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

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ZAID WOLDEMICAEL,

Appellant,

v.

STATE OF WASHINGTON DEPARTMENT OF SOCIAL AND  
HEALTH SERVICES,

Respondent.

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**RESPONDENT'S BRIEF**

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ROBERT W. FERGUSON  
Attorney General

SETH DICKEY, WSBA #47472  
Assistant Attorney General  
PO Box 40124  
Olympia, WA 98504-0124  
(360) 586-6464  
Seth.Dickey@atg.wa.gov  
OID# 91021

**TABLE OF CONTENTS**

I. INTRODUCTION.....1

II. COUNTER STATEMENT OF ISSUES PERTAINING TO ASSIGNMENTS OF ERROR .....2

III. STATEMENT OF THE CASE .....3

    A. Adult Family Homes and Their Regulation.....3

    B. Debora and Her Death .....5

    C. The Settlement .....8

    D. DSHS Investigated Ms. Woldemicael and the Win AFH, Issued Licensing Sanctions, and Found that She Committed Neglect of a Vulnerable Adult .....9

    E. Procedural History .....12

IV. ARGUMENT .....13

    A. Standard of Review.....13

    B. Ms. Woldemicael Neglected a Vulnerable Adult .....15

        1. Ms. Woldemicael neglected Debora when she failed to provide necessary assistance with eating on February 12, 2017.....16

        2. *Brown* is distinguishable, as Ms. Woldemicael knew what care Debora needed.....19

        3. Reference to the previous definition of neglect is immaterial.....21

        4. APS policy is irrelevant based on the standard of review .....23

C.	RCS Properly Suspended and Revoked the Win AFH License, and Stopped Placement to the Facility .....	24
1.	Win AFH violated WAC 388-76-10670 by failing to ensure that Debora was not neglected. ....	24
2.	Win AFH violated WAC 388-76-10400 because it failed to provide Debora with necessary care.....	25
3.	WAC 388-76-10355 was violated due to the inadequacy of Debora’s Negotiated Care Plan.....	26
4.	WAC 388-76-10220 was violated due to the failure to log the incident of Debora’s choking and death.....	27
5.	WAC 388-76-10020 was violated due to Ms. Woldemicael’s demonstrated inability to understand and provide care .....	28
6.	The Department properly exercised its discretion in its enforcement selection .....	30
D.	There is No Due Process or Other Procedural Violation Because Ms. Woldemicael Agreed to the Procedure of the Administrative Hearing.....	31
E.	Substantial Evidence Supports the Challenged Findings.....	33
F.	Fees Should Not be Awarded to Ms. Woldemicael if She Prevails.....	36
V.	CONCLUSION .....	38

## TABLE OF AUTHORITIES

### Cases

<i>ARCO Products Co. v. Wash. Utils. and Transp. Comm'n</i> , 125 Wn.2d 805, 888 P.2d 728 (1995).....	15
<i>Beatty v. Wash. Fish and Wildlife Comm'n</i> , 185 Wn. App. 426, 341 P.3d 291 (2015).....	14
<i>Brown v. Dep't of Soc. &amp; Health Servs.</i> , 190 Wn. App. 572, 360 P.3d 875 (2015).....	19, 20
<i>City of Redmond v. Central Puget Sound Growth Mgmt. Hearings Bd.</i> , 136 Wn.2d 38, 959 P.2d 1091 (1998).....	14
<i>Conway v. Dep't of Soc. &amp; Health Servs.</i> , 31 Wn. App. 406, 120 P.3d 130 (2005).....	30
<i>Crosswhite v. Dep't of Soc. and Health Servs.</i> , 197 Wn. App. 539, 389 P.3d 731 (2017).....	14, 18, 19, 32
<i>Densley v. Dep't of Ret. Sys.</i> , 162 Wn.2d 210, 173 P.3d 885 (2007).....	37
<i>Graves v. Dep't of Emp't Sec.</i> , 144 Wn. App. 302, 182 P.3d 1004 (2008).....	32
<i>Heidgerken v. Dep't of Natural Res.</i> , 99 Wn. App. 380, 993 P.2d 934 (2000).....	14, 23
<i>Heinmiller v. Dep't of Health</i> , 127 Wn.2d 595, 903 P.2d 433 (1995).....	15
<i>Kali v. Bowen</i> , 854 F.2d 329 (9th Cir. 1988).....	36
<i>Overton v. Econ. Assistance Auth.</i> , 96 Wn.2d 552, 637 P.2d 652 (1981).....	14

<i>Plum Creek Timber Co. v. Wash. State Forest Practices Appeals Bd.</i> , 99 Wn. App. 579, 993 P.2d 287 (2000).....	36
<i>Postema v. Pollution Control Hearings Bd.</i> , 142 Wn.2d 68, 11 P.3d 726 (2000).....	15
<i>Prostov v. Dep’t of Licensing</i> , 186 Wn. App. 795, 349 P.3d 874 (2015).....	37
<i>Raven v. Dep’t of Soc. and Health Serv.s</i> , 177 Wn.2d 804, 306 P.3d 920 (2013).....	18, 19
<i>Silverstreak, Inc. v. Dep’t of Labor &amp; Indus.</i> , 159 Wn.2d 868, 154 P.3d 891 (2007).....	36
<i>Wash. Indep. Tele. Ass’n</i> , 149 Wn.2d 17, 65 P.3d 319 (2003).....	15

**Statutes**

RCW 26.44.020(16).....	19
RCW 34.05.570 .....	13, 32
RCW 34.05.570(1)(a) .....	13
RCW 34.05.570(3).....	13
RCW 34.05.570(3)(e) .....	14, 32
RCW 4.84.350.....	36
RCW 4.84.350(1).....	37
RCW 70.128 .....	3
RCW 70.128.010(1).....	3
RCW 70.128.070 .....	5
RCW 70.128.090 .....	5

RCW 70.128.100 .....	31
RCW 70.128.140(2).....	3
RCW 70.128.160 .....	5
RCW 70.128.160(1).....	30
RCW 70.128.160(2).....	30
RCW 74.34 .....	12, 21
RCW 74.34.020 .....	22
RCW 74.34.020(15).....	22, 24, 25
RCW 74.34.020(15)(b) .....	16, 17
RCW 74.34.020(16).....	22
RCW 74.34.020(2).....	21
RCW 74.34.020(22).....	16
RCW 9A.42.100.....	25

**Regulations**

WAC 388-02-0260.....	31
WAC 388-02-0485.....	15
WAC 388-106-0010.....	6
WAC 388-71-0105.....	22
WAC 388-76.....	3
WAC 388-76-10000.....	25
WAC 388-76-10015.....	5

