

No. 48666-1-II

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

ALICE KARANJAH,

Respondent

v.

**STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND
HEALTH SERVICES,**

Appellant.

RESPONDENT'S OPENING BRIEF

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I. INTRODUCTION

Alice Karanjah is a 54-year-old immigrant from Kenya who holds an active Certified Nursing Assistant credential from the Washington State Department of Health (“DOH”). She is nevertheless barred from her chosen occupation based on a single incident in which she physically restrained an assaultive and unpredictable Alzheimer’s patient at the dementia care facility in which she worked. The incident resulted in a finding by the Department of Social and Health Services (“DSHS,” the “Department,” or the “agency”) that Ms. Karanjah physically abused a vulnerable adult when she acted to protect residents and staff in an emergency. Ms. Karanjah is the Respondent in this appeal of Superior Court orders reversing that administrative finding of abuse and awarding her fees and costs under the Equal Access to Justice Act (“EAJA”).

Ms. Karanjah’s initial administrative appeal resulted in a Board of Appeals (“BOA”) decision that the Superior Court set aside in 2014. The Court remanded the matter to the Department, and included instructions on the proper application of the law. On remand, the BOA issued its *Review Decision and Final Order on Remand* (BOA’s “2015 Order”), which reinstated DSHS’s abuse finding. The Superior Court has reversed and awarded attorneys’ fees. The Department has appealed.

Following the 2014 remand, the BOA failed to follow the Superior Court's explicit instructions. The agency failed to apply the law properly, and engaged in arbitrary and unsupported fact-finding. Most critically, the BOA failed to consider Ms. Karanjah's actions in light of all of the facts and circumstances, by substituting "defensive" for "protective" in the required analysis under *Brown v. State, Dep't of Soc. & Health Servs.*, 145 Wn. App. 177, 185 P.3d 1210 (2008). The meaningful difference between the two words directly affected the scope of analysis in this case. By conflating defensive actions with protective actions, the Department Review Judge improperly restricted the legal analysis and applicability of the facts that would have supported Ms. Karanjah's actions. It was on this error of law that the Department based its finding of abuse. For that reason alone, this Court should affirm the Superior Court's 2016 order reversing the abuse finding.

Additionally, as the Superior Court concluded, the abuse finding is unsupported by substantial evidence and the Department's decision to uphold it was arbitrary and capricious. For these reasons as well, Ms. Karanjah asks this Court to affirm the Superior Court's order reversing the BOA's 2015 Order.

II. ASSIGNMENTS OF ERROR

1. The Department erroneously interpreted or applied the law, entitling Ms. Karanjah to relief under RCW 34.05.570(3)(d).
2. The Final Order is not supported by evidence that is substantial when viewed in light of the whole record before the Court, entitling Ms. Karanjah to relief under RCW 34.05.570(3)(e).
3. The DSHS Board of Appeals *Review Decision and Final Order on Remand* is arbitrary or capricious, entitling Ms. Karanjah to relief under RCW 34.05.570(3)(i).

III. ISSUES PERTAINING TO ASSIGNMENTS OF ERROR

1. Whether the DSHS Board of Appeals Review Judge erroneously interpreted and applied the holding in *Brown v. State, Dep't of Soc. & Health Servs.*, 145 Wn. App. 177, 185 P.3d 1210 (2008), by conflating “protective” actions with “defensive” actions. RCW 34.05.570(3)(d). (BOA *Review Decision and Final Order on Remand* – Conclusions of Law Nos. 15-19).
2. Whether the DSHS Review Judge erroneously interpreted and applied the law by not properly considering Petitioner Karanjah’s Legal Obligations under Other Statutory and Regulatory Authority. RCW 34.05.570(3)(d). (BOA *Review Decision and Final Order on Remand* – Conclusions of Law Nos. 13, 14, 18).

3. Whether the final agency order is supported by substantial evidence on the record as a whole. RCW 34.05.570(3)(e). (*BOA Review Decision and Final Order on Remand – Findings of Fact Nos. 23, 24, 27, 28*); *BOA Review Decision and Final Order on Remand – Conclusions of Law Nos. 12, 17-19*).
4. Whether the final agency order is arbitrary and capricious. RCW 34.05.570(3)(i).
5. Whether Ms. Karanjah is entitled to an award of attorney fees for this level of review and whether the Superior Court's award of attorney fees should be affirmed. RCW 4.84.340-360.

IV. STATEMENT OF THE CASE

A. Alice Karanjah

Ms. Karanjah is a 54-year-old immigrant from Kenya. AR 371,¹ CP 409. In 2010 and 2011, she worked at Pioneer Place Alzheimer Residence (“Pioneer Place”), which is an assisted living facility in Tacoma, Washington, for approximately three-and-a-half months as a caregiver. AR 244. That position was her first job in the United States.² CP 410. She obtained her credential to practice as a registered nursing assistant on October 14, 2010 from DOH. On November 23, 2011, that

¹ “AR” is reference to the Administrative Record; “CP” is reference to the Clerk’s Papers. Pages 87-105 of the Administrative Record appear as separately designated.

² Ms. Karanjah previously provided care for her grandmother in Kenya. CP 410.

agency granted her a credential to practice as a certified nursing assistant. AR 330, 335.

On the night in question, January 3, 2011, Ms. Karanjah was working an overnight and early morning shift at Pioneer Place. AR 339; CP 497. There were approximately 60 residents in the facility, which consisted of two buildings with 24-30 residents each. CP 403.

B. Resident Ivan

The vulnerable adult and alleged victim in this case was Ivan,³ who was a resident of Pioneer Place. AR 3. In January 2011, Ivan was a 69-year-old man who stood 6'1", and weighed between 180-190 lbs. AR 347. Ivan spoke Spanish and not much English. CP 484. Ivan suffered from the "worst and most aggressive form of Dementia—a combination of Vascular and Alzheimer's-related Dementia." AR 345. According to Director of Nursing at Pioneer Place, Corey Ellis, Ivan was "combative," and the staff was "scared of him." *Id.* Additionally, his behavior could "definitely" be characterized as "difficult to control." *Id.*

Ms. Ellis described Ivan's cognitive level and some of the "added issues" that came with his vascular dementia. CP 463-464. For example, Ivan could not "put two and two together," and if he were thirsty, "he would pick a vase with flowers in it and start drinking it." *Id.* Ms. Ellis

³ Although Ivan's surname is redacted in the administrative record, his first name is not. It is used herein to avoid confusion.

elaborated, “If you said, ‘Let’s put your t-shirt on,’ he would grab a cardboard box and try to put the – the cardboard box over his head.” *Id.* Ivan, according to Ms. Ellis, was “very out there” in terms of his cognition. CP 464. Though Ivan had an unsteady gait, as his balance was off, he was “still very strong in walking.” *Id.*

Ms. Ellis characterized Ivan as a “special case.” CP 463. Unlike many cases in which a patient with one form or another of Dementia is “re-directable,” **Ivan was not re-directable**, and “not appropriate in his actions.” CP 463; AR 345. (emphasis added). She testified that Ivan was “probably one of the most difficult cases” she had seen in her career. CP 463. According to Ms. Ellis, “*he was above our level and ability to care for him.*” AR 345. (emphasis added). Ms. Ellis further stated, “We finally had his wife take him to Highline Medical Center, Geriatric Psychiatric Ward to find the right modification of his medications.” *Id.*

Angela Varney was the nursing assistant assigned to Ivan on the night in question. She also described him as being “combative,”⁴ “aggressive,”⁵ as well as “overpowering,”⁶ “confrontational,”⁷ and as someone who had “injured staff.”⁸ Ms. Varney told investigators that at

⁴ AR 343.

⁵ CP 484.

⁶ *Id.*

⁷ AR 343.

⁸ *Id.*

the time of the incident, Ivan was reaching back to grab Ms. Karanjah and he “probably would’ve hurt her.” AR 343. In her 2014 testimony, Ms. Varney elaborated that Ivan was a “very violent person,” and that “if he would have gotten ahold of [Ms. Karanjah] he probably would’ve hurt her.” CP 402. According to Ms. Varney, because Ivan only spoke Spanish, “he didn’t understand us, and we didn’t understand him.” *Id.*

Leticia Simmons, the facility’s medical technician supervisor, stated that Ivan could be “physically resistive” to personal care and had a “problem” with “physical contact.” AR 347. On one occasion, he struck her shoulder with a photo album, while she was changing his socks. *Id.* Ms. Simmons also acknowledged that at times she would be “called to assist” with Ivan’s difficult-to-control behavior. AR 347. Similarly, Ms. Ellis testified that Ivan would “lash out during care.” CP 463.

