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

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ZAID WOLDEMICAEL,

Appellant,

v.

STATE DEPARTMENT OF SOCIAL AND HEALTH  
SERVICES,

Respondent.

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**APPELLANT'S OPENING BRIEF**

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## I. INTRODUCTION

For several years, Appellant Zaid Woldemicael operated Win Adult Family Home (AFH) in Lynnwood, WA. One of the Win AFH residents was Debora, who was admitted into Win AFH in March 2014. On February 12, 2017, Debora died of asphyxia after silently choking on chewed food. As discussed in detail below, Ms. Woldemicael had prepared the food and monitored Debora in a manner that was consistent with her care plan and which had led to no prior incident. Once Ms. Woldemicael recognized that something was wrong with Debora, she did the best that she could, especially considering her limited medical training and experience. She called 911, performed CPR and followed the directives of emergency personnel. She acted consistent with standards of care. Sadly, Debora's demise was the result of an unfortunate accident.

Rather than recognizing this situation for what it was, DSHS elected to charge Ms. Woldemicael with statutory neglect. This was based on an Adult Protective Services (APS) investigation that was conducted in a manner that was biased and in contravention of DSHS policy. DSHS defied Court of Appeals decisions which hold that it cannot make career-ending findings of neglect based on observations from hindsight, bad outcomes, or ordinary negligence.

In addition to the neglect charge, DSHS cited Ms. Woldemicael for

several regulatory deficiencies, most of which are incorrect and based on the same erroneous conclusions as the neglect finding. Further evincing its biased and capricious treatment of Ms. Woldemicael, DSHS trumped up its allegations against Ms. Woldemicael and added new citations only after she appealed its initial actions. Most inequitably, DSHS opted for the most severe sanctions of summary suspension, stop placement of admissions and license revocation. This selection of remedies was not in the best interest of the remaining residents, as several guardians, and residents and even DSHS representatives attested. They uniformly endorsed the excellent quality of care that Ms. Woldemicael offered. In many ways, DSHS's actions were erroneous, arbitrary and capricious.

The Administrative Law Judge (ALJ) below carefully considered the witness testimony and reversed the DSHS neglect finding and licensing enforcement actions. On DSHS's appeal, the Board of Appeals ("Board") reversed again. The Board's Review Decisions and Final Orders reflect numerous incorrect applications and interpretations of law and clearly erroneous factual determinations. On judicial review, the Superior Court entered orders summarily affirming the Board's Review Decisions. The Board's and Superior Court's orders substantially prejudiced Ms. Woldemicael and set an unlawful and dangerous precedent for future DSHS proceedings involving similar issues. This inequitable and harmful result

should be reversed by this Court.

## **II. ASSIGNMENTS OF ERROR**

### **A. Assignments of Error.**

1. The DSHS Board of Appeals erred in finding that Ms. Woldemicael neglected a vulnerable adult.

2. The Superior Court erred in finding that Ms. Woldemicael neglected a vulnerable adult.

3. The DSHS Board of Appeals erred in affirming DSHS's licensing enforcement actions against Ms. Woldemicael, including summary suspension and revocation of Ms. Woldemicael's AFH license, and "stop placement" of admissions.

4. The Superior Court erred in affirming DSHS's licensing enforcement actions against Ms. Woldemicael, including summary suspension and revocation of Ms. Woldemicael's AFH license, and "stop placement" of admissions.

5. The Superior Court erred in determining that all of the findings of fact made by the DSHS Board of Appeals are supported by substantial evidence in the record, specifically including:

- a. finding of fact 6 in the Final Order – APS;
- b. finding of fact 14 in the Final Order – APS;
- c. finding of fact 15 in the Final Order – APS;

- d. finding of fact 24 in the Final Order – APS;
- e. finding of fact 4 in the Final Order – AFHL;
- f. finding of fact 15 in the Final Order – AFHL;
- g. finding of fact 20 in the Final Order – AFHL;
- h. finding of fact 22 in the Final Order – AFHL;
- i. finding of fact 26 in the Final Order – AFHL; and
- j. finding of fact 27 in the Final Order – AFHL.

6. The Superior Court erred in determining that the DSHS Board of Appeals correctly interpreted and applied the law.

7. The DSHS Board of Appeals erred in determining that Ms. Woldemicael failed to follow the specific instructions in the care and support plans for Deborah; and that this constituted neglect of a vulnerable adult and a failure to prevent neglect in violation of the Adult Family Home Rules.

8. The Superior Court erred in determining that Ms. Woldemicael failed to follow the specific instructions in the care and support plans for Deborah; and that this constituted neglect of a vulnerable adult and a failure to prevent neglect in violation of the Adult Family Home Rules.

9. The DSHS Board of Appeals erred in determining that the agreement to surrender Ms. Woldemicael's previous Adult Family Home license is clear and not ambiguous; and that Ms. Woldemicael's later

contracting with the Department was a breach of that agreement, despite the Department's role in those subsequent contracts.

10. The Superior Court erred in determining that the agreement to surrender Ms. Woldemicael's previous Adult Family Home license is clear and not ambiguous; and that Ms. Woldemicael's later contracting with the Department was a breach of that agreement, despite the Department's role in those subsequent contracts.

11. The DSHS Board of Appeals erred in affirming violations of Adult Family Home rules as determined by DSHS, specifically including violations of WAC 388-76-10670 (Prevention of abuse), WAC 388-76-10020 (Care and services) and WAC 388-76-10355 (Negotiated care plan).

12. The Superior Court erred in affirming the violations of Adult Family Home rules as determined by the DSHS Board of Appeals.

13. The DSHS Board of Appeals erred in determining that none of the DSHS actions were arbitrary and capricious.

14. The Superior Court erred in determining that none of the DSHS actions were arbitrary and capricious

#### **B. Issues Pertaining to Assignments of Error.**

1. Were the Review Decisions and Final Orders of DSHS based on incorrect interpretations and applications of applicable law? (Assignments of Error 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12).

2. Were the findings of fact made by DSHS in its Review Decisions and Final Orders unsupported by substantial evidence in the record, specifically including: findings of fact 6, 14, 15 and 24 in the Final Order – APS; and findings of fact 4, 15, 20, 22, 26 and 27 in the Final Order – AFHL? (Assignments of Error 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12).

3. Were the Review Decisions and Final Orders of DSHS based on erroneous conclusions of law and unlawful procedures and decision-making processes, specifically including: conclusions of law 14, 15, 16, 17 and 18 in the Final Order – APS; and conclusions of law 10, 13, 27, 28, 29, 30 and 31 in the Final Order – AFHL? (Assignments of Error 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12)

4. Did DSHS deny Ms. Woldemicael rightful due process of law by relying on DSHS allegations which were made without adequate notice to Ms. Woldemicael and DSHS evidence which was late-disclosed, resulting in the denial of adequate opportunity to conduct additional discovery prior to hearing and to introduce certain written and oral evidence into the hearing record? (Assignment of Error 3, 4, 6, 9, 10, 11, 12).

5. Are the Review Decisions and Final Orders of DSHS arbitrary and capricious? (Assignments of Error 1, 2, 3, 4, 11, 12, 13, 14).

6. Is Ms. Woldemicael entitled to an award of attorneys' fees and costs pursuant to the Equal Access to Justice Act? (Assignments of Error 1, 2, 13,

14).

### III. STATEMENT OF THE CASE

#### A. Zaid Woldemicael, Win AFH and Debora.

For several years, Appellant Zaid Woldemicael operated Win Adult Family Home (AFH) at 5431 189th St SW, Lynnwood, WA 98036. One of the Win AFH residents was Debora, who was admitted into Win AFH in March 2014. Agency Record (hereinafter “AR”)<sup>1</sup>, 601. Debora suffered from many medical and cognitive issues, including a seizure disorder that caused her to suffer frequent seizures, often multiple times per week. AR 613.

#### B. Ms. Woldemicael Prepared Debora’s Meal.

On February 12, 2017, Ms. Woldemicael prepared Debora a meal consisting of a chicken sandwich and chips, which meal she had eaten many times before without any complications. Verbatim Report of Proceedings (hereinafter “RP”),<sup>2</sup> Vol. I, at 125, 126. Consistent with Debora’s care plan, Ms. Woldemicael cut the sandwich into small pieces. *Id.* Having lived at Win AFH for nearly three years, Debora had never choked on any food. *Id.*,

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<sup>1</sup> There were two nearly – but not entirely - identical versions of the Agency Record that were filed with the Superior Court. *See* Clerk’s Papers (CP) 15-16, 120-121. Unless otherwise stated, all references to the Agency Record refer to that filed with the Superior Court in Case No. 18-2-04218-34 on October 3, 2018.