WAC 388-76-10020.....	11, 28, 29
WAC 388-76-10020(1).....	4
WAC 388-76-10220.....	4, 10, 27
WAC 388-76-10355.....	4, 6, 11, 27
WAC 388-76-10355(6).....	27
WAC 388-76-10355(7).....	27
WAC 388-76-10360.....	6
WAC 388-76-10370.....	6
WAC 388-76-10400.....	4, 11, 25, 26
WAC 388-76-10670.....	4, 11, 22
WAC 388-76-10670(2).....	24
WAC 388-76-10940.....	5, 30
WAC 388-76-10945.....	5, 31
WAC 388-76-10950.....	5
WAC 388-76-10955.....	5, 31
WAC 388-76-10960(14).....	11
WAC 388-76-10965.....	5
WAC 388-76-10970.....	5, 30
WAC 388-76-10975.....	5
WAC 388-76-10976.....	5
WAC 388-76-10980.....	5, 30

WAC 388-76-10985.....	5
WAC 388-829A-250.....	6

## I. INTRODUCTION

Ms. Woldemicael is the licensee for the Win Adult Family Home (Win AFH). Debora,<sup>1</sup> a vulnerable adult, was a resident in the Win Adult Family Home. Debora was left alone by her caregiver, Ms. Woldemicael, during a meal and choked to death on a breaded chicken sandwich. Debora's Individual Support Plan (ISP) stated that she needed extensive assistance while eating: to be monitored for choking, cued to eat, and that liquids were to be provided and encouraged throughout the meal. Debora's food was supposed to be cut into small pieces, but the chicken sandwich she was eating was cut into quarters.

Two Department of Social and Health Services (DSHS or the Department) investigations determined that Ms. Woldemicael committed neglect of a vulnerable adult (a determination by Adult Protective Services (APS)) and had violated several regulations that govern adult family homes, several of which involved actual or potential threats to patient safety or welfare (a determination by Residential Care Services (RCS)). Based on its findings, DSHS summarily suspended and revoked Ms. Woldemicael's license for the Win AFH, and issued a stop placement order prohibiting admissions. The DSHS Board of Appeals upheld the

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<sup>1</sup> To protect her privacy, only Debora's first name will be used.

finding of neglect, license suspension, revocation, and stop placement order, and the Thurston County Superior Court affirmed. The Board of Appeals's order is supported by substantial evidence and is consistent with law. This Court also should affirm.

## **II. COUNTER STATEMENT OF ISSUES PERTAINING TO ASSIGNMENTS OF ERROR**

1. The Department presented evidence that Ms. Woldemicael did not provide required care to a vulnerable adult by failing to monitor for choking or provide other necessary assistance during a meal. Was the APS finding of neglect supported by substantial evidence?
2. The Department presented evidence that the Win AFH violated program rules, by failing to conduct background checks, prevent neglect, maintain a complete incident log, develop an adequate negotiated care plan, ensure that each resident received necessary care and services, and demonstrate an ability to meet the care needs of residents. Were the licensing violations found by DSHS supported by substantial evidence?
3. Was it arbitrary and capricious for DSHS to revoke the Win AFH license as a result of the neglect finding and licensing violations?

4. DSHS amended its notice to include one additional basis for its action, before the record was closed during the administrative hearing, as allowed by DSHS rule. The Appellant agreed to proceed given that the administrative record would remain open to give her the opportunity to submit additional evidence and her request was granted. Did this procedure afford the Appellant due process in the administrative hearing?

### **III. STATEMENT OF THE CASE**

#### **A. Adult Family Homes and Their Regulation**

An adult family home (AFH) is a long-term care facility that provides room and board, personal care, and special care for up to six residents. RCW 70.128.010(1). An AFH must be licensed by DSHS<sup>2</sup>, and is subject to DSHS regulations, inspections, and investigations. *See generally* chapter 70.128 RCW. AFHs are generally located in typical single-family residences and in neighborhoods zoned for such residences. *See* RCW 70.128.140(2).

AFHs must follow a regulatory structure set out by the Legislature and DSHS. *See generally* RCW 70.128, *see also* 388-76 WAC. Relevant to this case, AFHs have several duties. They must:

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<sup>2</sup> Through its subsidiary agency, Residential Care Services.

- Prevent instances of abuse or neglect from happening to residents. WAC 388-76-10670.
- Maintain an incident log that includes, among other things “[a]ny injury to a resident.” WAC 388-76-10220.
- Develop a “negotiated care plan” that details how care to each resident will be provided. WAC 388-76-10355. This must include a plan to “[f]ollow in case of a foreseeable crisis due to a resident’s assessed needs.” *Id.*
- Ensure that each resident receives the care and services they need. WAC 388-76-10400. This includes “[t]he necessary care and services to help the resident reach the highest level of physical, mental, and psychosocial well-being consistent with resident-choice, current functional status, and potential for improvement or decline.” *Id.*
- The licensee must have the “[u]nderstanding, ability, emotional stability and physical health necessary to meet the psychosocial, personal, and special care needs of the vulnerable adults under the home’s care.” WAC 388-76-10020(1).

If an AFH fails to meet these requirements, or any of the other regulations it is required to follow, DSHS has the responsibility to issue a citation, require correction, and, possibly, impose an enforcement remedy.

*See* RCW 70.128.070, .090, .160, .167; *see also* WAC 388-76-10940 to -10985. Enforcement remedies vary in type and include civil fines, conditions on a license (such as requiring specific training or barring admission of a certain kind of resident), stop placement of any additional residents in the home, revocation of the home's license, and immediate suspension of adult family home operations. RCW 70.128.160; WAC 388-76-10940.

Ms. Woldemicael is the licensee for Win AFH, the facility at issue in this case. Agency Record (APS<sup>3</sup>-AR) 678. As the licensee, she is ultimately responsible for ensuring that the Win AFH followed all of these regulations. WAC 388-76-10015.

## **B. Debora and Her Death**

Debora was admitted to the Win AFH in March of 2014. APS-AR 635. She suffered from a severe seizure disorder, a developmental disability, and mental health issues. APS-AR 612. She could not eat by herself, and when she was eating required extensive assistance from a caregiver.