Ivan’s progress notes document serious behavior issues in the days and hours leading up to the incident on January 3, 2011. AR 229. Ms. Simmons, who authored two such notes, indicated an “alert status” for behavior issues:

Alert status for behavior issues. Rsd. wandering in other residents’ rooms, refusing care, undressing and taking off brief. 12-31-10, 0510am...

Alert status for behavior issues. Rsd. wandering into other resident’s [sic] rooms, refusing care. 1-1-11, 0505am...

AR 229.

The three other note entries made in the week prior to the incident by an employee stated Ivan's "behavior issues":

Rsd Having aggressive [sic] behavior hard to redirect gave meds will continue to monitor. 12-31-10, 10:20pm

...Rsd walking Building [sic] likes to be without clothing... 1-1-11, 6:47pm.

Rsd aggressive [sic] with care providers early am shift and during Rsd care slapping Rsd...1-2-11, 6:45pm.

Id.

Ivan had a history of entering other residents' rooms and trying to get into their beds, as well as interfering with a resident's oxygen equipment. CP 497-498; AR 339.

Ms. Karanjah provided care for Ivan during the few months that she worked at Pioneer Place. CP 410. She testified that the level of care he required depended on his mood on a given day. CP 411. Ms. Karanjah expressed that there were times in which Ivan was a very difficult resident. For example, feeding him would become a challenge for staff. CP 412. Because Ms. Karanjah does not speak Spanish, she could not communicate with Ivan verbally. *Id.*

C. Pioneer Place's Staff Training and Procedures

Ms. Ellis spoke to DOH investigators about the training that Pioneer Place provides to staff in handling difficult residents such as Ivan.

AR 345. Ms. Ellis told DOH that “as a new employee, we tell them, ‘if someone is upset, walk away. Two minutes later they could be in a different mindset and not even remember [being upset].’” AR 345. Ms. Ellis did not witness the January 3, 2011 incident at issue in this case. She nevertheless opined to DOH investigators that “clearly, [Ivan] got the best of [Ms. Karanjah] . . . she should have left him alone.” AR 346.

The same DOH investigators interviewed Leticia Simmons, the facility’s Medical Technician and night shift supervisor. AR at 347-48. They also questioned Ms. Simmons about the facility’s policies and procedures in place relating to the January 3, 2011 incident. She told them, “I don’t know about here, I use a more **common sense approach**. We try to **re-direct** through a lot of coaching, a lot of talking.” AR 347. (emphasis added).

Ms. Varney, Ivan’s assigned care provider on the night of the January 3, 2011 incident, testified that she had not had much training in handling difficult residents. CP 489. She had also not taken time to read the facility’s policy manual, nor was she familiar with the policies and procedures in place. AR 343. She had not done so, even though on the day of the incident, she had been there for over six months. CP 490; AR 343. In 2014, Ms. Varney testified that her superiors at Pioneer Place “want us to walk away and re-approach later.” CP 402.

D. January 3, 2011 Incidents

On January 3, 2011, Ms. Varney, Ms. Karanjah, and Jalissa Harris (whom Ms. Varney was training) were the only staff present in Building 2 of Pioneer Place. CP 403-402. Medical Technician/Supervisor Leticia Simmons was present in Building 1. CP 403; AR 347.

There were at least three incidents involving Ivan on the night of January 3, 2011, in which he created potentially life-threatening situations. AR 7-8. The first incident happened around 12:00AM. Ms. Karanjah had found him out of his room, wearing only a diaper, attempting to get into the bed of an elderly female resident. CP 497; AR 339. That resident was partially paralyzed and unable to speak. She was, however, able to make a sound loud enough to alert Ms. Karanjah. CP 415-16; AR 339. Ms. Karanjah informed Ms. Varney of the incident and Ms. Varney came and took Ivan to his room. AR 8.

The second incident that night is the focus of this case. AR 7. At 1:00AM, Ms. Harris discovered that Ivan had entered the building's Soiled Utility Room, which should have been locked. CP 405. Ivan, who was wearing only a t-shirt and diaper (no pants), had spread soiled adult diapers throughout the floor. CP 416-18. Ms. Karanjah, who was close, heard Ms. Harris' call for help. CP 418, 498; AR 4. When Ms. Karanjah arrived at the Soiled Utility Room, Ivan was holding Ms. Harris by the

wrist and trying to hit her. AR 4, 339. He had fecal matter on his hands. AR 4-5. Ivan ignored Ms. Harris' request that he walk out of the room. CP 418. Ms. Karanjah feared for her own safety and was "afraid of him hitting [her]." CP 498. She nonetheless managed to convince Ivan to release his hold on Ms. Harris. CP 498.

Continuing to fear Ivan, Ms. Karanjah then held him from behind in order to avoid his hands, as she escorted him out of the utility room and down the hall, past several other patient rooms, and back to his own room⁹. CP 498-99. The BOA found that Ms. Karanjah released Ivan at the foot of his door. AR 254. She left and asked Ms. Varney, who had been approaching, to "please take care of him," so that Ms. Karanjah may return to her client. CP 500, 488; AR 339.

Ms. Karanjah testified that, despite the cold that night, Ivan was wearing only a t-shirt. CP 418-19. She first tried to talk to him softly to coax him out of the utility room and down the hall and into his room. *Id.*

⁹ Though Ms. Karanjah's account of how she restrained him and escorted him to his room is at odds with the BOA's findings in the 2013 *Review Decision and Final Order* ("2013 Final Order"), she accepts that those findings left undisturbed by the Superior Court are verities on appeal. The BOA has found that Ms. Karanjah "took both of Ivan's wrists, held them behind his back, and restrained him, shoving him forward out of the utility room, down the hallway, and then into his room." AR 7. Ms. Karanjah has testified that she placed her right hand on Ivan's right wrist and her left hand right below his left shoulder. They were unable to turn around in the room, but managed to walk out of it. When they exited the room, Ms. Karanjah walked to Ivan's left side, adjusted her left hand to the elbow area, and they walked slowly "side by side" to his room. CP 421-423; CP 498-99.

She testified that it was both “from [her] heart” and her obligations as a nursing assistant that she could not leave Ivan in the utility closet or the hallway with access to several patient rooms. CP 424, 403. She could also not allow him to wander through the facility, with fecal matter on his hands, risking the spread of bacteria and further contamination. CP 424-25.

The third incident involving Ivan occurred at around 3:00AM that night. AR 8. Ivan had set off one of the facility’s alarms and locked himself in a staff bathroom. AR 339, 347; CP 500-01. He had soiled himself, removed his undergarments, and was found naked from the waist down. CP 501; AR 339. Ms. Karanjah, Ms. Varney, and Supervisor Ms. Simmons all responded to the alarm. AR 339.

At Ms. Varney’s request, Ms. Karanjah left to get Ivan’s clothing, and when she returned, she found him sitting on the toilet. CP 501-02; AR 339. Ms. Karanjah observed both Ms. Simmons and Ms. Varney struggle to get Ivan dressed. *Id.* Ivan had “**over powered**” Ms. Simmons because she was restraining him by “**holding both of his hands.**” *Id.* (emphasis added). Ms. Simmons and Ms. Varney “both dressed him and walked him to the dining room and he sat on a chair and slept.”¹⁰ AR 339.

¹⁰ There is no evidence that this use of restraint on Ivan, two hours after the 1:00AM incident, was ever even investigated by Pioneer Place or the Department, and there is no evidence that the Department ever alleged abuse for that incident.

Ms. Varney waited approximately two hours¹¹ to inform Ms. Simmons of the 1:00AM incident. AR 347, 213. Ms. Varney only did so after Ivan set off an audible alarm in one of the facility's rooms. AR 347. Pioneer Place's policy required Ms. Simmons to inform Ms. Ellis immediately of the incident involving Ms. Karanjah and Ivan. AR 345. Ms. Simmons delayed doing so, however, until seven hours after it occurred, because she was "feeling nervous." AR 347.

DOH investigators asked Ms. Varney to describe what she witnessed. AR 343-44. She told them Ms. Karanjah "had hold of the back of [Ivan's] shirt. His hands were loose, [he was] flailing his arms and reaching back to get her. He probably would've hurt her." AR 343. When the investigators asked her to demonstrate, "Investigator Johnson stood and turned his back to Ms. Varney, who then placed her hands on his upper back just below the shoulders and grabbed handfuls of his shirt, then pushed against him as if to push him from the shoulders." AR 343.

