

69303-4

69303-4

NO. 69303-4

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

DAVID MURESAN,

Appellant,

v.

WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH
SERVICES,

Respondent.

BRIEF OF RESPONDENT

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COURT OF APPEALS
DIVISION I
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 ORIGINAL

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I. INTRODUCTION

David Muresan appeals the agency's final order denying him a license to operate an adult family home (AFH). See Appendix A. Mr. Muresan has a history of significant violations and noncompliance as an AFH licensee which precludes him from being granted a new AFH license. Mr. Muresan has had three previous AFH licenses revoked by the Department of Social and Health Services (the Department) and he has had two previous license applications denied. Mr. Muresan also has a finding of neglect of a vulnerable adult issued by the Department. All of these actions have been reviewed on appeal and are now final.

As there can be no genuine issue of material fact regarding Mr. Muresan's established licensing history, the Department relied on that history in denying his application for a new AFH license and the matter was properly disposed of below on the Department's Motion for Summary Judgment.

II. ASSIGNMENTS OF ERROR

1. Mr. Muresan did not assign error to the final agency order. Instead, his appeal brief is a collateral attack on the merits of rulings in other matters which have become final.¹

¹ The content of appellate briefs is governed by RAP 10.3. Pursuant to RAP 10.3(h), the Appellant's brief must set forth a concise statement of the error a party contends was made by the agency issuing the final order being reviewed. *See also* RCW

III. STATEMENT OF THE CASE

The Department received David Muresan's application for an AFH license on or about June 23, 2009. *Ex 13*.² The Department denied this application by letter dated September 9, 2009, amended on October 21, 2009. *Ex 14*. The denial was based on Mr. Muresan's licensing history. *Ex 1-12*. That history includes three previous license revocations and an Adult Protective Services (APS) finding of neglect of a vulnerable adult under his care. *Id.* All of those actions have withstood various challenges including appeals to superior courts, state appellate courts, the United States Supreme Court, and have all now become final.³ *Id.* Therefore, the procedural history cannot be in dispute and the administrative record supports the following findings outlined below.

34.05.558. The Appellant appears to argue that error was committed by the superior court on judicial review by not ruling on the merits of his arguments made in previous venues. The superior court order on judicial review is superfluous for purposes of this appeal. *Verizon Northwest, Inc. v. Emp't Security Dept.*, 164 Wn.2d 909, 915, 194 P.3d 225 (2008); *Markham v. Emp't Security Dept.*, 148 Wn. App. 555, 560-61, 200 P.3d 748 (2009). David Muresan bears the burden of assigning error to the Review Judge's determinations in the Agency's Final Order. For the purposes of this brief, the Department assumes Mr. Muresan is alleging lack of substantial evidence based on the arguments he made in the proceedings below. Moreover, the Appellant does not assign error to any of the factual findings made by the Review Judge in the Agency's Final Order. Therefore, all of the factual findings must be considered verities on appeal. *Kitsap Cy. V. Cent. Puget Sound Growth Mgmt. Hrgs. Bd.*, 138 Wn. App. 863, 872, 158 P.3d 638 (2007).

² Appellant did not designate Clerk's Papers; however, the Administrative Record has been filed with this Court, and therefore, Respondent's Brief will cite to the Exhibits contained therein, and also attached herein as Appendix B.

³ RCW 74.34.020(17) defines a vulnerable adult to include all residents of adult family homes.

On April 29, 2002, the Department revoked Mr. Muresan's license number 52400 for his adult family home located at 18204 30th Avenue in Seattle, Washington. *Ex 1-5*. This revocation was affirmed by the Department's Board of Appeals on December 6, 2002, Docket No. 02-2002-L-1515. *Id.* The revocation was further upheld on reconsideration by the Department's Board of Appeals on December 23, 2002. *Id.* Mr. Muresan appealed to the King County Superior Court and on July 30, 2003, that court affirmed the Board of Appeals, Cause # 02-2-14237-9. *Id.* On September 8, 2004, the Washington State Supreme Court denied Mr. Muresan's petition for review, No. 75062-9. *Id.* Likewise, the Supreme Court of the United States denied Mr. Muresan's writ of certiorari on February 22, 2005, No. 04-7056. *Id.*

Mr. Muresan's license number 390100 for another home at 18210 30th Avenue in Seattle, Washington, was also revoked. *Ex 6-7*. This revocation occurred on June 9, 2003. *Id.* The Office of Administrative Hearings (OAH) upheld that revocation on December 31, 2003, Docket Nos. 06-2003-L-1154 & 06-2003-L-0967. *Id.* The Department's Board of Appeals further affirmed that revocation on March 18, 2004, Docket No. 06-2003L-1154. *Id.*

In addition, Mr. Muresan had an AFH at 1473 Crestview Drive on Camano Island, Washington; that license was revoked as well. *Ex 8-9*.

Subsequently, OAH granted the Department's Motion for Summary Judgment, affirming that revocation and also affirming the Department's denial of two new AFH license applications filed by Mr. Muresan at that time. *Id.* Those revocations and denials were further upheld by the Department's Board of Appeals on February 11, 2005. *Id.*

Moreover, David Muresan has a final finding of neglect of a vulnerable adult. *Ex 10-12, 16.* The Department made findings of neglect against Mr. Muresan on January 23, 2004. *Id.* These findings were upheld by OAH on August 16, 2004, Docket No. 02-2004-L-0175. *Id.* Those findings were upheld by the DSHS Board of Appeals on November 24, 2004, Docket No. 02-2004-L-0175. *Id.* Mr. Muresan appealed to the Court of Appeals Division One, and on February 16, 2006, that court granted the Department's Motion to Affirm on the Merits, No. 56798-5-1. *Id.* On May 2, 2006, the Court of Appeals further issued an order denying Mr. Muresan's Motion to Modify, No. 56798-5-1. *Id.* David Muresan is now listed in the Adult Protective Services Registry of persons who have abused, neglected or exploited a vulnerable adult. *Id.*

IV. ARGUMENT

A. Standard Of Review

Under the Administrative Procedure Act (APA), David Muresan bears the burden of demonstrating the invalidity of the Final Order.

RCW 34.05.570(1)(a); *Hillis v. Dep't of Ecology*, 131 Wn.2d 373, 381, 932 P.2d 139 (1997). The Court of Appeals stands in the same position as the superior court and reviews the Agency's Final Order by applying the APA standards directly to the agency record. On review, a court may grant relief of an administrative decision only if the party challenging the agency's final order shows: (1) the agency erroneously interpreted or applied the law; (2) the decision is not based on substantial evidence; or (3) the decision is arbitrary or capricious. RCW 34.05.570(3); *Tapper v. Emp't Sec. Dep't*, 122 Wn.2d 397, 402, 858 P.2d 494 (1993). An administrative agency cannot be said to have acted in an arbitrary or capricious manner if the action is exercised honestly upon due consideration, even though there may be room for two opinions or even though one may believe that conclusion to be erroneous. *Dupont-Ft. Lewis Sch. Dist. No. 7 v. Bruno*, 79 Wn.2d 736, 739, 489 P.2d 171 (1971); *Trucano v. Dep't of Labor & Indus.*, 36 Wn. App. 758, 761-762, 677 P.2d 770 (1984). See also *Pierce Cy. Sheriff v. Civil Serv. Comm'n of Pierce Cy.*, 98 Wn.2d 690, 695, 658 P.2d 648 (1983).

The Court reviews de novo both the agency's conclusions of law and its application of the law to the facts. *Tapper v. Emp't Sec. Dep't*, 122 Wn.2d 397, 402-03, 858 P.2d 494 (1993); *Terry v. Emp't Sec. Dep't*, 82 Wn. App. 745, 746, 919 P.2d 111 (1996). However, the Court accords

weight to the agency's view of the law it administers. *Postema v. Pollution Control Hearings Bd.*, 142 Wn.2d 68, 77, 11 P.3d 726 (2000); *William Dickson Co. v. Puget Sound Air Pollution Control Agency*, 81 Wn. App. 403, 411, 914 P.2d 750 (1996). The Court's review is confined to the record before the administrative law judge and board. RCW 34.05.558; *Port of Seattle v. Pollution Control Hearings Bd.*, 151 Wn.2d 568, 587, 90 P.3d 659 (2004).

Factual findings made by the administrative law judge are sustained if they are supported by substantial evidence "when viewed in light of the whole record before the court." *Heinmiller v. Dep't of Health*, 127 Wn.2d 595, 607, 903 P.2d 433 (1995). Substantial evidence is "a sufficient quantity of evidence to persuade a fair-minded person of the truth or correctness of the order." *City of Redmond v. Cent. Puget Sound Growth Mgmt. Hrg's Bd.*, 136 Wn.2d 38, 46, 959 P.2d 1091 (1998) (citation omitted).

The Court can modify conclusions of law if the agency's review judge "erroneously interpreted or applied the law." RCW 34.05.570(3)(d); *Heinmiller*, 127 Wn.2d at 601. The Court may substitute its judgment for that of the reviewing officer, but must accord substantial weight to the agency's interpretations of the law within its area of special expertise. *Macey v. Dep't of Empl. Sec.*, 110 Wn.2d 308, 313, 752 P.2d 372 (1988).

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

Here, the governing regulation is found in Washington Administrative Code (WAC) 388-76-10120(3)(a),(f) and mandates the denial of an application for an AFH license when the applicant has a history of non-compliance with licensing regulations or is listed on a state registry with a finding of neglect. Specifically, the rule provides in relevant part:

WAC 388-76-10120 License – Must be denied.

(3) The department **must** deny a license if the department finds that the applicant or the applicant's spouse, domestic partner, or any partner, officer, director, managerial employee or majority owner of the applying entity:

(a) Has a history of significant noncompliance with federal or state laws or regulations in the provision of care or services to children or vulnerable adults;

.....
(f) Is listed on a state registry with a finding of abuse, neglect, financial exploitation, or abandonment of a minor or vulnerable adult;

WAC 388-76-10120(3)(a),(f) [Emphasis added].

The denial of David Muresan's June 23, 2009, application for an AFH license falls within the ambit of WAC 388-76-10120(3). David Muresan has had previous AFH licenses revoked due to violations of state regulations and has a final finding of neglect of a vulnerable adult placing him on the State's registry of offenders. There is no discretion under the rule: the Department must deny the application when there is a history of significant noncompliance, and the Department must deny an application for a person who is listed on a state registry with a finding of neglect of a vulnerable adult.

The administrative record demonstrates that David Muresan has a history of significant violations of AFH licensing rules and regulations. His history has resulted in the revocation of three previous adult family home licenses, two previous license denials, and has resulted in a final finding of neglect placing him on the State's registry. Mr. Muresan has had opportunities to seek review of those revocations and of his finding of neglect, and he has had those determinations reviewed on appeal. Those decisions have all become final, and the facts supporting those decisions

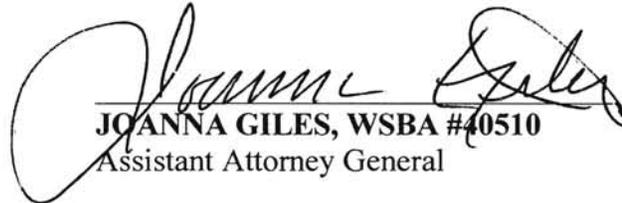
cannot be collaterally attacked here on review of his most recent application denial. David Muresan is disqualified from operating an AFH and his application for a new AFH license was properly denied.

V. CONCLUSION

For the foregoing reasons, the Department respectfully requests this Court affirm the Review Decision and Final Agency Order dated April 19, 2012.

RESPECTFULLY SUBMITTED this 3rd day of June, 2013.

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APPENDIX A

BOARD OF APPEALS

DSHS BOARD OF APPEALS

In Re:)	Docket No. 12-2009-L-1554
)	
DAVID MURESAN)	REVIEW DECISION AND FINAL ORDER
)	
Appellant)	Adult Family Home License
)	Client ID No. ANWOOO7794

I. NATURE OF ACTION

1. The Department of Social and Health Services (Department) denied David Muresan's (Appellant) application for an Adult Family Home (AFH) license based on a history of significant noncompliance with AFH regulations as evidenced by the revocation of previous AFH licenses, and because the Appellant is on the APS Registry based on a finding of neglect of a vulnerable adult . The Appellant requested a hearing to contest the Department's denial of the AFH license. On February 24, 2010, the Department filed a motion for summary judgment and supporting memorandum of law requesting that the Department's denial of Appellant's application for an adult family home license be upheld and judgment on the merits granted to the Department as a matter of law. Administrative Law Judge Bill Gales held a prehearing conference and heard oral argument on the Motion for Summary Judgment on March 19, 2011. He issued an Initial Order Granting Motion for Summary Judgment (Initial Order) on September 2, 2011, affirming the Department's denial as a matter of law.

2. This Final Order incorporates the Petition for Review, and Response, for the easy reference of the reader.¹ The Appellant filed a Petition for Review of the Initial Order to the Department's Board of Appeals (BOA) on September 9, 2011. The Petition states:

The administrative hearing ignored the only issue I presented: that was the RCS-nurse delegation mandatory while the legislation statutory authority say to be optional and the director also say is not mandatory.

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¹ The content of these documents is replicated without comment or correction, with the exception of the footnotes which are numbered consecutively throughout this Review Decision and Final Order.

Facts which made DSHS-RCS angry on David Muresan.

Case explanation: RCS has a rule saying. **Medication Administration is mandatory** in Adult family Homes. Legislative statutory authority for RCS rule say. **Adult family Homes may have medication administration.** Director of RCS wrote that **medication administration is not mandatory in Adult family Homes.**

During the previous license revocations **David did not know the statutory authority saying that Nurse Delegation shall be optional in Adult Family Homes.**

Based on the RCS rule seniors in Washington state are financially exploited and even Medicaid pay for medication administration.

David Muresan asked the RCS to clarify the confusion of the RCS rule. RCS become angry on David Muresan and revoked all 3 licenses David Muresan had in that time, between 2002 and 2004.

Administrative Hearings did not address the Nurse Delegation issue.

I annex the following materials, which were presented to Administrative Hearings.:

1) Appellant Brief. Contains; 1) The RCS director Patricia Lashway letter saying Nurse delegation are not mandatory. 2) The administrative hearings Initial Decision for a license revocation saying that "Nurse Delegation issue was not addressed in the director letter" 3) Citation for license 390100 revocation saying that David say "Nurse delegation is not mandatory" and not the director wrote that

2) DSHS Facts. Contains: DSHS restriction to appeal their license revocation and david acceptance of the DSHS request.

3) Appellant's response. Contains. 1) DSHS notes showing that all the complaints were made by DSHS workers.

I ask the DSHS board of appeal to reverse the DSHS decision to deny my license for a new Adult family Home or address if the DSHS rule is correct, or the Directory letter is incorrect.

3. The Department filed a response to the Appellant's Petition for Review on September 19, 2011. The response states:

The Department of Social and Health Services ("Department") files this response to the Appellant's petition to the Board of Appeals ("BOA") for review of the Initial Order of September 2, 2011, in the matter of *In re David Muresan*, Docket No. 12-2009-L-1554.

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I. PROCEDURAL BACKGROUND

The Appellant, David Muresan, submitted an application to the Department for an adult family home (AFH) license on or about June 23, 2009. Initial Order, Finding of Fact 1 (FF 1).² On October 23, 2009, Mr. Muresan was served with the Department's amended denial letter, denying his application. FF 2. The denial was based on Mr. Muresan's licensing history, three previous license revocations, and an Adult Protective Services (APS) finding of neglect of a vulnerable adult which placed Mr. Muresan on the Abuse Registry. FF 3-11. Mr. Muresan filed an appeal of that denial to the Office of Administrative Hearings (OAH) and a telephone prehearing conference (PHC) was held on January 14, 2010. Initial Order, page 1. Subsequently, on February 24, 2010, the Department filed a Motion for Summary Judgment. *Id.* Another telephone hearing was held on March 19, 2010, before Administrative Law Judge (ALJ) Bill Gales. *Id.* The Department's motion was granted by Initial Order dated September 2, 2011. Mr. Muresan petitioned BOA for review on September 8, 2011, and the Department files this response.

II. ARGUMENT

The ALJ properly applied the law to the undisputed facts and granted the Department's Motion for Summary Judgment. Pursuant to WAC 10-08-135, a motion for summary judgment may be granted and an order issued if the written record shows that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. *Id.* Here, there are no genuine issues of material fact. The written record in this matter supports the findings made by the ALJ that Mr. Muresan has three previous revocations of AFH licenses that have become final, and has a finding of neglect of a vulnerable adult which has also become final. FF 3-11. In addition, Mr. Muresan is listed in the Department's Registry of Abuse. FF 3-11. Mr. Muresan cannot now collaterally attack his final revocations and findings of abuse in this tribunal, or in any other tribunal.