Debora was a client of the Developmental Disabilities Administration, an agency of DSHS—meaning that DSHS paid for her care

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<sup>3</sup> APS-AR refers to the Administrative Record in OAH/BOA case # 04-2017-LIC-01138. RCS-AR refers to the Administrative Record in OAH/BOA case #s 04-2017-LIC-01141, -01141, -01142, -01151 and -01152.

at the Win AFH through public assistance programs, such as the Medicaid program. *See* Report of Proceedings (RP) Vol. II at 31-37. The Developmental Disabilities Administration, as part of its assessment of DSHS clients, creates an Individual Support Plan (ISP), which details the results of its care assessment (which is based on stated and documented medical needs), and specifies what kind of care the client requires. *See* WAC 388-829A-250. Debora’s ISP required that she receive protective supervision, and not be left unattended. RCS-AR 611. It specified that she required “extensive assistance” when eating. RCS-AR 624; *see also* WAC 388-106-0010 (defining “self-performance for [Activities of Daily Living]” and describing “extensive assistance”). This assistance required that during meals she be monitored for choking, her food cut into small pieces, liquids kept available and encouraged, and that she needed to be cued to eat throughout. APS-AR 614. Debora’s Negotiated Care Plan<sup>4</sup> stated that she “needs assistance with eating” and “[the] caregiver [has] to cut her food into small [pieces] and sometimes help her on feeding if she lets caregiver help her.” APS-AR 640. She also had a seizure disorder

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<sup>4</sup> A Negotiated Care Plan is a document developed by the facility which is required to detail various aspects of a client’s care needs, and how those needs will be met. *See* WAC 388-76-10355. An AFH must ensure that it is developed and completed within thirty days of a resident’s admission. *See* WAC 388-76-10360. The AFH must involve the resident to the greatest extent possible, professionals involved with their care, any resident representative, and certain other individuals. *See* WAC 388-76-10370.

(RCS-AR 612), and would sometimes have seizures while eating. *See* RP Vol. I at 62-63. However, the Negotiated Care Plan does not direct how to provide care for such an occurrence. *See* RCS-AR 635-48.

On February 12, 2017, Debora choked to death during her dinner. RCS-AR 578. She was served a breaded chicken sandwich, cut into quarters, with chips and a drink. *See* RP Vol. I at 142; *see also* APS-AR 223. Debora eats separately from the other residents. RP Vol. I at 134. After serving her, Ms. Woldemicael returned to the kitchen to continue preparing food. *See* RP Vol. I at 142. At some point, Ms. Woldemicael turned around to look at Debora, saw that she looked different, and found her to be non-responsive. *Id.* Ms. Woldemicael screamed for help, to her husband Michael who was also a caregiver in the home, and called 911. *Id.* She did not look in Debora's mouth or check whether she was breathing. *Id.* at 146. Ms. Woldemicael called 911 and was told to start CPR by the operator, but did not do so until 2 minutes and 37 seconds into the call, after a prolonged exchange with the operator. RP Vol. II at 183; AR 566-69. That 2 minutes and 37 second delay was due to Ms. Woldemicael's failure to follow the operator's specific instructions, and going to get another person to assist her. *See* APS-AR 566-69. A police officer arrived, shortly before the paramedics. RCS-AR 581. After resuscitation attempts ended, the officer noticed that Debora still had food in her mouth. *Id.* The autopsy found a

“tongue-shaped” piece of food measuring 1.75 x 1.0 x .25 inches, which completely obstructed Debora’s airway. RCS-AR 592, *see also* RCS--AR 925.

**C. The Settlement**

Several years prior, in May 2013, Ms. Woldemicael entered into a settlement involving her surrender of a previous AFH license for a different facility. RCS-AR 825-30. She surrendered the license in exchange for DSHS’s promise not to revoke it. *Id.* The pending revocation in that matter was due, in part, to a failure to “ensure each resident [was] free from verbal, physical, and mental abuse” and a failure “to protect each resident who was a victim of abuse and [] to prevent future abuse from occurring.” APS-AR 896. The surrender agreement included the following language: “[Ms. Woldemicael] agrees that the Department will not enter into any new contracts for the purposes of providing care to vulnerable adults or children with Zaid Woldemicael for a period of twenty years following the date of this agreement.” RCS-AR 827. It further states that Ms. Woldemicael “agrees that the Department will also not contract for the purposes of providing care to vulnerable adults or children with Zaid Woldemicael's spouse and/or with any entity that Zaid Waldemicael or her spouse is affiliated with as a partner, officer, director, managerial employee, or majority owner, for a period of twenty years following the date of this

agreement.” *Id.* This provision prohibited Ms. Woldemicael from contracting with DSHS to be a Medicaid provider. It further stated that her failure to comply with the agreement would cause the revocation to “remain in full force and effect.” *Id.* In October of 2016, Ms. Woldemicael violated this agreement by entering into a Medicaid provider contract with DSHS, doing business as Win AFH. RCS-AR 833-60.

**D. DSHS Investigated Ms. Woldemicael and the Win AFH, Issued Licensing Sanctions, and Found that She Committed Neglect of a Vulnerable Adult**

The Department was notified of Debora’s death, and investigations were conducted by Residential Care Services (RCS), the regulatory agency for long-term care facilities, and Adult Protective Services (APS), the agency tasked with investigating vulnerable adult neglect. *See* APS-AR 502, 520.

During the RCS investigation, it was discovered that the facility incident log did not reference the death of Debora. *See* RCS-AR 669, *see also* Testimony of Ms. Witman, RP Vol. II at 123.<sup>5</sup> RCS also determined that Debora was neglected based on the failure to provide her with necessary

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<sup>5</sup> At the administrative hearing, Ms. Woldemicael produced a document purporting to be another page of the incident log, that the Department had not previously received. *See* Testimony of RCS Investigator Ms. Witman, RP Vol. II at 144, RCS-AR 425. Both the Administrative Law Judge and the DSHS Review Judge had concerns about the credibility of this document, given that the first log still had space for more entries, and visual differences between the two. AR 5.

care during her dinner on February 12, 2017. APS-AR 898-911. In addition, RCS reviewed the Negotiated Care Plan, and found that it did not contain necessary information regarding Debora's care needs involving eating. *Id.* Specifically, it did not contain the specific needs articulated in the Individual Support Plan, including: the need for cueing throughout the meal, cutting food into small pieces, encouraging liquids, keeping liquids available, monitoring for choking, providing a calm environment and wiping her mouth as needed. *Id., see also* APS-AR 939. It also determined that required background checks had not been conducted on herself and her husband, and that her husband and another caregiver did not have the required certifications for continuing education. *Id.* Based on these circumstances, on March 28, 2017, DSHS issued a Statement of Deficiencies, which identified seven AFH rule violations. APS-AR 898-911. Two of these violations are undisputed, as Ms. Woldemicael did not challenge them below: Win AFH's failure to properly background check its staff and its failure to ensure that staff meet all educational requirements. *See* APS-AR 4-5. The disputed citations are:

- A violation of WAC 388-76-10220 for failure to log Debora's choking death in the required incident log;

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- A violation of WAC 388-76-10670 for failing to prevent neglect to Debora that was caused when Ms. Woldemicael neglected her;
- A violation of WAC 388-76-10400 for failing to ensure that Debora received the care she needed, specifically the extensive assistance she needed with eating;
- A violation of WAC 388-76-10355 for failing to include Debora's needs relating to eating on her negotiated care plan;
- A violation of WAC 388-76-10020 because Ms. Woldemicael showed she did not have the capacity to appropriately care for residents.

