STATE OF WASHINGTON, DEPARTMENT OF SOCIAL AND HEALTH SERVICES

BOARD OF APPEALS

In Re:	)	Docket No. 11-2020-LIC-03037
	)	
[APPELLANT]	)	**REVIEW DECISION AND FINAL ORDER**
	)	
	)	
Appellant	)	Adult Protective Services

I. NATURE OF ACTION

1. The Department of Social and Health Services (Department) received allegations of inappropriate sexual conduct by the Appellant with a vulnerable adult. After investigation and review, the Department entered a substantiated initial finding of sexual abuse against the Appellant. The Appellant requested a hearing to contest the Department's substantiated initial finding of sexual abuse. Administrative Law Judge (ALJ) Timothy M. Moran held a hearing on June 24 and 25, 2021, and issued an *Initial Order* on August 26, 2021, reversing the Department's substantiated initial finding of sexual abuse.

2. The Department filed a petition for review of the *Initial Order* with the Board of Appeals (BOA) on September 16, 2021. The Appellant filed a response to the petition for review on October 4, 2021. Based on the following Findings of Fact and Conclusions of Law, the *Initial Order* is **reversed** and the Department's substantiated initial finding of sexual abuse is **affirmed.**

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II. FINDINGS OF FACT

1. On October 13, 2020, the Department issued a notice to the Appellant informing her that the Adult Protective Services ("APS") investigation into sexual abuse of a vulnerable adult (the alleged victim in this case, [VULNERABLE ADULT]) had resulted in a substantiated finding.[1]

2. The Department mailed the October 13, 2020, notice to the Appellant by regular mail and certified mail.[2] That notice was delivered to the Appellant by certified mail on October 15, 2020.[3]

3. On November 9, 2020, the Office of Administrative Hearings (OAH) received the Appellant's request for an administrative hearing.[4]

4. The Appellant was hired as a Certified Nursing Assistant ("CNA") at [FACILITY 1] in February 2019. Prior to being hired at [FACILITY 1], the Appellant had worked for 1 – 1½ years at a nursing home.

5. The Appellant received training at [FACILITY 1] with respect to caring for children. She does not recall any training with respect to professional boundaries. She is familiar with the [FACILITY 1] policy binders, and knew where they were located. Any training the Appellant had with respect to caring for [VULNERABLE ADULT] came from him directly. He told her exactly what to do and how to do it. She was nervous around him because of his ability to direct his own care. She felt he was unique among the residents at [FACILITY 1] in his ability to do that.

[1] Exhibit 4.
[2] Exhibit 4, page 8.
[3] Exhibit 4, page 9.
[4] The Appellant's request for hearing is a necessary jurisdictional document and is entered into the hearing record as Exhibit J-1.

6. The Appellant and one other CNA provided care for [VULNERABLE ADULT]. Their shifts overlapped. The other CNA did not train her.

7. [FACILITY 1] had two houses. One of those houses was for children. [VULNERABLE ADULT] lived in the other house, [FACILITY 2], with one other adult.

8. The Appellant began working with [VULNERABLE ADULT] in approximately August or September 2019. At that time, she recalls that he was [AGE 1] or [AGE 2] years old, and she was [AGE 3] or [AGE 4]. Other than being the same age, they had other things in common, such has having multiple siblings, and they found that a lot of their stories related. She looked up to him, and thought he had a good heart. He was very positive about the things he went through involving his injury.

9. The Appellant provided [VULNERABLE ADULT] with care that included bathing and toileting. He was able to use his left hand, and could eat with it. He is also able to talk. She also provided some bowel and catheter care, at the direction of a nurse.

10. At some point in time, the Appellant entered into a more intimate relationship with [VULNERABLE ADULT] beyond her caretaking duties. That relationship was on and off, meaning that it was not every day or every time she saw him. She does not recall that anything came to mind at the time about any policy prohibiting her new relationship with [VULNERABLE ADULT].

11. The Appellant's more intimate relationship with [VULNERABLE ADULT] started with him asking her to kiss him. She said no. He asked her again the next day to kiss him, and she again said no. [VULNERABLE ADULT] continued to ask her to kiss him every time she saw him. She finally gave in after a week or two and did kiss him. They were friends prior to this.

When she worked the night shift, the Appellant would fix dinner for him, and they would talk about things they had in common.

12. The Appellant had physical contact with [VULNERABLE ADULT] more than one time, but did not call herself his girlfriend. She estimates that she kissed him fewer than 10 times. She recalls that she visited [VULNERABLE ADULT] at his [RELATIVE]'s house once or twice. On one of those occasions she gave him a "hickey." ("A reddish mark on the skin caused by kissing, biting, or sucking, as in lovemaking.").[5]

13. In response to a question from the Department as to whether her contact with [VULNERABLE ADULT] was for gratification, she responded that she was not sure how to answer that question, but believes it was gratification for [VULNERABLE ADULT], because he asked her to kiss him. All of her contacts with him were at his request. Kissing him and giving him "hickeys" were not part of his care.

14. The Appellant never reported [VULNERABLE ADULT]'s behavior to her supervisor, and never told her supervisor that she wanted to stop working with him, or to move to a different house at [FACILITY 1]. She worked in both houses. She did not report [VULNERABLE ADULT]'s behavior because she loved her job and did not want to give up working with the children there. She also did not feel threatened, and did not feel the need to report the situation.

