STATE OF WASHINGTON, DEPARTMENT OF SOCIAL AND HEALTH SERVICES

BOARD OF APPEALS

In Re:	)	Docket No. 12-2015-LIC-00417
	)	
	)	
[APPELLANT'S NAME]	)	**REVIEW DECISION AND FINAL ORDER**
	)	
	)	
Appellant	)	Adult Protective Services
	)	

I. NATURE OF ACTION

1. The Department of Social and Health Services (Department) received an allegation of physical abuse through improper use of restraint of a vulnerable adult by the Appellant. After investigation and review, the Department determined the allegation of improper use of restraint was substantiated. The Appellant requested a hearing to contest the Department's substantiated initial finding. Administrative Law Judge (ALJ) Jason C. Kinn held a hearing on December 2, 2016, and closing oral arguments on January 4, 2017. The ALJ issued an *Initial Order* on March 7, 2017, reversing the Department's substantiated initial finding of abuse by improper use of restraint on a vulnerable adult.

2. The Department filed a petition for review of the *Initial Order* with the Department's Board of Appeals (BOA) on March 27, 2017. The Appellant filed a response to the Department's petition for review. Based on the following findings of fact and conclusions of law, the *Initial Order*, as amended and supplemented in this decision, is **affirmed.**

II. FINDINGS OF FACT

1. By letter dated December 8, 2015, the Department informed the Appellant that a substantiated initial finding had been entered based on her improper use of restraint on a

vulnerable adult. This letter was sent by certified and regular mail. The Appellant signed for the letter on December 16, 2015.[1]

2. The Appellant requested an administrative hearing to challenge the substantiated initial finding. Her request was received by the Office of Administrative Hearings (OAH) on December 30, 2015.[2]

3. The alleged vulnerable adult victim in this case is [NAME 1]. She was born in [YEAR] and was [AGE] years old at the time of the incident relevant to this case. She cannot follow a conversation or communicate effectively.[3] She presents as confused. She could not complete a mental status screening exam administered by the Department investigator in this matter.[4]

4. [NAME 1] can usually walk with a walker but also uses a wheelchair.[5] Her vision is poor.[6]

5. At the time of the October 24, 2015 incident at issue in this case, [NAME 1] was admitted as a resident of the [BUSINESS NAME 1] ([BUSINESS NAME 1]).[7]

6. One section of [BUSINESS NAME 1] is dedicated to more independent adults. The other side is dedicated to "assisted living" – to adults who need more help.[8]

7. [NAME 1] was living in the "assisted living" side of [BUSINESS NAME 1].[9]

8. [BUSINESS NAME 1] is regularly understaffed. The turnover of nurses and CNAs is high.[10] [BUSINESS NAME 1] was understaffed in October 2015.[11]

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[1] Exhibit 4.
[2] The Appellant's request for hearing is a necessary jurisdictional document and is entered into the hearing record as Exhibit J-1.
[3] Testimony of David Voelker; testimony of [NAME 2].
[4] Testimony of Mr. Voelker.
[5] *Id.*
[6] Testimony of [NAME 3] (f/k/a [NAME 3a]).
[7] Testimony of the Appellant.
[8] Testimony of [NAME 3]; testimony of the Appellant.
[9] Testimony of [NAME 3].
[10] Testimony of [NAME 3]; testimony of the Appellant.
[11] Testimony of the Appellant.

9. The Appellant has a two-year nursing degree. She has been a registered nurse since 1991, and has worked in that profession since then. She now works as a care coordinator for [BUSINESS NAME 2] in [CITY 1]. Her current supervisor is aware of the allegation against her made by Adult Protective Services (APS).[12]

10. The Appellant worked at [BUSINESS NAME 1] between the first week of August 2015 and November 2015. She was not hired on a more permanent basis after her three-month probationary period.[13]

11. As a nurse at [BUSINESS NAME 1], the Appellant had a duty to care for the residents she was assigned. She does not dispute that she had such a duty to [NAME 1] at the time of the October 24, 2015 incident.[14]

12. [NAME 3] (formerly [NAME 3a]) is a certified nursing assistant (CNA) at [BUSINESS NAME 1]. She has worked for [BUSINESS NAME 1] for 11 years. As a CNA, she helps assist vulnerable adults with their activities of daily living. She often worked with the Appellant when the Appellant was working at [BUSINESS NAME 1].[15]

13. [NAME 2] works as an area executive director at an assisted living facility. She worked at [BUSINESS NAME 1] as executive director from August 2015 to October 2016. While at [BUSINESS NAME 1], she oversaw the daily operations of the facility. She had eight managers who reported to her each day.[16]

14. [NAME 2] conducted an internal investigation of the events of October 24, 2015, for [BUSINESS NAME 1].