APS-AR 898-911. On June 26, 2017, DSHS issued another Statement of Deficiencies, alleging that Ms. Woldemicael's violated WAC 388-76-10960(14) because she entered into a contract with DSHS to provide care to DSHS clients in violation of the 2013 settlement agreement. RCS-AR 895-97.

On July 28, 2017, DSHS (RCS) issued an Amended Summary Suspension, Revocation of License, and Stop Placement Order Prohibiting Admissions, based on the violations of the March 28 Statement of Deficiencies, Win AFH's extensive history of rule violations over the preceding decade. *See* RCS-AR 912-15. The effect of these sanctions was

that the Win AFH was required to immediately suspend operations, cease admitting new residents; if DSHS's action is upheld, the Ms. Woldemicael's license for the Win AFH will be permanently revoked. *Id.*

Based on the APS investigation involving the circumstances of Debora's choking and death, on April 13, 2017, DSHS issued a notice informing Ms. Woldemicael that it made a neglect finding against her under its authority in chapter RCW 74.34 . APS-AR 502-04.

#### **E. Procedural History**

The administrative hearing in this matter occurred in July, August, and September, 2017. RCS-AR 1. The Office of Administrative Hearings issued its Initial Order on April 6, 2018. RCS-AR 73-92. The Administrative Law Judge overturned DSHS's findings that the Win AFH violated each of the rules mentioned above. RCS-AR 81-92. The finding that Ms. Woldemicael neglected Debora was also overturned. RCS-AR 73-88. The Department petitioned for review by the DSHS Board of Appeals, which reversed the initial order, and reinstated both the neglect finding, and the AFH regulatory violations on August 8, 2018. RCS-AR 1-26. Ms. Woldemicael requested judicial review of these final agency actions before Thurston County Superior Court on August 27, 2018. Clerk's Papers (CP) 1-14, 78-119. The Superior Court determined that Ms. Woldemicael's  
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failure to follow the negotiated care plan constitutes neglect, and affirmed the Department's actions on October 4, 2019. CP 67-69, 209-211.

#### **IV. ARGUMENT**

Ms. Woldemicael committed neglect of a vulnerable adult when she failed to provide the necessary care to Debora during her dinner on February 12, 2017. The Department properly determined that Ms. Woldemicael committed the disputed rule violations listed in the July 28, 2017, Notice. Even if this Court determines that the neglect finding should be overturned, DSHS was still within its discretionary authority to revoke the Win AFH license based on the other AFH rule violations and settlement violation. Finally, Ms. Woldemicael was afforded adequate due process in the administrative proceeding.

##### **A. Standard of Review**

This is a petition for judicial review of a final agency action under RCW 34.05.570(3). The Court reviews only the final agency action, here the final orders issued by the Board of Appeals on August 8, 2018. RCW 34.05.570. There are limited grounds upon which an appellant can challenge a final agency action. RCW 34.05.570(3). It is the Appellant's burden to prove these grounds. RCW 34.05.570(1)(a). The Court can affirm the agency action on any theory adequately supported by the administrative

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record. *Heidgerken v. Dep't of Natural Res.*, 99 Wn. App. 380, 388, 993 P.2d 934 (2000).

Questions of law are reviewed de novo, except that agency interpretations of law are given deference where the agency has expertise. *City of Redmond v. Central Puget Sound Growth Mgmt. Hearings Bd.*, 136 Wn.2d 38, 46, 959 P.2d 1091 (1998). “Where an administrative agency is charged with administering a special field of law and endowed with quasi-judicial functions because of its expertise in that field, the agency’s construction of statutory words and phrases and legislative intent should be accorded substantial weight when undergoing judicial review.” *Overton v. Econ. Assistance Auth.*, 96 Wn.2d 552, 555, 637 P.2d 652 (1981).

The substantial evidence standard is “highly deferential to the agency fact finder.” *Beatty v. Wash. Fish and Wildlife Comm’n*, 185 Wn. App. 426, 449, 341 P.3d 291 (2015). On judicial review, the court does not substitute its judgment for the agency as to the credibility of witnesses or the relative weight of conflicting evidence. *Id.* Rather, the court only grants relief if the agency’s decision “is not supported by evidence that is substantial when viewed in light of the whole record before the court.” RCW 34.05.570(3)(e). The appellant has the burden of showing the action is invalid. *See Crosswhite v. Dep’t of Soc. and Health Servs.*, 197 Wn. App. 539, 389 P.3d 731 (2017). The evidentiary standard

applicable to this matter is a preponderance of the evidence. WAC 388-02-0485. Unchallenged findings of fact are treated as verities on appeal. *Postema v. Pollution Control Hearings Bd.*, 142 Wn.2d 68, 100, 11 P.3d 726 (2000).

Arbitrary or capricious agency action as action that “is willful and unreasoning and taken without regard to the attending facts or circumstances.” *Wash. Indep. Tele. Ass’n*, 149 Wn.2d 17, 26, 65 P.3d 319, (2003). The “arbitrary and capricious” standard is only met if there is room for but one decision based on the administrative record. “Where there is room for two opinions, action is not arbitrary and capricious even though one may believe an erroneous conclusion has been reached.” *Heinmiller v. Dep’t of Health*, 127 Wn.2d 595, 609, 903 P.2d 433 (1995). To set aside an agency order as arbitrary and capricious, the Petitioner must put forth a “clear showing of abuse” of discretion. *ARCO Products Co. v. Wash. Utils. and Transp. Comm’n*, 125 Wn.2d 805, 812, 888 P.2d 728 (1995).

**B. Ms. Woldemicael Neglected a Vulnerable Adult**

The Board of Appeals correctly concluded that Ms. Woldemicael neglected Debora. The Board of Appeals’s reference to the 2012 version of the statute, rather than the 2015 version, is immaterial, and it properly distinguished case-law involving child neglect. Further, APS policy was not

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violated, neglect does not require a finding of harm, and there was no due process violation.

**1. Ms. Woldemicael neglected Debora when she failed to provide necessary assistance with eating on February 12, 2017**

Debora needed care that should have been, but was not, provided by Ms. Woldemicael. She needed monitoring and assistance to eat. Without it, she was at risk of choking to death. Ms. Woldemicael did not provide her with this assistance and monitoring during her dinner, on February 12, 2017. This constitutes neglect, as “an act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such magnitude as to constitute a clear and present danger to the vulnerable adult’s health, welfare, or safety....” RCW 74.34.020(15)(b).