<sup>2</sup> Unless otherwise stated, all references to the Verbatim Report of Proceedings or Transcript refer to that which was filed with the Superior Court in Case No. 18-2-04218-34 on October 10, 2018. *See* CP 122.

Vol. I, at 126, 127.

Kristina Sherriff was Debora's Developmental Disabilities Administration (DDA) case manager from 2015 until December of 2016. RP, Vol II, at 82, 84. Ms. Sherriff developed the November 8, 2016 Individual Support Plan or "assessment" that was in effect as of February 12, 2017. *Id.*, Vol. II, at 31, 32; *see also* AR 601-634 (11/8/16 Individual Support Plan). Ms. Sherriff gave specific testimony that the chicken sandwich, prepared as was it was that day, was consistent with Debora's assessed needs:

Q. And then it [referring to assessment] indicates that all foods must be cut into small pieces, what does that mean to you?

A. Bite size pieces.

Q. Okay. Well, I suppose 'bite size'. What do you mean by 'bite size'?

A. *I don't have a template for that. It's more the knowledge that the caregiver would have. I would say smaller is better.*

Q. So would 'bite size', based on your understanding of Debora's needs, would that mean a size that she could put that in her mouth to chew and swallow?

A. Yes.

Q. I want you to assume that there was testimony yesterday that Debora's sandwiches were served to her cut in quarters, and would that be 'bite size' in your opinion?

A. *I would say quarters is pretty adequate.*

RP, Vol. II, at 77, 78 (alteration supplied; emphasis added).

Oddly, DSHS investigator Jennifer Witman never contacted Ms. Sherriff, although many of the allegations she later made involved an

interpretation of the very assessment that Ms. Sherriff developed. RP, Vol. III, at 35, 36. During the investigation, Ms. Witman was also not aware that Debora had regularly eaten a chicken sandwich, prepared in the same way, without prior incident; she admitted that this was a “significant fact”. *Id.*, Vol. III, at 44, 45. Ultimately, Ms. Witman admitted that Ms. Sherriff was better able to interpret the terms of the assessment and the level of care required than Ms. Witman was. *Id.*, Vol. III, at 47.

**C. Ms. Woldemicael Monitored Debora.**

Ms. Woldemicael monitored Debora from the kitchen adjacent to the dining area, mere feet away from where Debora sat and certainly “within line of sight or earshot,” as required by her assessment. RP, Vol. I, at 42. There was extensive testimony from Ms. Woldemicael, Ms. Sherriff and others about the location Debora sat during the February 12 meal and its proximity to the kitchen where Ms. Woldemicael was working. RP, Vol. VI, at 8, 9; *see also* AR 225-232 (photographs of Win AFH), AR 600 (floor plan). Ms. Sherriff, who had visited Win AFH several times, testified specifically about Ms. Woldemicael’s compliance with several requirements of Debora’s assessment regarding monitoring for choking and protective supervision:

Q. [Referring to Debora’s assessment] ...a section called “protective supervision,” what does that mean?

A. That is what we classify proximity of where a caregiver

needs to be, typically. And this one is “close observation.”

Q. What does that mean?

A. It means within line of sight or earshot. So, the client falls down, you are able to hear that, call out for you, you can hear that. Or you can see something.

RP, Vol. II, at 61 (alteration supplied).

Q. Again on exhibit eighteen [floor plan], if Deborah was sitting at the table eating - and that's marked as “dining room” where there's a rectangle and the space “X” marked - Deborah was sitting, and in this living room near the front of the home where its marked “parking” there were residents sitting on the couch here, and they are watching TV, they're watching cartoons, and the provider, the only other caregiver in the home at the time, was in the kitchen cooking and washing dishes, would the provider be able to have adequate earshot of Deborah eating such she could monitor for choking?

A. I believe she would even have line of sight there. I would sit on that side of the table to do my assessments and had a clear view of the kitchen and had a clear view of the living room. So, I believe that the sink is on this side. So, if she was able to just turn her hand to the right she would have line of sight of Deborah. So, that's typically where I sat, was that seat.

Q. But my question wasn't about line of sight. My question was about earshot. Would she be able to adequately hear, have Deborah in earshot?

A. Well my assessment tool said “line of sight or earshot,” so I know your question is specifically about line of sight, but it's a drop-down box. *So the fact that I put it as line of sight or earshot I believe that she's within proximity for that.*

*Id.*, Vol. II, at 69, 70 (emphasis added; alteration supplied).

Q. What was your understanding of Deborah's needs from her caregiver as far as monitoring for choking?

A. It would be kind of what we talked about earlier: line of sight or earshot.

*Id.*, Vol. II, at 79. Debora's care needs *did not* require that she remain in continuous or uninterrupted line of sight throughout her meal. *Id.*, Vol. II, at 86, 87.

Ms. Woldemicael and several other witnesses who were present in Win AFH at the relevant time testified that they never heard Debora make sounds of gagging, choking, retching, vomiting or any other audible signs of distress. RP, Vol. VI, at 13, 14 (9/21/17 Woldemicael testimony); *id.*, Vol. V, at 146 (9/20/17 M. Kibrom testimony); *id.*, Vol. V, at 132 (Ogbamichael testimony); *id.*, Vol. V, at 119 (H. Kibrom testimony)<sup>3</sup>. Even Ms. Witman admitted that Debora could have possibly choked silently, whether due to seizure, or otherwise.<sup>4</sup> RP, Vol. III, at 58-60. Ms.

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<sup>3</sup> There was varied and often speculative testimony about the presence of a modest amount of "food and/or vomit" on Debora's clothing shown in post-mortem photographs. No witness had actual knowledge of when this substance would have been first visible on her shirt, or precisely what the substance consisted of. Multiple witnesses with medical training testified that vomiting is a known complication of CPR and/or other emergency resuscitation efforts. However, Ms. Woldemicael testified that, while she did not notice this substance when she first found Debora in distress, if she had, it would not have changed her actions, since Debora had no pulse and was not breathing. RP, Vol. VI, at 16.

<sup>4</sup> When asked, hypothetically, whether Debora would have been able to summon help if she was choking, Ms. Sherriff did not know. However, she confirmed the possibility of silent choking, citing her own personal experience:

Q. What if, uh, Deborah was sitting at the table and the caregiver was not in the room and she was choking. Would she be able to summon help?

A. I don't know. I don't know if she would be able to make any noises. I know personally from the time that I have choked, um, no one knew until I was turning blue.

RP, Vol. II, at 71.

Woldemicael disputed that she left Debora unattended for “five minutes”, or that she told the police as much.<sup>5</sup> RP, Vol. VI, at 20. The witnesses present in the home also testified that Ms. Woldemicael remained in the kitchen and did not leave Debora’s vicinity throughout the meal. RP, Vol. V, at 146 (9/20/17 M. Kibrom testimony); *id.*, Vol. V, at 130, 131 (Ogbamichael testimony); *id.*, Vol. V, at 116, 117 (H. Kibrom testimony). No percipient witnesses disputed these first-hand accounts.

**D. Ms. Woldemicael Responded to Signs of Distress.**

At one point, while she was preparing other residents’ dinner in the kitchen, Ms. Woldemicael turned around, looked at Debora’s face, and could tell something was very wrong. RP, Vol. I, at 141, 142. Debora did not then respond to Ms. Woldemicael and was apparently not breathing. However, lacking any medical training beyond that required for a Nursing Assistant (NAC) credential, and having no training in “clinical judgment,” Ms. Woldemicael was unable to readily diagnose the cause of distress. RP, Vol. VI, at 18, 19. Ms. Woldemicael had observed a person choking before, and the victim’s presentation was entirely different, with loud audible symptoms and writhing. *Id.*, Vol. VI, at 14, 15. In this moment of extreme urgency, Ms. Woldemicael initially thought that Debora could be having a

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<sup>5</sup> This “five minute” statement was derived from a single police record and later repeated by others. A different first responder’s record suggested a different time of “30 seconds.” See AR 562-564 (Lynnwood Fire Department Patient Care Record).

seizure, as she often did.<sup>6</sup> *Id.*, Vol. VI, at 17. Ms. Woldemicael had been trained that, during an apparent seizure, a caregiver should not insert hands or objects into the victim's mouth, owing to the risk of further injury. *Id.*, Vol. V, at 176-177. Ms. Woldemicael also briefly considered that Debora could be suffering cardiac arrest. *Id.*, Vol. I, at 144. She immediately called 911. *Id.*, Vol. VI, at 17.

