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NO. 70411-7-I

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**COURT OF APPEALS, DIVISION I  
OF THE STATE OF WASHINGTON**

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WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH  
SERVICES,

Appellant,

v.

MARIANA GLIGOR, DBA EVERGREEN SEASONS ADULT  
FAMILY HOME,

Respondent.

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**BRIEF OF APPELLANT**

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## I. INTRODUCTION

Adult family homes in Washington State are governed by Chapter 70.128 RCW and Chapter 388-76 WAC. An adult family home is a residential home that provides “personal care, special care, room, and board to more than one but not more than six adults who are not related by blood or marriage” to the provider. RCW 70.128.010(1). An adult family home resident is defined as “an adult in need of personal or special care” and is also referred to as a vulnerable adult. RCW 70.128.010(4); WAC 388-76-10000. The adult family home provider is ultimately responsible for the day-to-day operations of the adult family home; for promoting the health, safety, and well-being of each resident; and for complying with statutory and regulatory requirements. RCW 70.128.130(1) & (2); WAC 388-76-10015(1), WAC 388-76-10015(2) & WAC 388-76-10015(3).

DSHS requests that this Court affirm the Final Order of the review judge that upheld findings that Ms. Gligor violated adult family home licensing requirements and upheld the stop placement of admissions and revocation of Ms. Gligor’s adult family home license. DSHS’ enforcement action was warranted because Ms. Gligor humiliated and

reprimanded residents Richard and Yetta,<sup>1</sup> failed to update their care plans and provide them with necessary care and services, discharged Richard without proper notice, brought a dog into the home that seriously injured a resident and failed to protect residents from future harm from the dog, and demonstrated an egregious lack of understanding, ability and emotional stability to care for vulnerable adults.

## II. ASSIGNMENTS OF ERROR

1. The superior court erred when it reversed the review judge's decision to uphold the stop placement and license revocation, as the order was supported by substantial evidence.

2. The superior court erred when it found that the stop placement and license revocation was arbitrary and capricious.

3. The superior court erred by concluding without any basis that DSHS' revocation decision was arbitrary and capricious because DSHS authorized the relocation of residents from Evergreen Seasons to Ms. Gligor's other adult family home.

4. The superior court erred when it reversed the review judge's finding that Ms. Gligor was given notice of the allegation that she failed to protect one resident from another resident.

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<sup>1</sup> The vulnerable adults residing in Evergreen Seasons, who are the subject of these proceedings, will be identified as "Richard" and "Yetta".

5. The superior court erred when it reversed the review judge's finding that Ms. Gligor failed to give a proper discharge notice to a resident as this finding was supported by substantial evidence.

### **III. ISSUES PERTAINING TO ASSIGNMENTS OF ERROR**

1. Was there substantial evidence to support the review judge's decision that Ms. Gligor violated adult family home regulations, warranting stop placement of admissions and license revocation?

2. Did the superior court err by concluding without any basis that DSHS' revocation decision was arbitrary and capricious because DSHS authorized the relocation of residents from Evergreen Seasons to Ms. Gligor's other adult family home?

3. Did Ms. Gligor have notice of an allegation that she failed to protect one resident from another resident?

4. Was there substantial evidence to uphold the review judge's finding that Ms. Gligor failed to give a proper discharge notice to a resident or to ensure his safe and orderly discharge?

### **IV. STATEMENT OF THE CASE**

#### **A. Factual Basis For The Final Order**

**1. Ms. Gligor had two adult family home licenses, but only one was subject to enforcement action**

At the time of this enforcement action, Mariana Gligor was licensed to operate two adult family homes: Evergreen, licensed in 2000, and Evergreen Seasons, licensed in 2007. Tr. 25; AR 293. The enforcement action that is the subject of these proceedings was only taken against Evergreen Seasons. Ms. Gligor's other business, Evergreen, was not the subject of any enforcement action. Tr. 261, 295-296.

## **2. The vulnerable adults**

Richard entered Evergreen Seasons in September 2009, just 3 months after losing his wife of 59 years. Tr. 163. Richard was about 81 years old, had dementia and was confused, depressed and grieving. Tr. 163, 182. Richard sometimes thought his daughter, Valerie Larson, was his deceased wife or his other daughter Theresa. Tr. 189, 191. When Richard saw his image in the mirror, he'd say, "who's that man" or "he looks so sad" and he never understood that image was himself. Tr. 213.

Bonita Sykes, a registered nurse with a geriatric specialty, completed an assessment of Richard on September 23, 2009. Tr. 607, 623; AR 312-336. Ms. Sykes noted that Richard has dementia, wandering behavior, irregular sleep, needs to be cued to his new environment, needs assistance at night with toileting, and is easily worried or anxious. Tr. 31-33; AR 327, 333, 335. Ms. Gligor determined that she could meet Richard's needs based on this assessment and accepted him into her adult

family home. Tr. 33-34. She claimed to have experience with dementia and to have “awake” staff at night. Tr. 144, 163, 336.

Shortly after Richard moved in, Ms. Gligor expressed concern that Richard was awake and wandering at night but she continued to care for him. In October 2009, Ms. Gligor told the DSHS licenser for Evergreen Seasons, Estelle Sylvester, that Richard was not sleeping at night and needed a caregiver to monitor him at night. Tr. 258, 259, 264, 266, 270. Ms. Gligor told Richard’s daughter, Theresa Pinto, that Richard was frequently up at night, asking for food and being a little bit belligerent at times. Tr. 335-336. When Ms. Larson asked Ms. Gligor how Richard slept, Ms. Gligor reported that sometimes he slept well and other times badly. Tr. 192, 200. Sometimes Ms. Larson asked Ms. Gligor if she should find a new home for Richard, and Ms. Gligor always said she could handle him and that he was better this week. Tr. 198.

Elizabeth Frost, a registered nurse with more than 25 years of experience in long term geriatric care, was the DSHS complaint investigator in this matter. Tr. 99-101. Ms. Frost testified that Richard needed nighttime care, was incontinent at times, and needed to be directed to the toilet because he was getting up at night and getting lost. Tr. 125. Ms. Frost stated that Richard’s dementia was so severe that “he couldn’t find his way around the home, which is not uncommon with elders with

dementia” and could "get lost just trying to get to the toilet.” Tr. 125. Ms. Gligor’s only intervention for Richard was to request more medication for him. Tr. 126; AR 304. Ms. Gligor told Ms. Frost that “if you don’t overmedicate him, then you can’t deal with him.” Tr. 126; AR 304. When Richard was admitted to Evergreen Seasons, there was a night time caregiver, but the caregiver left in December 2009. Tr. 125-126. Ms. Gligor told Ms. Frost that Richard’s family would have to pay for a night time caregiver for Richard to remain in the home, which Ms. Frost found inappropriate because the state was paying for Richard’s care. Tr. 126-127 AR 304.

Ms. Gligor reported that Richard’s nighttime wandering behavior “escalated progressively.” AR 384. At trial, Ms. Gligor described Richard as “pacing, unrested, exit-seeking,” aggressive, hypersexual and asking for sex. Tr. 603-604. She testified that Richard’s nighttime needs increased beginning in January 2010 and by February or March 2010, he started to become sexually aggressive. Tr. 34. Ms. Gligor testified that Richard became “very hyper sexual” and came to her bedroom many times with his pants in his hand asking her to help him or to sleep with him. Tr. 34-37, 56-58, 115; AR 385.

Ms. Gligor testified that during the night Richard was also going into the bedroom of another resident, Yetta, and asking to sleep with her.

Tr. 36-37. On February 4, 2010, Ms. Gligor found Richard naked in Yetta's bed waiting for her. Tr. 36-37, 67-68, 85; AR 385, 455. Ms. Gligor reported that she was concerned for Yetta's safety. Tr. 715; AR 455.

Ms. Gligor also reported that Yetta found Richard naked in her bed and was very upset by this. Tr. 115, 117. Ms. Gligor wrote in the facility's progress notes:

I found him [Richard] all naked under covers in Yetta's bed waiting for Yetta to come. . . Yetta came and she was very upset complaining that he goes to her bedroom during nights, and she does not want to have sex with him . . .

