCW 74.34.020(12)(a), but consistent with the BOA's interpretation of RCW 74.34.020(2)—does not appear to require there to be a duty of care to find a person or entity committed neglect against a vulnerable adult if there was "…an act or omission 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

16. The Appellant argues that the WAC provision addressing license capacity in effect at the time of the Department's action against the Appellant somehow undermines the statutory and regulatory definitions of "capacity" and of an "adult family home," and must be construed to include only those persons who actually lived or resided[564] in House 2 on a full-time basis.[565] This argument is based on former subsections (1), (2)(c), and (2)(e) of that WAC, which stated, "[t]he Department will only issue an adult family home license for more than one but not more than six residents" and "[i]n determining the home's capacity, the Department must consider… "[t]otal number of people living in the home who require personal or special care… and [t]he ability for the home to safely evacuate all people living in the home," respectively.[566]

17. Rules of statutory construction, such as those that require consideration of all provisions in relation to one another, harmonizing the provisions to ensure proper construction of each provision, and reconciling conflicting provisions to give effect to each of them without distorting the language used, also apply to the interpretation of

---

9A.42.100." *See also* WAC 388-76-10000 (although this rule was amended effective February 15, 2010, and January 1, 2011, this provision defining "neglect" was unchanged. *See* WSR 10-03-064 and WSR 10-16-082). Alternatively, the caregiver at House 2 may be defined as a "person or entity with a duty of care," as set forth at WAC 388-71-0101, to the House 1 residents when they were at House 2 if she was providing "…the basic necessities of life to the vulnerable adult on a continuing basis…" Or the caregiver may be viewed as an extension or agent of the Appellant—who certainly was a "person or entity with a duty of care" to both House 1 and House 2 residents according to the regulatory definition—since the Appellant was "…ultimately responsible for the operation of the adult family home" pursuant to WAC 388-76-10015(2).

[564] The terms "lived," "live," "living," "resided," "reside," and "residing" are not defined in Chapter 388-76 WAC or Chapter 70.128 RCW, but the term "resident" is. In RCW 70.128.010(4), a resident is defined as "…an adult in need of personal or special care in an adult family home who is not related to the provider." In WAC 388-76-10000, the term "resident" is defined, in relevant part, as "…any adult unrelated to the provider who lives in the adult family home and who is in need of care…" (although this rule was amended effective February 15, 2010, and January 1, 2011, this provision defining "neglect" was unchanged. *See* WSR 10-03-064 and WSR 10-16-082).

[565] *See* former WAC 388-76-10030, amended effective February 15, 2010 (describing license capacity). *See* WSR 10-03-064 at 23.

[566] Former WAC 388-76-10030(1), (2)(c), and (2)(e), amended effective February 15, 2010. *See* WSR 10-03-064 at 23.

administrative rules and regulations.[567] Application of these rules of statutory construction leads the undersigned to conclude that the provisions of former WAC 388-76-10030 cited by the Appellant do not preclude counting persons who resided in another AFH (House 1) on a full-time basis toward the total number of "…persons in need of personal or special care…" present at House 2, especially in the context of the authorizing statutes and as part of the regulatory framework that includes the definitions of "capacity" and "adult family home." Former WAC 388-76-10030(1) stated that the Department would not issue a license to an AFH with more than six residents, but the persons who live at House 1 are also "residents" of an AFH as that term is defined in RCW 70.128.010(4) and WAC 388-76-10000. In addition, this prohibition on the issuance of a license to an AFH with less than one resident or more than six residents does not necessarily mean that license capacity is restricted or refers only to residents or only to the residents of House 2, particularly when read in conjunction with the definition of "capacity" included in RCW 70.128.010(9) and the former WAC 388-76-10000, both of which refer more broadly to the number of people in an AFH who are in need of care. The mandate in former WAC 388-76-10030(e) that the Department consider the ability to safely evacuate all those who live in the home when determining capacity did not restrict the definition of license capacity only to those persons who actually live in that AFH on a full-time basis. Instead, it highlights that the purpose for limiting the capacity of an AFH is not only to ensure that the quality of life for those adults who receive care and services in the AFH is not diminished, but is also to ensure their safety.

[567] *See Tommy P. v. Bd. of County Comm'rs*, 97 Wn.2d 385, 391-92 (1982) (citing *Burlington N., Inc. v. Johnston*, 89 Wn.2d 321 (1977) and *State v. Fagalde*, 85 Wn.2d 730 (1975)) and *State v. Burke*, 92 Wn.2d 474, 478 (1979).

18. Further, former WAC 388-76-10030(c) included "[t]he number of people for whom the home provides adult day care" in its list of factors the Department must consider when determining license capacity.[568] An appendix to the U.S. Code of Federal Regulations defines "day care services—adults" as "…services or activities provided to adults who require care and supervision in a protective setting for a portion of a 24-hour day… [c]omponent services or activities may include opportunity for social interaction, companionship and self-education; health support or assistance in obtaining health services; counseling; recreation and general leisure time activities; meals; personal care services; plan development; and transportation."[569] Because there is no applicable Department rule on-point, the undersigned relied on this federal definition as "…the best legal authority and reasoning available…" to decide the issue of whether House 2 may have been providing adult day care to the residents of House 1.[570] Given that the full-time residents of House 1 (1) require care and supervision in a protective setting for at least a portion of a 24-hour day and (2) spent significant time at House 2 for the purposes of social interaction; companionship; meals; personal care services, such as toileting and showering; and transportation, House 2 was providing at least some of them with adult day care services on a consistent basis and thus those individuals should be considered when determining House 2's capacity.

19. The evidence established that the Appellant required House 1 residents to go to House 2 when the Appellant and [APPELLANT'S RELATIVE 1] went to church or shopping, which subsequently required the House 2 residents to have the House 1

---

[568] Amended effective February 15, 2010. *See* WSR 10-03-064 at 23
[569] 45 C.F.R. Part 96 Appendix A. A LexisNexis search of the Washington State and Federal regulations, statutes, and case law for definitions of or related to "adult day care" revealed only a definition for the term "day care services—adult," as described in Conclusion of Law 18 above.
[570] *See* WAC 388-02-0220(2) and *id.*

residents foisted upon them and their sole caregiver. Combined with the findings that the House 1 residents are also residents of an AFH, they all needed 24-hour care, and there was no caregiver at House 1, as well as the requirement of former WAC 388-76-10195(1) that the AFH have enough staff to meet the needs of each resident regardless of whether "…the residents were in the home or not…,"[571] the undersigned cannot conclude that the House 1 residents were only visitors to House 2 and that the caregiver at House 2 had no obligation to them.[572] Sending House 1 residents to House 2 not only increased the number of residents in need of care at House 2 and restricted all the residents' freedom of choice, in violation of WAC 388-76-10510(4),[573] but it also impeded the ability of that single caregiver to meet the needs of these vulnerable adults and placed them at risk of harm. Because the Appellant had sought and received special permission from the Department previously to house all of the residents of

---

[571] Amended effective February 15, 2010. *See* WSR 10-03-064 at 34.

[572] *See, e.g.,* RCW 74.34.020(12)(b), which—in contrast to RCW 74.34.020(12)(a), but consistent with the BOA's interpretation of RCW 74.34.020(2)—does not appear to require there to be a duty of care to find a person or entity committed neglect against a vulnerable adult if there was "…an act or omission 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." *See also* WAC 388-76-10000 (although this rule was amended effective February 15, 2010, and January 1, 2011, this provision defining "neglect" was unchanged. *See* WSR 10-03-064 and WSR 10-16-082). Alternatively, the caregiver at House 2 may be defined as a "person or entity with a duty of care," as set forth at WAC 388-71-0105, to the House 1 residents when they were at House 2 if she was providing "…the basic necessities of life to the vulnerable adult on a continuing basis…" Or the caregiver may be viewed as an extension or agent of the Appellant—who certainly was a "person or entity with a duty of care" to both House 1 and House 2 residents according to the regulatory definition—since the Appellant was "…ultimately responsible for the operation of the adult family home" pursuant to WAC 388-76-10015(2) (amended effective February 15, 2010, but not changing the provider's duties. *See* WSR 1003-064 at 23).

[573] *See also* RCW 70.129.005 (stating the intent that "…residents have the opportunity to exercise reasonable control over life decisions…"); RCW 70.129.140(2)(b) (granting residents "…the right to… [i]interact with members of the community both inside and outside the facility"); WAC 388-76-10595(6) (stating that the AFH "…must not interfere with each resident's right to have access to and from… [i]mmediate family or other relatives and others who are visiting with the consent of the resident, subject to reasonable limits to protect the rights of others…"); and testimony of Pam Hildreth (acknowledging that this is not a simple situation because prohibiting residents of House 1 from visiting residents of House 2 could also impinge on the rights of House 1 residents, but that the ultimate issue in this matter was that none of the residents from either House 1 or House 2 were given a choice about whether the House 1 residents had to go to House 2 for the convenience of the Appellant when there was no caregiver at House 1).

House 1 and House 2 at House 2 while House 1 was undergoing repairs from flooding and understood that at least two caregivers had to be present at all times to meet the needs of that many residents, it cannot be stated that the Appellant was unaware of the capacity limits at House 2 or the absolute minimum number of caregivers required to meet the needs of the residents from both House 1 and House 2. Requiring three to six House 1 residents to join the six residents of House 2 at House 2 for the Appellant's own convenience, with no caregiver at House 1 and only one at House 2, underscores that her two AFHs were insufficiently staffed and that she gave little regard to the residents' rights or the capacity limit for House 2.