Consistent with her past first aid training, Ms. Woldemicael advised the 911 operator that Debora had Physician Orders for Life-Sustaining Treatment (POLST), also referred to as a "Do Not Resuscitate" (DNR) order. RP, Vol. VI, at 17-18. Ms. Woldemicael's first aid instructor, Priscilla Bunch Baker, testified that considering this information is perfectly appropriate, as the existence of a DNR order substantially alters the next steps to be taken during an emergency. RP, Vol. V, at 179, 180. Even investigator Ms. Witman agreed that Debora's DNR affected the appropriate response. *Id.*, Vol. III, at 80, 81.

As is reflected in the 911 call transcript, the operator directed Ms. Woldemicael to begin CPR. *See* AR 565-572. Due to Debora's obesity and partial paralysis from a historical stroke, Ms. Woldemicael called for help from her husband, and he and his friend, Pawlos Ogbamichael, helped to

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<sup>6</sup> *See also* AR 566 (transcript of 911 call).

move Debora from her chair and down to the ground. RP, Vol. I, at 153, 154 (7/31/17 Woldemicael testimony); *id.*, Vol. I, at 85, 92, 93 (7/31/17 M. Kibrom testimony); *id.*, Vol. V, at 131, 132 (Ogbamichael testimony). Ms. Woldemicael made her best effort to follow the operator's instructions exactly, and carried out CPR until paramedics arrived. *Id.*, Vol. VI, at 18 (9/21/17 Woldemicael testimony); *Id.*, Vol. V, at 133, 134 (9/20/17 Ogbamichael testimony). The paramedics inquired about whether Debora had a DNR order, and then directed Ms. Woldemicael to retrieve the order, which she did. RP, Vol. VI, at 18, 19.

#### **E. DSHS Actions, Initial Orders and Final Orders.**

On April 13, 2017, DSHS notified Ms. Woldemicael that she had been subjected to a substantiated finding of neglect pursuant to Chapter 74.34 RCW. AR 512-518. Ms. Woldemicael timely appealed the April 13, 2017 finding. AR 519-523. On April 18, 2017, DSHS summarily suspended and revoked Ms. Woldemicael's AFH license, and issued a Stop Placement Order prohibiting admissions to her AFH, based on a March 28, 2017 Statement of Deficiencies (SOD). AR 524-528. Ms. Woldemicael timely appealed the April 18, 2017 actions. AR 529-542

Well after Ms. Woldemicael had appealed the April 13 and April 18 enforcement actions, and after the close of discovery according to the Case Schedule which governed the appeals, DSHS issued a July 28, 2017

“amended” notice of enforcement action based on an “amended” SOD that was signed by a DSHS representative on July 28, 2017. AR 898-911 (amended SOD); AR 912-915 (amended notice). The amended notice and SOD alleged new deficiencies that formed the basis for the DSHS enforcement actions. *Id.* DSHS also proposed and had admitted into evidence exhibits related to the late amended enforcement notice and SOD. *See* RP Vol. I, at 21-24. Ms. Woldemicael timely objected to the late introduction of these allegations and related evidence. RP, Vol. I, at 10-12, 24.

On July 6, 2017, DSHS sent to Ms. Woldemicael an additional SOD that was completed June 26, 2017. AR 892-897. This late SOD arose from Ms. Woldemicael’s alleged non-compliance with a 2013 settlement and the agreed disposition of a 2012 licensing action involving a totally different AFH that had formerly been operated by Ms. Woldemicael. *Id.* DSHS also proposed and had admitted into evidence many exhibits which related to the late SOD. RP, Vol. I, at 21-24; AR 691-830. Ms. Woldemicael timely objected to the late introduction of these allegations and related evidence. RP, Vol. I, at 10-12, 24.

Ms. Woldemicael’s appeals as to all of the DSHS actions were consolidated for hearing. Hearings were conducted by ALJ Jason Grover on July 31, 2017; August 1, 2017; and September 18-21, 2017. *See* RP Vol.

I-VI. Subsequent to these hearings, ALJ Grover reversed the DSHS finding of neglect pursuant to an April 6, 2018 Initial Order entered under Docket No. 04-2017-LIC-01138 (hereinafter “Initial Order – APS”). CP 154-165.<sup>7</sup> ALJ Grover also reversed the DSHS enforcement actions in summarily suspending and revoking Ms. Woldemicael’s Adult Family Home license and issuing a Stop Placement Order prohibiting admissions and remanded the matter to DSHS for consideration of appropriate remedies, pursuant to an April 6, 2018 Initial Order entered under Docket Nos. 04-2017-LIC-01141, 04-2017-LIC-01142, 04-2017-LIC-01151, and 04-2017-LIC-01152 (hereinafter “Initial Order – AFHL”). AR 73-88.

On May 16, 2018, DSHS filed a consolidated Petition for Board of Appeals Review regarding both Initial Orders. AR 47-69. On May 24, 2018, Ms. Woldemicael filed a Response to the Department's Petition for Review. AR 28-45.

On August 8, 2018 the DSHS Board of Appeals (“Board”) issued a Review Decision and Final Order – Adult Protective Services (hereinafter “Final Order – APS”) reversing the ALJ’s Initial Order – APS and affirming the Department’s prior determination of neglect. CP 167-182.<sup>8</sup> On August

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<sup>7</sup> The Initial Order – APS was apparently omitted from in the Original Agency Record filed with the Superior Court in Case No. 18-2-04218-34 on October 3, 2018. *See also* CP 15-16.

<sup>8</sup> The Final Order – APS was apparently omitted from in the Original Agency Record filed with the Superior Court in Case No. 18-2-04218-34 on October 3, 2018. *See also* CP

8, 2018, the Board issued a Review Decision and Final Order – Adult Family Home License - Expedited (hereinafter “Final Order – AFHL”) reversing the Initial Order – AFHL and affirming the DSHS summary suspension and revocation of Ms. Woldemicael’s AFH license, and its Stop Placement Order.<sup>9</sup> AR 1-24.

Ms. Woldemicael filed two petitions with the Superior Court seeking judicial review of both Final Orders. CP 1-24, 78-119. Briefing was filed, the matters were assigned for a joint hearing before the Superior Court, and the hearing was held on August 30, 2019. *See* Report of Proceedings, August 30, 2019, Vol. 1. On October 4, 2019 the Superior Court entered orders summarily affirming all the findings of fact of the Board and making brief conclusions of law upholding the Board’s prior conclusions. CP 67-69, 209-211. Ms. Woldemicael timely filed notices of appeal as to each Superior Court order. CP 70-74, 212-216.

#### **IV. SUMMARY OF THE ARGUMENT**

A finding of statutory neglect pursuant to Chapter 74.34 RCW is a gravely serious and often career-ending event for the “alleged perpetrator,” who is placed on a registry for life, foreclosing the opportunity of future

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15-16.

<sup>9</sup> Herein below, Ms. Woldemicael will refer to the Initial Orders and Final Orders by name and will cite their respective Findings of Fact (hereinafter “FF”) and Conclusions of Law (hereinafter “CL”) by paragraphs.

employment in not just AFH operations but countless other occupations and settings. As such, several appellate courts have recognized two important principles which together establish a high threshold for a neglect finding based on “an act or omission by a person or entity with a duty of care that demonstrates *a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety*”: (1) the conduct at issue must be well beyond that which amounts to simple negligence; and (2) whether the conduct rises to that level cannot be judged by the gravity of the outcome for the alleged victim, nor by any analysis based on hindsight.

In the wake of a tragic choking death suffered by Debora, one of her developmentally disabled AFH residents, Ms. Woldemicael was subjected to a series of DSHS actions that fundamentally abandoned these legal principles. Even though it was widely known that accidental choking deaths are not uncommon in AFH settings, DSHS for some reason could not accept the explanations provided by Ms. Woldemicael and several other first-hand witnesses as to how and why this most unfortunate but accidental event occurred. DSHS even discredited and minimized the testimony of Debora’s own DSHS case manager, who confirmed that Ms. Woldemicael’s meal preparation and monitoring at the time of the event was consistent with Debora’s assessment and care plan and had been employed without incident

for years. DSHS's hearing evidence filled a void of percipient evidence with post-hoc speculation and retrospection – essentially, argument from hindsight.