AR 455. Ms. Gligor later reported that Yetta did not see Richard naked in her bed. Tr. 117, 516-517. Yetta told her case manager, Bonita Sykes, that Richard entered her room naked. Tr. 625-626, 653-655, 674-675.

Ms. Larson told Ms. Gligor that her father doesn't know what he's doing. Tr. 193-194; 455. Ms. Gligor wrote in the facility's progress notes "that [Richard] 'actually knows' what he was doing." AR 455. Registered nurse Bonita Sykes opined that Richard did not have the cognitive ability to understand that this behavior was inappropriate. Tr. 665.

In early February 2010, Richard became "very upset" after Ms. Gligor told him in front of a caregiver and other residents that she was not

interested in his [sexual] offers and not to use her toilet. AR 456. Ms. Gligor wrote in her progress notes that this infuriated Richard and he told his daughter that he doesn't want to come back to Ms. Gligor's home. AR 456. Ms. Larson testified that when she arrived after this incident, her father was so upset he was visibly shaking. Tr. 61-65, 138; AR 304-305. Her father had his jacket on and some of his favorite pictures and treasures and told Ms. Larson, "you [sic] got to get me out of here." Tr. 178. He was very agitated and wanted to move out. Tr. 180. Ms. Larson asked Ms. Larson what was wrong, and Ms. Gligor stated that Richard went into her bathroom, used her brush and peed on her floor on purpose. Tr. 178, 180. Ms. Gligor stated in her progress notes that she "advised Val [Ms. Larson] to keep her emotions away, to detach herself from [her father] as he is like a child, trying to get attention." AR 456.

Ms. Gligor admitted to DSHS investigator Elizabeth Frost that she told Richard in front of others that she didn't like Richard's offer of sex and that he was not to pee on the floor or use her bathroom. Tr. 136. Ms. Frost asked Ms. Gligor why she said this to a person with dementia in front of other residents and a caregiver, and Ms. Gligor responded, "well, wouldn't you do that?" Tr. 136. Ms. Frost responded by saying no, "[y]ou do not humiliate a client in front of other residents." Tr. 136.

Ms. Gligor testified that on February 5, 2010, she asked Ms. Larson to find Richard another home. Tr. 94-95. She did not provide a written 30-day notice of discharge to Richard or his family. Tr. 94-95, 598-601, 714-715. Richard continued to reside in the home.

In January 2010, Valerie Hudson recommended in-home mental health services to address Richard's sleep issues to Ms. Gligor. Tr. 470-471, 478, 482-483. Valerie Hudson is a registered nurse who provided nurse delegation services to Ms. Gligor for Richard and other residents at Evergreen Seasons. Tr. 464-467, 469, 476. Ms. Gligor did not obtain mental health services for Richard.

Ms. Sykes, the registered nurse who performed Richard's assessment, testified that she observed a significant change in Richard's behavior as a result of his lack of sleep. Tr. 650. For about six weeks starting in early February 2010, Ms. Sykes observed that Ms. Gligor and Richard were very tired and Ms. Gligor was becoming burnt out. Tr. 627, 629-630, 634, 639, 676. Ms. Sykes opined that having "awake staff" in the home would definitely have helped with Richard's care. Tr. 651. Ms. Sykes kept telling Ms. Gligor to get medical attention for Richard because Richard was decompensating to a point where he couldn't express himself. Tr. 631-632. Ms. Gligor replied by reassuring Ms. Sykes that she was trying to work with Richard's family and doctor. Tr. 633, 661.

Ms. Sykes stated that Richard needed a medical review, close monitoring, redirection and behavioral intervention. Tr. 673-674.

Timothy Anderson, D.O., testified that he started treating Richard for dementia in October 2009. Tr. 432. Ms. Larson took Richard to the doctor seeking help for Richard to sleep. Tr. 192. From October 2009 to the spring of 2010, Richard had five in person visits with Dr. Anderson. Tr. 433, 440.

Ms. Gligor made calls to Dr. Anderson's office regarding Richard and sent him a fax about Richard's sleep issues and a request to lower Richard's sex drive. Tr. 434. Dr. Anderson testified that Richard's sleeping difficulties are very common with someone with dementia and concern about Richard's sexual drive was consistent with his Alzheimer's dementia. Tr. 446, 452-453. Ms. Gligor never told Dr. Anderson that Richard was being sexually aggressive toward a female resident. Tr. 437.

Dr. Anderson prescribed medication to Richard to help him sleep and to address his anxiety. Tr. 436, 442-443. Dr. Anderson made changes to Richard's prescriptions and was in the process of having a geriatric nurse practitioner evaluate Richard in his home. Tr. 437, 447, 455, 459. His plan was to have Richard evaluated by a licensed mental health counselor and a psychiatric nurse practitioner. Tr. 448. Ms. Gligor later discharged Richard before these services could be provided.

Penny Davis, a nursing care consultant for DSHS, performed an assessment of Richard on February 8, 2010. Tr. 35-36, 372-373, 383; AR 337-357. Ms. Gligor participated in this assessment and provided information to Ms. Davis. Tr. 36-37. Ms. Gligor reported that Richard had sleep walking issues, wandered at night and forgets the location of his room. Tr. 36, 119, 337-357, 374-377-380. The concerns that Ms. Gligor reported to Ms. Davis focused on Richard's nighttime activity and toileting and incontinence issues. Tr. 399, 418. Ms. Gligor did not tell Ms. Davis that Richard wandered into other residents' rooms. Tr. 399. Ms. Davis testified that Ms. Gligor never mentioned that Richard had been sexually aggressive toward Ms. Gligor or other residents or presented any danger to others. Tr. 380, 407.

Ms. Davis' assessment diagnosed Richard with dementia and stated he has nightmares and difficulty staying asleep. Tr. 339, 343. There was no mention in the assessment that Richard engaged in sexually inappropriate or aggressive behavior or that Richard posed a threat to others. AR 337-357. In the section of the assessment that relates to Richard's behaviors, there was nothing to indicate that Richard had sexualized behaviors. Tr. 119.

On March 1, 2010, Ms. Gligor signed a statement affirming her agreement with the services outlined in Richard's assessment. Tr. 406;

AR 357. Ms. Gligor acknowledged reviewing and signing this assessment and thereby agreeing to its contents. Tr. 38, 93-94, 718. Ms. Gligor testified that the information she reported to Ms. Davis about Richard being hypersexual and coming into her bedroom and asking for sex was not in the assessment. Tr. 38-39; AR 337-357. Ms. Gligor explained that she signed Richard's assessment, even though it excluded information about Richard walking into another resident's room naked. Tr. 718.

Ms. Davis testified that Ms. Gligor should have notified her if she disagreed with Richard's assessment. Tr. 408. Ms. Davis stated that any sexually aggressive behavior should have been disclosed so the assessment could be updated. Tr. 408. When there is a significant change, the provider should call the case manager to update the resident's assessment. Tr. 414. Ms. Gligor could have asked for an extra caregiver or nighttime assistance and Ms. Davis could have made an exceptional rate request. Tr. 409. Ms. Gligor admits that she never called Ms. Davis to talk with her about Richard's escalating behaviors. Tr. 95.

Ms. Davis testified that in March 2010, Ms. Gligor called her and told her that she could no longer handle Richard and needed to have him removed. Tr. 381, 396-397. Ms. Davis told Ms. Gligor that she needed to give Richard and his family written notice, which is required so the family

can find another home for the client. Tr. 382. Ms. Gligor never gave written notice to have Richard moved out of the home. Tr. 182.

On about March 22<sup>nd</sup> or 23<sup>rd</sup>, 2010, Ms. Gligor verbally demanded that Ms. Larson find Richard another home by April 1<sup>st</sup>, 2010.<sup>2</sup> Tr. 71-73, 86, 89, 95, 96, 541, 601-602; AR 460. Ms. Gligor told Ms. Larson to find her father another home because he kept her up all night, she was tired and couldn't deal with him anymore. Tr. 173, 174, 177. Ms. Gligor reported at this time that Richard was up 24 hours, was anxious and unrested, and wanted to go to work at 4:00 a.m. Tr. 88-89; AR 460. At trial, Ms. Gligor testified that Richard was a danger to himself, the caregivers and other residents and so she told Ms. Larson to "take him and place him out." Tr. 602-603, 710.