Ms. Ellis determined that Ivan had no visible injuries (and no evidence of redness or swelling) when she inspected his wrist

¹¹ AR 339. Ms. Karanjah estimates this other incident occurred at 3:00AM that morning; *See also* Exhibit D at 8: "Ms. Simmons was in Bldg 1 and was called to Bldg 2 by Nursing Assistant Angela Varney because of an audible alarm going off by the Victim, Ivan room #17. After dealing with the alarm, Varney informed Ms. Simmons of the incident involving [Ivan] and [Ms. Karanjah]." AR 347. The notification times on Ms. Simmons' incident report [Exhibit 16] also corroborate the 3:00AM timeline. AR 228.

approximately seven hours later.¹² Ms. Simmons told the DOH investigators that she had examined Ivan for injuries only after the 3AM incident. While she “confirmed redness around his left wrist,” she found “**no breaks in the skin.**” AR 348. (emphasis added).

E. The Department of Health Investigation and Disposition

The DOH, which is the licensing authority that oversees Ms. Karanjah’s nursing credential, conducted an investigation of the alleged January 2011 incident. AR 340, 359. In May 2011, Ms. Karanjah and the DOH resolved the licensing investigation through a *Stipulation to Informal Disposition*. AR 330-334. By its terms, the Stipulation was not a finding of unprofessional conduct, violation of licensing requirements, or inability to practice. AR 330.

The DOH Stipulation was not a formal disciplinary action, and the Secretary of DOH agreed to “forgo further disciplinary proceedings concerning the allegations.” AR 331. Ms. Karanjah agreed to have her credential to practice as a registered nursing assistant placed on probation for at least twelve (12) months. AR 332. As the disciplining authority, DOH applied WAC 246-16-800, *et seq.*, to determine appropriate remedial action. AR 331.

¹² CP 470. Ms. Ellis testified: “...one of the first things I did when I came into the facility that morning was just to go see if he had a visible injury or anything I needed to deal with medically. And – and there wasn’t.”

Ms. Karanjah and DOH stipulated that her conduct fell in Tier A of the “Practice Below Standard of Care” sanction schedule. WAC 246-16-810. Conduct falling in Tier A is that which “cause[s] no or minimal harm or a risk of minimal patient harm.”¹³ AR 331-32. DOH determined that the sanction range associated with Tier A did “adequately address the alleged facts of this case.” *Id.* DOH also identified “factors that justify a sanction that falls toward the bottom of that identified tier.” *Id.* Among the factors that DOH identified was that: “**there was no harm to the Resident.**” AR 332. (emphasis added).

On November 23, 2011, while Ms. Karanjah’s nursing credential was on probation, the DOH issued her a further credential to practice as a certified nursing assistant. AR 335. In May 2012, Ms. Karanjah successfully completed the terms of her probation with DOH. As a result, the Secretary of DOH issued an Order on Termination of Probation at the request of the Nursing Assistant Program. AR 335.

F. The DSHS Investigation

On March 21, 2012, DSHS Resident and Client Protection Program (RCCP) began an “abbreviated investigation” into the January 3, 2011 incident. AR 359. DSHS did not begin its investigation until well over a year after that incident. AR 371. The DSHS RCCP investigator,

¹³ DOH did not apply the sanction schedule in WAC 246-16-830 regarding “Abuse—Physical and Emotional.”

Taryn Savory, did not interview Ms. Karanjah, and there is no evidence that she ever interviewed any other witnesses. Instead, she “*reviewed* the Department of Health document Stipulation to Informal Disposition and contacted the chief investigator requesting the investigation reports.” AR 359. (emphasis added). Without conducting any investigation on her own, Ms. Savory referred the matter to the Quality Assurance Administrator to review for a preliminary finding of physical abuse. AR 359.

On April 17, 2012, DSHS issued a Notice of Preliminary Finding of Abuse against Ms. Karanjah. AR 355. Specifically, the Department alleged that Ms. Karanjah, in her capacity as a nursing assistant at Pioneer Place, physically abused a resident of a boarding home by: (1) taking the resident’s arms behind his back, and pushing him into his room; and (2) hitting the resident’s left wrist on the door frame. AR 355.

G. Administrative Appeal and Procedural History

In May 2012, Ms. Karanjah timely requested an administrative hearing with the Office of Administrative Hearings to challenge the DSHS Preliminary Finding of Abuse. AR 362. The hearing was held on October 15, 2012. AR 287.

On January 2, 2013, the ALJ issued an *Initial Order*, affirming the Department’s preliminary finding of physical abuse. AR 1. Ms. Karanjah timely sought review of that order with the DSHS BOA. AR 253. The

BOA issued its *Review Decision and Final Order* on September 17, 2013 (“BOA’s 2013 Order”). AR 1. Ms. Karanjah timely petitioned for judicial review. AR 206.

On June 6, 2014, the Pierce County Superior Court reversed BOA’s 2013 Order and remanded the matter to the Department. CP 543, 549. The Court’s order concluded that physical abuse “requires evidence of an actual infliction of bodily injury or physical mistreatment.” CP 546. The Court held that there was no evidence of physical injury to Ivan. *Id.* The Court also concluded that the BOA erroneously interpreted or applied the law governing what conduct by a care provider may constitute abuse of a vulnerable adult. CP 546-47. The Court held that the BOA failed to:

properly apply the holding in *Brown . . .*, by not determining whether resident Ivan’s contact or restraint by Petitioner Karanjah was reasonable, in light of all of the surrounding circumstances including: Ms. Karanjah’s obligations to Ivan as a patient, as a state registered nursing assistant; Ivan’s patient history, including a history of elopement; and the risk of harm that resident Ivan presented to himself and to others in the facility.”

Id.

Additionally, the Court’s 2014 Remand Order concluded that BOA’s 2013 Final Order was not supported by evidence that is substantial when viewed in light of the whole record before the court. CP 547. Specifically, the Court determined that while Ms. Karanjah did intentionally restrain Ivan, there was “no substantial evidence that [Ms.

Karanjah] intentionally injured or willfully injured resident Ivan.” *Id.* Similarly, the Court held that Ms. Karanjah had not caused him any injury, or that he even sustained an injury. *Id.* The Court also found the BOA’s 2013 determination that Ms. Karanjah had physically abused Ivan was arbitrary and capricious, because the BOA expressly refused to consider all of the extenuating surrounding facts and circumstances, based on the existing record. *Id.*

By concluding that Ivan had not sustained an injury, the Superior Court necessarily reversed a BOA finding that related to that alleged injury. The reversed finding stated, “Ivan’s wrist was injured when he hit it against the door-jam [sic], and that this injury caused swelling and pain.” AR 253. The Court’s 2014 order concluded that there was no substantial evidence that Ivan suffered any injury. CP 547. The Superior Court reversed no other finding of fact. AR 181.

On remand from Superior Court, the parties agreed that any undisturbed findings of fact and conclusions of law in the 2013 BOA order would not be at issue on remand. AR 193. Similarly, the parties stipulated that the decision-maker on remand “shall make no findings of fact or conclusions of law contrary to the findings of fact and conclusions of law in the [2013] *Review Decision and Final Order* that were not reversed by the Superior Court.” AR 193. The parties agreed, however, that the

decision-maker on remand had the authority to make “additional findings of fact and conclusions of law to the extent necessary to comply with the Court’s order.” *Id.*

Upon receipt of the Superior Court’s order on remand, the BOA instructed the parties to read the *unpublished* decision *In re Aleksentev*, No. 31255-1-III / (Wn. Ct. App. Div. III, May 8, 2014), which provides a discussion of the *Brown* case. AR 191. The BOA then ordered the parties to “provide an analysis consistent with that [*Aleksentev*] provided beginning at paragraph 20 of the [unpublished] decision.”¹⁴ AR 191.

A hearing on remand took place on November 5, 2014. AR 1. On February 11, 2015, an *Initial Order on Remand*, reinstated the finding of abuse. CP 551-52. Ms. Karanjah timely requested review of that order and on April 1, 2015, the BOA issued its *Review Decision and Final Order on Remand* (BOA’s “2015 Order”), which also affirmed the abuse finding. AR 10, 20.

BOA’s 2015 Order adopted all of the findings of fact in the *Initial Order* with a near verbatim recitation. AR 20. The Review Judge also adopted all of the *Initial Order*’s Conclusions of Law and added his own set of Conclusions in the 2015 Order. AR 1-20.

¹⁴ [Ms. Karanjah is not citing *Aleksentev* as binding authority on judicial review, under GR 14.1. The BOA, however, relied on *Aleksentev* to further define the “improper” element from *Brown* as meaning “not justified”].