15. During the time that she was involved in her relationship with [VULNERABLE ADULT], the Appellant was also involved in a relationship with someone else. At some point [VULNERABLE ADULT] told the Appellant that he wanted things to get more serious, and

[5] *The American Heritage Dictionary* 610 (2d college ed. 1985).

wanted a full relationship. He wanted her to be his girlfriend and have a life with him. He told her that if she wouldn't be with him he didn't want her to work there any longer. They probably had a few conversations like this before she finally told him that she did not want that kind of relationship.

16. The Appellant was fired from her job on June 29, 2020, following [VULNERABLE ADULT]'s disclosure of their relationship to her supervisor [EMPLOYEE 1][6] The Appellant got a call from [FACILITY 1] telling her she was fired due to a policy violation, and she assumed it was about [VULNERABLE ADULT].[7] She has not had any contact with [VULNERABLE ADULT] since then.

17. The Appellant recalls speaking with the APS investigator, Brianna, and recalls that she was very upset and emotional at the time. She did not realize that she could refuse to provide a statement. The Appellant realized that her relationship had been wrong because she was [VULNERABLE ADULT]'s caregiver. [VULNERABLE ADULT] had threatened her with her job, and she was fighting for her professional career. The Appellant also recalls getting the APS substantiated-finding letter. She was surprised to get it, because she knew that [VULNERABLE ADULT] could consent to their relationship, they were the same age, and she did not do anything that he did not ask her to do.

18. On July 1, 2020, the Appellant was interviewed by [COUNTY] County Detective [WITNESS 1].[8] She told Detective [WITNESS 1] that she and [VULNERABLE ADULT] had a strong relationship, and that they had entered into an incorrect relationship. She told Detective

[6] Exhibit 13, page 2.
[7] Exhibit 14, page 2.
[8] Exhibit 15, pages 4 – 5 and 24 – 33.

[WITNESS 1] that she had kissed [VULNERABLE ADULT] at work, and that she saw him at his [RELATIVE]'s house because no one else was there. She was nervous during this interview, so if she laughed when speaking, that was the reason.

19. On August 5, 2020, the Appellant provided a written declaration as part of the APS investigation. In that declaration, she acknowledged saying that her relationship with [VULNERABLE ADULT] went too far, and that she had kissed him and had given him a hickey. She stated in her declaration that "I know this was wrong," and "I know I let things go too far."[9]

20. [EMPLOYEE 1] is the Assistant Director of Nursing Services at [FACILITY 1], where she had worked for 7 years as of September 2021. In that role, she assists the Director in oversight of patient care and staff. [FACILITY 1] and [FACILITY 2] are licensed care facilities.

21. [EMPLOYEE 1] is familiar with [VULNERABLE ADULT], and recalls that he came to [FACILITY 1] as a juvenile, after he had an accident that rendered him a quadriplegic. When he turned 18 he left to go to another facility, because [FACILITY 1] did not have any adult facilities at that time. When [FACILITY 1] did open an adult facility, [VULNERABLE ADULT] returned to live there, which she believes was in 2018. The adult home at [FACILITY 1] was licensed in 2019, and she recalls that prior to licensure they were allowed to have one resident living there. She recalls that [VULNERABLE ADULT] has been at [FACILITY 1] for a total of approximately six years.

22. [EMPLOYEE 1] is familiar with the Appellant. The duties of a Certified Nursing Assistant are to help all residents with their activities of daily living, which includes doing rounds on all residents every two hours. Each patient has individualized care needs, and the CNAs are supervised by the nurse on shift.

[9] Exhibit 14.

23. When the Appellant started at [FACILITY 1], she received training in the pediatric program, and later received a 1-day orientation with respect to the individual needs of the residents in the adult program. Adult residents who are able to direct their own care do so, and educate staff as to their needs.

24. [VULNERABLE ADULT] is very competent, and likes his care provided in specific ways. He knows his needs very well.

25. New CNAs at [FACILITY 1] also receive general training that includes a review of [FACILITY 1] policies. There is no policy specifically or training regarding improper conduct or boundaries, but there is a handbook that includes information on proper conduct and expectations of staff. The *Employee Handbook* prohibits, *inter alia,* "[s]exual flirtations, touching, advances or propositions."[10]

26. If a resident were to ask a staff member to do something that was not related to their care, the staff member is not required to comply with that request.

27. On Sunday, June 28, 2020, [EMPLOYEE 1] received a message from [VULNERABLE ADULT] that he wanted to speak with her.

28. On Monday, June 29, 2020, in response to [VULNERABLE ADULT]'s message of the day prior, [EMPLOYEE 1] went to the adult building where [VULNERABLE ADULT] lived. [VULNERABLE ADULT] then informed her that he and the Appellant had had a relationship that had been ongoing for 8 - 9 months. He described it as not boyfriend-and-girlfriend, but said that he and the Appellant did what boyfriends and girlfriends would do, including kissing and hickeys. His demeanor was calm, but he told her that the relationship was coming to an end

[10] Exhibit 10, page 7.

and he was upset about it (his words), although he did not appear upset when he was telling her this.

29. [EMPLOYEE 1] filed an incident report on June 29, 2020, following her meeting with [VULNERABLE ADULT].[11] On a related Incident Log, under the "nature of injury" column, she wrote "inappropriate relationship."[12] In the Incident Report, she described the incident as follows: "[VULNERABLE ADULT] reported that he had been having an unproffesional [sic]/inappropriate relationship with [the Appellant], CNA for the last 8 or 9 months."[13] [EMPLOYEE 1] used the word "unprofessional" in that incident description because [VULNERABLE ADULT]'s wording of the relationship seemed to indicate it was outside professional boundaries. She is a mandated reporter, and so she was required to report this relationship because [VULNERABLE ADULT] was considered to be a vulnerable adult and the Appellant was a staff member. She did not use the word "abuse," because she felt at the time that her report was sufficient.