WAC 388-76-10120 mandates that an application for an Adult Family home must be denied if the applicant has a "history of significant noncompliance" with regulations in the provision of care or services to vulnerable adults and/or has a finding of neglect that is listed on "any registry". WAC 388-76-10120(3)(a) and (3)(j)(1). The appellant has such a final finding of neglect, is listed in such a registry, and has demonstrated by his three previous revocations of adult family home licenses that he has a history of significant noncompliance with the regulations. Therefore, the Department is entitled to summary judgment as a matter of law.

III. CONCLUSION

The Board of Appeals should uphold the Administrative Law Judge's Initial Order, granting the Department's Motion for Summary Judgment and denying Mr. Muresan's application for an Adult Family Home License. The record supports the Department's action in this case.

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² In his Petition for Review, the appellant assigns no error to the findings of fact in the Initial Order, therefore they are considered verities on appeal. See, David Muresan's September 8, 2011, Petition for Review of Initial Decision.

II. UNDISPUTED FACTS THAT ARE THE BASIS OF THE DECISION

The undersigned has reviewed the audio record of the pre-hearing conference, the documents admitted as exhibits, the Initial Order, the Appellant's petition for review, and the Department's response to determine the adequacy and appropriateness of the undisputed facts listed as Findings of Fact by the ALJ in the Initial Order. After review, the undersigned adopts the Initial Facts as there are no questions of fact in this matter, and they form the foundation for the legal conclusions of the ALJ and the Review Judge. The facts have been viewed in the manner most favorable to the Appellant. They have not been challenged by either party on review.³

1. On or about June 23, 2009, Appellant David Muresan submitted an application to the Department for an Adult Family Home (AFH) license for the location 1578 S. Crestview Dr., Camano Island, Washington. Exhibit D-13.

2. On September 9, 2009, the Department wrote the Appellant a letter informing him that his application for an AFH license had been denied. Exhibit D-14. The Department attempted to serve the Appellant with the letter by certified mail, but the letter was returned as unclaimed. *Id.* The letter was sent, in error, to the address of the proposed AFH, instead of the mailing address of the Appellant. On October 21, 2009, the Department sent the Appellant an amended denial letter, with the correct address, and served him by certified mail on October 23, 2009. Exhibit D-15.

3. In the denial letter, the Department stated that the denial was based on WAC 388-76-10120, subsections (3)(a) and (3)(f), which describe circumstances in which the Department must deny an applicant's AFH license application. In support of its decision the Department cited three previous AFH license revocations and an Adult Protective Services (APS) finding of neglect of a vulnerable adult involving the Appellant. *Id.*

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³ RCW 34.05.464(8).

AFH license revocations

4. On April 29, 2002, the Appellant's AFH license (#524000 - King County) at the location 18204 - 30th Ave., Seattle, Washington, was revoked by the Department. The revocation action was upheld in a final order of the Department's Board of Appeals on December 12, 2002. Exhibit D-1 (Docket number 02-2002-L-1505). The decision was affirmed on reconsideration, by an order mailed December 23, 2002. Exhibit D-2. The decision was affirmed on Judicial Review in State of Washington, King County Superior Court No. 02-2-1437-9-SEA on July, 2003. Exhibit D-3. The Supreme Court of Washington denied a petition for review in No. 75062, C/A No. 52733-9-I on September 8, 2004. Exhibit D-4. The Supreme Court informed the Appellant that his motion for reconsideration of his petition for review was not proper since the court's decision on the petition for review was not subject to reconsideration by letter dated September 16, 2004. *Id.* The Supreme Court of the United States denied the Appellant's petition for a writ of certiorari on February 22, 2005. Exhibit D-5.

5. On June 9, 2003, the Appellant's AFH license (# 390100 - King County) at the location 18210 - 30th Ave., Seattle, Washington, was revoked by the Department. The revocation action was upheld in an initial order of the Office of Administrative Hearings on December 31, 2003, which became a final order by operation of law. Exhibit D-6 (Docket Nos. 06-2003-L-1154 and 06-2003-L-0967). A request for review in Docket No. 06-2003-L-1154 was received by the Board of Appeals on March 12, 2004, more than 51 days later. An Order Denying Request for Review was entered on March 18, 2004. Exhibit D-7.

6. On May 11, 2004, the Appellant's AFH license (# 512600 - Island County) at the location 1473 S. Crestview Dr., Camano Island, Washington, was revoked by the Department. The revocation action was upheld in a final order of the Department's Board of Appeals on February 11, 2005. Exhibit D-8 (Docket No. 05-2004-L-1744).

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AFH license denials

7. In 2003 the Appellant submitted two applications for AFH licenses at the locations 1476 and 1578 S. Crestview Dr., Camano Island, Washington, which were denied by the Department. (Docket Nos. 02-2003-L-0860 and 05-2004-L-1507). The denials were affirmed by an Initial Order Granting Summary Judgment mailed December 30, 2004. Exhibit D-8. The denial actions were upheld in a final order of the Board of Appeals on February 11, 2005. Exhibit D-9.

APS neglect of a vulnerable adult findings

8. On June 17, 2003, the Department issued a finding that the Appellant had neglected a vulnerable adult. At the time the finding was made the rules did not provide a procedure for administratively challenging APS findings.

9. On November 7, 2003, the Department issued a finding that the Appellant and his wife had neglected a vulnerable adult. The finding was upheld in a final order of the Department's Board of Appeals on November 24, 2004. Exhibit D-10 (Docket No. 02-2004-L-0175). This order was affirmed by the Washington State Court of Appeals in a Commissioner's Ruling Granting Motion on the Merits to Affirm in No. 56798-5-1 entered February 16, 2006. Exhibit D-11. An Order Denying Motion to Modify was entered May 2, 2006. Exhibit D-12.

10. Based on the above APS, the Appellant is listed on the state Adult Protective Services Abuse Registry. Exhibit D-16, p. 3.

III. CONCLUSIONS OF LAW

Jurisdiction and Standards of Review

1. The Appellant filed a petition for review of the Initial Order and the petition is otherwise proper.⁴ Jurisdiction exists to review the Initial Order and to enter the final agency order.⁵

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⁴ WAC 388-02-0560 through -0585.

2. In an adjudicative proceeding regarding an adult family home license application, the undersigned has the same authority as the ALJ to enter Findings of Fact, Conclusions of Law, and Orders.⁶ The Washington Administrative Procedure Act also states that the undersigned Review Judge has the same decision-making authority when deciding and entering the Final Order as the ALJ had while presiding over the hearing and deciding and entering the Initial Order, unless the Review Judge or a provision of law limits the issue subject to review.⁷ RCW 34.05.464(4) grants the undersigned Review Judge the same decision-making authority as the ALJ and in the same manner as if the undersigned had presided over the hearing.⁸

3. The undersigned has reviewed the audio record of the hearing, the documents admitted as exhibits, the Initial Order, and the Appellant's petition for review to determine the adequacy and appropriateness of the Findings of Fact made by the ALJ in the Initial Order. The undersigned has reviewed the entire hearing record in this matter and found no irregularities in the proceedings, no unsupported findings of fact, and no errors of law.

4. As set forth in the Initial Order, the Department is required by regulation to deny an application for a license to operate an AFH when an applicant has a history of significant noncompliance. Such a history of significant noncompliance is defined as including the revocation or suspension of a license for the care of vulnerable adults.⁹

5. In his petition for review, the Appellant attempts to challenge the previous revocations of his AFH licenses, arguing previous orders wrongly decided an issue regarding nurse delegation. As correctly concluded by the ALJ in the Initial Order, the previous AFH

⁵ WAC 388-02-0530(2) and 388-02-0570.

⁶ WAC 388-02-0600(1) and WAC 388-02-0217(3). See also RCW 34.05.464(4); *Tapper v. Employment Security*, 122 Wn.2d 397 (1993); and *Northwest Steelhead and Salmon Council of Trout Unlimited v. Washington State Dept. of Fisheries*, 78 Wn. App 778 (1995).

⁷ RCW 34.05.464(4). See also WAC 388-02-0600(1).

⁸ *Kabbae v. Dep't of Soc. & Health Servs.*, 144 Wn. App. 432, 443 (2008) (citing RCW 34.05.464(4) as the basis for invalidating WAC 388-02-0600(2)(e)—now repealed—which purported to limit the scope of the undersigned's decision-making authority when reviewing certain types of cases).

⁹ WAC 388-76-560(7)(a).

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license revocation have become final, and the Appellant cannot collaterally attack the previous final license revocations in a subsequent hearing to challenge the denial of a new application for an AFH license. The time to successfully challenge the previous license revocations has come and gone.

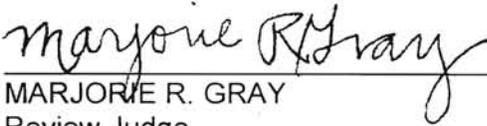
6. The Appellant has been found to have neglected a vulnerable adult, and is listed on the APS Abuse Registry. He has had previous licenses for adult family homes revoked. He has had subsequent license applications denied. The Appellant is collaterally estopped from relitigating the previous revocations and license denials, as well as his finding of neglect. The Department's action denying his new application for an adult family home license should be affirmed as a matter of law.

7. The procedures and time limits for seeking reconsideration or judicial review of this decision are in the attached statement.

IV. DECISION AND ORDER

Based on the above conclusions, the Appellant's Petition for Review of the Initial Order is denied and the Department's denial of the Appellant's application for an Adult Family Home license is **affirmed**.

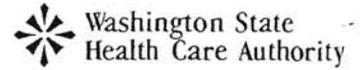
Mailed on the 19th day of April, 2012.


MARJORIE R. GRAY
Review Judge

Attached: Reconsideration/Judicial Review Information

Copies have been sent to: David Muresan, Appellant
Joanna Giles, Department's Representative, MS: TB90
Joyce Stockwell, Program Administrator, MS: 45600
Janice Schurman, Program Administrator, MS:S53-4
Bill Gales, ALJ, Seattle OAH

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PETITION FOR RECONSIDERATION OF REVIEW DECISION

See information on back.

Print or type detailed answers.

NAME(S) (PLEASE PRINT) DOCKET NUMBER CLIENT ID OR "D" NUMBER

MAILING ADDRESS CITY STATE ZIP CODE

TELEPHONE AREA CODE AND NUMBER

Please explain why you want a reconsideration of the Review Decision. Try to be specific. For example, explain:

- Why you think that the decision is wrong (why you disagree with it).
- How the decision should be changed.
- The importance of certain facts which the Review Judge should consider.

I want the Review Judge to reconsider the Review Decision because. . .

PRINT YOUR NAME SIGNATURE DATE

<u>MAILING ADDRESS</u> BOARD OF APPEALS PO BOX 45803 OLYMPIA WA 98504-5803	<u>PERSONAL SERVICE LOCATION</u> DSHS / HCA Board of Appeals Office Bldg 2 (OB-2), 1st Fl. Information Desk 1115 Washington St. SE, Olympia WA
<u>FAX</u> 1-(360) 664-6187	<u>TELEPHONE (for more information)</u> 1-(360) 664-6100 or 1-877-351-0002

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RECONSIDERATION REQUEST

Page ____ of ____

If You Disagree with the Judge's Review Decision or Order and Want it Changed,
You Have the Right to:

- (1) Ask the Review Judge to reconsider (rethink) the decision or order **(10 day deadline)**;
- (2) File a Petition for Judicial Review (start a Superior Court case) and ask the Superior Court Judge to review the decision **(30 day deadline)**.

DEADLINE for Reconsideration Request - 10 DAYS: The Board of Appeals must RECEIVE your request within ten (10) calendar days from the date stamped on the enclosed Review Decision or Order. The deadline is 5:00 p.m. If you do not meet this deadline, you will lose your right to request a reconsideration.

If you need more time: A Review Judge can extend (postpone, delay) the deadline, but you must ask within the same ten (10) day time limit.

HOW to Request: Use the enclosed form or make your own. Add more paper if necessary. You must send or deliver your request for reconsideration or for more time to the Board of Appeals on or before the 10-day deadline (see addresses on enclosed form).

COPIES to Other Parties: You must send or deliver copies of your request and attachments to every other party in this matter. For example, a client must send a copy to the DSHS office that opposed him or her in the hearing.

Translations and Visual Challenges: If you do not read and write English, you may submit and receive papers in your own language. If you are visually challenged, you have the right to submit and receive papers in an alternate format such as Braille or large print. Let the Board of Appeals know your needs. Call 1-(360)-664-6100 or TTY 1-(360) 664-6178.

DEADLINE for Superior Court Cases - 30 DAYS: The Superior Court, the Board of Appeals, and the state Attorney General's Office must all RECEIVE copies of your Petition for Judicial Review within thirty (30) days from the date stamped on the enclosed Review Decision or Order. There are rules for filing and service that you must follow.

EXCEPTION: IF (and only if) you file a timely reconsideration request (see above), you will have thirty days from the date of the Reconsideration Decision.

Refer to the Revised Code of Washington (RCW), including chapter 34.05, the Washington Administrative Code (WAC), and to the Washington Rules of Court (civil) for guidance. These materials are available in all law libraries and in most community libraries.

If You Need Help: Ask friends or relatives for a reference to an attorney, or contact your county's bar association or referral services (usually listed at the end of the "attorney" section in the telephone book advertising section).

Columbia Legal Services, Northwest Justice Project, the Northwest Women's Law Center, some law schools, and other non-profit legal organizations may be able to provide assistance. You are not guaranteed an attorney free of charge.

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APPENDIX B

STATE OF WASHINGTON, DEPARTMENT OF SOCIAL AND HEALTH SERVICES

BOARD OF APPEALS

In Re:) Docket No. 02-2002-L-1505

DMMD ADULT FAMILY HOME CARE)
C/O DAVID AND MARIA MURESAN) REVIEW DECISION AND FINAL ORDER
18204 30TH AVENUE NORTHEAST)
SEATTLE WA 98155)

MAILED
DEC 06 2002

Appellants) Adult Family Home License BOARD OF APPEALS

NATURE OF ACTION

Rynold C. Fleck, Administrative Law Judge, held a hearing on May 23, 2002. The Administrative Law Judge (ALJ) issued the Initial Decision on July 22, 2002. The Initial Decision overturned the Department's revocation of Appellants' adult family home license and imposed a civil fine of \$300.00.

The Department filed a Petition for Review on August 8, 2002. The Department argued, in summary, that Initial Finding of Fact 9 regarding caregiver qualifications was not supported by the evidence in the record. The Department further argued that the Initial Decision erroneously concluded that a resident did not experience a significant change in circumstances and erroneously overturned the remedy selected by the Department. The Department asked that Appellants' adult family home license be revoked.

Appellants filed a Response to the Department's Petition for Review on August 19, 2002. Appellants argued, in summary, that the Department's Petition for Review should be dismissed because of irregularities in the complaint process that led to the investigation in this matter. Appellants argued that the Initial Decision was correct and should not be overturned.

ISSUES

Should Appellants' adult family home license for adult family home license number 524000 be revoked?

EXHIBIT #1

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RECEIVED
DEC 10 2002
Department of Social and Health Services

RESULTS

Yes, Appellants' adult family home license for adult family home license number 524000 shall be revoked for violations of adult family home licensing rules.

FINDINGS OF FACT

The Findings of Fact in the Initial Decision are adopted under RCW 34.05.464(8) except as follows. Where findings are not supported by the evidence in the record, they are struck through. Where additional findings are needed, they are indicated by underlining.

4. David and Maria Muresan are owners and operators of DMMD Adult Family Homes (DMMD). DMMD has three homes, two of which are adjacent to one another in Seattle, Washington and one on Camano Island. The home which was the subject of a stop-placement and revocation of license notice is at 18204 30th Avenue N .E., Seattle, Washington. The license number for that facility is 524000.

5. On December 22, 2001, DSHS received a complaint regarding an occurrence at 18204 30th Avenue N.E.

6. Mary Wood, a Complaint Investigator for DSHS, made an unannounced investigation at said home on December 26, 2001 and January 15, 2002. As a result of that investigation, an Amended Statement of Deficiencies and Plan for Correction was issued. As a result of that Amended Statement of Deficiencies, DSHS issued an Amended Stop-Placement of Admissions and Revocation of License Notice. That Amended Notice was issued April 29, 2002.

7. David Muresan, on behalf of DMMD Adult Family Homes, filed a timely notice for a fair hearing on the Amended Stop-Placement of Admissions and Revocation of License Notice. The Amended Notice cites nine (9) findings of violations of the Washington Administrative Code (WAC) which, after due consideration, resulted in DSHS' s issuing the

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Stop-Placement of Admission Notice and the revocation of the license for said facility. The violations are in order as follows:

(1) **WAC 388-76-560(7) License Eligibility**

The licensees failed to demonstrate the understanding and ability to meet the emotional and physical needs of vulnerable adults in the home. This failure placed residents at risk from harm by not having their emotional and physical care needs met.