After being told to move her father, Ms. Larson was "very upset" and "didn't say a word" and sat beside her father and was trying to "troubleshoot" about "what's next." Tr. 710. Ms. Larson then went outside and contacted Edith (Dede) Cantu, who was friend of Ms. Gligor. Tr. 225-228. Ms. Larson told Ms. Cantu that Ms. Gligor wants her father out of the home "imminently" and asked her what she should do. Tr. 175, 217, 710-711. Ms. Cantu stated that Ms. Larson told her that her father

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<sup>2</sup> Sometime later, Ms. Gligor wrote in her facility's notes that she told Richard's daughter "to find him another place as soon as April 1<sup>st</sup>, 2010, yet [Richard] could stay here until finding a new place (May or June)." Tr. 71-73, 86, 89, 96; AR 460.

had been evicted from the home and she had only until April 1<sup>st</sup> to find him a new home. Tr. 148, 228, 251.

Ms. Larson testified that all of a sudden, Ms. Gligor came tearing out of the house, screaming that she and Ms. Cantu shouldn't talk with each other. Tr. 147-148, 175-176. Richard's granddaughter testified that Ms. Gligor came out of the door so aggressively that Ms. Larson "felt attacked" and also "flustered" that she had to quickly find a place for her father. Tr. 217, 221. Ms. Cantu stated that Ms. Gligor was very angry and upset, came "storming out" into the driveway, and was telling Ms. Cantu not to talk with Richard's daughter. Tr. 147, 148, 485. Ms. Gligor admitted that she had a fiery conversation with Ms. Larson. Tr. 147.

Ms. Larson testified that after this encounter with Ms. Gligor, she was very concerned and frightened to leave her father in Ms. Gligor's care. Tr. 194-195. She believed that her father had to be removed from the home because of Ms. Gligor's anger and because his care was no longer adequate. Tr. 196-198, 541. She felt she "had no choice but to get him out of there for his own good." Tr. 198. Ms. Larson removed her father from Ms. Gligor's home within a few days and before April 1. Tr. 75-76, 95, 197. Ms. Cantu (Dede) helped Ms. Larson find another home. Tr. 195, 248-249. Ms. Cantu also indicated that Richard needed to be

removed from the home for his own safety and wellbeing, because Ms. Gligor was upset, out-of-control and burned out. Tr. 151-152, 231.

At trial, Ms. Gligor presented new information not previously disclosed to the DSHS investigator nor recorded in the facility's progress notes. Ms. Gligor testified that on or about March 23, 2010, Richard ran after her caregiver Sylvia with his cane, called her names, hit her and spit on her face. Tr. 73-74, 602-603, 682-683, 709. Then Ms. Gligor testified that Richard *didn't* kick the caregiver. Tr. 713. Ms. Gligor stated she did not report this incident to DSHS or to the police. Tr. 74-77, 712; AR 298-308. She explained that she did not call 911 because she was embarrassed and was concerned that Richard would have to move out for abusing his caregiver and did not want to traumatize Richard. Tr. 74-77. At trial, Ms. Gligor admitted that she did not write about this incident in her progress notes *before* the DSHS investigator came to her home. Tr. 712, 714. She testified that she later wrote about Richard's incident with Sylvia in her progress notes, but could not show her entry because pages were missing from her notebook. Tr. 712, 714.

Sylvia Denisiuc testified that she worked as a caregiver in Ms. Gligor's home for five days from the 21<sup>st</sup> through the 24<sup>th</sup> of April 2010, but wasn't sure of the month. Tr. 682-683. She stated that every night, Richard would walk around all the rooms. Tr. 684, 686. Richard would

open the door and try to go outside. Tr. 686-687. On the last night she worked, Richard was annoying a female resident and trying to get in bed with her. Tr. 684. When Ms. Denisiuc tried to persuade Richard to leave the room, Richard waved his stick at her, tried to hit her and spit on her. Tr. 684-685, 686. Richard was very angry and nervous. Tr. 686. Ms. Denisiuc ran to her room, but later returned to the female resident's room and with the help of the female resident, was able to remove Richard from the room. Tr. 685, 689. Later Richard came to Ms. Denisiuc's room and tried to get in bed with her. Tr. 685. Then Richard went into a man's room and tried to get in bed with him, while Richard was only wearing underwear. Tr. 685. Ms. Denisiuc called Ms. Gligor, who later returned to the home and helped return Richard to his room. Tr. 685-686, 690.

Ms. Gligor explained that she did not call 911 after this incident because she is "a gracious person" and "has a great heart" and didn't want to distress Richard. Tr. 710. Ms. Gligor never reported to Ms. Larson or Ms. Pinto that their father chased and spit at a caregiver or that he was aggressive or sexually aggressive toward others. Tr. 169, 339.

Another vulnerable adult named Yetta resided at Evergreen Seasons. Yetta required adult family home care after she was hit by a car in her mid-80's and suffered a traumatic brain injury and fractured neck.

Tr. 608-609. Yetta had short term memory loss and behavioral issues. Tr. 610, 613.

Bonita Sykes completed an “Assessment and Care Plan for Yetta” in January 2009 that reported Yetta had a traumatic brain injury and mood swings, and is manic, paranoid at times, easily irritated and agitated. Tr. 43-44, 121, 644-646; AR 378-380. Ms. Sykes is a registered nurse who specializes in geriatrics and was a private case manager for Yetta. Tr. 606-607. The assessment also indicated that Yetta used foul language and had been resistant to care. AR 378. The assessment directed the caregiver to cue, re-approach and re-direct Yetta as needed. Tr. 44; AR 378-380. For out of control behaviors, the caregiver was directed to call Yetta’s medical provider or 911 as needed. Tr. 44, 121; AR 379.

Ms. Gligor’s dealt with Yetta’s behavior by making her write an apology in the facility’s progress notes and referred to this as therapy for Yetta. Tr. 44-45, 69, 122; AR 458. Ms. Gligor had Yetta write that she was sorry for her outburst. Tr. 45, 122-123. Ms. Gligor had Yetta write an apology in the facility’s progress notes for all the residents, and not in a private journal. Tr. 122-123. Yetta’s case manager, Bonnie Sykes, stated that this was not appropriate and she had not been aware that Ms. Gligor was having Yetta write apologies in the progress notes. Tr. 123, 662, 663.

Ms. Gligor also had Yetta, a vulnerable adult with a brain injury, sign a statement that provided in part: “Things You Need to Do . . . Be friendly to everyone who comes to Mariana’s [Ms. Gligor’s] no matter who they are or what they say;” “Be thankful and appreciative of what Mariana does for me and others who come in contact with her;” “Mariana is an excellent cook, let her know I appreciate all her meals “yummy for the tummy;” “All in All I Need to Try Harder to Be a Nice Person.” AR 458.

At trial, Ms. Gligor explained that making Yetta write down these things would help Yetta, because it really helped Ms. Gligor deal with students when she was a teacher. Tr. 47, 69. Ms. Gligor stated it was very upsetting to hear Yetta “say all of the kind of negative words and comments against me and my work.” Tr. 70.

Ms. Gligor brought a dog into the home that was untrained, jumped on the residents, nipped at them, ran out the door, did not follow commands and was generally out of control. Tr. 110-111, 169-170, 381, 517. Donald Hamby, a friend of Richard’s, testified that the dog was jumping up and down on Richard and making Richard nervous. Tr. 423.

In February, 2010, Yetta was bitten by the facility’s dog and suffered a puncture wound that became infected. Tr. 105. Yetta was diagnosed with cellulitis and abscess and over a period of 2 ½ months,

required multiple medical visits, extensive debridement, wound care and antibiotics. Tr. 105, 618-619, 643; AR 381-383.

After the dog bite incident, Ms. Gligor failed to implement measures to ensure that the dog would not pose any future health or safety threat to the residents. Instead, Ms. Gligor told Yetta's Power of Attorney to not allow Yetta to play with the dog and wrote in the facility's notes that Yetta plays with the dog at her own risk. Tr. 79, 108; AR 459. Ms. Gligor also wrote in her progress notes that she asked Yetta's case manager and representative to not allow Yetta to play with the dog. Tr. 108-109.<sup>3</sup> Ms. Gligor testified that:

Yetta is demented, so she cannot play at her own risk. But I guess I just log that in. And I told the family and the provider, the POA and the nurse, I said, Well, I'm getting this puppy for Yetta. And if anything happens, I don't want to have this responsibility for the puppy dog.