30. [EMPLOYEE 1] recalls giving a statement to Detective [WITNESS 1] on July 7, 2020.[14] She recalls telling Detective [WITNESS 1] that she saw a hickey on the left side of [VULNERABLE ADULT]'s neck, which she describes as a very dark mark, that was a few inches in diameter, and noticeable. She had received prior reports from CNAs that they had seen a hickey on [VULNERABLE ADULT]. [VULNERABLE ADULT] had stated that those had happened outside of the [FACILITY 1]'s campus and were caused by someone other than staff ("a girl he

[11] Exhibit 13.
[12] *Id*., page 3.
[13] Exhibit 13, page 1.
[14] Exhibit 15, pages 18-23.

knew from up North")[15], so they were not documented. From a staff perspective, the hickeys were not evidence of abuse. [EMPLOYEE 1] described the Appellant as a "really great employee," who "just made some poor choices."

31. [EMPLOYEE 1] also recalls giving a declaration to APS during its investigation, and told the investigator that [VULNERABLE ADULT] had told her that the Appellant had given him hickeys in the past as well.

32. [EMPLOYEE 1] is aware that there is a requirement under the Adult Family Home provisions in the Washington Administrative Code that any suspected abuse must be reported. She agrees that her Incident Report does not include any language about suspected abuse.

33. After the incident between [VULNERABLE ADULT] and the Appellant, [FACILITY 1] and [FACILITY 2] have updated their training on abuse and neglect, and what is not allowed. [EMPLOYEE 1] has also had meetings with staff with respect to proper boundaries between staff and residents.

34. Although [FACILITY 1] did not provide any specific training as to proper boundaries, [EMPLOYEE 1] believes that the general training that CNAs received would have included that topic.

35. [EMPLOYEE 2] is Director of Nursing Services for [FACILITY 1]. Her duties in that role include overseeing the nurses and CNAs, and the general care of residents. She also establishes policies and makes sure they are carried out. She ensures that training is completed and does performance evaluations. She also monitors residents' care needs, and does case management for them. [EMPLOYEE 2] was the Appellant's supervisor.

[15] Exhibit 15, page 3.

36. [FACILITY 1] has an Employee Handbook, which highlights the most important policies.[16] Each new employee is a provided with a copy on their first day, and they are required to sign an acknowledgement that they have received and reviewed it, so that they are aware of expectations and policies. The handbook references a Policies and Procedures manual, and the employees are required to acknowledge that they have read that manual as well. Copies of that manual are kept in each building.

37. Exhibit 16 is a policy document for [FACILITY 1] that guides care in the facility. The document sets forth the obligation of all facility personnel to report when they have reasonable cause to believe a resident has suffered abuse. The policy document replicates the statutory definitions of abuse and neglect, including stating specifically, "[s]exual abuse also includes any sexual conduct between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under chapter 71A.12 RCW, and a vulnerable adult living in that facility . . . whether or not it is consensual.." The document also contains the statutory definition for vulnerable adults.

38. Staff were expected to have had general training on maintaining appropriate relationships with residents during their professional training before being employed at [FACILITY 1]. It is a part of general nursing ethics that staff should always have appropriate relationships with patients and maintain professional boundaries. That expectation would have applied to the Appellant.

39. For residents who are self-directing their care, staff can take guidance from those residents, but they are required to follow [FACILITY 1] policies. Self-directing residents do

[16] Exhibit 10.

not provide official training for staff, but can express their wishes as to how they like a task done, as long as it is within policy guidelines. Facility management expectations are that If a resident asks staff to do something outside of what is allowed by policy, including engaging in a physical relationship, the staff member should report that to their supervisor. The staff member should also inform the resident that they are not allowed to do something outside of policy.

40. [EMPLOYEE 2] is familiar with the Appellant through her employment at [FACILITY 1]. She had general oversight over the Appellant, and monitored her with respect to her meeting the requirements to be employed at [FACILITY 1]. The Appellant had her initial training during the first two weeks of her employment, in February and March 2019.[17]

41. In late June 2020, [EMPLOYEE 1] reported to [EMPLOYEE 2] that [VULNERABLE ADULT] had disclosed to her that he had been in an inappropriate relationship with the Appellant. [EMPLOYEE 2] reported this to the [FACILITY 1] Human Resources person. She noted that there is no exception in [FACILITY 1] policies for a consensual relationship between staff and residents.

42. [EMPLOYEE 2] does not recall that the Appellant ever asked her about professional boundaries, or about any issues in caring for [VULNERABLE ADULT].

43. Prior to the Appellant being terminated from her employment at [FACILITY 1], [EMPLOYEE 2] is not aware of any issues relating to the Appellant's care of the residents there. [EMPLOYEE 2] reviewed the Appellant's performance, and does not recall any negatives. The Appellant was a hard worker, and there were no concerns about her employment.

[17] Exhibit 12.

[EMPLOYEE 2] was not aware of any allegations of abuse by the Appellant relating to [VULNERABLE ADULT] prior to the one at issue in this case, and did not even know that they had a relationship.

44. After [VULNERABLE ADULT] reported his relationship to [EMPLOYEE 1], [EMPLOYEE 2] has seen firsthand that he has had a lot of anxiety about that situation, and he has expressed that to her. It has affected his eating habits, mood, and attitude toward receiving care. When he is stressed, he wants to be left alone, is more reserved, and does not want to eat, shower, or get out of his wheelchair. [VULNERABLE ADULT] told [EMPLOYEE 2]'s assistant that he would be uncomfortable if the Appellant still worked there, and that he had thought that they would have a life together. [EMPLOYEE 2] read that as indicating that [VULNERABLE ADULT] was disappointed and did not know what was going to happen.