It is not contested that Debora was a vulnerable adult. *See* RCW 74.34.020(22) (defining “vulnerable adult” in part as “a person . . . [a]dmitted to any facility” such as an adult family home). She suffered from a seizure disorder, a developmental disability, and mental health issues. APS-AR 602. She needed extensive assistance with eating. APS-AR 624. She needed “protective supervision” and could not be left unattended. APS-AR 601. One of the reasons Debora needed this extensive assistance was so that she could be monitored for choking. APS-AR 624. Leaving Debora to eat without supervision was clearly contraindicated by her ISP. *Id.*

However, On February 12, Ms. Woldemicael set a chicken sandwich (quartered) and a bag of chips in front of Debora and then left her alone. *See* RP Vol. I at 142. The quarters of the breaded chicken sandwich, as depicted in the photographs submitted by Ms. Woldemicael, were large enough to become lodged in Debora's airway. *Compare* APS-AR 223 and RCS-AR 925.

Ms. Woldemicael had the duty to provide the care required by the ISP and the Negotiated Care Plan. She did not do so. During Debora's dinner, Debora was not monitored for choking, and Ms. Woldemicael did not encourage Debora to drink fluids, cue Debora throughout the meal, or cut Debora's food into small portions (as depicted in the photograph at APS-AR 223). When Debora choked to death, Ms. Woldemicael was occupied with food preparation in another room and had her back turned to Debora. *See* RP Vol. I at 142. Ms. Woldemicael did not know anything was wrong until she turned around and found Debora unresponsive. *See* RP Vol. I at 142. The failure to provide for these care needs were omissions, amounting to a serious disregard of consequences, of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health. That magnitude of danger is illustrated, in part, by Debora's choking and death. This is neglect, under RCW 74.34.020(15)(b).

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Ms. Woldemicael relies on *Raven* to suggest that a failure to meet professional standards is not neglect (Appellant’s Brief (App. Br.) at 25), however that case is readily distinguishable. The Court in *Raven* determined that “a guardian’s good-faith decision not to place an incapacitated person in a nursing home against the incapacitated person’s wishes cannot be the basis for a finding of neglect.” *Raven v. Dep’t of Soc. and Health Serv.s*, 177 Wn.2d 804, 817, 306 P.3d 920, 926 (2013). That determination was guided by the requirement that guardians make decisions based on their ward’s attitudes, biases, and preferences, as opposed to a reasonable person standard. *Id.* Based on that unique characteristic of guardian decision-making, it was not neglect to honor the wishes of the vulnerable adult. The circumstances of *Raven* are not similar to this case. There is no suggestion that Debora did not want or did not need extensive assistance with eating. Instead, Ms. Woldemicael simply did not provide it, in direct contravention of Debora’s care plans.

*Crosswhite*, like *Raven*, implicates a person who acted out of concern for a vulnerable adult. *See Crosswhite*, 197 Wn.App. at 562-65. In that case, Ms. Crosswhite loudly demanded to know whether Jodi told her doctor about her health-threatening eating habits and abuse of pain medication. *Id.* at 546. Further, *Crosswhite* examines an allegation of mental abuse, not neglect. *Id.* Here, however, Ms. Woldemicael left Debora

unattended while she was eating, effectively withholding necessary care. There is no suggestion that this was in Debora's interest, according to her wishes, or for her own good. On the contrary, Ms. Woldemicael withheld that necessary care, in favor of starting her next task, preparing food for other residents. *See* RP Vol. I at 142. For these reasons, *Raven* and *Crosswhite* have no practical application to this case.

**2. *Brown* is distinguishable, as Ms. Woldemicael knew what care Debora needed**

Ms. Woldemicael relies heavily on *Brown v. Dep't of Soc. & Health Servs.*, 190 Wn. App. 572, 360 P.3d 875 (2015), for her argument that the statutory definition of "negligence" must be narrowly interpreted. App. Br. at 25. But the *Brown* case examined child neglect, a separate statute than is at issue here (former RCW 26.44.020(16)), and that case is also factually distinguishable from this case. In *Brown*, a child suffered burns when he was given a bath. The child's parents purchased burn cream and spoke to several individuals about how to best care for the burn, but did not seek medical attention for the burn until it bled. *Id.* at 575-77. A physician testified that a reasonable parent would have taken the child to a doctor's office or the emergency room right away, but there was no evidence that showed the parent knew or had any reason to know that would be the best course of action. *Id.* at 594-95. The court held that such conduct did not

demonstrate a serious disregard of a clear and present danger to the child's health or well-being. *Id.* at 593.

Here, in contrast, Ms. Woldemicael was specifically instructed in Debora's ISP that Debora had to be monitored while she ate. RCS-AR 624. Debora had to be monitored because she was at risk of choking to death on her food. *Id.* However, on February 12, Ms. Woldemicael did not, and Debora choked to death. This is not a case of a caregiver innocently doing what she thought best given limited information. This was the owner and licensee of an AFH specifically disregarding the identified care needs of her resident.

Further, applying *Brown* to vulnerable adult neglect would result in significantly increased risk to the elderly and disabled citizens of Washington. Doing so would arguably require proof of an *intentional* omission to meet the "serious disregard" standard (which the Court in *Brown* equates to "reckless disregard"). *See Brown*, 190 Wn.2d at 590. Such a requirement may be appropriate when reviewing the conduct of parents, who are not trained professionals, when they face a situation they are unfamiliar with (like treating a burn) involving their child. However, caregivers employed by the elderly and disabled, who have the benefit of training and care plans, who are paid for their services and typically not  
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related to their clients, are not in a comparable relationship as parent to their young children.

We trust professional caregivers to follow the medical instructions of their clients, guardians, and doctors. Requiring proof that a failure to provide needed care was intentional would cause significant overlap with the definition of vulnerable adult abuse, which includes “willful [...] inaction that inflicts injury [...] on a vulnerable adult.” RCW 74.34.020(2). Under that framework, arguably any degree of substandard care, which is not (provably) intentional, would be permitted. In this circumstance, if the State receives reports that a caregiver’s incompetence is causing harm to residents, there would be effectively no regulatory remedy unless the resulting neglect is provably intentional. This would drastically undermine the safe provision of care for our State’s most vulnerable populations. The consequence of taking away the State’s ability to regulate to a standard of care, short of provably intentional misconduct, would drastically increase the risk of harm to our elderly and disabled citizens.

**3. Reference to the previous definition of neglect is immaterial**

Ms. Woldemicael had a duty of care to Debora established apart from the definition section of RCW 74.34, and for this reason the Board of Appeals’s reference to the prior version of the neglect definition in

RCW 74.34.020 is immaterial. At the time of Debora’s death on February 12, 2017, “neglect” was defined as “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.” Former RCW 74.34.020(15) (2015) *emphasis added*. That is still the definition. *See* RCW 74.34.020(16). The Board of Appeals cited the 2012 version of RCW 74.34.020(15), which, except for the underlined words (which were added in Laws of 2013, ch. 263, § 1), is identical to the current version. But APS regulations defined a “person with a duty of care” to include a “[p]erson providing the basic necessities of life to a vulnerable adult where [...] the person is employed by or on behalf of the vulnerable adult.” WAC 388-71-0105. Ms. Woldemicael had such a duty of care to Debora, as she was employed on Debora’s behalf as a caregiver and was the licensee of the AFH where Debora resided. In addition, AFH providers are specifically tasked with ensuring that their residents are protected from neglect. WAC 388-76-10670.