15. Before October 24, 2015, [NAME 1] had been acting disoriented for at least the week prior to the incident. She had had diarrhea for a few days and had low potassium,

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[12] *Id.*
[13] *Id.*
[14] *Id.*
[15] Testimony of [NAME 3].
[16] Testimony of [NAME 2].

perhaps as a result of inadequate fluids.[17] Based on her limited contact with, and care of, [NAME 1], the Appellant believed [NAME 1]'s status was also deteriorating generally and that she should have been placed in a higher level of care than what [BUSINESS NAME 1] was able to offer her.[18]

16. On the morning of October 24, 2015, [NAME 1] fell beside her hide-a-bed sofa in her room at [BUSINESS NAME 1]. Staff found her and arranged for her transport to [HOSPITAL 1] at about 7:00 a.m. She was at the hospital for only a few hours.[19]

17. Later that day, on October 24, 2015, [NAME 1] returned to [BUSINESS NAME 1] from the hospital sometime between 11:00 a.m. and 12:00 p.m.[20] At some point after her return, the Appellant contacted [NAME 1]'s [RELATIVE 1].[21]

18. When [NAME 1] came back to [BUSINESS NAME 1] from [HOSPITAL 1], the front desk radioed for assistance. [NAME 3] responded. By then the EMT staff had transferred [NAME 1] into the wheelchair that she owned and used at [BUSINESS NAME 1]. The Appellant walked with [NAME 3] while [NAME 3] wheeled [NAME 1] back to her room. The Appellant reviewed the medical records from the hospital.[22]

19. [NAME 1] was again acting disoriented when she came back from the hospital. She falsely stated to [NAME 3] that she had just gotten married. [NAME 1] seemed to be imagining seeing things above [NAME 3]'s head.[23]

20. When they got to [NAME 1]'s room, [NAME 3] and the Appellant transferred [NAME 1] from the wheelchair to [NAME 1]'s rocking chair.[24] [NAME 3] and the Appellant tried to have [NAME 1] stand when they transferred her from the wheelchair to her rocking chair.

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[17] Testimony of the Appellant; Exhibit 7, page 1.
[18] *Id.*
[19] Testimony of [NAME 3].
[20] *Id.*; testimony of the Appellant.
[21] Testimony of [NAME 3]; Exhibit 7, page 2.
[22] Testimony of [NAME 3].
[23] *Id.*
[24] *Id.*

[NAME 1] was "not able to move around like she normally would on a normal day. So instead of using a walker she was in a wheelchair that day. . . . She wasn't able to stand like she normally could."[25] [NAME 1] was unable to bear her own weight at the time [NAME 3] and the Appellant took [NAME 1] back to her room.[26]

21. [NAME 1]'s nurse at [HOSPITAL 1] had recommended that [NAME 1] be supervised at all times and be offered fluids frequently.[27]

22. After [NAME 3] left [NAME 1]'s room, the Appellant offered [NAME 1] a beverage from [NAME 1]'s refrigerator that [NAME 1]'s [RELATIVE 1] had recently stocked with drinks. The Appellant helped her drink about six ounces of juice.[28]

23. After she drank the juice, [NAME 1] needed to use the bathroom. The Appellant had to perform four one-person assist transfers to help [NAME 1] do so, since [NAME 1] was unable to walk unassisted at the time. [NAME 1] could stand when asked to do so, but required one-person assistance to complete the transfers from sitting chair-to-wheelchair, wheelchair-to-toilet, toilet-to-wheelchair, and wheelchair-back-to-sitting chair. The Appellant assisted transferring [NAME 1] from the sitting chair into the wheelchair. Then the Appellant pushed the wheelchair to the bathroom. The Appellant assisted [NAME 1] from the wheelchair onto the toilet and remained with [NAME 1] in the bathroom. The Appellant did not have to pick [NAME 1] up but did need to assist her by guiding her on and off the toilet. After [NAME 1] was finished using the toilet and had wiped herself, the Appellant put a Depends undergarment on [NAME 1] and pulled her elastic waistband pants up. The Appellant then assisted transferring [NAME 1] from the toilet back into the wheelchair. After wheeling [NAME 1] back to her sitting chair, the Appellant assisted [NAME 1] back into the chair. In conducting this operation to help [NAME 1]

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[25] *Id.*
[26] *Id.*
[27] Testimony of the Appellant.
[28] *Id.*

use the toilet, the Appellant used a one-person transfer four times.[29] She had to do so because [NAME 1] could stand when asked, but could not ambulate nor bear her own weight for any appreciable time without assistance.[30]

24. After the Appellant transferred [NAME 1] back into her rocking (sitting) chair, she became concerned that [NAME 1] might use the tea table upon which her food rested to hoist herself up to a standing position. The Appellant was concerned that the table would not bear [NAME 1]'s weight, so the Appellant angled the hide-a-bed to wedge the table against the sitting chair and prevent [NAME 1] from moving it and then using it as a support.[31]

25. The Appellant placed the cushion from the hide-a-bed sofa on the floor in front of [NAME 1]. It was placed far enough distance to allow [NAME 1] to put her feet down between her chair and the cushion but not far enough to walk forward.[32] The cushion is about three feet long and about three inches thick.[33]