45. Following the Appellant's termination from employment, [FACILITY 1] has instituted specific training on boundaries, including establishing an additional policy to make boundary limits clear, although [EMPLOYEE 2] felt the original policy was sufficiently clear.

46. Rachel Dana is a supervisor with APS, a position she has held since 2018. Prior to taking that position, she was an APS investigator for 8 years.

47. Briana Ryan was the investigator who was initially assigned the investigation of the relationship between [VULNERABLE ADULT] and the Appellant. In approximately August 2020, she left APS and so Ms. Dana took over from her. Ms. Ryan's last case note on the investigation was dated August 14, 2020, and Ms. Dana's first case note is dated September 2, 2020. Ms. Dana had trained Ms. Ryan, and considers her to be very thorough and precise, and an excellent investigator.

48. In the investigation reports, Briana Ryan was the author "RyanBJ," and Ms. Dana is "JonesRD."

49. There was another investigator at the beginning, Jared Suchosky, who did the initial interview with [VULNERABLE ADULT], because Ms. Ryan was not able to meet a required timeline for APS to do so.[18] Ms. Dana noted that he had received the same training as Ms. Ryan, and was a thorough, good investigator. She agrees that the fact that [VULNERABLE ADULT] was not able to complete the Mini Mental Status Examination due to physical limitations that Mr. Suchosky attempted to administer to [VULNERABLE ADULT] is no reflection of [VULNERABLE ADULT]'s cognitive ability.[19]

50. Ms. Dana agrees that "sexual abuse" is a subset of "abuse" in the Washington Administrative Code definition. If a report came in to APS that did not specifically use that term, but indicated that there was an inappropriate relationship between a staff member and resident at a facility, she would consider that to be sexual abuse. Whether there was consent does not matter.

51. Ms. Dana is aware that Law Enforcement declined to file criminal charges, but notes that a criminal case has a higher burden of proof. Law enforcement's decision not to file criminal charges did not have any effect on the APS investigation.

52. The Outcome Report[20] is generated at the end of the investigation. It is sent out to other entities, such as Law Enforcement, Department of Health, etc. The Investigative Review Team panel reviewing the report agreed that the finding of sexual abuse be

[18] Exhibit 5; Exhibit 2, pages 6 – 8.
[19] Exhibit 5, page 2.
[20] Exhibit 3.

substantiated, based on the statutory definition.[21] Ms. Dana's findings were based largely on the Appellant's admissions, but she also took into account [VULNERABLE ADULT]'s statement, agency policies, and everything else that APS received as part of its investigation.

53. In response to a question on cross-examination as to whether there was any indication of harm to [VULNERABLE ADULT], Ms. Dana responded that she would have to review the case. As to whether that was something that she considered in substantiating her finding of sexual abuse, Ms. Dana noted that the Appellant had a duty of care and an inappropriate relationship with [VULNERABLE ADULT].

54. [VULNERABLE ADULT] is a [AGE 5]-year-old man, who is quadriplegic with a history of ventilator dependency[22] due to a hunting accident in October 2013 when he was a teenager, but he is not developmentally delayed.[23] He is able to, and does, direct his own care. He has been living at [FACILITY 1] since approximately [YEAR 1], and in [YEAR 2 – YEAR 3] he was residing in [FACILITY 2], which is called [FACILITY 2].[24]

55. [VULNERABLE ADULT] has known the Appellant since she started working at [FACILITY 1]. They got along pretty well, and had a friendship. At some point they became more than friends, which he initiated, but never did anything more than kissing, and her giving him a few hickeys. He thinks that their more intimate relationship lasted 9 - 11 months. The Appellant visited him at his [RELATIVE]'s house a few times.

56. [VULNERABLE ADULT] wanted the relationship with the Appellant to continue, but towards the end he could tell the Appellant was only staying in the relationship to keep him

[21] *Id*., page 3; Exhibit 2, page 16.
[22] Exhibit 6, pages 8, 14, and 17; Exhibit 7, page 1.
[23] Exhibit 7, page 1; Exhibit 15, page 7.
[24] Exhibit 10, page 4.

happy. He asked her if they were going to continue the relationship, but she would not answer. [VULNERABLE ADULT] told her that he would report her if she didn't answer, and that she would not be able to work at [FACILITY 1] any longer if they were not going to continue the relationship.[25]

57. When the Appellant refused to continue with the relationship, [VULNERABLE ADULT] called [EMPLOYEE 1] and asked to speak with her. She came the next day and he told her about his relationship with the Appellant.

58. [VULNERABLE ADULT] is clear that the Appellant did not harm him in any way, even when she gave him hickeys. His care did not suffer at all during the time he had a relationship with the Appellant.

59. [VULNERABLE ADULT] believes the substantiated finding of sexual abuse against the Appellant is "ridiculous," and "comical," because he was the one who initiated most of the contact, which was entirely consensual. When the APS investigator told him the investigation involved allegations of sexual abuse, he laughed, because he thought it was "crazy."

60. At the time of his relationship with the Appellant, [VULNERABLE ADULT] was completely decisional in his care and in all aspects of his life.

61. During the entire time of their relationship, [VULNERABLE ADULT] feels that the Appellant was a great worker. Before she would come to see him she made sure that she checked on all the other residents. He believes she did her job very well.