It is indisputable that Ms. Woldemicael had a duty of care to Debora. For this reason, the Board of Appeals’s reference to the previous definition of neglect is immaterial, and should not be cause to remand or reverse the

finding. *See Heidgerken*, 99 Wn. App. at 388 (holding that administrative findings can be upheld on any basis adequately supported by the record).

**4. APS policy is irrelevant based on the standard of review**

Ms. Woldemicael argues that APS policy requires a determination that the alleged perpetrator was the proximate cause of actual or potential harm, to support a finding of neglect. *See App. Br.* at 32. This is apparently inferred from Factors 3 and 4, cited by Ms. Woldemicael, which suggest that the findings (in this case, the neglect) be the result of action or inaction of the perpetrator (Ms. Woldemicael), and relate to the scope of their duty of care. However, because this Court conducts a *de novo* review of questions of law, and may affirm the agency action on any theory adequately supported by the administrative record, *Heidgerken*, 99 Wn. App. at 388, APS policy is not dispositive for this Court's decision. Ms. Woldemicael does not explain who else could be could have been responsible for her inaction or how her duty to act could have been outside the scope of her duty of care.

If APS did conduct a causation analysis when considering whether to make an initial finding of neglect, there would be sufficient proximate cause between Ms. Woldemicael's failure to provide care, and the clear and present danger to Debora. Neglect does not require harm, but instead "a clear and present danger to the vulnerable adult's health, welfare, or safety

...” Former RCW 74.34.020(15) (2015). The failure to provide Debora with assistance while eating creates such a clear and present danger. The ISP indicates that Debora has a risk of choking on her food and has poor hand to mouth coordination. APS-AR 614. The caregiver instructions then require that Debora be cued to feed herself (throughout the meal), have her food cut into small pieces, be encouraged to drink liquids, have her mouth wiped as needed, and be monitored for choking. *Id.* Ms. Woldemicael did none of those. Given that those tasks were to reduce the risk of choking, not providing that care placed Debora in a clear and present danger to her health, welfare, or safety.

**C. RCS Properly Suspended and Revoked the Win AFH License, and Stopped Placement to the Facility**

RCS found numerous violations of the AFH rules in addition to the finding of a failure to prevent neglect. Those rule violations were sufficient to warrant revocation and summary suspension of Ms. Woldemicael’s license for Win AFH, in addition to stopping the placement of new residents in her facility.

**1. Win AFH violated WAC 388-76-10670 by failing to ensure that Debora was not neglected.**

Because Ms. Woldemicael neglected Debora, Debora’s right to be free from neglect was violated. WAC 388-76-10670(2) requires that an AFH ensure such a right. The neglect definition for the purposes of this rule,

found in WAC 388-76-10000,<sup>6</sup> is identical to the neglect definition in RCW 74.34.020(15). If this Court determines that Ms. Woldemicael neglected Debora under RCW 74.34.020(15), it should likewise find that her right to be free from neglect was violated, in violation of this rule.

**2. Win AFH violated WAC 388-76-10400 because it failed to provide Debora with necessary care**

Win AFH failed to provide Debora with necessary care, as summarized below, during her dinner on February 12, 2017. That failure constitutes a violation of WAC 388-76-10400, which requires that an AFH ensure each resident receives:

- (1) The care and services identified in the negotiated care plan.
- (2) The necessary care and services to help the resident reach the highest level of physical, mental, and psychosocial well-being consistent with resident choice, current functional status and potential for improvement or decline.
- (3) The care and services in a manner and in an environment that:
  - (a) Actively supports, maintains or improves each resident's quality of life;
  - (b) Actively supports the safety of each resident;
  - ...

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<sup>6</sup> WAC 388-76-10000 defines “neglect” to mean:

(1) 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

(2) 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.

WAC 388-76-10400. Each of these subparts was violated when Ms. Woldemicael left Debora while she ate. Ms. Woldemicael did not provide the specific care and services identified in the Negotiated Care Plan: “assistance with eating” and “caregiver have to cut her food into small and sometimes help her on feeding if she lets caregiver help her.” RCS-AR 640. Ms. Woldemicael also failed to provide Debora with the care required by the ISP: extensive assistance while eating, to be monitored for choking, cued, provide liquids and encouragement throughout the meal, and cut food into small pieces. RCS-AR 624. This care was necessary to help Debora reach the highest level of physical well-being, and to actively support her quality of life and safety. Because these care services were not provided, WAC 388-76-10400 was violated.

**3. WAC 388-76-10355 was violated due to the inadequacy of Debora’s Negotiated Care Plan**

Debora’s ISP identified care needs that were not incorporated into her Negotiated Care Plan. Her ISP assessed her as needing extensive assistance with eating, including that she be monitored for choking, that liquids were to be kept available and encouraged during the meal, and that she needed to be cued to eat throughout. RCS-AR 624. Her Negotiated Care Plan stated that she “needs assistance with eating” and “[the] caregiver [has] to cut her food into small [pieces] and sometimes help her on feeding if she

lets caregiver help her.” RCS-AR 640. Further, the ISP identifies Debora’s risk of choking (RCS-AR 624) but this is not identified in the Negotiated Care Plan, nor is there any plan to follow if choking occurs. *See* RCS-AR 640. The AFH has the responsibility to develop the Negotiated Care Plan. *See* WAC 388-76-10355. If a resident has care needs that are not reflected in the negotiated care plan, the AFH has failed at its responsibility in that regard.

WAC 388-76-10355 requires that a Negotiated Care Plan include preferences and choices about issues important to the resident, including, but not limited to food; and, a plan to follow in case of a foreseeable crisis due to a resident’s assessed needs. *See* WAC 388-76-10355(6) and (7). Because the Negotiated Care Plan did not contain this information, which is necessary given Debora’s assessed care needs, Win AFH violated WAC 388-76-10355.

**4. WAC 388-76-10220 was violated due to the failure to log the incident of Debora’s choking and death**

Debora’s death is not recorded in the Win AFH log of injuries and accidents. WAC 388-76-10220 requires that “the adult family home must keep a log of: (1) Alleged or suspected instances of abandonment, neglect, abuse or financial exploitation; (2) Accidents or incidents affecting a resident’s welfare; and (3) Any injury to a resident.” The incident log that

the RCS investigator, Ms. Witman, scanned when she was at the facility on February 22, 2017, does not reference Debora's choking or death. *See* RCS-AR 669, *see also* Testimony of Ms. Witman, RP Vol. II at 123.

