

NO. 70411-7-1

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

MARIANA GLIGOR, DBA EVERGREEN SEASONS ADULT
FAMILY HOME,

Respondent,

v.

WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH
SERVICES,

Appellant.

FILED
COURT OF APPEALS DIV I
STATE OF WASHINGTON
2014 JAN 13 PM 1:39

BRIEF OF RESPONDENT

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INTRODUCTION

Opening statement

Your Honors, my name is Mariana S. Gligor, Master's Degree in Teaching and Master's Degree in Education, Certified Nursing Assistant, and provider of Evergreen & Evergreen Seasons Adult Family Homes since the year 2000. Prior to opening my home for business, I taught thousands of students from kinder garden to high school in Seattle, Renton, Mercer Island, Ann Arbor, Michigan, and Phoenix Arizona. Took care of hundreds of residents in "Sunrise," "Kirkland Lodge," and "Issaquah Nursing home."

On April 15, 2009 DSHS revoked my "Evergreen Seasons" license due to one complaint **only**, Ms. Valery Larson (V.L.) daughter of subject resident, Mr. Richard Jacome, (R.J.) out of jealousy and revenge.

After exhausting all administrative remedies, I filed documents in the Superior Court pursuant to RCW 34.05.570 (3); Honorable Judge Jim Roger has reversed a portion of the findings of fact and conclusion of law and reversed the adult family home license revocation decision on April 18, 2013.

The department appealed. This is my Respondent Brief to Appellant, DSHS, mailed on September 28, 2013.

In the following I will address the issues Ms. Roth has addressed in the Appellant Brief.

Here are the facts prior to the license revocation. R.J. was admitted to "Evergreen Seasons" on September 22, 2009, after he changed a few facilities from Kirkland Lodge (about five days),

and Kirkland Nursing Home (about two months). He was diagnosed with Advanced Alzheimer, Dementia, Diabetes Type II, and wandering behavior. The Assessment concealed, by his daughters, the many extra diagnoses soon to be discovered: Sleep walker, Sun Downer, Agitated, Anxiety Fits, Exit Seeker and Hypersexual.

Ms. Larson (V.L.) was attracted for months to a male caregiver that worked for me at the Evergreen Seasons Adult Family Home. She would come almost daily to talk with him for hours. When I asked V.L what she is talking about with my caregiver, she would say that “We talk about Dad’s care.” After months of endurance, I had to ask the caregiver to take a vacation with his wife and four children, as he previously mentioned that they would like to do that. Coupled with this situation was the ever increasing care of the resident. He gradually became very difficult to handle. With no significant help from his daughters, doctor, case manager, the resident was left alone, in my total care.

Ms. Larson threatened to call the Department on me if I didn’t keep the resident in my home, as he “likes his bedroom very much.” She turned the phone off during nights, not to be disturbed by her father, who would ask to talk with her as a means to calm him down when hallucinating, and having scenarios of acute fear.

Gradually, about six month after admission, “the resident R.J. became a threat to himself and other people.” Per WAC 70- 129.110 (4) (b) resident becoming a danger to caregivers, was reason for immediate discharge.

In an attempt to help R.J., out of extra compassion, I hired a new caregiver, Ms. Dinisiuc. R.J. ran with his cane to hit her, as she was trying to reorient him to his bedroom.

After the male caregiver was sent home, I could not do anything right any longer in care giving for R.J. Per Ms. Larson, "I made a terribly wrong mistake to let that man go."

Per Notes in Discovery of Ms. Frost, DSHS Investigator, character assassination and professional suitability to do the caregiving job were under attack. Ms. Larson degraded my professional work. I **never** had a professional suitability assassination. Quote from Ms. Frost from Discovery of what Ms. Larson attacked: "MG is the worst caregiver I've ever seen," and she "screams at both of us," "we never knew her personality, **BI POLAR**, much worse" "is Hostile," etc.

With the goal of the license revocation, in a panic mode, the investigator looked at all details and magnified all faults, with a preconceived mindset. Both V.L., and Ms. Cantu, another provider, who happened to visit my house at the time when I asked V.L. to find the resident a new home, had cunningly persuaded the investigator, out of jealousy and revenge, unethically, and in an evil manner, as if work of a "Witch hunt," per Ms. Mitchell, POA of resident Doug Mitchell, who had witnessed the progression of this evil and degraded attack against my great and professional work.

Ms. Frost went so far at the investigation, to take a picture of another resident Doug Mitchell, who sustained a blue eye a few days before. I had called 911 and the family, and advised about his fall, which was not uncommon due his health issues. Ms. Frost asked Mr. Mitchell under a recording camera in his bedroom, "did Mariana hit you?" His x-wife Ms. Geri Mitchell advised me about this terrible insult, and was testified by Ms. Mitchell herself, in the documentation at the IDR in 2009.

The allegations were incorrect, and were nothing but a pact out of jealousy and envy to destroy me and my amazing hard work. This situation with license revocation is been going on since 2009. The significance is that when an individual loses a license, he cannot live in that house or open another one for the space of twenty years.

My approach to health care has always been about being helpful and generous to the extreme. The good work should not be confused or diminished to the discounted line of **not** being capable of taking care of residents. I have proved myself to be a responsible and generous professional. I have been “under the radar” for a long time by now, and I strongly believe that I am clear, transparent, and have an exemplary conduct, if I may say this with a dash of humility.

Ms. Roth’s negative statements in the Introduction about my conducting the adult family home business cannot stand since there is no merit in the allegations. There is absolutely no evidence that I have reprimanded residents R.J. and Y.B., and the care plans were not updated. The family, doctors, case managers and nurse delegator were involved and asked to help with new health changes for the residents, ample evidence was provided at ALJ Hearing. R.J. was discharged by his daughter, as she admitted at the Formal hearing that it was her choice alone to take him out. Immediately after I asked her to find him a home, as he became a danger to himself and others, V.L took him out right away. I did not even have time to type a thirty day discharge letter. The puppy dog was brought in the home at resident Y’s request and pleadings for months. Proper steps to take care of Y.B.’s dog scratch followed, her POA called, and Ms. Sykes, the case manager took her to the doctor, and there are documents pertaining to this issue filed with her doctor, nurse and case manager. Practically, at the first doctor’s visit, the doctor saw the scratch, washed it, and told the case manager to keep it clean only. There was no documentation whether her foot was properly washed at doctor’s office. This issue escalated totally out of

control as a result of hate and jealousy to destroy my character and exemplary reputation. DSHS rushed to judgment by degrading “provider that is lacking understanding, ability and emotional stability to care for vulnerable adults,” by only looking at one complaint that had its roots in hate and revenge of V.L., daughter of R.J. There was no damage to any of the two residents involved during the stay in my care. V.L. had no doctor’s order that the provider was “Bi-Polar,” or worse, yet Ms. Frost jumped in panic to agree with V.L. that the provider is mentally lacking emotional stability and is not capable to manage two residents. I may have looked very tired, after all the nights providing extra care for R.J. This in turn speaks volumes on how people abuse power at great cost. After all, during the lapse of about 5 years, I continued to prove myself as a capable and clear professional, like an open book before all people, and everybody who deals with me respects me. The department allowed new providers to be trained in my home before opening their homes. V.L. was outraged by her own guilt, hate and jealousy, and stirred up Ms. Frost, and here we are today, five years later. Today it is a proven fact that by the grace of God I am capable. During ten years tenure, I helped many mental health and dementia residents in “Evergreen AFH,” with a sustainable and appropriate care, abiding by the WACS, and new rules and regulations. Justice shall prevail, as His Honorable Judge Jim Rogers at the Superior Court has ruled, from a neutral point of view, on April 18, 2013 that the “license revocation for Evergreen Seasons BE REVERSED AND REMANDED.”

II. THERE ARE NO ERRORS IN THE SUPERIOR COURT FINDINGS ON 2/18/2013

The superior court reversed the review judge’s decision, as justice prevailed. The License revocation and Stop placement were reversed! There was no supported evidence to destroy a license as no Bi-Polar evidence followed during the extensive five years period, after which Ms. Frost dropped the conclusions on 4/15/2009. Though the monitoring by the state after that date,

4/15/09, followed in earnest, we have been conducting professional care at the other licensed “Evergreen home,” and continued to have a good reputation with both, the licensors, the residents, and the new investigators.

1. The superior court was right when it found that the stop placement and the license revocation were capricious.
2. The superior court was right when it said the DSHS decision was arbitrary and capricious, as no signs of emotional instability were observed and evidenced. During this five year period I worked in my Evergreen adult family home, as well as in my other occupation, being a solid yet humble professional.
3. The superior court was right when it reversed the review judge’s findings that I did not fail to protect one resident from another, as both residents Yetta Brenner (Y.B.) and Mr. Richard Jacome (R.J.) had no more direct contact with one another, except talking around the table when having lunch or dinner. Those activities were supervised by me or my staff.
4. The superior court was right when it reversed the review judge’s findings that resident R.J. was taken by his daughter to another home, as Ms. Larson clearly stated that it was her decision to move him. Minutes after I told V.L. that R.J. ran with his cane in an attempt to hit my caregiver, she and Ms. Cantu went out. The home where Ms. Cantu

placed the resident charged a fee of \$5,000 per month, while in my home, he was assessed State paid, at a rate of about \$1,500 per month.