(2) **WAC 388-76-60070(5) What are some of the other resident rights that must be considered?**

WAC 388-76-620(1). (4)(a), (b) Provision of Services and Care:

The licensees failed to ensure that 1 of 3 residents in the home was free from neglect and received necessary services and care provided in a manner that promoted the maintenance and safety of the resident. This failure resulted in the resident experiencing a decline in function from being left alone while seriously ill and not receiving timely and appropriate intervention for the illness. In addition, the licensees failed to ensure that a qualified caregiver was present in the home.

(3) **WAC 388-76-610700) Does the Assessment Have to be updated?**

The licensee failed to ensure that 1 of 3 residents had a current assessment. This failure placed the resident's health at risk from harm from not having care needs met and causing deterioration in the condition.

This is a repeat citation from 11/5/01 and 11/29/01 for license #512600.

(4) **WAC 388-76-61550(2), (4) - How often must the negotiated care plan be reviewed and revised?**

The licensee failed to ensure that 1 of 3 residents had current care plan. The failure placed the resident's health at risk from harm from not having care needs met and causing deterioration in condition.

(5) **WAC 388-76-640(2)(a) (b) Resident Medications:**

The licensee failed to ensure that all medications were kept in locked storage in the original containers with the original label. This failure placed residents at risk from harm from ingestion of medications.

This is a repeat citation from 11/5/01 for license #512600.

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(6) **WAC 388-76-655(5)(d) General Management and Administration:**

The licensee failed to ensure that all caregivers possessed a valid First Aid and CPR card. This placed the residents at risk from harm in the event of a medical emergency.

This is a repeat citation from 11/5/01 for license #512600.

(7) **WAC 388-76-655(6)(a) General Management and Administration:**

The licensees failed to ensure that the caregiver was present in the home one or more of the residents were in the home. This failure placed the residents' health and safety at risk in the event of an emergency.

(8) **WAC 388-76-665(1) Resident Records:**

The licensees failed to ensure that all residents' records were kept confidential. This failure placed 3 former residents at risk of having their confidential information disclosed.

(9) **WAC 388-76-770(1) Safety and Maintenance:**

The licensee failed to provide an environment that was safe, clean, comfortable and homelike, due to the temperature of the home causing at least one resident [sic, discomfort?] and a commode in a resident's bedroom that contains sharp edges and is unsafe. These failures place the resident at risk from diminished quality of life and their safety at risk from potential injury and illness.

Exhibit 1.

8. On December 26, 2001, Mary Wood, the Complaint Investigator for DSHS, arrived at 18204 30th Avenue N.E., Seattle, Washington, at approximately 2:00 p.m. Three residents were occupying the facility with no one else there for approximately one half hour. The Muresans were next door in their second facility. One of the residents was acting as a temporary caregiver although the resident, Susie, was not qualified to act as a caregiver. Susie had not completed a background check, caregiver training, CPR, or TB testing. Department's Exhibit 10, p. 6. Ms. Wood observed Resident #2 (Mary) who appeared to her to be in respiratory distress. When confronted by Ms. Wood about the fact 0001101 that there was no qualified caregiver in the home, Mr. Muresan offered to send Ursula to the home. However, Ursula was not qualified to act as a caregiver. RP, p. 90. After Ms. Wood's

insistence, the caregiver Appellants called 9-1-1 and Mr. Muresan went to 18204 30th Avenue. Ms. Wood observed Resident #2 ([M.S.]) struggling with her breathing and gurgling. Mr. and Mrs. Muresan had acknowledged that ~~that behavior~~ M.S.'s shortness of breath and inability to stand had commenced ~~on that day~~ several days prior to December 26, 2001. RP, pp. 160, 165. Mr. Muresan had considered sending M.S. to the hospital on December 25, 2001, because of her condition. RP, p. 165. Later in the day on December 26, 2001, Resident #2 ([M.S.]) was taken to the hospital where her breathing rate was determined to be 44 which is twice normal, and her blood oxygen was at 80% when 95%+ is normal. She had a 102.9° temperature. It was determined that Resident #2 ([M.S.]) had a lung infection. Her condition, in Ms. Wood's opinion, constituted a significant deterioration in her condition.

9. While performing this investigation, Ms. Wood found that the temperature in the house was 68.4°. RP, p. 91. ~~One of the residents complained to Ms. Wood that she was cold.~~ Ms. Wood also observed a handmade commode ~~which~~ that was made of wood and was not finished or painted. RP, p. 91. Mr. and Mrs. Muresan were utilizing a woman whose name was Ursula as a caregiver. Ursula was not a qualified caregiver. She did not have a cardiopulmonary resuscitation (CPR) card or a First Aid card. RP, pp. 90, 175. Ursula was only employed by the Muresans for one week. On December 26, 2001, there were no qualified caregivers in either home except for the Appellants. ~~On the day in question, the Muresans had a qualified caregiver, Susie, who they utilized as a caregiver, but she was at the neighboring Adult Family Home (AFH), which is approximately 50 feet, from door to door.~~

10. Resident #2 ([M.S.]) had been enrolled in special activities. She would go to those activities two to three times per week. Those activities lasted from 9:00 a.m. until 2:00 p.m. She had been involved in those activities and attending these activities ~~within the week~~ before the complaint inspection until December 12, 2001, two weeks before the complaint inspection. Ms. Wood left the AFH prior to the arrival of the emergency care personnel.

11. The Emergency Room physician who attended to Resident #2 ([M.S.]) determined that she was suffering from pneumonia and dehydration. Resident #2 ([M.S.]) had no complaints of her own and denied that she was in pain. As reported by the doctor, symptomatically, Resident #2 ([M.S.]) had no cold or flue-like symptoms, no ear, nose, throat or mouth problems. Her cardiovascular examination was negative for heart failure. Her respiratory examination was negative for emphysema and asthma. A chest x-ray was done which showed a right lower-lobe infiltration. She was admitted to the hospital for care, due to the pneumoma.

12. Mr. Muresan discovered M.S. next to her bed on the morning of December 14, 2001. M.S. was unable to stand so Mr. Muresan assisted her back into bed. RP, p. 166. At 3:00 a.m. on December 15, 2001, a caregiver found M.S. on the floor beside her bed. The caregiver was unable to assist M.S. back into her bed so the caregiver gave M.S. a pillow and blanket and left her on the floor until 8:00 a.m. The caregiver called Appellants at 8:00 a.m. and Appellants instructed the caregiver to call 911. RP, p. 167. Resident #2 ([M.S.]) had gone to the hospital earlier in the month. On December 14, 2001, she was discovered next to her bed. When Resident #2 ([M.S.]) was found, she was observed with lacerations on her nose and under one eye. She was admitted to the hospital. M.S. was admitted to the hospital on December 15, 2001. The hospital noted lacerations on M.S.'s face.

Department's Exhibit 7. The doctors noted that although there were no significant abnormalities, the subject was unable to walk and they were unable to find a treatable cause for her gait problems. They did note that she had a history of psychiatric problems. Resident #2 ([M.S.]) was released from the hospital on December 18, 2001. In the concluding of their release report, it appears as though the doctors concluded that the hospitalization was successful and she returned to near baseline. It appears as though the doctors decided to reduce some of the psychiatric medication that Resident #2 ([M.S.]) was on. Although in

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their initial intake, they had considered that potentially Resident #2 ([M.S.]) would need nursing home care, they did not conclude this upon discharge. They specifically stated that she was alert and could be discharged to DMMD Adult Family Home. They referred her to Community Mental Health to deal with the recommendations from the psychiatrist on her medication. Department's Exhibit 7. When M.S. left the hospital on December 18, 2001, she was able to walk six feet and she required minimum to moderate assistance in transferring. RP, p. 43. A hospital social worker asked Appellants if they were prepared to offer wheelchair level assistance and moderate to maximum transfers "if needed." Department's Exhibit 9, p. 1. For the first few days after M.S. returned to Appellants' home, she was able to stand and walk on her own. RP, p. 165.

13. On November 5, 2001, DSHS issued a Statement of Deficiencies and Plan for Correction for the Camano Island facility of DMMD, which included a citation for failure to maintain medications and prescriptions in locked storage. On November 29, 2001, DSHS issued a Statement of Deficiencies and Plan of Correction also for the Camano Island facility because the current assessment and the care plan for one of the residents did not correspond to the assessment of the physician.

14. On December 26, 2001, the investigator was directed to a set of drawers in the living room by one of the residents when inquiring about medications. The medications were found in an unlocked drawer and included Glyburide (used for regulating blood sugar) and Cumadin (which is used to prevent blood clots). RP, p. 89. The unlocked drawer also contained records of former residents. RP, p. 91.

15. A Department case manager completed an assessment of M.S. on November 1, 2001. Under the heading "ambulation," the assessment notes that M.S. requires minimum assistance and states, "Ambulates with cane. Endorsed difficulty with steps and difficulty

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ambulating at any distance. Needs supervision when walking alone or with the help of a mechanical device.” Department’s Exhibit 5, p. 7.

CONCLUSIONS OF LAW

JURISDICTION AND PROCEDURE

1. **Jurisdiction for Review-** The Petition for Review of the Initial Decision in this matter was timely filed and is otherwise proper. WAC 388-02-0580. Jurisdiction exists to review the Initial Decision and to enter the final agency order. WAC 388-02-0560 to -0600.

2. **Scope of Review-** In adult family home licensing matters, the undersigned’s authority is the same as the ALJ’s with the exception that the undersigned is required to consider the ALJ’s ability to observe the witnesses. WAC 388-02-0600(1)(a).

3. **Jurisdiction for Appeal-** A licensee who is aggrieved by the Department’s revocation of his/her adult family home license has a right to an adjudicative proceeding pursuant to WAC 388-76-710(3). The licensee’s request for adjudicative proceeding must be received within 28 days of the licensee’s receipt of a notice of revocation. WAC 388-76-710(3). The Department’s Notice of Revocation is dated February 13, 2002. The Office of Administrative Hearings received Appellants’ request for hearing on February 21, 2002, the eighth day after the date of the Notice of Revocation (Department’s Exhibit 10). This timely request for hearing provided jurisdiction for the ALJ to convene a hearing pursuant to WAC 388-76-710(3).

ALLEGATIONS

4. The Department alleged that Appellants committed multiple violations of ten Department rules. The undersigned addresses each allegation from the Department’s Notice of Revocation (Department’s Exhibit 1).

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WAC 388-76-61070(2)- Assessment Update

5. **Applicable Law-** The Department alleged that Appellants violated WAC 388-76-61070(2), which states "The provider must ensure that the assessment is reviewed and updated to document the resident's ongoing needs and preferences ... [w]hen there is a significant change in the resident's physical or mental condition." The Department alleged that Appellants violated this rule by not updating M.S.'s assessment. Findings of Fact 12 and 15 contain the information supporting this allegation. This allegation was not proven.

6. **M.S. Assessment Update-** The Department alleged that Appellants failed to ensure that M.S.'s assessment was updated. Specifically, the Department alleged that M.S. experienced a significant change in condition from November 1, 2001, when her assessment was completed, until December 18, 2001, when she was released from the hospital. Department's Exhibit 2, p. 9. The Department noted that M.S. was able to ambulate independently on November 1, 2001, but, by the time she left the hospital on December 18, 2001, M.S. was unable to maintain her balance and was unable to walk. The Department further noted that M.S. was discharged back to the home as a wheelchair-dependent resident who required moderate to maximum assistance. *Id.* The Department alleged that Appellants should have completed a re-assessment of M.S.'s abilities because M.S.'s ability to ambulate declined between November 1, 2001, and December 15, 2001.

7. As an initial matter, the undersigned notes that the phrase "significant change in condition" is not further defined in chapter 388-76 WAC. In the absence of any additional definition, the undersigned presumes that the significant change in condition must be expected to continue into the future. It would not be possible for a licensee to update a resident's assessment each time the resident experienced a brief, acute illness that affected his/her functioning. As Ms. Wood explained to Appellants on December 26, 2001, it might take several days for a Department case manager to visit a resident upon the request of a provider. RP, p. 82. If the resident's

change in condition is likely to subside before the case manager is able to come to the home to perform the re-assessment, then the change in condition cannot be the kind of change that requires a reassessment. For example, a vulnerable adult who is otherwise able to ambulate independently might spend several days in bed if he/she is suffering from a cold or flu. The undersigned cannot conclude that the assessment must be updated to reflect this condition and then updated again three days later when the resident recovers from the condition. While a change need not be permanent to be considered significant, the change must last longer than a few days.

8. Based on the evidence in the record, it appears that the change in M.S.'s functioning in mid-December 2001 was the result of an acute condition and was not expected to impact her ongoing condition. The change in M.S.'s condition came on suddenly on December 14, 2001, and was resolved by the time M.S. left the hospital on December 18, 2001. Mr. Muresan testified that he found M.S. on her knees in her room on December 14, 2001. Mr. Muresan did not testify about any other loss of function prior to December 14, 2001. No other witness testified about any other change in condition prior to December 14, 2001. When M.S. was released from the hospital on December 18, 2001, Mr. Muresan testified that M.S. was once again able to stand and walk, just as she had been able to do before. RP, p. 164. Ms. Butchers confirmed that, when M.S. left the hospital on December 18, 2001, she was again able to transfer with minimum to mild assist and she was able to walk six feet. RP, p. 43; Department's Exhibit 9, p. 1. Therefore, M.S.'s condition upon release from the hospital was not significantly different than the condition expressed in her November 1, 2001, assessment, which required minimal assistance and stated, "Ambulates with cane. Endorsed difficulty with steps and *difficulty ambulating at any distance*. Needs supervision when walking alone or with the help of a mechanical device." (Emphasis added). Department's Exhibit 5, p. 7. Even if Appellants had asked M.S.'s case manager to complete a reassessment on December 14, 2001, the case

manager would not have found a significant change of condition when she saw M.S. upon her release from the hospital. The acute condition appeared to have resolved itself during M.S.'s hospital stay.

9. The Department based its citation on Ms. Butcher's notation that she discussed the possibility of wheelchair-level care and moderate to maximum transfers with Appellants on December 18, 2001. However, Ms. Butcher did not testify that M.S. actually needed wheelchair-level care. Ms. Butcher was discussing wheelchair-level care and maximum assistance "if needed." Department's Exhibit 9, p. 1. There was no evidence to indicate that wheelchair-level care or maximum assistance was actually necessary for M.S. Instead, as stated above, M.S. was walking when she left the hospital. Just as she had at the time of her assessment, M.S. needed assistance when walking alone or at any distance. The Department failed to prove, by a preponderance of the evidence, that M.S. experienced a significant change in condition between November 1, 2001, and December 18, 2001, requiring an updated assessment.

WAC 388-76-61550- Negotiated Care Plan Update

10. **Applicable Law-** The Department alleged that Appellants violated WAC 388-76-61550, which states:

The provider must ensure that the plan is reviewed and revised according to the following schedule...

(2) When there is a significant change in the resident's physical or mental condition...

(4) If changes or additions to assessment information result in significant changes to the resident's identified needs or preferences and choices.

The Department alleged that Appellants violated this rule by failing to update M.S.'s negotiated care plan (NCP). Finding of Fact 8 contains the information supporting this allegation. This allegation was not proven.

11. **M.S. NCP Update-** The Department alleged that M.S. experienced a significant change in her condition and Appellants failed to update her NCP. This allegation addresses a different time period than the assessment allegation discussed above. Regarding this allegation,

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the Department alleged that Appellants failed to update M.S.'s NCP when her condition changed between November 1, 2001, and the day she left the home permanently, December 26, 2001. The Department alleged that M.S. was able to care for herself independently in the areas on toileting, ambulation, hygiene, and eating on November 1, 2001. The Department alleged that M.S. was not capable of performing any of these tasks when she left the home on December 26, 2001. Department's Exhibit 2, p. 10.

12. As stated above, the term "significant change in condition" must mean something more than a brief or transient change in condition. There is no question that M.S. was unable, on December 26, 2001, to independently ambulate or feed herself. Instead, the issue before the undersigned is whether this was a brief and transient change in M.S.'s functioning or whether this was a significant change in M.S.'s ongoing condition. Mr. Muresan stated that the change in M.S.'s condition arose "several days" before December 26, 2001. RP, pp. 160, 169. Mr. Muresan testified that M.S. was only in bed for the last two days before she went to the hospital. This testimony is supported by the testimony of Ms. Butchers, who stated that M.S. was able to walk six feet when she was released from the hospital one week before. The Department did not provide any other evidence to indicate that M.S.'s decline in functioning took place before December 26, 2001 because the Department investigator saw M.S. only on December 26, 2001. Therefore, the preponderance of the evidence indicates that M.S. able to walk and feed herself on December 18, 2001, but she was no longer able to do so by approximately December 24, 2001.

