STATE OF WASHINGTON, DEPARTMENT OF SOCIAL AND HEALTH SERVICES

BOARD OF APPEALS

In Re:	)	Docket No. 05-2018-LIC-02044
	)	05-2018-LIC-02045
	)	05-2018-LIC-02046
	)	05-2018-LIC-02047
[APPELLANT'S NAME],	)	05-2018-LIC-02048
	)	05-2018-LIC-02049
	)	
	)	**REVIEW DECISION AND FINAL ORDER**
	)	
Appellant.	)	Adult Protective Services

I. NATURE OF THE CASE

1. Appellant ran several Adult Family Homes (AFH), including 2 adjoining homes in [CITY 1]: a Men's AFH and a Women's AFH. A Residential Care Services (RCS) investigator made an unannounced visit to the Men's AFH on December 20, 2017; when she went next door to the Women's AFH, she found no caregiver there, only the 6 residents. When she could not reach the Appellant by phone, she stayed with the residents until Appellant arrived, over an hour later. Adult Protective Services (APS) investigated and made 6 findings that Appellant had neglected the 6 vulnerable adults in the Women's AFH. When Appellant contested the findings, Administrative Law Judge (ALJ) Jill H. Brown held an administrative hearing. Her *Initial Order*, mailed on June 12, 2019, affirmed the 6 findings of neglect.

2. Appellant filed a *Petition for Review of Initial Decision*, which the Board of Appeals (BOA) received on July 16, 2019, having granted Appellant an extension of time to file.

3. The Department filed a *Response*, which the BOA received on August 6, 2019.

II. RESULT OF REVIEW

The *Initial Order* is ***affirmed.*** Appellant's hours-long failure to ensure caregiving for 5 mobility-challenged residents, and 1 mobile resident known for setting fires, created a clear and present danger for the residents. Therefore, the Department's findings of neglect are ***affirmed.***

III. FINDINGS OF FACT

The undersigned has reviewed the record of the hearing, the documents admitted as exhibits, the *Initial Order*, Appellant's *Petition for Review,* and the Department's *Response*. The following necessary Findings of Fact were relevant and supported by substantial evidence in the record.

The Appellant and her Adult Family Homes

1. The Appellant owned and ran several Adult Family Homes (AFH) in Washington State, including homes in [CITY 2], [CITY 3], and [CITY 1].[1]

2. She was licensed as a caregiver in 1990 and started operating her first AFH in 1997.[2]

3. Two of the Appellant's AFHs located in [CITY 1], Washington, are located next to each other with decks and patios connecting the two.[3] The AFH referred to as "the Small House," because it is a one-story house, houses female residents only (Women's AFH). The AFH referred to as "the Big House," because it has two stories, houses male residents only (Men's AFH).[4]

9:00 a.m. to 11:30 a.m., December 20, 2017

4. An investigator for Residential Care Services (RCS investigator) went to the Men's AFH, arriving around 9:00 a.m. on December 20, 2017.[5] The investigator worked as a Community Complaint Investigator for RCS, a division of the Department of Social and Health

[1] 2 RP 57-58. The testimony of the hearing on March 27, 2019, is transcribed in a one volume transcript that will be referred to here as 1 RP, for volume 1 of the Report of Proceedings (RP), followed by a page number, e.g., 1 RP 65-66. The testimony from the hearing on the following day, March 28, 2019, is transcribed in a second, separately paginated volume, which will be referred to here as 2 RP, followed by a page number, e.g., 2 RP 17.
[2] 2 RP 57.
[3] 2 RP 14.
[4] 2 RP 14.
[5] 1 RP 171.

Services (Department).[6] She came to the home unannounced concerning a complaint about the qualifications of the staff in the Men's AFH.[7]

5. When the RCS investigator arrived at the Men's AFH, there appeared to be two caregivers present, a primary caregiver and another. Around 11:00 a.m.,[8] the RCS investigator decided to look at the second caregiver's[9] credentials, but she could not be found and a resident suggested "she might be next door."[10] The investigator went next door to the Women's AFH[11] around 11:15 a.m.[12]

6. The RCS investigator told what happened next:

> … I asked permission to come in, and I - - I said, "Who's your caregiver?" And, uh, I didn't really get an answer. Um, they said they didn't really know. Uh, one resident thought that it was somebody named [NAME 1] maybe, uh, but she wasn't sure about his name. And, um, the other residents didn't really know, didn't have a name . . .
>
> That home is a one story home, so there's no basement, there's no upstairs. And, uh, after talking to all the residents in the home, ***I just didn't think there was a caregiver there***.[13]

7. The investigator said she found 6 residents in the home, 4 were in the common area, 1 "was kind of wandering in and out from her room to the common area," and 1 was "bedbound" and so was "in her room."[14] When asked how she knew there was no caregiver in the home, the investigator's first-hand observation followed:

> Well, ***because I looked***. Uh, because it's a one story home, and, um, you know, I – ***I looked in the rooms***. And, um, I – ***I didn't see anybody***.[15]

8. After about 5 minutes, she returned to the Men's AFH and asked the primary caregiver there, "Who was supposed to be the caregiver in the Women's AFH?" He said,

---

[6] 1 RP 65-66.
[7] 1 RP 156-157.
[8] 1 RP 171.
[9] After further investigation, this second "caregiver" turned out to have been hired to do cleaning and was determined to not be qualified as a caregiver; see 1 RP 166-167.
[10] 1 RP 158, 172. Although another version of why the investigator went next door is in the transcript, the one here is the more credible.
[11] 1 RP 158.
[12] 1 RP 161.
[13] 1 RP 158-159 (emphasis added).
[14] 1 RP 159.
[15] 1 RP 160 (emphasis added).