20. Based on the foregoing Findings of Fact and Conclusions of Law, it was appropriate for the Department to include the House 1 residents as part of the total count of residents and "…persons in need of personal or special care…" regularly present at House 2 when determining whether House 2 was over its licensed capacity. As a result, the Appellant exceeded the capacity for House 2 and the Department's cited violation of WAC 388-76-10960(16)[574] for exceeding licensed capacity in the operation of an AFH was correct.

21. **Care & Services**. WAC 388-76-10400(2) mandates that the AFH ensure each resident receives the care and services necessary to help him or her "…reach the highest level of physical, mental, and psychosocial well-being consistent with resident choice, current functional status and potential for improvement or decline." Further, WAC 388-76-10400(3)(a) and (3)(b) require that those care and services are provided in a manner and environment that "[a]ctively supports, maintains or improves each

---

[574] Although this rule was slightly amended, effective February 15, 2010, these applicable provisions were relatively unchanged. *See* WSR 10-03-064 at 49.

resident's quality of life [and]… [a]ctively supports the safety of each resident."

22. The evidence in this matter established that [RESIDENT 3]'s oral health and home care steadily declined after her admission to House 2 in 2007 as a result of the Appellant's admitted failure to recognize that the Appellant could no longer brush her own teeth, hitting its lowest point in October 2009 when food was observed in [RESIDENT 3]'s mouth at a dental cleaning and her dentition was very poor. [RESIDENT 3]'s dentist wrote a letter to the Appellant directly after that dental visit noting that "…no one is brushing her teeth or at least not effectively."[575] This letter contradicts the conclusion that there was "…no evidence in the record that the caregivers did not provide oral health care or did not try to provide oral health care."[576] Following [RESIDENT 3]'s October 2009 dental cleaning, House 2 staff made more of an effort to provide assistance to [RESIDENT 3] with brushing her teeth and [RESIDENT 3]'s oral health and home care improved by the time of her next dental visit in April 2010. This improvement occurred despite evidence that [RESIDENT 3] continued to eat sweets at House 2 during that time. As a result, the undersigned concludes that prior to October 2009 [RESIDENT 3] was not receiving proper oral care at House 2 and sufficient effort was not put forth by staff to assist or re-approach her to ensure that she did. The Department's cited violation of WAC 388-76-10400(2) was correct.

23. The failure to check [RESIDENT 2]'s blood glucose levels in accordance with his physician's directions, possibly resulting in inaccurate monitoring, and the failure to report his high and varying blood glucose levels to his physician—as set forth

---

[575] Department's exhibit 7.
[576] *Initial Order*, Conclusion of Law 5.8 at 70.

in Findings of Fact 68 through 71 of this *Review Decision and Final Order*—violated both WAC 388-76-10400(2) and (3)(b). This is particularly true given the dire health problems that can result from high blood glucose levels.

24. Although it was acknowledged in Conclusion of Law 5.9 of the *Initial Order*—and both the Appellant and [MANAGER 1] admitted—that the Appellant kept the residents' narcotic (Vicodin/hydrocodone) and anti-anxiety (Ativan/lorazepam) medications locked in her room or in her purse, making them unavailable when the Appellant was not at House 2, the ALJ concluded that there was no violation of WAC 388-76-10400(3)(a).[577] The brief reasoning provided for this was because there were no records that [RESIDENT 10] was prescribed Ativan/lorazepam or that [RESIDENT 4] was prescribed Vicodin/hydrocodone.[578] However, this conclusion ignores the ample evidence that each resident's medication was nonetheless inaccessible when the Appellant was away from House 2, sometimes for very long periods of time, regardless that it was actually [RESIDENT 10] who was prescribed Vicodin/hydrocodone for pain on a PRN (as needed) basis and [RESIDENT 4] who was prescribed Ativan/lorazepam for anxiety PRN. The issue is not which resident was prescribed what medication, but whether the medication prescribed to each resident was available. Simply because Ms. Corey, the investigator, may have confused these two residents based on her observation of [RESIDENT 10]'s behaviors indicating anxiety does not obviate the fact that these residents did not have access to their respective medications when they may have been needed. Even [RESIDENT 10'S RELATIVE 2] also believed [RESIDENT 10] was on Ativan/lorazepam at the time of the hearing and previously. [RESIDENT 10'S

---

[577] *Initial Order*, Conclusion of Law 5.9 at 71-2.
[578] *Id.*

RELATIVE 2] testified that [RESIDENT 10] had been diagnosed with and treated for anxiety, the symptoms of which—including [RESIDENT 10]'s fearfulness and desire to go home—he described in detail, making the investigator's mistake even more understandable if Ms. Corey had reviewed those records.

25. Regardless of Ms. Corey's transposition of [RESIDENT 10]'s and [RESIDENT 4]'s medications, two caregivers testified about [RESIDENT 10]'s clear expressions of pain, requests for relief, and their inability to provide her with her prescribed pain medication when the Appellant was absent from House 2. Although [RESIDENT 10]'s physician eventually discontinued her Vicodin/hydrocodone prescription and replaced it with Tylenol extra strength in November 2009, [RESIDENT 10]'s prescribed pain medication was often unavailable to her when needed prior November 2009 and [RESIDENT 10] unnecessarily suffered pain. As a result, the Appellant failed to meet the requirements of WAC 388-76-10400(3)(a) and the Department's citation for this violation was correct.

26. The record reflects that [RESIDENT 4] suffered from anxiety and sometimes had trouble sleeping at night as a result, but there was no evidence presented at the hearing that she needed or requested her Ativan/lorazepam prescription while the Appellant was absent from House 2 or that [RESIDENT 4] was unable to get her anti-anxiety medication when needed. Nonetheless, had [RESIDENT 4] expressed a need for her medication while the Appellant was away from House 2, there undoubtedly would have been a delay in [RESIDENT 4]'s access to it just as there was with [RESIDENT 10] and her pain medication because the Appellant also kept [RESIDENT 4]'s anti-anxiety medications separate from the others, either in her locked

room upstairs or in her purse, along with the narcotic medications. This is not consistent with ensuring the provision of care and services in a manner and in an environment that actively supported, maintained, or improved [RESIDENT 4]'s quality of life. As such, the Department's citation for this violation was correct with regard to [RESIDENT 4] as well.

27. Similarly, although the Appellant may have left [CAREGIVER 1] two tablets of non-narcotic diclofenac to treat [RESIDENT 1]'s pain and [RESIDENT 1] may have regularly refused offers of pain medication, his prescribed Vicodin, a narcotic, was not available to him if needed while the Appellant was gone. This is not consistent with ensuring the provision of care and services in a manner and in an environment that actively supported, maintained, or improved [RESIDENT 1]'s quality of life. As such, the Department's citation for this violation was correct with regard to [RESIDENT 1] as well.

28. Contrary to the conclusion in the *Initial Order* that the Department offered no evidence of [RESIDENT 1]'s swallowing problem,[579] the Department's notice and Ms. Corey's testimony established that [RESIDENT 1]'s swallowing difficulties were set forth in the assessment for [RESIDENT 1] that Ms. Corey reviewed during her investigation. It is true that [RESIDENT 1]'s assessment itself was not submitted by either party as an evidentiary exhibit despite that it may have been helpful, but this does not support the conclusion that there was no evidence [RESIDENT 1] had a swallowing problem. There was a great deal of testimony about various issues—including [RESIDENT 1]'s swallowing difficulties—during the hearing that may not have been supported by documentation, but that does not mean there was no evidence presented related to those issues. Further, the swallowing evaluation that was eventually completed for [RESIDENT 1] listed complex feeding directions indicative of swallowing

[579] *Id.*, Conclusion of Law 5.8 at 71

difficulties and made several dietary recommendations. In addition, [MANAGER 1] admitted at the hearing that [RESIDENT 1] had swallowing problems when he asserted that these issues had previously been raised by the Appellant with [RESIDENT 1]'s physician. Although the undersigned did not find [MANAGER 1]'s assertion credible that the Appellant contacted [RESIDENT 1]'s physician before her conversation with Ms. Corey, it does establish that [RESIDENT 1]'s swallowing issue existed and was acknowledged (although not appropriately addressed) by the Appellant and [MANAGER 1]. Alternatively, if the Appellant had previously spoken with [RESIDENT 1]'s physician about [RESIDENT 1]'s swallowing difficulties then she should have been aware that it would have been challenging (and potentially dangerous for him) to eat foods such as a breaded chicken patty and salad.

29. The Appellant failed to consult with [RESIDENT 1]'s physician about a swallowing evaluation prior to the Department's investigation, despite information in [RESIDENT 1]'s assessment indicating swallowing difficulties and her acknowledgement of these difficulties. In addition, some of the food provided to [RESIDENT 1] while Ms. Corey observed him eating a meal was not suitable for someone with swallowing and choking problems, and Ms. Corey observed him coughing and having swallowing difficulties during that meal on November 13, 2009.[580] The Appellant did not adequately address [RESIDENT 1]'s swallowing and choking problems prior to the Department's investigation. For these reasons, the undersigned concludes that the Appellant did not satisfy the requirements of WAC 388-76-10400(2) and (3)(b) and the Department's citation was proper.