Ms. Woldemicael asserts that the Incident Log at her Exhibit O (RCS-AR 436) contains the necessary recording. However, this document was not received by the Department until it was presented at the administrative hearing months later. *See* Testimony of Ms. Witman, RP Vol. II at 144. Further, it appears to be a different form than the one provided to Ms. Witman on February 22, 2017. *See* RCS-AR 669. In addition, the document originally provided to Ms. Witman has five empty rows, so there is no reason a new page would be necessary to add an entry. *Id.* Both the Administrative Law Judge and the DSHS Review Judge shared these concerns about the credibility of the document at Exhibit O (RCS-AR 436). RCS-AR 5. For this reason, it does not meet the burden of proving by substantial evidence that this rule violation was in error.

**5. WAC 388-76-10020 was violated due to Ms. Woldemicael's demonstrated inability to understand and provide care**

In addition to the deficient care provided to Debora, several other failures by Ms. Woldemicael demonstrate that she does not have the understanding to meet the various needs of vulnerable adults. Such an understanding is required by WAC 388-76-10020, which states that "the

provider must have the (1) understanding, ability, emotional stability, and physical health necessary to meet the psychosocial, personal, and special care needs of vulnerable adults under the home's care..." Ms. Woldemicael showed a lack of understanding and ability in this regard when she was told to start CPR on Debora by the 911 operator, but did not do so until two minutes and 37 seconds into the call after a prolonged exchange with the operator (due to Ms. Woldemicael's failure to follow instructions and need for assistance). RP Vol. II at 183; RCS-AR 566-69. In addition, Ms. Woldemicael has demonstrated a lack of understanding necessary to abide by the terms of the 2013 settlement, by contracting to provide care to Department clients in 2016. RCS-AR 833-60.

These issues are added to by the circumstances underlying the other rule violations at issue in this matter: Ms. Woldemichael's failure to provide the necessary care and services to Debora, which led to her death; her failure to record Debora's choking death in the facility incident log; and her failure to include Debora's assessed care needs and appropriate emergency plans in the Negotiated Care Plan. Finally, her history of noncompliance with AFH rules also evidences her failure in this regard. For these reasons, there is substantial evidence that WAC 388-76-10020 was violated.

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**6. The Department properly exercised its discretion in its enforcement selection**

The Department did not abuse its discretion by suspending and revoking the Win AFH license, or ordering a stop placement. DSHS has discretion in the remedies it chooses to impose against AFHs, and its decision is overturned on judicial review only if it is found to be arbitrary and capricious. *Conway v. Dep't of Soc. & Health Servs.*, 131 Wn. App. 406, 419, 120 P.3d 130 (2005). A discretionary decision is only arbitrary and capricious if it is “willful and unreasoning action in disregard of facts and circumstances.” *Id.* The Legislature has authorized the Department to revoke a license and suspend admissions to an adult family home when the home has failed to comply with the laws and rules governing its operation. *See* RCW 70.128.160(1) and (2). This broad authority is echoed by the AFH rules in WAC 388-76-10940, -10970, and -10980. These rules, implementing the authority granted in RCW 70.128.160, allow the Department to deny a license, impose conditions, civil penalties, stop placement orders, suspend a license, or revoke it, for failure to comply with the laws and rules that govern adult family homes. *See* WAC 388-76-10940. Further, the Department *must* impose a remedy when the violations are repeated, uncorrected, pervasive, ///

or present a threat to the health, safety, or welfare of one or more residents. WAC 388-76-10945; *see also* WAC 388-76-10955.

A stop placement and revocation are supported by the facts of this case given the rule violations, the history of noncompliance, and the statutory authority for those remedies on that basis. Further, the serious nature of the violations, evidenced by the death of Debora, support the selected remedies. This degree of harm also supports the decision to immediately suspend the Win AFH license. “The department has the authority to immediately suspend a license if it finds that conditions there constitute an imminent danger to residents.” RCW 70.128.100. Given the harm that resulted to Debora, and the systemic nature of the various rule violations, the Department did not abuse its discretion by imposing this remedy.

**D. There is No Due Process or Other Procedural Violation Because Ms. Woldemicael Agreed to the Procedure of the Administrative Hearing**

The admission of certain evidence, or consideration of certain allegations, did not violate Ms. Woldemicael’s right to due process. Further, the conduct of the APS or RCS investigators does not create a basis for challenging the final agency action.

The Department may amend the notice of its action “before or during the hearing to match the evidence and facts.” WAC 388-02-0260.

The Administrative Law Judge must offer to continue the hearing in this circumstance, which was done in this case, and Ms. Woldemicael declined that offer through her attorney. *See* RP Vol. I at 14-17. Instead, Ms. Woldemicael agreed to waive that right in exchange for the re-opening of discovery and the opportunity to submit additional exhibits. *See id.* There is no basis for her to claim that her due process was somehow violated when she agreed, with assistance of counsel, to the procedure that was undertaken. Further, she fails to articulate how her due process rights were violated, and provides no reasoning or legal analysis. Such an argument, without analysis, may be disregarded by the Court. *See Graves v. Dep't of Emp't Sec.*, 144 Wn. App. 302, 312, 182 P.3d 1004, 1008 (2008).

Second, issues relating to whether the agency engaged in a satisfactory investigation are irrelevant to whether the Ms. Woldemicael can show that the factual findings in the final agency action are not supported by substantial evidence. If the agency's decision "is not supported by evidence that is substantial when viewed in light of the whole record before the court," the appellant will prevail. RCW 34.05.570(3)(e). There is no need, or legal basis, for speculating about who was not interviewed, or why some interviews were not longer. Ms. Woldemicael has the burden of showing the action is invalid. RCW 34.05.570; *see also Crosswhite*, 197 Wn. App. at 549. If substantial evidence exists in the record to prove

that the agency's findings are not supported by a preponderance of the evidence, then those findings should be overturned. A second layer of analysis, to speculate on what might have been said by people who were not interviewed, is inappropriate and does not show that the agency acted in an arbitrary or capricious manner.

**E. Substantial Evidence Supports the Challenged Findings**

All of the challenged agency findings of fact are supported by substantial evidence. Ms. Woldemicael challenges findings 6, 14, 15, and 24 in the Board of Appeals's APS decision, and findings 4, 15, 20, 22, 26, and 27 in the Board of Appeals's RCS decision.

Ms. Woldemicael argues that APS Finding 14 is unsupported in concluding that she did not cut Debora's food into small pieces, monitor for choking, cueing throughout the meal, or wiping her mouth as needed. *See* App. Br. at 34. However, Ms. Woldemicael testified that when "she was eating, I was in the kitchen making the rest of the residents'; um, dinner ready" and "when I turned around to look at her, she looks different ..." RP Vol. I at 142. Although she states that she was making eye contact, she then suggests that she had to turn around to look at her. *Id.* She could not have been providing the necessary care while occupied while preparing food in an adjacent room with her back to Debora (for at least some of that time). This supports APS Finding 14.