26. The cushion was on the floor in front of [NAME 1] as she sat in her chair. The Appellant testified that there was about a foot of space between the cushion and the hide-a-bed sofa on [NAME 1]'s left. She testified there were about three feet of space between the cushion and the wall on [NAME 1]'s right. She testified that if [NAME 1] could ambulate on her own she could get up and walk around the cushion on the right. The Appellant's testimony in this regard conflicts with the declaration of [NAME 4] and the testimony of [NAME 3], both of whom stated that [NAME 1] was unable to move by the cushion. Only three persons are known to have knowledge of, and the ability to convey, what exactly was the furniture arrangement in [NAME 1]'s room during the incident at issue: the Appellant, [NAME 4], and [NAME 3]. The ALJ found, and the undersigned concurs, that the Appellant's testimony in this regard more credible because:

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[29] *Id.*
[30] *Id.*; testimony of [NAME 3].
[31] Testimony of the Appellant
[32] *Id.*
[33] *Id.*; testimony of [NAME 3].

- The Appellant was subject to cross-examination, and her statements regarding distance between the cushion and the wall were consistent and reasonable;
- [NAME 4] was not subject to cross-examination;
- [NAME 3] did not measure the distance between the cushion and the bed or the wall. She did not measure the distance between the cushion and [NAME 1][34]; and
- The *Resident Incident/Accident Report* completed by [NAME 3] shortly after the incident and her testimony at hearing conflicted to a certain extent. In the earlier written report, [NAME 3] indicated that the "bed was pulled in front of [NAME 1]'s chair blocking her from being able to walk couch cushion was laying on top of bed. . . that someone had pulled [NAME 1]'s (*sic*) bed in front of her chair & layed (sic) her couch pad on top of that."[35] During her testimony at hearing, [NAME 3] indicated the bed was "not exactly in front of [NAME 1] because that's where the cushions were . . . It looked like [the bed] was placed in front of the cushions to help keep her in the position that she was in."[36]

27. After angling the hide-a-bed sofa toward [NAME 1] and placing the cushion in front of her, the Appellant asked [NAME 1] if she could hear her. Then the Appellant told [NAME 1] that if she was awake, she should know that the Appellant was going to bring her food. On her way out of the room, the Appellant asked a medical technician in the hall to try to get somebody to come supervise [NAME 1] as soon as possible.[37]

28. While the Appellant was assisting [NAME 1] to use the bathroom, [NAME 3] was assigned to respond to call lights during the lunch hour. In the course of responding to calls, she noticed how [NAME 1]'s room had been re-arranged. The Appellant was not in the room.[38]

29. When [NAME 3] observed [NAME 1] over the lunch hour, the hide-a-bed sofa was angled towards [NAME 1]. The hide-a-bed was normally in the middle of the room.

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[34] Testimony of [NAME 4].
[35] Exhibit 7, pages 4-5.
[36] *Verbatim Report Of Proceedings,* Volume I (Tr.), p. 149, lines 6-23.
[37] Testimony of the Appellant.
[38] Testimony of [NAME 4].

[NAME 3] did not measure the distance between the cushion and the rocking chair. She approached to about the edge of the cushion on the floor. She could not tell whether [NAME 1] was asleep or awake because, due to her eyesight, [NAME 1] often did not keep her eyes open even when she was awake.[39]

30. [NAME 3] opined during testimony that the primary danger that the cushion presented was the danger that [NAME 1] would stand up and then, if walking forward, trip over it and fall.[40]

31. [NAME 3] testified that, when she entered [NAME 1]'s room, the cushion was on top of other objects. This testimony raises some doubts and is not particularly convincing for the following reasons:

- [NAME 3] frankly admitted she could not remember what the other things were, even though she testified that she had removed the top cushion from the pile, thus giving her a clear view of whatever would have been underneath;
- [NAME 3] testified that she left the items on the floor when she left the room, only having put the cushion back on the bed. It is inconsistent for her to testify that the Appellant was creating a hazard while at the same time she was leaving a hazard, even though she claims she checked to ensure [NAME 1] was safe before leaving her alone. [NAME 3] has worked with vulnerable adults for 11 years. It is doubtful that she would have left materials on the floor for [NAME 1] to slip on if she were concerned about that same hazard;
- [NAME 3]'s statements conflict with those of [NAME 4]. [NAME 4] states that *she* was the one who removed the cushion from the floor.[41]
- [NAME 3]'s memory a year after the event may have faded.

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[39] Testimony of [NAME 3].
[40] Testimony of [NAME 3].
[41] Exhibit 6, page 4, wherein the reporter of the incident to APS indicated that [NAME 4] ([NAME 4]) removed the mattress (sleeper couch cushion); Exhibit 7, page 7; Exhibit 10.