"He didn't know who was supposed to be next door."[16] The investigator asked him for Appellant's phone number, and called her "on her cell phone . . . there was no pickup . . . the phone said that . . . the mailbox was full."[17] The investigator then called another AFH where the primary caregiver thought the Appellant might be, but "I didn't get a pickup there either."[18]

9. The investigator checked again with the primary caregiver, who said he had been able to contact the Appellant, and she would be "right there."[19] About 11:30 a.m. the investigator returned to the Women's AFH "to wait at that home . . . with the residents."[20] When asked why she returned to the Women's AFH, she said it was out of concern for the safety of the residents:

> I did know some of the residents, uh, from previous investigations. And I felt like, um - - uh, uh, ***I knew that some of the residents weren't allowed to be without 24 hour care. And also, uh, I felt that if there was an emergency, the residents wouldn't be able to - - all of the residents would not be able to get out of the home, uh, safely by themselves. So, I stayed with the residents.***[21]

She stayed in the Women's AFH with the residents, though she returned a couple of times to the Men's AFH, once to tell the primary caregiver there that the women residents, given the time of day, were saying they were hungry.[22] From prior visits and investigations, the investigator said she knew 4 of the 6 residents in the Women's AFH, and her testimony demonstrated she knew accurately some of their limitations.

[This space intentionally left blank.]

---

[16] 1 RP 160.
[17] 1 RP 160.
[18] 1 RP 161.
[19] 1 RP 161.
[20] 1 RP 161.
[21] 1 RP 161 (emphasis added).
[22] 1 RP 162.

Residents of Appellant's Adult Family Home for Women on December 20, 2017

10. [RESIDENT 1],[23] [RESIDENT 2], [RESIDENT 3], [RESIDENT 4], [RESIDENT 5], and [RESIDENT 6] were residents of the Women's AFH on December 20, 2017. They were between the ages of [AGE 2] and [AGE 3], 5 of them had difficulty with mobility, particularly in emergencies, and all of them had a variety of physical and mental health challenges, as discussed below and in the *Initial Order's* Findings of Fact pertaining to each resident, which are adopted here.

One resident was fully mobile, and had a history of setting fires

11. [RESIDENT 6]'s Negotiated Care Plan (NCP) in November 2017 stated she was [AGE 1]. With regard to her mobility for emergency evacuation purposes, the NCP stated she was physically and mentally capable of safely getting out of the home without assistance.[24] Further with regard to mobility, it stated she was independent in all aspects of mobility, goes out for a walk multiple times a day, does not tell staff where she is going, and, once when she received money in the mail, she walked to the store, 8 to 10 blocks away, to buy cigarettes. Staff were advised to make sure the front door alarm was set to alert them to someone going out or coming in.[25]

The NCP notes [RESIDENT 6] is a smoker and that staff must "control her lighter" related to past fire setting behavior.[26] The NCP noted some of her "past behaviors" as including unsafe cooking, unsafe smoking, and fire setting.[27] Her "more serious" behaviors are noted as being assaultive, disrobing in public, fire setting, and unsafe smoking. More specifically, the NCP states, in all capital letters, the following:

---

[23] In using the vulnerable adults' first names only, no disrespect is intended. By statute, the identity of vulnerable adults and alleged victims of abuse are to remain confidential. RCW 74.34.090; RCW 74.34.095; WAC 388-71-01250.
[24] Ex. 32 at 1.
[25] Ex. 32 at 8.
[26] Ex. 32 at 4.
[27] Ex. 32 at 6.

STAFF MAY NEED TO CALL THE POLICE IF SHE SHOULD START A FIRE, IF FIRE IS STARTED EVACUATE THE HOME FOR SAFETY.[28]

Five residents had extremely limited mobility, especially in an emergency

12. [RESIDENT 1]'s Negotiated Care Plan (NCP) in August 2017 stated she was [AGE 2]. With regard to her mobility for emergency evacuation purposes, the NCP stated she was "***not physically capable of getting out of the house without assistance from another individual or mobility aids***." It notes as well that she was using a wheelchair and that "she could not propel" the wheelchair over door thresholds or follow directions.[29] Regarding her care and services generally, the NCP states her decision making is poor and that she has little insight into what situations would put her at risk for falls. She displayed little safety awareness, which placed her at risk for falls or near falls.[30]

With regard to her mobility generally, the NCP states she can propel her wheelchair around the AFH, but with fluctuating ability to do so; she does not ask for or wait for assistance, which puts her at risk of falling; she does not lock the wheelchair's brakes; and she does not turn safely. Her bed mobility was also limited, and her "self transfers" in and out of bed were unsafe and increased her risk of falling. Further, "[RESIDENT 1] tends to repeat same unsafe acts," i.e., not locking wheelchair brakes, plopping down in the seat, and forgetting where to place her hands during a transfer.[31]

13. [RESIDENT 2]'s Negotiated Care Plan (NCP) in October 2017 stated she was [AGE 3]. With regard to her mobility for emergency evacuation purposes, the NCP stated that she was "***not physically capable of getting out of the house without assistance from another individual or mobility aids***." Further, regarding emergency evacuation the NCP said

[28] Ex. 32 at 6 (all caps in original; bold added for emphasis).
[29] Ex. 8 at 2; ex. 34 at 1.
[30] Ex. 8 at 6 (emphasis added).
[31] Ex. 8 at 8.

while she "***might be able to exit*** it would be safer for staff to use hands on to direct her to proper place."[32]

Regarding mobility, the NCP states that she needs staff guidance with an evacuation, she is dependent upon oxygen, and the tubing for the oxygen "could increase" her risk of falling or tripping. Elsewhere it notes the oxygen is "used continually."[33] Nevertheless, she was a smoker and staff were instructed to not leave her alone when she was "outside smoking."[34] Several notes, including several for 2017, note that [RESIDENT 2] was at risk for falling, for example, one note states she "has had 4 falls/near falls" mostly related to her behavior, especially in thinking she did not need assistance. It is noted she can be "unsteady during transfers," and in 2017 it is noted that staff need to realize that she feels she does not need any assistance and because she does not call for assistance "she is at greater risk for repeat falls" related to this behavior. Staff are advised "to provide one on one to reduce risk of falling."[35] Further, the plan states that "***staff must be available to offer***" her assistance and "***staff will assist with any evacuation***."[36]