In the BOA’s 2015 Order, the Review Judge confined the analysis to whether Ms. Karanjah’s actions—holding Ivan from behind as she escorted him to his room—were “defensive,” as opposed to “protective”—the more broadly defined word that the *Brown* case applies. AR 18-20. In a section entitled, “**The Defense of Self Defense and Defense of Others,**” the Review Judge interpreted and applied *Brown* to the present case. AR 18-20. (emphasis added). Within this section the Review Judge stated: “there simply was not the necessary immediacy of defensive action in this case that the Court of Appeals found was present in the Brown [sic] case.” AR 19.

The 2015 BOA order further asserts in the same section that Ivan’s history could “explain [Ms. Karanjah’s] frustration, and thus over assertiveness, in using physical restraint and force (shoving) to compel the resident into his own bedroom.” AR 19. The order does not explain the apparently new fact finding that Ms. Karanjah was “frustrated” or “over-assertive” when she ushered Ivan to his room. *Id.*

Ms. Karanjah timely filed a petition in Pierce County Superior Court for judicial review of the BOA’s 2015 Order. CP 527. The same judicial department that heard the previous 2014 petition also heard the second judicial review proceeding. CP 534, 549. On February 5, 2016,

Pierce County Superior Court Judge Bryan Chushcoff reversed the BOA's 2015 Order and awarded \$25,000 in attorney fees. CP 533, 538-39.

As in its 2014 Order on Judicial Review, the Court concluded that "Physical abuse" requires evidence of an infliction of bodily injury or physical mistreatment that is not present in this case. CP 529. It also held that *Brown* requires the Department to determine whether Ivan's "contact or restraint by Ms. Karanjah was reasonable, by considering all of the surrounding circumstances..." CP 529. Under the *Brown* analysis, the Court concluded, actions that are "protective," and "non-injurious," or not "ill-intended" do not constitute physical abuse under the APS statute and governing rules. CP 530.

The Superior Court again determined that the Department erroneously interpreted or applied the law, by failing to properly apply the holding in *Brown*. CP 530. The Court concluded that the Department arbitrarily limited its analysis in Ms. Karanjah's case to whether a "defensive" action was necessary, as opposed to a "protective" action. *Id.* The Court held that the BOA did not properly consider whether Ms. Karanjah's actions were "protective," and "non-injurious," or "ill-intended." The Court further held that, "by restricting its analysis, the Department unnecessarily narrowed the scope of the evidence it actually considered and it therefore did not properly determine whether Ms.

Karanjah's contact or restraint of Ivan was 'reasonable,' 'in light of all the surrounding facts and circumstances.'" *Id.*

As before, the Court also determined that there was no substantial evidence that Ms. Karanjah caused any injury to Ivan or physically mistreated him. CP 530. Again, the Superior Court concluded that there was no substantial evidence that Ivan had any injury at all. Finally, the Court determined that the Department had disregarded the facts and circumstances surrounding Ms. Karanjah's physical restraint of Ivan. CP 530-31. As a result, the Court held that the BOA's 2015 decision was arbitrary and capricious. *Id.*

The Superior Court reversed the agency's determination that Ms. Karanjah had physically abused a vulnerable adult. It did not again remand the matter to the agency. The Court awarded Ms. Karanjah \$25,000 in fees and costs, CP 538-39, which is the maximum amount that is available under EAJA. RCW 4.84.350(2). The Court did so after concluding that she was the prevailing party in the matter and that the Department's actions were not substantially justified. CP 538.

On March 2, 2015, the Department filed its Notice of Appeal of the Court's February 5, 2016 *Order on Judicial Review of Administrative Decision, Judgment and Order for Attorney's Fees and Costs*, and *Order on Petitioner's Motion for Attorney's Fees and Costs*.

V. ARGUMENT

A. Standing and Standard of Review under the APA

The DSHS finding of abuse in this case substantially prejudices Ms. Karanjah because it completely prevents her from working in her chosen profession.

Individuals may not work in healthcare if their background contains, among other things, a finding of abuse:

Any individual who applies for a license or temporary practice permit or holds a license or temporary practice permit [with DOH] and has a final finding issued by the department of social and health services of abuse or neglect of a minor or abuse, abandonment, neglect, or financial exploitation of a vulnerable adult is prohibited from practicing a health care profession in this state until proceedings of the appropriate disciplining authority have been completed under RCW 18.130.050.

RCW 18.130.400.

Similarly, individuals with adverse findings of abuse or neglect may not have unsupervised access to children or vulnerable adults. RCW 43.43.832(4). The Department's regulations require a background check for in-home care providers or other ". . . individuals who may have unsupervised access to children or to individuals with a developmental disability in department licensed or contracted homes, or facilities which provide care." WAC 388-06-0110(3), WAC 388-71-0553.

A Department witness summarized the barriers to employment that a final finding of abuse could have for Ms. Karanjah:

If there was a final finding against Ms. Karanjah this would be a permanent finding that her name would be placed on the registry. And anytime a DSHS background check was done it would show up that she has a finding against her. So that would limit her ability to be employed in the five settings¹⁵ that DSHS licenses and certifies.

CP 456.

Under the Administrative Procedure Act, RCW 34.05 *et seq.*, an individual who is substantially prejudiced by a state agency adjudicative order may seek relief from the courts via a Petition for Judicial Review. RCW 34.05.570(3); *see also* RCW 34.05.570(1)(d); RCW 34.05.530; RCW 34.05.570(2)(a). In Ms. Karanjah's case, the Court may set aside the BOA's 2015 *Review Decision and Final Order on Remand*, if it determines, as the Superior Court did, that: (1) the order erroneously interprets or applies the law; (2) the order is not supported by substantial evidence in view of the record as a whole; or (3) the order is arbitrary or capricious. RCW 34.05.570(3).

This case concerns an application of a statute and regulation to a particular set of facts. As such, this Court need not defer to the

¹⁵ According to earlier testimony, the five settings include: "nursing homes, boarding homes, which we now call assisted living facilities, adult family homes, [and] residential habilitation centers." CP 450.

Department's legal determinations. While courts may grant deference to an agency's findings of fact, the application of law to facts is a question of law that courts review *de novo*. *Mader v. Health Care Auth.*, 149 Wn.2d 458, 470, 70 P.3d 931 (2003); *See also Franklin County Sheriff's Office v. Sellers*, 97 Wn.2d 317, 330, 646 P.2d 113 (1982) ("We have invoked our inherent power to review *de novo* those issues.").

B. Summary of Physical Abuse Law in Washington State

At the time of the BOA's March 2015 final order in Ms. Karanjah's case, the Abuse of Vulnerable Adults Act defined "abuse" as follows:

"Abuse" means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult...Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation of a vulnerable adult....

RCW 74.34.020(2).

"Physical abuse" is defined as:

The willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints unless the restraints are consistent with licensing requirements, and includes restraints that are otherwise being used inappropriately.

Id. at (2)(b).

Washington jurisprudence regarding the abuse statute has not only related to alleged physical abuse, as discussed below, but also to mental abuse. *Kraft v. State, Dep't of Soc. & Health Servs.*, 145 Wn. App. 708, 713, 187 P.3d 798 (2008); *Goldsmith v. State, Dep't of Soc. & Health Servs.*, 169 Wn. App. 573, 280 P.3d 1173 (2012). In either context, however, there must be substantial evidence of a “willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult.” RCW 74.34.020(2). The “willful” element of abuse is defined by Department regulation as “the nonaccidental [sic] action or inaction by an alleged perpetrator that he/she knew or reasonably should have known could cause harm, injury or a negative outcome.” WAC 388-71-0105.

