STATE OF WASHINGTON, DEPARTMENT OF SOCIAL AND HEALTH SERVICES

BOARD OF APPEALS

In Re:	)	Docket No. 08-2013-L-0829
	)	
[FACILITY 1]	)	**REVIEW DECISION AND FINAL ORDER**
	)	
	)	
	)	Adult Family Home License
Appellant	)	Client ID No. [NUMBER 1]

I. NATURE OF ACTION

1. The Department of Social and Health Services (DSHS or Department) issued the Appellant an *Imposition of Civil Fine Letter* assessing a $2000.00 civil fine for violation of WAC 388-76-10655(1), and (3). The letter was served by certified mail, return receipt requested on July 12, 2013. The Appellant requested a hearing to contest the Department's proposed action. Administrative Law Judge Johnette Sullivan held hearings on February 25, 2014, and February 26, 2014, in response to the Appellant's request. The Administrative Law Judge (ALJ) issued an *Initial Order* on March 26, 2014, affirming the Department's *Imposition of Civil Fine Letter* assessing a $2000.00 civil fine, for violation of WAC 388-76-10655(1), and (3).

2. Per a timely request, the Appellant was granted an extension of the timely filing deadline until April 30, 2014.

3. The Appellant filed a *Petition for Review of the Initial Order* with the Department's Board of Appeals (BOA) on April 30, 2014.

4. The Department filed no *Response* to the Appellant's petition.

II. FINDINGS OF FACT

The undersigned has reviewed the record of the hearing, the documents admitted as exhibits, the *Initial Order*, and the *Petition for Review of the Initial Decision.* The following necessary findings of fact were relevant and supported by substantial evidence in the record.

1. On July 12, 2013, the Assistant Director of Aging and Disability Service Administration's (ADSA) Residential Care Services sent to the Appellant, via certified mail, a notice imposing a civil fine of $2,000 for a violation of WAC 388-76-10655(1) and (3). The notice alleged that the Appellant "failed to ensure one resident was free from a physical restraint when a staff member used a seat belt to restrain a resident for the purpose of staff convenience and without having medical justification for the use of the seat belt." The notice alleged that over the course of several months, a resident was repeatedly subjected to being restrained by a seat belt to his recliner.

2. On August 13, 2013, the [CITY 1] Office of Administrative Hearings (OAH) received the Appellant's request for hearing, which bore an August 8, 2013, postmark. The Department concedes the request was timely filed.

3. [FACILITY 1] ([FACILITY 1]) is one of several licensed adult family homes located in a [CITY 2] neighborhood and owned by [FACILITY 2], a corporation owned by the Appellant. His [RELATIVE 1], [NAME 1], is vice-president. Each home is individually licensed. Only [FACILITY 1] is at issue here. The group of homes is managed by a facility manager, and to her report each home's resident manager or supervisor and caregivers. The Appellant is an active owner, and with his [RELATIVE 1], is on-site at [FACILITY 1] and the neighboring licensed homes daily.

4. The Appellant appealed because he wanted to confront the notice's reference to a seat belt, and because he believed it was wrong for ADSA to punish [FACILITY 1] for doing the right thing by conducting an internal investigation and reporting a potential violation.

5. The care of one resident is at issue. The resident was born in 1951 and had been injured in an accident. He transferred from another facility to [FACILITY 1] in [DATE 5] 2012. [FACILITY 1] used a needs assessment dated [DATE 4], 2012, until it could negotiate a care plan for the resident. The assessment informed [FACILITY 1] the resident had suffered

two falls in [DATE 1] 2012. The resident had fallen from his geri-chair which resulted in a swollen eye, and had fallen from his mattress which resulted in a cut above his eye. The resident had spent 10 days in a local hospital to recover from these injuries. He arrived at [FACILITY 1] with his geri-chair and a helmet. The resident was totally dependent and required one-person physical assist for locomotion outside of his immediate living environment, in his room and his immediate living environment, and for bed mobility. He was not able to walk. The assessment described his limitations to include that he falls back, could not propel a wheelchair, leans to the left, has poor safety awareness, slides down in a chair, and would be unable to exit in an emergency. The resident was very slightly built, short in height and weighed less than 110 pounds. He was unable to speak or communicate. The resident has since passed away.