13. Because M.S. had only experienced a change in functioning for two days before December 26, 2001, the undersigned cannot conclude that Appellants should have arranged to have M.S.'s NCP updated by December 26, 2001. As stated above, even if Appellants had called M.S.'s case manager on December 24, 2001, it would have taken several days for the case manager to come to the home to participate in the update. Because M.S.'s condition had only changed two days before, Appellants may have assumed this change was a result of a temporary

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illness that would not impact M.S.'s ongoing functioning. By the time she left the home, M.S. had only been declining in functioning for two days. This brief decline was not sufficiently significant to have required a reassessment of her ongoing condition and NCP.

14. The undersigned notes that this allegation only addresses Appellants' obligations to update M.S.'s NCP. This allegation does not address the issues of whether Appellants provided sufficient care and services for M.S. or whether Appellants should have sought medical care for M.S. sooner. These issues will be discussed below. The only issue regarding M.S.'s NCP was whether M.S.'s change in condition was sufficiently significant to warrant an update to her NCP by December 26, 2001. The undersigned concludes the change in M.S.'s condition did not yet warrant an update on December 26, 2001, because M.S.'s condition had changed only two days before.

WAC 388-76-640- Resident Medications

15. **Unlocked Drawer-** The Department alleged that Appellants violated WAC 388-76-640(2), which states:

The provider shall ensure that all prescription and over the counter medications are kept in:

(a) Locked storage....¹

The Department alleged that Appellants violated this rule by keeping medications in a drawer that was not locked. Finding of Fact 14 contains the information supporting this allegation. Ms. Wood testified that a resident directed her to an unlocked drawer that contained resident medications. RP, p. 89. Appellants did not contest Ms. Wood's account of the unlocked drawer. This allegation was proven.

WAC 388-76-655(5)- First Aid, CPR

16. **Applicable Law-** The Department alleged that Appellants violated WAC 388-76-655, which requires an adult family home provider to ensure that all caregivers, "Possess a valid 000119

¹ WAC 388-76-640 was repealed and replaced by WAC 388-76-64010 on October 19, 2002. WSR 02-20-005. The undersigned applies the rule in effect at the time of the revocation of Appellants' license.

first aid and CPR card prior to providing care for residents unless such care is directly supervised by a fully qualified caregiver who has a valid first aid and CPR card." The Department alleged that Appellants violated this rule by allowing a caregiver named Ursula to provide care without confirming that Ursula had valid first aid and CPR cards. Findings of Fact 8 and 9 contain the information supporting this allegation. This allegation was proven.

17. **First Aid and CPR-** Ms. Wood testified that she was not able to locate CPR and first aid cards for Ursula during the inspection on December 26, 2001. RP, p. 90. Mr. Muresan acknowledged that Ursula had lied to him when she told him that she had completed CPR training. RP, p. 175. Therefore, the undersigned concludes that Appellants failed to ensure that all caregivers possessed first aid and CPR cards. Appellants should not have relied on Ursula's assurances that she possessed first aid and CPR cards. Appellants should have obtained copies of these cards before they permitted Ursula to provide care for residents, particularly because WAC 388-76-595(3) requires providers to maintain such copies on the facility premises at all times.

18. Appellants argued that Ursula never worked at home number 524000 and that Ursula had already been fired at the time of Ms. Wood's inspection. Neither of these statements is credible because Mr. Muresan attempted to send Ursula over to home number 524000 on December 26, 2001, when Ms. Wood pointed out that there was no caregiver in that home. RP, p. 90. Appellants conceded that they employed Ursula as a care provider without first ensuring that she had completed first aid and CPR training, in violation of WAC 388-76-655.

WAC 388-76-655(6)- Caregiver

19. **Applicable Law-** The Department alleged that Appellants violated WAC 388-76-655(6), which requires an adult family home provider to ensure that there is at least one caregiver present in the home whenever one or more residents are on the premises. The Department alleged that Appellants violated this rule because there was no qualified caregiver in the home

when Ms. Wood arrived on December 26, 2001. Finding of Fact 8 contains the information supporting this allegation. This allegation was proven.

20. **December 26, 2001, Visit-** Appellants were not on the premises of home number 524000 when Ms. Wood arrived on December 26, 2001. Susie, a resident, had been left in charge of the residents and she had been instructed to contact Appellants if there were any problems in the home. However, Appellants conceded that Susie had not completed training, CPR, TB testing, and a criminal background check. Therefore, Susie was not qualified to act as a caregiver and Appellants violated WAC 388-76-655 by failing to ensure that there was a caregiver on the premises on December 26, 2001.

21. Mr. Muresan argued that he should be permitted to go outside without violating WAC 388-76-655 because residents sometimes want to leave the home and go into the yard. This argument is irrelevant to this matter. Appellants were not outside in the yard. Appellants were in the home next door. While the word "premises" is not defined in chapter 388-76 WAC, the premises of home number 524000 cannot include the home next door. No matter how close the second home was to home number 524000, the second home was part of another premises and was not part of the premises of home number 524000.

22. Appellants further argued that Susie, a resident of the facility, was exempt from the qualifications of a caregiver because she was not providing care. Department's Exhibit, pp. 6-7. However, WAC 388-76-655(6) requires that there be a *caregiver* on adult family home premises at all time and WAC 388-76-540 defines a caregiver as one who *provides direct personal care*. Therefore, there are two possible scenarios. The first possibility is that Susie provided direct personal care and satisfied the requirement of a caregiver in the home, which results in a violation because Susie was not qualified to act as a caregiver. The second possibility is that Susie was not providing direct personal care, which results in a violation because Appellants left the residents without a caregiver to provide direct personal care. Susie cannot

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satisfy the requirement of a caregiver unless she is qualified to provide direct personal care. If Appellants want to employ Susie as a volunteer caregiver, then she must either meet the Department's qualifications for a caregiver or she must be supervised by another qualified caregiver.

WAC 388-76-665- Resident Records

23. **Applicable Law-** The Department alleged that Appellants violated WAC 388-76-665(1), which requires the provider or resident manager to "Keep confidential all information contained in the resident's records, regardless of the form or storage method of the records...." Finding of Fact 14 contains the information supporting this allegation. This allegation was proven.

24. **Resident Records-** Ms. Wood testified that she found resident records in the same unlocked drawer that contained resident medications. RP, p. 91. Appellants did not contest this allegation. Appellants argued that the rule does not explicitly require that the records be in a locked drawer. This argument is not persuasive because the rule requires that the records be kept confidential. There is nothing confidential about an unlocked drawer in a common area of the home.

WAC 388-76-770- Safety and Maintenance

25. **Applicable Law-** The Department alleged that Appellants violated WAC 388-76-770(1), which requires the provider to ensure that the "adult family home is maintained to provide a safe, clean, comfortable, and homelike environment." The Department alleged two violations of this rule. Finding of Fact 9 contains the information supporting these allegations.

26. **Commode-** The Department alleged that Appellants violated WAC 388-76-770 by placing a commode with a wooden seat and sharp edges in M.S.'s room. This allegation was proven.

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27. Ms. Wood testified that she saw the commode in M.S.'s room and that it was made of unpainted wood. RP, p. 91. This commode was not safe and clean, as required by WAC 388-76-770. As noted by Ms. Wood, it would be extremely difficult or impossible to adequately clean and disinfect a commode that was constructed of unfinished wood. Appellants should have either sealed and painted the wood or Appellants should have chosen another material for the commode.

28. **Temperature-** The Department alleged that Appellants violated WAC 38-76-70(1) because one resident complained of being cold. This allegation was not proven.

29. Ms. Wood testified that the temperature in the home on December 26, 2001, was 68.4° and that Susie complained that she was cold. RP, pp. 91-92. As an initial matter, the undersigned notes that WAC 388-76-785(1) requires adult family home providers to maintain a temperature of at least 68° during waking hours. The allegation in this matter is not that the temperature in the home fell below the minimum temperature required by rule, but that Appellants did not maintain the temperature preferred by residents.

30. The only evidence that Appellants failed to maintain the temperature preferred by residents is a statement from Susie to Ms. Wood. However, Susie did not testify in the hearing and her statement to Ms. Wood is hearsay. WAC 388-02-0475(3) prohibits the ALJ and the undersigned from basing a Finding of Fact exclusively on hearsay evidence unless the parties had the opportunity to question or contradict the hearsay statement. In this matter, Appellants did not have an opportunity to question Susie's statement. Appellants were not able to ask Susie if she did, in fact, want the temperature turned up on December 26, 2001. Appellants were not able to ask Susie if she knew how to turn up the thermostat herself or whether she had told Appellants that she was not warm enough in the home. In the absence of any supporting evidence, the hearsay statement of Susie is not sufficient to prove that Appellants failed to provide a comfortable and homelike environment for residents.

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WAC 388-76-620- Services and Care

31. **Applicable Law-** The Department alleged that Appellants violated WAC 388-76-620(1), (4), which states:

(1) The provider shall ensure that the resident receives necessary services and care to promote the most appropriate level of physical, mental, and psychosocial well-being consistent with resident choice...

(4) The provider shall ensure that resident services are delivered in a manner and in an environment that:

(a) Promotes maintenance or enhancement of each resident's quality of life;

(b) Promotes the safety of all residents....

The Department further alleged that Appellants violated WAC 388-76-60070(5), which states "The resident shall be free from abuse, neglect, abandonment, or financial exploitation." The Department alleged four distinct violations of these rules.

32. **Absence of Caregiver-** The Department alleged that Appellants failed to provide all necessary services because Appellants left the residents without a caregiver on December 26, 2001. Finding of Fact 8 contains the information supporting this allegation. This allegation was proven.

33. As stated above, when Ms. Wood came to the home on December 26, 2001, Appellants were both in the home next door. By not providing residents with a trained and qualified caregiver, Appellants failed to provide the services necessary to promote residents' most appropriate level of physical, mental, and psychosocial well-being. The supervision and assistance of a qualified caregiver is the most basic service offered by an adult family home. The presence of a qualified caregiver is necessary to ensure that each resident's routine care needs are met. The presence of a caregiver is also necessary to protect each resident in an emergency. As the Legislature stated "many residents of community-based long-term care facilities are vulnerable and their health and well-being are dependent on their caregivers. The quality, skills, and knowledge of their caregivers are the key to good care." RCW 70.128.005. 2001 241

By not providing a qualified caregiver in the adult family home at all times, Appellants failed to

promote the safety of residents and Appellants neglected residents, in violation of WAC 388-76-620 and WAC 388-76-60070.

34. **December 15, 2001, Fall-** The Department alleged that Appellants failed to provide all necessary services because M.S. was forced to lay on the floor for at least five hours on December 15, 2001. Finding of Fact 12 contains the information supporting this allegation. This allegation was proven.

35. A caregiver found M.S. on the floor at 3:00 a.m. on December 15, 2001. M.S. was not able to stand and the caregiver was not able to lift M.S. back into bed. Rather than seeking immediate medical attention, the caregiver left M.S. on the floor until at least 8:00 a.m. RP, p.167. The failure of the caregiver to seek medical attention for M.S. failed to promote M.S.'s most appropriate level of physical, mental, and psychosocial well-being. A vulnerable adult who is found on the floor could be injured or could be experiencing a medical crisis. Even a layperson should have been able to discern that M.S.'s health might be at risk. A vulnerable adult who is not able to stand should not be forced to lay on the floor for five hours, even with a pillow and blanket. When the caregiver was not able to assist M.S. into bed, she should have either sought additional assistance to get M.S. into bed or she should have called 911 to have M.S. examined. Although Appellants were not in the home at the time of this incident, Appellants are ultimately responsible for the care of the residents in the home. Appellants should have trained the caregiver to respond appropriately to emergency situations in the home. By failing to provide a caregiver who could meet M.S.'s needs, Appellants failed to provide the services necessary for M.S.'s well-being and Appellants failed to promote the safety of M.S., in violation of WAC 388-76-620.

36. **Medical Care for M.S.-** The Department alleged that Appellants violated WAC 388-76-620 by failing to obtain medical care for M.S. on December 26, 2001. Finding of Fact 8 contains the information supporting this allegation. This allegation was proven.

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37. When Ms. Wood came to the home on December 26, 2001, M.S. was having great difficulty breathing and she was making a gurgling sound. Appellants acknowledged that M.S. had been experiencing shortness of breath for several days and that her condition declined on December 26, 2001. Mr. Muresan stated that he intended to call 911 to obtain medical care for M.S. but he had not done so by the time Ms. Wood arrived at the home at 2:00 p.m. RP, p. 169. Appellants' failure to obtain medical care failed to promote M.S.'s most appropriate level of physical, mental, and psychosocial well-being. The coordination of emergency medical care is one of the most important services offered by adult family home providers. In this matter, Appellants noted the decline in M.S.'s condition over several days. Appellants were aware of the severity of M.S.'s condition because they first considered sending her to the hospital on December 25, 2001. RP, p. 165. When M.S.'s condition had not improved on the morning of December 26, 2001, there was no reason for Appellant to wait until the afternoon to call 911. However, Appellants did not arrange for any medical care for M.S. until they were explicitly asked to do so by Ms. Wood after 2:00 p.m. on December 26, 2001. In the intervening hours, M.S. was forced to endure additional discomfort and her health was placed at further risk. Appellants failed to obtain necessary services for M.S. and Appellants neglected M.S., in violation of WAC 388-76-620 and WAC 388-76-60070.

38. **Keeping M.S. in Bed-** The Department alleged that Appellants failed to provide necessary services for M.S. because Appellants forced M.S. to stay in bed from December 18, 2001, until she returned to the hospital on December 26, 2001. Finding of Fact 8 contains the information supporting this allegation. This allegation was not proven.

39. Ms. Wood testified that Appellants forced M.S. to remain in bed "over a period of weeks" without any doctor's order to do so. The Department argued that forcing M.S. to stay in bed placed her at risk of skin breakdown and urinary tract infection. This argument is not persuasive for two reasons. First, there is no evidence in the record to support a finding that M.S.

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was bed bound for more than two or three days. M.S. was only in the home for eight days between her two trips to the hospital. As stated above, Appellants stated that M.S. had been out of bed and walking until a few days before she went to the hospital. RP, p. 165. There was no other evidence in the record to support a finding that Appellants forced M.S. to stay in bed over a period of weeks.

40. The second reason that the Department's argument is not persuasive is that the Department did not prove that Appellants forced M.S. to remain in bed. It is certainly possible that M.S. was not feeling well on December 24 and 25, 2001, and was not able to get out of bed. There is no evidence that Appellants forced M.S. to stay in bed during this time period. There is also no evidence to indicate that M.S. would have been any better off if Appellants had forced her to get out of bed. The undersigned cannot conclude that an adult family home provider is prohibited from allowing a resident to stay in bed for two or three days when the resident is not feeling well. Based on the preponderance of the evidence in the record, the Department failed to prove that Appellants violated WAC 388-76-620 by forcing M.S. to stay in bed for weeks.

41. **Conclusion-** Appellants failed to provide the services necessary for M.S.'s well-being and Appellants neglected M.S. by leaving M.S. in the home without a qualified caregiver, and by failing to obtain timely emergency medical treatment on December 15, 2001, and December 26, 2001. Thus, Appellants violated WAC 388-76-620 and WAC 388-76-60070.

WAC 388-76-560- License Eligibility

42. **Applicable Law-** The Department alleged that Appellants violated WAC 388-76-560(7), which states "A provider shall have the understanding, ability, emotional stability and physical health suited to meet the emotional and physical care needs of vulnerable adults." The Department alleged that seven incidents demonstrated Appellants' failure to possess the understanding and ability to meet the care needs of vulnerable adults. Four of these allegations were proven.

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43. **Allegations Not Proven-** The Department alleged that Appellants' failed to demonstrate the understanding and ability to meet the care needs of vulnerable adults by failing to update M.S.'s assessment and by forcing M.S. to stay in bed. As stated above, the Department failed to prove these allegations. These allegations also do not support a finding that Appellants failed to demonstrate the understanding and ability to meet the care needs of vulnerable adults.

44. The Department also alleged that Appellants failed to demonstrate the understanding and ability to meet the care needs of vulnerable adults by failing to take precautions to prevent M.S.'s urinary tract infection (UTI). This allegation was not proven. Ms. Wood stated that, because M.S. had a history of UTI's, M.S. needed interventions such as increased clear liquids and frequent toileting. However, Ms. Wood is a registered nurse and Appellants are not. There is no evidence that any medical professional ever gave UTI prevention instructions to Appellants and no such instructions appear in M.S.'s assessment and care plan. There is no information in the record to indicate that UTI prevention is part of adult family home provider training or that all adult family home caregivers should know the proper protocol for UTI prevention without being instructed. There is no evidence in the record to indicate that the two or three days that M.S. spent in bed prior to being admitted to the hospital on December 26, 2001, contributed to the development of a UTI. While it is possible that Appellants' behavior contributed to M.S.'s UTI's, any such conclusion would be based on speculation about what Appellants knew or should have known.