The neglect finding was unsupported by substantial evidence. It was based on erroneous conclusions of law. So were several asserted violations of AFH regulations and severe licensing enforcement actions meted out by DSHS, all of which arose from the same facts and circumstances.

DSHS was so determined to find neglect that it violated its own investigative policy and failed to interview Ms. Woldemicael in the process of the investigation. DSHS's enforcement operatives failed to credit the opinions of many interested AFH residents, guardians and DSHS case managers, all of whom endorsed the exceptional quality of care provided by Ms. Woldemicael, urging the fact-finder to reverse DSHS's shuttering of her home. Only after Ms. Woldemicael requested a hearing to challenge the neglect finding and enforcement actions, DSHS added new late-disclosed allegations and evidence, in derogation of Ms. Woldemicael's due process rights.

Starting from an outdated and inapplicable definition of "neglect," the DSHS Board of Appeals engaged in a thoroughly flawed legal analysis, reversed the ALJ, and upheld all the pernicious DSHS actions. In many ways, DSHS's actions were erroneous, arbitrary and capricious. These

actions should be reversed by this Court.

## V. ARGUMENT

### A. Standards of Review.

The Washington Administrative Procedure Act (APA) governs review of final agency action. RCW 34.05.510; *Tapper v. Emp't Sec. Dep't*, 122 Wn.2d 397, 402, 858 P.2d 494 (1993). When reviewing an agency action, this court applies the standards of the APA directly to the record before the agency. *Tapper*, 122 Wn.2d at 402. “The findings of fact relevant on appeal are the reviewing officer’s findings of fact—even those that replace the ALJ’s.” *Hardee v. Dep't of Soc. & Health Servs.*, 172 Wn.2d 1, 19, 256 P.3d 339 (2011) (citing *Tapper*, 122 Wn.2d at 406). When reviewing an administrative agency decision, the Court reviews issues of law de novo. *Ames v. Med. Quality Assur. Comm'n*, 166 Wn.2d 255, 260, 208 P.3d 549 (2009). The Court may “then substitute [its] judgment for that of the administrative body on legal issues.” *Ames*, 166 Wn.2d at 260-61.

This Court grants relief from the reviewing judge’s order if:

(a) 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;

...

(c) The agency has engaged in unlawful procedure or decision-making process, or has failed to follow a prescribed procedure;

(d) The agency has erroneously interpreted or applied the law;

(e) The order is not supported by evidence that is substantial when viewed in light of the whole record before the court, ...;

...

(h) The order is inconsistent with a rule of the agency unless the agency explains the inconsistency by stating facts and reasons to demonstrate a rational basis for inconsistency; or

(i) The order is arbitrary or capricious.

RCW 34.05.570(3)(a), (c), (d), (e), (h), (i).

RCW 34.05.464(4) provides that an administrative review judge “shall exercise all the decision-making power that the reviewing [judge] would have had to decide and enter the final order had the reviewing [judge] presided over the hearing, except to the extent that the issues subject to review are limited by a provision of law.” And, “[i]n reviewing findings of fact by [ALJs], the reviewing [judge] shall give due regard to the [ALJ's] opportunity to observe the witnesses.” RCW 34.05.464(4) (alteration supplied).

The reviewing judge is justified in substituting its factual findings for those of the ALJ only if the ALJ's findings of fact are unsupported by substantial evidence based on the entire record, the decision includes errors of law, or findings of fact must be added because the ALJ failed to make an essential factual finding. *Costanich v. Dep't of Soc. & Health Servs.*, 138 Wn. App. 547, 556, 156 P.3d 232 (2007), *rev'd on other grounds*, 164 Wn.2d 925, 194 P.3d 988 (2008). The reviewing agency or court must accept the fact finder's “ ‘views regarding the credibility of witnesses and

the weight to be given reasonable but competing inferences.’ ” *Costanich*, 138 Wn. App. at 556 (quoting *Freeburg v. City of Seattle*, 71 Wn. App. 367, 371-72, 859 P.2d 610 (1993) ); *Hardee*, *supra*, 172 Wn.2d at 19 n.11 (when a “ ‘reviewing officer ignores or reverses the credibility findings of the hearing officer, heightened scrutiny should apply to substantial evidence review of any substituted findings of fact.’ ” (quoting *Tapper*, *supra*, 122 Wn.2d at 405 n.3) ); *Crosswhite v. Dep't of Soc. & Health Servs.*, 197 Wn. App. 539, 548, 389 P.3d 731 (2017) (“The review judge may commit an error of law if he or she fails to give due regard to findings of the ALJ that are informed by the ALJ’s ability to observe the witnesses.”))

Deference is generally given to an agency's view of the law in construing ambiguous statutes within the agency's area of expertise; absent such ambiguity, this Court is entitled to substitute its judgment on legal issues for those of the administrative tribunal. *See, e.g., Pasco v. Public Empl. Relations Comm'n*, 119 Wn.2d 504, 507, 833 P.2d 381 (1992).

#### **B. Burdens and Standards of Proof.**

In a hearing challenging a substantiated finding of neglect, or licensing enforcement actions, DSHS has the burden of proof. DSHS must have shown it was more likely than not that Ms. Woldemicael committed the alleged neglect of a vulnerable adult and the regulatory violations claimed as a basis for enforcement actions. WAC 388-71-01255(1); WAC

388-02-0485; *Kraft v. Dep't of Soc. & Health Servs.*, 145 Wn. App. 708, 716, 187 P.3d 798 (2008).

All DSHS allegations in these matters must have been supported by some amount of competent, non-hearsay evidence that Ms. Woldemicael had the fair chance to confront. RCW 34.05.461(4); WAC 388-02-0475(3). *See also* Index of Significant Decisions, Docket No. 10-2004-L-1070, p. 39 (“The information contained in the *Statement of Deficiencies/Plan of Correction* that was not directly observed by the Department’s investigator or does not fall under an exception to the hearsay rule (i.e., review of medical records or Appellant’s own statements to the investigator) cannot be used as an exclusive basis for findings of fact.”); *Nationscapital v. Dep’t of Fin. Insts.*, 133 Wn. App. 723, 751, 137 P.3d 78 (2006) (“By the rule’s plain terms, whether a party’s opportunity to confront witnesses has been unduly abridged becomes an issue only when the presiding officer relies ‘exclusively’ on evidence that would be inadmissible in a civil trial.”)

A licensed AFH provider has a regulatory, statutory and constitutional right to challenge DSHS’s discretionary decision revoking her license, and an administrative hearing is the proper forum to make that challenge. *Conway v. Dep't of Soc. & Health Servs.*, 131 Wn. App. 406, 418-419, 120 P.3d 130 (2005). Given the catastrophic consequences of a substantiated neglect finding, discussed *supra*, Ms. Woldemicael must have

a similar regulatory, statutory and constitutional right to a hearing to challenge DSHS's imposition of statutory neglect.

**C. The Review Decisions and Final Orders of DSHS Are Based on Incorrect Interpretations and Applications of Law.**

DSHS charged Ms. Woldemicael with “neglect” pursuant to Chapter 74.34 RCW. If DSHS substantiates a report of alleged neglect and its “substantiated” finding becomes final, it must place the reported “perpetrator’s” name on a state registry. WAC 388-71-01280. A final “substantiated” finding may be professionally disqualifying for the person charged with neglect since state law prevents such individuals from being employed in a position or holding a license that involves the care of vulnerable adults or children or from working or volunteering in a position giving them unsupervised access to vulnerable adults or children. RCW 74.39A.056(2); WAC 388-76-10120(3)-10180(1); RCW 26.44.100(2)(c), .125(2)(e); WAC 388-06A-0110.

Under RCW 74.34.020 (16):

“Neglect” means (a) a pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or (b) *an act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety*, including but not limited to conduct prohibited under RCW 9A.42.100.

(emphasis added).

Adjudicators must avoid interpretations of statutes that are unlikely or absurd. *Alderwood Water Dist. v. Pope & Talbot, Inc.*, 62 Wn.2d 319, 321, 382 P.2d 639 (1963). A reviewing court should construe agency rules in “ ‘a rational, sensible’ ” manner, giving meaning to the underlying policy and intent. *Mader v. Health Care Auth.*, 149 Wn.2d 458, 472, 70 P.3d 931 (2003) (quoting *Cannon v. Dep't of Licensing*, 147 Wn.2d 41, 57, 50 P.3d 627 (2002)). “The spirit or purpose of an enactment should prevail . . . .” *State v. Day*, 96 Wn.2d 646, 648, 638 P.2d 546 (1981). In authorizing DSHS to adopt regulations for AFHs, the legislature cautioned that “[i]n developing rules and standards the department shall recognize the residential family-like nature of adult family homes and not develop rules and standards which by their complexity serve as an overly restrictive barrier to the development of the adult family homes in the state. Procedures and forms established by the department shall be developed so they are easy to understand and comply with.” RCW 70.128.040(1).