6. The geri-chair was made with plastic webbing and suited for use in a shower as well as for transportation. On each side of the geri-chair was affixed a belt, and at the end of each belt was a mechanism. The two mechanisms were designed to couple together to secure someone seated in the geri-chair in the same manner as a seat belt in a car.

7. The resident's family provided him with a stuffed recliner which was placed in the [FACILITY 1] common living area. The resident repeatedly slipped or slid out of the recliner onto the living room floor. The resident was totally dependent on a caregiver to re-position him.

8. The event which [FACILITY 1] investigated and reported to ADSA in [DATE 5], 2013, did not involve the geri-chair.

9. The event which [FACILITY 1] investigated and reported to ADSA in [DATE 5] 2013, involved the recliner; however, the recliner did not have belts affixed to each side in seat belt style. The investigation concerned the alleged improper use of a specific distinctive strap, black in color, 2-3" in width, long enough to wrap completely around the stuffed recliner. The strap had the name of a transportation company stitched or printed or inked into it. At each end

of the strap was half of a coupling mechanism similar to a seat belt mechanism. The facility manager took possession of the strap during the investigation and placed it in storage.

10. The investigation was initiated because a caregiver in [FACILITY 1] reported that another caregiver, [NAME 2], used the strap to restrain the resident in the recliner, and recommended that the reporter restrain the resident similarly. [NAME 2] was questioned by the facility manager and the vice president. The facility manager placed [NAME 2] on administrative leave pending investigation. [NAME 1]'s response was to immediately quit. [NAME 2]'s decision to quit and her actions and statements during the Appellant's internal investigation, are found to be statements and actions against interest, and confirm her inappropriate use of restraints.

11. Although the ADSA investigator indicated in her notes and testimony that on [DATE 2], 2013, [NAME 1] and the [FACILITY 1] facility manager were aware that the resident had previously been restrained in his recliner, no other hearing evidence supports this determination. It appears that the investigator's determination was based on reports that the strap/belt in question was previously found near the recliner. However, no witness reported seeing this resident restrained in this recliner prior to this incident, and there is no evidence that any previous report was made to the Appellant, [NAME 1], or the facility manager.

12. [NAME 2] had participated in many internal and external training courses. Her choice to violate the rules regarding use of physical restraints was not due to a lack of training. [FACILITY 1] is committed to providing ongoing training to staff, and had provided many training opportunities to [NAME 2]. [FACILITY 1] provided its employees with easy access to ADSA's handbook for rules and procedures for adult family homes and residents. The hearing evidence did not indicate any training or precaution that [FACILITY 1] could have taken to prevent [NAME 2] from inappropriately using restraints.

13. The Appellant, vice-president and facility manager immediately responded to the receipt of an accusation on [DATE 2], 2013, by beginning an internal investigation. The Appellant directed that reports be made to the police and ADSA. He indicated to employees that he expected them to cooperate with ADSA's investigation. The hearing evidence demonstrated that the Appellant took all possible appropriate actions after receiving the use of restraint allegation.

14. The owner objects to the imposition of a large civil fine. The incident was not significant enough to warrant immediate investigation by ADSA. All complaints are prioritized and ADSA allowed several weeks to pass before the complaint investigator responded to [FACILITY 1]'s self-reporting. Also, the investigation was closed without a directive that [FACILITY 1] take further corrective action beyond the action it took at the time of its internal investigation. If the owner's investigation and actions on or about [DATE 3], 2013, were sufficient to resolve the matter, he is confused by the subsequent imposition of a civil fine.

15. The owner acknowledges the licensee's responsibility for all actions occurring in the AFH, but contends that self-reporting is essential in situations when a violation is discovered. He contends that the mutual cooperation or partnership between ADSA and licensees is not supported and is in fact harmed if ADSA responds to a self-report by issuing a large civil fine. He believes such action is contrary to the regulatory purpose and tempts licensees to be less cooperative and forthcoming.

16. ADSA admits that it has discretion to impose or not impose a remedy in response to some licensee violations. However, it must impose a remedy in response to certain violations, including issues of health, safety, or welfare of a resident and harm or potential of harm to a resident. ADSA found both harm and potential for harm to the resident, and that restraint in his recliner was a threat to his health, safety, and welfare. ADSA contends this is the type of violation for which a penalty is mandated.