The RCS investigator knew [RESIDENT 2] and knew she was dependent upon oxygen and thought [RESIDENT 2] "certainly would need a person to help her . . . out of the home and . . . bring her oxygen tank with her."[37]

14. [RESIDENT 4]'s Negotiated Care Plan (NCP) in June 2017 stated she was [AGE 4]. With regard to her mobility for emergency evacuation purposes, the NCP stated she was "***not physically capable of getting out of the house without assistance from another individual or mobility aids***." Further, the NCP stated though she was able to exit in an emergency, she could be confused or display increased anxiety in a "true emergency," and that

[32] Ex. 13 at 3 (emphasis added); ex. 34 at 1.
[33] Ex. 13 at 6.
[34] Ex. 13 at 7.
[35] Ex. 13 at 11.
[36] Ex. 13 at 11.
[37] 1RP 163.

she would "do best with staff cueing and to ensure she stayed in proper place once outside."[38] Other behaviors noted were disrobing in public and forgetting to use her "seated front wheeled walker and will move about with out it," which "places her at risk of falls" due to "unsteady balance."[39]

More specifically regarding mobility, the NCP noted she was able to use her walker and able to evacuate in an emergency "***with staff supervision for safety***."[40]

15. [RESIDENT 3]'s Negotiated Care Plan (NCP) in January 2018 stated she was [AGE 5]. With regard to her mobility for emergency evacuation purposes, the NCP stated she was "***not physically capable of getting out of the house without assistance from another individual or mobility aids***." Further, with regard to emergencies, her NCP stated that in 2017 she "most likely would not understand the full impact of emergency" and that she had poor safety awareness that "increases risk factors during an emergency evacuation."[41] Other behaviors noted included a history of following others out of the home, and going outside, and opening the door when someone knocks, with no insight about why doing so is a bad idea. Staff are advised to ensure that the doors are alarmed and to monitor where [RESIDENT 3] is when she is in the AFH.[42] Further, staff are advised to "attempt to" keep [RESIDENT 3] in sight to prevent her ***exit seeking behavior*** and to instruct any visitors to not let any residents out of the AFH without permission.[43]

Specifically regarding mobility, the NCP states [RESIDENT 3] displays poor safety awareness when moving about the AFH and that she would need staff assistance when out in the community. Regarding 2017, when in the community she "must remain in line of sight"

[38] Ex. 23 at 1 (emphasis added); ex. 34 at 1.
[39] Ex. 23 at 7.
[40] Ex. 23 at 9.
[41] Ex. 18 at 1 (emphasis added); ex. 34 at 1.
[42] Ex. 18 at 6.
[43] Ex. 18 at 7 (emphasis added).

because she has no safety awareness nor would she be able to tell someone where she lived if she got lost.[44]

The RCS investigator, who knew [RESIDENT 3] from a prior AFH as well as from Appellant's AFH, testified consistently with the NCP. She said she "wasn't sure about [RESIDENT 3] . . . whether . . . any of the other residents could tell [RESIDENT 3], you know, 'We need to get out,' and, uh, [RESIDENT 3] would know what to do in that instance."[45]

16. [RESIDENT 5]'s Negotiated Care Plan (NCP) in January 2018 stated she was [AGE 6]. With regard to her mobility for emergency evacuation purposes, the NCP stated she was "***not physically capable of getting out of the house without assistance from another individual or mobility aids***." Further, it stated she could not "self transfer," that transferring was a "heavy one/two person" process, and that she would need assistance in getting over thresholds.[46]

Other specifics in the NCP regarding her mobility note that she can "self propel" for a short distance in the home using her feet or arms, and specifically regarding 2017, it is noted that while she can walk, she has refused to do so, and has not gotten out of bed in the "look back period." Regarding bed mobility, the NCP states she is unable to come to sitting, cannot move her legs off the bed or raise her legs into the bed, and that she "has not gotten out of bed or transferred in several months."[47]

The RCS investigator knew [RESIDENT 5] and was most concerned about her in an emergency:

> I was particularly concerned about, uh, [RESIDENT 5], who was in the bed, because, uh, I knew even from before that, uh, ***[RESIDENT 5] was pretty much bedbound***. Um, she would have to be - - uh, someone would have to get her into her wheelchair. And I wasn't sure at the time whether, uh, uh, [RESIDENT 5] could get in the wheelchair

[44] Ex. 18 at 8.
[45] 1 RP 163.
[46] Ex. 28 at 2 (emphasis added); ex. 34 at 1.
[47] Ex. 28 at 10-11.

by herself or not. Uh, ***but she definitely would need a wheelchair to get out of the home***.[48]

Around 12:30 p.m., December 20, 2017

17. The RCS investigator said that on the morning of December 20, 2017, she was with these 6 residents in the Women's AFH where there was no caregiver for "***an hour and fifteen minutes***" before Appellant – or anyone else - arrived.[49]

18. After Appellant arrived at the Women's AFH, she did not appear to know who the caregiver was supposed to be that day. When the investigator asked who it was supposed to be, Appellant said "[NAME 2]." When the investigator said the residents had told her it was a man, the Appellant said, "It -- it – well, it must be, uh [NAME 3]."[50]

19. Several of the women residents had told the RCS investigator that [NAME 2] had not been there that morning, but that a "tall man" had gotten them up, dressed, and made them breakfast.[51]