Two Court of Appeals decisions in the DSHS context demonstrate that, for purposes of determining whether “neglect” has occurred, the statutory definition must be narrowly rather than broadly interpreted.

In *Brown v. Dep't of Soc. & Health Servs.*, 190 Wn. App. 572, 360 P.3d 875 (2015), the Court of Appeals reversed and vacated a finding of

neglect that DSHS had made against the mother of an injured child. The statutory definition of “abuse or neglect” at issue in *Brown* was substantially similar to that at issue here because the pertinent portion of that definition incorporated by reference a second definition, of “negligent treatment or maltreatment,” that read: “ ‘[n]egligent treatment or maltreatment’ means an act or a failure to act, or the cumulative effects of a pattern of conduct, behavior, or inaction, that *evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to a child's health, welfare, or safety*, including but not limited to conduct prohibited under RCW 9A.42.100.” *Brown*, 190 Wn. App. at 588-589 (citing RCW 26.44.020(1), (16); court’s emphasis). The court was also confronted with a DSHS regulation, WAC 388-15-009(5), that expanded the definition of “negligent treatment or maltreatment” by listing various exemplary acts and omissions.

Based on a detailed analysis of the statutory language and other precedents, the *Brown* court ultimately concluded that the words employed in the statutory definition of “negligent treatment or maltreatment” – specifically including the terms “serious disregard of consequences” and “clear and present danger” - meant that DSHS could not invoke a “reasonable person” standard, and could not sanction a person for “neglect” based on conduct amounting to simple negligence. *See Brown*, 190 Wn.

App. at 590-593.

Further, in *Raven v. Dept. of Soc. & Health Svcs.*, 177 Wn.2d. 804, 306 P.3d 920 (2013), the Supreme Court reversed a finding of neglect against a certified professional guardian arising from her management of the care for an incapacitated ward. In so holding, the Court illustrated that, even if an alleged perpetrator failed – in numerous respects - in her duty to meet applicable professional standards this is not sufficient to prove statutory neglect: “This record does not establish that Raven's conduct—while lacking in many respects from a professional standpoint—failed to provide the goods and services needed to maintain [the alleged victim’s] physical health or that her conduct resulted in physical or mental harm or pain to [the alleged victim].” 177 Wn.2d at 829-830 (alteration supplied).

In a further observation that is also pertinent here, the *Brown* court rejected a DSHS argument that the accused’s lack of health care qualifications should have led her to take extra pre-cautions in managing a burn injury. “The argument [] employs hindsight that is unbecoming even for a negligence standard. Under negligence law, courts will not view a party's acts with the clarity of hindsight.” *Brown*, 190 Wn. App. at 596 (citations omitted). In a recent unreported decision, Division II of this Court concurred with *Brown* and held, in the context of a DSHS neglect case, that “the Board improperly relied on hindsight to conclude serious disregard and

clear and present danger existed because harm occurred.” *See Pal v. Dept. of Soc. & Health Svcs.*, 2019 Wash. App. LEXIS 489, at 28-29 (March 5, 2019) (unreported decision); *see also In re Dependency of Lee*, 200 Wn. App. 414, 438, 404 P.3d 575 (2017) (holding that the trial court's reliance on hindsight to conclude that parents’ rejection of a feeding tube for their medically complex son constituted abuse or neglect was improper).

In *Crosswhite, supra*, the Court of Appeals considered the DSHS regulatory definition of “abuse” found in WAC 388-71-0105 in comparison with the statutory definition of the term set forth in RCW 74.34.020(2). In holding that the regulatory definition erroneously interpreted the statute and exceeded DSHS’s authority, the court made various observations that are applicable here, including that a “negative outcome” is not among “the types of harm that could support a professionally disqualifying finding of abuse”:

...Adding “negative outcome” to the types of harm that will support a professionally disqualifying finding of abuse is overly broad and irreconcilable with RCW 74.34.020(2).

...

While deferring to agency expertise where appropriate, this court has consistently rejected department interpretations of statutes that broaden its authority to take punitive action. We have already discussed the 2008 decision in *Brown*, in which this court rejected the Department's view that it was authorized to make a substantiated finding of physical abuse even though Ms. Brown intervened in a situation with a violent client to take actions that, while physical and objectionable to the client, were “protective, not injurious or

ill-intended.” *Brown v. Dep’t of Soc. & Health Servs.*, 145 Wn. App. 177, 183, 185 P.3d 1210 (2008).

...

Last year, in [Ashley] *Brown* (we modify the case name to distinguish it from this court’s 2008 *Brown* decision), this court rejected the Department’s incorporation of a “reasonable person” standard into the legal standard required to uphold a finding of neglect or abuse against a parent. [Ashley] *Brown v. Dep’t of Soc. & Health Servs.*, 190 Wn. App. 572, 587, 360 P.3d 875 (2015). In addition to a textual basis for the decision, the court found “[g]ood reason ... to reject a negligence benchmark,” for “[a] negligence standard could place every Washington parent in jeopardy because what is ‘reasonable’ under a negligence regime varies depending on the situation and actors involved.” *Id.* at 593.

*Crosswhite*, 197 Wn. App. at 556-558 (citations altered).

As an initial matter, the Board here used an outdated and inapplicable definition of “neglect” throughout the Final Order – APS, repeatedly citing “RCW 74.34.020(12).” *See* CP 177-178 (Final Order – APS). The Board apparently relied upon a definition that was made effective as of June 7, 2012 (*see* Laws of 2012, ch. 10, § 62), but modified several times since, including before the 2017 events at issue in this case. *See* Laws of 2017, ch. 268, § 2; Laws of 2015, ch. 268, § 1; Laws of 2013, ch. 263, § 1. As a result, the Board erroneously concluded that “[t]he requirement that a *duty of care* exist is only set forth in RCW 74.34.020(12)(a) and not in subparagraph (12)(b) of the *neglect* definition,” and engaged in an extended discussion of the reasons for this purported

omission. *See* CP 177-178 (Final Order – APS). This in and of itself may be reversible error.

The Board also erroneously rejected the ALJ’s careful analysis of the *Brown* decision and the ALJ’s related conclusion that “...the undersigned must find that the Appellant intentionally acted or failed to act, in breach of a duty, knowing or having reason to know facts that would lead a reasonable person to realize that her conduct created an unreasonable risk of bodily harm to Debora and that there was a high degree of probability that substantial harm would result to her.” *See* CP 161-164 (Initial Order – APS), CL 5.10-5.17; CP 181-182 (Final Order – APS), CL 17-18. The Board offered a summary explanation as to why the *Brown* analysis<sup>10</sup> was not binding upon DSHS and the Board in their application and interpretation of the neglect standard, but this discussion at best partially explained why the Board determined that “[t]he ALJ’s analysis is not persuasive, or accepted by the undersigned reviewer.” CP 181 (Final Order – APS), CL 17.

The ALJ’s formulation invoked a measure of the probability of substantial harm, which the Board summarily rejected. Perhaps this was done because it enabled the Board to avoid any consideration of the

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<sup>10</sup> The Board did not address *Crosswhite* at all.

undisputed evidence that the measures employed by Ms. Woldemicael for meal preparation and monitoring of Debora had proven effective and had avoided any incidents of choking over the course of nearly three years. But if the Board's hostility toward a probabilistic approach to the consideration of the possibility of harm were accepted, how could there be any rational evaluation of whether there existed "a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety?" To reject any consideration of probabilities defies logic and effectively enables the kind of backward-looking, outcome-driven approach that is prohibited by the legal authorities cited above.