17. No evidence was presented to show how often [NAME 2] inappropriately used restraints, or for how long the restraints were used. Additionally, there was no evidence to indicate that the resident had ever been left alone while restrained. However, ADSA found that the use of the restraint risked harm to the resident because the strap could impede circulation or could cut off his oxygen supply if it tightened around his upper chest or neck. ADSA found use of the strap risked serious harm or even death, given the resident's total dependence on others to reposition himself and for mobility, his propensity to slide or lean, and his lack of ability to communicate if he was in pain or needed help. The evidence does not support a finding the resident felt discomfort or pain, and no finding of actual harm based on discomfort or pain or inability to express discomfort or pain is made.

18. The Department testified that a $2000.00 civil fine is required in this matter, because WAC 388-76-10976 requires the imposition of a $2000.00 fine pursuant to an "initial" incident of "serious harm," and [NAME 2]'s actions caused the AFH's resident "serious harm." There was no evidence presented to indicate that the Department had considered any remedy other than a civil fine.

III. CONCLUSIONS OF LAW

1. The petition for review of the *Initial Order* was timely filed and is otherwise proper.[1] Jurisdiction exists to review the *Initial Order* and to enter the final agency order.[2]

2. The Washington Administrative Code (WAC) and the Washington Administrative Procedure Act (APA) provide that the undersigned Review Judge has 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.[3] WAC 388-02-0600(1) specifically grants the Review Judge the authority to decide the issues *de novo* (anew). This includes the authority to

[1] WAC 388-02-0580.
[2] WAC 388-02-0560 to -0600.
[3] RCW 34.05.464(4). *See also* WAC 388-02-0600(1).

make credibility determinations, weigh the evidence, and change or set aside the ALJ's findings of fact.[4] This is because *"…administrative review is different from appellate review."*[5] The undersigned Review Judge does not have the same relationship to the 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.[6] 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.[7] However, if the ALJ specifically identifies any findings of fact in the order to be reviewed that are based substantially on the credibility of evidence or demeanor of the witnesses,[8] 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.[9] This does not mean a Review Judge must defer to an ALJ's credibility findings, but it does require that they be considered.[10]

3. 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

[4] *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).
[5] *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 (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").
[6] *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).
[7] *Id.*
[8] RCW 34.05.461(3).
[9] RCW 34.05.464(4) and WAC 388-02-0600(1).
[10] *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).

(BOA), 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.[11] 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).[12] This is because ALJs and Review Judges must first apply the Department rules adopted in the WAC to resolve an issue.[13] If there is no Departmental 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 and Washington constitutions, statutes and regulations, and court decisions.[14] 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.[15]

4. Standard of proof refers to the amount of evidence needed to prove a party's position.[16] A preponderance of the evidence means that it is more likely than not that something happened or exists.[17] The burden of proof is borne by the party attempting to persuade the ALJ that their position is correct.[18]

5. Unless a WAC provision, RCW provision, or published case law states otherwise, the standard of proof in a Departmental hearing is a preponderance of the evidence.[19] 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.

6. It is also important to note that the Washington State Legislature has statutorily

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[11] *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 which provides, "The authority of the ALJ and the review judge is limited to those powers conferred (granted) by statute or rule. The ALJ and the review judge do not have any inherent or common law powers."
[12] *Id.*
[13] WAC 388-02-0220(1).
[14] WAC 388-02-0220(2).
[15] WAC 388-02-0225(1).
[16] WAC 388-02-0485.
[17] *Id.*
[18] WAC 388-02-0480(2).
[19] WAC 388-76-10995(3) and WAC 388-02-0485.

found the State has a "compelling interest" to protect and promote the well-being of vulnerable adults residing in AFHs.[20] 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 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."[21]

7. An AFH must comply with all applicable licensing laws and regulations ***at all times.***[22] The Department must conduct unannounced inspections, complaint investigations, and monitoring visits to determine if the adult family home is in compliance with chapters RCW 70.128, RCW 70.129, RCW 74.34, WAC chapter 388-76, and other applicable laws and regulations.[23] The Department is authorized to take actions in response to AFH noncompliance or violations of these legal authorities.[24]

8. Pursuant to WAC 388-76-10655:

"The adult family home must ensure:

(1) Each resident's right to be free from physical restraints used for discipline or convenience;

(2) Less restrictive alternatives have been tried;

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[20] RCW 70.128.005(4) (further noting that "[t]he health, safety, and well-being of vulnerable adults must be the paramount concern…").
[21] *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).
[22] WAC 388-76-10903.
[23] WAC 388-76-10910.
[24] WAC 388-76-10002.