32. [NAME 3] testified that she went to go tell the Appellant about what she viewed as an improper restraint. She testified she found the Appellant eating lunch in her office. The Appellant testified that at no point was she eating lunch after giving [NAME 1] something to drink and then leaving her. The Appellant testified that she was getting [NAME 1]'s lunch instead. The Appellant testified that she was only gone five to ten minutes. The ALJ found, and the undersigned concurs, that [NAME 3]'s testimony on this point was more credible than the Appellant's, for the following reasons:

- [NAME 3] testified consistently with what she wrote at the time and reported to [NAME 2] at the time; that she had found the Appellant eating lunch.[42]
- The Appellant found time at 12:00 p.m. to record a page and a half of notes.[43] These notes indicate that she took longer than the five to ten minutes it would have taken to get food service to prepare a tray of food and for her to bring it back to [NAME 1].
- The Appellant's memory may have faded; she did not write any notes contemporaneous with the incident about what she was doing after she placed the cushion in front of [NAME 1].

33. CNA [NAME 4] also observed the room and found the placement of the hide-a-bed sofa unacceptable. She moved the hide-a-bed sofa back into place. No photographs of the arrangement as the Appellant had set it up were taken.[44]

34. [NAME 1] was asleep or otherwise resting during the time the cushion was placed in front of her.[45]

35. Shortly after the event, [BUSINESS NAME 1] placed the Appellant on administrative leave. She was terminated from employment on November 4, 2015.[46]

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[42] Exhibit 7, pages 4-5; Exhibit 8, page 1; Exhibit 11, page 1.
[43] Exhibit 7, pages 2-3.
[44] Testimony of [NAME 3]; testimony of Mr. Voelker.
[45] Testimony of the Appellant.

36. On November 10, 2015, Adult Protective Services (APS) program of the Department received an allegation through its reporting line that the Appellant improperly restrained [NAME 1] at [BUSINESS NAME 1].[47]

37. David Voelker is a unit supervisor with APS. He had been with APS for 14 months at the time of the hearing. He was an investigator before he became a unit supervisor in January 2016. He has two associate's degree and a bachelor's degree from the University of Washington. He received training in the academy that APS offers its investigators.[48]

38. Previous to starting at APS, Mr. Voelker worked as a law enforcement officer for 25 years. For the last six years of his career as an officer, he was lead detective. As lead detective, he was responsible for conducting investigations and interviewing people. He has taken advanced training in several areas of interviewing techniques from the Federal Bureau of Investigation and other law enforcement academies.[49]

39. Mr. Voelker conducted the Department investigation in this matter. Mr. Voelker's investigation began on November 12, 2015, and lasted until November 19, 2015. Mr. Voelker made a recommendation of a substantiated finding on November 19, 2015.

40. During his investigation, Mr. Voelker spoke with, among others:

- The Appellant;
- [NAME 1]
- [NAME 2], Director of [BUSINESS NAME 1]
- [NAME 4], CNA at [BUSINESS NAME 1]
- [NAME 5], Staff member at [BUSINESS NAME 1]

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[46] Exhibits 2, page 5; Exhibit 9.
[47] Stipulation of parties on record.
[48] Testimony of Mr. Voelker.
[49] *Id.*

- [NAME 3], formerly known as [NAME 3a], CNA at [BUSINESS NAME 1][50]

41. As part of his job duties, Mr. Voelker takes notes during his interviews with people and then inputs those notes into the electronic case notes system that the Department maintains in the regular course of business.[51]

42. When he spoke with the Appellant by phone on November 13, 2015, Mr. Voelker used a ruse by telling her that he knew absolutely that [NAME 1] was being restrained from movement. He had no such knowledge.[52] Mr. Voelker wrote in his case note for that meeting that the Appellant "admitted she did completely block the AV for the purpose of restraining her from walking about the facility." Mr. Voelker's interview and interrogation technique and tactic, identified by him as a "ruse," may have been useful and condoned in his 25 years of criminal investigations as a law enforcement officer, but is questionable in attempting to arrive at exactly what and why certain events occurred during the incident under investigation in this case. Mr. Voelker's tactic of appearing to be sympathetic to the Appellant's position and informing her that he believed her actions were "reasonable" and "for a good reason," were contrary to his ultimate recommendation to substantiate the finding and did not result in an admission by the Appellant when she simply failed to correct him. However, the Appellant's other statements to Mr. Voelker during the phone interview[53], coupled with her statements to [NAME 3][54] and [NAME 4][55] can be considered as an *admission by party opponent*[56], contained in a contemporaneously kept business record, and thus have considerable *indicia of reliability.* However, such admissions only confirm that the Appellant was responsible for the rearrangement of [NAME 1]'s bedroom furniture and not a final determination as to the extent of the furniture movement or ultimate restrictive effect on [NAME 1]. For these reasons, even the

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[50] Testimony of Mr. Voelker; Exhibit 2.
[51] Testimony of Mr. Voelker.
[52] Exhibit 2, page 6; testimony of Mr. Voelker.
[53] Exhibit 2, pages 5-6.
[54] Exhibit 7, page 5.
[55] Exhibit 10.
[56] Washington Court Rules of Evidence (ER) 801(d)(2).

Appellant's alleged use of the term "restraint" at the time is not definitive confirmation such movement of the bed and cushion rose to the level of unreasonable confinement by improper use of restraint as contemplated by the statute. As properly found by the ALJ, it is unclear what exactly the Appellant was admitting to in her statements to her co-workers and Mr. Voelker.