45. **Proven Violations-** The Department alleged that the following incidents proved that Appellants failed to possess the understanding and ability to meet the needs of vulnerable adults: leaving residents without a qualified caregiver on December 26, 2001; failing to obtain emergency medical care for M.S. on December 26, 2001; failing to obtain emergency medical care for M.S. on December 15, 2001; leaving medications in an unlocked drawer. These four 0001281 allegations have been discussed extensively above as violations of other rules. The undersigned

concludes that these allegations also demonstrate that Appellants failed to possess the understanding and ability to meet the care needs of vulnerable adults, in violation of WAC 388-76-560. In each case, Appellants failed to meet the needs of vulnerable adults and Appellants placed vulnerable adults at risk.

Violations

46. As explained above, Appellants violated the following Department rules:

WAC 388-76-640	Resident Medications	
WAC 388-76-655(5)	First Aid/CPR	
WAC 388-76-655(6)	Caregiver	
WAC 388-76-665	Resident Records	
WAC 388-76-770	Safety and Maintenance	
WAC 388-76-620	Provision of Services	(3 violations)
WAC 388-76-560	License Eligibility	(4 violations)

47. **Opportunity to Correct-** WAC 388-76-705(2) states, in part:

For failure or refusal to comply with any applicable requirements of chapters 70.128 and 70.129 RCW or of this chapter, the department may provide consultation and shall allow the provider a reasonable opportunity to correct before imposing remedies under subsection (3)(a) unless the violations pose a serious risk to residents, are recurring or have been uncorrected.

The undersigned must determine whether the violations in this matter posed a serious risk to residents, were recurring, or have been uncorrected. If the alleged violations did not pose a serious risk to residents or were not recurring or uncorrected, then the Department is not permitted to revoke Appellants' license.

48. One of the proven violations in this matter had been cited as a violation in Appellants' other adult family home on November 5, 2001. A Department investigator testified about the November 2001 investigation and proved that Appellants had been cited for a violation of WAC 388-76-640, regarding resident medications in an unlocked drawer.² RP, p. 24.

² The Department also alleged that the violation of WAC 388-76-655(5) in this matter, regarding an unqualified caregiver, was a repeat violation from the November 2001 inspection. However, this was not a recurring violation because the violation in November 2001 was based on Appellants' failure to keep first aid and CPR cards on the premises while the violation in this matter was based on a caregiver who had not completed first aid and CPR training. RP, p. 25.

*Violations
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Therefore the undersigned concludes that the violation of WAC 388-76-640 in this matter was recurring.

49. In addition to the recurring violation, the undersigned concludes that Appellants' other violations posed a serious risk to residents. In particular, the undersigned notes that Appellants failed to obtain timely emergency medical care for one resident on two different occasions. Appellants also left residents, including one resident who was ill, alone in the home with no qualified caregiver. These actions placed all of the residents in the home at serious risk of not having their care needs met. These actions also placed all residents in the home at serious risk of harm. There is no way of knowing whether M.S.'s medical problems were actually caused by the actions of Appellants, but the rule requires only proof of a serious *risk of harm*. Because one of the violations in this matter was recurring and because some of the violations in this matter placed residents at serious risk of harm, the Department was not required to give Appellants an opportunity to correct before imposing a remedy.

50. **Revocation-** WAC 388-76-705(1),(3) permits the Department to revoke an adult family home provider's license when a provider fails or refuses to comply with the requirements of chapter 388-76 WAC. As stated above, the Department proved 12 violations of seven Department rules. Therefore, the Department had the discretion to revoke Appellants' license for the violations of Department rules.

51. The Initial Decision concluded that the violations proven by the Department did not warrant a revocation of Appellants' license. The Initial Decision substituted a remedy of a civil fine and reversed the revocation of Appellants' license. This conclusion was erroneous and is not adopted by the undersigned. The authority of the administrative adjudicator in a DSHS hearing is limited to deciding whether the Department has met its burden of proving, on a de novo basis, that the violations it alleged occurred did in fact occur. Neither the Administrative Law Judge nor the undersigned has been delegated the authority to decide what remedy is

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appropriate to impose if the Department proves its allegations. The Department has the discretion to impose any one of several possible remedies. See WAC 388-76-705. Because the Department proved its allegations at the hearing, the Administrative Law Judge and the undersigned have no choice but to revoke the Appellants' license. Whether or not the Department chose the "correct," "best," or "most appropriate" remedy is not an issue the administrative adjudicator can decide. Neither can the administrative adjudicator decide whether the Department's choice of remedies reflects an abuse of the Department's discretion.

The procedures and time limits for seeking reconsideration or judicial review of this decision are in the attached statement.

DECISION AND ORDER

The adult family home license for adult family home license number 524000 shall be revoked.

Mailed on December 6, 2002.


S. ANDREW GRACE
Review Judge

Attached: Reconsideration/Judicial Review Information

Copies have been sent to: DMMD Adult Family Home Care
C/O David and Maria Muresan, Appellants
Daphne Huang, Department Rep, Seattle AAG
Janice Shurman, Program Admin, MS S53-4
Joyce Pashley Stockwell, Program Admin, MS 45600
Rynold C. Fleck, ALJ, Seattle OAH

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STATE OF WASHINGTON, DEPARTMENT OF SOCIAL AND HEALTH SERVICES

BOARD OF APPEALS

MAILED
DEC 23 2002

In Re:) Docket No. 02-2002-L-1505

DMMD ADULT FAMILY HOME CARE)
C/O DAVID AND MARIA MURESAN)
18204 30TH AVENUE NORTHEAST)
SEATTLE WA 98155)

DECISION ON RECONSIDERATION

DSHS
BOARD OF APPEALS

Appellant) Adult Family Home License

NATURE OF ACTION

1. The undersigned issued a Review Decision on December 6, 2002, revoking Appellants' adult family home license.
2. Appellants filed a Petition for Reconsideration of the Review Decision on December 10, 2002. Appellants argued, in summary, that: there were special circumstances regarding Appellants' adult family home that should have been taken into account; Susie was not required to be qualified as a caregiver; the Department never told Appellants to call 911 on December 26, 2001; Appellants never acknowledged that M.S. experienced shortness of breath; there was no evidence that Ursula ever worked in the home unsupervised; an unpainted wooden toilet seat would not be difficult to clean; M.S. was not forced to lay on the floor; Appellants did not neglect residents; Appellants provided timely medical care to M.S.; and residents never complained of the care they received in the Appellants' home. Appellants asked that the revocation of their license be overturned.
3. The Board of Appeals did not receive a Response to Appellants' Petition for Reconsideration.

FINDINGS OF FACT

The Findings of Fact in the Review Decision are adopted as findings in this decision under RCW 34.05.464(8).

EXHIBIT #2

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CONCLUSIONS OF LAW

1. The Petition for Reconsideration was timely filed and is otherwise proper. WAC 388-02-0620. Jurisdiction exists for the undersigned Review Judge to reconsider the Review Decision. RCW 34.05.470.
2. **First Aid, CPR-** The undersigned concluded, in the Review Decision, that Appellants violated WAC 388-76-655, which requires an adult family home provider to ensure that all caregivers "Possess a valid first aid and CPR card prior to providing care for residents unless such care is directly supervised by a fully qualified caregiver who has a valid first aid and CPR card." The Review Decision stated that Appellants violated this rule by permitting Ursula to provide care to residents. Conclusions of Law 16-18. These Conclusions were in error and shall be reconsidered.
3. WAC 388-76-655 permits a caregiver to care for residents without a valid first aid or CPR card so long as a qualified caregiver is also present. Appellants argued, in their Petition for Reconsideration, that there was no evidence in the record to indicate that Ursula provided unsupervised care to residents. Petition for Reconsideration, p. 3. Appellants are correct that no witness testified that Ursula provided unsupervised care to residents. Therefore, the Department failed to prove that Ursula was permitted to provide unsupervised care to residents without a first aid or CPR card. Conclusions of Law 16-18 to the contrary are in error and are hereby amended. The allegation regarding WAC 388-76-655 was not proven.
4. The reconsideration of Conclusions of Law 16-18 has no effect on the outcome of this matter. As stated in the Initial Decision, WAC 388-76-705(1)(3) permits the Department to revoke a provider's adult family home license for any violation of the Department's adult family home rules. Even without the allegation regarding Ursula, the Department proved 11 other violations of Department rules. Therefore, the revocation of Appellants' adult family home license shall not be reconsidered.

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5. **Other Arguments-** In the Review Decision, the undersigned concluded that the Department proved that Appellants committed 11 violations of adult family home rules. In Appellants' Petition for Reconsideration, Appellants argue that numerous Findings of Fact and Conclusions of Law in the Review Decision are incorrect. The arguments in the Petition for Reconsideration are either identical or equivalent to the arguments that Appellants raised in the hearing and in their Response to the Petition for Review of the Initial Decision. However, nothing that Appellants have said or argued in their Petition for Reconsideration has convinced the undersigned that the Review Decision was incorrect and should be changed. While Appellants may disagree with some of the Findings of Fact, they are supported by a preponderance of the evidence in the record. While Appellants may disagree with the Conclusions of Law reached in the Review Decision, Appellants have not shown that the Conclusions were erroneous based on the evidence in the record.

6. Except for the Conclusions of Law regarding first aid and CPR training discussed above, Appellants' Petition for Reconsideration shall be denied. The undersigned has considered the Review Decision and Final Order, the Petition for Reconsideration, and the entire record or the documents provided by the parties. Any arguments in the Petition for Reconsideration that are not specifically addressed have been duly considered but are found to have no merit or to not substantially affect a party's rights. The Conclusions of Law in the Review Decision and Final Order are adopted except as modified above. RCW 34.05.464(8).

The procedures and time limits for judicial review are described in the attached statement.

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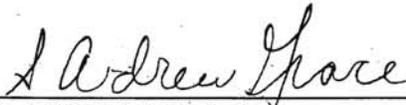
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DECISION

Except for the Conclusions of Law regarding first aid and CPR training for a caregiver, Appellants' Petition for Reconsideration is denied. The Review Decision is the final administrative order.

NOTICE: The deadline for filing a Petition for Judicial Review in Superior Court is thirty (30) days from the date of mailing of this Order on Reconsideration.

Mailed on December 23, 2002.



S. ANDREW GRACE
Review Judge

Encl. (Judicial Review Information)

Copies have been sent to: DMMD Adult Family Home Care
C/O David and Maria Muresan, Appellants
Daphne Huang, Department Rep, Seattle AAG
Janice Shurman, Program Admin, MS S53-4
Joyce Pashley Stockwell, Program Admin, MS 45600
Rynold C. Fleck, ALJ, Seattle OAH

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IF YOU DISAGREE
YOU HAVE THE RIGHT TO APPEAL TO SUPERIOR COURT

DEADLINE for Superior Court Cases - 30 DAYS: The Superior Court, the Board of Appeals, and the state Attorney General's Office **must all RECEIVE** copies of your Petition for Judicial Review within thirty (30) days from the date stamped on the enclosed Reconsideration Decision.

Refer to the Revised Code of Washington (RCW), including chapter 34.05, the Washington Administrative Code (WAC), and to the Washington Rules of Court (civil) for guidance. These materials are available in all law libraries and in most community libraries.

If You Need Help: Ask friends or relatives for a reference to an attorney, or contact your county's bar association or referral services (usually listed at the end of the "attorney" section in the telephone book advertising section). Columbia Legal Services, Northwest Justice Project, the Northwest Women's Law Center, some law schools, and other non-profit legal organizations may be able to provide assistance. **You are not guaranteed an attorney free of charge.**

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KING COUNTY
SUPERIOR COURT CLERK
SEATTLE WA

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DSHS/AASA/RCS
Adult Family Home Enforcement

STATE OF WASHINGTON
KING COUNTY SUPERIOR COURT

DAVID MURESAN, Pro se

NO. 02-2-14237-9 SEA

Petitioner,

ORDER ON JUDICIAL REVIEW

v.

[Clerk's Action Required]

STATE OF WASHINGTON,
DEPARTMENT OF SOCIAL AND
HEALTH SERVICES,

Respondent.

This matter came before the court on a petition for judicial review of the Department's final administrative hearing decision, in Office of Administrative Hearings Docket Number 02-2000-L-1505. Petitioner David Muresan appeared, representing himself, and Assistant Attorney General Daphne Huang appeared on behalf of the respondent Department of Social and Health Services (DSHS).

The court, being familiar with the records and files herein, and having heard argument of counsel, **IT IS HEREBY ORDERED** that:

1. The court has jurisdiction in this matter.
2. The Department's findings of fact are supported by substantial evidence in the record, and its conclusions of law are supported by applicable law, therefore the Review

ORDER ON JUDICIAL REVIEW
EXHIBIT #3

COPY

ATTORNEY GENERAL OF WASHINGTON
900 Fourth Avenue, Suite 2000
Seattle, WA 98164
(206) 464-7744

1 Decision and Final Order of the DSHS Board of Appeals, Office of Administrative Hearings

2 Docket Number 02-2000-L-1505 is affirmed.

3 3. The parties shall bear their own costs and attorney fees.

4 DATED this 30th day of July, 2003.

5
6
7 
8 JUDGE

9 Presented by:
10 CHRISTINE O. GREGOIRE
11 Attorney General

12 
13 DAPHNE HUANG
14 WSBA No. 28434
15 Assistant Attorney General
16 Attorney for Respondent

17 **COPY RECEIVED; APPROVED FOR ENTRY;
18 NOTICE OF PRESENTATION WAIVED:**

19 
20 DAVID MURESAN
21 Petitioner representing himself
22
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THE SUPREME COURT OF WASHINGTON

DAVID MURESAN,

Petitioner,

v.

DEPARTMENT OF SOCIAL AND HEALTH
SERVICES FOR THE STATE OF
WASHINGTON,

Respondent.

NO. 75062-9

ORDER

C/A NO. 52733-9-I

Department I of the Court, composed of Chief Justice Alexander and Justices Johnson, Sanders, Bridge and Owens, considered this matter at its September 8, 2004, Motion Calendar, and unanimously agreed that the following order be entered.

IT IS ORDERED:

That the Petition for Review is denied.

DATED at Olympia, Washington this 8th day of September, 2004.

For the Court

Gerry J. Alexander
CHIEF JUSTICE

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SUPREME COURT
STATE OF WASHINGTON
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K.C.J. MERRITT
CLERK

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EXHIBIT #4

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THE SUPREME COURT
STATE OF WASHINGTON

C.J. MERRITT
SUPREME COURT CLERK

RONALD R. CARPENTER
DEPUTY CLERK/CHIEF STAFF ATTORNEY



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e-mail: supreme@courts.wa.gov
www.courts.wa.gov

September 16, 2004

Mr. David Muresan
18204 30th Avenue NE
Seattle, WA 98155

Ms. Daphne Jiling Huang
Aty Gen Office TB-14
900 4th Ave Ste 2000
Seattle, WA 98164-1012

RECEIVED
SEP 17 2004
OFFICE OF THE ATTORNEY GENERAL
DSHS SEATTLE

Re: Supreme Court No. 75062-9 - David Muresan v. State of Washington, DSHS
Court of Appeals No. 52733-9-I

Clerk, Counsel and Mr. Muresan:

This will acknowledge receipt on September 16, 2004, of the Petitioner's motion for reconsideration. The pleading seeks reconsideration of this Court's September 8, 2004 order denying the petition for review.¹

A denial of a petition for review is not subject to reconsideration. The RULES OF APPELLATE PROCEDURE (RAP) provide that a party may file a motion for reconsideration only of "a decision terminating review", see RAP 12.4(a). One element of "a decision terminating review" is that it must be an opinion, order or judgment of the appellate court filed after review is accepted, see RAP 12.3(a). A denial of a petition for review is an act declining to accept review. As such, the Court's decision on the petition for review is not subject to reconsideration.

Accordingly, although the pleading has been placed in the closed file, this Court can take no further action on it.

Sincerely,

RONALD R. CARPENTER
Supreme Court Deputy Clerk

RRC:drc

¹ It is noted that the Department of the Court that unanimously denied the petition for review was comprised of five of the nine Justices of this Court, a majority of the Court

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THE SUPREME COURT
STATE OF WASHINGTON

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OFFICE OF THE ATTORNEY GENERAL
DHS SEATTLE

September 8, 2004

Mr. David Muresan
18204 30th Avenue NE
Seattle, WA 98155

Ms. Daphne Jiling Huang
Office of the Attorney General, TB-14
900 Fourth Ave., Ste. 2000
Seattle, WA 98164-1012

Supreme Court No. 75062-9 - David Muresan v. State, Dept. of Social & Health Services
Court of Appeals No. 52733-9-1

Counsel:

Enclosed is a conformed copy of the Order entered on September 8, 2004, following hearing of the above matter on the Court's September 8, 2004, Motion Calendar.

Sincerely,

ROBIN DERRINGER
Legal Secretary

RED:red

Encl.