5. The superior court was right concluding that DSHS authorized the relocation of the residents from Evergreen Seasons to Evergreen adult family home.

The state realized they made mistakes, and there are some good people within the state, who had the courage to stand for truth. I have proved myself to be a compassionate and caring provider. The state also realized that the punishment was too great, and that I could take care of dementia and mental health people, after all, after Ms. Larson's departure.

III. THERE ARE NO ISSUES PERTAINING TO ASSIGNMENTS OF ERROR

1. The review judge's decision did not have substantial evidence to support the decision warranting license revocation and stop placement.
2. The superior court was right when it concluded that License revocation was capricious and arbitrary, since the same residents, except resident R.J., were allowed to be moved to my other home, Evergreen adult family home.
3. The residents did not suffer any injuries one from another, as a result of my protection and having a system in place, like bells on doors and alarms that would give notice of any resident coming in and going out.

4. The review judge's decision was correct since there was no evidence that resident R.J. was discharged disorderly.

5. Judge Conqlin has ruled on a new allegation that was not in the original department's allegations that I failed to protect resident Y.B. from potential sexual advances of resident R.J. It is a Constitutional right for an accused person to have the right to defend herself, and address the new issue brought in the ALJ Hearing by Judge Conqlin. This Constitutional right was not provided; therefore the amendment 14 to the Constitution prevails in provider's favor.

IV.STATEMENT OF THE CASE

1.Factual Basis for the Final order

Evergreen adult family home open in 2000. Evergreen Season open in 2007. Only Evergreen Seasons had enforcement letters. Tr. 25; AR 293.

The enforcement action that is the subject of these proceedings was only taken against Evergreen Seasons. Evergreen, the other business, was not subject to any enforcement actions. Tr. 261, 295-296.

2.The vulnerable adults

R.J., 81 years old, moved in September 22, 2009 as he changed facilities: Kirkland lodge 5 days, and Kirkland Nursing Home, about two months. On 9/23/09 I called a geriatric nurse specialist,

for assessment and care plan, by Bonnie Sykes, RN & Case Manager. Tr. 607, 623; AR 312-336. He was diagnosed with Alzheimer, Dementia, Diabetes Type II, wandering behavior, and was easily worried or anxious. Tr. 31-33; AR 327, 333, 335. His daughters concealed the many extra diagnoses that, a few days after being admitted, were discovered: Sleep walk, sun downer, agitation, anxiety fits, exit seeker, and hyper sexual behavior exhibited towards females, as “he would also make comments to female out on the street. “This was a change in behavior for him,” per Mr. Hamby, R.J.’s friend in Tr. 426, 427 “At first it was like lost, you know, he was ... Theresa (daughter) told me that he was trying to get in bed with other woman” (at the second adult family home), which is a big no, no.” R.J. tried “to get in bed with this other woman (at second adult family home), and the fellow almost had a heart attack trying to keep him out of there, and Theresa interpreted it as trying to sleep with another woman.” Mr. Leary’s cross examination continued, “More than just I don’t know where my bed is? Mr. Hamby “Yeah.” Tr. 428. For the past 10 years I took care of residents with Dementia. I never claimed to have “awake” staff at night. Tr.144, 163, 336. We had 24-hour care; again, this implies residents rest during nights.

I never stated we had 24-H **awake** staff. When Judge Conklin asked Ms. Frost where did she find the statement that the provider has 24 – hour awake staff, Ms. Frost backed –up by saying she did not remember where she found that statement.

On 10/14/09 I asked the doctor to help with this resident’s check-up and medications. A THS Test was done and thyroid medication was prescribed along with Doss, Snoot, Glipizide, and Seroquel. On 10/16/09 Levothyroxine Sodium was prescribed, in attempts to help him. 10/23/10 I checked with Doctor Anderson for a follow-up appointment. The doctor increased Seroquel from 50 -100mg for agitation. 10/29/09 I called doctor and Buspar was ordered. I spoke and

faxed to Dr. Anderson's office about having difficulty with the patient, who would get up 3-5 times a night. The family said he does sleep walk, and also when he awakes during the night, has a lot of anxiety. 11/24/09 I called doctor to see if Advil PM could be ordered. The resident used to take this medication in the past, as he would get up now 5-6 times a night. I called ER a few times for a Geropsychiatric evaluation by RN and mental health doctors. The ER team called a few hospitals, but there were no vacancies. R.J. was taken to Evergreen hospital and brought back the same day with no extra medications for mental health. On 12/14/09 I called Valery Hudson, an RN delegator, who came to the house to delegate medication for the resident. I asked her for help regarding the resident's SEX DRIVE, and mental health. She recommended asking the doctor to refer the resident for an in home mental health, dementia specialist RN, and dementia doctor. The same request was made to Ms. Davis, RN, state case manager, when she came to assess R.J. Ms. Davis denied, at the ALJ hearing, that I mentioned to her my loaded concerns about R.J.'s hyper sexuality, being an overload case, his being up and going 24-hours, restless, and deserted by his daughters.

GUIDELINES with blood sugar levels for less than 70 or more than 240 and vital signs was established with Ms. Hudson's direction. On 12/15/09 a new medication list was faxed: Vitamin D 50,000U, Snoot, Doss, Seroquel, Proscar, Pacerone, Metropolol, and Flomax, doctor's visit and a printed chart from doctor's office were included. On 1/4/10 I faxed the doctor and I asked for a new Glucometer. On 1/7/10 a doctor meds list was faxed to the doctor. I asked the doctor for Melatonin, as the resident "was up walking at 3:00AM and was very hard on us." On 1/12/10 I called the doctor to order Melatonin. On 1/13.10 I called again and fax order for a new Glucometer. On 1/13/10 I faxed and asked doctor regarding 81 mg aspirin change. The resident's sex drive increased. He came to my bedroom during nighttime, asking to sleep with him. He

pleaded with me and handed me a credit card he had in his pocket to pay. I told his daughters and initially they denied it, saying that “he misses Mom, and not to sleep with you.” A few days later, one by one at the resident’s urging, both daughters ask me indirectly while arranging resident’s clothes in his bedroom, for me to “go ahead and sleep, it is MONEY.... Money in the bank...” Tr.34-37, 56-58, 115; AR 385.

At the time, I stopped folding clothes and I asked Ms. Larson, what exactly she meant, by asking me “to sleep with him, with Richard?” Her response was “I didn’t say anything!” On 1/19/13 PRN medications were delegated by Ms. Hudson for Melatonin, and Buspar.

I called the doctor for help, since the resident was not sleeping, Tylenol PM was ordered. On 1/25/10 R.J. walked to my bedroom during nighttime with his underwear in his hand, naked, asking to please let him sleep with me. I got up, made and fed him his breakfast. Then I made sure that he went back to his bed. Ms. Larson got upset. She denied the resident’s sexual drive. “He is sweet, he is lonely.”

On numerous occasions I called V.L. at night to help with calming down the resident. She helped a few times. After that she turned her phone off, saying “this is your problem and have to work tomorrow. I call the state on you!” Ms. Pinto, V.L.’ sister, would help sometimes, by returning my phone calls, and come to visit the resident during rough nights, and each Friday night was a rough night. On 2/4/10 R.J. went in Y.B.’s bedroom at 7:30 PM. He was found totally naked under covers, waiting for Y.B., a female resident, to go to bed. Y.B. did not see him in her bed so there was no contact. Since there were only 3 residents on the premises, we had no problem to watch them. On 2/5/10 R.J. walked to my bedroom and asked me to please marry him. I was in the living room area. The TV was loud, as all residents had hearing

problems, and Y.B. was deaf in an ear. So I had to **speak loud**. These hearing issues could not be disclosed to the visitors, per privacy rights. Y.B. was watching TV. Cornelia (a visiting caregiver) was in the kitchen. Nobody witnessed me humiliating or yelling at the residents. I was firmly reorienting him **again** that I am not interested in marrying him, and that I am a nurse who takes care of him. If R.J. "looked in the mirror and asked who that man, he looks so sad," and " he never understood that that image was himself," according to Tr. 213, how would he feel "humiliated," or "reprimanded," as the department alleged?

On 2/16/10 I faxed the doctor asking him to help with medication to lower R.J.'s sex drive. I also requested that R.J. be checked by an RN dementia specialist and a dementia doctor in order to get help with a mental health assessment. This was recommended by the RN Delegator, Valery Hudson. On 3/9/10 the doctor's order changed Seroquel to 25mg, Ativan, D/C Bus par as urinalysis were done. On 3/17/10, the Levothyroxine prescription for thyroid was added to the pile. On 3/17/10 the resident went to the doctor's office to check his thyroid gland.