62. In response to [EMPLOYEE 2]'s testimony about him being anxious, [VULNERABLE ADULT] admits that that is a fair statement, but he explained that his anxiety was

[25] Exhibit 15, page 3.

due primarily to having people come and talk to him repeatedly about his relationship with the Appellant. He was very clear that his anxiety had nothing to do with what happened between him and the Appellant.

63. On July 1, 2020, [VULNERABLE ADULT] was interviewed by Detective [WITNESS 1] of the [COUNTY] County Sheriff's Office.[26] [VULNERABLE ADULT] told Detective [WITNESS 1] that the kissing and hickeys between him and the Appellant was completely consensual, and the Appellant did not take advantage of him.[27] He never felt like his care at the facility was neglected, nor was he favored.[28]

III. CONCLUSIONS OF LAW

Jurisdiction and Standards of Review

1. The Department timely submitted a petition for review and it is otherwise proper.[29] Jurisdiction exists to review the *Initial Order* and to enter the final agency order.[30]

2. In an adjudicative proceeding regarding a substantiated initial finding of sexual abuse of a vulnerable adult, the undersigned has the same authority as the ALJ to enter Findings of Fact, Conclusions of Law, and Orders.[31] The Washington Administrative Procedure Act broadly states that the reviewing officer 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 reviewing officer or a provision of law limits

[26] Exhibit 15, pages 7 – 17.
[27] Exhibit 15, page 3.
[28] *Id*.
[29] WAC 388-02-0560 through -0585.
[30] WAC 388-02-0530(2) and -0570.
[31] WAC 388-02-0600(1) and WAC 388-02-0217(3). *See also* RCW 34.05.464(4); *Tapper v. Employment Security*, 122 Wn.2d 397 (1993); and *Northwest Steelhead and Salmon Council of Trout Unlimited v. Washington State Dept. of Fisheries,* 78 Wn. App 778 (1995).

the issue subject to review.[32] This includes the authority to make credibility determinations, weigh the evidence, and change or set aside the ALJ's findings of fact.[33] This is because "…administrative review is different from appellate review."[34] 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.[35] 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.[36] However, if the ALJ specifically identifies any findings of fact in the *Initial Order* that are based substantially on the credibility of evidence or demeanor of the witnesses,[37] 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.[38] This does not mean a Review Judge must defer to an ALJ's credibility findings, but it does require that they be considered.[39] In conducting this review, the

[32] RCW 34.05.464(4). *See also* WAC 388-02-0600(1).
[33] *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).
[34] *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").
[35] *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).
[36] *Id.*
[37] RCW 34.05.461(3).
[38] RCW 34.05.464(4) and WAC 388-02-0600(1).
[39] *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).

undersigned is required to consider the ALJ's ability to observe the witnesses, when applicable.[40] Based on the legal conclusions entered below, credibility of witnesses is not an issue in this case.

3. This administrative hearing process has unique characteristics and specific limitations. An administrative hearing is held under the auspices of the *executive branch of government* and a presiding administrative or review officer does not enjoy the broad equitable authority held by a superior court judge within the *judicial branch of government.* It is well settled in law and practice that administrative agencies, such as the Office of Administrative Hearings and the Board of Appeals, are creatures of statute, and, as such, are limited in their powers to those expressly granted in enabling statutes, or necessarily implied therein. *Taylor v. Morris,* 88 Wn.2d 586, 588 P.2d 795 (1977). 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 or Department rule found in the Washington Administrative Code (WAC). An ALJ or Review Judge, acting as a presiding or reviewing officer, is required to apply the regulations adopted in the WAC as the first source of law to resolve an issue unless a regulation has been ruled invalid by published appellant court decision. If there is no WAC provision governing the issue, the presiding officer or review judge is to 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.[41] The ALJ or

[40] WAC 388-02-0600(1).
[41] WAC 388-02-0220.

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.[42]

4. "The power of an administrative tribunal to fashion a remedy is strictly limited by statute."[43] Again, the only discretionary authority afforded to ALJs and Review Judges is that which is set forth, either explicitly or implicitly, in statute or agency rule.[44] As a result, the ALJ and the undersigned have extremely limited authority to grant equitable relief in this administrative forum.[45] Equity within the administrative hearing process generally comes from equal application of the law to the supported facts for all who appear before the tribunal. ALJs and Review Judges do not have the same opportunity as Superior Court Judges to fashion an equitable remedy.

5. The undersigned has reviewed the written transcript of the hearing held on June 24 and 25, 2021, the documents admitted as exhibits, the *Initial Order*, the Department's petition for review, and the Appellant's response, to determine the adequacy and appropriateness of the *Findings of Fact* made by the ALJ in the *Initial Order.* After review, the undersigned finds that the *Findings of Fact,* with minor amendments, are supported by substantial evidence based on the entire record. For this reason, the *Findings of Fact,* with minor amendments, are adopted as set forth above.[46] The ALJ's finding as to the actions taken by the [COUNTY] County Sheriff's Office is not relevant to resolution of this case and is, therefore, not adopted into this decision.

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[42] WAC 388-02-0225(1).
[43] *Skagit Surveyors & Eng'rs. L.L.C.,* 135 Wn.2d at 558.
[44] WAC 388-02-0216.
[45] WAC 388-02-0495 (setting forth the only explicit equitable remedy of which the undersigned is aware in administrative hearings applying the Department's WAC provisions).
[46] RCW 34.05.464(8).