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Supreme Court of the United States
Office of the Clerk
Washington, DC 20543-0001

February 22, 2005

Mr. William B. Collins
Senior Assistant Attorney General
1125 Washington Street, SE
Olympia, WA 98504-0100

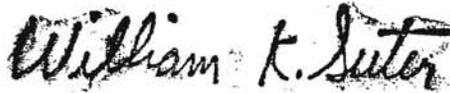
Re: David Muresan
v. Washington Department of Social and Health Services
No. 04-7056

Dear Mr. Collins:

The Court today entered the following order in the above-entitled case:

The petition for a writ of certiorari is denied.

Sincerely,



William K. Suter, Clerk

RECEIVED

MAR 23 2005

DSHS/AASA/RCS
Adult Family Home Enforcement

William K. Suter
Clerk of the Court
(202) 479-3011

2005 FEB 29 AM 7:21
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COMMUNICATION

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EXHIBIT #5

BEFORE THE WASHINGTON STATE OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES

MAILED
SHS-SEATTLE

DEC 31 2003

OFFICE OF
ADMINISTRATIVE HEARINGS

In Re:

DAVID AND MARIA MURESAN
DBA D M M D ADULT FAMILY HOME CARE

Appellants.

Docket Nos. 06-2003-L-1154
06-2003-L-0967

INITIAL DECISION

(Adult Family Home License)

On November 3, 2003 through November 5, 2003 Administrative Law Judge (ALJ) Barbara Boivin held on a hearing on the above captioned matter at Seattle Washington. The Appellants, David and Maria Muresan, d.b.a. DMMD Adult Family Home (DMMD), appeared Mr. Muresan represented them. The Department of Social and Health Services (DSHS) appeared through Lynne Dasher, Registered Nurse (RN), DSHS field manager for Region 4, Unit A, Residential Care Services, and was represented by Daphne Huang, Assistant Attorney General (AAG).

DSHS called the following witnesses: Lynne Dasher; Joanne Wells, RN, BSN, MBA, DSHS Institutional Nurse Consultant/Adult Family Home (AFH) licenser; Judy Mikanus, RN, MHSA, DSHS Institutional Nurse Consultant/AFH complaint investigator; Barbara Bizilia, RN, MN, DSHS Home and Community Services case manager and Adult Protective Services consulting nurse; Margaret Gaines, MD; Charles McClain, Licensed Practical Nurse (LPN), Visiting Nurse Services; Mr. Muresan.

Mr. and Ms. Muresan testified on their own behalf.

At hearing, Mr. Muresan moved to call the state's witnesses as witnesses for DMMD despite having failed to list them as DMMD witnesses, give notice to the state of his intention to call them or give notice to the witnesses themselves either informally or through subpoenas. He was allowed to call DSHS's three main witnesses, the persons responsible for the investigation and licensing action, because the state did not object and the state agreed to allow direct exam

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by Mr. Muresan immediately following Mr. Muresan's opportunity for cross examination to avoid inconvenience and scheduling problems. He was not allowed to call the other DSHS witnesses as his own as he had failed to provide any notice, the state objected and established potential prejudice, and Mr. Muresan failed to establish that he had any questions for the witnesses which would not be objectionable.

Mr. Muresan wished to ask more questions than he was allowed to ask of Ms. Dasher, Ms. Wells and Ms. Mikunas as most of his questions were objectionable on numerous grounds. Most were irrelevant, argumentative, assumed facts not in evidence, repetitive, called for speculation, were unclear and, in general, better characterized as statements rather than questions. The questions he wished to ask Ms. Dasher, Ms. Mikunas, Mr. McCain, Dr. Gaines and Ms. Bizilia are preserved at Exhibit H. He decided to ask different questions of Ms. Wells than were shown in Exhibit H. Therefore, the portion of Exhibit H related to questions for Ms. Wells was stricken. He declined to submit any further offer of proof for questions he was not allowed to ask DSHS witnesses.

The following exhibits were admitted: DSHS Exhibits 1 through 19; Appellant's Exhibits A-E, F 1-4, 11-14, 16-39, H 14 through 28, I; and ALJ Exhibits ALJ 1 through 4.

Appellants withdrew Exhibit G (a tape of a person calling out, played at hearing in conjunction with some of Mr. Muresan's questions).

The state submitted a written prehearing brief and made an oral closing argument.

The Appellants submitted the notes from which Mr. Muresan testified as their closing argument. They also submitted Mr. Muresan's opening statement in writing as part of Exhibit H (pp. 29-30).

The record closed November 5, 2003.

ISSUES

DMMD contests:

1. A June 4, 2003 Notice of Imposition of Civil fine; and
2. A June 9, 2003 Notice of Summary Suspension, License Revocation and Stop Placement Order as modified by an Amended Notice dated July 8, 2003.

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Both actions refer to their AFH at 18210-30th Avenue N.E., Seattle, Washington, license number 390100.

RESULTS

1. The hearing request on the Notice of Imposition of Civil Fine is DISMISSED for lack of jurisdiction as the Notice was rescinded.

2. DMMD violated several Minimum Licensing Requirements. Several of the violations were repeat violations and/or posed a serious risk to their residents. License number 390100 for their AFH at 18210 30th Avenue N.E., Seattle, Washington, is therefore REVOKED.

FINDINGS OF FACT

BACKGROUND

Licensing history

Homes Operated by DMMD

1. Mr. and Mrs. Muresan were first licensed to operate an Adult Family Home (AFH) in September 1997. That home is located at 18204 30th Avenue N.E. Seattle, Washington (18204 home). It is located adjacent to the Muresans' second licensed AFH located at 18210 30th Avenue N.E. (18210 home). This home is also their residence and the subject of this hearing. The Muresans operate a third AFH on Camano Island (Camano home). They have recently opened a fourth home. *-oh really?!*

Revocation of 18204 Home License

2. The license for the 18204 home was revoked by a Board of Appeals Review Decision issued December 6, 2002. That decision was upheld by a King County Superior Court Decision entered July 30, 2003. Exhibits 10, ALJ 3 and ALJ4. That decision is pending appeal.

Notice of Imposition of Civil Fine on Camano Home

3. There is an administrative hearing pending on a recently issued Notice of Civil Fine on their Camano Island AFH.

Status of Fourth Home

4. No information was provided about the licensing status of the fourth home.

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Procedural History in this Action

Civil Fine

5. On March 12 and March 14, 2003, DSHS, through Ms. Wells, conducted an unannounced annual inspection of the 18210 home. Ms. Wells completed a Statement of Deficiencies. Exhibit ALJ 1.4 On June 4, 2003, the Muresans were served with a Notice of Imposition of Civil Fine (Fine Notice). ALJ Exhibit 1.2.

Revocation

6. On May 28 and 29, 2003 and June 4, 5 and 9, 2003, DSHS conducted an unannounced complaint investigation at the Muresans' 18210 home. This investigation was conducted by a team of three DSHS employees, Ms. Dasher, Ms. Wells, and Ms. Mikunas (the DSHS team). In concert, the team completed a Statement of Deficiencies on June 10, 2003 (amended on June 19, 2003). Exhibit 2

7. DSHS personally served the Muresans with a Notice of Summary Suspension, License Revocation and Stop Placement Order (Revocation Notice) on June 9, 2003 (amended on July 8, 2003). Exhibit 1.

Requests for hearing

8. On June 9, 2003 the Muresans requested a hearing regarding the Fine Notice. ALJ Exhibit 1.

9. On June 11, 2003, the Muresans requested a hearing on the Revocation Notice. ALJ Exhibit 2.

Fine Rescission

10. On August 18, 2003, DSHS rescinded the Fine Notice. Exhibit 17.

CREDIBILITY

DSHS

11. Each one of the DSHS team members has extensive educational credentials and experience in the provision of care for elderly people in various settings, including AFHs. Ms. Wells had been the licenser for the 18210 and the 18204 homes since at least early 2001, had visited the homes on numerous occasions and had had numerous contacts with the Muresans, their residents, the residents' families and other service providers prior to the

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investigation leading to the adverse actions in this case. Each of the other DSHS witnesses has extensive credentials and experience as well. Ms. Bizilia is familiar with both the 18210 and the 18204 homes as she has been the DSHS Home and Community Services (HCS) case manager for all of the residents receiving Medicaid for approximately four years. Each witness had an opportunity to directly observe that which they testified about and had either a clear memory of the events or had made reliable contemporaneous notes from which they refreshed their recollections. To the extent a witness provided hearsay testimony, it was established to be reliable in part through corroboration by documents, Mr. Muresan's own testimony or his failure to contradict or ever address the statements.

12. Mr. Muresan did not establish bias on the part of any of the witnesses or any other basis to discount their testimony. In particular, his past success in prevailing on a disagreement with DSHS about the validity of a CPR card (Exhibit B) and his demonstration that an internal log of DSHS actions on his licenses (Exhibit F 1-4) does not reflect updated information, as agreed by DSHS, does not indicate bias. Further, his evidence that Ms. Wells noted that he was "...difficult to deal with- is stubborn in his viewpoint and discredits what nursing, state has to say as advice or education" (Exhibit F16), a statement amply supported by evidence presented by Mr. Muresan and the state, does not show bias but rather an accurate statement of Mr. Muresan's approach to dealing with DSHS.

13. The testimony of all DSHS witnesses is found to be credible.

14. Mr. Muresan's evidence, cross examination and legal arguments did not primarily refute DSHS's version of the facts. Rather, he attempted to show bias, address irrelevant issues, make assertions based on evidence taken out of context, ask questions that were rhetorical, based on facts not in evidence, argumentative, related to policy and often incomprehensible. He demonstrated through his presentation a propensity to distort information and remove it from its context to support his own version of reality. It is also noted that Muresan did not call any of the persons as witnesses whose hearsay statements were introduced by DSHS and which were included in the Statement of Deficiencies. He did not call persons with direct knowledge of any of the facts supporting DSHS's action to refute the allegations. The one person whom he considered calling as a witness, JB, a former resident, did not have any direct

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knowledge about any of the allegations and, based on her condition, it is unlikely that she would have been competent to testify. Further, Mr. Muresan's ferocious belief in the "DMDD Health Theory" and his disdain for DSHS and health care professionals who disagree with him reduce confidence in his ability to reliably observe and report objectively. Finally, Mr. Muresan has an obvious motivation to prevaricate, that is, to protect his business and other interests in continuing to operate this and his other AFHs.

15. To the extent that Mr. Muresan's testimony contradicted DSHS testimony on factual matters, it is determined to be not credible.

16. It was obviously emotionally difficult for Ms. Muresan to testify. Her testimony, though limited, was sincere and heartfelt about the good care she had provided for her residents, her different approach from Mr. Muresan's and the difficulties of experiencing the DSHS actions including working under the gaze of investigators. Her testimony is determined to be credible.

VIOLATIONS

The Muresans

17. The Muresans did not have any formal health care credentials at the time of their initial licensure and had no prior experience in home care for the disabled or elderly. Their post-licensing training is limited to the mandatory Orientation and Fundamentals of Caregiving classes, as well two other short courses on mental health and dementia issues in 1998. They were required to retake the Orientation and Fundamentals courses in 2002 as a condition of maintaining their license (further described below). It is inferred from the lifting of the conditions that they did take the classes a second time in 2002. Mr. Muresan has a Bachelor of Science (BS) and an Master of Arts (MA) in Electrical Engineering which he completed in 1972. Most recently, prior to becoming an AFH licensee, he taught science in high school for seven years. Ms. Muresan's educational and work experience is unknown.

18. Mr. Muresan was excitable, hostile, argumentative, stubborn, often incomprehensible, and insistent on the correctness of his point of view during almost every contact with every other person described in connection with the various allegations in this case as described in the following Findings. On more than one occasion when Ms. Wells attempted to provide an educational consultation with him he refused to accept her instruction with

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dismissive sounds, gestures, arguments and continued practices inconsistent with her instructions. Documentation regarding citations and consultations provided by Brenda Mooney, the Muresans' previous licensor, reveal that Mr. Muresan also ignored her instructions as demonstrated by his continued practices inconsistent with her advice.

19. During the investigation Mr. Muresan became visibly angry and raised his voice and waved his hands at the DSHS team despite their request that he not do so, when they were attempting to discuss regulatory requirements with him. He shouted at Ms. Muresan and blamed her for various deficiencies discovered by the team during their investigation.

20. His approach with DSHS is consistent with Mr. Muresan's approach at hearing. He failed to comply with clear instructions about preparation of exhibits. When ordered to comply before hearing he did so and then submitted additional documents on the day of hearing which did not comply, despite a demonstrated understanding and ability to do so. Despite repeated instructions to ask only questions on cross examination and hold his testimony until it was his turn and he was sworn in, he continued to make statements during his cross-examination. Despite repeated instructions to allow each witness (and the undersigned) to complete his or her statements, he continued to interrupt. His pre-trial preparations (see, e.g. Exhibit H and his correction of his initial mis-marking of his exhibits) and his educational background and work experience demonstrate his ability to understand and to follow such instructions as well as the instructions given by trained DSHS staff.

21. Mr. and Ms. Muresan intend to provide quality care for their residents and sincerely believe they are doing so.

Residents

22. At the time of the investigation, the 18210 home had six (6) residents. The circumstances of all 6 residents and one former resident were reviewed by the DSHS team. All of the residents are extremely vulnerable. They are elderly with significant and multiple physical and mental deficits.

23. Resident AD is a large elderly woman who suffers from Parkinson's disease, hypertension, progressive dementia, anxiety and depression for which she takes approximately

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ten prescribed medications. She has also suffered a stroke. She is totally dependent for all activities of daily living. She requires two persons for transfers.

24. Former resident LM is a woman in her late 80s who suffers from late-stage Alzheimer's dementia, CVA, hypertension, visual impairment and difficulty swallowing for which she takes approximately five prescribed medications. Exhibit F.36.

25. Resident LS is an 82-year-old woman who suffers from dementia, paranoia, delusions, schizophrenia and cardiovascular disease for which she takes approximately fifteen (15) prescribed medications. Exhibit 12.

26. Resident EN is a 101-year-old woman who is legally blind, hearing impaired, suffers from dementia, glaucoma and circulatory problems for which she takes several prescribed medications and has care needs related to a hip replacement. Exhibit D.

27. Ms. NC is a 73-year-old woman who suffers from dementia and has had a stroke for which she takes several prescribed medications. Exhibit F.26.

28. Ms. AZ is as an 82-year-old woman who suffers from bipolar affective disorder, obsessive compulsive disorder, paranoia, osteoporosis arthritis, hyperthyroidism and hypertensive retinopathy for which she takes prescribed medications. She has been institutionalized all of her life. She needs substantial assistance in most activities of daily living. Exhibit 14.

29. Ms. JB is a 74-year-old woman who suffers from schizophrenia and hypertension for which she takes prescribed medications. She needs substantial assistance in most activities of daily living. Exhibit 13.

30. At the time of the investigation, AD had been a resident of the 18210 Muresan AFH since May 11, 2003, LS since January 1998, EN since 1998, NC since October 10, 2002, AZ since at least March 11, 2003, and JB for several years. LM was a resident from August 2002 (but most recently since mid to late March 2003 when she was discharged from the hospital) through approximately May 11, 2003 when she was transferred to the 18204 home to make room for another resident.

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DMMD Health Theory

31. Mr. Muresan developed "DMMD Health Theory," the bizarre nature of which speaks for itself, in Exhibit I. The central tenet of the theory is that most, if not all, disease can be prevented and/or cured by keeping the body protected from exposure to air that is less than 97 degrees Fahrenheit by wearing multiple layers of clothing or heavy clothing and blankets from head to toe. He further believes that most, if not all, troublesome behaviors or conditions of his residents are not symptoms of their diseases but side effects of their prescribed medications. Mr. Muresan aggressively promoted this health theory as an alternative to the medications prescribed by the residents' doctors in conversations with residents' decision-makers, their doctors and DSHS personnel. Exhibits I, F.36, 11 and testimony.

32. Wearing clothes in excess of what is appropriate for a particular person to be comfortable given their condition and the environment can create at best discomfort and at worst can exacerbate or cause ailments such as skin break down from excess moisture. It can also infringe upon residents' rights to choose their own attire directly or through their representative and to be maintained in a dignified way.

33. Mr. Muresan created a form which informed residents and their families of his opinion about the resident's medical condition and the effects of their medications on same and asked them to work with the resident's doctor to remove any medication with negative side effects for a full month so that they could determine if the resident functioned better without the medication. If a decision-maker refused to remove the medications as requested, the resident would be charged \$200.00 extra per month, per medication. Exhibit 11.2.

34. The Muresans regularly dressed the residents in multiple layers of clothing, many of them purchased at used clothing stores by the Muresans, without regard for season, ambient temperature, the wishes of the resident's decision makers, appearance of the clothes, or medical contraindications.

35. On May 29, 2003, AD was in bed wearing sweat pants, two sweaters and a hat.

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36. On June 5, 2003, AD was in bed wearing sweat pants, a long sleeved blouse and a long sleeved cardigan sweater. Her face was flushed and the ambient temperature was 85.3 °F.

37. Mr. Muresan told AD's decision maker that all of her symptoms were related to medications and asked him to take her off her medications.