NEW ASSESSMENT and CAREPLAN: I called Ms. Sykes, RN, to prepare an updated assessment with new care plan. R.J.'s daughters would **not** pay for the in-home mental health RN to help with resident's challenging conditions. I recommended a geriatric specialist doctor. Actually, I went and talked with a director of a clinic in the Kirkland area to help me with taking care of R.J. Doctor Smith would have admitted R.J., as she knew me from taking another resident to her office. Even though Ms. Larson knew that it was quite difficult to help the resident R.J., she did not want to move him, as this change would have taken too much time for her. On 3/22/10 a new caregiver was hired in a final approach to keep the resident on the premises as he would continually weep and plead with me to keep him in my home. From 3/22/10-3/24/10, Silvia Dinisiuc, helped me, as I was in meetings, but available by phone. . She

called me to come home to help with R.J. as he was nervous, spit on her, called her names, and ran to hit her with his cane. When I arrived home the resident was on his couch watching TV. I put him in bed, and gave him his night medications. I did not call 911 in an effort to not put extra stress on him. IMMEDIATE WRITTEN NOTICE - WAC 70-129.110 (4) (b) was given when the SAFETY of the individuals in the AFH would be otherwise endangered.

R.J. had a toilet inside his bedroom, with a light on 24/7, so he could not wander around the house for toileting. When he wandered in the house, **he was an exit seeker**. I never told Ms. Frost “if you don’t overmedicate him, then you can’t deal with him.” Tr.126; AR 304. As is her habit, Ms. Frost continued to mischaracterize me; this accusation cannot stand. And when I asked for Discovery notes, many lines and words were blacked out, so I could not read them. Edited notes in a legal document. The caregiver left in December 2009, Tr. 125-126, as V.L. came and talked to him for hours, almost daily, disrupting the working environment. Everybody involved with R.J.’s care was asked to help: the doctor, RN delegator, RN case manager, licenser, daughters, etc. When resident was up 24/7 and resident needed a night AWAKE staff, then at any level of pay, private or state, additional funds have to be allocated. At a \$1,500 per month rate, there were not enough funds to cover the day shift, let alone the night one. Even so, I made best efforts to hire Ms. Dinisiuc, in a final attempt to keep him.. “To find it inappropriate, to ask for pay for a night caregiver,” should not be misconstrued by Ms. Frost Tr. 126-127 AR 304. In a nursing home the R.J.’s care would cost about \$10,000 per month.

R.J. was an active wanderer, an exit seeker. However, we had a loud alarm installed on his bedroom door that would let us know anytime he was getting out of his bedroom, 24/7. On February 4, 2010, around 7:00PM I found R.J. naked in Y.B. bed, under covers. Tr. 36-37, 67-68, AR 385, 455. My concerns only intensified about R.J.’s hyper sexuality, and how there was

no WAC on how to respond in helping, no medication available for this specific issue. Dr. Anderson admitted my fax was enough to put him on notice, Tr. 435 line3 -17 “I believe to the best of my knowledge, we received this fax, yes.” I asked Ms. Hudson, the RN Delegator, Ms. Sykes, RN, Ms. Davis, RN, state case manager, and the family of R.J. to help manage the hyper sexuality with no avail. All the time, my caregiver(s) and I, were aware where he was roaming, and heard his footsteps pretty loud on hardwoods flooring when in wander mode. Y.B. was protected from R.J.’s sexual advances. Tr. 115, 117; 516-517. Yetta told both Ms. Sykes and me that R.J. entered her bedroom, which was in his habit to do so while being an exit seeker. This was during the day, mainly, while Y.B. was watching TV in the living room area, from 9AM to 7:00 PM. Ms. Sykes visited briefly when needed only for professional reasons, however she was not on the premises 24/7 to report that R..J. was walking naked in Y.B.’s bedroom. Tr. 625-626, 653-655, 674-675. Ms. Sykes said that one time R.J. was seen at 3:00AM by Y.B. in her bedroom, then another time she said “she does not remember,” whatever Y.B. told her. “Yetta just said he came into her bedroom, but he was clothed. “ Tr. 625 V.L.’s response to this issue was “he is sweet, he is impotent.” V.L. gave both of us, “glaring, spine-chilling stares” Tr. 624 Ms. Sykes also asked if the state had training dealing with hyper sexuality combined with dementia Tr.656 When Ms. Petersen asked Ms. Sykes if she would have called the hotline after dealing with hyper sexuality, the response was “No, as provider works with doctor, family, etc. to redirect, and monitor.” Tr. 658. Ms. Sykes continued, “I think, though—again, you can’t anticipate, you know a demented person and what they are doing in the moment.” Tr. 669 And yet, continued Ms. Sykes, demented people **have lucid moments** when they remember things, (long term memory), as with R.J. remembering his wife. Tr. 670, line15-20. In this context, Mr. Leary stated “He may be confused about certain parts, acting intentionally in terms of thinking

that he wants to have sex with Yetta, or it could be a part of dementia, or it could be a combination of all the various factors; is that accurate? Ms. Sykes, responded: "Yes." Tr. 670. This response resonates with my provider's dealings with R.J., and yes, I have been dealing with demented residents for over 10 years. Ms. Sykes has not seen provider say anything demeaning towards R.J. or inappropriate about him in front of him or anything like that. Tr. 661. The incident with R.J. when he urinated on the floor, intentionally, was a lucid moment of dementia. He had never done that before, or after that time. It was a reaction to the response of the same conversation we had for a long time, asking to marry. Tr. 178, 180. R.J. exhibited daily anxiety, paranoia, acute fear, which at times made him visibly shaking, as dementia and the other ailments progressed. Ms. Larson resisted taking her father to the dementia RN & doctor specialists, or talking to him during nights when needed, yet she liked creating conflicts. This was common behavior with both R.J and V.L., trying to get attention. AR 456.

Ms. Frost got my words mischaracterized again, when she said that I humiliated R.J. in the front of the residents. However, Y.B. was watching loud TV (deaf in an ear), and Doug Mitchell, was hard of hearing. I had to reorient R.J. and be firm with him about his unexpected behaviors. The phrase "Wouldn't you do that?," would be only appropriate to say in this situation, reorienting, firmly, R.J. Tr. 136

On January 2010, Ms. Hudson, RN delegator, was asked for help with R.J.'s behaviors and progression of dementia. At my insistence, she recommended and I faxed to Dr. Anderson the request to have an in-home dementia and mental health RN and doctor to help. Tr. 464-467, 469, 476. It is a fact that the daughters resisted and did not want to have any in-home mental health services for R.J.. It was not the case that "I did not obtain them, or asked for them," as Ms. Roth eludes. Providers cannot diagnose residents, as the family was in denial that their dad

needs mental health in the home to better address his magnifying issues. When Judge Conklin asked Ms. Sykes, the geriatric nurse, what would have been the appropriate way in handling R.J.'s hyper sexual behavior, Ms. Sykes's response was "to redirect him, to call the doctor, the family, monitor the situation. The family did not engage my services. " Tr. 666 Practically, I was left alone to care for R.J.

Dr. Anderson saw R.J. in person during his five visits. Faxes and follow-up phone calls increased progressively. Tr. 436, 442-443. He had a referral to evaluate R. J. by a licensed mental health counselor and a psychiatric nurse practitioner, per my continual request. Tr. 437, 447, 455, 459. However, the daughters did not want to pay for the services, in denial that their dad does not need that." Tr.448 After R.J. became a threat to Ms. Dinisiuc, on 3/21/09, as she was trying to redirect him to his bedroom, he spited on her, and ran after her, trying to hit her with his cane. At this point, as I told V.L., we could not provide for him any longer. As he became a danger for my caregiver, he was immediately discharged by his daughter. V.L., who admitted at the ALH that it was "her decision to immediately remove her dad out."

Ms. Davis, a nursing consultant for the state, did an assessment for R.J. on February 8, 2010. At that time I asked Ms. Davis for help with a night caregiver, as the provider "did not sleep 5 hours of sleep during an eight-hour period." Tr. 7 "Correct, that's the answer down? Correct." Tr. 408 Ms. Davis denied I advised her about R.J.'s sleep-walk during the night, as dementia with sundowners, and hyper sexuality issues had escalated his level of care. Ms. Davis shrugged her shoulders, and moved on to another page in the assessment, leaving the raised question unanswered. I continued to call her, and leave messages from my cell, to her direct number, asking for support and assistance with R.J., or else, how could I have asked Ms. Hudson, Ms. Sykes, and Dr. Anderson for help with R.J.'s hyper sexuality and sleep disorders, and not asked

Ms. Davis at the assessment, about these ardent issues? If she was concerned about the provider not being able to help dementia residents, how come she did not follow-up with another unannounced visit ? Ms. Davis said at the records examination at the ALH, on 10/5/09 that the provider had tried only one medication with the resident, Tr.417, and continued, “The use of psychology to deal with sundowners is a possible tool.” TR 417 This feed-back ignored completely the dynamics of caregiving, from one person’s point of view, versus practicum experience. Ms. Davis said that she could not change the assessment unless the condition changed, yet did not updated the assessment either at that time or at a later date, or after my calls put her on notice. She also mentioned that “**people with dementia have periods of lucidity** and therefore, R.J. was able to understand some things we were talking about, at the table when initial consultation was done.” Tr. 379

I had called and faxed to Ms. Davis pages asking for an assessment update, bringing up all the conditions of R.J., asking for a night caregiver, and increased pay, as the rate of \$1,500 was very low.

After months of no rest, I felt very tired. Yet, I went ahead to hire another caregiver, Ms. Dinisiuc, believing that the next day something would happen, so both R.J. and I could sleep during nights. My health was at risk by getting too stressed out. There were no WACS so far, that protect the providers. Fortunately, there are these types of hearings, where the providers can speak to get help, if they have enough courage to stand!