[580] As noted in the foregoing Finding of Fact 84, [RESIDENT 1] died nearly three weeks later on December 1, 2009, from aspiration pneumonia, which is caused by breathing foreign material—such as food or liquids—into the lungs, the risk of which may increase when individuals have trouble swallowing.

30. **Resident Assessment and Emergency Placement**. WAC 388-76-10330 states:

> The adult family home must
> (1) Obtain a written assessment that contains accurate information about the prospective resident's current needs and preferences before admitting a resident to the home;
> (2) Not admit a resident without an assessment except in cases of genuine emergency

WAC 388-76-10395 states:

> (1) The adult family home may only admit a resident to the home without an assessment or a preliminary service plan if a true emergency exists.
> (2) To establish that a true emergency exists, the home must verify that the resident's life, health or safety is at serious risk due to circumstances in the resident's current place of residence or harm to the resident has occurred.

Uncontroverted evidence was presented that [RESIDENT 1] was admitted to House 2 prior to completion of an assessment, in contravention of WAC 388-76-10330(1). As such, it was established by a preponderance of the evidence that [RESIDENT 1] was admitted to House 2 without an assessment. The issue is whether his admission prior to assessment was justified as a genuine or true emergency in accordance with WAC 388-76-10330(2) and WAC 388-76-10395(1) and (2).

31. [RESIDENT 1] was admitted to House 2 on Friday, October 16, 2009, from the hospital, but Mr. Robinson could not do the required pre-admission assessment until Monday, October 19, 2009. It is unclear from the record whether [RESIDENT 1] had been admitted to the hospital or only visited the emergency department or how long he had been at the hospital prior to his admission to House 2. However, no argument was presented at the hearing that his current place of residence at the time of his admission to House 2 was not the hospital. Although there was some

testimony that [RESIDENT 1]'s [RELATIVE 5] was on the verge of exceeding her capability to continue personally providing care to [RESIDENT 1] in their home, no evidence was presented that she could not obtain temporary help caring for him at home over the weekend until an assessment for admission to an AFH could be completed or that [RESIDENT 1] could not stay at the hospital until that time. On the contrary, Mr. Robinson testified that hospitals sometimes admit patients to the hospital or delay discharge until suitable placement can be found.

32. It is irrelevant that Mr. Robinson's October 19, 2009, assessment indicated that House 2 could meet [RESIDENT 1]'s care and services needs. The purpose of requiring an assessment prior to admission is to identify the potential resident's needs and ensure that the AFH can provide the care and services needed by the potential resident. Harm could have occurred to [RESIDENT 1] over the weekend if, in fact, his needs could not have been adequately be met at House 2. However, although the Appellant admitted she was aware of the requirement to obtain an assessment before admission, she substituted her judgment for that of the assessor rather than waiting until Mr. Robinson was available to do the assessment or finding another assessor to do the assessment before admitting [RESIDENT 1] to House 2.

33. There was no evidence establishing why [RESIDENT 1]—if he was not already admitted to the hospital—could not be admitted until his assessment was completed three days later on Monday, October 19, 2009. Similarly, there was no evidence presented why [RESIDENT 1]'s discharge from the hospital—if he was already admitted—could not be delayed until his assessment was completed. The record does not reflect that [RESIDENT 1] was being forced from the hospital or from

his home. No evidence was presented to explain why an assessment was not completed in the two weeks prior to October 16, 2009, during which time [RESIDENT 1]'s [RELATIVE 5] and [RELATIVE 3] had found House 2 to their liking. The record does not show that [RESIDENT 1]'s health, life, or safety was at serious risk either at the hospital or at his home, or that he had suffered harm in either location. Further, Ms. Corey, in her regulatory role for the Department and as an R.N., testified that moving a person who is safely in a hospital into an AFH does not constitute an emergency. The undersigned concludes that the inclusion of the words "genuine" and "true" in WAC 388-76-10330(2) and 10395(1) and (2), respectively, to qualify the term "emergency" denotes a more objective than subjective standard. Many residents are admitted to AFHs precisely because their family members feel they can no longer care for the resident on their own—just as with [RESIDENT 1]'s [RELATIVE 5]—but this does not make such an admission an "emergency," particularly when that term is prefaced in the applicable rules with words such as "genuine" and "true."

34. The Department met its burden of proving by a preponderance of the evidence that (1) [RESIDENT 1] was admitted to House 2 without an assessment and (2) a true or genuine emergency did not exist to justify [RESIDENT 1]'s admission to House 2 without an assessment. The Appellant did not rebut the regulatory presumption that admission to an AFH must be preceded by an assessment or establish by a preponderance of the evidence that there was a true emergency when the burden shifted to her[581] to prove the exception (i.e., a true or genuine emergency) to the rule that an assessment is needed prior to admission to an AFH. As such, the undersigned

[581] See WAC 388-02-0480(b) (stating that the burden of proof is borne by a party attempting to persuade the ALJ that his or her position is correct).

concludes that it was not reasonable of the Appellant to determine that a true emergency necessitated [RESIDENT 1]'s immediate admission to House 2 without an assessment. The Department was correct in citing the Appellant for violating WAC 388-76-10330(1) and (2) and WAC 388-76-10395(1) and (2).

35. **Medication Organizer**. WAC 388-76-10480 requires that all resident medication organizers have labels. Specifically, the rule states:

> The adult family home must ensure...
> (4) Medication organizer labels clearly show the following:
> (a) The name of the resident;
> (b) A list of all prescribed and over-the-counter medications;
> (c) The dosage of each medication; and
> (d) The frequency with which the medications are given.[582]

There was no dispute that the Appellant did not have [RESIDENT 1]'s medication organizer labeled. It is unclear from the evidence whether it had been unlabeled since [RESIDENT 1]'s admission to the House 2, which was over two weeks before the commencement of the Department's investigation, or if the label had fallen off more recently and had not been replaced. Regardless, multiple staff administered medication at House 2 and [RESIDENT 1] was at risk for a medication error without a label on his medication organizer.

36. WAC 388-76-10480 does not distinguish between emergency admissions and regular admissions to an AFH in its mandate to include labels on medication organizers nor does it grant a grace period for compliance with this requirement.[583] As

---

[582] WAC 388-76-10480 (4).
[583] *Contra, e.g.,* WAC 388-76-10360 (noting that an AFH has 30 days after a resident's admission to develop and complete the resident's negotiated care plan); WAC 388-76-10395(3)(a) (granting the AFH five working days to complete an assessment following an emergency admission to the AFH); and WAC 388-112-0075(3) (stating that "…caregivers must complete basic training [which is distinguished in Chapter 388-112 WAC from CPR and first-aid training] within one hundred twenty days of when they begin providing hands-on personal care"). These WAC provisions highlight that the drafters were aware and capable of drafting rules that permit a grace period and that they consciously chose not to do so in

such, contrary to the Appellant's argument,[584] it is irrelevant whether or not [RESIDENT 1]'s emergency admission to House 2 was justified or if the Appellant may have been in the process of complying with WAC 388-76-10480 because she had purportedly already printed [RESIDENT 1]'s label but had not yet affixed it. At the time of the Department's investigation and for some time prior, [RESIDENT 1]'s medication organizer did not have the required label. As such, the Appellant was in violation of WAC 388-76-10480(4) and the Department's citation for this was proper.

37. **Caregiver CPR and First-Aid Certification**. According to WAC 388-76-10135(6), "[t]he adult family home must ensure each caregiver has… a current valid first-aid and cardiopulmonary resuscitation (CPR) card or certificate as required in chapter 388-112 WAC."[585] Similarly, WAC 388-112-0260(3)(b) requires caregivers in AFHs to "…obtain and maintain a valid CPR and first-aid card or certificate… [b]efore providing care for residents, if the provision of care is not directly supervised by a fully qualified caregiver who has a valid first-aid and CPR card or certificate."[586] Furthermore, RCW 70.128.130(10) mandates that AFH providers "…ensure that staff are competent and receive necessary training to perform assigned tasks… [s]taff must satisfactorily complete department-approved staff training, basic training, and continuing education as specified by the department by rule."

38. The parties agreed that [CAREGIVER 1] did not have a valid CPR card in

---

WAC 388-76-10480.

[584] *See also Initial Order,* Conclusion of Law 5.11 at 74.

[585] Although this rule was slightly amended, effective January 1, 2011, these applicable provisions were relatively unchanged. *See* WSR 10-16-082 at 17-8.

[586] *Contra* WAC 388-112-0075(3) (noting that caregivers have 120 days after they start providing care to complete basic training [which is distinguished in Chapter 388-112 WAC from CPR and first-aid training] thus highlighting that the drafters consciously chose to make CPR certification a condition precedent to working in an AFH rather than a requirement that could be fulfilled after one started providing hands-on care to residents).

her possession when the Appellant hired her in May 2009 because [CAREGIVER 1]'s purse containing the card was stolen in October 2008. [CAREGIVER 1] told the Appellant she did not know when the card expired. By the time of the Department's investigation in November 2009, the Appellant still had not obtained a copy of [CAREGIVER 1]'s CPR card and could not be certain that it was valid. Between her hire in May 2009 and her re-certification in November 2009, [CAREGIVER 1] provided months of unsupervised[587] care to several elderly House 2 residents with known cardiac conditions despite some evidence presented at the hearing that [CAREGIVER 1]'s CPR certification may have expired in September 2009 or even earlier. Based on the undisputed evidence that [CAREGIVER 1] did not have current CPR certification for at least two months during her eight-month tenure at House 2, it can only be concluded that the Appellant failed to "ensure," by definition,[588] that [CAREGIVER 1], as a caregiver at House 2, had the minimum qualification of having a current, valid first-aid and CPR card. The Department's citation was correct.