Applicable Law

6. Chapter 74.34 of the Revised Code of Washington (RCW) is titled "Abuse of Vulnerable Adults." The statute establishes a system for reporting instances of abuse of a vulnerable adult. The Department has implemented chapter 74.34 RCW by adopting chapter 388-71-0100 through -01281 of the Washington Administrative Code (WAC),[47] entitled "Home and Community Services and Programs-Adult Protective Services." The first sentence of WAC 388-71-0105 incorporates by reference and makes applicable those definitions found in RCW 74.34.020, including the definitions for "sexual abuse," "vulnerable adult," and "facility." Administrative hearings conducted under these regulations are controlled by statutes and regulations found at RCW 34.05 and WAC 388-02, respectively.[48]

Standard and Burden of Proof Applicable to a APS Hearing

7. Applicable regulations address what standard of proof is to be used in APS 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."[49] 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.[50]

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[47] **Note:** WAC 388-71 was re-codified at WAC 388-103 by WSR 21-11-108, filed May 19, 2021, and effective July 1, 2021. Pursuant to WAC 388-02-0220(3), the provisions of former WAC 388-71 are applicable to this case as they affect the substantive rights and responsibilities of the parties and were in effect at the time of the Department's relevant actions. Any further citations to any provisions of WAC 388-71 in this decision are intended to mean *former, but applicable, WAC 388-71."*

[48] WAC 388-71-01245.

[49] WAC 388-71-01255(1).

[50] WAC 388-02-0485.

Duty of Care

8. Although a *duty of care* is required to exist in finding abandonment or neglect of a vulnerable adult, it is not required in showing sexual abuse of a vulnerable adult. ***Any person*** can be found to have sexually abused a vulnerable adult, just as any person could physically abuse or financially exploit a vulnerable adult.[51]

Vulnerable Adult Defined

9. 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.[52] During the period of time at issue in this case, [VULNERABLE ADULT] was a person admitted to a "facility" as that term is defined in WAC 388-71-0105 **"Facility"** and RCW 74.34.020(6). [VULNERABLE ADULT] is a vulnerable adult as defined by the statute and is entitled to the protections provided therein.

Analysis

10. There is no dispute among the parties as to what actually occurred in this case relevant to the incidents that led to the Department's investigation and substantiated initial finding of sexual abuse. The dispute lies with the interpretation and application of the relevant statute's definition of "abuse" and "sexual abuse."

11. The relevant statutory definitions found at RCW 74.34.020 are:

[51] *See* RCW 74.34.020(2) and (6) as opposed to (1) and (12).
[52] RCW 74.34.020(13).

> (2) "Abuse" means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult which have the following meanings:
> (a) "Sexual abuse" means any form of nonconsensual sexual conduct, including but not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse also includes any sexual conduct between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under chapter 71A.12 RCW, and a vulnerable adult living in that facility or receiving service from a program authorized under chapter 71A.12 RCW, whether or not it is consensual.[53]

12. Published appellate court decisions support the premise, "[c]ourts may discern the plain meaning of nontechnical terms from their dictionary definitions."[54] The term "sexual" has been defined as "of or relating to the sphere of behavior associated with libidinal gratification,"[55] and "implying or symbolizing erotic desires or activity."[56] The evidence, both the prior statements and hearing testimony of the Appellant and [VULNERABLE ADULT], supports the conclusion that their conduct was "sexual conduct." Both the Appellant and [VULNERABLE ADULT] described their "kissing" as that between "a boyfriend and a girlfriend," and that the "kissing" was intense enough, on at least a couple of occasions, to lead to visible "hickeys" on [VULNERABLE ADULT]'s neck.

13. As correctly concluded by the ALJ in the *Initial Order,* the Court of Appeals has provided guidance when engaged in statutory interpretation by ruling:

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[53] The term "facility" used in the definition of "sexual abuse," is defined to include "any . . . facility licensed or certified by the department." *See* RCW 74.34.020(6).
[54] *Crosswhite v. Dep't of Soc. & Health Servs.,* 197 Wn. App. 539, 553, 389 P.3d 731, *review denied,* 188 Wn.2d 1009 (2017) *citing State v. Kintz,* 169 Wn.2d 537, 547, 238 P.3d 470 (2010) (*quoting State v. Cooper,* 156 Wn. 2d 475, 480, 128 P.3d 1234 (2006)).
[55] *Webster's Third New International Dictionary Unabridged* 2082 (3d ed. 1981).
[56] *The American Heritage Dictionary* 1124 (2d college ed. 1985).

> As always in interpreting a statute, '[t]he court's fundamental objective is to ascertain and carry out the Legislature's intent.' *Dep't of Ecology v. Campbell & Gwinn, LLC,* 146 Wash.2d 1, 9, 43 P.3d 4 (2002). '[I]f the statute's meaning is plain on its face, then the court must give effect to that plain meaning as an expression of legislative intent.' *Id.* at 9–10.[57]

The ALJ then proceeds to conclude that since "sexual abuse" is a subpart of "abuse" within the statutory definition (a subdivision of a subsection), the Department must prove by a preponderance of the evidence that the Appellant's willful actions in engaging in sexual conduct with a vulnerable adult inflicted injury in addition to proving the Appellant engaged in sexual conduct (consensual or otherwise) with a resident she cared for in a state licensed care facility.

14. The ALJ's reliance on *Crosswhite* in support of this conclusion under the specific facts of this case is misplaced. The Court of Appeals addressed a substantiated finding of "mental abuse" in *Crosswhite,* a term defined in Subdivision (c) of Subsection (2) to require a showing of action "that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult." The injurious effect required to be proven by the *Crosswhite* decision is contained within the definition of "mental abuse" itself. The requisite injurious effect is also set forth, to some degree, in the Subdivisions defining "physical abuse," "personal exploitation," and "improper use of restraint." Subdivision (a) is unique in defining "sexual abuse" as any form of nonconsensual sexual conduct with a vulnerable adult ***or*** any sexual conduct between a facility caregiver and a resident of that same facility, consensual or not.