1. *Brown v. DSHS*

The Division III of the Court of Appeals has clarified the above definitions, in the context of a facility-based care provider. *Brown*, 145 Wn. App. at 177. The *Brown* case contains similar factual circumstances to those in Ms. Karanjah’s case. Ms. Brown was a care provider at an assisted living facility that had a “no hands” policy when dealing with residents. *Id.* at 180. While on duty at the facility, Brown witnessed one of the residents hit a staff member while the staff member was escorting the agitated resident to her room. *Id.* In order to prevent further assault, Brown

intervened and pushed the agitated resident away from the other staff member and onto the bed. *Id.* Ms. Brown restrained the resident there for a short period of time. *Id.*

A few moments after Ms. Brown released her, the agitated resident went outside and began to verbally attack another person. *Brown*, 145 Wn. App. at 180. Brown stood in between the two. *Id.* The agitated resident scratched Brown and grabbed her wrists, while threatening to kill the other resident. *Id.* Using her training, Ms. Brown performed a release move to free herself from the resident's grip. *Id.* at 181. The agitated resident lost her balance and fell to the ground. *Id.*

The resident stood and resumed her harassment of the other resident. *Brown*, 145 Wn. App. at 181. Brown then grabbed the agitated resident with both hands, put her foot and leg behind the resident's legs, and pushed her to the ground. *Id.* at 181. Brown held her on the ground until she agreed to calm down. *Id.*

Despite the obvious extensive physical contact between Ms. Brown and the resident, Division III held that Ms. Brown had not abused a vulnerable adult. *Brown* at 183. The Court concluded that "her actions were protective, not injurious or ill intended, thus they were warranted and not abusive." *Id.* The *Brown* court concluded that physical abuse of a vulnerable adult occurs when there is a willful action to inflict injury or

unreasonable confinement and that action is improper. *Id.* The Court specifically held that protective actions by a care provider, such as Ms. Brown's well-intentioned physical restraint of an assaultive and unpredictable resident, are warranted and not abusive. *Id.*

2. Recent Legislative Amendments

Following the BOA's 2015 decision in Ms. Karanjah's case, Washington House Bill No. 1726, passed and became effective July 24, 2015. That law added a paragraph to the section of RCW 74.34.020 further defining "physical restraint:"

(17) "Physical restraint" means the application of physical force without the use of any device, for the purpose of restraining the free movement of a vulnerable adult's body. 'Physical restraint does not include (a) briefly holding without undue force a vulnerable adult in order to calm or comfort him or her, or (b) holding a vulnerable adult's hand to safely escort him or her from one area to another.

See, Washington House Bill No. 1726.

The Washington State House of Representatives, Office of Program Research, Bill Analysis states:

It is a defense to an allegation of physical abuse or improper use of restraint that the alleged perpetrator reasonably acted to prevent an imminent danger of substantial likelihood of harm to any person, the conduct was necessary to prevent the harm, and the conduct was proportional to the danger. This defense must be proven by the alleged perpetrator by a preponderance of the evidence.

House Bill Analysis, at 3. (Accessed on July 8, 2015),

<http://app.leg.wa.gov/billinfo/summary.aspx?bill=1726&year=2015>
APPENDIX 1.

Although the amendment to the statute came after the order in Ms. Karanjah's case, the Court should consider these comments as persuasive authority that indicates a legislative intent to resolve ambiguities in the Abuse of Vulnerable Adults statute as applied to care providers like Ms. Brown and Ms. Karanjah. As seen in Ms. Karanjah's case, these ambiguities have the potential to improperly label as abuse hands-on actions by a care provider necessary to prevent self-harm and/or physical altercations initiated by a resident like Ivan.

Ms. Karanjah's restraint of the resident was an isolated event, was not repetitive, and occurred within a short duration of time. She believed physically removing the resident from that situation was the best way to prevent further harm to the staff, other residents, and the vulnerable adult. Her response was also proportionate to the aggressive behavior he had already shown.

C. This Case Is Analogous to *Brown*, and the Review Judge Erroneously Interpreted and Applied the Holding in *Brown*, by Conflating "Protective" Actions with "Defensive" Actions. RCW 34.05.570(3)(d).

1. The Case Facts Here Are Analogous to Those in *Brown*.

The *Brown* Court concluded that Ms. Brown's actions did not amount to physical injury or mistreatment. The Court reached this

conclusion, despite the facility's "no hands" policy when dealing with residents (like Pioneer Place), and Ms. Brown nevertheless physically restraining a resident. *Brown*, 145 Wn. App. at 180. Specifically, Ms. Brown: (1) pushed a hostile resident onto her bed and held her down after that resident had been attacking another staff member; (2) performed a release move to free herself from the resident's grip, resulting in the resident losing her balance and falling to the ground; (3) grabbed the resident with both hands, tripped her, and pushed her onto the grass; and (4) held her face down on the ground for an undetermined amount of time until she agreed to calm down. *Id* at 180-181.

Ms. Karanjah's actions included holding Ivan from behind to prevent him from assaulting others and herself. CP 498-99. She did so as she escorted him down the hallway and delivered him to his room. These actions were clearly less physically invasive than those of Ms. Brown, who held down an angry and out-of-control resident on her bed and then on the ground. Ms. Brown held the resident on the ground for an undetermined amount of time until the resident calmed down. While both scenarios involved restraint, both were reasonable given the circumstances involved. Both were protective in nature and proper given the circumstances. Neither constituted abuse.

Under the BOA's analysis in Ms. Karanjah's case, however, the care provider in *Brown* would have had to let the angry and assaultive resident immediately up. She could not have held her down at all, because doing so was more preventative than defensively taking her down in response to an imminent risk.

The BOA Order in this case fails to articulate how physically holding an angry resident, who had just assaulted someone, down on the ground for some period of time until he/she calmed down, is any different from physically escorting an unpredictable dementia patient who had just assaulted someone back to his room. Both actions are clearly protective.

2. "Protective" vs. "Defensive" Actions

The Department Review Judge in this case incorrectly interpreted and applied the holding in *Brown*, by conflating "protective" actions with "defensive" actions. In doing so, the Department inappropriately restricted its analysis of the facts, regarding the propriety of Ms. Karanjah's actions. AR 18-20. The *Brown* court held that there was no improper action because Ms. Brown's actions were "protective, non-injurious or ill-intended, and thus were warranted and not abusive." *Brown*, 145 Wn. App. at 183. Under this interpretation, there must be substantial evidence of an improper and willful action to uphold a finding of abuse. *Id.*

Protective actions, which are not injurious or ill intended, are not abusive. *Id* at 183.

There is a meaningful difference between the words *protective*- as the *Brown* court used- and *defensive*- as the DSHS Review Judge used in this case. That difference directly affected the scope of analysis in this matter. The definition of “protective” is “to keep (someone or something) from being harmed, lost, etc.” *See*, MERRIAM-WEBSTER, online dictionary, (July 7, 2015), www.merriam-webster.com/dictionary. This definition is broad and it is very different from the definition of “defensive,” which is “defending or protecting someone or something from attack.” *Id*. The latter definition involves action in response or in opposition to an attack, whereas the former is broader and includes any measures taken to avoid harm, including offensive and preventative actions.

The Department Review Judge improperly restricted the legal analysis and applicability of the facts that would have supported Ms. Karanjah’s actions. The Review Judge’s focus on “**The Defense of Self Defense and Defense of Others**,” was misplaced and resulted in an improper interpretation and application of *Brown*. AR 18-20. (emphasis added). The Review Judge concludes, “There simply was not the necessary immediacy of *defensive* action in this case that the Court of

Appeals found was present in the Brown [sic] case.” AR 19. (emphasis added).

By focusing only upon whether or not Ms. Karanjah’s actions were defensive, the Department would have incorrectly determined that her actions were proper only if she had acted in response to an attack. As a result, protective actions resulting from factual scenarios like Ms. Karanjah’s, where preventive measures were taken to make sure that violence or other dangerous or problematic resident behavior did not continue or escalate, would not be warranted. This interpretation of the law, which replaces the plain language, “protective” with “defensive,” is erroneous and not supported by *Brown*. It also would lead to an absurd result. Caregivers would have to allow situations to escalate into physical violence before they could physically intervene without fear of an abuse finding.

While the Review Judge briefly acknowledged Ivan’s patient history, the Final Order’s legal analysis did not weigh that history in its analysis of Ms. Karanjah’s actions. Conclusion of Law 15 mentions the resident’s history: “although the resident that was restrained in [*Brown*] was known to be verbally abusive and aggressive, as the resident is in this case, there exist material differences in the two cases.” AR 18. The Review Judge then compared and contrasted the two cases. He focused

solely on whether there was an adequate threat to the caregiver herself to justify using defensive action. Under this approach, after Ivan released his hold on Ms. Harris' wrist, and before he assaulted Ms. Karanjah or another resident or care provider the Review Judge concluded that Ms. Karanjah's actions were not to have been proper, because there was no "immediacy of defensive action required." AR 19.

By erroneously applying only a defensive action analysis, instead of a protective action analysis, the BOA did not follow the Superior Court's 2014 remand order. The Review Judge did not properly consider whether Ms. Karanjah's actions were "reasonable in light of all of the surrounding facts and circumstances." The Review Judge conflated the definition of "protective" with that of "defensive," erroneously restricting proper actions to those in direct response to an attack. This Court should affirm the Superior Court and conclude that the Department erroneously interpreted and applied the law in affirming the abuse finding.

D. The Review Judge Did Not Properly Consider Ms. Karanjah's Legal Obligations under Other Statutory and Regulatory Authority, and Therefore Erroneously Interpreted and Applied the Law in Her Case. RCW 34.05.570(3)(d).

1. Ms. Karanjah Had a Duty to Intervene to Prevent Neglect from Occurring.

Washington State statutes and regulations required Ms. Karanjah to intervene to prevent further neglect of Ivan and other vulnerable residents.