Gina Giefer, R.N. testified at hearing that Ms. Woldemicael acted reasonably under the circumstances and complied with the standard of care. *See, e.g., RP, Vol. IV, at 98.* However, even if Ms. Woldemicael had been *negligent*, the decisions in *Raven, Brown* and *Crosswhite* cited above make it clear that mere negligence cannot support a professionally disqualifying finding of neglect. Nor can neglect be supported by a bad outcome, or by DSHS judgments made in hindsight with the benefit of forensic medical evidence. Yet this is what the essence of DSHS's evidence at hearing consisted of, contravening the accounts of many percipient witnesses. The Board and Superior Court erroneously disregarded these important legal

principles and effectively adopted a standard of neglect equivalent to simple negligence.<sup>11</sup>

In addition, applicable DSHS policy effectively establishes that there is need for DSHS to establish that the alleged act or omission of the alleged perpetrator is a proximate cause of the actual or potential harm. Chapter 6 of the DSHS Aging and Long-Term Support Administration Long-Term Care Manual (hereinafter “APS Manual”) sets forth “Substantiation Factors” that DSHS and APS must consider before deciding to substantiate a finding of neglect. Factors 3 and 4 provide as follows:

**Factor 3** The findings are a result of action or inaction by the perpetrator.

**Factor 4** The findings relate to the scope of duty of the individual, and the action or inaction of the perpetrator is a breach of that duty (i.e., What should have occurred, but did not

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<sup>11</sup> The initial DSHS finding of neglect was also tainted by a similarly erroneous understanding of the law. After making repeated references to her opinion that Ms. Woldemicael had committed “negligence,” APS investigator and representative, Michelle Rosell, testified as follows:

Q. You talked about negligence today. What do you mean by that?

A. *She was a provider with a duty of care and is paid to follow care plans to keep people safe and she neglected to do that in this case, causing the ultimate outcome.*

Q. *Did you know there's a difference between statutory neglect and negligence?*

A. *There probably is. You're talking about legal?*

Q. Yes.

A. Like law enforcement type negligence?

Q. No legal terms. *Do you understand the distinction?*

A. *I know what we need for neglect to substantiate.*

Q. *Do you know it's different from negligence. Did you know that, in legal terms?*

A. No.

RP, Vol. IV, at 84, 85 (9/19/17 Rosell testimony; emphasis added).

happen? Or, what should not have occurred, but did?)

See APS Manual, p. 89, 90<sup>12</sup>. Thus, to the extent that proximate causation is merely implied (but not expressed) in RCW 74.34.020(16), the APS Manual clarifies that it is a necessary element that DSHS must consider before imposing a career-ending neglect finding.

Here, the Board found that “[i]t is unknown to what extent this Appellant's failure to provide Debora with required physical assistance with eating, or this Appellant's failure to follow her emergency training when finding Debora unresponsive, contributed to Debora's death.” CP 180 (Final Order – APS), CL 15 (emphasis added). When the Board set forth the purported “basic elements” of neglect – without citation to any specific legal authority – it omitted any mention of causation. *Id.*, CL 14. These findings demonstrate that the Board failed to consider the requisite element of proximate causation that is implied in the statutory definition of neglect and made express in applicable DSHS policy.

The Board’s and Superior Court’s erroneous legal analysis thus represents a basis for relief under RCW 34.05.570(3)(d).

**D. Findings of Fact in the Review Decisions and Final Orders of DSHS Are Unsupported By Substantial Evidence.**

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<sup>12</sup> Available at: <https://www.dshs.wa.gov/altsa/aging-and-long-term-support-administration-long-term-care-manual>

## **1. Final Order – APS.**

In contravention of the pertinent facts summarized above, the Final Order - APS issued by the Board sets forth several clearly erroneous factual determinations that were used to support its affirmation of neglect.

### **a. Finding of Fact 14.**

Most notably, the Board concluded that “[Ms. Woldemicael] had not cut Debora’s food into small pieces...she was not monitoring Debora for choking, she was not cueing Debora throughout the meal, or wiping Debora's mouth as needed.” CP 171-172 (Final Order – APS), FF 14. These Board findings contradicted the specific testimony of Ms. Woldemicael as to what had occurred; she was the only percipient witness to the subject events. These findings also contradicted the testimony of Ms. Sherriff as to her interpretation of what Debora’s assessment and care needs required in terms of food preparation and monitoring, together with the ultimate admission of the DSHS investigator that Ms. Sherriff’s views should be considered authoritative.

### **b. Findings of Fact 15 and 6.**

The Board also found that “[i]n violation of her training, the Appellant did not look into Debora's mouth, check Debora's airway, or check to see if Debora was breathing.” *Id.*, FF 15 (emphasis added). This was erroneous in two respects. First, Ms. Woldemicael testified that she *did*

*check* to see if Debora was breathing. RP, Vol. I, at 145. Second, the Board’s conclusion that Ms. Woldemicael acted “in violation of her training” ignored the testimony of Ms. Woldemicael and Ms. Bunch-Baker, cited above, regarding the specific instruction to avoid inserting fingers into the mouth of a person suspected of seizure. The Board’s separate finding regarding the pertinent contents of Ms. Woldemicael first aid training was similarly flawed. CP 169-170 (Final Order – APS), FF 6.

**c. Finding of Fact 24.**

Finally, without making any comment as to relative credibility, the Board erroneously found that “[t]he Appellant also told Resident Care Services (RCS) Investigator Jennifer Witman that she may have been in the kitchen for five (5) minutes.” CP 173-174 (Final Order – APS), FF 24. As noted above, Ms. Woldemicael specifically denied making this statement to *anyone*. And Ms. Witman admittedly derived this information from the police report, not Ms. Woldemicael’s statement. RP, Vol. III, at 92.

**2. Final Order – AFHL.**

**a. Findings of Fact 4, 15, 22, 27.**

DSHS cited Ms. Woldemicael for violation of WAC 388-76-10670 (Prevention of abuse) in relation to Debora and the events of February 12, 2017. AR 3 (Final Order – AFHL), FF 5, 8, 9. In its amended SOD completed July 28, 2017, DSHS also cited Ms. Woldemicael for violations

of WAC 388-76-10020 (Care and services) and WAC 388-76-10355 (Negotiated care plan) based on the same events. *Id.* The Board affirmed the related citations via incorporation and reference to its related findings regarding neglect. *Id.*, FF 4, 15, 22, 27. Ms. Woldemicael incorporates the discussion above to demonstrate why these findings are not supported by competent evidence, forming a basis for reversal under RCW 34.05.570(3)(e).

**b. Finding of Fact 26.**

In the June 26, 2017 SOD, DSHS asserted that Ms. Woldemicael had failed to comply with a 2013 settlement regarding an agreed disposition of a 2012 licensing action involving a totally different AFH that had formerly been operated by Ms. Woldemicael, Samuel’s AFH. AR 892-897. Specifically, DSHS alleged that “[r]eview of Department licensing files revealed from 5/30/13 until 3/28/17 the provider continued to maintain contracts to be paid for the care and services she provided to state-funded residents.” *Id.*<sup>13</sup>

Acting on the advice of her attorney, and based on other business and family considerations, Ms. Woldemicael decided in May 2013 to settle the licensing action against Samuel’s AFH. RP, Vol. VI, at 34 (9/21/17

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<sup>13</sup> Although DSHS manager Mike Anbesse had signed the June 26, 2017 SOD, he was unable to identify any such “contracts” at hearing, and instead just repeatedly referenced the settlement agreement itself. RP, Vol. III, at 145-148.

Woldemicael testimony). Specifically, Ms. Woldemicael believed that the settlement terms applied only to Samuel’s AFH, and would not affect her ability to continue operations at Win AFH. *Id.*, Vol. VI, at 34, 35. She noted that the settlement document itself referenced only the AFH name and license number for Samuel’s AFH, and not Win AFH. *See* AR 825 (Agreed Order of Dismissal).

Courts interpret settlement agreements in the same manner in which they interpret other contracts. *Mut. of Enumclaw Ins. Co. v. USF Ins. Co.*, 164 Wn.2d 411, 424 n.9, 191 P.3d 866 (2008). “In doing so, we attempt to determine the intent of the parties by focusing on their objective manifestations as expressed in the agreement.” *McGuire v. Bates*, 169 Wn.2d 185, 189, 234 P.3d 205 (2010). When determining the intent of contracting parties, courts apply the “context rule” adopted by the Supreme Court in *Berg v. Hudesman*, 115 Wn.2d 657, 667, 801 P.2d 222 (1990).<sup>14</sup> “A contract provision is ambiguous when its terms are uncertain or when

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<sup>14</sup> Under the *Berg* context rule:

...the intent of the parties to a particular agreement may be discovered not only from the actual language of the agreement, but also from “viewing the contract as a whole, the subject matter and objective of the contract, all the circumstances surrounding the making of the contract, the subsequent acts and conduct of the parties to the contract, and the reasonableness of respective interpretations advocated by the parties.” *Scott Galvanizing, Inc. v. Nw. EnviroServices, Inc.*, 120 Wn.2d 573, 580-81, 844 P.2d 428 (1993) (quoting *Berg*, 115 Wn.2d at 663; emphasis added); *Stender v. Twin City Foods, Inc.*, 82 Wn.2d 250, 254, 510 P.2d 221 (1973).

its terms are capable of being understood as having more than one meaning.” *Mayer v. Pierce County Med. Bureau, Inc.*, 80 Wn. App. 416, 421, 909 P.2d 1323 (1995). Courts construe any ambiguity in the settlement agreement against the drafter, here DSHS. *Rouse v. Glascam Builders, Inc.*, 101 Wn.2d 127, 135, 677 P.2d 125 (1984). Here, because the settlement agreement made specific reference to Samuel’s AFH but not Win AFH, it was ambiguous.