20. Appellant later testified that she was working in the Women's AFH that morning. She said [NAME 3] was also working, as was "[NAME 4]," who was "a cleaning person." Also there was someone applying for a job, [NAME 5]. Appellant said these 3 were in the house when she left that morning, around 10 or 10:30.[52] She said her [RELATIVE 1], the primary caregiver at the Men's AFH, called her, only once, to tell her the RCS investigator was there, about 11:50 a.m.[53]

---

[48] 1 RP 162-163 (emphasis added).
[49] 1 RP 162 (emphasis added).
[50] 1 RP 164. The name [NAME 3] is also spelled [NAME 3A] in the record; a check written to him uses "[NAME 3A]" (Ex. B); a background check concerning him, however, spells it [NAME 3] (Ex. A); with no certain spelling, and in part because the court reporter transcribed it as [NAME 3], that is the spelling used in this *Order*.
[51] 1 RP 198.
[52] 2 RP 71, 73.
[53] 2 RP 74-75. It was undisputed that the RCS investigator arrived around 9:00 a.m.; why the primary caregiver would wait nearly 3 hours to call Appellant to tell her the investigator had arrived is unexplained. It seems more likely than not there was either more than one call or a call earlier than 11:50 a.m.

21. Appellant testified that on the morning of December 20, 2017, [NAME 3], [NAME 4], and [NAME 5], at some point, all "got scared" and left the house because another man, [NAME 6], had come to the house demanding he be paid for a day he had spent waiting to interview for a job with the Appellant and she had forgotten the interview. Appellant had refused to pay him for the day, and he came to the house on the 20th because, according to Appellant, he knew that was payday. Appellant testified about her arrival back at the Women's AFH after noon on December 20:

> [W]hen I came home no one was there. I start calling everybody. [NAME 5], [NAME 4], and [NAME 3]. ***And then [NAME 5] and, uh, [NAME 4] came back later that day***. I told them to come. And, um, I talked to them. What happened? Why -- why'd you leave? Why'd you left? And they said that it's going to be a big problem. He [NAME 6] asked them to help him to take me down. And, um, the DSHS there, and they got scared and left. . . .[54]

Who was the caregiver supposed to be on the morning of December 20, 2017?

22. The RCS investigator called [NAME 3] on December 21, 2017; he told her he had not worked for the Appellant for "a while," and had not worked for her either on December 19 or 20.[55]

23. That same day the RCS investigator called [NAME 2] who told her she had not been the caregiver on December 20, 2017, because she had taken the day off for a personal appointment. [NAME 2] said she had not been at the AFH "in a while," and had been off for 3 or 4 days so she did not know which caregiver was supposed to be there that day.[56]

24. Also on December 21, 2017, the RCS investigator spoke with [NAME 7], the resident manager of the Women's AFH when [NAME 7] was in the office at the Men's AFH. [NAME 7] told the investigator she had been off "the last few days" because she had been

---

[54] 2 RP 81 (emphasis added).
[55] 1 RP 165.
[56] 1 RP 165.

sick and she did not know who was supposed to be the caregiver at the Women's AFH on the morning of December 20, 2017.[57]

25. The primary caregiver at the Men's AFH, who was also Appellant's [RELATIVE 1],[58] later told an investigator for Adult Protective Services (APS) that it was actually Appellant who was supposed to be the caregiver at the Women's AFH that morning.[59] He later testified that Appellant had been working at the Women's AFH on the morning of December 20, 2017, but he said "[NAME 3]" had been the caregiver that morning in the Women's AFH.[60] He also said that despite others saying "[NAME 2]" frequently worked at the Women's AFH as a caregiver and at least one work schedule showed she was supposed to work on December 20, 2017, he did not know anyone named [NAME 2].[61]

26. A written work schedule that started on December 20, 2017, which Appellant had submitted to the Department and as a hearing exhibit, showed that [NAME 2] was ***scheduled to work 24 hours a day for every day from December 20 to December 31, 2017***.[62] Appellant later testified that she had asked one of her employees, [NAME 8], to prepare this schedule and fax it to DSHS, but that the schedule was not accurate. She said [NAME 2] was not working because she was "tired," not sick.[63]

27. An investigator for Adult Protective Services said she received at least two work schedules from Appellant and perhaps other work schedules from other sources, but

[57] 1 RP 165-166; 2 RP 15.
[58] 2 RP 22.
[59] 1 RP 85.
[60] 2 RP 33-34.
[61] 2 RP 35.
[62] Ex. 3 (emphasis added).
[63] 2 RP 80.

the investigator was never able to establish with certainty who was supposed to be the caregiver at the Women's AFH on the morning of December 20, 2017.[64]

28. Appellant said she did the work scheduling for the Women's AFH all by herself because "nobody can handle that."[65] Appellant testified that she was "always in charge" of the scheduling.[66] She was asked to clarify how exactly the schedules got done:

> Q: How do you prepare your schedule for caregivers working in the women's home?
>
> A: Uh, in any home, I, uh, write it. I have mostly also on my mind. Like I said, I don't have shared schedules. I have 24 hours. They live there. So, most of the time works not just working one week. They will be -- be living two weeks or a month, or, like I said, some of them three, four days.
>
> Q: You said sometimes you write it. Do you write that before their scheduled time to work?
>
> A: Yes, unless I have emergency I have to reconstruct that.
>
> Q: Did you write a schedule prior to December 20th, 2017 for that day?
>
> A: I had it on my notebook, which is I don't have anymore. Yes, I had it.
>
> Q: Did you produce that document to, um, anyone with DSHS?
>
> A: Um, no, because I didn't have it. Uh, you know, I -- I come to think of it. That one was writ -- not written. What happened was [NAME 2], she wants to take off. So, I had to put somebody, uh, uh, to cover that shift, which was [NAME 3].[67]

Appellant said that in 2017 the schedules were never posted in the home.[68]