39. **Resident Manager**. Former WAC 388-76-10036 states that when a provider has more than one licensed AFH, each AFH must ensure that "[e]ach home has one person responsible for managing the overall delivery of care to all residents in the home;… [t]he designated responsible person is the provider, entity representative or a qualified resident manager; and… [e]ach responsible person is designated to manage

[587] There was also no indirect supervision, as that term is (and was) defined in WAC 388-76-10000, of the care that [CAREGIVER 1] provided to the residents of House 2 because there were at least two times while [CAREGIVER 1] was on duty at House 2 that the Appellant was off-site and was not "…quickly and easily available to the caregiver…" It is also not clear from the record whether the Appellant was herself currently certified in CPR during the time when [CAREGIVER 1] was not, as would also be required for indirect supervision.

[588] Defined by *Webster's Third New International Dictionary* 756 (2002) as "to make sure, certain, or safe…a making of an outcome or event sure, certain, or inevitable…"

only one adult family home at a time."[589] Uncontroverted evidence was presented that the Appellant did not have a "designated responsible person" at House 2 from the time [FORMER MANAGER 1], the former RM of House 2, resigned on October 23, 2009, until [MANAGER 1] became qualified to be the new RM, which—at the earliest—was not until November 7, 2009.[590] The Appellant could not be the "designated responsible person" of House 2 because she already fulfilled this role at House 1 as the provider and RM there and thus was not permitted by WAC 388-76-10036(3) to manage more than that one AFH at a time. There was no "designated responsible person" at House 2 at the time of the Department's complaint investigation on November 2, 2009 and there had not been since October 23, 2009.

40. Despite [MANAGER 1]'s references to himself at the hearing as the "acting" RM and the Appellant's appointment of him as such in early October 2009—pending successful completion of the training necessary to become an RM—to ensure she had a back-up RM should the need arise, there is no definition of "acting" RM in the WAC and the term has no legally operative effect. In addition, had [MANAGER 1] been able to assume the mantle of RM in October 2009, the Appellant would have been in violation of WAC 388-112-0075(2), which requires that RMs complete basic training prior to provision of services in an AFH,[591] because he testified that he did not complete the basic training[592] requirements until November 2009 and began providing care at

---

[589] Amended effective February 22, 2010. *See* WSR 10-04-008 at 5.
[590] Testimony of [MANAGER 1] (noting that he did not complete the 48-hour administrator training course until January 9, 2009; per WAC 388-112-0270, providers must complete this training before operating or receiving a license to operate an AFH).
[591] *See also* WAC 388-112-0160(1) (requiring that RMs complete manager specialty training "before" serving residents with special needs related to mental illness, dementia, or a developmental disability). House 2 was required by WAC 388-76-10505 to ensure that the provider, entity representative, RM, and staff completed specialty care training in order to admit and keep residents with dementia.
[592] Also referred to as the "fundamentals of caregiving" training during [MANAGER 1]'s testimony.

House 2 in October 2009. It cannot be implied that an "acting" RM fulfills the regulatory requirements or that there is a "grace period" for replacing an RM precisely because the WAC is clear that a provider who operates more than one AFH must not only have a distinct "designated responsible person" in each AFH, but also that the resident manager must be "qualified" and that providers, entity representatives, and RMs (i.e., all those who are permitted to be a "designated responsible person") must complete basic training and specialty training "before" they assume such a role.[593] This underscores that RMs must be fully prepared for the role upon taking it. This is because the RM is responsible for managing the overall delivery of care to all residents on a continual, ongoing basis, in a position that is necessarily continual and ongoing due to the residents' 24-hour care requirements. As such, the role of RM is not conducive to a ramping-up or grace period such as the 120 days given to caregivers to complete basic training after they begin providing services in an AFH.[594]

41. In contrast, it was concluded in the *Initial Order* that certain rules of statutory construction must be applied to the requirement in former WAC 388-76-10036 that each AFH have a qualified RM and contorted to permit a grace period for replacing the RM, which is not stated in the WAC,[595] because otherwise the result would purportedly be strained or absurd.[596] This conclusion was based on an assumption that

---

[593] Former WAC 388-76-10036(2) and (3); WAC 388-112-0075(1) and (2); and WAC 388-112-0160(1).

[594] *See* WAC 388-112-0075(3).

[595] *Contra, e.g.,* WAC 388-76-10360 (noting that an AFH has 30 days after a resident's admission to develop and complete the resident's negotiated care plan); WAC 388-76-10395(3)(a) (granting the AFH five working days to complete an assessment following an emergency admission to the AFH); and WAC 388-112-0075(3) (stating that "…caregivers must complete basic training within one hundred twenty days of when they begin providing hands-on personal care"). These WAC provisions highlight that the drafters were aware and capable of drafting rules that permit a grace period and that they consciously chose not to do so in former WAC 388-76-10036 to allow a period of time when an AFH may be exempt from the requirement of having an RM.

[596] *See also Initial Order*, Conclusion of Law 5.4 at 67-8.

the loss of an RM would then result in loss of the AFH license and eviction of the residents on short notice, leaving the AFH with the untenable choice of breaching its contracts with the residents or violating the applicable WAC.[597] These assumptions are generally false.[598] Based on the evidence presented and the applicable law, it does not necessarily follow that losing an RM, whether by resignation, injury, illness, or death, would result in license revocation or immediate eviction of residents. Further, [FORMER MANAGER 1]'s resignation was not unexpected—she gave the Appellant more than two weeks notice that her last day at House 2 would be October 23, 2009. There was ample time for the Appellant to hire a replacement who was already qualified to be the RM or to contact the Department, explain the situation, and seek a temporary exception to the regulatory requirement, just as the Appellant did when she exceeded the capacity for House 2 in 2007 due to the flooding of House 1.

42. The Appellant argued that the Appellant's purported efforts to ensure that House 2 had a continuous RM constituted substantial compliance with the regulatory requirements.[599] However, the applicable rule, which the ALJ and the undersigned Review Judge are compelled by WAC 388-02-0220(1) to apply, does not address substantial compliance or any other exceptions to strict compliance with the rule as written.[600] The Appellant's failure to have an RM or other "designated responsible

---

[597] *Id.*

[598] Even if the assumptions were not false, neither the ALJ nor the undersigned is authorized to ignore the plain reading of the WAC, which does not address a grace period as other WAC provisions in the same and related Chapters do; other rules of statutory construction requiring harmonization and reconciliation of potentially conflicting provisions; or the basic premise of administrative law that "…the interpretation of the agency charged with administering the statute is generally entitled to deference." *Skamania County v. Columbia River Gorge Commission*, 144 Wn.2d 30, 43 (2001); *Tommy P. v. Bd. of County Comm'rs*, 97 Wn.2d 385, 391-92 (1982) (citing *Burlington N., Inc. v. Johnston*, 89 Wn.2d 321 (1977) and *State v. Fagalde*, 85 Wn.2d 730 (1975)) and *State v. Burke*, 92 Wn.2d 474, 478 (1979).

[599] *See also Initial Order*, Conclusion of Law 5.4 at 68.

[600] *See* WAC 388-76-10036.

person" at House 2 for more than two weeks violates the former and current WAC 388-76-10036. As a result, the Department's citation was correct.

43. **Negotiated Care Plans**. WAC 388-76-10355 states, in pertinent part,

> The adult family home must use the resident assessment and preliminary care plan to develop a written negotiated care plan. The home must ensure each resident's negotiated care plan includes:
> (1) A list of the care and services to be provided;
> (2) Identification of who will provide the care and services;
> (3) When and how the care and services will be provided…

Similarly, RCW 70.128.007(4) states that the purpose of the Chapter is to "…[p]rovide for appropriate care of residents in adult family homes by requiring that each resident have a care plan that promotes the most appropriate level of physical, mental, and psychosocial well-being consistent with client choice…" As set forth in Findings of Fact 105 through 115 of this *Review Decision and Final Order*, negotiated care plans existed for five of the six residents[601] at House 2 at the time of the Department's complaint investigation in November 2009, but four of these plans were not provided to Ms. Corey, the investigator; the fifth plan, for [RESIDENT 2], lacked significant information that was included in his assessment; and many of the plans had not been updated to reflect changes articulated by [MANAGER 1] at the hearing. It is also not clear to the undersigned that these plans were available to or consulted by the caregivers providing services to the residents of House 2.

44. Written resident assessments and care plans are more than technical paperwork. They constitute a critical and essential tool for staff who provide daily care to AFH residents. This is especially true for an AFH holding a specialty license for the care

[601] A negotiated care plan was not required for [RESIDENT 1] at the time of the Department's investigation because WAC 388-76-10360 gives an AFH 30 days from the date of a resident's admission to develop and complete the care plan.

of residents with developmental disabilities, dementia, and/or mental health issues. The Appellant's failure to ensure these documents were fully updated in a meaningful manner and that staff were fully aware of and complying with the plans' requirements could result in harm to residents if their care, services, and supervision needs were not met.