Tr. 80.

Yetta's case manager, Ms. Sykes, testified that after the dog bite, she directed Ms. Gligor to prevent Yetta from playing with the dog and that it was not appropriate for Ms. Gligor to say that Yetta plays with the dog at her own risk. Tr. 647. Ms. Frost testified that Yetta suffers from a traumatic brain injury, has dementia and does not have the judgment or the ability to make a decision to stay away from the dog for her own safety.

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<sup>3</sup> Y's family lives in New York State. Tr. 608.

Tr. 109. Ms. Frost testified that it was Ms. Gligor's responsibility to protect Yetta from the dog, not the responsibility of Yetta's representative, who lived out-of-state, or Yetta's case manager, who is not in the adult family home on a daily basis. Tr. 108-109, 518.

Ms. Frost reported that Yetta's "Assessment and Care Plan" contained no therapeutic approaches to manage Yetta's behaviors, no treatment plan to address Yetta's wound care for the dog bite, and no care plan to protect Yetta from future dog bites. AR 302-303. There was also no care plan that provided "specific mental health approaches" to address Yetta's "care needs when she became manic, paranoid or impulsive . ." AR 302-303. Ms. Sykes could not specifically identify a care plan that addressed Yetta's wound care. Tr. 644-646. Ms. Frost testified that Yetta should have had a negotiated care plan that addressed how to protect Yetta from the dog and did not. Tr. 124. Rather than develop a care plan consistent with Yetta's assessment, Ms. Gligor used her own techniques to try to manage Yetta's behaviors. Tr. 47-48; AR 358-380.

### **3. The enforcement action**

In late March 2010, DSHS initiated an investigation of Evergreen Seasons after receiving a complaint. Tr. 100-101. The complaint alleged that Ms. Gligor discharged a vulnerable adult from the adult family home suddenly and without proper notice and displayed anger toward the

vulnerable adult and his family. Tr. 100-101. In addition, the complaint alleged that another vulnerable adult received a puncture wound from the facility's dog and that the home was unsanitary. Tr. 102. After the investigation was concluded, DSHS found several violations of the adult family home licensing regulations and ordered the stop placement and revocation of Ms. Gligor's adult family home license for Evergreen Seasons. AR 294-308.

DSHS cited Ms. Gligor for lacking the understanding and ability to provide care and services to vulnerable adults. AR 299-300. Ms. Gligor demonstrated a lack understanding of her residents' care needs by reprimanding and humiliating Richard in front of other residents, accusing Richard of making sexual advances, failing to appropriately discharge Richard, screaming at Richard's family member, instructing Yetta to write an apology in the facility's progress notes, and stating that Yetta plays with the dog at her own risk after Yetta suffered a serious bite wound. Tr. 517; AR 299.

DSHS found that Ms. Gligor lacked the understanding and ability to care for residents with dementia and treated dementia patients like children. Tr. 398, 533-534, 588-589, 591-592. DSHS investigator, Elizabeth Frost, testified that it is inappropriate to scold or reprimand dementia patients, as this can make them more agitated or anxious, and

may upset them if they realize they are losing their memory. Tr. 534. Ms. Frost stated that dementia patients need to be serene and peaceful and live in a gentle environment, and Ms. Gligor's adult family home was chaotic for residents. Tr. 534. Ms. Gligor was talking loudly and reprimanding Richard in front of other residents. Tr. 534-535.

DSHS also cited Ms. Gligor for failing to ensure that the dog living on the adult family home premises had a suitable temperament and posed no significant health or safety risks to any resident. AR 300. Ms. Gligor exposed Yetta to harm when she was bit by the facility's dog. AR 300-301. Ms. Gligor stated that Yetta plays with the dog at her own risk and failed to protect her from future dog bites. AR 301.

DSHS also cited Ms. Gligor for failure to have an updated negotiated care plan for two of the residents. Tr. 113; AR 302-303. Ms. Frost found that Ms. Gligor failed to make an updated care plan for Richard, who was diagnosed with dementia and exhibited "increased wandering at night," and failed to establish "approaches for managing the behavior such as redirection, night time assistance or making sure he was toileted and in comfortable sleeping attire." AR 302. Ms. Frost found that Ms. Gligor failed to make an updated care plan for Yetta, who was diagnosed with mood swings and paranoia, and did not establish "specific mental health approaches to address [Yetta's] "care needs when she

became manic, paranoid or impulsive .” AR 302. Instead, Ms. Gligor had Yetta write about her feelings in the facility’s progress notes, which was not a therapeutic approach. AR 303. Ms. Gligor also failed to update Yetta’s care plan to address treatment for the dog bite and measures needed to prevent future dog bites. AR 303.

DSHS also cited Ms. Gligor for failure to provide necessary care and services for residents Richard and Yetta to help them reach the highest level of physical, mental and psychosocial well-being and provide care and services that actively support, maintain or improve their quality of life. Tr. 124; AR 303-307.

Ms. Frost testified that Ms. Gligor violated care and service requirements by not watching Richard nor giving him the help he needed at night and by not redirecting him. Tr. 138. Ms. Frost testified that Richard’s assessment and care plan did not address Richard’s nighttime care needs. Tr. 503. Richard’s assessment stated that he had dementia and needed to be cued to his new environment, but there was no care plan indicating how this was to be done. Tr. 504; AR 333. Ms. Gligor complained that Richard was urinating outside the bathroom and not sleeping at night but she did not have a care plan to address these issues and provide direction to caregivers. Tr. 504-505. There was no updated

care plan to show the true picture of Richard and how to meet his needs. Tr. 504-506.

Ms. Gligor also failed to meet care and service requirements for Yetta. She made Yetta write in the facility notebook that she was sorry for her outbursts, wrote about Yetta's negative behaviors in the notebook, and made Yetta responsible for protecting herself against future dog bites. Tr. 139-140; AR 306-307. Ms. Frost testified that vulnerable adults with dementia should not have to apologize to the provider. Tr. 141. Further, Ms. Gligor brought a dog into the AFH that was not trained and could not follow commands and inappropriately managed the care of this resident by stating that Yetta plays with the dog at her own risk. Tr. 139.

Ms. Gligor's failure to provide necessary care and services resulted in harm to Richard, "who suffered mental anguish and a sudden involuntary discharge," and harm to Yetta, "who sustained a dog bite and did not have her mental health issues appropriately addressed." AR 303.

Finally, DSHS cited Ms. Gligor for failing to appropriately discharge Richard, which resulted in his "sudden, disorderly discharge." AR 307-308. Ms. Gligor wrote in her facility notes that on March 22, 2010, Rrichard was "up 24 hours" and so she asked Richards's daughter, Valerie Larson, "to find him another place as soon as April 1<sup>st</sup>, 2010." AR 307. Ms. Gligor told the daughter to get her father out and began

screaming at her. AR 308. Edith Cantu, a friend of Ms. Gligor, reported to Ms. Frost that Ms. Gligor came “storming out” of the adult family home and began screaming at her. AR 308. Ms. Gligor admitted to Ms. Frost that she had a “fiery” conversation with Richards’s daughter. AR 308. The daughter stated that she realized she had to immediately remove Richard from the AFH to ensure her father’s safety. AR 308.

**B. Procedural History**

On April 15, 2010, DSHS notified Ms. Gligor that it was issuing a stop placement of admissions and revoking her adult family home license for Evergreen Seasons. AR 294. DSHS’ enforcement action was based upon its findings that Ms. Gligor: (1) Violated WAC 388-76-10020(1) by lacking the ability to provide care and services to two residents; (2) Violated WAC 388-76-10220(2) and WAC 388-76-10220(3) by failing to ensure that an incident log was kept; (3) Violated WAC 388-76-10230(2) by failing to protect the residents from the facility’s dog; (4) Violated WAC 388-76-10380(2) by failing to ensure that two residents had their care plans updated to meet their needs; (5) Violated WAC 388-76-10400(2), WAC 388-76-10400(3)(a) & WAC 388-76-10400(3)(b) by failing to ensure that two residents received appropriate care and services in a manner that actively supported and improved their quality of life; and

(6) Violated WAC 388-76-10615(2)(a), WAC 388-76-10615(3) & WAC 388-76-10615(6) by failing to ensure that one resident was appropriately discharged from the adult family home. AR 294-308.