43. On November 19, 2015, Mr. Voelker completed his outcome report. He concluded that an incident of improper restraint was substantiated.[57]

III. CONCLUSIONS OF LAW

Jurisdiction and Standards of Review

1. The petition for review of the *Initial Order* was timely filed and is otherwise proper.[58] Jurisdiction exists to review the *Initial Order* and to enter the final agency decision.[59]

2. ALJs and Review Judges must first apply the regulations adopted in the Washington Administrative Code (WAC). If no WAC provision 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.[60]

3. In an adjudicative proceeding involving an Adult Protective Services substantiated initial finding of abuse or neglect, the undersigned Review Judge has the same decision-making authority as the ALJ to decide and enter the *Review Decision and Final Order,* in the same way as if the undersigned had presided over the hearing.[61] The Washington Administrative Procedure Act broadly states that the undersigned Review Judge has precisely the same decision-making authority when deciding and entering the *Final Order* as the ALJ had while presiding over the hearing and deciding and entering the *Initial Order*, unless the Review

[57] Exhibit 3; testimony of Mr. Voelker
[58] WAC 388-02-0580.
[59] WAC 388-02-0217(3) and 388-02-0560(1).
[60] WAC 388-02-0220.
[61] WAC 388-02-0217(3) and -0600(1).

Judge or a provision of law limits the issue subject to review.[62] This includes the authority to make credibility determinations, weigh the evidence, and change or set aside the ALJ's findings of fact.[63] This is because "…administrative review is different from appellate review."[64] 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.[65] 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.[66] 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,[67] 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.[68] This does not mean a Review Judge must defer to an ALJ's credibility findings, but it does require that they be considered.[69]

4. It may help to explain briefly at the outset the unique characteristics, and specific limitations, of the administrative hearing process. An administrative hearing is held under the

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[62] RCW 34.05.464(4). *See also* WAC 388-02-0600(1)and *Kabbae v. Dep't of Soc. & Health Servs*., 144 Wn. App. 432, 443 (2008) (citing RCW 34.05.464(4) as the basis for invalidating WAC 388-02-0600(2)(e)—now repealed—which purported to limit the scope of the undersigned's decision-making authority when reviewing certain types of cases).

[63] *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).

[64] *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").

[65] *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).

[66] *Id.*

[67] RCW 34.05.461(3).

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

[69] *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).

auspices of the executive branch of government and neither the ALJ nor the Review Judge enjoys 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 BOA, are creatures of statute, without inherent or common law powers, and, consequently, they may exercise only those powers expressly granted in enabling statutes or necessarily implied therein.[70] It is also well settled that an ALJ's or a Review Judge's authority to render a decision in an administrative hearing is limited to that which is specifically provided for in the authorizing statute(s) or Washington Administrative Code (WAC) provision(s).[71] "The power of an administrative tribunal to fashion a remedy is strictly limited by statute."[72] 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 regulation.[73] As a result, the ALJ and the undersigned have extremely limited authority to grant equitable relief in this administrative forum.[74] 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, 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 those *Findings of Fact,* with minor amendments and supplements, are supported by substantial evidence based

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[70] *Skagit Surveyors & Eng'rs, L.L.C. v. Friends of Skagit County*, 135 Wn.2d 542, 558 (1998), and *Taylor v. Morris,* 88 Wn.2d 586, 588 (1977). *See also* WAC 388-02-0216 (stating that "[t]he authority of the ALJ and the review judge is limited to those powers conferred (granted) by statute or rule… [t]he ALJ and the review judge do not have any inherent or common law powers").
[71] *Id.*
[72] *Skagit Surveyors,* 135 Wn.2d at 558.
[73] WAC 388-02-0216. *But see* WAC 388-02-0220(2) (stating that if there is no WAC provision that addresses a specific issue then the ALJ and the Review Judge must refer to "…the best legal authority and reasoning available").
[74] 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).

on the entire record. For this reason, the *Findings of Fact,* with minor amendments and supplements, are adopted as set forth above.[75]

Review of Credibility Determinations Made by the Trier of Fact

6. Both the applicable statute (Administrative Procedure Act at RCW 34.05) and hearings regulations (WAC 388-02) require the undersigned to give due regard to the ALJ's opportunity to observe the witnesses when reviewing those factual findings by the ALJ and making his own determinations.[76] In addition to the relevant statute and regulation, the Washington Court of Appeals has ruled as recently as five months ago that "the review judge may commit an error of law if he or she fails to give due regard to findings of the ALJ that are informed by the ALJ's ability to observe the witnesses." *Crosswhite v. Dep't of Soc. & Health Servs.,* 197 Wn. App. 539, 548, 389 P.3d 731 (2017). The undersigned takes this directive seriously and when an ALJ has made a credibility determination based, in part, on the demeanor of a witness that the ALJ was able to personally observe during testimony, the undersigned will give careful and considerable deference to that credibility determination. The reason for this directive is clear, the ALJ was at the hearing and was able to personally observe the witnesses as they testified. The ALJ was able, in essence, to see "the sweat of their brows," whereas the undersigned was not. The ALJ provided a reasoned basis for the credibility findings in the *Initial Order* and there does not exist sufficient reasons to change the ALJ's credibility determinations on review, other than minor amendments and supplements as set forth in the adopted findings, above.