RCW 74.34.020(12) (“Neglect”), WAC 246-841-400(6)(h) (“Standards of Practice for Nursing Assistants”), and WAC 388-78A-2660(7) (Assisted Living Facility Licensing Rules). *Warner v. Regent Assisted Living*, 132 Wn. App. 126, 130 P.3d 865 (2006), illustrates this duty. There, a facility allegedly failed to provide basic housekeeping and hygiene necessities to care for a resident who had dementia and who was wheelchair bound. *Id.* at 129. The resident’s children alleged that they routinely found him in dirty clothing and soiled incontinence pads. *Id.* On one occasion, they found him lying in bed, covered in feces. *Id.*

The *Warner* court looked to the facility’s own policy on abuse and neglect. As that policy included examples such as “being left to sit or lie in urine or feces,” the court held that genuine issues of material facts precluded summary judgment. *Warner*, Wn. App at 126, 129.

Here, Ms. Karanjah was left with a choice. She could intervene when Ivan, who had feces on his hands, was attacking another staff person. Alternatively, she could do nothing and hope that Ivan’s assigned caregiver, Angela Varney, would respond in time. Had Ms. Karanjah chosen to wait for Ms. Varney, who only arrived at the end of the incident, the trainee whom Ivan attacked could have been seriously injured. Ivan could have entered into another resident’s room, spreading human excrement through the facility and potentially assaulting other vulnerable

adults. Ms. Karanjah then faced the choice to intervene, release the trainee from Ivan's grip, and return Ivan to his room. She could have also done nothing, or removed Ivan's grip from the trainee but not return Ivan to his room, as the BOA suggests. AR 19. If Ms. Karanjah had, however, left Ivan standing in the utility closet, wearing no pants, and with excrement on his hands, she risked neglecting him. She also risked violating Department of Health licensing requirements that required her to intervene when "neglect is observed." WAC 246-841-400(6)(h).

2. Licensing Requirements Also Required Ms. Karanjah to Prevent the Spread of Infectious Material.¹⁶

WAC 388-78A-2450 requires each assisted living facility to "provide sufficient, trained staff persons to maintain the assisted living facility free of safety hazards." WAC 388-78A-2450(1)(b). Similarly, WAC 388-78A-2610 ("Infection Control) imposes requirements on assisted living facilities to "prevent and limit the spread of infections." WAC 388-78A-2920 requires the facilities to maintain, accessible only by staff persons, a "soiled" utility room for the purposes of storing soiled linen, cleaning and disinfecting soiled nursing care equipment, and disposing of refuse and infectious waste..."

¹⁶ "Infectious" is defined as "capable of causing infection or disease by entrance of organisms into the body, which grow and multiply there, including, but not limited to, bacteria, viruses, protozoans, and fungi." WAC 388-78A-2020 (Definitions).

DOH regulations also require nursing assistants to prevent the spread of microorganisms, such as feces. WAC 246-841-400(8). Kathy Houck Weed, Nursing Assistant Program Manager for DOH, testified at the 2014 hearing that, if a Dementia resident at a facility had feces on his hands, a nursing assistant *must* act to prevent the spread of that feces. CP 393. (emphasis added). She also testified that it is consistent with nursing standards of practice for a nursing assistant to be expected to follow the applicable facility regulations. *Id.*

An interpretation of the law that prohibits the use of restraints in assisted living facilities, *regardless of the circumstances*, is irrational and potentially dangerous. Here, Ivan had an infectious substance that he could have spread to others or put in his mouth. He also had a history of wandering into resident rooms without clothing, and a history of interfering with patients' oxygen equipment and setting off alarms. Just an hour before the incident with Ms. Karanjah, he had been found undressed, and in the bed of a paralyzed female resident.

Ms. Karanjah had a duty to intervene to prevent further neglect of Ivan or other vulnerable residents. She also had a duty to prevent the spread of infectious material in a healthcare facility. When she found Ivan during the second incident, he had just been rifling through soiled diapers. The fact that Ms. Karanjah's contact or restraint of Ivan did not involve

touching his hands is understandable. Additionally, the facility's chart notes reflect that Ivan was being very aggressive, not re-directable, and wandering into other resident rooms around the time in question. AR 229.

There is substantial evidence in the record that Ms. Karanjah's contact or restraint of resident Ivan was reasonable and protective given the circumstances. By not fully considering all of these circumstances, including a nursing assistant's legal obligations, the BOA erroneously interpreted and applied the law as stated in *Brown*. This Court should therefore affirm the Superior Court.

E. The 2015 Final Order is Not Supported by Substantial Evidence on the Record as a Whole.

Substantial evidence supports a finding when the evidence in the record is sufficient to persuade a rational, fair-minded person that the finding is true. *Cantu v. State, Dep't of Labor & Indust.*, 168 Wn. App. 14, 21, 277 P.3d 685 (2012). As discussed below, there is not substantial evidence that Ms. Karanjah abused a vulnerable adult, in light of Washington case law.

1. There Is No Substantial Evidence That Ivan Actually Sustained an Injury, and, Even If He Did, There Is No Substantial Evidence of a Nexus Between Ms. Karanjah's Actions and Any Injury to His Wrist. Finding of Fact 24 of the BOA's 2015 Order Is Therefore Unsupported by Substantial Evidence.

It is a verity on appeal that Ms. Karanjah released Ivan from restraint *prior* to when he entered his room. Ms. Karanjah, therefore, was not restraining Ivan at the point when his wrist might have had contact with the doorjamb.¹⁷ That finding, which appeared in the BOA's 2013 decision¹⁸, remained undisturbed by the superior court's order on remand. It also contradicts¹⁹ the later BOA finding in the 2015 decision that Ms. Karanjah shoved Ivan through the door of his room (causing Ivan to hit his wrist on the doorjamb).

Finding of Fact 24 states that "Ivan's wrist was injured when he slammed it into the doorjamb of his room . . . Angela Varney inspected the

¹⁷ Unchallenged findings of fact by an administrative agency are verities on appeal. *Heidgerken v. State, Dep't. of Natural Resources*, 99 Wn. App. 380, 993 P.2d 934, *rev. denied*, 141 Wn.2d 1015 (2000).

¹⁸ In Finding of Fact 23, the Review Judge found, in part, that "Ms. Varney saw Ivan try to grab the doorjamb and he hit his wrist on it as [Ms. Karanjah] was shoving him through." AR 8-9. This finding, which relies on testimony that comes nearly four years after the incident, contradicts a verity on remand. AR 254. In a finding of fact that was labeled as a conclusion of law, the BOA previously found in its 2013 Final Order that Ms. Karanjah released him from restraint "**at the foot of his door.**" AR 254. (emphasis added). Findings of fact by an administrative agency, which are labeled as conclusions of law, will be treated as findings of fact when challenged on appeal. *Morgan v. Dep't of Soc. & Health Servs.*, 99 Wn. App. 148, 992 P.2d 1023, *rev. denied*, 141 Wn.2d 1014 (2000). Because the Superior Court did not reverse it, that finding is a verity on remand and is the law of the case. The Court should conclude that there is no substantial evidence to support a finding that Ivan "hit his wrist while Ms. Karanjah shoved him through his door."

¹⁹ The parties agreed that unless the Superior Court had reversed Findings of Fact and Conclusions of Law in BOA's 2013 Order, those findings and conclusions would not be at issue on remand, and the decision maker would not make contrary findings or conclusions. AR 193.

wrist and saw that it was red and swollen.” AR 9. To support that finding, the Review Judge relies on evidence that is nearly identical to evidence the Superior Court had already determined was not substantial and did not rise to the level of physical abuse. AR 9. Ms. Varney previously wrote that she “heard [Ivan] hit his left wrist on the door jam,” and she “looked at his left wrist and noticed some swelling on the outside bone.” AR 363.

The “Incident Investigation” report attached to Ms. Varney’s statement indicates that Ivan’s left wrist was red at the time of the incident. AR 364. The report also states, however, that Ms. Ellis observed no redness or swelling when she assessed Ivan, approximately seven hours later. *Id.* Similarly, the record previously contained evidence that Ms. Simmons had examined resident Ivan’s wrist and found redness, but “no breaks in skin.” AR 348. This examination occurred after the second incident of restraint that night, when Ivan was in the bathroom. The BOA, however, did not engage in any fact-finding as to whether that incident might have been the cause of the redness.