Dealing with a delayed system with no significant help from doctors, and case manager on one hand, and defiance and resistance from resident’s family members, who practically refused to help, on the other hand, R.J. arrived at the right conclusion himself, of being a

danger to others, spitting on Ms. Dinisiuc, and running to hit her with his cane. I could have called the police right away, but I decided to wait till the next day, to advise his daughter, V.L. Within twenty – five minutes after that, Ms. Cantu came to the house, went out with V.L., and R.J., and found another home, where he was placed the very same day. I had no time to write a thirty day notice, and technically, I did not have to do it, since he became a danger to us, per WAC .70-129.110 (4) (b). Tr. 602-603, 710. That was the time V.L. was advised that R.J. had to move out, imminently, as Ms. Dinisiuc was there, testifying to V.L. Tr. 685

Ms. Cantu, V.L, R.J. went out, and started talking in the driveway. Per Ms. Cantu, “I recall her saying this is inappropriate for you to be here discussing the matter here in these premises,” Tr. 249, and “why did you not bring the party back into the house and we all could have discussed this situation.” Tr. 251 Per Ms. Cantu at the ALJ hearing, “Ms. Gligor did not yell at Ms. Larson. Ms. Larson yelled, defending herself to a statement that was made.” Tr.242

From my point of view, Ms. Cantu should have asked both of us, as she stated that she wanted to help both parties, to brainstorm and figure out the best route for the situation, inside the home, and not in a parking lot. As she was a visitor only, she was not in the position to take over the situation, and manage it, so to speak, taking R.J. and V.L. right away to another home.

V.L. was very troubled, and denied Ms. Dinisiuc’s testimony on R.J.’s behavior. At ALH she never admitted her father was discharged from the second adult family home and placed in a lock unit in a nursing home, because of sexual misconduct.

At the ALH Ms. Dinisiuc testified the truth. R.J. spit, and threatened her, and **became a danger** for the other residents, and caregiver. No letter was needed, and after all, V.L. adamantly affirmed that it was her decision to remove him from the home. Tr. 204, 198.

Ms. Frost came loaded with misinformation by V.L.'s complaints, with a predetermined mindset to revoke the license. Ms. Larson's motivation sprang out of rage of me letting the male care giver go, with whom she visited daily at my house. Ms. Larson wanted to make sure that she managed to destroy my professional reputation and work record. Ms. Larson blew the details out of proportion and made a mountain out of a mole hill. However, Ms. Larson's words did not match her self-declared good will to help or to be awakened during nights to talk to her own father who would have acute fear attacks, and would constantly ask to talk with Ms. Larson. She chose, instead, to turn her phone off during night time and reminded "me that to deal with him at night was my job." After that she felt guilty for not helping her own father and for not cooperating, but she then dealt with her guilt by attacking me and my provider's services.

Resident Y.B.'s care was under control. I recommended Ms. Sykes to help with mood swings, and behavior. Both the RN and I took Y.B. to Dr. Rappaport, who prescribed Abilify 10 mg, and had regular visits to his office. Y.B.'s behavior has drastically improved as Dr. Rappaport stated in his letter, "doing good under provider's care." Y.B.'s assessment and updates of about three hundred pages were uploaded with care plans on how to address her manic and impulsive health issues along with pages of direct studies from specialty books, and directions from the RN, case manager, Ms. Sykes. Even when resident R.J. assessment was not immediately updated, as his daughters did not pay Ms. Sykes, I went ahead and provided everything the doctor prescribed. R.J.'s doctor and I were in constant communication to help him as his Alzheimer and additional health problems gradually progressed.

Ms. Frost cited me with lacking ability to provide care and services to vulnerable adults. It bears repeating that I took care for over ten years of the residents diagnosed with dementia, and mental

health issues. I also took about three hundred clock hours in dementia and continuing education training, during the ten years interval of working in the field.

Y.B., per her POA, wrote her a note at her own free will, and she continued to write daily notes, as means of being appreciated and to get attention. Y.B. told me and her POA that day that writing in the journal made her feel better, and it did. The POA from New York was always informed about Y.B.'s journaling, and stages of caustic behavior, as Ms. Sykes classified at ALH 43-44, 121, 644-646; AR 378-380. When out of control behaviors escalated, I called doctors, re-directed, and increased personal attention. She was seeking attention, and gratification, most of the times. I dealt with this by giving her small gifts almost daily, and allowing her to vent her feelings. It always worked with Y.B. After the feelings were vented out, she would feel better. The dementia residents were not interested about reading the facility notes, or facility's notebooks, even when having lucid moments. Y.B. would have daily many **outburst attacks**, and screamed at everything for no reason. Ms. Sykes helped locate a psychiatrist, to help us with her screaming, and mood-swings. We went to Dr. Rappaport, and Abilify helped improve her moods, making her feel good, along with having a puppy, Sparky. "I've never seen her happier. I have never seen her as well-balanced. And I have never seen her as tranquil at this time of her life," per Ms. Sykes, Tr. 638. Y.B.'s foot was under professional care, directed by Ms. Sykes, RN, who was available during the entire time, when needed. Everything was under control. Ms. Sykes was informed, and she went and bought a journal for Y.B. in order to ventilate her feelings, most of them caused by her trauma in the car accident. Tr.663 Ms. Sykes, a geriatric RN testified that "she thinks provider does a very good job," Tr. 639. The same qualification was given by Dr. Rappaport in his letter of reference, "provider does a good job with re-directing," as patient moods improved. The same attributes were expressed

by the POA, Claire O'Connor, in her three letters of recommendation. When Mr. Leary asked Ms. Sykes, "would you agree or disagree with the statement that Mariana is incapable of caring for people with dementia, the response was "I would disagree with that." Tr. 640 Ms. Sykes continued, "She is a good provider. I have faith in her. I think she does a very good job." Tr. 640 "She's very loving, she's very outgoing, and she has a zest for life." Tr. 641 Y.B.'s writing her feelings helped her improve her behavior. It actually worked very well. The three months old puppy, Sparky, was a joy for all the residents and the family members. The puncture in Y.B. foot was washed by the doctor. We don't know how it was washed. Y.B. foot was well taken care of, and both Y.B. and R.J. adamantly agreed to have Sparky with us, on the premises, after the incident.

Y.B. continued to stay with us for about three more years after that, and Sparky behaved well, and we had no more problems of this sort. Our approach to help Y.B., as providers, is not expected to be as that of a doctor to diagnose and have therapeutic sessions in home. Also, we called 911 for about five times during her stay, when Y.B. had to see immediately a licensed doctor, and was admitted to the hospital about three times during her stay. Y.B. was directly seen and treated by her case manager RN, Ms. Sykes. This is quite rare for a resident to have so much professional attention and help. Therefore, Ms. Sykes took care of her doctor's appointments. The specific mental health approaches for Y.B. were directed by her psychiatrist, Dr. Rappaport, whom I called many times during her stay. It all boils down to Y.B. thriving under my care, per Ms. Sykes, and Dr. Rappaport. AR 302-303. Our assessments were updated, most of the times, right away. And even when we did not immediately make changes on the papers; we did administer the medications and addressed the needs as prescribed by the doctors. The safety of the residents was always of high priority in the care we provided. Sparky was trained to obey

commands by both Ms. Sykes and me, and he continued to be an adorable dog, gentle, small, intelligent, and good with people. My techniques to manage Y.B.'s behavior were easily assimilated, as we always found practical ways that worked with her at a specific time. There was no technique that fitted her all the time, like a glove. Tr.47-48; AR 358-380 My techniques were praised by a specialist doctor, Dr. Rappaport, and Dr. Fernando, who thought Y.B. was thriving in my care.

3.The enforcement action

The DSHS license revocation was, per Judge Rogers and defensive attorney Mr. Leary, arbitrary and capricious. At ALJ hearing R.J.'s discharge reason for "becoming a threat to himself and other people," was exposed by a witness other than me, by Ms. Dinisiuc, and was enough proof of how dangerous he was.

The dog scratch on Y.B. was completely healed and under control. The house was always clean, per a host of witnesses at the ALH: Ms. Sykes, RN, Ms. Hudson, RN, Mr. Gustafson, Ms. Cantu, Ms. Mitchell, Mr. Mitchell, and all visitors. Only Ms. Frost took the camera, at V.L.'s admonition, to take pictures of the dog's poop under the beds, and she found none. DSHS cited my ability to provide care and understanding to vulnerable adults, only to allow me to get them moved from one home to another. I could not have done it without the department's approval. After all, there was no Bi-Polar problem, and the residents continued to do well at the other home, and Sparky continued to be one of the reasons the residents loved to be with us. Tr. 171 Ms. Frost accused me of being "hostile," yet when Ms. Petersen asked Ms. Cantu when she saw me being hostile, Ms. Cantu said she "never said that." Tr. 232

R.J. was not reprimanded, but redirected. There were no witnesses to prove that I yelled, screamed and reprimanded him. It was Ms. Cantu who stated that V.L. yelled at the provider. R.J. made sexual advances was hypersexual, and he was found, later on, in another female resident's bed, under covers, at the second home where he was placed, and finally locked in a dementia unit for committing sexual assault. Yet, V.L. covered it up, and denied it, by saying in the ALJ hearing that he was doing good, always in denial, as was her habit. V.L. testified at ALJ hearing that R.J. was "like children, and urinated on the plastic flowers at the nursing home where he was."