45. According to WAC 388-76-10315(1) and WAC 388-76-10320(6), the AFH must ensure that each resident has a resident record that contains a negotiated care plan. These resident records containing the care plans must "…[b]e available so that department staff may review them when requested…" and staff must have access to the portions of the residents' records needed to provide care and services.[602] In this case, the evidence established that neither the Appellant nor [MANAGER 1] provided Ms. Corey with the negotiated care plans for [RESIDENT 4], [RESIDENT 10], [RESIDENT 3], and [RESIDENT 6] as required by WAC 388-76-10315(1)(g). As a result, it is impossible to know for certain if the plans presented to Ms. Corey at the hearing in May 2010 met the regulatory requirements at the time of her investigation in November 2009, especially since at least some of the assessment and negotiated care plan documents were altered afterward, but prior to their admission as exhibits at the hearing, thus undermining the reliability and veracity of their contents. In addition, the undersigned concludes, based on the Appellant's apparent confusion about the distinction between assessments and negotiated care plans in her conversation with Ms. Corey in November 2009 and [MANAGER 1]'s admitted unfamiliarity with the care plans until at least November 13, 2009, that staff likewise did not have access to the

---

[602] WAC 388-76-10315(1)(g) and (2). *See also* WAC 388-76-10915(1)(b) (requiring the AFH to ensure the Department has access to resident records).

care plans or their contents when providing services as required by WAC 388-76-10315(2).

46. WAC 388-76-10350(2) and WAC 388-76-10380(2) require updating of a resident's assessment and negotiated care plan, respectively, when the plan no longer reflects the resident's current status, needs, and preferences. Neither the Appellant nor [MANAGER 1] seemed to be aware of this requirement as evidenced by the former's response to Ms. Corey when questioned about updating the care plans and the latter's testimony that [RESIDENT 4] and [RESIDENT 10] no longer liked to take part in many of the activities listed in their plans. As such, the undersigned can only conclude that the Appellant did not update the residents' assessments and care plans as mandated by the rules. As such, the plans did not reflect current information.

47. In accordance with WAC 388-75-10355, a resident's assessment must be used to develop the negotiated care plan. In this case, [RESIDENT 2]'s assessment stated that "AFH will provide moderate assists with feeding, supervision, cueing, and now actual assistance with some meals…" and also noted that he "[m]ay choke on larger bits of vegatables…"[603] In contrast, his negotiated care plan did not include this information[604] and [CAREGIVER 3], the caregiver on duty when Ms. Corey made note of this, did not seem aware of these needs and risk. As a result, the Appellant was not in compliance with the general premised of WAC 388-76-10355 that requires use of the assessment to develop the care plan. This also constitutes a violation of subsections (1) through (3) of WAC 388-76-10355 because this crucial information (i.e., caregiver

[603] Appellant's exhibit 16-42. *Contra Intial Order*, Conclusion of Law 5.7 at 71 (noting that the Department's assertions that [RESIDENT 2] required supervision while eating and was a choking risk were "overstatements" of the issues identified in his assessment).
[604] Appellant's exhibit 16-24.

supervision while eating and his choking risk) in [RESIDENT 2]'s assessment was not included in [RESIDENT 2]'s negotiated care plan to identify the care and services to be provided, who would provide them, and when and how they would be provided.

48. **Activities**. WAC 388-76-10510(5) requires the AFH to ensure that every resident "[i]s provided the opportunity to engage in religious, political, civil, recreational, and other social activities of their choice…" In the same vein, WAC 388-76-10620(2)(a) mandates that AFHs ensure residents have the "…right to… [c]hoose activities, schedules, and health care consistent with his or her interests, assessments, and negotiated care plan…" RCW 70.128.130(9) requires AFH providers to "…offer activities to residents under care as defined by the department in rule." RCW 70.129.140(2)(a) and (4) grant a resident the rights to "[c]hoose activities…consistent with his or her interests, assessments, and plans of care…" and "…to participate in social religious, and community activities that do not interfere with the rights of the other residents in the facility."

49. As set forth in Finding of Fact 129 of this *Review Decision and Final Order*, the totality of the evidence presented in this matter leads the undersigned to conclude that the Department did not satisfy its burden of proving by a preponderance of the evidence that the Appellant violated the regulatory and statutory requirements related to activities. Although [CAREGIVER 4] testified that only one scheduled activity took place during the two months she worked at House 2 and only a limited number of activities were observed when Ms. Corey and Mr. Tosch visited House 2 in November 2009, the applicable WAC provisions do not indicate the amount or frequency of activities that must take place in order to satisfy the requirements. In addition, there was

no evidence presented that the residents did not make a choice about the activities in which they were or were not engaging.

50. **Meals/Food**. Former WAC 388-76-10420 stated

> The adult family home must:
> (1) Serve at least three meals:
> (a) In each twenty-four hour period;
> (b) At regular times comparable to normal meal times in the community; and
> (c) That meet the nutritional needs of each resident.
> (2) Make nutritious snacks available to residents:
> (a) Between meals; and
> (b) In the evening.
> (3) Get input from residents in meal planning and scheduling;
> (4) Serve nutrient concentrates, supplements, and modified diets only with written approval of the resident's physician;
> (5) Only serve pasteurized milk; and
> (6) Process any home-canned foods served in the home, according to the latest guidelines of the county cooperative extension service.[605]

Former WAC 388-76-10840 further provided that

> The adult family home must have an on-site emergency food supply that can be stored with other food in the home and that:
> (1) Will last a minimum of seventy-two hours for each resident and each household member; and
> (2) Meets the dietary needs of each resident, including any specific dietary restrictions the resident may have.[606]

Ms. Corey checked the regular food supply in the kitchen at House 2 and found it lacking in sufficiency to satisfy the amounts required by the regulation and the nutritional needs of the residents. As she noted, there were very limited amounts of food and, as a result, also very limited choices for the residents, in possible violation of the requirement in WAC 388-76-10510(4)[607] that the AFH ensure each resident has a choice. Upon notifying the Appellant of the insufficient amount of food Ms. Corey observed at House

---

[605] Amended effective February 15, 2010. *See* WSR 10-03-064 at 39.
[606] *Id.* at 45-6.
[607] *See also* RCW 70.129.005 (stating the intent that "…residents have the opportunity to exercise reasonable control over life decisions…")

2, the Appellant did not direct her to any other areas in the House 2 where food might be found, but merely stated that most of the food for both houses was stored at House 1.

51. Ms. Corey did not check the food supply at House 1 because House 1's food supply is not dispositive of whether House 2 had an adequate amount of food. WAC 388-76-10420 does not address if the AFH may have had access to food elsewhere, whether it was in the house across the street or at a grocery store down the road, but rather it states that the AFH must have food in adequate supply for the residents. It is not possible to be certain that there would be enough food at House 2 when it was stored off the premises at House 1, an entirely separate AFH with its own licensing requirements, as underscored by the flooding –which was as deep as four feet, according the Appellant's testimony—of House 1 in 2007.

52. Ms. Everett inspected both the regular and emergency food supply at House 2 by checking the cabinets in the kitchen and the cupboard above the refrigerator in the kitchen because she was told by the Appellant that was where the regular and emergency food were located. When Ms. Everett specifically asked where these food supplies could be found, neither the Appellant nor [MANAGER 1] directed her to a hallway closet at House 2 that was purportedly used for emergency food storage. If, in fact, emergency food was stored in the hallway closet and neither Ms. Corey nor Ms. Everett were directed there during the investigation and inspection, despite that they asked where the House 2 food was located, the Appellant may have violated WAC 388-76-10915(2) by failing to cooperate with Department staff in the performance of official duties. In addition, WAC 388-76-10840 explicitly requires that the

emergency food supply be “on-site,” again making it irrelevant that additional food may have been stored at House 1.

53. Undisputed evidence was presented at the hearing that Ms. Everett found two cans of refried beans in the cabinet above the refrigerator that were expired, along with a condiment, Vegenaise, in the refrigerator that was also expired. It cannot be contended that expired food meets the nutritional or dietary needs of the residents, as required by WAC 388-76-10420(1)(c) and WAC 388-76-10840(2). Regardless of who may have brought the expired refried beans or Vegenaise into House 2 or whether they were included as a meal item in the undated menus submitted as exhibits, these items were available as food to be served to the residents. Further, if judicial or official notice was taken that expiration dates are actually best by dates as indicated in the *Initial Order*,[608] it was not done in compliance with WAC 388-02-0445 or RCW 34.05.452(5) because no evidence was presented to support this contention nor were the parties notified that the ALJ intended to take judicial notice or given an opportunity to object.

54. Based on Ms. Corey’s and Ms. Everett’s credible testimony and documentary evidence about the food they inspected at House 2 in November 2009 and undisputed evidence that there was expired food on the premises, the undersigned concludes that both the quantity and quality of the regular and emergency food at House 2 were inadequate to satisfy the residents’ nutritional and dietary needs. This violates both WAC 388-76-10420 and WAC 388-76-10840. As such, the Department’s citation was correct.