[57] *Crosswhite* 539 Wn. App. at 550.

15. A careful reading of Subsection (2) with each of the ensuing five subdivisions ("Sexual abuse," "Physical abuse," "Mental abuse," "Personal exploitation," and "Improper use of restraint") must lead to the conclusion that the Legislature intended for each subdivision to stand on its own in defining each proscribed activity. The ALJ's analysis fails to recognize that the Legislature, in succinctly defining "sexual abuse" in RCW 74.34.020(2)(a), intended to proscribe certain behavior under two circumstances by defining such behavior specifically and unequivocally as "sexual abuse." The first was to prohibit ***any form*** of nonconsensual sexual conduct with a vulnerable adult. The second was to prohibit ***any*** sexual conduct, consensual or otherwise, between a staff person of a care facility and resident of that same facility. The fact that the Legislature defined these two specific scenarios, without further qualification, as "sexual abuse" shows a clear intent that the Legislature found the two activities inherently injurious to vulnerable adults, in and of themselves, once the elements of each scenario have been proven. Such a reading of the Legislature's intent is consistent with the four other separate definitions of "abuse" found in RCW 74.34.020(2)(b) through (e), which set forth the injurious effect, at least to some extent, in each of the separate subdivisions.

16. To accept the ALJ's analysis under the first situation set forth in RCW 74.34.020(2)(a) would mean that even if the sexual conduct was proven nonconsensual, the Department would still have to prove some form of "injury" every time an alleged perpetrator engaged in nonconsensual sexual conduct with the vulnerable adult. This would lead to the inane result of an alleged perpetrator being able to claim, "I raped the cognitively intact vulnerable adult, but you cannot assume injury based on my conduct alone, and must separately prove 'injury, unreasonable confinement, intimidation, or punishment' of the

vulnerable adult." Yes, the Department *may* be able to obtain the vulnerable adult's statements as to "injury," but this would not be possible where the victim has passed away or refuses to cooperate due to fear or for any other reason. This is an untenable interpretation of the statute and could not have been the intent of the Legislature as many forms of nonconsensual sexual conduct could occur without provable "injury, unreasonable confinement, intimidation, or punishment." When interpreting this first sentence of RCW 74.34.020(2)(a), it must be concluded that the Legislation intended to presume some form of physical or emotional injury to the vulnerable adult whenever nonconsensual sexual conduct involving a vulnerable adult has been proven to have occurred regardless of any other evidence of "injury," or lack thereof.

17. This interpretation of Legislative intent must also be applied to the second scenario addressed in the statutory definition of "sexual abuse." The two scenarios are specifically defined as "sexual abuse" within two consecutive sentences contained in the same paragraph. Furthermore, a vulnerable adult who is a full-time resident of a care facility and relies completely upon facility staff to meet his/her daily care needs, such as a person who suffers from quadriplegia, is in a critically dependent relationship with such care staff. As unfair as it is, such a vulnerable adult is in an extremely unequal (compromised) position, and thus in a "vulnerable" relationship, with most persons he or she may come into contact with, but especially a person in a position of trust upon whom the vulnerable adult must rely on to meet his/her basic survival needs. The Legislature, in recognizing this critically important relationship between caregiver and a vulnerable adult within a care facility, adopted the second sentence of RCW 74.34.020(2)(a), specifically providing "[s]exual abuse also includes any sexual conduct

between a staff person . . . and a vulnerable adult living in that facility . . . whether or not it is consensual."

18. The specific and clear language of the statute creates "statutory sexual abuse" whenever the preponderance of the evidence proves that a facility staff member, that is also not a resident or client of the facility, has any sexual conduct with a vulnerable adult living in that facility. The relevant language creating the proscribed behavior does not state "any sexual conduct that results in provable injury or harm to the resident." The statute simply prohibits "*any sexual conduct*" and defines such conduct as "sexual abuse." In adopting the specific and clear language of RCW 74.34.020(2)(a), the Legislature recognized the inherent injurious effect of sexual conduct between a facility caregiver and a resident of that facility who is dependent upon the caregiver for daily care.

19. The harm to the individual vulnerable adult specifically, and to the caregiver – resident relationship generally, is presumed when any such proscribed conduct occurs. To give effect to the plain meaning of the statute as an expression of legislative intent, harm must be presumed based on the care staff/resident relationship and sexual conduct, consensual or not. Otherwise the words "whether or not it is consensual" would be rendered meaningless, as the Department would rarely, if ever, be able to prove a separate "injury" where there was full consent by the vulnerable resident to engage in sexual conduct with facility care staff. The ALJ's analysis would render the statute ineffective in preventing the behavior proscribed by the statute and explicitly defined as "sexual abuse."

20. There are reasons why the Legislature would prohibit sexual conduct between a facility care giver and a resident of that facility and adopt language making such conduct

"sexual abuse" based solely on that relationship and conduct, regardless of consent and evidence of "explicit injury." These are real concerns such as bias of caregivers towards certain residents or distractions from care duties – neither of which occurred in this case. However, when a resident has no cognitive disabilities and is able to make a conscious decision to engage in sexual conduct (such as in this case), that resident must then have physical disabilities serious enough to require full-time care in the licensed facility (again, such as in this case), physical disabilities that render that resident significantly, if not totally, dependent on facility caregivers.