29. Appellant said that [NAME 3] had "walked out" on December 20, 2017, and that she could not control a person "walking out."[69] She at first said he did not get paid for the 20th.[70] But she had submitted an exhibit that was a cancelled check written on January 22, 2018, to [NAME 3], which stated on it that it was in payment of his "caregiving

[64] 1 RP 126-127.
[65] 2 RP 59.
[66] 2 RP 60.
[67] 2 RP 88-89.
[68] 2 RP 99.
[69] 2 RP 85.
[70] 2 RP 91.

services" on December 14, 15, 16, 17, 18, and 20, 2017.[71] The check was for $600.00 for 6 days of work; Appellant said she paid him $100.00 per day as a "contractor" because he did not have a Social Security number.[72] Appellant testified that in 2017, [NAME 3] had worked for her a total of 20 days.[73]

When she was asked why she would pay him for a full day's work for December 20, 2017, when he had allegedly "walked off" the job that day and not returned, and in so doing jeopardized her entire livelihood, she stated the following:

> I can't tell you that right now. You know, sometimes we just -- you know, well, they were there. And it just make easier just to pay them. It's just $100. We just -- it takes, you know --[74]

Investigation, Findings, Request for Hearing

30. The matter was assigned to an APS investigator. Based on the investigation, APS sent 6 substantiation letters to the Appellant dated May 14, 2018. These letters informed the Appellant that the Department had determined that she had neglected the 6 vulnerable adults in her Women's AFH on the morning of December 20, 2017. The Department sent the letters to Appellant via regular and certified mail.

31. The APS letter concerning the vulnerable adult [RESIDENT 1], stated in pertinent part the following:

> The Department of Social and Health Services' (DSHS) Adult Protective Services (APS) program recently investigated a report that you may have mistreated a vulnerable adult (Investigation ID#[NUMBER 1]/Intake ID#[NUMBER 2]). Based on this investigation, APS has determined that you neglected a vulnerable adult. As specified in RCW 74.34.095 and RCW 74.34.068, neither the name of the victim nor the reporter may be disclosed to you in this notification letter.
>
> **Because this APS decision will limit where you can work or volunteer for the rest of your life if not appealed, you should read this letter carefully. [RCW 74.39A.56(2)].**

[71] Ex. B.
[72] 2 RP 67.
[73] 2 RP 93.
[74] 2 RP 91-92.

Based on the evidence, APS finds that it is more likely than not that the following events happened:

> You had a duty of care to a vulnerable adult as a licensed facility owner/operator/staff. The vulnerable adult required 24 hour care, extensive assistance for meeting daily living needs, could not be left alone, had an unsteady gait, had safety issues, including poor safety awareness, had mental health and behavioral issues and required assistance to evacuate the facility in the event of an emergency. On or about December 20, 2017, you failed to provide a qualified caregiver for a period of approximately one and one half hours. During that time, the vulnerable [adult] was unattended, unsupervised and had no staff available to attend to care or safety needs or respond in an emergency.

APS decided that these actions meet the definition of neglect in RCW 74.34.020(15):

"Neglect" "Neglect" means (a) a pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or (b) an act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100.[75]

The Department's letter also explained the Appellant's appeal rights.[76]

32. The APS letter concerning the vulnerable adult [RESIDENT 2], stated essentially the same information as the letter above, but specifically with regard to [RESIDENT 2], stated the core finding as follows:

> You had a duty of care to a vulnerable adult as a licensed facility owner/operator/staff. The vulnerable adult required 24 hour care; could not be left unattended; was unable to stand alone; was unable to safely exit independently in an emergency; was oxygen dependent; required extensive assistance to navigate door thresholds; required extensive assistance to meet daily living needs; had poor safety awareness; got lost outside of the residence; and needed assistance to evacuate the facility during an emergency. On or about December 20, 2017, you failed to provide a qualified caregiver for a period of approximately one and one half hours. During that time, the vulnerable [adult] was unattended, unsupervised and did not have the services necessary to maintain the vulnerable adult's health and well-being.[77]

[75] Ex. 7 at 1 – 2.
[76] Ex. 7.
[77] Ex. 12 at 1.

33. The APS letter concerning the vulnerable adult [RESIDENT 3], stated essentially the same information as the letters above, but specifically with regard to [RESIDENT 3], stated the core finding as follows:

> You had a duty of care to a vulnerable adult as a licensed facility owner/operator/staff. The vulnerable adult required 24 hour care and could not be left alone; was unable to safely exit the facility independently in an emergency; had psychiatric issues including schizophrenia, paranoia, delusions, anxiety disorder, and hallucinations; had difficulty communicating and required staff to use the telephone; had exit seeking behaviors, poor safety awareness and an unsteady gait. On or about December 20, 2017, you failed to provide a qualified caregiver for a period of approximately one and one half hours. During that time, the vulnerable [adult] was unattended, unsupervised and did not have the services necessary to maintain the vulnerable adult's health and well-being.[78]

34. The APS letter concerning the vulnerable adult [RESIDENT 4], stated essentially the same information as the letters above, but specifically with regard to [RESIDENT 4], stated the core finding as follows:

> You had a duty of care to a vulnerable adult as a licensed facility owner/operator/staff. The vulnerable adult required 24 hour care; had developmental delay, depression; anxiety; used a front wheeled walker for mobility; had poor safety awareness, including forgetting to use the walker; got lost outside of the residence; required 1 person extensive assistance with activities of daily living; was not able to dial the telephone to summon help; required supervision to evacuate the facility in case of emergency. On or about December 20, 2017, you failed to provide a qualified caregiver for a period of approximately one and one half hours. During that time, the vulnerable [adult] was unattended, unsupervised and did not have the services necessary to maintain the vulnerable adult's health and well-being.[79]

35. The APS letter concerning the vulnerable adult [RESIDENT 5], stated essentially the same information as the letters above, but specifically with regard to [RESIDENT 5], stated the core finding as follows:

> You had a duty of care to a vulnerable adult as a licensed facility owner/operator/staff. The vulnerable adult used a wheelchair for mobility; required extensive assistance to meet daily living needs; had poor safety awareness; navigated poorly; and needed assistance to evacuate the facility during an emergency. On or about

[78] Ex. 17 at 1.
[79] Ex. 22 at 1.