38. Mr. Muresan was particularly concerned with AD's frequent episodes of calling out which he attributed to the medications. This behavior is a common symptom of dementia; it is called "sun downer's syndrome." Testimony of all health care professionals.

39. On May 23, 2003 Dr. Gaines, AD's doctor, met with AD, her son and Mr. Muresan. Mr. Muresan appeared agitated as soon as Dr. Gaines arrived. He aggressively harangued her to stop all of AD's medications for one month. He raised his voice and moved into Dr. Gaines's personal space, within inches of her face, as he tried to persuade her of the wisdom of this experiment when she disagreed with him. Dr. Gaines tried to explain AD's need for the medication, the need to speak to her previous doctors and care givers about her medication history before making changes (Dr. Gaines had only seen AD once before) and the need to taper off some medications if the decision was to eliminate them. When Dr. Gaines took AD's blood pressure that day it was higher than normal (170/100). At this meeting Mr. Muresan handed Dr. Gaines a copy of the above described form.

40. Dr. Gaines was eventually coerced by Mr. Muresan and AD's family members to make a change in AD's blood pressure medication.

41. After discussing AD with her previous doctor who had cared for her for years and the staff at Christa Care Center, her previous residence, Dr. Gaines learned that AD had a long history of anxiety and depression preceding the insidious onset of dementia, and had needed medications for a long time and further, that previous attempts to reduce her medications had been unsuccessful. Dr. Gaines attributed negative changes in AD's condition and behavior, if any, to be a result of her removal from Christa Care Center where she received great care and did very well.

42. As a result of Mr. Muresan's aggressive insistence on his point of view, Dr. Gaines was concerned that he would stop her medications despite her orders to the contrary.

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She therefore requested Visiting Nurse Services to monitor Ms. AD's blood pressure on a regular basis and, while they were at it, generally monitor AD's well-being and look for signs of withholding of medications.

43. Dr. Gaines found Mr. Muresan's promotion of his health theory so outrageous and potentially dangerous that she felt a duty as a mandatory reporter to report his activities to DSHS. Exhibit 11.

44. On June 5, 2003, Mr. Muresan again expressed his opinions to the DSHS team about AD's medication regimen, that is, he believed that her "yelling" was a result of the medications and he wanted to experiment by taking her off all of her medications for 30 days and see how she did.

45. Mr. Muresan also contacted Ms. LM's family to request that she stop taking her prescribed medications. They were also given the above described form. LM's doctor responded in writing to Mr. Muresan, politely but unequivocally, refusing to take her off any of her medications as they are crucial to maintaining her health. Exhibit F.36.

46. During the course of an Adult Protective Services investigation, Mr. Muresan told Ms. Bizilia that LM did better without her medications.

47. LM's family had more than one conversation with the Muresans about their displeasure with the number of layers of clothing the Muresans put on her. Mr. Muresan refused to respond to their request that she not be so dressed.

48. On May 30, 2003, LM was examined by Ms. Bizilia. LM was in bed at the 18204 home, wearing four layers of clothing on her upper body, two cotton knit long sleeve shirts, a sweater and a fleece jacket. She was wearing incontinent briefs and sweat pants on her bottom half. She had a heavy sock and slipper on her left foot and nothing on her right. She was also covered with a blanket. Ms. Bizilia instructed the Muresans that LM was wearing too much clothing for such a hot day.

49. On June 9, 2003, LM was at the 18210 home. She was bundled up in multiple layers of clothes, wearing a hat and slippers.

50. Mr. Muresan also asked LS's family to reduce her medications because he could not care for her with all of her medications, she was on too many of them and doctors do

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not know what they are doing. Whenever her family called to get information from the Muresans about how LS was doing, the conversation would be sidetracked to the issue of medication reduction. On one occasion the family had to insist that Mr. Muresan give them LS's medication to take with them on an outing during which time she would be due for medications. At that time he claimed that the resident did not need them anyway and would be fine without them.

51. LS's family also asked Mr. Muresan to stop dressing LS in so many clothes. Mr. Muresan refused to do so.

52. Mr. Muresan also asked EN's family to stop or reduce her bladder medication. The family checked with the doctor and then had to insist that EN continue to get her medication.

53. Mr. Muresan's argument that he merely suggested that residents take drug holidays and that all decisions would be made by the doctors is unpersuasive. The form, though oddly phrased, speaks for itself, and the ferocity and tenacity of his opinion on this matter are amply demonstrated through his numerous conversations with a variety of people.

54. Similarly, Muresan's argument that the portion of his health theory involving staying very warm is supported by training materials (source unknown) is unpersuasive. His reliance on Exhibit A "....Encourage layers of clothing to provide the best insulation...." is clearly taken out of context.

Reporting of Medical Needs

55. As of May 28, 2003, the Muresans had not logged any accidents and injuries to residents since May 2002. DSHS had previously instructed the Muresans to maintain some kind of incident-reporting system.

56. AD's most recent assessment prior to her admittance to the Muresans' AFH was done on March 8, 2003. There was no mention of skin breakdown or history of skin breakdown.

57. On May 31, 2003, AD's left heel was slightly reddened and the right heel had white scaly dry skin. The visiting nurse who saw her that day, at Dr. Gaines's request, was concerned that this was an indication of potential pressure sores. The nurse advised the Muresans to elevate her heels off the mattress to prevent the development of pressure sores.

58. Pressure sores are a serious concern because they can lead to blood

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poisoning, infection (including infection of the bone) and gangrene. Regular monitoring to maintain elevation is required to prevent this type of sore when a person moves their feet as much as AD did. Mr. Muresan does not think it is a reasonable expectation to monitor with the frequency necessary to keep her feet off the bed all of the time.

59. On June 3, 2003, AD had a six centimeter scratch on her right hip, shaped like a "C," the lower end of which was red and slightly rounded, a dark, dime sized scab on her right knee, a crescent shaped bruise from her forehead to her jaw line, and dry flaky skin on her legs. The Muresans explained that the knee abrasion occurred during a transfer and speculated that the bruise on her face came from laying her face on her arm. Mr. Muresan did not see the need to log any of these injuries.

60. By June 4, 2003, AD had pressure sores on her heels. The right heel had a large, red, fluid filled blister, the left, scaly skin surrounding a one centimeter blister. The Muresans had not called her doctor about the sores. Her feet were somewhat propped up with a towel, but she was still working her heels against the bed and one foot had a heavy sock on it. The DSHS team brought this to the Muresans' attention and informed them that they needed to call her doctor so that the doctor could prescribe the proper treatment. Further, the Muresans were informed that her feet needed to be kept elevated, without socks.

61. The Muresans were unconcerned, stating their opinion that this was not a problem, that all people who stayed in bed got bed sores, that the doctor would not do anything but prescribe more medications, that they could heal her in a week using some shoes of Mr. Muresan's invention to keep her feet up off of the bedding.

62. On June 5, 2003, AD's heels were again pressed against her mattress. Her movements had pulled the sheet off the mattress so her feet were rubbing against the rubber (or plastic) mattress cover. This was again pointed out to the Muresans who adjusted the sheet but took no meaningful action to elevate her heels. AD's feet were swollen, the right more than the left. The pressure sores on both heels had become worse. The sore on the right heel was a large cloudy fluid filled blister, approximately 2.5 centimeters in diameter which was surrounded by an area of reddened tissue approximately one centimeter wide all around it. The sore on the left heel was a fluid-filled blister of approximately one centimeter, surrounded by an

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area of reddened tissue approximately .5 centimeters wide. Her toenails were uncut and wrapped around the ends of the toes.

63. Additionally, AD had a oval shaped dark blue bruise on the middle knuckle of her left middle finger approximately 2 centimeters in diameter and a light blue bruise on her left hand between her index finger and thumb. The Muresans had made no attempt to ascertain how these injuries had occurred. Mr. Muresan speculated that the hand bruises were caused by pulling AD up by her hands or by bumping her hands up against the table while being positioned there. These injuries were not logged or reported.

64. On June 5, 2003 Mr. Muresan had still not reported the pressure sores to AD's physician and said he would do so when he felt it was time. He stated his opinion that they were no worse than before and that he was planning to have the visiting nurse look at them on June 7, 2003 as they would be just the same then. When informed by the DSHS team that these sores were serious and AD's doctor needed to be informed, he became angry and stated that he would let no one see her for a week. When the DSHS team insisted a doctor be called, he shouted at Ms. Muresan to call the doctor to come immediately.

65. On May 30, 2003, LM had areas of skin breakdown, including a pressure sore on her left heel which was in the development, not the healing process, and an itchy painful red rash in her genital area with a yeast infection, unusual for a person wearing an incontinence pad who is receiving attentive care. None of this had been reported to her doctor.

66. LM was finally seen by her doctor on June 2, 2003. She concluded that LM's incontinence pad had not been changed soon enough, resulting in the problems in her genital area.

67. An APS investigation involving LM at the 18204 home resulted in a substantiated finding of abuse entered on or about June 5, 2003. Exhibit E.

68. The Muresans routinely called Kara Mitchell to report medical concerns about LS. Ms. Mitchell was the mental health caseworker for LS. She is not a medical doctor and is not responsible for arranging medical care for her clients. She is responsible for providing weekly mental health therapy for LS. She repeatedly told the Muresans this but they would not be persuaded that it was not within her scope of authority or responsibility to take care of LS's

medical needs. Mr. Muresan continues, inexplicably, to maintain that it is her job to take her clients to the doctor and/or otherwise meet their medical needs. Ms. Mitchell scheduled the necessary medical care because based on her conversations with Mr. Muresan she feared LS would not get the necessary care if she did not take care of it.

69. On May 6, 2003, AFH staff noted that "(LS) has Ensure, lost 10 #, stays more and more in bed. Became incontinent. Night after night call for help 5-8 times."

70. On May 28, 2003, LS was dressed but lying flat on her back in bed, apparently in a deep sleep. She was pale and thinner than she was when Ms. Wells saw her on March 14, 2003. She did not respond to a quiet "hello." On previous visits by Ms. Wells she had usually been up and active. Ms. Muresan stated in response to questioning that she had been worried about LS for approximately three weeks but had not called the doctor as they were waiting for Ms. Mitchell's next visit as she always informs the doctor. Further, the Muresans explained that LS had a previously scheduled appointment with her doctor on May 29, 2003 and that would serve as adequate notice to the doctor. They had informed the DSHS case manager about LS's decline only earlier that day.

71. LS refused to go to a scheduled doctor's appointment on May 29, 2003. The Muresans still failed to inform the doctor about her deteriorating condition. The doctor came to the AFH on May 30, 2003 to see her and sent her immediately to the hospital.

Improper Transfer

72. On May 29, 2003, the Muresans awkwardly transferred AD from the bed to the wheelchair by Mr. Muresan first lifting her by her hands with his thumbs pressing down on her hands. He then held her around her chest while Ms. Muresan held the wheelchair in place without using the breaks, while also lifting AD by the back of her waistband. This technique can result in injuries to the resident including bruising, torn rotator cuffs, and abrasions to the perineum. When the team questioned them about their technique, they were unaware of alternative methods such as using a gait belt or a mechanical lift.

73. On or about June 4, 2003, Mr. McClain, pursuant to Dr. Gaines's instructions, 0001571 visited AD to check her blood pressure and check to see if Mr. Muresan was withholding AD's medications. When he arrived, Mr. Muresan appeared agitated. Mr. Muresan told him that her

blood pressure was not a problem. Mr. McClain disagreed and Mr. Muresan told him that he (Mr. Muresan) knew how to take care of AD better than any nurse or doctor.

74. While Mr. Muresan and two female attendants were wheeling her from one room to another for Mr. McClain's examination, AD slipped out of the wheelchair hitting her head on the seat on the way to the floor where she landed prone. Mr. Muresan became frantic, grasped AD by the wrists and "jerked" her back into position.

75. Mr. McClain characterized Mr. Muresan's transfer as a criminal assault and reported the incident to the police and APS.

76. When Mr. McClain confronted Mr. Muresan about his inept transfer Mr. Muresan became more agitated and began yelling at Mr. McClain.

77. Mr. Muresan's defense, that "jerking" her back into the chair would not be physically possible given Ms. AD's size, is unpersuasive. Mr. McClain's testimony on this point was unequivocal. He was standing in close proximity to the incident. Mr. Muresan did not establish any motive for Mr. McClain to fabricate this story. He did not produce the two other people present at the incident to testify to the contrary. He did not directly deny the incident or provide an alternative scenario.

78. On June 9, 2003 LM had a large scab on her shin and bruises on the backs of both of their hands. Mr. Muresan explained that these injuries occurred during transfer and could not be prevented. He indicated the initiation of his transfer method by holding onto her hands as if to pull upwards, with his thumbs over the bruises (it's not clear at what point in the transfer the shin bruise must occur according to Mr. Muresan's assertion). He would not accept the investigator's statement that transfers can be accomplished without injury if done correctly. These injuries were not logged or reported.

79. At hearing Mr. Muresan offered pages, possibly from a training manual, about transfers in support of his transfer technique. Exhibits F.21 and F.22. These pages do not support his contention.

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Medication Administration Record

80. On May 28, 2003, there were no entries at all in AD's medication administration logs since May 23, 2003, including the change in medication made by her physician on May 23, 2003. The DSHS team informed Mr. Muresan of the importance of entering all information regarding the administration of the medications in a timely manner. Ms. Muresan said she forgot to make the entries. Mr. Muresan said the entries were not made because the record was in another room, left there days before after being used for a meeting. Further, Mr. Muresan argued that the record need only be completed within 30 days to be timely, not within one hour, as advised by the DSHS team, that within one day was the best they could do and that such recording was not important.

81. On June 4, 2003, the team again reviewed AD's medication records. Some medications and/or dosages had not been signed off on for June 3, 2003 or through lunch on June 4, 2003 and others were signed off on as administered before they were scheduled to be given on June 4, 2003. Mr. Muresan again explained that it was the best he could do.

82. On June 5, 2003, the team again reviewed AD's medication records. Again, some medications had not been signed off on. The Muresans conceded that this was true. When again it was explained that the per the regulations the documentation must be made within one hour of the prescribed time of administration, Mr. Muresan stated that he was aware of the regulation but he chose not to follow it because the best that they could do was sign off on the same day and that if someone wanted to know if the medications had actually been given, they could look at the bubble pack.

83. On June 9, 2003, again medications that had not been given were charted as given to AD. This was discovered when AD was being prepared for transport to the emergency room. Ms. Muresan corrected the form so the hospital would have accurate information to properly administer AD's medications while there.

84. On June 9, 2003, dosages for one of NC's medications were not listed on her medication administration log, only the name of the medication and the time given.

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85. Mr. Muresan's general defense regarding his failure to timely chart medication administration is that he has submitted comments to the rule-making people at DSHS regarding a more appropriate time frame than the current time frame.

911 Calls

86. Upon admission to the AFH, all residents or their surrogate decision makers signed an agreement which stated "In the event of an emergency, DMMD will call 911 but the resident will pay all costs. The decision to call 911 belongs to 1. (family member name) , 2. (provider name)." Mr. Muresan explained to the DSHS team that the family should be contacted first as they may choose not to pursue treatment.

Transfer Without Notice

87. On May 11, 2003, the Muresans moved LM from the 18210 home to the unlicensed 18204 home without first informing her family or getting permission. The purpose of the transfer was to open a space in the home for AD. They had asked her decision maker's permission to move her to their Camano home, but he refused as he lived only a mile away from the 18210 home. The next time he went to visit his mother he discovered that she had been moved to the 18204 house.

88. Mr. Muresan asserts that the contract between DMMD and his residents allows such a transfer because the contract states "This contract can by [be] chang[ed] any time without notice if both sides agree upon." The contract he provided, Exhibit F30, does not state this nor does it directly address transfers. It includes this related provision:

This contract may be terminated with 30 days written notice. The decision of termination of the contract does not require any explanation. For the last mo[n]th the resident will pay only for the days in DMMD house. This contract may be modified by mutual agreement.

In any event, he did not have permission to transfer her which is required by his own version of the requirements.

Nurse Delegation

89. The Muresans administered medications to EN and NC pursuant to nurse delegations until February 9, 2003 when the nurse delegator rescinded the delegation due to lack of payment. The Muresans continued the administration through at least May 28, 2003.

Mr. Muresan asserted that residents and/or their families do not want to pay for nurse delegation and that he can administer medications without a delegation.

90. EN required several medications which she could no longer administer herself. Some were eye drops and some were oral, some were prescribed on a daily basis, some on an as needed basis.

91. NC's medication must be crushed before she takes it due to a swallowing problem.

92. On March 15, 2003, DSHS issued a "Dear Provider" letter to AFH providers informing them of changes in the nurse delegation laws and regulations. In sum, in relevant part, the letter informs providers that the new Washington Administrative Code (WAC) eliminates the task list for nurse delegation and gives the registered nurse delegator discretion to determine which tasks can be delegated using an established protocol. It lists sterile procedures, injections, and central line maintenance as the only three nursing tasks which cannot be delegated. It concludes with the paragraph:

7. Is nurse delegation mandatory?

Nurse delegation is not mandatory. However, if you provide any type of nursing service in your home, consult with your registered nurse as to whether nurse delegation would be appropriate."