An administrative hearing was conducted in October 2010. AR 179; TR 1-733. Ms. Gligor appeared and was represented by attorney Timothy Leary. On November 18, 2010, ALJ Conklin issued an Initial Order which upheld all of the violations found by the Department, except that of having an unclean dog and no incident log. AR 185-190. The ALJ also upheld the Department's revocation of Ms. Gligor's license to operate Evergreen Seasons AFH. AR 190-191.

On December 8, 2010, Ms. Gligor filed a petition for review of the Initial Order. AR 168-176. On September 7, 2011, DSHS Board of Appeals Review Judge James Conant (review judge) issued a Review Decision and Final Order that generally adopted the findings of fact and conclusions of law set forth in the Initial Order with minor amendments. AR 104-145. Ms. Gligor subsequently sought reconsideration by the Review Judge. On October 25, 2011, reconsideration was denied. AR 1.

Ms. Gligor sought judicial review in King County Superior Court. On April 18, 2013, Superior Court Judge James Rogers reversed the Review Judge's findings that Ms. Gligor was given notice of the allegation that she failed to protect one resident from another resident, and that Ms.

Gligor failed to give a proper discharge notice to a resident. CP 1-4. Judge Rogers also reversed the license revocation, but affirmed the remaining findings of fact and conclusions of law. CP 1-4.

The Department timely filed a Notice of Appeal. CP 5-6.

## V. ARGUMENT

### A. Standard Of Review

This is an appeal of a final agency order in an adjudicative proceeding under the Administrative Procedure Act (APA), RCW 34.05. The Court's review authority is limited to review of the DSHS Board of Appeals' final order, not the ALJ's initial order, or the superior court's order. *Tapper v. Empl. Sec. Dep't*, 122 Wn.2d 397, 403-404, 858 P.2d 494 (1993). Therefore, the order under review is the DSHS Board of Appeals Review Decision and Final Order entered on September 7, 2011, which upheld most of the violations found by the Department and upheld the Department's revocation of the adult family home license. AR 104-145.

The reviewing court applies the APA standards of review directly to the record made before the administrative agency, and may not consider new evidence. RCW 34.05.558; *Heinmiller v. Dep't of Health*, 127 Wn.2d 595, 601, 903 P.2d 433 (1995), *cert. denied*, 518 U.S. 1006 (1996).

Ms. Gligor has the burden of showing the invalidity of the DSHS Board of Appeals Review Decision and Final Order. RCW 34.05.570(1)(a); *Hillis v. Dep't of Ecology*, 131 Wn.2d 373, 381, 932 P.2d 139 (1997). The Court may grant relief from an agency order in an adjudicative proceeding only on the grounds provided under RCW 34.05.570(3).<sup>4</sup> *Tapper*, 122 Wn.2d at 402.

**1. Review of factual matters**

Review of factual findings must be based solely on the administrative record. RCW 34.05.558. Unchallenged findings of fact are treated as verities on appeal. *Tapper*, 122 Wn.2d at 407.

The Court will affirm challenged findings that are supported by “evidence that is substantial when viewed in light of the whole record before the court.” *Bond v. Dep't of Social & Health Svcs.*, 111 Wn. App. 566, 572, 45 P.3d 1087 (2002); *see also* RCW 34.05.570(3)(e). Substantial evidence is that which is sufficient “to persuade a fair-minded person of the truth or correctness of the order.” *City of Redmond v. Central Puget Sound Growth Management Hearings Board*, 136 Wn.2d

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<sup>4</sup> Relief may be granted only if (a) the order or rule on which it is based is unconstitutional; (b) the order exceeds the agency’s statutory authority; (c) the agency’s procedure or decision-making process was unlawful; (d) the agency erroneously interpreted or applied the law; (e) the order is not supported by substantial evidence in light of the whole record before the court; (f) the agency has not decided all issues requiring resolution by the agency; (g) a motion for disqualification should have been granted; (h) the order is inconsistent with the agency’s rules; or (i) the order is arbitrary or capricious. RCW 34.05.570(3).

38, 46, 959 P.2d 1091 (1998) (citations omitted). If sufficient evidence supports the finding, it does not matter that there are conflicting facts in the record or other interpretations of the facts. The reviewing court determines only if the evidence most favorable to the prevailing party reasonably supports the challenged finding. *Dep't of Rev. v. Sec. Pacific Bank*, 109 Wn. App. 795, 803, 38 P.3d 354 (2002).

Additionally, the Court may not weigh witness credibility or substitute its judgment for the agency's findings of fact on credibility. *Port of Seattle v. Pollution Control Hearings Bd.*, 151 Wn.2d 568, 588, 90 P.3d 659 (2004). RCW 34.05.464(4) requires the reviewing court to give "due regard" to the administrative law judge's opportunity to observe the witnesses. *Kabbae v. Dep't of Social and Health Services*, 144 Wn. App. 432, 444, 192 P.3d 903 (2008). The reviewing court must accept the fact finder's views regarding the credibility of witnesses. *Costanich v. Dep't of Social and Health Services*, 138 Wn. App. 547, 556, 156 P.3d 232 (2007).

## **2. Review of questions of law**

In reviewing a question of law, the reviewing court is restricted to the determination of whether the agency has "erroneously interpreted or applied the law." RCW 34.05.570(3)(d). Issues of law are subject to *de novo* review by the Court. *Bond*, 111 Wn. App. at 572. The Court may

substitute its judgment for that of the agency; however, where interpretation of law is in the agency's area of expertise, the Court accords substantial deference to the agency on review. *City of Redmond*, 136 Wn.2d at 46.

The Court reviews *de novo* both the agency's conclusions of law and its application of the law to the facts. *Tapper*, 122 Wn.2d at 402-403. The Court can modify conclusions of law if the agency's Review Judge "erroneously interpreted or applied the law." RCW 34.05.570(3)(d); *Heinmiller*, 127 Wn.2d at 601. The Court may also substitute its judgment for that of the reviewing officer, but it must accord "substantial weight" to the agency's interpretations of the law within its area of expertise. *Macey v. Empl. Sec. Dep't*, 110 Wn.2d 308, 313, 752 P.2d 372 (1988).

### **3. Review of order as arbitrary and capricious**

Washington's APA allows a reviewing court to reverse an agency decision when the decision is arbitrary or capricious. *Bond*, 111 Wn. App. at 572; RCW 34.05.570(3)(i). This standard is highly deferential, and the Court "will not set aside a discretionary decision absent a clear showing of abuse." *ARCO v. Util. & Transp. Comm'n*, 125 Wn.2d 805, 812, 888 P.2d 728 (1995) (citations omitted). Action by an agency is arbitrary and capricious if it is "willful and unreasoning and taken without regard to the attending facts or circumstances." *Hillis*, 131 Wn.2d at 383. "Where

there is room for two opinions,” a decision reached after due consideration is not arbitrary and capricious even if the reviewing court believes it to be in error. *Id.*

**B. Substantial Evidence Supports The Finding That Ms. Gligor Violated Adult Family Home Regulations, Warranting Stop Placement Of Admissions And License Revocation.**

Substantial evidence supports the finding that Ms. Gligor violated numerous adult family home regulations warranting a stop placement of admissions and license revocation. Given the nature of the violations committed by Ms. Gligor, DSHS’ enforcement action was supported by substantial evidence. DSHS has the statutory authority to impose a stop placement and revoke an adult family home license when the provider has failed or refused to comply with state laws governing adult family homes. RCW 70.128.160(1)(a); RCW 70.128.160(2)(f); RCW 70.128.160(g); WAC 388-76-10940.