> December 20, 2017, you failed to provide a qualified caregiver for a period of approximately one and one half hours. During that time, the vulnerable [adult] was unattended, unsupervised and did not have the services necessary to maintain the vulnerable adult's health and well-being.[80]

36. The APS letter concerning the vulnerable adult [RESIDENT 6], stated essentially the same information as the letters above, but specifically with regard to [RESIDENT 6], stated the core finding as follows:

> You had a duty of care to a vulnerable adult as a licensed facility owner/operator/staff. The vulnerable adult had bipolar disorder, schizoaffective disorder, anxiety, insomnia, emphysema, hypothyroidism and multiple behavioral issues including, but not limited to delusions, hallucinations, disrobing in public, verbal abuse, physically assaultive behavior and intimidating/threatening behavior. The vulnerable adult also had difficulty communicating. On or about December 20, 2017, you failed to provide a qualified caregiver for a period of approximately one and one half hours. During that time, the vulnerable [adult] was unattended, unsupervised and did not have the services necessary to maintain the vulnerable adult's health and well-being.[81]

37. Though no *Request for Hearing* appears in the record, no one contested Appellant's right to a hearing, and the hearing on this matter was held on two days, March 27, and 28, 2019.

IV. CONCLUSIONS OF LAW

1. The *Petition for Review* was timely filed and is otherwise proper.[82] Jurisdiction existed to review the *Initial Order* and to enter the final agency order. [83]

2. Pursuant to WAC 388-02-0220, ALJs and review judges must first apply the Department of Social and Health Services (DSHS) rules adopted in the Washington Administrative Code (WAC). If no DSHS rule applies, the ALJ or review judge must decide the issue according to the best legal authority and reasoning available, including Federal and Washington State constitutions, statutes, regulations, and court decisions.

---

[80] Ex. 27 at 1.
[81] Ex. 33 at 1.
[82] WAC 388-02-0560 through -0585.
[83] WAC 388-02-0215, -0530(2), and -0570.

3. In an adjudicative proceeding involving a finding of neglect of a vulnerable adult, a review judge has the same decision-making authority as the ALJ to decide and enter the *Final Order,* in the same way as if the review judge had presided over the hearing.[84] This includes the authority to make credibility determinations and to weigh the evidence. Because the ALJ is directed to decide the issues *de novo* (as new), this Review Judge has also decided the issues *de novo* and in reviewing the Findings of Fact, has given due regard to the ALJ's opportunity to observe the witnesses, but has otherwise independently decided the case.[85] A review judge does not have the same relationship to the presiding officer as an appellate court judge has to a trial court judge; and the case law addressing that judicial relationship does not apply in the administrative hearings forum.

4. The Washington Administrative Procedure Act directs review judges to personally consider the entire hearing record.[86] Consequently, this Review Judge has considered the adequacy, appropriateness, and legal correctness of all initial Findings of Fact and Conclusions of Law, regardless of whether any party has asked that they be reviewed.

5. The administrative hearing process has unique characteristics, and specific limitations. 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 in them.[87]

---

[84] WAC 388-02-0217(3).
[85] WAC 388-02-0600, effective March 3, 2011.
[86] RCW 34.05.464(5).
[87] *Skagit Surveyors & Eng'rs, L.L.C. v. Friends of Skagit County*, 135 Wn.2d 542, 558, 958 P.2d 962 (1998), and *Taylor v. Morris,* 88 Wn.2d 586, 588, 564 P.2d 795 (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."

6. Department regulations address what standard of proof is to be used in these types of hearings, providing that, "The ALJ shall decide if a preponderance of the evidence in the hearing record supports a determination that the alleged perpetrator committed an act of abandonment, abuse, financial exploitation, or neglect of a vulnerable adult."[88] The "preponderance of the evidence" standard is required under the regulations relevant to this proceeding. This standard means that it is more likely than not that something happened or exists.[89]

7. A review judge, in most cases, only considers evidence given at the original hearing.[90] Evidence includes documents, objects, and the testimony of witnesses, that parties provide in order to prove their positions at hearing.[91] Either party to a hearing may bring evidence to any prehearing meeting, prehearing conference, or hearing, or may send in evidence before these events.[92] No more evidence may be taken without *good cause* after the record is closed.[93] Therefore, a review judge may only accept additional evidence on review under certain circumstances.[94] These circumstances are generally limited to evidence that is newly discovered and could not have been presented at the hearing, highly reliable documents that are necessary to resolve the dispute, items to which both parties agree, or matters that affect jurisdiction to proceed.

8. Hearsay is a statement made outside of the hearing used to prove the truth of what is in the statement.[95] While hearsay evidence would not ordinarily be admissible in Superior Court, it can be admitted in an administrative hearing so long as “it is the kind of

---

[88] WAC 388-71-01255(1).
[89] WAC 388-02-0485.
[90] WAC 388-02-0565.
[91] WAC 388-02-0390.
[92] WAC 388-02-0395.
[93] WAC 388-02-0510.
[94] *See Messer v. Snohomish County Board of Adjustment*, 19 Wn. App. 780, 787, 578 P.2d 50 (1978); *State ex rel. Lige & Dickson v. Pierce County*, 65 Wn. App. 614, 618, 829 P.2d 217 (1992).
[95] WAC 388-02-0475(3).

evidence on which reasonably prudent persons are accustomed to rely in the conduct of their own affairs."[96] The ALJ may only base a finding on hearsay evidence if the ALJ finds that the parties had the opportunity to question or contradict it.[97] In this case, the hearsay evidence and the credible testimony elicited in the hearing were similar. In addition, the Appellant had an opportunity at the hearing to question and contradict the Department's witnesses. Therefore, pursuant to RCW 34.05.452 and RCW 34.05.461(4), the initial ALJ, and this Review Judge, were authorized to adopt or create Findings of Fact based on the hearsay testimony elicited during the hearing.