55. **Emergency Lighting**. WAC 388-76-10740(2) requires the AFH to provide “[e]mergency lighting, such as working flashlights for staff and residents that are

[608] *Initial Order*, Conclusion of Law 5.10 at 75.

accessible." The evidence presented at the hearing established that there was only one immediately operable, accessible flashlight at House 2. No other types of emergency lighting were observed or pointed out during the complaint investigation and inspection. No evidence was presented at the hearing that any other emergency lighting existed at House 2. The WAC lists "working flashlights" as an example of accessible emergency lighting, specifically indicating by use of the plural form that more than one flashlight must be available to constitute that form of emergency lighting.

56. As described in Findings of Fact 3 and 4 of this *Review Decision and Final Order*, House 2 is quite large, with many bedrooms, bathrooms, hallways, stairs, and doorways that may need to be navigated through, down, around, and out by at least six high-needs residents, some of whom were not independently ambulatory, others who were ambulatory but who had a tendency to wander, and all of whom required varying levels of assistance with evacuation,[609] in the event of an emergency. A caregiver grabbing a rechargeable flashlight plugged into the wall, under the mistaken belief that it was operable, would put residents at risk when he or she discovered that it did not work and could waste valuable time during an emergency. Likewise, fumbling around, possibly in the dark, to put batteries in another flashlight that may or may not exist and may or may not work even with fresh batteries would take time that could be used instead to quickly evacuate residents or otherwise keep them safe from harm during an emergency. Contrary to the Appellant's argument, shining the headlights of the

---

[609] [RESIDENT 1] was bedridden, [RESIDENT 4] used a wheelchair on a regular basis, [RESIDENT 2] needed constant stand-by assistance with a gait belt when walking, and although [RESIDENT 3] and [RESIDENT 10] could both walk on their own—with stand-by assistance in [RESIDENT 10]'s case—they each had a history of elopement from House 2. *See* Appellant's exhibit 16-22, 16-59, 16-81, 16-125, 16-172, 16-182, and 16-217; Appellant's exhibit 11-1; Department's exhibit 2 at 6; Department's exhibit 10 at 1; testimony of [RESIDENT 10'S RELATIVE 1]; testimony of [RESIDENT 10'S RELATIVE 2]; testimony of Donna Andrews-Dennehy; and testimony of Candace Corey.

Appellant's care into the front windows of House 2[610] would not adequately illuminate any of the many rooms at House 2, other than possibly the combined living and dining room, but doing so would require time for the caregiver or Appellant to go outside to turn on the headlights that could be better spent looking after the residents. It is precisely for these reasons that there must be multiple flashlights that work or other forms of functional lighting and that are accessible to the staff and residents of an AFH for emergency lighting. Because the Appellant failed to meet the regulatory requirement to have sufficient emergency lighting as set forth in WAC 388-76-10740, the Department's citation was correct.

57. **Notice of Inspection Results**. The version of WAC 388-76-10585(2) in effect at the time of the Department's action in this matter in December 2009 required the AFH to "[p]ost a notice in a visible location in the home indicating the inspection report is available for review."[611] Uncontroverted evidence was presented that the inspection report posted on the House 2 bulletin board was covered up by a newspaper clipping. Nonetheless, it was argued by the Appellant that there was no violation because the rule required only that the notice be posted in a visible location, not that the notice itself be visible.[612] By this reasoning, one could put the notice in a locked safe in the middle of the living room and contend that the location where it was posted was visible. However, that would not constitute notice[613] nor would it indicate to anyone that the inspection report was available for review. If the bulletin board on which the

[610] *See also Initial Order*, Conclusion of Law 5.14 at 79.
[611] Amended effective July 31, 2010. WSR 10-14-058. *See also* RCW 70.128.080(2) (requiring that inspection reports be "readily available" for review by the Department, residents, and the public).
[612] *See also Initial Order*, Conclusion of Law 5.13 at 78.
[613] Defined in *Webster's Third New International Dictionary* 1544-45 to include an "…announcement…[or] communication… [to] notify [or] to make known [or] to inform…" and "…actual knowledge of a pertinent legal fact."

inspection report was posted had actually been in a visible location and only the report itself was not visible, the undersigned would be required to apply certain rules of statutory construction to avoid such an absurd, unlikely, strained, and irrational interpretation of the WAC's literal language as argued by the Appellant.[614] However, as set forth in Finding of Fact 148 of this *Review Decision and Final Order*, the location of the bulletin board on which the notice was posted was not visible because it was in the office of House 2, which was not a readily accessible, conspicuous common area. As also found, the inspection report was obscured.

58. Because neither the location nor the report itself were visible to residents or their representatives when the report was covered up by a newspaper clipping and posted to a bulletin board hanging in the office at House 2, there was no notice that the inspection report was available for review. Consequently, the Department's citation for this violation was proper pursuant to the former WAC 388-76-10585(2).

59. **Understanding/Ability to Provide Care & Services**. Former WAC 388-76-00020 states that the AFH "…must have the understanding, ability, emotional stability and physical health suited to meet the personal and special care needs of vulnerable adults."[615] Admittedly, this is a somewhat general regulation that could be used to encompass a broad array of actions or omissions on the part of an AFH licensee. However, the regulation sets forth fundamental obligations that must be met by all licensees and potential licensees who wish to care for vulnerable adults in an AFH setting. The evidence in the hearing record does not show that the Department used

---

[614] *See Alderwood Water District v. Pope & Talbot, Inc.*, 62 Wn.2d 319, 321 (1963) and *Children's Hosp. v. Dep't of Health*, 95 Wn. App. 858, 864 (1999) (quoting *State v. McGinty*, 80 Wn.App. 157, 160 (1995), *review denied*, 139 Wn.2d 1021 (2000)).

[615] Amended effective February 15, 2010. *See* WSR 10-03-064.

this encapsulating provision in an overreaching or arbitrary manner. Instead, the evidence presented supports the Department's findings that the Appellant failed to comply with numerous Department regulations and that two of those violations (i.e., the failure to ensure CPR certification and to have adequate, non-expired food at House 2) were recurrent, thereby reflecting a history of failing to comply with the applicable WAC provisions.

60. The Appellant's refusal to acknowledge that any of the Department's many citations may have been appropriate, despite overwhelming evidence on a number of issues and her prior statements against self-interest,[616] creates significant doubt in the mind of the undersigned that the Appellant fully understands and can thus comply with the requirements for an AFH license to meet the residents' needs. In addition, the Appellant's attempt to portray all Department staff involved in this matter as intent on finding violations that did not exist, overblowing those that did, or blatantly lying about what they observed and to depict the caregivers who testified as disgruntled former employees looking for revenge is belied by the enormity and consistency of the credible evidence presented by multiple parties, including the long-term care ombudsman. Dismissing the allegations as minor or blaming others rather than assuming responsibility leads the undersigned to believe the Appellant does not grasp the significance of the violations, why compliance is necessary, or that the Department's role in this matter is to ensure the health and safety of vulnerable adults in House 2, not

---

[616] *See, e.g.,* the Appellant's admissions that House 1 residents could not leave House 2 and return to House 1 because there was no caregiver there, thus effectively confining House 1 residents involuntarily to House 2 or in the community, involuntarily subjecting the House 2 residents to the company of House 1 residents, placing additional demands on the sole caregiver at House 2, and exceeding the capacity of House 2 until a caregiver returned to House 1 and the House 1 residents could leave House 2 to go to House 1.

to randomly target the Appellant and her AFH.

61. By choosing to have AFH licenses and to take responsibility for the vulnerable adults entrusted to her care in these AFHs, the Appellant agreed to comply with all the Department's minimum licensing requirements on a continual basis. Failing to do so at House 2 illustrates that she does not have the understanding to carry out the care obligations, many of which are encompassed in the regulations she violated, owed to the vulnerable adults at House 2 and as required by former WAC 388-76-00020. As such, the Department's citation was correct.

62. **Remedies**. RCW 70.128.160(1) delegates discretionary authority solely to the Department to impose a remedy for failure or refusal to comply with Chapter 70.128 RCW or Chapter 388-76 WAC; operating an AFH without a valid license; knowingly making a false statement of material fact when applying for a license or in any matter being investigated by the Department; or willfully preventing or interfering with any inspection or investigation by the Department. WAC 388-76-10940 states that the Department has authority to impose any and all of the following remedies on an AFH for failing or refusing to comply with the minimum licensing requirements set forth in Chapter 388-76 WAC: deny a license application, impose reasonable conditions on a license, impose civil fines, order stop placement, suspend a license, or revoke a license.[617]

63. The Department "may" take these remedial actions "…in any case which the department finds that an adult family home failed or refused to comply with the applicable requirements of chapters 70.128, 70.129, or 74.34 RCW or this chapter [388-

[617] *See also* RCW 70.128.160(2).