The Review Judge partially relies on the Department’s newly submitted Exhibit 16, which is simply Ms. Simmons’ report regarding the 1:00AM incident. AR 228. Her description of the incident, which is based entirely on Ms. Varney’s version of the event, states, “care provider reported seeing another staff push Rsd in his room pretty hard and

slamming door, Rsd reached out with (L) hand and the door slammed his wrist against the door jam [sic].” AR 9, 228. Ms. Simmons also noted that there was “no first aide [sic] required, just redness”. *Id.* Again, this examination occurred *after* the second incident in which Ivan was restrained that night. The Review Judge also cites to Exhibit 17, which contains a nearly identical statement by Ms. Simmons in a progress note made over four hours after the incident: “alert for hurt (L) wrist . . . was slammed into door jam [sic] area of his room . . . some redness and swelling noted.” AR 9, 229. The Review Judge also relies on Ms. Varney’s new testimony. That testimony contradicts the undisturbed BOA finding that Ms. Karanjah released him from restraint *at the foot of his door*. AR 254. (emphasis added).

The only evidence of injury is based on Ms. Varney’s version of events. Her approximately two-hour delay in notifying Ms. Simmons, her supervisor, about the incident casts additional doubt as to whether Ivan was injured and if so, by whom. Ms. Varney had an obligation to report any patient injury immediately. Ms. Simmons, however, has stated that Ms. Varney had only informed her *after* Ivan had set off an alarm. AR 347.

Ms. Simmons also prepared an injury report and faxed it to the primary care physician, further corroborating the 3:00AM timeline. AR

227. Ms. Varney never testified that Ivan had set off any alarms during the 1:00AM incident, which provides additional indication that she did not report what happened until much later. If Ivan had been injured during the 1:00AM incident, as Ms. Varney has now alleged, then he went without any medical care²⁰ for that injury for approximately two hours. AR 348.

In spite of all the evidence to the contrary, the BOA has once again determined that Ivan sustained an injury. That evidence includes the DOH investigation, which concluded that the resident was not harmed. It also includes the night shift supervisor's examination of Ivan's wrist, which found redness around his wrist, but "no breaks in the skin." AR 348. Finally, there was Ms. Ellis' examination of Ivan, in which she found no evidence at all of visible injury. AR 348, 352, CP 470. Even if Ivan had sustained an injury, as regrettable as it might be, there is no substantial evidence of a nexus between Ms. Karanjah's actions and any injury to his wrist. This Court should affirm the Superior Court, and conclude that there is no substantial evidence to support Finding of Fact 24 in the BOA's 2015 Order.

2. There Is No Substantial Evidence That Ms. Karanjah Physically Mistreated Ivan, or That She Was "Frustrated" and "Overly-Assertive" in Her Handling of Him.

²⁰ As a nursing assistant, Ms. Varney was prohibited from administering medication.

In Conclusion of Law 12 of the 2015 Order, the BOA concluded that Ms. Karanjah's actions in restraining and escorting Ivan constituted physical mistreatment. AR 16. In Conclusion of Law 17 of that order, the Department engaged in apparently new fact-finding that Ms. Karanjah was "frustrated" and "over-assertive" when she ushered Ivan to his room. AR 19. Ms. Karanjah challenges Conclusion of Law 12 and the fact-finding in Conclusion of Law 17, for the reasons below.

Just as there is no substantial evidence that Ms. Karanjah caused actual injury to Ivan, there is no substantial evidence that she mistreated him. The legal analysis is the same, regardless of whether the finding of abuse is based on actual injury or physical mistreatment. *Brown* applied the same definition of physical abuse found in RCW 74.34, and determined that Ms. Brown's actions were "proper" in light of the surrounding circumstances.

Here, despite his combative and aggressive nature, Ms. Karanjah cared for Ivan as a person. She would sing for him and had attended to him over a several month period. CP 410-11. Her sense of humanity, as well as Ivan's patient history, prevented her from leaving him alone in a hallway, undressed, with feces on his hands. CP 424-25. Because Ivan was not re-directable and only speaking Spanish, Ms. Karanjah needed to use some measure of restraint that avoided direct contact with his hands.

The only eyewitness to the alleged abuse was the care provider who was actually responsible for Ivan, Ms. Varney. If Ms. Karanjah did injure or mistreat Ivan, then Ms. Varney should have reported the matter to her supervisor immediately. Ms. Varney, instead, waited two hours to do so, thereby depriving Ivan of any needed medical care in the process. If anyone harmed Ivan, it was Ms. Varney due to her inaction.

The Court should conclude that there is no substantial evidence that Ms. Karanjah physically mistreated Ivan, or that she was “frustrated” and “overly-assertive” with him, and affirm the Superior Court.

3. The Review Judge’s Finding of Fact That Ms. Karanjah Did Not Alert Staff That Ivan Needed to Be Cleaned Is Not Supported by Substantial Evidence.

In Finding of Fact 28 of the 2015 Order, the BOA found that Ms. Karanjah left Ivan alone in his room and “did not notify other staff members that his hands needed to be cleaned.” AR 10. There is substantial evidence, however, that Ms. Karanjah did ask Ms. Varney to take care of Ivan when she escorted him to his room. Ms. Karanjah testified in 2012 that she specifically asked Ms. Varney to care for Ivan. CP 500. Ms. Karanjah’s testimony is corroborated by her March 15, 2011 statement, which was closer in time to the incident. In that statement, which the BOA

determined was among the most credible evidence in the record²¹, Ms. Karanjah noted that she had left Ivan for Ms. Varney to dress him, as he had no pants. AR 339.

Ms. Varney was responsible for Ivan's cleanliness and was aware that he had been in the soiled utility room. This Court should conclude that Finding of Fact 28 is not supported by substantial evidence, and affirm the Superior Court.

4. There Is No Substantial Evidence to Support a Finding That Any Injury to the Resident Was Anything More Than Accidental.

As discussed above, the "willful" element of abuse is defined as, "the nonaccidental [sic] action or inaction by an alleged perpetrator that he/she knew or reasonably should have known could cause harm, injury or a negative outcome." WAC 388-71-0105. Ms. Karanjah did willfully engage in the decision and the action to physically take the resident back to his room. Any injury to his wrist, however, was not reasonably foreseeable. By concluding that Ms. Karanjah had already abused Ivan by restraining him, the BOA did not properly consider all of the circumstances regarding whether Ms. Karanjah's conduct amounted to a "willful" action, as defined above. This Court should conclude that there is no substantial evidence in the record that the resident's injury was

²¹ AR 6.

anything more than accidental. The Court should affirm the Superior Court and reverse the finding of abuse.

F. The BOA's 2015 Order Is Arbitrary and Capricious.

An agency action is arbitrary and capricious if it is made in disregard of the facts and circumstances. *Seymour v. State, Dep't of Health, Dental Quality Assur. Comm'n*, 152 Wn. App. 156, 172, 216 P.3d 1039 (2009). In the present case, the Superior Court specifically instructed the Department on what law to apply and what facts and circumstances to consider. Specifically, the Department was instructed to determine if Ms. Karanjah's contact or restraint of Ivan was reasonable in light of all the surrounding facts and circumstances. However, the Department failed, once again, to correctly apply the law and arbitrarily restricted its analysis to whether a "defensive" action was warranted, as opposed to a "protective" action. Additionally, the Department did not properly consider whether Ms. Karanjah's actions were "protective," and "non-injurious," or "ill-intended."

By restricting its analysis, the Department unnecessarily narrowed the scope of the evidence it actually considered. Despite the Superior Court's clear directions for what the agency should do and consider on remand, the agency chose to ignore the directives. This Court should

conclude that the Department's 2015 BOA decision was arbitrary and capricious and affirm the Superior Court's order.

G. Ms. Karanjah Is Entitled to an Award of Attorney Fees for This Level of Review, and this Court Should Also Affirm²² the Superior Court's Award of Attorney Fees for That Court's Level of Review. RCW 4.84.340-360.

Attorneys' fees are available to the prevailing party where authorized by "contract, statute, or a recognized ground in equity." *Cosmopolitan Eng'g Group, Inc. v. Ondeo Degremont, Inc.*, 159 Wn.2d 292, 296-297, 149 P.3d 666 (2006). In the present case, Ms. Karanjah is entitled to recover her attorney fees under Washington's Equal Access to Justice Act ("EAJA"), RCW 4.84.340-360, which provides in pertinent part:

Except as otherwise specifically provided by statute, a court shall award a qualified party that prevails in a judicial review of an agency action fees and other expenses, including reasonable attorneys' fees, unless the court finds that the agency action was substantially justified or that circumstances make an award unjust. A qualified party shall be considered to have prevailed if the qualified party obtained relief on a significant issue that achieves some benefit that the qualified party sought.