The Washington’s Court of Appeals has found that, “[w]hen balancing the needs of vulnerable adults entrusted to state care and the interests of even well-meaning caregivers who fail to provide necessary and adequate supervision over their charges, DSHS must give priority to the safety of these vulnerable adults.” *Bond*, 111 Wn. App. at 575. In *Bond*, the Court considered a summary suspension and revocation of an adult family home license. The Court determined that the licensee placed

five developmentally disabled residents at imminent risk of harm by failing to ensure that these vulnerable residents were cared for by a fully qualified caregiver when the licensee was absent for a six hour period. *Bond*, 111 Wn. App. at 572-74. Because of the serious risk posed to residents in that case, the Court reasoned that DSHS was not required to allow the licensee a reasonable opportunity to correct. *Bond*, 111 Wn. App. at 577 (citing former WAC 388-76-705(2)(a)). DSHS must rely on licensed adult family home providers to take action to *prevent* harm. In meeting its statutory obligation to enforce adult family home regulations, DSHS need not wait until a resident is harmed before taking licensing action.

**1. Ms. Gligor failed to demonstrate necessary understanding, ability and emotional stability to provide care to two residents**

Substantial evidence supports the Review Judge’s finding that Ms. Gligor failed to demonstrate the necessary understanding, ability and emotional stability to provide care for residents Richard and Yetta. WAC 388-76-10020(1) requires that an adult family home provider have the “[u]nderstanding, ability, emotional stability and physical health necessary to meet the psychosocial, personal, and special care needs of vulnerable adults.” WAC 388-76-10020(1).

Ms. Gligor demonstrated her lack of understanding and ability to meet the psychosocial, personal, and special care needs of vulnerable by reprimanding and humiliating her residents. Ms. Gligor reprimanded Richard in front of other residents and another caregiver by telling him she was not interested in his [sexual] offers and to stop using her bathroom, and this humiliated Richard causing him to be “visibly upset and shaking.” Tr. 61-65, 138; AR 304-305. Ms. Gligor made Yetta, an elderly woman with a traumatic brain injury, write an apology and sign a directive on how to be a nicer person in the facility’s progress notes for all the residents. Tr. 69, 122-123; AR 458.

Ms. Gligor also showed her lack of respect and understanding for vulnerable adults with dementia, when she likened her residents to children. Tr. 47, 69, 367, 533. She had Yetta write an apology in the progress notes because this approach helped Ms. Gligor as a school teacher. Tr. 69. Ms. Gligor told Richard’s daughter that she needs to treat Richard like a child. Tr. 143.

Ms. Frost, a registered nurse with extensive experience in long term geriatric care, testified that Richard is a vulnerable adult with dementia; he is not a child and should not be treated like one. Tr. 143. Ms. Gligor failed to treat her residents in a dignified and respectful manner. Tr. 138. Ms. Sykes, a registered nurse and case manager for

Yetta, and Ms. Frost stated it was not appropriate to make Yetta write her private feelings in a notebook that others could read. Tr. 123, 662, 663.

Ms. Gligor also demonstrated her lack of understanding and ability to “meet the psychosocial, personal, and special care needs” of the vulnerable adults in her care by failing to revise or update the care plans for Richard and Yetta. WAC 388-76-10020(1). Ms. Frost testified that the provider should look at the vulnerable adult’s diagnosis and care needs and develop a care plan to address those needs. Tr. 143. Ms. Gligor failed to make a care plan for Yetta that addressed her wound care for her dog bite, that protected her from future dog bites and that contained therapeutic approaches to manage Yetta’s behaviors. Tr. 124, 644-646; AR 302-303. Ms. Gligor also failed to develop an appropriate care plan for Richard to monitor and address his nighttime activities when he would frequently get lost and wander into the bedrooms of other residents and caregivers. Tr. 34-37, 56-58, 67-68, 85, 115, 125, 603-604; AR 384, 385, 455. Ms. Gligor demonstrated a lack of understanding and ability to care for vulnerable adults by failing to make a care plan that addressed Richard’s nighttime behaviors and needs, when she believed that he posed a threat to another resident. Tr. 715; AR 455. Ms. Gligor’s only intervention for Richard was to medicate him. Tr. 126; AR 304.

Ms. Gligor also demonstrated her lack of understanding and ability to meet Richard's special needs by failing to obtain an evaluation and diagnosis for Richard, when she purportedly believed he was sexually aggressive toward others. Tr. 142, 510-511, 532. Ms. Gligor made accusations that Richard was hypersexual and even accused Richard of asking his daughter to have sex with him, even though he never used the word "sex." Tr. 58-59, 66-67, 119-120. Ms. Frost, a registered nurse with expertise in geriatric care, believed that Richard's behaviors were consistent with his dementia and nothing more than wandering at night. Tr. 512-513, 516. Clearly, an evaluation was needed to evaluate Richard, obtain recommendations and develop an appropriate care plan for him.

Ms. Gligor demonstrated her lack of emotional stability to care for vulnerable adults in violation of WAC 388-76-10020(1), when she suddenly discharged Richard during an emotional outburst. In late March 2010, Ms. Gligor demanded Richard's removal from the home by April 1<sup>st</sup>, and she came tearing out of the home screaming at Richard's daughter, resulting in the sudden relocation of Richard without proper notice or a safe and orderly transfer. Tr. 95, 147-148, 175-176, 182, 194-198, 217, 221, 485; AR 460, 541.

Ms. Gligor also showed her lack of understanding and ability to meet the care needs of vulnerable adults by imposing on Yetta, who has

dementia, a traumatic brain injury and mood swings, the responsibility to keep herself safe from the dog. Tr. 43-44, 79, 109, 121, 518, 644-646; AR 378-380, 459.

Clearly, there is substantial evidence that Ms. Gligor violated the provisions of WAC 388-76-10020(1) as set forth in the Review Judge's conclusion as follows:

The type and number of rule violations cited by the Department . . . support the ultimate conclusion that the Appellant [Ms. Gligor] does not have the requisite understanding to provide daily care to vulnerable adults in need of special care. The citations relate to basic core elements necessary for the care and safety of residents. Supportive and compassionate directives towards residents; completion, updating, and adherence to comprehensive negotiated care plans; providing necessary care and services to maximize residents' well-being and quality of life; and treating all residents with respect . . . are all core elements in providing vulnerable adult care in a safe and positive environment.

AR 136.

**2. Ms. Gligor failed to ensure two residents received appropriate care and services resulting in potential or actual harm to both residents**

Substantial evidence supports the Review Judge's conclusion that Ms. Gligor violated the provisions of WAC 388-76-10400(2), (3)(a), and (3)(b) "by failing to ensure that two residents received appropriate care and services resulting in mental anguish; sudden involuntary discharge for one resident; and harm to another resident who suffered a dog bite and did

not have her mental issues addressed.” AR 131. WAC 388-76-10400(2); (3)(a) and (3)(b) provides that the adult family home must ensure each resident receives:

(2) The necessary care and services to help the resident reach the highest level of physical, mental, and psychosocial well-being consistent with resident choice, current functional status and potential for improvement or decline.

(3) The care and services in a manner and in an environment that:

- (a) Actively supports, maintains or improves each resident's quality of life;
- (b) Actively supports the safety of each resident. . .

WAC 388-76-10400(2), (3)(a) & (3)(b).

Ms. Gligor violated these provisions because she failed to provide necessary care and services to Richard and Yetta and failed to actively support, maintain and improve their quality of life. Ms. Gligor failed to ensure there were “awake” staff at night to monitor Richard and to otherwise request help to address his nighttime needs. Tr. 125-127, 409, 419. Ms. Gligor’s failure to monitor and address Richard’s nighttime behavior enabled Richard to disturb Yetta’s peace and tranquility with his nocturnal wanderings. Tr. 36-37, 67-68, 85, 603-604, 625-626, 653-655, 674-675; AR 385, 455. Ms. Gligor failed to supervise Richard at night even though she purportedly feared that Richard posed a risk to Yetta’s safety. Tr. 715; AR 455. Ms. Gligor failed to notify Penny Davis, a

nursing care consultant for DSHS, that Richard wandered into other residents' rooms and was sexually aggressive toward another resident and herself. Tr. 35-36, 95, 372-373, 380, 383, 399, 407. Ms. Sykes indicated that Richard posed a risk of sexual abuse to Yetta and needed to be monitored by "awake staff" at night and by an alarm system. Tr. 625-626, 657-659, 669.