Patients with dementia were not treated like children. Children don't need assessments, doctors, or medications. It was an inartful comment only, and not a practical application. Tr. 398, 533-534, 588-589, 591-592. Dementia residents have moments of lucidity, as agreed by Ms. Davis, RN, case manager. R.J. was sexually aggressive, as evidenced by being transferred in a nursing home, and not scolded and reprimanded, but redirected. The home was clean, professional, and not chaotic. Yes, I was talking loudly, as all residents were hard of hearing or deaf in one ear. The three month old puppy had a good temperament with people. The POA and case manager of Y.B. were advised after the incident, and Y.B continued to play with Sparky about three years later, with no more incidents. In this context, there were no more bites. AR 301

The negotiated care plans were updated, and practically speaking, providers who are not doctors to prescribe medications, etc., can resort to the same measurements, such as redirections, firm limits, and engaging all parties involved in the care. Ms. Sykes made changes to address assessments, and she came almost daily when needed and took care of the paper work.

Residents have the right to exercise their rights and sleep in their daily clothes at bedtime, if they like to. AR 302. Y.B. assessment and care plan was all in one, and addressed issues from the very beginning along with approaches on how to deal with her. The assessments were seen and acknowledge by Ms. Sylvester, our licensor. AR 302 Y.B.'s approach to ventilate her caustic feelings in notebooks, was working well with her, and that was why she "thrived in my care," per Ms. Sykes. We actually had lots of activities, taking the residents for birthday outings, for tea or coffee, to restaurants, and they were thriving physically, per Ms. Cantu in ALJ hearing, who described these activities in her testimony. Ms. Cantu "had no concerns about her ability as a provider." Tr. 254 "I saw joy in the residents' interaction with the dog" Tr. 240 Again, with R.J.'s care plan and reorientation at any hour during night and day, we called his daughter(s), and offered food. This approach was on the assessment, and care plan. R.J.'s case manager, Ms. Davis, was advised about all his needs, and she did not either offer advice, or any plan of action. As he had to have a 24/hour awake staff, and I have mentioned that "provider did not sleep 5 out of 8 hours sleep," she did not increase the rate to afford a night wake staff. Even at \$1,500 month rate, for a 24/7, I hired Ms. Dinisiuc, in an attempt to help, yet R.J. became a danger to my caregiver. Proper steps to provide for R.J. were taken, yet the parties who should have come to help have deserted or simply ignored the call to get involved and help. Finally, V.L. stated in ALJ hearing, it "was her choice" to remove him immediately. Per Ms. Cantu, it was V.L. who screamed at the provider.

B. Procedural History

On April 15, 2009, DSHS issued a stop placement and license revocation for Evergreen Seasons,

Citing the following WACS:

1. WAC 388-76-10020 (1) License ability to provide care and services
2. WAC 388-76-10220 (2) (3) Incident log
3. WAC 388-76-10230 (2) Pets
4. WAC 388-76-10380 (2) Negotiated care Plans – reviews and revisions
5. WAC 388-76-10400 (2) (3) (a) (b) Care and services
6. WAC 388-76-10615 (2) (a) (3) (6) Resident rights- Transfer and discharge

At the administrative Hearing in October 2010, Judge Conklin ruled on a new allegation that **was not** an initial allegation of the department that, “resident Y was endangered by not being protected from sexual advances of resident R.” In this context, I did not have the Constitutional right to address this new allegation, at the A L Hearing, yet the license revocation was finally addressing this new issue, as the witnesses helped clear parts of the allegations.

On December 8, 2010, and September 7, 2011, petitions were filed for review of initial finding with DSHS Board of Appeals, to follow the steps of the legal system provided.

I continued the process at the judicial review at the King County Superior Court. On April 18, 2013, the Superior Court Judge James Rogers reversed initial judge’s findings as I was not given notice of the allegations that I failed to protect one resident from another resident, and that I failed to provide a discharge notice to a resident, as he had to be discharged, immediately, per WAC. His daughter firmly stated at the ALJ hearing it was her choice to remove R.J. CP 1-4. Judge Rogers also reversed the license revocation.

V.ARGUMENT

A.Standard of Review

The appellant stresses this is an adjudicative proceeding under the Administrative Procedure Act (APA) under RCW 34.05 limited to "Appeal Review Judge" entered on September 7, 2011. The appellant also brought up the Superior court Judge Roger's findings, when the license revocation was reversed, on 2/18/13.

The appellant has failed to demonstrate by clear and convincing evidence or by the preponderance of the evidence that I failed to be professionally unfit, after eleven years of working as a managing provider. The burden of proof is on the appellant. So far the appellant has failed to be convincing. It is a fact that the DSHS allowed the transfer of the residents from Evergreen Seasons to Evergreen adult family home. An emotionally unstable provider would not be capable to keep things in balance. Furthermore, Ms. Frost does not represent the voice of the two licensors and new investigators who have made many unannounced visits to my home during the five years interval, and found no reasons to revoke the other license. For a few years after the incident, I hired a live-in LPN, and later had, for a few months, a RN live-in on a PRN basis. Both helped and helped proved the big picture that I strive for a professional image. Justice stands on its own grounds. Light engulfs the darkness, which dissipates darkness. In my case Justice prevailed when Honorable Judge Rogers, at the Superior Court, reversed the license revocation on April 18, 2013. His Honor has ruled from a neutral point of view! WAC 388-76-10940 states that the Department take one or more of the following actions in any case which

the department finds that an adult family home failed or refused to comply with the applicable requirements of chapters 70.128, 70.129, or 74.34 RCW or this chapter: (1) Denial of an application for a license (2) Impose reasonable conditions on a license; (3) Impose civil penalties; (4) Order stop placement; and/or (5) Suspend or relocate a license

RCW 70.128.160 (1) WAC 388-76-10940 clears the condition to when the

Department authority to take actions: in response to noncompliance or violation if provider

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

Per Mr. Leary, in “Closing Argument of the Appellant” page 5:

“The Department is required to impose one of the aforementioned remedies when the violation pose a serious risk to any resident, are recurring or are uncorrected. WAC 388-76-10945.

Nowhere in the regulation is there a requirement that the Department resort to license revocation in her situation. In evaluating the allegations made by the Department it is important to recognize that hindsight provides a biased perspective. When the outcome is known, it is easy to analyze and dissect a series of events and say what could have been done, what should have been done. Such a retrospective analysis ignores the realities of and the dynamics of caregiving. The testimony of complaint investigator, Ms. Frost, and the questions raised by Judge Conklin highlight how individuals look at the same set of facts and raise opposing questions. Ms. Frost concluded that there was no basis for Ms. Gligor to conclude that R.J. was acting sexually and that there was no basis for discharging him from the home. At the conclusion of the testimony,

Judge Conklin questioned whether Ms. Gligor waited too long to discharge R.J. given his behaviors. The scrutiny applied at a later date to analyze the propriety of a provider's response must consider what information was available at the time of the incident, not what was learned later. Further, the analysis must account for the role of the provider. The provider cannot make diagnoses and is dependent on the resident's medical provider and decision makers to respond and help address the resident's conditions."

The DSHS Board of Appeals, and the review Decision and Final Order followed, biased, the department's allegations.

The Appellate Court may grant relief from an agency order in this case based on RCW 34.05.570 (3), where the agency erroneously interpreted the law. The order was not supported by the evidence "that is substantial evidence in light of the whole record before the court," and the order is arbitrary and capricious." *Tapper*, 122 Wn.2d at 407.1.

1. Review of factual matters

The administrative record bases its findings on "Judicial review of facts confined to record." RCW 34.05.558.

The Court affirms challenged findings that are "evidence 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).

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*

“Evidence that is substantial when viewed in light of the whole record before the court.”

Hearings Board, 136 Wn. 2d 38, 46, P.2d 1091 (1998)

The appellate Court determines only if the evidence to the prevailing party supports the challenged finding. *Dep’t of Rev. v. Sec. pacific Bank*, Wn. App. 795, 803, 38 P.3d 354 (2002).

RCW34.05.464 (4) requires the reviewing court to give “due regard to ALJ’s position to observe the witnesses.” *Kabbae v. dept’s of Social and Health Services*, 144 Wn. App.432, 192 P.3d 903 (2008)

The judicial review of disputed issues of fact shall be conducted by the court without a jury and must be confined to the agency record for judicial review as defined by this chapter, supplemented by additional record.

RCW 34.05.570 ... (3) reviews with fresh eyes the “Review of agency orders in adjudicative proceedings. ... (e) that “that (the Initial order) was not supported by evidence that is substantial when viewed in light of the whole record.”

2. Review of questions of law

The RCW 34.05.570 (3) (d) states that the Judicial review formed by the Appellate Court, reviews to whether the (d) The court shall grant relief only if it determines that a person seeking judicial relief has been substantially prejudiced by the action complained because,

the (d) The agency has erroneously interpreted or applied the law, and (i) The order is arbitrary or capricious.

Issues of law are subject to *De Novo* review by the Court. *Bond*, 111 Wn. App. At 572.