76 WAC]."[618] One of the specifically enumerated violations for which the Department has discretion to impose a remedy is overcapacity.[619] One of the discretionary remedies available for this violation is revocation.[620]

64. The Department "must" impose at least one of the listed remedies when violations of Chapters 70.128, 70.129, and 74.34 RCW and Chapter 388-76 WAC "…pose a serious risk to any resident, are recurring, or are uncorrected."[621] As written, WAC 388-76-10945 would require Department action to address repeat citations for failing to ensure CPR certification and to have adequate, unexpired food in House 2. Given the Appellant's failure to provide necessary care and services with respect to [RESIDENT 3]'s dental health, [RESIDENT 2]'s diabetes management and choking risk, the unavailability of three resident's narcotic or anti-anxiety medications, and [RESIDENT 1]'s swallowing and choking problems, imposition of a remedy is also mandated under WAC 388-76-10945 because these all present a serious risk to the residents.[622] One of the mandatory remedies available for these violations is revocation of the Appellant's AFH license.[623]

65. Regardless of whether the Department is merely authorized or strictly mandated to impose a remedy for violating the AFH regulatory requirements, the

[618] WAC 388-76-10940. *See also Williams-Batchelder v. Quasim*, 103 Wn. App. 8, 16 (2000) (noting that the purpose of the AFH statutes and regulations is "…to require that AFH providers meet certain minimum licensing requirements to ensure that the vulnerable adults living in those facilities have their care needs met…" and that the laws provide "…reasonable licensing procedures for AFHs in this state").
[619] WAC 388-76-10960(16). Although this rule was slightly amended, effective February 15, 2010, this applicable provision was unchanged. *See* WSR 10-02-064.
[620] RCW 70.128.160(2)(d) and WAC 388-76-10940(5). *See also* WAC 388-76-10960(16).
[621] WAC 388-76-10945. *See also* WAC 388-76-10955.
[622] The Appellant's violation of this rule requiring provision of necessary care and services is sufficient alone to justify revocation of the Appellant's AFH license for House 2. *See also Williams-Batchelder v. Quasim*, 103 Wn. App. 8, 16 (2000) (noting that the purpose of the AFH statutes and regulations is "…to require that AFH providers meet certain minimum licensing requirements to ensure that the vulnerable adults living in those facilities have their care needs met…" and that the laws provide "…reasonable licensing procedures for AFHs in this state").
[623] RCW 70.128.160(2)(d) and WAC 388-76-10940(5). *See also* WAC 388-76-10945.

Department is not required to prove actual harm to the residents of an AFH as a result of the violation.[624]

66. In addition, there is no longer a regulatory requirement that the Department consider "…the severity of the potential or actual impact of the violations on residents and which remedy or remedies are likely to improve resident outcomes and satisfaction in a timely manner…"[625] when determining the appropriate remedy to impose on an AFH. Although the Department may still take these factors into consideration as part of its discretionary authority to take remedial action, the factors must be viewed in light of the sources of such speculative opinion evidence. In this case, the residents themselves—as individuals with dementia—were unable to articulate the severity of the impact of the Appellant's violations on them or whether revocation of the Appellant's AFH license to operate House 2 may timely improve their outcomes and satisfaction or if another remedy may be more likely to result in such improvement. Instead, the sources of this opinion evidence were the House 2 residents' family members and friends, which further attenuates the speculative nature of the evidence. In addition, these family members and friends (1) did not live in House 2 full-

---

[624] *See* WAC 388-76-10940; WAC 388-76-10945; WAC 388-76-10955; and WAC 388-76-10960. *See also* RCW 70.128.005 (finding that "…the state of Washington has a compelling interest in protecting and promoting the health, welfare, and safety of vulnerable adults residing in adult family homes," not simply reacting to harm after it has already occurred). For example, [RESIDENT 1]'s death from aspiration pneumonia may illustrate that ignoring swallowing difficulties and choking risks may have severe consequences and underscores why the Department must be proactive in preventing—rather than merely responding to—harm to vulnerable adults in AFHs.

[625] Former WAC 388-76-705(2)(b), which set forth this standard and upon which part of the holding in *Conway v. DSHS,* 131 Wn. App. 406, 415 and 420 (2005) was explicitly premised, was repealed effective January 1, 2008. *See* WSR 07-21-080 at 1. Although the *Conway* court concluded otherwise, former WAC 388-76-705(2)(b) did not facially require consideration of evidence about the impact that revocation would have on the AFH residents and no current provision in Chapter 388-76 WAC of which the undersigned is aware requires consideration of this factor. *See Conway*, 131 Wn. App. at 420 (stating that the BOA must "…take into account all relevant evidence under WAC 388-76-705(2)(b) including Conway's testimony, the testimony of the DSHS investigator, and the testimony of the residents and their family members regarding Conway's extraordinary level of care and the impact revocation would have on them").

time and some visited infrequently; (2) focused in their testimony and written statements primarily on the cleanliness of the premises, group gatherings, and the palatability of the meals; (3) may not fully understand the significance of some of the violations or how they may negatively impact resident safety, care, and quality of life; and (4) may have an inherent desire to see the operations of House 2 in a positive fashion since they have placed their loved ones there. For these reasons, the undersigned did not necessarily put great weight on the evidence presented by these family members and friends when determining the appropriateness of the Department's decision to impose remedies or the specific remedial action taken by the Department.

67. Before determining that stop placement and revocation of the Appellant's AFH license for House 2 were the most appropriate remedies in this matter, Department staff discussed the possibility of imposing a lesser remedy to address the violations observed at House 2 during the November 2009 complaint investigation and inspection. Conditions on the license to require the Appellant to limit the capacity of House 2 to only six residents, to have a qualified caregiver, or to have sufficient staff on the premises to meet the needs of the residents could not be imposed because the law in effect at the time of the Department's action already mandated that the Appellant do these things.[626] Other possible conditions were considered, but determined not to be measurable or enforceable because they would require very frequent inspections and pre-staffing monitoring visits to ensure compliance with the capacity limits and caregiver requirements. Presumably, the difficulty in imposing such conditions was due, at least in part, to the considerable Department resources that would be required for

---

[626] RCW 70.128.010(1) and (9); former WAC 388-76-10000 (amended effective February 15, 2010, WSR 10-03-064); former WAC 76-10135 (amended effective January 1, 2011, WSR 10-16-082); and former WAC 388-76-10195(1) (amended effective February 15, 2010, WSR 10-03-064).

enforcement.[627]

68. Ultimately, because the remedies authorized under Chapter 70.128 RCW and Chapter 388-76 WAC are for the purpose of protecting residents by compelling current and future compliance with the AFH statutes and regulations[628] and the Department is required by law to give priority to the safety of vulnerable adults over the interests of AFH providers,[629] Department staff reached the conclusion that stop placement and revocation were the only enforcement options available that would compel compliance. These remedy recommendations were then reviewed by a compliance specialist for the Department as well as the assistant director of RCS to ensure they reflected the facts and citations observed and were consistent with statewide application of such remedies for similar violations before the stop placement order and license revocation were approved as the appropriate remedies.

69. The Department's determination to stop placement and revoke the Appellant's license to operate House 2 as an AFH, pursuant to WAC 388-76-10940(4) and (5), may not be reversed without a clear showing of abuse because it was a discretionary decision.[630] When an agency exercises its discretion in an arbitrary and capricious manner, that constitutes abuse of its discretion.[631] "A decision is arbitrary and capricious if it is 'willful and unreasoning action in disregard of facts and circumstances.'"[632]

---

[627] Candace Corey testified that they did not know how they would impose such conditions without monitoring House 2 for 24 hours per day, 7 days per week.
[628] *Williams-Batchelder*, 103 Wn. App. at 16.
[629] RCW 70.128.005(4) and *Bond*, 111 Wn. App. at 575.
[630] *Conway*, 131 Wn. App. at 419 (citing *ARCO Prods. Co. v. Wash. Utils. & Transp. Comm'n*, 125 Wn.2d 805 (1995)). *See also* RCW 70.128.160(1) and (2); WAC 388-76-10940; and WAC 388-76-10960.
[631] *Id.* (citing *Aponte v. Dep't of Soc. & Health Servs.*, 92 Wn. App. 604 (1998)).
[632] *Id.* (quoting *Aponte,* 92 Wn. App. at 621 (quoting *Wash. Waste Sys., Inc. v. Clark County*, 115 Wn.2d 74, 81, 794 P.2d 508 (1990)).

70. Given the many complaints received by the Department and the long-term care ombudsman about House 2, the lengthy Department investigation, as well as extensive deliberations about and the number of qualified people involved in determining the appropriate remedy for the many violations cited, the Department's actions of ordering stop placement and revoking the Appellant's AFH license cannot be said to be willful and unreasoning action in disregard of the relevant facts and circumstances of this case. The Department's revocation of the Appellant's AFH license has not been shown to be arbitrary and capricious. There has not been a clear showing of abuse when the Department exercised its discretionary decision to stop placement at House 2 revoke the Appellant's AFH license to operate House 2.

71. The hearing record supports by a preponderance of the evidence the Findings of Fact and resulting Conclusions of Law contained in this *Review Decision and Final Order* that the Appellant operated House 2 in excess of its licensed capacity, did not provide the necessary care and services to residents or failed to do so in a way that supported their safety and quality of life, and violated several other AFH rules.[633] Operating overcapacity and failing to provide the necessary care and services, which posed a serious risk to residents, each constitute an independent basis for stop placement and revocation.[634] In addition, operating an AFH over its capacity impaired the Appellant's ability to satisfy other minimum licensing requirements, such as ensuring that the necessary care and services are provided to residents, thus contributing to the Appellant's violation of those requirements in this case. The cumulative effect of these

[633] Although the undersigned concluded that the Department did not prove by a preponderance of the evidence that the Appellant violated WAC 388-76-10510(5) and WAC 388-76-10620 with respect to resident activities, this does not change the ultimate conclusion that stop placement and revocation of the Appellant's AFH license were proper.
[634] WAC 388-76-10960(16) and WAC 388-76-10945(2)(a).

minimum licensing violations also constitute a basis for stop placement and revocation of the Appellant's AFH license.[635] Further, the Appellant has a history of noncompliance with state regulations in the provision of care and services of vulnerable adults, as reflected by her two recurrent violations of the CPR and food regulatory requirements. WAC 388-76-10945 specifically mandates that the Department impose a remedy or remedies when violations of the minimum licensing requirements are recurrent. The Department proved that the remedies selected are permitted by rule and statute in response to noncompliance with regulatory requirements and that they were appropriate.