(3) That physical restraints used have been assessed as necessary to treat the resident's medical symptoms; and
(4) That if physical restraints are used to treat a resident's medical symptoms that the restraints are applied and immediately supervised on-site by a:

(a) Licensed registered nurse;
(b) Licensed practical nurse; or
(c) Licensed physician; and
(d) For the purposes of this subsection, immediate supervised means that the licensed person is in the home and quickly and easily available."

As correctly concluded by the ALJ, an [FACILITY 1] caregiver, [NAME 2], physically restrained a [FACILITY 1] resident in his recliner, in violation of WAC 388-76-10655. It is further concluded that the Appellant violated this rule by failing to ensure that his resident was free from physical restraints used for convenience, because the restraint occurred in the [FACILITY 1].

9. Concluding that the Appellant was not in compliance with AFH regulations leads to the issue as to whether the remedy implemented by the Department was correct. The Legislature has afforded the Department broad discretion in the assessment of remedies imposed against adult family homes. RCW 70.128.160(1) states:

"(1) The Department is authorized to take one or more of the actions listed in subsection (2) of this section in any case in which the department finds that an adult family home provider has:

(a) Failed or refused to comply with the requirements of this chapter or the rules adopted under this chapter;….

(2) When authorized by subsection (1) of this section, the department ***may*** take one or more of the following actions:

(a) Refuse to issue a license;
(b) Impose reasonable conditions on a license, such as correction within a specified time, training, and limits on the type of clients the provider may admit or serve;
(c) Impose civil penalties of at least one hundred dollars per day per violation;
(d) Impose civil penalties of up to three thousand dollars for each incident that violates adult family home licensing laws and rules, including, but not limited to, chapters 70.128, 70.129, 74.34, and 74.39A RCW and related rules. Each day upon which the same or substantially similar action occurs is a separate violation subject to the assessment of a separate

penalty;
(e) Impose civil penalties of up to ten thousand dollars for a current or former licensed provider who is operating an unlicensed home;
(f) Suspend, revoke, or refuse to renew a license; or

(g) Suspend admissions to the adult family home by imposing stop placement."

(Emphasis added.)

10. Similarly, the relevant WAC states, "The department ***may*** take one or more of the following 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:

(1) Denial of an application for a license;

(2) Impose reasonable conditions on a license;

(3) Impose civil penalties;

(4) Order stop placement; and/or

(5) Suspension or revocation of a license."[25]

(Emphasis added.)

11. The Department's broad discretion comes from the language of the applicable regulation and statute. WAC 388-76-10940, and RCW 70.128.160, each state that the Department ***may*** impose civil penalties upon proof of noncompliance of the statutory or regulatory requirements. In interpreting this provision, the undersigned considers the following canons of statutory construction:

> "[C]ourts must give effect to every word, clause, and sentence whenever possible; no part should be deemed inoperative or superfluous unless the result of obvious mistake or error; (ii) when both 'may' and 'shall' are contained in the same provision, 'may' presumably indicates a permissive duty, while 'shall' indicates a mandatory duty; and (iii) words should be given their ordinary or plain meaning absent ambiguity or statutory/regulatory definition."[26]

[25] WAC 388-76-10940.
[26] *Aponte v. Dep't of Soc. & Health Servs*., 92 Wash. App. 604, 617-18, 965 P.2d 626 (1998) (internal citations omitted).

Because the undersigned must apply the Department rule and statute precisely as they are written and may not deem any part of the rule or statute inoperative, the undersigned must give effect to the choice of the permissive word "may." In choosing the word "may," the Legislature clearly intended to afford the Department the discretion to decide whether to revoke a license or to impose some other remedy. The word "may" is given its plain meaning and means exactly what it says - that the Department is permitted to take the action specified in the statute in every case in which a provider has failed or refused to comply with an AFH rule.

12. If the ALJ were authorized to overturn the remedy and select a different remedy when the Department has proven by a preponderance of the evidence that a licensee has failed to comply with an AFH rule, then the discretion granted the Department by the use of the word "may" in WAC 388-76-10940, and RCW 70.128.160, would be rendered meaningless. If the ALJ were permitted to substitute some other remedy, this would ignore the discretionary language selected by the Legislature and echoed in the Department rule. The ALJ must give effect to the discretionary language in WAC 388-76-10940, and RCW 70.128.160, because the ALJ must apply the Department rule and statute precisely as they are written.