The Court reviews *de novo* both the agency's conclusions of law and its applications to facts vs. hearsays. The Court can modify conclusions of law when the ALJ judge or the department "erroneously interpreted or applied the law." RCW 34.05.570(3) (d), *Heinmiller*, 127 Wn. 2d at 601

3. Substantial evidence supports that the department decision to revoke my license was arbitrary and capricious and not supported by the evidence.

The APA standards allow a reviewing Court to review an agency decision when it was arbitrary and capricious. *Bond*, 111 wn. App. At 572; RCW 34.05.570 (3) (i). When an accused person is not given the Constitutional right to defend herself, clearly constitutes abuse of powers, and there is no room for two opinions. *Hillis*, 131 wn.2d at 383. The Review Court could only view the initial order followed by department review judges' orders as biased, arbitrary and capricious.

1. DSHS has failed to demonstrate that there was an adequate basis to revoke the Evergreen Seasons AFH license. As noted in closing arguments of the appellant -12, Mr. Leary states that Judge Conklin had the authority to review the department decision based on the Department allegations originated on 4/15/09.

2. The order, or the statute or rule on which the order is based, is in violation of constitutional provisions on its face or as applied RCW 34.05.570

Mr. Leary in Closing Argument of the Appellant -8 states that it is “a fundamental provision in the Constitution that an accused person must be informed of the charge he is to meet at trial and cannot be tried for an offense not charged. Const. art. I #22 (in criminal prosecutions the accused shall have the right to demand the nature and cause of accusations against him). Failure to put the accused person at notice of what charges he must face so he can answer the charge and prepare his defense requires dismissal of the charge. *State v. Rhinehart*, 92 Wn. 2d 923, 928, 602 P.2d 1188(1979). The court dismissed the charges as the accused was charged with possession of a stolen car when he had in possession only a car part.”

In the light of the WACS and regulations, Honorable Judge Rogers at the King County Superior Court stated that “Ms. Gligor was not afforded due process on the allegation that she endangered a resident Y., by not protecting her from sexual advances of resident R. The Court reverses Conclusion of law 5&9 as Ms. Gligor was not given notice of the allegation. The defense was clearly surprised, as noted in closing argument and appeal briefing by Mr. Leary.

3. The agency has erroneously interpreted or applied the law (RCW 34.05.570)

In this context, Honorable Judge Rogers continued by stating: “The Court reverses Findings 20 and Conclusion 17 that Ms. Gligor failed to give a 30 day notice letter as not supported by evidence. R’s daughter Valerie Larson clearly testified that it was her idea to move her Father on the same day that Ms. Gligor stated that she had intended to have R move, and thus Ms. Gligor never had a chance to issue a 30 day letter. Report of Proceedings at 198; 204. The findings

completely ignore this evidence, which is contrary to the finding, and makes no attempt to reconcile it.

The Review Order attempted to address this other evidence on the 30 day notice, but in part by citing (at 16) the February incident, as if this could be considered for why Ms. Gligor failed to give notice in March. But the Department did not charge Ms. Gligor with failure to give R's family notice to move him in February 2010 (even though it was in the report attached to the Notice, Ex2), and as a result the Administrative Judge declined to even consider it as a basis for revocation. Conclusion of Law 16. The Review Order nowhere addresses this issue of notice."

Mr. Leary, in Appeal to the Board of Appeals-6, condensed findings in: "According to Mrs. Larson, she was the person who made the decision to remove the resident R from the home, and there was no discharge. Without a discharge, there can be no violation of the notice requirements. The Department failed to prove its alleged violation of WAC 388-76-10615."

4. The two subject residents had Negotiated Care Plans and Updated Negotiated care plans that addressed their continually developing, health needs. Even when resident's Y.B.'s care plan was not immediately updated per her private RN & Case Manager, who had her foot scratch under control, she came to see and monitor Y.B.'s progress every other day. I followed up with all prescribed directions from the RNs. At the first visit the doctor's assistant washed Y. B.'s foot and sent her home without any medications. It was not determined how the doctor's assistant washed her foot.

With regards to resident R.J., his daughters were in denial that he needed updated assessment, and refused to pay for any additional assessments. Ms. Sykes updated it anyways, at my advise,

and brought hundreds of pages on specific health issues from Web MD or related web sites, with regards to health issues and how to treat them. Ms. Sykes went to the extent to meet with me and other caregivers to help both subject residents, and we got training that only a few providers would ever take. We filed printed books with pages of specialty knowledge in the files of Y.B. and R.J. The nurse delegator, Ms. Valery Hudson, RN, MSN, came and delegated R.J.'s medication and provided extra pages on diabetes and related areas. At my request and disclosure of the facts about R.J.'s hyper sexuality, and Alzheimer's progression, she had recommended a mental health RN to come to the house to prescribe medications and monitor the resident. The doctor was informed by faxing about 25 pages, overall. However, it was again, the daughters who did not follow doctor's orders. R.J. was sent to ER for a geropsychiatric evaluation and medications review by a specialized psychiatric doctor. The 911 made a few calls, and there was no room available. However, he was sent to Evergreen hospital, and brought back the same day, without any additional prescriptions or medications.

Per Dr. Rappaport, we took Y.B. to a psychiatrist and specialist who helped improve the mental and behavioral responses in her, by prescribing Abilify. Every month I called the office, reported how Y.B. was doing, and together with the doctor continued to increase or decrease the dosages.

We managed to help Y.B. improve her overall reactions and her feelings of **feeling good** increased in a remarkable progression. There was no evidence of the alleged violation of WAC 388-76-10380(2), since we kept the documents up to date, with exception of a few occasions when even if not immediately updated in the book, we continued to administer the proper support, and advised all parties involved in the caregiving of the residents about the new needs and their progression. Per Ms. Sylvester at the ALJ Hearing, when Mr. Leary asked her at the

annual inspection on October 27, 2009, if she had problems with the assessment and care plans, she responded “I did not have any issues with that.” Tr.281 Overall, Ms. Sylvester was “to be pretty fair with providers,” per Mr. Leary at the ALJ Hearing.

B. EVIDENCE

4. Specific Findings of Fact were not supported by the testimony of the witnesses or the evidence produced at the hearing

Given the nature of the violations and the background in which they were looked at with magnifying glasses, as the provider was labeled “incompetent” by the evil pact doer, V.L, the Department has not convinced and proved that the license revocation was the greatest and final punishment for “the crime” of taking care of R.J., who was practically deserted by his own daughters, and not significantly helped by the parties involved in his care. The Provider has not failed or refused to comply with the laws governing the adult family home, and WAC 388-76-10940 clearly stated the reasons for a license revocation. Furthermore, I continued to provide for Y.B. and Doug Mitchell (D.M.) at my Evergreen home, for approximately three more years, after the Evergreen Season’s license revocation.

Per Mr. Leary in Appeal to the Board of Appeals-8:

“The following findings of fact are not supported by the testimony of the witnesses or the evidence produced at the hearing: Findings of Fact (“Ms. Gigot’s intent was to reprimand R for his inappropriate behavior”; 13 (“Ms. Gligor did not mention to Ms. Davis her concerns about R’s hyper sexuality”); and finding of fact 15 (“... but the bite was not cleaned well and became infected.”). Ms. Gligor ’s intent was not to reprimand but redirect R. Ms. Gligor did mention

R's hyper sexuality to Ms. Davis and Ms. Davis failed to respond. Finally, there was no testimony regarding whether the doctor properly or improperly cleaned resident Y's wound. Further, Findings of Fact 18 fails to adequately summarize Dr. Anderson's testimony. He stated that the fax from Ms. Gligor was sufficient to put him on notice that she had concerns with his sexual acting out and that was common behavior exhibited by males who suffer from dementia."

5. Ability to Provide Care and Services

Per Ms. Sykes, RN case manager, Ms. Hudson, RN delegator, Dr. Anderson, Ms. Mitchell, POA for resident Doug, and Ms. O'Connor, POA for resident Y.B., had expressed in writing or verbally, or both, positive feed-back on me and my work.

In Closing Argument of the Appellant- 9, Mr. Leary writes:

"Next, the Department alleges that Ms. Gligor lacked the understanding, lacking ability, emotional stability necessary to meet the needs of her residents. The claim is without merit. The testimony of the Department's own licensor refuted the allegation. Unquestionably there was ample evidence that R.J. was a difficult resident who presented a complicated set of issues. The lack of support and the lack of responsiveness by R.J's doctor and his family compounded the issue.

The testimony of Licensor Estelle Sylvester was **enlightening** as to Ms. Gligor 's character, dedication and demeanor. Ms. Sylvester described Ms. Gligor as personable, gracious, well-educated and someone whose intent was to provide the best care for her residents. She said that if anything, Ms. Gligor tried too hard and had the belief that she could help anyone at any time. Her dedication should not be misconstrued as emotional unfitness." 76-10380(2), In the same

train of thought, Honorable Judge James Rogers in Notice of Appeal to Court Appeals, Division I, and Page 3 states that:

“Both the Administrative Law Judge and the Review Order Judge upheld the Department’s decision that Ms. Gligor was personally unfit to be a caretaker and upheld the Department’s remedy of revocation on that basis. See Conclusion 20, 21; Review Order at para, 42. But even though the Department decided on the most drastic sanction, license revocation, for Ms. Gligor’s adult home at issue, the Department allowed her to transfer her clients from the adult family home at issue to her second adult family home, Evergreen AFH.”