72. **Investigation.** AFHs are inspected at the time of licensure and at least every 18 months thereafter.[636] Unannounced inspections may be made at any time to ensure that the AFH and provider are in compliance with the regulations.[637] Likewise, the Department "must conduct… complaint investigations… to determine if the adult family home is in compliance with chapter 70.128, 70.129, 74.34 RCW, this chapter, and other applicable laws and regulations."[638]

73. Although the Appellant alleges that the Department's investigator and other staff made mistakes in this particular case; the undersigned determined that the investigator sometimes confused Resident #1 ([RESIDENT 4]) and Resident #2 ([RESIDENT 10]);[639] and the undersigned has indicated that copies of the client assessments and medication logs that were reviewed by the Department investigator

---

[635] WAC 388-76-10960(14)(b).
[636] RCW 70.128.070(2)(a) and (b).
[637] RCW 70.128.070(2)(c).
[638] WAC 388-76-10910.
[639] This confusion did not change the nature of the violation insofar as both residents' medications were unavailable while the Appellant was off the premises because she was the only person who had access to them.

and surveyor during their visits to House Two would have been helpful, it must be noted that there is no requirement that the Department conduct its investigation of an AFH or gather its evidence in a certain manner for the case to proceed to hearing.[640] It is possible that the Department could present no information regarding its investigation process at hearing and still prevail if the sworn witness testimony and relevant documents created apart from the investigation and admitted into the hearing record are found credible and prove by a preponderance of the evidence that stop placement and revocation are correct. In the end, the final decision depends on the evidence presented by both sides at the hearing and the weight afforded that evidence by the presiding and reviewing officers.[641] Nonetheless, the purpose of an investigation and to investigate is to systematically, and through careful inquiry, uncover facts and determine the truth.[642] To accomplish this, it is very helpful to both the ALJ and the Review Judge, and, ultimately, to the parties involved, if the investigation and any additional evidence are as complete and unaltered as possible.

74. In this particular case, prior to issuance of the Department's stop placement order and revocation of license, there were several layers of review and corroborating evidence from various sources, including:

---

[640] While the specific manner for conducting AFH license investigations is not prescribed in statute or rule, RCW 74.34.067(2) does require the Department to interview facility staff and consult any available independent sources of information in other types of cases in the long-term care setting, specifically when investigating allegations that a provider abused, neglected, or financially exploited a vulnerable adult. It was also noted in *Kraft v. Dep't of Soc. & Health Servs.*, 145 Wn. App. 708, 741 (2008), that "…neither the ALJ nor the review judge has the authority to evaluate the APS investigator's interview techniques," but it was not stated whether other aspects of such investigations may be subject to review. Although compliance with RCW 74.34.067(2) is not technically required in this AFH case because it did not include allegations of abuse, neglect, or financial exploitation, the Department did interview facility staff and consult available independent sources of information.

[641] *See Kraft*, 145 Wn. App. at 741 (quoting Clerk's Papers at 92 to explain, "[I]f [DSHS] presents and relies upon poor factual information at the hearing, the consequence may be that [DSHS] is unable to meet its burden of proof and/or prevail").

[642] *See Webster's Third New International Dictionary* 1189 (2002).

- Four complaints about House 2 received by the CRU from separate individuals;
- Two days of on-site investigation and document review by Ms. Corey;[643]
- A licensing inspection by Ms. Everett;
- Follow-up interviews by Ms. Corey with the Appellant and collateral contacts;
- Research and examination of additional documents by Ms. Corey after the two-day investigation and inspection;
- Reports by advocate volunteers to the regional long-term care ombudsman, Mr. Tosch, of complaints about House 2 that the ombudsman followed-up with phone calls to the complainants and on-site visits to House 2;
- Reports and testimony from caregivers with first-hand knowledge of the operations at House 2;
- Consultation between Ms. Corey, the investigator, and Ms. Hildreth, the field manager, to review the citations made for the observed violations and to make recommendations about the appropriate remedy to address the violations;
- Review of the citations and recommendations by Janice Schurman, the RCS compliance specialist, for accuracy and statewide consistency in application of the relevant law; and
- Review and approval of the field recommendations by the assistant director of RCS, Lori Melchiori.

The comprehensiveness of the Department's review of House 2's operations, coupled with the extensive corroborating evidence, not only satisfied the undersigned of the reliability of the entire investigation process but also enabled the Department to satisfy its burden of proving by a preponderance of the evidence that the Appellant was correctly cited for various deficiencies resulting in stop placement and revocation of her license to operate House 2 as an AFH.

75. **Summary**. The Appellant's attorney attempted to minimize some of the

[643] Candace Corey testified that she spent 5.5 hours at House 2 on November 2, 2009 and then another 5 hours on November 13, 2009.

Department's cited violations of the AFH minimum licensing requirements, such as the number of flashlights required for emergency lighting and the insufficient and expired food, as well as [CAREGIVER 1]'s lack of current CPR certification for at least a two-month period. However, it is not inconceivable that there could be a situation, such as flooding, fire, or earthquake, that could result in a power outage and require quick, lighted evacuation of all the residents, the stress of which might cause one (or more) of the elderly residents at House 2 to go into cardiac arrest or to panic and flee, and could cut off access to House 1 where most of the food for both houses was stored. This would not be a situation in which a caregiver could pause to look for fresh batteries for a non-functioning flashlight or to go outside to aim a car's headlights into the home. When House 1 residents were also at House 2 and there was only one caregiver present, such a hypothetical situation would be significantly compounded as she or he tried to evacuate all of the residents, with only one working flashlight, and while also trying to remember and perform CPR based on training taken long ago and keep all the residents safe. Even if only one or two of this parade of horribles became reality, the overcapacity of House 2, when coupled with only with the lack of sufficient emergency lighting, adequate food, a qualified caregiver, or another cited violation, significantly increases the risk of harm to the residents.

76. These safety considerations are one of the reasons why the capacity of AFHs is limited to only six residents. It is also why the minimum licensing requirements are—by definition—a floor. The minimum licensing requirements are not goals to which a provider should aspire or strive to attain, but rather they are the absolute minimum threshold that a provider must meet in order to satisfy the licensing requirements for an

AFH. Because these regulatory requirements constitute a baseline or a starting point, there can be no “process of complying” or “substantial compliance” with them. The Department has shown by a preponderance of the evidence that the Appellant failed to achieve and maintain the bare minimum and also exceeded the capacity of House 2. As a result, the Department’s stop placement order and revocation of her license to operate House 2 was correct.

77. The licensing relationship between the Department and a private AFH is not the usual relationship between a government licensing agency and a private business, a relationship usually established to generate possible tax revenue and governed by general regulations beneficial to the public welfare at large. This is, in part, because the Department is mandated to ensure that health, safety, and well-being of vulnerable adults in AFHs is the “paramount concern” in its interactions with its licensee, the AFH.[644] Also, the Department must encourage the establishment and maintenance of AFHs that provide a humane, safe, and residential home environment for persons with functional limitations who need personal and special care.[645] In furtherance of this responsibility, the Department is charged with the establishment of standards for regulating adult family homes that adequately protect residents.[646] In essence, AFH licensees become contracted care providers with the Department for this vulnerable population. For this system to work, the relationship between the Department and each AFH licensee must be based on trust, cooperation, and a firm belief by the licensor (Department) that the licensee is treating vulnerable adults consistently in a manner conducive to their well-being, safety, and quality of life. The Appellant’s actions in failing

[644] RCW 70.128.005(4).
[645] RCW 70.128.007(1).
[646] RCW 70.128.007(2).

to meet minimum, but significant, AFH regulations seriously jeopardized the necessary trust that she will meet all the residents' service and care needs in the future. The evidence in the hearing record supports the conclusion that this relationship of trust and cooperation between the Appellant and the Department has been undermined by the actions and inactions of the Appellant.

78. The undersigned has considered the *Initial Order*, the Department's petition for review of the *Initial Order,* the Appellant's response to the Department's petition for review, and the entire hearing record. Any arguments in the Department's petition for review and the Appellant's response that are not specifically addressed in this decision have been duly considered, but are found to lack merit or to not substantially affect a party's rights. The procedures and time limits for seeking reconsideration or judicial review of this decision are in the attached statement.

IV. DECISION AND ORDER

1. The ALJ's Decision in the *Initial Order* is ***reversed.*** The Department's revocation of the Appellant's adult family home license and stop placement order is **sustained**.

Mailed on the _____ day of April, 2011.

____
DIAMANTA TORNATORE
Review Judge/Board of Appeals

Attached: Reconsideration/Judicial Review Information

Copies have been sent to: [FACILITY 2], c/o [APPELLANT], Appellant
Thomas Grimm, Appellant's Representative
Angela Coats McCarthy, Department's Representative
Janice Schurman, Program Administrator
Joyce Pashley Stockwell, Program Administrator
Erika Lim, ALJ, [City] OAH