Contrary to the allegations of the June 26, 2017 SOD, the subsequent acts and conduct of the parties to the 2013 settlement show that their intent was not to forbid Ms. Woldemicael from contracting with DSHS with respect to residents of Win AFH. DSHS continued to contract with Ms. Woldemicael for years after the settlement, and as recently as July 25, 2017 DSHS executed yet another contract with her. RP, Vol. VI, at 36, 37 (9/21/17 Woldemicael testimony); AR 831-860 (Client Service Contracts). As of July 21, 2017, DSHS wrote to Ms. Woldemicael requesting that she execute a new contract with DSHS. AR 434-435 (7/21/17 email). For years after June of 2013, DSHS also continued to place state-funded residents at Win AFH. *See, e.g.*, RP, Vol. III, at 97, 98 (Angle testimony).

The terms of the 2013 settlement imposed no specific requirement upon Ms. Woldemicael to notify any division of DSHS regarding settlement terms. *See* AR 825-830. DSHS manager Bett Schlemmer testified that the

2013 settlement document would have been kept in a “central file” to be accessed by any DSHS representative, and that pertinent divisions of DSHS would have been informed of it. RP, Vol. VI, at 74, 75 (Schlemmer testimony).

In reliance upon years of subsequent conduct by DSHS, Ms. Woldemicael reasonably believed that the prior settlement did not limit her ability to contract with respect to residents of Win AFH. RP, Vol. VI, at 34, 35 (9/21/17 Woldemicael testimony). The Board erroneously interpreted the settlement agreement and implicitly concluded that it was unambiguous. AR 7 (Final Order – AFHL), FF 26. As noted, any ambiguity in the 2013 agreement is to be interpreted against DSHS. As such, the evidence at hearing does not support a finding that Ms. Woldemicael willfully violated the terms of the agreement.

For the reasons discussed above, the forgoing regulatory violations cited by the Board are unsupported by substantial evidence, and Ms. Woldemicael is entitled to relief pursuant to RCW 34.05.570(3)(e).

**E. The Review Decisions and Final Orders of DSHS Are Based on Erroneous Conclusions of Law and Unlawful Procedures and Decision-making Processes.**

**1. Final Order – APS.**

**a. Conclusions of Law 14, 15, 16, 17, 18.**

The Board’s ultimate conclusion that DSHS had established the

“basic elements” of neglect was expressly based on the foregoing erroneous findings of fact. *See* CP 179-182 (Final Order – APS), CL 14, 15, 16, 17, 18. Specifically, the Board’s determination that Ms. Woldemicael had failed to provide “physical assistance” to Debora was necessarily based on these erroneous factual findings. The Board’s conclusion that Ms. Woldemicael’s actions “...demonstrated a serious disregard of consequences of such a magnitude to constitute a clear and present danger to Debora’s health, welfare, or safety, and constituted neglect of a vulnerable adult pursuant to RCW 74.34.020(12)(b),” (*id.*, CL 15) stemmed from these flawed findings, together with the Board’s concomitant failure to make any factual findings regarding the undisputed evidence that Ms. Woldemicael’s methods for meal preparation and monitoring had proven effective in avoiding any incidents of choking for nearly three years prior to the subject event. Further, as discussed above, the Board erroneously applied and interpreted the law. This represents a basis for reversal pursuant to RCW 34.05.570(3)(d) and (e).

**2. Final Order – AFHL.**

**a. Conclusions of Law 10, 13, 27, 28, 29, 30.**

Reversing opposite conclusions of the ALJ, the Board incorrectly found that Ms. Woldemicael had committed violations of WAC 388-76-10670 (Prevention of abuse), WAC 388-76-10020 (Care and services) and

WAC 388-76-10355 (Negotiated care plan) all via incorporation and reference to its related findings regarding neglect. AR 13-14 (Final Order – AFHL), CL 10, 13. On the same bases, the Board concluded that the serious enforcement remedies imposed by DSHS were appropriate and necessary. *Id.*, CL 27-30. For the reasons discussed above, these conclusions are based on erroneous factual findings and flawed legal analysis and should be reversed pursuant to RCW 34.05.570(3)(d) and (e).

Also, as discussed *supra*, the Board erroneously interpreted the 2013 settlement agreement and implicitly concluded that it was unambiguous. AR 7 (Final Order – AFHL), FF 26. The related conclusions of law are therefore without factual basis, and Ms. Woldemicael is entitled to relief pursuant to RCW 34.0.5.570(3)(d) and (e).

**F. Denial of Due Process of Law by Introduction Of Late-Disclosed Allegations and Evidence.**

At a minimum, due process requires notice and an opportunity to be heard. *Soundgarden v. Eikenberry*, 123 Wn.2d 750, 768, 871 P.2d 1050 (1994). Here, as is detailed in the statement of facts above, DSHS denied Ms. Woldemicael rightful due process of law by relying on late DSHS allegations which were made without adequate notice to Ms. Woldemicael, and DSHS evidence which was late-disclosed. This resulted in the denial of adequate opportunity to conduct additional discovery prior to hearing and

to introduce certain written and oral evidence into the hearing record. This represents a separate basis for relief RCW 34.05.570(3)(a).

DSHS contended that there was a supposed “waiver” of Ms. Woldemicael’s due process-based objections to the late introduction of newly alleged deficiencies and numerous related exhibits, owing to her counsel’s discussion of a plan to conduct late discovery on such newly introduced allegations. But the record reflects that Petitioner agreed to this accommodation only because the ALJ had already rejected Petitioner’s written and oral requests to exclude these allegations and evidence. *See* AR 179-180 (pre-hearing brief); RP Vol. I, at 10-12, 14 (“I think that what we would do, *based on your decision*, would be to ask for the right to possible seek discovery on the new SODs and Citations --...and introduce new exhibits, if necessary.”) (emphasis added). This record does not support a waiver of Petitioner’s objections on judicial review.

#### **G. Arbitrary and Capricious Actions of DSHS.**

The right to be free from arbitrary and capricious actions is a fundamental right. *Williams v. Seattle Sch. Dist. No. 1*, 97 Wn.2d 215, 221-22, 643 P.2d 426 (1982). “An agency abuses its discretion when it exercises its discretion in an arbitrary and capricious manner. A decision is arbitrary and capricious if it is ‘willful and unreasoning action in disregard of facts and circumstances.’ ” *Conway, supra*, 131 Wn. App. at 419 (citations

omitted).

### **1. Final Order – APS.**

The testimony of APS investigator Ms. Rosell established that the neglect investigation in this case was conducted in a cursory, biased and capricious manner which ultimately inured to the great detriment of Ms. Woldemicael.

In total, Ms. Rosell interviewed just a handful of persons regarding the case: Ms. Witman, Sgt. Teachworth of the Lynnwood Police (who had not responded to Win AFH on February 12, 2017), an unnamed “QA person” with the DDA, and Debora’s brother, Ken. *See* RP, Vol. IV, at 65, 66 (9/19/17 Rosell testimony). Ms. Rosell spoke with Ms. Witman – apparently her primary source – for only “five or ten minutes” on “one or two” occasions. *Id.*, Vol. IV, at 82.

Remarkably, Ms. Rosell never spoke to Ms. Woldemicael – the “alleged perpetrator” – or any other witnesses who were present in the home at the time of Debora’s demise. *Id.*, RP, Vol. IV, at 66. While acknowledging that failing to interview an alleged perpetrator during an APS investigation in the AFH setting was “rarely” done, Ms. Rosell tried to justify this by referencing the APS manual. *Id.*, Vol. IV, at 66-68. Contrary to this assertion, the manual does not include “using another investigative body” as a justification for APS’s failure to interview the alleged

perpetrator. *See* APS Manual, *supra*, p. 52-53<sup>15</sup>. DSHS’s failure to adhere to its own investigative policy and procedure represents is grounds to afford Ms. Woldemicael relief under RCW 34.05.570(3)(c) and (i).