²² It is the Department's burden to present a "clear showing" that the Superior Court abused its discretion by awarding attorney fees awarded under the EAJA. *ZDI Gaming, Inc. v. State ex rel. Washington State Gambling Com'n* (2009) 151 Wn. App. 788, 214 P.3d 938, *rev. granted* 168 Wash.2d 1010, 227 P.3d 853, *affirmed* 173 Wash.2d 608, 268 P.3d 929, *corrected, reconsideration denied*. See also, *Alpine Lakes Protection Society v. State, Dep't of Natural Resources* (1999) 102 Wn. App. 1, 979 P.2d 929, *amended on denial of reconsideration*; and *Costanich v. State, Dep't of Soc. & Health Servs.* (2007) 138 Wn. App. 547, 156 P.3d 232, *amended on reconsideration, rev. granted* 165 Wash.2d 1012, 203 P.3d 380, *reversed* 164 Wash.2d 925, 194 P.3d 988

RCW 4.84.350(1).

Here, Ms. Karanjah is a “qualified party,”²³ and will have prevailed if the Court reverses the Department’s action affirming the finding of physical abuse.

Upon establishing that Ms. Karanjah is a “qualified prevailing party,” the Department can avoid an attorney fees award only by convincing the Court that its action, affirming the finding of abuse, was “substantially justified.” *See Language Connection, LLC v. Employment Sec. Dep’t*, 149 Wn. App. 575, 586, 205 P.3d 924 (2009). To meet this burden, the Department would have to demonstrate that its action “had a reasonable basis in law and fact.” *Id.*

As the Superior Court concluded, the Department cannot meet this burden. The Department made the finding after failing to follow the Superior Court’s instructions on remand, which led to the application of a much more restrictive legal standard. In doing so, the Department deprived Ms. Karanjah of the benefit of considering whether her contact or restraint of Ivan was “reasonable,” “in light of all the surrounding facts and circumstances.”

²³ A “qualified party” for purposes of an EAJA award is defined as “an individual whose net worth did not exceed one million dollars at the time the initial petition for judicial review was filed...” RCW 4.84.340(5). Ms. Karanjah’s affidavit of financial need confirming her financial eligibility for an EAJA award will be separately filed and served no later than 10 days prior to oral argument in this matter as required by RAP 18.1(c).

All of the requirements in the EAJA for authorizing an award of reasonable attorneys' fees to Ms. Karanjah are met in this case. The Court should authorize an award of fees and costs, including reasonable attorneys' fees pursuant to RAP 18.1 and RCW 4.84.350, for this level of review and should affirm the award of fees and costs for the Superior Court level of review.

VI. CONCLUSION

The record in this case establishes that Ms. Karanjah's actions to restrain Ivan were necessary, protective in nature, non-injurious, and therefore not abuse. In making a finding of abuse, the Department erroneously interpreted and applied the law. It also did so absent substantial evidence that the restrained resident suffered any actual injury, and absent evidence of a "willful" action intended to inflict injury. This Court should therefore affirm the Superior Court's order reversing the 2015 BOA *Review Decision and Final Order*, and make an award of attorney fees, as prayed for in her Petition for Judicial Review. **RESPECTFULLY SUBMITTED**, this 20th day of July 2016.

NORTHWEST JUSTICE PROJECT



Alberto Casas, WSBA #39122

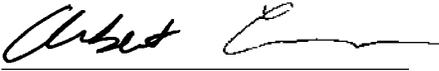
Attorneys for Respondent, Alice Karanjah

VII. CERTIFICATE OF SERVICE

I, ALBERTO CASAS, hereby certify under penalty of perjury under the laws of the State of Washington that on July 20, 2016 I caused a true and correct copy of *Respondent's Opening Brief* to be served on William McGinty by email to WilliamM1@atg.wa.gov , by prior agreement between the parties, and also by sending a copy by U.S mail, first-class postage prepaid addressed as follows:

William McGinty, Assistant Attorney General
7141 Cleanwater Drive SW
P.O. Box 40124
Olympia, WA 98504-0146

DATED this 20th day of July 2016, at Tacoma, Washington.



Alberto Casas

APPENDIX 1

Judiciary Committee

HB 1726

Title: An act relating to modifying certain definitions concerning vulnerable adults, including the definitions of abuse and sexual abuse.

Brief Description: Modifying certain definitions concerning the abuse of vulnerable adults.

Sponsors: Representatives Moeller, Jinkins, Tharinger and Appleton; by request of Department of Social and Health Services.

Brief Summary of Bill

- Makes changes to the definitions of "vulnerable adult," "abuse," and other terms applicable to abuse of vulnerable adults.
- Creates an affirmative defense to an allegation of physical abuse or improper use of restraint if the conduct was necessary to prevent an imminent danger of a substantial likelihood of harm.

Hearing Date: 2/5/15

Staff: Omeara Harrington (786-7136).

Background:

The Department of Social and Health Services (DSHS) investigates allegations of abandonment, abuse, financial exploitation, self-neglect, and neglect of vulnerable adults. The statutes regarding vulnerable adults require certain persons to report suspected incidents of mistreatment to the DSHS, and, in some cases, to law enforcement. Individuals found to have abused a vulnerable adult are prohibited from being employed in the care of vulnerable adults. In addition, a vulnerable adult, interested person on behalf of a vulnerable adult, or the DSHS may file a petition for an order for protection of a vulnerable adult who has been abandoned, abused, financially exploited, or neglected, or is threatened with such.

A vulnerable adult includes a person who:

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

- is 60 years of age or older and has the functional, mental, or physical inability to care for himself or herself;
- is found to be incapacitated (meaning the individual is at a significant risk of personal harm based upon a demonstrated inability to adequately care for himself or herself);
- has a developmental disability as defined in statute;
- is admitted to a facility;
- is receiving services from a home health, hospice, or home care agency, or an individual provider; or
- self-directs his or her own care but receives services from a personal aide.

"Abuse," as it pertains to mistreatment of vulnerable adults, is defined as willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation:

- Sexual abuse refers to nonconsensual sexual contact, or sexual contact between a vulnerable adult and a facility staff person.
- Physical abuse is the willful infliction of bodily injury or physical mistreatment, and may include the use of physical or chemical restraints in a manner that is inappropriate or inconsistent with licensing requirements.
- Mental abuse is any willful action or inaction of mental or verbal abuse, including but not limited to: coercion, harassment, inappropriate isolation from friends, family, or regular activity, and verbal assault that includes ridicule, intimidation, yelling, or swearing.
- Exploitation is an act of forcing, compelling, or exerting undue influence over a vulnerable adult, causing that vulnerable adult to act inconsistently with relevant past behavior or causing the vulnerable adult to perform services for the benefit of another.

"Financial exploitation" is defined separately than "exploitation" and is the illegal or improper use, control over, or withholding of the property, income, resources, or trust funds of a vulnerable adult for any advantage other than the vulnerable adult's profit or advantage.

Summary of Bill:

Several changes are made to the definitions of terms concerning vulnerable adults.

The definition of vulnerable adult includes any person the DSHS reasonably believes to have a developmental disability based on school or medical records (in addition to persons who have a developmental disability as defined in statute).

Abuse includes financial exploitation, as well as personal exploitation. Additionally, abuse includes the improper use of restraint against a vulnerable adult, meaning the inappropriate use of chemical, physical, or mechanical restraints for convenience or discipline in manner that is: (i) inconsistent with facility licensing or certification requirements; (ii) is not medically authorized; or (iii) otherwise constitutes abuse.

- Chemical restraint is defined as the administration of any drug to manage a resident's or client's behavior in a way that reduces the safety risk to the resident or others, restricts the resident's freedom of movement, and is not standard treatment for the resident's medical or psychiatric condition.
- Physical restraint is defined as the application of physical force without the use of any device, for the purpose of restraining the free movement of a resident's body. Physical

restraint does not include briefly holding without undue force in order to calm or comfort, or holding a hand for safe escort from one area to another.

- Mechanical restraint means any device attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.

Sexual abuse includes nonconsensual sexual conduct, or sexual conduct between a vulnerable adult and a facility staff person, rather than sexual contact.

Mental abuse is a willful verbal or nonverbal action (rather than a willful action or inaction of mental or verbal abuse) that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult. Mental abuse may include ridiculing, yelling or swearing.

It is a defense to an allegation of physical abuse or improper use of restraint that the alleged perpetrator reasonably acted to prevent an imminent danger of a substantial likelihood of harm to any person, the conduct was necessary to prevent the harm, and the conduct was proportional to the danger. This defense must be proven by the alleged perpetrator by a preponderance of the evidence.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

NORTHWEST JUSTICE PROJECT

July 20, 2016 - 4:13 PM

Transmittal Letter

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