13. Although WAC 388-02-0215(1) requires the ALJ to complete a de novo review, this does not mean that the ALJ takes on all the discretionary powers of the Department. This regulation is not an independent grant of subject matter jurisdiction to the ALJ. Rather, "de novo" is a standard for reviewing evidence and does not authorize the ALJ or the Review Judge to take actions that he/she is not otherwise authorized to take. The de novo requirement clarifies that an ALJ considers all of the evidence in the record, even if the evidence was not available to the Department at the time the Department made its decision. However, the ALJ is still limited to adjudicating the issues raised in the Department's notice. The ALJ must still give effect to the discretion afforded the Department in WAC 388-76-10940 and RCW 70.128.160. The regulatory de novo requirement does not empower the ALJ to raise new allegations,

impose new remedies, or exercise any of the Department's other discretionary powers. The de novo provision of WAC 388-02-0215(1) is primarily an evidentiary standard, and does not authorize the ALJ to exercise all of the powers of the Department.

14. In September 2005, the Court of Appeals of Washington, Division One, ruled that the presiding officer of the administrative hearing (ALJ) does have the authority to review the propriety of the Department's discretionary decision to revoke an AFH license, but did not have the authority to impose a different remedy.[27] The court concluded that WAC 388-76-710(3) [a former regulation relevant to AFH licensing cases] allowed a licensee to administratively challenge any decision by the department to impose a remedy notwithstanding such a decision was discretionary.[28] The court ruled that not only could the licensee challenge the Department's determination a violation had occurred and that it posed a serious risk to a resident, was recurring, or uncorrected, but that the licensee could also challenge whether the Department properly took into account the severity of the potential or actual impact of the violations on the residents and whether the chosen remedy is likely to improve resident outcomes and satisfaction in a timely manner. Although the cited regulation speaks of "***impact of violations*** *on the residents*," the court also interpreted the concept of improving "resident outcomes and satisfaction in a timely manner" to include consideration of the "level of care and the ***impact revocation*** would have on [residents and their family members]." The court specifically ruled:

> "In order to determine whether DSHS's decision to revoke Conway's AFH license was warranted, the DSHS board must give deference to the ALJ under RCW 34.05.464 and 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." [29]

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[27] *Conway v. DSHS,* 131 Wn. App. 406, 419, 120 P.3d 130, 136 (2005).
[28] *Conway,* 131 Wn. App. at 417.
[29] *Id* at 420. The AFH regulations were modified effective January 1, 2008, eliminating the requirement that rule violations ***must*** be of "a serious risk to a resident, are recurring or have been uncorrected" before license revocation could be implemented. *See specifically* WAC 388-76-10940 *and generally* WAC 388-76-10940 through -10985.

15. The *Conway* court also ruled that, *"An agency's discretionary decision will not be reversed without a clear showing of abuse. An agency abuses its discretion when it exercises its discretion in an arbitrary and capricious manner. A decision is arbitrary and capricious if it is 'willful and unreasoning action in disregard of facts and circumstances.'"*[30]

16. While recognizing the protected property interest in an AFH license,[31] the licensing relationship between the Department and a private adult family home is not the usual relationship between a government licensing agency and a private business, a relationship usually established to provide possible tax revenue and general regulations beneficial to the public welfare at large. As concluded above, by law, the Washington Legislature has determined, *". . . 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. The 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."*[32] The Department is mandated to encourage the establishment and maintenance of adult family homes that provide a humane, safe, and residential home environment for persons with functional limitations who need personal and special care. In furtherance of this responsibility, the Department is charged with the establishment of standards for regulating adult family homes that adequately protect residents.[33] But for the existence of the adult family home, vulnerable adults would often be relegated to state run institutions or highly regulated nursing homes. In essence, adult family home 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

[30] *Id* at 419-420 (internal citations omitted).
[31] *Conway,* 131 Wn. App. at 418.
[32] RCW 70.128.005(4).
[33] RCW 70.128.007(2).

complying with all AFH regulations. However, the ability to operate an AFH is not a "right," but a privilege under law as evidenced by the need to obtain a license through the Department to operate such an enterprise.

17. The AFH regulations set out in WAC 388-76 are not "suggestions" or "guidelines." They are mandatory minimum requirements that must be complied with prior to or within strict time lines of commencing care of AFH residents.