21. The Appellant's actions constituted infliction of a significant "risk of harm" to [VULNERABLE ADULT]. The fact that such unprofessional conduct has an inherent injurious impact based on the commission of *"any sexual conduct,"* consensual or not, between a facility staff member and a resident is borne out in this case as evidenced by [VULNERABLE ADULT]'s suffering rejection, feeling compelled to misrepresent to care staff how he got a "hickey," and feeling compelled to threaten the Appellant with loss of her job when he realized the futility of pursuing an intimate relationship with her. Notwithstanding his testimony at hearing, [VULNERABLE ADULT]'s statements to others and actions towards the Appellant at the end of their relationship show him to be upset and unhappy about not being able to continue his relationship with the Appellant.[58] One may, perhaps somewhat cynically, argue that such "injury" to [VULNERABLE ADULT] would not have occurred if the Appellant had continued in the prohibited behavior. However, it was the inappropriate behavior on the part of the Appellant that helped bring about [VULNERABLE ADULT]'s eventual despondency and again

[58] *See Verbatim Report Of Proceedings,* Vol. I, page 44, lines 8 – 16, page 56, lines 14 – 15, page 58, lines 17 - 21, page 96, lines 17 – 24, page 99, lines 10 – 22, page 101, lines 9-18, page 115, lines 21 – 24, and page 187, lines 9 – 17; Exhibit 2, pages 4, 6, 7, and 14; Exhibit 14; and Exhibit 15, pages 3 – 5.

demonstrated the Legislature's wisdom in specifically proscribing such activity and defining it as "sexual abuse" when a facility caregiver and resident are involved.

22. In any discussion of presumed infliction of injury or risk of injury under the facts of this case, it cannot be ignored that the Appellant created a significant "risk of injury" to the vulnerable adult by engaging in mouth-to-mouth contact with [VULNERABLE ADULT], a quadriplegic with a history of ventilator dependency. This conduct occurred at the onset and in the midst of a global viral pandemic affecting respiratory functions, prior to the availability of an effective vaccine, and with the Appellant admitting she was seeing another person at the time. The Appellant's (and the facility's) possible lack of knowledge of the pandemic at the time did not negate the serious risk of harm to [VULNERABLE ADULT] when they engaged in sexual conduct during the onset of the pandemic. These circumstances further bring to light the "mischief" that can occur when facility staff become sexually involved with vulnerable facility residents they care for, and the wisdom of the Legislature in prohibiting any sexual conduct between a facility caregiver and a resident of that facility, regardless of consent, by defining such conduct under such circumstances as "sexual abuse," in and of itself.

23. The forgoing analysis and application of the relevant statute does not mean that a facility resident and staff member can never have an intimate relationship. But it does mean that such a relationship can only occur once the care staff or the resident leaves the facility. As set forth above, "sexual abuse includes any sexual contact between a staff person, who is not also a resident or client, of a facility . . . whether or not it is consensual." Perhaps one could argue that application of such a definition denies a vulnerable adult resident of a facility the freedom to choose with whom and where the vulnerable adult will be involved in the very

important and private human activity of romantic intimacy. But it must also be recognized, as the Legislature did in adopting RCW 74.34.020(2)(a), the significant imbalance of power, influence, and dependency between a vulnerable adult residing in a care facility and a caregiver employed by that same facility. It is because such facility residents are vulnerable, often totally dependent upon their caregivers, and potentially subject to undue influence by such caregivers, that sexual conduct, whether consensual or not, is prohibited and specifically and unequivocally defined as sexual abuse under the relevant statute.

24. It is important to keep in mind that this administrative hearing and appeal is neither a criminal nor a civil tort proceeding to determine "guilt" or "civil culpability" for abusive behavior. Rather, it is a process for determining who should or should not have unsupervised contact and care over a vulnerable adult under circumstances licensed by or otherwise involving the Department through financial support. The protection of vulnerable adults is paramount when measured against any limitations to an individual's activities brought about by an APS registry listing. The courts have held, "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 meet professional conduct requirements related to the vulnerable adults they are charged with caring for, the Department must give priority to the safety of these vulnerable adults."[59] The Appellant's non-accidental actions of engaging in sexual conduct with a vulnerable adult resident she was providing care for in a state licensed facility support the ultimate outcome of this case, that she should not have unsupervised contact or care over a

[59] *Bond v. Dep't of Soc. & Health Servs.,* 111 Wn. App. 566, 575, 45 P.3d 1087 (2002).

vulnerable adult under circumstances licensed by or otherwise involving the Department. An APS registry listing is not intended as a punitive measure or some other form of personal punishment, but rather a process established solely for the protection of vulnerable adults. The purpose of an APS registry listing is not only to protect [VULNERABLE ADULT], but to protect vulnerable adults into the future as well. The Appellant cannot expect the Department to partner with her in the unsupervised care of vulnerable adults when she has demonstrated the lack of judgment and inappropriate behavior at issue in this case.

IV. DECISION AND ORDER

The *Initial Order,* entered on August 26, 2021, is **reversed.** The Department's substantiated initial finding of sexual abuse of a vulnerable adult by the Appellant is **affirmed**.

Mailed this 15th day of November, 2021.

DSHS BOARD OF APPEALS

/S/
JAMES CONANT
Review Judge

Attached: Reconsideration/Judicial Review Information

Copies have been sent to: [APPELLANT], Appellant
Jessica Creager & Casey Pence, Appellant's Representatives
Karen Clark, Department's Representative; MS: 45600
William Reeves, Program Administrator, MS: 45600
Timothy M. Morgan, ALJ, [CITY] OAH

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