Despite not having any first-hand information or eye-witness

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<sup>15</sup> The APS Manual provides in pertinent part as follows:

***When a Face to Face Interview is Not Required***

Perform a Face to Face Interview with the AV/AP. A Face to Face interview is not required when:

- The AV/AP is deceased;
- The AV/AP cannot be located by APS when all attempts are exhausted (refer to Interviewing the Alleged Victim or Interviewing the Alleged Perpetrator);
- The AV/AP eludes or refuses to communicate with APS;
- The AV/AP is incarcerated (refer to Person to be Interviewed is Incarcerated);
  - o If the AV is incarcerated, you may send the AV a declaration form and “Your Rights” DSHS 14-521 form, to obtain information.
  - o If the AP is incarcerated, you may send the AP a declaration form and the APS Fact Sheet.
- The situation poses a serious safety risk to the APS worker or to others and the risk cannot be diffused. Notify law enforcement if criminal activity has occurred (refer to Safe Field Work Practices).
- Law enforcement or medical staff request APS to not interview the AV/AP because of a compelling legal or medical reason.
- The APS worker has already obtained sufficient investigation information to determine that the alleged mistreatment was not possible and will be found “unsubstantiated” (e.g., allegations by the person with dementia, of financial exploitation, are unsubstantiated because no funds are missing and the alleged perpetrator did not have any access to them). Supervisory approval is required before closing a case with an unsubstantiated finding under this circumstance.

***For AP interviews only when investigation is leading to a substantiated finding:***

- When Law Enforcement has already completed an interview on the same subject matter as the allegation, has forwarded the case for prosecution and has provided their interview documentation to APS. NOTE: You must interview the AV as in any other investigation.
- When the allegation can be substantiated by APS based on completed proceedings, such as a judge’s order that addresses the matter (e.g., criminal conviction). Note: You must interview the AV as in any other investigation.

interviews, Ms. Rosell took it upon herself to contact the local police and urge them to “re-open” a criminal investigation against Ms. Woldemicael. RP Vol. IV, at 72-74. She did this knowing that the case had already been investigated and closed by the police. *Id.* This pernicious effort further evinces DSHS’s great bias against Ms. Woldemicael.

Further, as discussed in detail above, DSHS and the Board each applied erroneous legal standards that disregarded the critical difference between statutory neglect and simple negligence.

The foregoing conduct demonstrates that DSHS’s investigation and finding of neglect was arbitrary and capricious pursuant to RCW 34.05.570(i).

## **2. Final Order – AFHL.**

Under WAC 388-76-10940, the most severe of the several possible remedies are to order “stop placement” of admissions and revocation of an AFH license. Under WAC 388-76-10945, the imposition of *any* remedies is required only if regulatory violations are repeated, uncorrected, pervasive or present a threat to the safety, health or welfare of the residents.<sup>16</sup> *See also*

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<sup>16</sup> In addition to the citations subject to challenge, as explained above, DSHS also cited Ms. Woldemicael for two minor technical violations of WAC 388-76-10165 (Background checks) and WAC 388-111-0205 (Continuing education requirements). Both deficiencies were actually cured even before the operative Statement of Deficiencies (SOD) even issued. The background check deficiency was innocuous, because the caregivers at issue were Ms. Woldemicael and her husband, Michael Kibrom, and not some newly-hired strangers. Ms. Woldemicael obviously knew that their backgrounds were clear. DSHS manager Mr. Anbesse agreed that these citations, standing alone, would not warrant the

*Gligor v. Dep't of Soc. & Health Servs.*, 2014 Wash. App. LEXIS 2542, at 9 (April 18, 2013) (unreported decision) (“The availability of other, more appropriate sanctions, makes the remedy imposed all the more arbitrary and capricious”). *See also* AR 182-186.

In evaluating the propriety of license revocation, the presiding officer should give consideration to the impact revocation would have on AFH residents and their guardians or family members. *Conway, supra*, 131 Wn. App. at 420. Here, revocation and summary suspension were not in the best interest of the remaining residents of Win AFH.

Debora’s guardians, the representatives of other residents, two former residents and others who worked with Ms. Woldemicael each provided compelling testimony at hearing to the detrimental impacts the residents of Win AFH suffered because of DSHS’s displacing them from their home and services, as well as their strong desire that the AFH had not been closed so that the residents could have remained there. *See, e.g.*, RP, Vol. IV, at 28, 29 (Derum testimony); *id.*, Vol. IV, at 18-20 (Converse testimony); *id.*, Vol. IV, at 57, 58 (Blattner testimony); *id.*, Vol. IV, at 46, 47, (Paola testimony); *id.*, Vol. V, at 21, 22 (Wallace testimony); *id.*, Vol.

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extremely severe enforcement actions that were meted out by DSHS in this case. RP, Vol. III, at 127-130. Even the Board recognized that “[n]ot all rule violations warrant license revocation or the imposition of civil fines. AR 21 (Final Order – AFHL), CL 26.

V, at 36, 37 (Hanvey testimony); *id.*, Vol. V, at 140, 141 (Melissa testimony).

Even DSHS's own representatives in the DDA expressed their support for Ms. Woldemicael and her quality of care. *See, e.g., id.*, Vol. II, at 84 (Sherriff testimony); *id.*, Vol. III, at 98-100 (Angle testimony); *id.*, Vol. V, at 60, 61 (Williams testimony). Adina Angle, who has many years of experience working for DSHS with regard to numerous adult family homes, testified as follows:

Q. What was your opinion of that decision?

A. Of the decision to close the home?

Q. Yeah

A. I was very taken back.

Q. Why?

A. Because I have experienced many clients choke and die under the many years I have worked in my role, and other capacities. And I also didn't think, from my professional vantage point, that the other people were in danger for remaining in the home.

Q. Are you speaking of the other residents that remained there?

A. Yes, yes. And...yeah.

Q. Would it be your preference given your role that you could continue to place residents at Win Adult Family Home?

A. Yes.

*Id.*, Vol. III, at 104.

Q. You testified earlier that you have known about or had experienced many clients choking and dying. Does that include in adult family home settings?

A. Yes. And also I used to work for RCS, and I was the state evaluator for all of our supportive living agencies for five

years. So, I read hundreds of records through that period of time and, you know, so from that experience, so, yes, I had a breadth of experience.

Q. So having an adult family home resident choke and die is unfortunate, but not unusual?

A. It's not, no. It's not unusual. It happens.

*Id.*, Vol. III, at 113.

DSHS's disregard for the opinions and preferences of these many concerned, interested and knowledgeable parties further demonstrates the arbitrary, capricious and harmful nature of its actions. While Ms. Woldemicael maintains that no neglect or repeated and serious violations of regulations have occurred, rather than have her AFH shuttered and career destroyed, Ms. Woldemicael would have entertained any number of limitations or other conditions on her AFH license that DSHS might rationally suggest. These alternative remedies were never fairly considered or offered by DSHS, and its imposition of revocation, stop placement and summary suspension is arbitrary and capricious. Ms. Woldemicael is entitled to relief from these actions pursuant to RCW 34.05.570(3)(i).

**H. Ms. Woldemicael is Entitled to an Award of Attorneys' Fees Pursuant to the Equal Access to Justice Act.**

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. Woldemicael

is entitled to recover her attorneys' fees and costs under the Equal Access to Justice Act ("EAJA"), RCW 4.84.340, *et seq.*, 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.

RCW 4.84.350(1).

Here, Ms. Woldemicael is a "qualified party,"<sup>17</sup> and will have prevailed if the Court reverses one or more of the Board's decisions regarding the neglect finding or the various enforcement actions imposed against Ms. Woldemicael's AFH license. In that event, 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 the proceedings before the Superior Court and Court of Appeals.

## VI. CONCLUSION

For the reasons discussed above, this Court should reverse the orders

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<sup>17</sup> 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. Woldemicael's affidavit confirming her financial eligibility 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).

of the Superior Court and the Board of Appeals, and restore the findings of fact and conclusions of law of the ALJ.

DATED this 20th day of March, 2020.

LYBECK PEDREIRA & JUSTUS, PLLC

By:       /s/ Benjamin Justus        
Benjamin Justus (WSBA #38855)

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