Ms. Woldemicael argues that APS Findings 6 and 15 are unsupported because she testified that she did “check” to see if Debora was breathing. *See App. Br.* at 35. However, she clearly contradicts this statement shortly after making it. She testified that she “felt the pulse” and “her eye was closed and she was not responding. So, I know she wasn’t breathing.” RP Vol. I at 145. She did not actually listen for Debora’s breath, look in her mouth, or listen to her chest. *Id.* at 146. She also argues that these findings were incorrect because of testimony that fingers should not be put in the mouth of someone who is suffering from a seizure. *See App. Br.* at 35. However, these findings do not suggest that Ms. Woldemicael should have put her fingers in Debora’s mouth. *See APS-AR* 3, 6.

Ms. Woldemicael argues that APS Finding 24 is unsupported because it states that she told Ms. Witman that she may have been in the kitchen for five minutes, when Ms. Witman testified that she obtained that information from the police report. *See App. Br.* at 35. Nevertheless, police officer Alex Dyngen testified that Ms. Woldemicael told him that she left Debora unattended for five minutes. RP Vol. II at 25. No concern was raised by the Administrative Law Judge or the Board of Appeals about the credibility of Officer Dyngen, so the fact that he testified to this statement rather than Ms. Witman is immaterial.

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Ms. Woldemicael summarily challenges the RCS Findings of Fact 4, 15, 22, and 27, by referencing her prior assertions and providing no specific argument to any. Regarding Finding 26, she argues that the settlement was ambiguous (App. Br. at 35), and that because she was able to enter into a contract with the Department she “reasonably believed the prior settlement did not limit her ability to contract ...” App. Br. at 39. However, the agreement stated “[Ms. Woldemicael] agrees that the Department will not enter into any new contracts for the purposes of providing care to vulnerable adults or children with Zaid Woldemicael for a period of twenty years following the date of this agreement.” RCS-AR 827. And, that Ms. Woldemicael “agrees that the Department will also not contract for the purposes of providing care to vulnerable adults or children with Zaid Woldemicael’s spouse and/or with any entity that Zaid Waldemicael or her spouse is affiliated with as a partner, officer, director, managerial employee, or majority owner, for a period of twenty years following the date of this agreement.” *Id.* This is language is not ambiguous. Further, it would be unnecessary if it were limited to only the license that was being relinquished, given that she would not be able to contract under it (because of its relinquishment). The agreement is not ambiguous in this way, and her violation of that term causes the revocation to be reinstated. *Id.*

**F. Fees Should Not be Awarded to Ms. Woldemicael if She Prevails**

Even if Ms. Woldemicael prevails in her appeal, a prevailing, qualified party is not automatically entitled to attorney fees under RCW 4.84.350 or the Equal Access to Justice Act (EAJA). The award is denied if the agency's action was "substantially justified." RCW 4.84.350. An agency action may be substantially justified even when the agency's action is ultimately determined to be unfounded. *See Kali v. Bowen*, 854 F.2d 329, 332 (9th Cir. 1988) (The agency's failure to prevail does not create a presumption that its position was not substantially justified).

In determining whether agency action is substantially justified, the court examines whether the agency has a statutory authority to act, whether it has a duty to construe the substantive law liberally in favor of protected individuals, and whether or not there is guiding precedent on point. *See Silverstreak, Inc. v. Dep't of Labor & Indus.*, 159 Wn.2d 868, 892-93, 154 P.3d 891 (2007). In addition, agency action taken with an effort to balance "sensitive, sometimes competing or conflicting interests in a controversial area" is substantially justified, making it appropriate for the court to deny an award under the EAJA. *See, e.g., Plum Creek Timber Co. v. Wash. State Forest Practices Appeals Bd.*, 99 Wn. App. 579, 595-96, 993 P.2d 287 (2000). In this case, those sensitive and competing interests are the need to protect vulnerable adults from harm, and a respondent's interest

in working in the caregiving industry. The strong public interest in protecting vulnerable adults weighs strongly in favor of substantial justification in most cases like this one, and it should weigh strong here too.

Ms. Woldemicael would not be a “prevailing party” and therefore not entitled to an EAJA award, if this Court maintains only the finding of neglect, but overturns the other components of the agency actions. A qualified party “prevails” if the party obtains “relief on a significant issue that achieves some benefit” that the party sought in the judicial review proceeding. RCW 4.84.350(1). Whether a party has prevailed for purposes of the EAJA depends on that party’s degree of success. *See, e.g. Densley v. Dep’t of Ret. Sys.*, 162 Wn.2d 210, 173 P.3d 885 (2007) (denying fees because party gained only 4 of 14 months of retirement service credits sought and failed to properly brief the fee request on review). In *Prostov v. Dep’t of Licensing*, 186 Wn. App. 795, 349 P.3d 874 (2015), the court denied attorney’s fees even though the agency proved only one of its two allegations of driver’s license application fraud because proving just one was enough to support the agency’s suspension of the license. The court reasoned that the party did not prevail because he failed to obtain the relief sought.

In this case, if Ms. Woldemicael has a finding of neglect, she will not be qualified to hold an AFH license, or have unsupervised access to

vulnerable adults. Even if the other aspects of this appeal are overturned, Ms. Woldemicael should not be considered the “prevailing party.”

## V. CONCLUSION

The Department respectfully requests that this Court affirm its agency actions, by finding that Ms. Woldemicael committed neglect, finding that the AFH rule violations occurred, and upholding the Win AFH license revocation, suspension, and stop placement order.

RESPECTFULLY SUBMITTED this 20th day of May, 2020.

ROBERT W. FERGUSON  
Attorney General

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

SETH DICKEY, WSBA #47472  
Assistant Attorney General  
PO Box 40124  
Olympia, WA 98504-0124  
(360) 586-6464  
Seth.Dickey@atg.wa.gov  
OID# 91021

**CERTIFICATE OF SERVICE**

I certify that on the date indicated below, I caused to be served a true and correct copy of the foregoing document on all parties or their counsel of record as follows:

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Lybeck Pedreira & Justus  
7900 SE 28<sup>th</sup> Street  
Mercer Island, WA 98040  
[ben@lpjustus.com](mailto:ben@lpjustus.com)

I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

EXECUTED this 20th day of May, 2020 at Olympia, WA.



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Seth Dickey, AAG

**SOCIAL AND HEALTH SERVICES DIVISION, ATTORNEY GENERALS OFFICE**

**May 20, 2020 - 3:33 PM**

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**Appellate Court Case Title:** Zaid Woldemicael, Appellant v. State Department of Social and Health Services, Respondent  
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