Ms. Gligor failed to provide the care needed to help the residents reach the "highest level of physical, mental, and psychosocial well-being" and to provide care "in a manner . . . that . . . [a]ctively supports, maintains or improves each resident's quality of life" in violation of WAC 388-76-10400(2) and WAC 388-76-10400(3). WAC 388-76-10400(2) & (3). She reprimanded and humiliated Richard in front of others and made Yetta write an apology in the facility's progress notes, instead of addressing their behaviors in a supportive and reassuring manner. Tr. 44-45, 61-65, 69, 122, 138; AR 304-305, 458.

Ms. Gligor also failed to provide Yetta with necessary care to promote her physical wellbeing, in violation of WAC 388-76-10400(2), by trying to make Yetta responsible for her own safety in relation to the dog. Tr. 108-109. Ms. Frost testified that Yetta suffers from a traumatic brain injury and dementia and does not have the judgment or the ability to make a decision to stay away from the dog for her own safety. Tr. 109.

Hence, there is clear evidence that Ms. Gligor violated the provisions of WAC 388-76-10400(2), (3)(a) and (3)(b) and that this failure resulted in potential or actual harm to Richard and Yetta.

**3. Ms. Gligor failed to ensure that two residents had their negotiated care plans updated to address their needs**

Substantial evidence supports the Review Judge's finding that Ms. Gligor failed to ensure that each resident's negotiated care plan was revised and updated to meet their current needs. WAC 388-76-10380(2) mandates that an "adult family home must ensure that each resident's negotiated care plan is reviewed and revised . . . [w]hen the plan, or parts of the plan, no longer address the resident's needs and preferences." WAC 388-76-10380(2).

A negotiated care plan is a written document that describes all of the care needs of the resident, including the resident's activities of daily living, mobility, behaviors, and need for assistance. The provider is responsible for updating the negotiated care plan, and may receive input from the resident and his or her family and case manager. Tr. 113. The negotiated care plan is important because it guides the provider and all the caregivers on how to meet the resident's daily needs and provide appropriate assistance for the resident. Tr. 114. Ms. Gligor was aware of and acknowledged this was her responsibility. Tr. 30-31.

The evidence shows that Richard's care needs were significantly increasing. Ms. Gligor testified that Richard's nighttime needs increased beginning in January 2010 and he started to become sexually aggressive in February or March, 2010. Tr. 34-37, 56-58; AR 385. She testified that Richard was going into Yetta's bedroom during the night and asking to sleep with her, and on February 4, 2010, she said she found Richard naked in Yetta's bed waiting for Yetta. Tr. 36-37, 67-68, 85; AR 385, 455.

Ms. Gligor failed to appropriately address Richard's escalating needs by revising and updating his care plan, in violation of WAC 388-76-10380(2). In January 2010, Valerie Hudson, a registered nurse who provided nurse delegation services for Richard, recommended to Ms. Gligor in-home mental health services to address Richard's sleep issues. Tr. 464-467, 470-471, 469, 476, 478, 482-483. Ms. Sykes testified that Richard needed medical review, close monitoring, redirection and behavioral intervention. Tr. 651, 673-674. There is no evidence that Ms. Gligor updated Richard's care plan to appropriately provide for these services and interventions.

Ms. Gligor also failed to appropriately address Richard's care needs by failing to ensure that Ms. Davis' February 2010 assessment of Richard included what Ms. Gligor described as Richard's sexually aggressive behavior, so that a care plan could be developed to

appropriately address and monitor his behaviors. Tr. 38-39, 119, 408; AR 337-357. Ms. Gligor admitted that she never called Ms. Davis to talk with her about Richard's escalating behaviors. Tr. 95.

Ms. Gligor also failed to appropriately revise and update Yetta's care plan in violation of WAC 388-76-10380(2). Yetta's assessment provided no "specific mental health approaches" to address Yetta's "care needs when she became manic, paranoid or impulsive ." AR 302-303. It contained no therapeutic approaches to manage Yetta's behaviors, no treatment plan to address Yetta's wound care for the dog bite, and no care plan to protect Yetta from future dog bites. Tr. 108, 109, 124; AR 302-303. Rather than develop a care plan consistent with Yetta's assessment, Ms. Gligor inappropriately made Yetta write out her feelings in the facility's progress notes and referred to this as therapy. Tr. 44-45, 122, 123.

There is overwhelming evidence that Ms. Gligor violated the provisions of WAC 388-76-10380(2) by failing to ensure that she had updated negotiated care plans for Yetta and Richard to appropriately address their current needs.

**4. Ms. Gligor failed to ensure that residents were safe from the facility's dog.**

Substantial evidence supports the finding that Ms. Gligor violated WAC 388-76-10230(2) by failing to ensure that the facility's dog had a suitable temperament and posed no significant threat to the residents' safety. WAC 388-76-10230(2) provides in part: "The adult family home must ensure any animal visiting or living on the premises . . . [h]as a suitable temperament . . . and otherwise poses no significant health or safety risks to any resident. . . ." WAC 388-76-10230(2).

Ms. Gligor violated these provisions by bringing a dog into the home that was untrained, jumped on the residents, nipped at them, ran out the door, did not follow commands and was generally out of control. Tr. 110-111, 169-170, 381, 517. In early February 2010, the dog inflicted a serious bite wound on Yetta, who required extensive wound care. Tr. 79, 105; AR 381-383. After the dog seriously injured Yetta, Ms. Gligor failed to implement measures to ensure that the dog wouldn't pose any future health or safety threat to the residents. Tr. 108. Instead, Ms. Gligor told Yetta's Power of Attorney to not allow Yetta to play with the dog and wrote in the facility's notes that Yetta plays with the dog at her own risk. Tr. 79; AR 459.

**5. Ms. Gligor failed to give an appropriate discharge notice to resident Richard.**

Substantial evidence supports the finding that Ms. Gligor failed to give a timely and proper discharge notice to Richard and his family. *See below*, section V. F.

**C. The superior court erred when it found that the license revocation was arbitrary and capricious.**

The Department's actions in this case are not arbitrary and capricious. The Department considered other options before revoking Ms. Gligor's adult family home license to operate Evergreen Seasons. Tr. 536-538. These other options were considered and rejected. Arbitrary and capricious action has been defined as willful and unreasoning action, without consideration and in disregard of facts and circumstances. *Heinmiller*, 127 Wn.2d at 609. Where there is room for two opinions, action is not arbitrary and capricious even though one may believe an erroneous conclusion has been reached. *Id.*

The Review Decision and Final Order set forth the Department's position in great detail; it has not taken action without consideration, or in disregard of the facts and circumstances. Action taken after giving an ample opportunity to be heard, exercised honestly and upon due consideration, is not arbitrary or capricious, even if it may be believed an erroneous decision has been reached. *Id.* at 609-610.

Revocation of Ms. Gligor's adult family home license for Evergreen Seasons was appropriate due to the serious nature of the deficiencies and violations found. Tr. 490, 532-542. There is overwhelming evidence that Ms. Gligor lacked the necessary understanding, ability and emotional stability to meet the special care needs of vulnerable adults. She was disrespectful toward her residents and failed to provide them with a positive quality of life. Tr. 490-491, 532, 536-537. She failed to update the negotiated care plans for Richard and Yetta and failed to ensure that they received appropriate care and services to give them the highest level of mental and psychosocial well-being possible. Ms. Gligor's egregious violations and deficiencies caused Richard's wandering behavior and mental anguish to worsen, resulting ultimately in his sudden removal from the home without proper notice or a safe and orderly relocation. She also failed to protect Yetta from the dog. Therefore, license revocation was appropriate because as the Review Judge succinctly stated, "[a]ny one of the rule violations created a serious risk to the health and well-being of the residents." AR 143.

**D. DSHS did not have authority to prevent the relocation of residents to Evergreen**

The superior court erred by concluding that DSHS allowed Ms. Gligor to relocate residents from Evergreen Seasons to Evergreen, which

is Ms. Gligor's other licensed adult family home. There was no evidence presented that showed DSHS made the decision to relocate Yetta to Evergreen or otherwise authorized her relocation. Yetta had a private case manager, Bonita Sykes, and an out-of-state representative who were presumably making her placement decisions. Tr. 108-109, 606-607. There was also no evidence presented about how the other resident, identified as Douglas, came to be placed at Evergreen.