9. Chapter 74.34 of the Revised Code of Washington (RCW) is titled, "Abuse of Vulnerable Adults." The Department has implemented chapter 74.34 RCW by adopting WAC chapter 388-71-0100 through - 01280, entitled, "Home and Community Services and Programs-Adult Protective Services," and the definitions included in WAC chapter 388-97-0001, entitled, "Nursing Homes." Administrative hearings conducted under these regulations are controlled by statutes and regulations found at RCW 34.05 and WAC 388-02, respectively.[98]

10. RCW 74.34 establishes a system for reporting instances of abandonment, abuse, exploitation, financial exploitation, or neglect of a vulnerable adult. The definitional regulations applicable to Adult Protective Services (APS) investigations adopt by reference the statutory definitions contained in RCW 74.34.020.[99] The statute defines *"neglect"* as follows:

> (16) "Neglect" means (a) a pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or (b) an ***act or omission*** by ***a person or entity with a duty of care*** that demonstrates a ***serious disregard of consequences*** of such ***a magnitude as to constitute a clear and present danger*** to the ***vulnerable adult's health, welfare, or safety***, including but not limited to conduct prohibited under RCW 9A.42.100.[100]

---

[96] RCW 34.05.452.
[97] WAC 388-02-0475(3).
[98] WAC 388-71-01245.
[99] WAC 388-71-0105.
[100] RCW 74.34.020(16)(2017).

11. Subparagraph (16)(a) addresses circumstances where a person has assumed some responsibility of caring for a vulnerable adult and then, through their actions or inactions, fails to provide the goods and services that maintain the physical or mental health of that vulnerable adult. To prove neglect under subparagraph (16)(a) the Department must show a pattern of conduct or inaction exists. A singular incident such as failing to change a dressing or provide a scheduled meal would not support an allegation of neglect under this subparagraph. However, a pattern of such conduct or inaction would support an allegation of neglect even if the actions or omissions do not create a clear and present danger to the vulnerable adult. The *"clear and present"* danger aspect of *neglect* is only part of an allegation of neglect under subparagraph (16)(b), not (16)(a).

12. In proving a substantiated finding of *neglect through a pattern of conduct or inaction* under 16(a), the Department must prove 4 elements: (1) a person with a duty of care (2) to a vulnerable adult (3) engaged in a pattern of conduct or inaction (4) that failed to provide goods or services sufficient to maintain physical or mental health of a vulnerable adult or that failed to avoid or prevent physical or mental harm or pain to a vulnerable adult. The Department did not allege nor prove neglect here under (16)(a).

13. Subparagraph (b) of RCW 74.34.020(16) addresses a *neglect* allegation based on a single incident that is so egregious as to demonstrate a serious disregard of consequences of such a magnitude to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety.

14. To prove neglect in this case under 16(b), the Department had to prove 5 elements by a preponderance of the evidence. These elements are as follows: (1) the Appellant had a duty of care; (2) owed to the vulnerable adults residing in her Women's AFH; (3) Appellant did an act or omission; (4) the act or omission demonstrated a serious disregard of the consequences; and (5) the serious disregard was of such a magnitude to constitute a

clear and present danger to the vulnerable adults' health, welfare, or safety. As outlined in the Findings of Fact, the Department has proven each of these elements by a preponderance of the evidence.

Duty of Care

14.1 A Department rule defines a person "with a duty of care" as including a person providing the basic necessities of life to a vulnerable adult where the person is "employed by or on behalf of the vulnerable adult . . ."[101] The statute states an "entity" can have a duty of care as well. Appellant owned, operated, and provided oversight and care in her Women's AFH in [CITY 1] on behalf of the residents there. The Appellant's AFH, as an entity, owed a duty of care as well. As such, Appellant and her AFH had a duty of care toward the 6 residents, who were all vulnerable adults.

Vulnerable Adult

14.2. The statute defines "vulnerable adult" to include a person sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself; a person found incapacitated under RCW 11.88; a person with a developmental disability as defined under RCW 71A.10.020; a person admitted to any facility; a person receiving services from a home care agency licensed under RCW 70.127; or a person receiving services from an individual provider.[102] The parties in the case under consideration stipulated that all 6 residents involved in this case were vulnerable adults.[103]

Act or omission

14.3 The Appellant's culpable act here was leaving the Women's AFH without assurance that there would be a caregiver there at all times and her omission to act was the failure to ensure either she or another caregiver at the Women's AFH would provide 24 hour

[101] WAC 388-71-0105.
[102] RCW 74.34.020(13).
[103] 1 RP 15.

care as the residents required. This was Appellant's duty to act as the owner and operator of the facility: to ensure that it was adequately staffed and failing to do so was a culpable act or omission. Moreover, Appellant's apparent lackadaisical attitude regarding actually scheduling caregivers for the Women's AFH was a culpable omission to act with due regard for the safety of the residents in the AFH. Further, Appellant's changing stories and conflicting schedules about who should have been there and why the person who should have been there would have left were not credible. Finally, Appellant was ***unavailable*** on the morning of December 20, when there was no caregiver at the AFH: she did not answer her phone, her voice message system was too full to take further messages, and her staff guessed but did not know where she was, or at which one of her AFHs she might be. Given these acts or omissions, this Review Judge does not find it necessary to determine who exactly should have been, or if there was actually someone who should have been, at the AFH when no caregiver was there on the morning of December 20. It is sufficient to show that there was no caregiver in the home for over an hour. We have first-hand, indisputable evidence from the RCS investigator that no caregiver was in the AFH from around 11:15 a.m. until 12:30 p.m. This was a failure attributable to the Appellant. Thus, the Department proved the third element.