As a growing provider since 2000, and educator, I know where I stand. There was no evidence, only **hearsays** from the V.L.’s family on my dealing with R.J. I did not reprimand, making him shake: Tr. 61-65, 138; AR 304-305. Y.B., vented her caustic behavior. She wrote down her feelings. She did not sign a waiver. Tr. 69, 122-123; AR 458. If the patients diagnosed with dementia would read any private notes from the facility journal, as they could not remember anyhow what they read why would that be a problem to being with? V.L. affirmed in ALJ hearing “her dad is like a child, and doesn’t know rhyme from reason, why he is like that. “ Her daughter agreed with her. Tr. 143

Ms. Frost came to investigate with the mindset of license revocation, after V.L. approached her. It is a fact the residents were treated with respect, and dignity, per testimonies of all RNs, and residents’ family members, except V.L. It was appropriate for Y.B. to vent her feelings, and nobody else in the house cared to read her notes, except for her POA, who was informed about Y.B. at all times, and myself, who had to help her with mood swings, foul language, and provocative vocal and gestures when swearing. Ms. Sykes, RN, attributed at the ALH that

“Mariane thrives when dealing with difficult residents.” Ms. Frost ignored the dynamics of the business, and magnified details. Again, it bears repeating, the care plan was contained in the assessment Ms. Sykes wrote, as it was done all in one, by the new format. Lines on how to redirect, reorient, and have a bedroom bell to announce R.J.’s wanderings along with serving comfort food, and PRN medications were prescribed in a timely manner. Ms. Sykes, and Ms. Hudson, RN delegator agree with the licenser Ms. Sylvester’s testimony at the ALJ Hearing. At the annual inspection along with many unannounced inspections, Ms. Sylvester had seen the care plans, and assessments. Practically I have done all that I was expected to do, and more.

It is a fact that R.J. was hyper sexual, as Mr. Hamby, his best friend stated at the ALJ hearing. Along with Theresa, R.J.’s daughter, Mr. Hamby opened up the fact that R.J. was found under covers in a female bed, and discharged for sexual assault to a locked dementia unit in a nursing home. Truth prevailed. Tr. 142, 510-511, 532, Tr. 58-59, 66-67, 110-120. Ms. Frost believed, wrongfully, that his wandering was consistent with his dementia, and nothing more. Tr. 512-513, 516 It was only six to nine months later after, at the ALH, that R.J. behavior had him both discharged from the second adult family home, and locked in a nursing home, for sexual assault.

There was no WAC 388-76-10020(1) violation. V.L. said at ALH it was her choice to move R.J. in another home.

Y.B. was advised and asked by the POA, Ms. Sykes, Case Manager, RN, and myself **not** to play with the dog for a while. It was only until it was determined he was a good dog. And we had to remind it her many times, daily. There is nothing wrong with reminding and being firm with dementia patients, especially when they had **lucid** moments. The department’s review judge’s conclusions were biased, and were not evidenced by the RNs, doctors, family members,

and all the witnesses who have attributed us positive qualifications. AR 136 In the same train of thought, the residents continued to enjoy Quality life styles at Evergreen adult family home. We continued to have quality home care, as a work in progress evolves, continually.

The fact that both the residents and their POAs agreed to move from Evergreen Seasons to Evergreen AFH speaks louder. Everybody involved with the relocation situation felt comfortable and glad to be in a relaxed, quality home.

Ms. Sykes, RN, Case Manager of resident Y.B., Ms. Mitchell, and POA of resident D.M., Claire O'Connor, and POA of resident Y.B., all agreed with the transfer. I also called the State a few times with regards to this change. I could not have moved the residents to another licensed facility, in good standing AFH, without the permission from the Department.

The reason the State allowed the transfer was because of my nine years' experience as a good and caring provider. My team and I, have created master- atmospheres where "even difficult residents thrived," per Ms. Sykes, RN & case manager at the ALJ hearing.

The license revocation was an arbitrary and capricious act of Ms. Frost, at Ms. Larson's pleadings. The Evergreen license was in good standing, because I kept it clear for the space of nine years to today's date. I took care of only a few residents, as I pick and choose only the residents I would like to handle at a specific time. There was no evidence, whatsoever, that I was emotionally unfit to care for the residents. Any advice or support from the state with this situation, short of license revocation, would have been sufficient. The department should not punish caregivers for caring for overloaded resident(s), out of a caring heart, without having the necessary support from the family members, who refused to take action and coordinate

appropriately, as prescribed, by RNs, doctors, and nurse delegators. In reality, I was left alone to figure out how to help resident R. J.

Mr. Leary's view on this issue was expressed in his Closing Argument of the Appellant -13:

“Can the Department's actions, attempting to revoke the license of Evergreen Seasons AFH only to allow later the residents to move to Evergreen AFH, be described as anything but arbitrary and capricious? No. The simple answer is that the decision is an admission that Ms. Gligor provides good care for her residents and that her license should not be revoked. The testimony of Licensor Sylvester clearly demonstrates that she is educated, caring provider. The testimony of Ms. Sykes illustrates how effective Ms. Gligor can be with challenging clients. Geri Mitchell and Brent Mitchell discussed how pleased they were with the care Ms. Gligor provides for their husband/father.”

In this context, no witness except from V.L's family members had anything negative or degrading about me and my work. Testimonies of Dr. Anderson, Dr. Rappaport, Dr. Fernandez, Ms. Hudson, RN delegator, caregivers on staff, Ms. Sykes, two providers who trained in my home, and the many visitors who came in the AFH home during this time, all have witnessed in a way or another this fact to be true. All the professional and medical team, overall, had good qualifications on my work.

6. There was insufficient evidence to conclude that residents were not safe from facility's dog.

Ms. Silvester saw the dog interacting with the residents, sitting on their lap and bringing toys to the residents. I saw joy in the residents in just having the puppy around them. Tr. 240 The

condition of the house and the condition of the residents with respect to cleanliness and hygiene per Ms. Cantu, “they were clean.” Tr. 241

Mr. Leary in Appeal to the Board of Appeals – 7 stated that:

“Ms. Gligor’s willingness to get a dog demonstrates the lengths that she is willing to go to provide for her residents and accommodate their requests. Ms. Sykes testified about how Y.B. had strong opinions and was a feisty 89-year old woman. She describes her as being, at times, caustic and had difficulty accepting what she perceived poor choices by other residents. Despite the traits that might make the transition into an adult family home difficult, Y.B. thrived at Evergreen Seasons. Much to her delight, Ms. Gligor purchased the dog, Sparky, for her. The presence of Sparky was one of the reasons why Y.B. thrived in the home. There was ample testimony that Sparky was an active dog with lots of energy. However, there was no evidence that it was aggressive before the incident with Y.B. or afterwards. Further, there is no allegation that Y.B. did not receive appropriate care after the incident with the dog. Ms. Gligor specifically selected the breed because it was known for being good with people. Her entry in the facility journal that “(Y.B.) plays at own risk” was an inartful, unenforceable comment. It was not as if Ms. Gligor had Y.B. or her representative signs a waiver. Ms. Gligor and Ms. Sykes testified that Y.B. was asked not to engage with the dog after the incident. Only after the passage of time when it was determined that Sparky was not a risk to Y.B., was she allowed increasing her interactions with her. Conclusion of Law 7 finds that Ms. Gligor acted appropriately when the dog bit the resident Y.B. However, the conclusion that “she plays at own risk” does not and cannot establish that Ms. Gligor did not support Y.B.’s safety.

7. There were no allegations from the Department that the provider failed to protect one resident from another resident, specifically protect Yetta from sexual advance from Mr. Richard Jacome

The findings of fact and conclusion of law cannot be based on a factual theory that was not raised or alleged by the agency bringing action. A license revocation is a quasi-criminal proceeding and entitles to all protection of due process. Nguyen, 144 Wn.2d at 474; Washington State med. Disciplinary Bd. V. Johnson, 99 Wn. 2d 466, 663 P. 2d 457 (1983).

In Conclusion of Law 5, Judge Conklin found that the provider “did not actively support the safety of Y, by failing to protect her from sexual advances of R in violation of WAC 388-76-10400(3).” Nowhere in Department’s Exhibit 2, the notice of stop placement or Exhibit 3, the statement of deficiencies, did the Department allege that the provider failed to protect Y from sexual advances of R. Judge Conklin’s final legal conclusion rests on a factual assertion that was not alleged Conclusion law 21.

Judge Conklin’s ultimate legal conclusion rests on a factual assertion that was not alleged by the department, and cannot stand.

“In 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.”

There was no evidence that WAC 388-76-10400(2), (3), (a) and (3) (b) were violated. No damage was ever evidenced to the subject resident, Y.B., before and after that time. AR 131.