Applicable Law

7. By Washington State Register (WSR) 16-05-022, filed February 8, 2016, effective April 1, 2016, the Aging and Long-Term Support Administration of the Department, brought all investigations and findings responsibilities involving vulnerable adults, regardless of

[75] RCW 34.05.464(8) incorporating by reference RCW 34.05.461(3).
[76] *See* RCW 34.05.464(4) and WAC 388-02-0600(1), respectively.

their residential status, within the purview of the Adult Protective Services (APS) program. The introductory provision of the WSR states:

> Purpose: The department is adding new sections to chapter 388-71 WAC, Home and community services and programs, to transfer and amend the rules for residential client protection program found in chapter 388-76 WAC, Adult family home minimum licensing requirements; chapter 388-78A WAC, Assisted living facility licensing rules; chapter 388-97 WAC, Nursing homes; chapter 388-101 WAC, Certified community residential services and supports; and chapter 388-111 WAC, Residential habilitation centers—Compliance standards, to the adult protective services program.

8. Prior to this permanent rule change, the Department would generally identify and investigate reports of vulnerable adult abuse and neglect based on whether the alleged victim resided at home or in a particular type of care facility licensed by the Department. The OAH would delineate what type of hearing resulted from such investigations, again based on residential status of the alleged victim (Residential Client Protection Program (RCPP), Vulnerable Adult Abuse and Neglect (VAAN), etc.). However, nothing in the pre-WSR 16-05-022 regulations specifically prevented the Department from investigating and entering a substantiated initial finding of abuse or neglect under the APS regulations at WAC 388-71 against an individual who happened to be employed by a care facility regardless of the residential status of the alleged vulnerable adult victim. It is for this reason, that the Department can rely on the statutory definition of "improper use of restraint" found in RCW 74.34.020 as adopted by reference in WAC 388-71-0105 even though the Department's notice (December 8, 2015) predates the effective date of WSR 16-05-022 and notwithstanding WAC 388-02-0220(3).

9. The separate care facility programs have retained their own regulatory definitions for abuse and neglect for the purpose of investigating possible failures of the care facility (entity) in preventing abuse or neglect of its residents. For an example, WAC 388-78A-2020 provides definitions of "abuse," "financial exploitation," and "neglect" to be used when determining if the facility is ensuring that staff appropriately report such incidents under WAC

388-78A-2630(1)(a) and that staff do not abuse or neglect a resident under WAC 388-78A-2660(7). The APS regulatory definitions for abuse and neglect have prudently and simply adopted by reference the statutory definitions found in RCW 74.34 (see the first line of WAC 388-71-0105). The potential problem with the facilities' individual adoption of regulatory definitions for abuse and neglect is the risk of running afoul of the Washington State Court of Appeals decision in *Marcum v. Department of Social and Health Services,* 172 Wn. App. 546, 558, 290 P. 3d 1045 (2012). A facility program's regulatory definitions "cannot amend or change legislative enactments."[77] For an example, the Assisted Living Facility Licensing rules at WAC 388-78A-2020 **"Restraint"** (3) define "**Physical restraint"** to include use of a mechanical devise and do not define "mechanical restraint" elsewhere in the definitions whereas the statutory definition found at RCW 74.34.020(17) defines "Physical restraint" to exclude any devise and defines "mechanical restraint" elsewhere in the definitions at RCW 74.34.020(14). One could possibly argue that this is simply a consolidation by bringing the term "mechanical restraint" within the term "physical restraint," but it cannot be denied that this is a change in the statutory definition. It could further be argued that the statutory authority for WAC 388-78A falls under RCW 18.20 rather than RCW 74.23, but this does not explain the reference to RCW 74.34 in WAC 388-78A-2630(1)(a) and (b) as well as the lack of any statutory definitions for abuse and neglect within RCW 18.20.020.

10. Although the ALJ cites to WAC 388-71 three times in Conclusions of Law 5.7, 5.8, and footnote 63 in the *Initial Order*, it is clear from the context that this is a typographical

[77] *See,* Washington State Court of Appeals Division II decision in *Marcum v. Department of Social and Health Services,* 172 Wn. App. 546, 558, 290 P. 3d 1045 (2012). Although the Court of Appeals vacated the finding of neglect the Department entered against the appellant in *Marcum,* the case was remanded to the BOA to determine if the founded Child Protective Services (CPS) finding of negligent treatment or maltreatment should stand based on the facts without application of a *strict liability* standard. On remand from the Court of Appeals, the BOA re-affirmed the founded CPS finding of negligent treatment or maltreatment against that appellant based on her mistakenly leaving a child unattended. The case was decided on remand not on a *per se* finding of neglect based on lack of supervision, but on a determination that the lack of *adequate* supervision constituted a serious disregard of the consequences to the child of such a magnitude that it created a clear and present danger to the child's health, welfare, and safety.

error and the ALJ's intent is to cite to WAC 388-78A. It is confusing that the ALJ concludes that the definitions contained in WAC 388-78A are applicable, but cites to RCW 74.34.020(2) three times in footnotes 61, 62, and 65, and then bases his reversal of the Department's substantiated initial "finding of improper restraint as that term is defined in RCW 74.34.020." For the reasons given above, the applicable definitions are those found in RCW 74.34.020 as adopted by reference in WAC 388-71-0105 and the ALJ committed an error of law to the extent he applied WAC 388-78A-2020.