18. The *Conway* court, by its actions in remanding that case to the BOA to reconsider the propriety of license revocation under the facts of that case, recognized the authority of the BOA to enter a final agency decision that does alter the remedy selected even though the evidence supports the conclusion that one or more rule violations had occurred.[34] The applicable regulations set forth the remedies that can be imposed against an AFH. They are limited to issuance of a statement of deficiencies (SOD) with a necessary Plan of Correction (POC)[35]; denial of a license application; imposition of reasonable conditions on a license; fines; suspension of a license; revocation of a license; and/or a stop placement order.[36] Although the remedy selected by the Department is permitted by rule and statute in response to noncompliance with certain cited licensing requirements, the undersigned is charged with the responsibility to determine if the imposition of a $2000.00 civil fine is appropriate under the specific facts of this case.

19. The authorizing and underlying statute addressing sanctions to be imposed for violation of AFH regulations states specifically:

> "The Department shall by rule specify criteria as to when and how the sanctions specified in this section must be applied. The ***criteria must provide for the imposition of incrementally more severe penalties for deficiencies that are repeated, uncorrected, pervasive, or present a threat to the health, safety, or welfare of one or more residents. The criteria shall be tiered such that those homes consistently found to have deficiencies will be subjected to increasingly severe penalties.*** The Department shall implement prompt and specific enforcement remedies without delay

[34] *Conway,* 131 Wn. App. at 410 and 420.
[35] WAC 388-76-10930.
[36] WAC 388-76-10940.

> for providers found to have delivered care or failed to deliver care resulting in problems that are repeated, uncorrected, pervasive, or present a threat to the health, safety, or welfare of one or more residents. In the selection of remedies, the health, safety, and well-being of residents must be of paramount importance."[37]

20. The sanction (remedy) regulations adopted by the Department are found at WAC 388-76-10930, and WAC 388-76-1040 through -10985. Although the applicable regulations provide for when the Department "may" or "must" impose a remedy[38], there appears to be no criteria as to what remedies are to be applied under what circumstances, let alone a system of "*incrementally more severe penalties*." The only attempt at creating a gradation of remedies appears to be at WAC 388-76-10976, wherein civil fines are incrementally assessed on a grid based on level of harm to residents. Indeed, even the former applicable rule at WAC 388-76-705(2)(a) provided some incremental imposition of sanctions by requiring the Department to allow the provider a reasonable opportunity to correct a violation unless the violation posed a serious risk to residents, was recurring, or had been uncorrected. Absent regulatory direction in how and when to apply all the enumerated remedies, the undersigned, pursuant to WAC 388-02-0220(2), is forced to look to the statute in determining if the correct remedy has been applied in any particular AFH case.

21. RCW 70.128.160(7) makes it clear that sanctions are to be implemented on an incremental or increasingly severe basis. One may argue that the literal language of the statute only requires this "incremental" criteria when rule violations are "repeated, uncorrected, pervasive, or present a threat to the health, safety, or welfare of one or more residents." Such an interpretation makes no sense. Why would repeated, uncorrected, or otherwise more serious violations be subject to incrementally more severe sanctions, but not first-time, corrected, or less serious violations? Not all rule violations warrant license revocation or the imposition of civil fines. And not all violations of the same rule should result in imposition of the

[37] RCW 70.128.160(7). Emphasis added.
[38] *See,* WAC 388-76-10960 and WAC 388-76-10955, respectively.

same remedy or sanction in every case. Imposition of remedies must be considered on a gradation or incremental scale based on the specific facts of each individual case.

22. The testimonial evidence provided by the Department to support the remedy selection in this case was general and limited. The Department testified that a $2000.00 civil fine was required in this matter, because WAC 388-76-10976 requires the imposition of a $2000.00 fine pursuant to an "initial" incident of "serious harm," and [NAME 2]'s actions caused the AFH's resident "serious harm." Other than this assertion, the relevant testimony did not reveal what was specifically discussed or considered in determining that an imposition of a $2000.00 fine was appropriate against this AFH licensee. There was no evidence presented to indicate whether the Department's chosen remedy was likely to improve resident outcomes and satisfaction in a timely manner. Additionally, there was no evidence presented to indicate that the Department had considered any remedy other than a civil fine. The limited evidence regarding remedy selection in this case fails to support that decision under the requirements of the statute.