Furthermore, there was no factual or legal basis for DSHS to prevent the relocation of residents to Evergreen and there was no enforcement action pending against Evergreen. Tr. 27-28, 261, 295-296, 355. DSHS could have taken enforcement action against Evergreen to stop the placement of residents at Evergreen if Evergreen were violating licensing regulations that warranted such action. WAC 388-76-10940. But there was no evidence presented of this. DSHS could also have taken enforcement action against Evergreen to stop the placement of residents at Evergreen if DSHS found that violations at Evergreen Seasons were of such nature to present a serious risk of harm to residents at Evergreen.<sup>5</sup> But there was no evidence presented of this either. In fact, at the time that

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<sup>5</sup> WAC 388-76-10985(2) provides that if DSHS finds that "violations in an adult family home are of such nature as to present a serious risk or harm to residents of other homes operated by the same provider," the Department may impose remedies or enforcement action on those other homes. WAC 388-76-10985(2).

licensing action was taken against Evergreen Seasons, there were no residents at Evergreen. Tr. 26-28, 52, 261, 295-296.

Finally, the relocation of residents to Evergreen does not alter the fact that Ms. Gligor committed numerous egregious violations at Evergreen Seasons that warranted revocation of her license for Evergreen Seasons. Even had there been a basis for DSHS to stop the placement of residents at Evergreen, its failure to do so does not mean that the violations at Evergreen Seasons should have been ignored or that vulnerable adults should have remained at Evergreen Seasons.

Therefore, the superior court erred by concluding that DSHS' revocation decision was arbitrary and capricious, because its decision was based on the mistaken premise that DSHS authorized the relocation of residents. There was no factual or legal basis in the record to support the superior court's conclusion that DSHS allowed the relocation of residents or that DSHS had authority to impose a stop placement against Evergreen to prevent the relocation.

**E. Ms. Gligor had notice of the allegation that she failed to protect one resident from another resident.**

The Administrative Procedure Act under Chapter 34.05 RCW requires that the complaint, or in this case, the enforcement notice and statement of deficiencies, "apprise the parties proceeded against of the

violations charged.” *Int’l. Ass’n of Firefighters, Local 469 v. Public Empl. Relations Comm’n*, 38 Wn. App. 572, 579, 686 P.2d 1122 (1984).

Generally, an administrative law judge’s decision on an issue will not be upheld on review if the issue was not raised in the amended complaint, in the briefs, or in oral argument, and no evidence was presented concerning that issue.

*Id.* at 579. “However, where there is sufficient notice and the issue is fully litigated even though absent from the pleadings, the administrative law judge’s decision will be upheld.” *Id.* at 579.

Ms. Gligor received sufficient notice of the allegation that she failed to provide appropriate care and services and thereby failed to protect Yetta from the sexual advances of Richard. DSHS’ enforcement notice and statement of deficiencies clearly raised the issue that Ms. Gligor failed to monitor Richard’s nighttime wanderings into other bedrooms and exposed Yetta to inappropriate contact with Richard. The April 15, 2010 Notice of Stop Placement of Admissions and Revocation of License (enforcement notice) gave notice that Ms. Gligor violated WAC 388-76-10400(2), (3)(a) and (3)(b), by “failing to ensure two residents received appropriate care and services” and specifically incorporated by reference the enclosed Statement of Deficiencies dated April 12, 2010. AR 295. The Statement of Deficiencies cited the provider for violating the care and service requirements under WAC 388-

76-10400(2), (3)(a) and (3)(b) based on allegations that: Richard made sexual advances toward Ms. Gligor and another female resident;<sup>6</sup> Ms. Gligor found Richard naked in Yetta's bed; Yetta reported being awakened at night by Richard standing at her door while the provider was asleep; and Richard was "sexually active" in the home and knew what he was doing. AR 294-307.

Furthermore, the issue of whether Ms. Gligor provided appropriate care and services to Richard and adequate monitoring of his behavior was fully litigated at the hearing. Ms. Gligor's own testimony characterized Richard as aggressive, pursuing sexual relations with Yetta, disturbing Yetta and posing a threat to Yetta. Tr. 34, 36-37, 54, 73, 85, 385, 602-604, 715. Ms. Gligor presented evidence on this issue and her testimony increased the seriousness of her failure to protect resident Yetta. Her testimony showed that she failed to monitor Richard and address his night time needs and as a result, Richard engaged in disturbing and inappropriate contact with Yetta and made alleged sexual advances toward Yetta.

**F. Substantial Evidence Supports The Finding That Ms. Gligor Failed To Give A Proper Discharge Notice And Ensure Richard's Safe And Orderly Discharge.**

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<sup>6</sup> Yetta was the only female resident in Evergreen Seasons Adult Family Home at the time of the investigation. AR 298-308.

Substantial evidence supports that finding that Ms. Gligor violated the provisions of WAC 388-76-10615 by failing to give Richard and his family a proper discharge notice and failing to ensure his safe and orderly discharge. WAC 388-76-10615(2)(a), (3) and (6) provides:

(2) Before a home transfers or discharges a resident, the home must:

(a) First attempt through reasonable accommodations to avoid the transfer or discharge, unless agreed to by the resident;

...

(3) Except as specified in (4) of this section, the home must give notice of the transfer or discharge at least thirty days before the resident is transferred or discharged.

...

(6) The home must give residents enough preparation and orientation to ensure a safe and orderly transfer or discharge from the home.

WAC 388-76-10615(2)(a), (3) & (6).

Ms. Gligor violated the provisions of WAC 388-76-10615(2)(a) by failing to make accommodations to avoid the necessity of a discharge, such as by hiring a nighttime caregiver. Tr. 132. Ms. Gligor also could have requested a psychological evaluation for Richard or could have sent him to the hospital for a geropsychiatric evaluation. Tr. 511.

Ms. Gligor also violated the discharge regulations under WAC 388-76-10615(3) by forcing Richard's relocation from the home without at least 30 days notice and without giving Richard and his family enough

preparation and orientation to ensure a safe and orderly discharge. Tr. 95, 182, 507, 540-541; AR 307-308, 460. In late March 2010, Ms. Gligor demanded that Ms. Larson remove her father by April 1<sup>st</sup>. Tr. 541, 601-602; AR 460. She created a hostile and hectic environment for Richard that forced his family to quickly remove him to ensure his safety and well-being. Tr. 75-76, 147-148, 151-152, 175-176, 194-198, 231. The 30 day discharge notice is important so that the resident and his family have enough time to find another home, make arrangements and ensure a smooth transfer that is not hectic or chaotic. Tr. 132.

## VI. CONCLUSION

The Department respectfully requests that this Court reverse the Superior Court and affirm the Review Judge's Final Order. The Department's stop placement of admissions and license revocation is supported by the evidence and is not arbitrary and capricious.

RESPECTFULLY SUBMITTED this 26<sup>th</sup> day of August, 2013.

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NO. 70411-7- I

**COURT OF APPEALS FOR DIVISION I  
STATE OF WASHINGTON**

In Re:

MARIANA GLIGOR, DBA  
EVERGREEN SEASONS AFH

Respondent,

v.

WASHINGTON STATE  
DEPARTMENT OF SOCIAL AND  
HEALTH SERVICES,

Appellants.

DECLARATION OF  
SERVICE

2013 AUG 26 PM 4: 12  
COURT OF APPEALS  
STATE OF WASHINGTON

I, Lee Ann M. Wilson, declare as follows:

I am a legal assistant employed by the Washington State Attorney  
General's Office. On August 26, 2013, I sent a copy of: Brief of Appellant.

Said copy was sent by regular and certified mail, on the 26<sup>th</sup> day of  
August, 2013, to:

1. Mariana Gligor dba: Evergreen Seasons AFH  
15012 116<sup>th</sup> Place N.E.  
Kirkland, WA 98034

I declare under penalty of perjury, under the law of the State of  
Washington that the foregoing is true and correct.

DATED this 26<sup>th</sup> day of August, 2013 at Seattle, Washington.

  
LEE ANN M. WILSON  
Legal Assistant for Lisa M. Roth

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