We did provide the necessary care and services, in a professional manner, consistent with safety first and quality of life second. Per Ms. Sylvester, the licenser, “Ms. Gligor is a very personable, gracious individual. She has the intent to provide the best care for her residents.” Tr. 263. Ms. Davis, wrote in her assessment the “provider has not five hours sleep out of eight hours,” and failed to upgrade the assessment for a night “**awake staff.**” Per Ms. Silvester, at ALJ hearing, “the WAC doesn’t require 24-hour **awake staff.** Tr. 310 with an extra effort to help R.J., I hired Ms. Dinisiuc, with his overloaded care needs. Tr. 125-127, 409, 419. R.J.’s night wanderings were under control, with Rory, a male caregiver, Ms. Dinysiuc, and me. Y.B. was deaf in one ear, and did not like to associate with R.J., or do any talking with him. So, even when R.J. was wandering around, Y.B. was always in the living room, watching TV, during days.

R.J. was watched at night, and he was strictly monitored by his bedroom doors’ alarms. By closely monitoring him, I found him under cover at 7:00PM in Y.B.’s bedroom.

As the facts speak louder than the words, it was evidenced through the testimonies at the ALJ hearing, that we have improved Y.B.’s quality of life, per Ms. Sykes, Dr. Rappaport, and POA.

No violations of WAC388-76-10400(2) and WAC 388-76-10400(3). WAC 388-76-10400(2) & (3). R.J.’s health declined naturally, and providers simply could not revive aging and declining health, but only help improve the quality of life of the residents at any given stage of health.

Y.B.’s caustic behaviors were addressed with a supportive, ever increasing patience combined with delicate manners, as at any time, unexpectedly, she would cuss, swear, explosively and vocally express herself. Writing did her good, and she loved to write, in a way of getting the attention she was starving to get. WAC 388-76-10400(2) was not violated. Y.B. had moments of

lucidity, as agreed by RNs, and doctors, and she had to be aware and reminded all the time not to play with the dog. However, she was not asked to sign a waiver! Tr.109

In conclusion, there is no evidence, hearsays only, and the false statements from V.L. cannot stand. WAC 388-76-10400(2), (3) (a) and (3) (b) were not violated. The Review judge cannot rule on a potential future harm as there was no actual harm for both R.J. and Y.B.

Factual assertions cannot stand as evidence. In fact, a system in place was provided: a new caregiver was hired, and alarm system on R.J.'s bedroom was loud enough to awaken every person in the home, day or night. However the residents were either hard of hearing or deaf in one ear. Safety first care solidifies in the fact that we found R.J., under covers, in Y. B.'s bed around 7:00PM. Y.B. was protected from having to discover him, by herself. A few days later after that incident, when R.J. ran to hit a caregiver with his cane, the final decision quickly arrived to discharge him, per WAC requirement. Ms. Larson was verbally informed that he was going to be discharged, as we could not provide for his care. A few minutes later after that Ms. Larson took him out and placed him in another home. I did not even have time to prepare a 30 day notice letter. At the ALJ hearing she firmly stated "it was her decision to take R.J. out."

It is a fact that within a few months after he was discharged from Evergreen Season, he was placed in a locked dementia unit in a nursing home. The next adult family home he was admitted into was no better equipped to take care of him. In this context, within the period of about twelve months, he had changed to four different facilities. The family members, specifically, Ms. Larson, was in complete denial that their father was heavy care, and needed extra medical support and staff. R.J.'s needed about six caregivers per week on three shifts, to

realistically provide for his care, and constantly needed to be seen by a geriatric RN or MD to adjust medications.

Ms. Sylvester, my licenser for about nine years, testified in the ALJ hearing. She was right when she stated the provider is “compassionate, well educated, and thinks she can help everybody all the time.” The extra effort to help R.J. should not be misconstrued as being emotionally unfit to provide for the residents, after feeling exhausted, by having the night sleep interrupted by R.J.’s needs, during a five month period. Naturally, everybody would get frustrated when a resident’s family becomes hostile, refuses to help, and the provider’s sleep is continually interrupted. R.J.’s assessment did not disclosed from the very beginning his sleep walk problems, and asking for “breakfast” at 11:00PM, 3:00AM, and 5:00AM, etc. The dynamics in an adult family home can be realistically seen and dissected only by the provider and personnel involved in the dynamics of caregiving, as so many new factors always pop in.

The court affirmed the standard of proof in this proceeding as preponderance of the evidence. Honorable Judge Rogers affirmed the following in Review Decision and Final Order (“Review Order”), 4/18/13:

8. “Ms. Gligor was not afforded due process on the allegation that she endangered a resident, Y, by not protecting her from the sexual advances of R. The Court reverses Conclusion of Law 5 & 9 as Ms. Gligor was not given notice of her allegation. There are two ways in which she might have been given notice. First, the Administrative judge believed that the Department gave notice by incorporating all allegations from the investigator’s report in the Notice, Exhibit 2, from the attached report. It does not. The plain language of Exhibit 2 limits allegations to the ones listed in it, while referencing the attached report for further details of the allegations. The second way

notice might have been provided would be by amending the Notice before or even during the trial, much like amending a complaint to conform to the evidence. Given the evidence introduced, this would have allowed Ms. Gligor to address the allegation. This was not done. The defense was clearly surprised, as noted in their written closing argument and appeal briefing by Mr. Leary.

1. The Court reverses Findings 20 and Conclusion 17 that the provider failed to give a 30 day notice letter as not supported by evidence. R's daughter Ms. Larson clearly testified that it was her idea to move her Father on the same day that Ms. Gligor stated that she had intended to have R move, and thus Ms. Gligor never had a chance to issue a 30 day letter. Report of Proceedings at 198; 204. The findings completely ignore this evidence, which is contrary to the finding, and makes no attempt to reconcile it.

2. The Review Order attempted to address this other evidence on a 30 day notice, but in part by citing (at 16) the February incident, as if this could be considered for why Ms. Gligor failed to give notice in March. But the Department did not charge Ms. Gligor with failure to give R's family notice to move him in February, 2010, (even though it was in the report attached to the Notice, Ex.2), and as a result the Administrative Judge declined to even consider it as a basis for revocation. Conclusion of Law 16. The Review Order nowhere addresses this issue of notice.

3. The department choice of a remedy was arbitrary and capricious.

4. The Conclusion of law goes to great pains to discuss that the Department's decision of a remedy is accorded great deference. The Review Order, from pages 26-41, discusses this very

same issue in the same manner. The Department is given great deference under an arbitrary and capricious standard....

5. Both the Administrative Law Judge and the Review Order Judge upheld the Department's decision that Ms. Gligor was personally unfit to be a caregiver and upheld the Department's remedy of revocation on that basis. See Conclusion 20, 21; Review Order at para, 42. But even though the Department decided on the most dramatic sanction, license revocation, for Ms. Gligor adult family home at issue, the Department allowed her to transfer her clients from the adult family home at issue to her second adult family home, Evergreen AFH. " Testimony of Estelle Sylvester: "My only concern was that the residents be informed about it, that they receive a 30-day notice, in advance of the move, and they had the opportunity to go over to see the house to see if they thought they'd be comfortable there." Tr. 295 Ms. Sylvester continued "The monitoring visits amplified to ensure the safety and well-being of the residents who may still be residing in the home." Tr. 261

In this context, Ms. Silvester and Mr. Leary define the role of the provider: "the provider is not a doctor, a nurse, or a nurse practitioner" and the role is not to diagnose, but to provide care, Tr. 287, with the assistance of the team work, all parties involved in the resident's care.

6. It is arbitrary and capricious to revoke the license of a caregiver's adult family home where the Department concludes that the caregiver "lacks the requisite understanding, ability and emotional stability to meet the care needs of vulnerable adults in an adult family home yet allow the same caregiver to transfer her clients from the adult family home where the licensed was revoked to her second adult family home, where she continues to care for them."

VI.CONCLUSION

The state has not proven the evidence or preponderance of the evidence presented at the hearing merit license revocation. For the aforementioned reasons, the Department's decision the revoke the license should not stand. The Superior Court, Honorable Judge Jim Rogers, reversed the Review Judge's final order,

"REVERSED AND REMANDED consistent with this opinion."

The respondent respectfully request that this Court of Appeals uphold the decision that Evergreen Seasons license continue to be reinstated, per review judge, as the initial order of the Department's stop placement and license revocation was arbitrary and capricious. The provider was not afforded due process to address the new allegation, the ALJ judge ruled on.

RESPECTFULLY SUBMITTED this 10th Day of January, 2014

MARIANE GLIGOR, MA Ed



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

MARIANA GLIGOR, DBA

DECLARATION OF

SERVICE BY CERTIFIED MAIL

EVERGREEN SEASONS AFH,

Respondent,

v. STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES,

Appellant.

I, Mariana Gligor, declare the following:

I am the respondent and that on January 10, 2014 have mailed with Certified mail with return receipt a copy of Respondent's Brief by Certified Mail to: Lisa Monique Roth, Office of Attorney General 800 5th Ave Ste 2000, Seattle WA 98104-3188, and mailed with Regular mail a copy to Soc & Hlth Svcs A.G. Office Attorney at Law 800 Fifth Ave, Suite 2000 MS-TB-14 Seattle WA 98104 SHSSeaEF@atg.wa.gov.

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

January 10, 2014 at Kirkland, WA

A handwritten signature in black ink, appearing to read 'Mariana Gligor', written over a horizontal line.

MARIANA GLIGOR, Respondent

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STATE OF WASHINGTON
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