23. Pursuant to WAC 388-76-10945, a remedy is required in this matter, because the rule violation presented a threat to the health, safety, or welfare of one of the AFH's residents.[39] In determining the appropriate remedy, the Undersigned must consider remedies on an incremental basis, pursuant to the harm incurred by the resident and the actions of the Appellant, his [RELATIVE 1] [NAME 1], the resident manager, the reporting care giver, and [NAME 2].[40] Additionally, pursuant to *Conway vs. DSHS,* the Undersigned must evaluate the severity of the potential or actual impact of the violations on the existing residents and whether the chosen remedy is likely to improve resident outcomes and satisfaction in a timely manner. As stated above, the available remedies are limited to issuance of a statement of deficiencies

[39] WAC 388-76-10945(4).
[40] WAC 388-76-10950.

(SOD) with a necessary Plan of Correction (POC),[41] denial of a license application; imposition of reasonable conditions on a license; fines; suspension of a license; revocation of a license; and/or a stop placement order.[42]

24. Prior to imposing a civil fine, the Department was required to consider either issuing a SOD with a necessary POC, or the imposition of reasonable conditions on a license. A reasonable condition specifically outlined in the Department's rule would be training related to the deficiency or incident.[43]

25. Under the facts of this case, the Department's imposition of a $2000.00 civil fine failed to meet the directives for incremental imposition of penalties based on the severity of the deficiency. There was no evidence demonstrating that the Department considered any incremental penalties such as an SOD with a necessary POC or an imposition of reasonable conditions on a license. Although, it was uncontroverted that [NAME 2] inappropriately restrained a resident in violation of WAC 388-76-10655, there was no evidence of actual harm to the resident and the threat of harm was speculative. Additionally, the excellent responses to the incident by the Appellant, his [RELATIVE 1] [NAME 1], the resident manager, and the reporting caregiver, indicate that a "penalty" to insure future correct behavior is not required in this situation. Without this need to ensure more appropriate future behavior, the chosen remedy is not likely to improve resident outcomes. After review of the entire record and careful consideration of the rule violation, the undersigned cannot conclude that the imposition of a $2000.00 civil fine is appropriate under the statutorily mandated incremental enforcement of penalties in light of the specific and unique facts of this case.

26. This AFH and Appellant violated WAC 388-76-10655. Because this violation threatened the health, safety, or welfare of a resident, a remedy is required pursuant to

[41] WAC 388-76-10930.
[42] WAC 388-76-10940.
[43] WAC 388-76-10970(2)(b).

WAC 388-76-10945. Considering all available remedies on an incremental basis, and taking into account the actions of all individuals involved in the subsequent investigation and remedies most likely to improve resident outcomes, the Undersigned concludes that it is most appropriate to impose a reasonable condition on this AFH license. Specifically, [FACILITY 1] should be required to provide additional staff training regarding WAC 388-76-10655, and the appropriate use of restraints in the AFH.

27. The undersigned has considered the *Initial Order*, the Appellant's *Petition for Review*, and the entire hearing record. The initial Findings of Fact were not supported by substantial evidence based on the entire record and they are therefore adopted only pursuant to the clarifying modifications outlined above. Initial Conclusions of Law 1 through 9, cited and applied the governing law correctly and they are adopted and incorporated as conclusions for this decision. Initial Conclusions of Law 10 through 12, contained erroneous conclusions of law or were based on an earlier erroneous conclusion or finding of fact and are not adopted and incorporated as conclusions for this decision. Any arguments in the *Petition for Review* that are not specifically addressed in this decision have been duly considered, but are found to have no 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.

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IV. DECISION AND ORDER

1. The *Initial Order* is ***modified***.

2. The Department incorrectly assessed a $2000.00 civil fine for violation of WAC 388-76-10655(1), and (3).

3. The Department's decision to assess a $2000.00 civil fine against this Appellant's Adult Family Home License is ***reversed.***

4. The Appellant is required to provide an additional, one- time training to the [FACILITY 1] staff, regarding WAC 388-76-10655, and the appropriate use of restraints in the Adult Family Home, as a condition on his [FACILITY 1] License.

Mailed on the 18th day of July, 2014.

THOMAS L. STURGES
Review Judge

Attached: Reconsideration/Judicial Review Information

Copies sent to: [FACILITY 1], c/o [NAME 3], Appellant
Gigi Tsai, Department's Representative
Bett Schlemmer, Program Administrator, MS: 45600
Johnette Sullivan, ALJ, [CITY 2] OAH