Serious Disregard

14.4 Appellant's acts and omissions to act were a serious disregard of the residents' health, welfare, and safety. This serious disregard was beyond mere negligence. "Neglect" in the context of the vulnerable adult statute and Department regulations is a "term of art." That is, it has a specialized meaning in the law. It does not have the dictionary definition that we might ordinarily give to the verb neglect: "not pay proper attention to, disregard," or "fail to care for properly." Appellant's acts and omissions to act to ensure there was staffing at the AFH meet the dictionary definition of neglect – and more. Statutory, regulatory, and case law has required something more than dictionary neglect, something more than "mere negligence," to

support a finding of statutory neglect.

In construing exactly the same statutory "neglect" language as in this case, but in the context of Child Protective Services, our Court of Appeals has required a higher threshold than the "common sense" definition of neglect. The court there wrote as follows:

> An actor's conduct is in "**reckless disregard**" of the safety of another if he or she **intentionally does an act or fails to do an act** which it is his or her **duty to the other to do**, **knowing or having reason to know of facts** that would lead a reasonable person to realize that **the actor's conduct not only creates an unreasonable risk of bodily harm to the other but also involves a high degree of probability that substantial harm will result** to him or her. . . .We see **no difference between "serious disregard" and "reckless disregard."** Reckless and serious disregard signifies a higher degree of culpability than acting unreasonably or affording "negligent treatment."[104]

Indeed, by this definition it was ***reckless disregard*** for Appellant, as an owner and operator of and a caregiver in the Women's AFH, to leave the premises without assurance there would be a caregiver at all times in the AFH "**knowing or having reason to know of facts** that would lead a reasonable person to realize that **the actor's conduct not only creates an unreasonable risk of bodily harm to the other but also involves a high degree of probability that substantial harm . . . ."** Appellant as owner, operator, and caregiver knew or had reason to know of the extreme vulnerability of the 6 residents of the Women's AFH. One of them was "bedbound," four of them had distinct and documented challenges in mobility and in understanding safety risks, and a sixth resident, the most mobile of the six, had a known, well-documented penchant for setting fires – so much so that caregivers were instructed to "control" the resident's cigarette lighter and were warned to call the police and evacuate the building in case she started a fire. Knowing these facts and not knowing with certainty that there would be a caregiver at all times on the premises, was a serious disregard of the consequences of Appellant's acts and omissions. Appellant's explanations of the scheduling for December 20, 2017, - or lack of scheduling is more accurate – further demonstrated a

[104] *Brown v. DSHS*, 190 Wn. App. 572, 590, 360 P.3d 875 (2015) (emphasis added).

reckless disregard of the consequences of not having it firmly established that there would be a caregiver at all times in the AFH. Thus, the fourth element was proved.

Clear and Present Danger

14.5 The final element of neglect is serious disregard "of such magnitude as to constitute a clear and present danger to the vulnerable adult . . ." How this element has been analyzed by our courts in relation to the neglect of children again underlines the higher standard required to prove neglect. The *Brown* court quoted in 14.4 above provided guidance in interpreting "clear and present danger": "The legislature's use of the word '**magnitude**' implies . . . [that] **misconduct** must be of a greater level of fault than negligence."[105] The court continues: "Therefore, use of the idiom '**clear and present danger**' [in a neglect statute] further suggests **more serious misconduct than mere negligence**."[106] In essence, *Brown* established that a finding of "neglect" must be a finding of something more than "mere negligence." The preponderance of evidence in this case shows that "something more" than mere negligence was proved here. The residents being unattended by a qualified caregiver ***for over an hour***, given their vulnerabilities and given the propensities of some of the other residents, meant that there was a "clear and present danger" ***at every moment during that hour*** in which there were no caregivers for the residents. Such "neglect" seems to be the very sort of "neglect" the statute was created to deter. Thus, the Department proved the final element. Evidence and testimony showed that all five elements of neglect under 16(b) were proved by a preponderance of the evidence and thus it was more likely than not that under the statute Appellant neglected the 6 residents at the Women's AFH in [CITY1] she owned and operated.

[105] *Brown*, 190 Wn. App. at 590 (emphasis added).
[106] *Id.* at 591 (emphasis added).

15. The undersigned has considered the transcribed record of the hearing, the documents admitted as exhibits, the *Initial Order*, Appellant's *Petition for Review,* and the Department's *Response*. The initial Findings of Fact are adopted pursuant to the modifications outlined above. The initial Conclusions of Law cited and applied the governing law correctly and they are adopted and incorporated as conclusions for this decision. Any arguments in the *Petition for Review of the Initial Order* that are not specifically addressed 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.

[This space intentionally left blank.]

V. DECISION AND ORDER

1. The *Initial Order* is ***affirmed***.

2. The Appellant's failure to provide qualified caregiving for over an hour in her Women's AFH on the morning of December 20, 2017, was reckless disregard of the welfare and safety of the 6 residents and because 5 of them were mobility-challenged, and one was highly mobile and known for setting fires, Appellant's reckless disregard placed those residents in clear and present danger of harm, which constitutes neglect under the pertinent statutes and regulations.

3. The Department's determination that this Appellant ***neglected*** 6 vulnerable adults in her AFH in [CITY 1] is ***affirmed.***

Mailed on the 30th day of August 2019.

MARC LAMPSON
Review Judge/Board of Appeals

Attached: Reconsideration/Judicial Review Information

Copies have been sent to: [APPELLANT'S NAME], Appellant
Benjamin Justus, Appellant's Representative
Jack Vogel, Department's Representative, MS: TB-90
Vicky Gawlik, Program Administrator, MS: 45600
Jill H. Brown, ALJ, [CITY 4] OAH