11. 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 abandonment, abuse, exploitation, financial exploitation, or neglect 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), entitled "Home and Community Services and Programs-Adult Protective Services."

12. Administrative hearings conducted under WAC 388-71 are controlled by statutes and regulations found at RCW 34.05 and WAC 388-02, respectively.[78] The definitional regulations applicable to Adult Protective Services (APS) investigations adopt by reference the statutory definitions contained in RCW 74.34.020.[79]

13. The applicable regulations provide that the standard of proof in an APS hearing is a preponderance of the evidence.[80] This standard means that it is more likely than not that something happened or exists.[81] The "preponderance of the evidence" standard is required under the regulations relevant to this proceeding.

14. The relevant definitional statute provides:

> "Abuse" means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of

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[78] WAC 388-71-01245.
[79] WAC 388-71-0105.
[80] WAC 388-71-01255.
[81] WAC 388-02-0485.

> 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: [82]
> . . .
> (e) "Improper use of restraint" means the inappropriate use of chemical, physical, or mechanical restraints for convenience or discipline or in a manner that: (i) Is inconsistent with federal or state licensing or certification requirements for facilities, hospitals, or programs authorized under chapter 71A.12 RCW; (ii) is not medically authorized; or (iii) otherwise constitutes abuse under this section.

15. Because the evidence in the hearing record does not support any findings of use of chemical restraints and the term "physical restraint" under the statute excludes "use of any device,"[83] the only remaining method of "improper use of restraint" is "mechanical restraint," which is defined as:

> "Mechanical restraint" means any device attached or adjacent to the vulnerable adult's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body. "Mechanical restraint" does not include the use of devices, materials, or equipment that are (a) medically authorized, as required, and (b) used in a manner that is consistent with federal or state licensing or certification requirements for facilities, hospitals, or programs authorized under chapter 71A.12 RCW.[84]

16. The applicable statutory provision 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"; or "admitted to any facility."[85] The term "facility" is defined to mean "a residence licensed or required to be licensed under chapter 18.20 RCW, assisted living facilities."[86] On October 24, 2015, [NAME 1] was over sixty years of age, was unable to care for herself, and a resident of a "facility" as defined in the statute. For these reasons, she is a "vulnerable adult" by statutory definition, and is entitled to the protections provided under the statute.

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[82] RCW 74.34.020(2).
[83] *See* RCW 74.34.020(17).
[84] RCW 74.34.020(14).
[85] RCW 74.34.020(21)(a) and (d).
[86] RCW 74.34.020(6).

17. The statutory definition of "abuse" sets forth the results (inflictions) that are intended to be prevented by the statute and identifies those results as "injury, unreasonable confinement, intimidation, or punishment." The statute then proceeds to include specific behaviors that can cause the results (inflictions) that are intended to be prevented. "Unreasonable confinement"[87] is the result (infliction) associated with the proscribed abusive behavior of "improper use of restraint."

18. The statue requires the subject action or inaction to be "willful." The applicable regulations define "willful" to mean "the nonaccidental action or inaction by an alleged perpetrator that he/she knew ~~or reasonably should have known~~ could cause harm, injury ~~or a negative outcome~~."[88] Therefore, the Department is required to prove by a preponderance of the evidence a "willful action" inflicting "unreasonable confinement" through "improper use of restraint against a vulnerable adult." The statutory requirement of "willful action" inflicting "unreasonable confinement" by "improper use of restraint," combined with the regulatory clarification of "willful" to mean to have known that certain actions could cause harm or injury (unreasonable confinement), require a showing of something more than the intentional commission of the proscribed behavior in proving improper use of restraint. The Department has chosen to limit the term "willful" to require more than just a showing of an intentional act - there must be some evidence that the alleged perpetrator knew that commission of the proscribed act could cause harm or injury. Such a requirement is not only necessary to exclude completely accidental actions from abuse, but also to address those admittedly rare intentional

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[87] It is because the term "unreasonable confinement" is an integral part of the action in this case, that it is concerning that David Voelker, as a Department employee and investigator, would initially represent to the Appellant that he believed her actions were "reasonable" and then ultimately determine her actions inflicted "unreasonable confinement" by improper use of constraint. This part of Mr. Voelker's "ruse" was inconsistent with his later recommendation and deliberately deceptive.

[88] WAC 388-71-0105 **"Willful."** The Court of Appeals, Division Three, has ruled that the regulatory definition of the term "willful" improperly assigns a negligence standard by using the language "or reasonably should have known." The Court of Appeals also ruled that the use of the language "or a negative outcome" was impermissibly vague and exceeded statutory authority. *Crosswhite v. The Department of Social and Health Services,* No. 33718-9-III, 2017 WL 169089, 15 and 17-21 (Wash. Ct. App. Jan. 17, 2017). For this reason, the impermissible language has been struck through although the regulatory definition has not yet been amended.

actions that are done without the perpetrator's knowledge that such action would cause injury or harm.

19. The Court of Appeals in the *Crosswhite* decision has directed that the Department must show an action or inaction that an alleged perpetrator *knew could cause harm or injury*, and cannot consider what the alleged perpetrator *reasonably should have known,* as that creates a negligence standard. It can be argued it is beyond human capabilities for one individual to determine definitively what another individual *knew* related to what could cause injury or harm at any given time. Such a definitive determination would require literally "stepping into the mind" of the subject individual, The best that we can do as judges, is to review all relevant evidence and applying common human experience, assign knowledge based on that review. How to do this competently without making at least a fleeting sideward glance at "what an individual reasonably should have known" seems difficult at best. The *Crosswhite* court recognized this dilemma by holding that "if evidence persuades a fact finder that a reasonable person would have known something, then the fact finder may infer a defendant's 'knowledge' from that evidence as a matter of logical probability. . . the fact finder 'must still find subjective knowledge.'"[89]

20. The Appellant's knowledge of possible harm to [NAME 1] caused by the rearrangement of the bedroom furniture is inextricably tied to consideration of [NAME 1]'s physical and mental condition at the time. By all accounts, and based on the totality of the circumstances related to [NAME 1] at the noon hour on October 24, 2015, she was exhausted after her morning accident ordeal and trip to and from the hospital. She was resting in her chair after returning from the hospital, having received something to drink, and had used the toilet. There existed a reasonable expectation at that time that her immediate care needs had been met and that she would rest in place until the Appellant or other staff checked in on her shortly

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[89] *Crosswhite* at 17, *citing State v. Bryant*, 89 Wn. App. 857, 871, 950 P. 2d 104 (1998) and *State v.Shipp*, 93 Wn. 2d 510, 610 P.2d 1322 (1980) (The court recognizing the cited authority are criminal cases, but still applying plain meaning analysis.)

thereafter, as did occur. Under these circumstances, it was unlikely that the Appellant's re-arrangement of the bedroom furniture would have acted as restraint by restricting [NAME 1]'s "freedom of movement or normal access to her body" in the brief time she was left alone. [NAME 3] made basically this same summation when she removed only the top cushion, but leaving the other objects in front of [NAME 1], and "made sure that the resident where she was sitting, that she was safe at the moment" and left her there alone to seek out the Appellant.[90] There exists credible evidence that the Appellant's actions at issue here were taken, not for the Appellant's convenience, but for the purpose of protecting [NAME 1]'s safety and well-being while the Appellant grabbed her own lunch, retrieved some food for [NAME 1], and attempted to arrange for necessary ongoing care for [NAME 1] based on the hospital release directives.

21. The Legislature's use of the adjectives "unreasonable," "improper," "inappropriate," and "easily" in defining "abuse," "improper use of restraint," and "mechanical restraint" reflect an acknowledgment that there exists a spectrum of actions that may contain some elements of restraint, but are not all actionable as substantiated initial findings of abuse. While being keenly aware of both the ALJ's and the undersigned's extremely limited equitable authority in this forum as addressed in *Conclusion of Law 4,* above, the statutes use of these descriptors (adjectives) is evidence that a degree of discretion needs to be exercised when rendering such a critical decision as to affirm or reverse a substantiated initial finding of abuse.

22. Based on the uncertainty as to exactly where objects were placed in relation to [NAME 1]'s sitting position during the noon hour of October 24, 2015, including any possible existing passable area around these objects; based on the uncertainty as to what extent such objects created a restraining barrier against [NAME 1] when considering her physical and mental condition at the time; based on the uncertainty as to whether [NAME 1] could have maneuvered around the objects if she had been able to autonomously ambulate at the time;

[90] Tr., p. 164, lines 17-21 and p. 165, line 20 through p. 166, line 17.

and based on the uncertainty as to whether the Appellant's actions were grounded on convenience or a genuine desire to keep [NAME 1] temporarily safe as possible while a more permanent care resolution could be obtained, the undersigned cannot conclude that the ALJ errored as a matter of law in reversing the Department's substantiated initial finding of abuse by improper use of restraint.

IV. DECISION AND ORDER

Based on the conclusions entered above, the *Initial Order*, as amended and supplemented above, is **affirmed** and the Department's initial substantiated finding of abuse by improper use of restraint is **reversed**.

Mailed this 22nd day of May, 2017.

JAMES CONANT
Review Judge

Attached: Reconsideration/Judicial Review Information

Copies have been sent to:
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Jason C. Kinn, ALJ, [CITY 2] OAH