Exhibit 15. It does not define "nursing services." However, it does refer to the relevant statutes and WACs and attached with copies. Why medication administration is not specifically addressed in this letter is not clear.

93. After receiving this letter, the Muresans informed the families of the residents that nurse delegation was not mandatory to administer medications and that DMMD could provide this service without professional oversight if the family agreed.

94. DSHS personnel, including the director of Residential Care Services, informed him orally on numerous occasions and in writing on May 22, 2003 (Exhibit 15.3) that he had misinterpreted the letter, that nurse delegation was indeed necessary to administer medications. He adamantly disagreed and stated that he only complies with DSHS directives that are

mandatory. He continues to disagree that he ever needs nurse delegation to administer medication.

Provision of Services and Care - Miscellaneous

95. On May 29, 2003, AD was in bed wearing sweat pants, and two sweaters which were mismatched, a soiled stocking cap with uncombed hair underneath and wearing-off fingernail polish.

96. Because, according to the Muresans, on May 29, 2003, AD was becoming increasingly difficult for them to move, AD had been left in bed most of the previous two days.

97. On June 5, 2003, AD's fingernails were still partially covered with wearing-off polish.

98. On June 9, 2003, the day that the DSHS team, in the company of a police officer, served the Muresans with the notice of revocation, the Muresans entered AD's room and slammed the door. They thereafter (in the presence of a concerned DSHS investigator) roughly, hurriedly and without concern for AD's comfort, changed AD's soiled clothes and incontinence pad. Ms. Muresan explained at hearing that she knows that their method was inappropriate at that time, that it was not indicative of their usual practice, but rather reflected their distress at the presence of law enforcement officers.

99. On June 9, 2003, AD choked on a pill, requiring Ms. Muresan, who had been feeding her in bed, to retrieve it by hand. Aspirational pneumonia is a known and common risk for people who have difficulty swallowing. After the incident and her condition were reported to her doctor, her doctor ordered her to the emergency room.

Assessments

100. The assessment done for NC upon her admission was done on a form created by Mr. Muresan and completed by a physician. It contained no evaluation of her cognitive status and functioning, no indication of significant known behaviors requiring special care, no preferences or choices of daily life, and no input from her husband who had taken care of her for the 5 years preceding her admittance to the AFH. The form did not include a plan for evacuation when the assessment was reviewed. Exhibit F 28 shows an entry for this line. However, the form appears to be filled out in a variety of handwritings and the original was not

produced at hearing. Based on the inconclusive copy provided at hearing and Ms. Mikunas's credible testimony, it is determined that it is more likely than not that the information was added later.

101. The assessment done for EN upon her admission was also done on the form created by Mr. Muresan and is also incomplete. Glaucoma and blindness were not listed under diagnoses. Four separate glaucoma medications were lumped together generically as "glaucoma drops." No information was provided for significant known behaviors requiring special care or concern. No information was provided for social physical and emotional needs or preferences of daily living. Her needs associated with vision and hearing impairments were not addressed. This form also contains apparently different handwriting.

102. Both assessments noted "same as resident/family assessment" rather than making independent assessments.

103. DSHS staff had numerous conversations/consultations with the Muresans about the deficiencies inherent in the form and the inevitable problems with having it completed by a physician. DSHS staff had referred the Muresans to a nurse who was a trained assessor.

Evacuation Requirements

104. Neither NC's assessment nor her preliminary service plan addressed her level of evacuation capability.

105. AZ's evacuation capability is not addressed in her preliminary service plan. The Muresans do not have a negotiated service plan for her. Mr. Muresan asserts that they do not prepare negotiated care plans for state residents. They use the service plans only, which are "good enough."

106. JB's evacuation capability is not addressed in the preliminary service plan.

Water Temperature

107. On May 29, 2003, the water temperature in the residents' bathroom was 127.6 degrees Fahrenheit. The DSHS licensor had numerous conversations with Mr. Muresan prior to this date about keeping the temperature below 120 degrees Fahrenheit. He always responded that the problem was addressed by an invention of his creation installed under the

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sink and she needed to give the water a chance to run and cool itself through this invention. He further argued about the reasonableness of the 120 degree Fahrenheit rule.

PREVIOUS CITATIONS/PLANS OF CORRECTIONS/CONSULTATIONS

108. The Muresans were on notice that many of their practices were violations of the WAC through numerous informal conversations with their licensors, Ms. Mooney and Ms. Wells, adjudicated citations, and numerous other citations which either did not independently form the basis of enforcement action or were, for some reason, not adjudicated (some were a part of the Statement of Deficiencies underlying the notice of conditions, some were part of the fine notice which was rescinded) and formal consultations.

Previous Violations (Established by Adjudication)

January 27, 2003 Imposition of Conditions on License for 18210 home

109. On February 20, 2002, an unannounced annual inspection was conducted by DSHS through Ms. Wells, Estell Sylvester, MN, ARNP, AFH licensor and Mary Wood, RN, BSN, complaint investigator on the 18210 home. On April 4, they issued an Statement of Deficiencies. Exhibit 4. On April 26, 2002 a Notice of Condition on a License was issued. Exhibit 19.1. After hearing, conditions were imposed by Initial Decision issued January 27, 2003. Exhibit 19.3. On August 26, 2002 the conditions were lifted. Exhibit C.

110. The January 27, 2003 decision found that on January 26, 2002, an elderly resident of the 18210 home, who suffered from impaired judgment, hallucinations, delusions and wandering behavior, all known to the Muresans and addressed in her service plan, left the AFH unbeknownst to the Muresans, in stocking feet and wearing only light clothing over her pajamas on a cold snowy day as a result of the Muresans' failure to provide protective supervision as required by her service plan. The Muresans searched the AFH and called the police but failed to search outside because they believed she had been kidnaped by a former employee. The resident was found outside, three houses away, by her own family who searched for her. She was taken to the hospital. She had abrasions on her knees, was cold, shaken, confused and had hypothermia.

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111. As a result of this event as well as the Muresans' failure to have their residents' medications locked up on February 20, 2002, the Muresans were found to have

violated WAC 388-76-61010 and WAC 388-76-64010. The decision further noted that the Muresans had been previously cited for failing to keep medications in locked storage.

112. The conditions imposed prohibited the Muresans from admitting or retaining residents with wandering behavior and required them to retake the Fundamentals of Caregiving and Adult Family Home Provider orientation.

113. It is noted that the decision issued did not address all of the citations in the Statement of Deficiencies underlying the notice and found that the allegations violated different regulations than those cited by DSHS. The reasons for this are not in the record for this hearing. The unaddressed citations are therefore discussed below.

Revocation of License of 18204 Home

114. On December 26, 2001 and January 15, 2001, DSHS conducted an unannounced complaint inspection of the 18204 home. ALJ Exhibit 3. On January 28, 2002, DSHS completed a Statement of Deficiencies (amended on March 5, 2002). On February 13, 2002 DSHS issued a Notice of Stop Placement and Revocation (amended on April 29, 2002). Exhibit F.17. On July 2, 2002 an Initial Decision was issued substituting a fine for the revocation. ALJ Exhibit 3. On December 6, 2002, a Review Decision and Final Order was issued reversing the Initial Decision and revoking the license. ALJ Exhibit 4. On July 30, 2003, the Superior Court issued a decision upholding the revocation. Exhibit 2.

115. The Final Order based the stop placement and revocation on violations of

- * WAC 388-76-640 (failure to keep resident medications in locked storage);
- * WAC 388-76-655(6) (failure to have a qualified care giver on premises at all times);
- * WAC 388-76-665 (failure to keep residents' records confidential);
- * WAC 388-76-770 (failure to maintain a safe, clean, comfortable and homelike environment by placing a commode with an unfinished wooden seat and sharp edges in a resident's room);
- * WAC 388-76-620 and WAC 388-60070 (5) (failing to provide necessary care and services/abuse and neglect by failing to have a qualified care giver on the premises at all time, by leaving a fallen resident laying on the floor (albeit with a pillow and blanket) for at least 5 hours, failing to obtain emergency medical treatment for this resident on the day she had fallen and subsequently when he or she was having great difficulty breathing and was making a gurgling sound);

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- * WAC 388-76-560 (failing to have the understanding, emotional stability, etc. to meet the needs of vulnerable adults by leaving residents without a qualified care giver, failing to obtain appropriate medical care on two occasions, leaving medications in unlocked storage, all as described above under other violations).

See ALJ Exhibit 4.

116. The decision noted that of the proven violations, the failure to keep medications in locked storage was a repeat violation from November 2001, and that the other proven violations posed a serious risk of harm. ALJ Exhibit 4.

Previous Citations/consultations (Not Litigated)

October 10, 1998 inspection

117. On October 20, 1998, DSHS, through licenser Brenda Mooney, completed an inspection report for the Muresans'18210 home based on an annual inspection conducted that day. Exhibit 9.2. It cited violations of:

- * WAC 388-76-61500 (failure to have care plans for 2 residents);
- * WAC 388-76-640 (failure to keep resident medication in locked storage and failure to completely label medication organizer);
- * WAC 388-76-665 (failure to have written inventory of resident's personal belongings);
- * WAC 388-76-605 (failure to have Power of Attorney documentation for resident who has one);
- * WAC 388-76-670 (failure to have a written plan for emergencies/disaster);
- * WAC 388-76-770 (flooring and commode seat not in good/safe condition, drapes not in good repair);
- * WAC 388-76-605 (no written strategy to reduce symptoms for resident on psychoactive medication and no informed consent for psychoactive medication);
- * WAC 388-76-765 (no record of annual inspection for fire extinguisher);
- * WAC 388-76-770 (toxic substance accessible for residents in bathroom and water temperature at 129.8 degrees F);
- * WAC 388-76-655 (no record of current CPR for co-provider);
- * WAC 388-76-680 (no record of TB screening for provider);
- * WAC 388-76-085 (no background inquiry for family member living at AFH).

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December 4, 1998 Follow-up Inspection

118. On December 4, 1998, DSHS, through Ms. Mooney, completed an inspection report for the Muresans' 18210 home based on a follow-up inspection conducted on that day.

Exhibit 9.1. It cited violations of:

- * WAC 388-76-61500 (incomplete negotiated care plans);
- * WAC 388-76-670 (emergency/disaster plans inadequate);
- * WAC 388-640 (medication organizers inadequately labeled);
- * WAC 388-76-770 (water temperature at 126 degrees F);
- * WAC 388-76-605 (no written strategies in place for reduction of symptoms for resident taking psychoactive medications).

October 12, 1999 Annual Inspection

119. On October 12, 1999, DSHS, through Ms. Mooney, completed an inspection report for the Muresans' 18210 home based on findings from an annual inspection. Exhibit 6.

It cited violations of:

- * WAC 388-76- 59080 (failure to have evidence of specialty training for residents with dementia/mental illness);
- * WAC 388-76-61020 (incomplete assessments for 2 of 6 residents);
- * WAC 388-76-61550 (failure of negotiated care plan for 3 or 6 residents to meet assessed needs);
- * WAC 388-76-640 (failure to record medications administered for the previous 5 days for 5 of 5 residents);
- * WAC 388-76-65515 (no current first aid or CPR for 2 of 3 care givers);
- * WAC 388-76-680 (no evidence of TB screening for 1 care giver);
- * WAC 388-76- 605 (expired background checks for the Muresans);
- * WAC 388-76-640 (over the counter medication found in one resident's room).

December 16, 1999 Follow-up Inspection

120. On December 16, 1999, DSHS completed a Facility Status Report for the Muresans' 18210 home based on an unannounced follow-up inspection conducted on December 12, 1999. Exhibit 7. No violations serious enough to constitute a deficiency were noted. Detailed "consultations" were provided regarding requirements for assessments and negotiated care plans citing WAC 388-76-61020, WAC 388-76-61530 and WAC 388-76-61540. 0001671

121. One of four assessments was still not completed. The Muresans were concerned about the cost of the assessment and wanted to complete an assessment

themselves and have it signed off on by the resident's physician to avoid the cost. The licensor explained again the importance of having assessments which include all of the information listed in WAC 388-76-61020 and which are done by a qualified assessor, also as required.

122. The licensor noted that there had been no involvement of the residents/representatives in the update of the negotiated care plans as required by WAC 388-76-61530 and no signatures as required by WAC 388-76-61540. She explained the importance of resident/representative input and signatures including the promotion of resident's rights and establishing consent for the various services provided in the home.

September 14, 2000 Complaint Investigation

123. On September 14, 2000, DSHS, through Ms. Wood, conducted a complaint investigation and completed a report regarding the 18204 home. Exhibit 18. The complaint was related to the Muresans' dressing a resident in extra or heavy clothing in accordance with Mr. Muresan's health theory which the resident's representative was purported to agree with, against the resident's wishes, and to the Muresans' resistance to following a doctor's directive to elevate the resident's feet twice per day. The investigator was unable to verify the allegations and provided a consultation under WAC 388-76-60001, instructing the Muresans that residents have a right to exercise reasonable control over life decisions, even if the resident has a person holding their power of attorney, in particular, residents' rights to control their own environment, make their own decisions relative to accepting advice on health care issues and wearing clothing of their own choosing.

February 14, 2001 Annual Inspection

124. On February 14, 2001, DSHS, through Ms. Wells, completed an inspection report for the Muresans' 18210 home based on an annual inspection conducted on the same day. Exhibit 8. It cited violations of:

- * WAC 388-76-765 (failure to have fire drills every 2 months with documentation of the complete date, the last drill was documented as occurring "8/00") and
- * WAC 388-76-770 (water temperature above 120 degrees F).

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125. Consultation was provided regarding:

- * WAC 388-76-620 (necessity of documentation of purpose/consent when using bed rails);

- * WAC 388-76-665 (necessity of having inventories of resident's personal belongings signed and dated);
- * WAC 388-76-680 (importance of having care givers screened for TB and having proof thereof available at inspections);
- * WAC 388-76-685 (necessity of having background inquiry completed and available at inspections);
- * WAC 38-76-60070 (necessity of posting the results of the most recent inspection).

September 25, 2001 Annual Inspection

126. On September 25, 2001, DSHS, through Ms. Wells, completed a Statement of Deficiencies based on an unannounced annual inspection of the 18204 home on the same day. Exhibit 16. It cited violations of:

- * WAC 388-76-770 (water temperature 127.6 degrees F) and
- * WAC 388-76-640 (failure to completely label resident medications).

127. The associated inspection report (Exhibit F.11) also cited violations of:

- * WAC 388-76-640 (absence of medication records for 2 residents);
- * WAC 388-76-61500 and WAC 388-76-61520 (incomplete care plans for 2 residents, one missing numerous required items, the other not updated for recent changes);
- * WAC 388-76-61540 (failure to have negotiated care plan signed);
- * WAC 388-76-665 (incomplete and unsigned inventory of personal belongings for one resident);
- * WAC 388-76-595 (documentation of TB screening and completion of training for relief care giver not available);
- * WAC 388-76-655 (care giver inadequately trained).

128. Written consultations were given on:

- * WAC 388-76-60070 (hot line number not posted);
- * WAC 388-76-570 (no 24 hour staffing plan available) and
- * WAC 388-76-675 (no accident/injury log available).

November 5, 2001 Statement of Deficiencies

129. On November 5, 2001, DSHS completed a Statement of Deficiencies for the Camano home. ALJ Exhibit 3.5. Its citations included a violation of WAC 388-76-640 (failure to keep medications in locked storage).

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November 29, 2001 Statement of Deficiencies

130. On November 29, 2001, DSHS completed a Statement of Deficiencies for the Camano home. ALJ Exhibit 3.5. Its citations included a violation of WAC 388-76-61020 (failure of a negotiated care plan to correspond to the assessment of the resident's physician).

January 15, 2002 Complaint Investigation

131. On January 15, 2002, DSHS, through Ms. Wood and Ms. Wells, completed a Statement of Deficiencies for the 18210 home based on findings from an unannounced complaint investigation conducted on January 15, 2002. Exhibit 5. It cited violations of:

- * WAC 388-76-640 (failure to keep medications locked and properly labeled and failure to document administration/taking of any medications for any of the 6 residents for approximately 24 hours);
- * WAC 388-76-680 (failure of one care giver to have tuberculosis screening) and
- * WAC 388-76-685 (failure to have one care giver's criminal history checked).

April 4, 2002 annual inspection and complaint investigation

132. On April 4, 2002, DSHS, through Ms. Wells and Ms. Sylvestor, completed a Statement of Deficiencies for the 18210 home based on findings from an unannounced annual inspection and complaint investigation conducted on February 20, 2002. Exhibit 4. (This Statement of Deficiencies was the basis for the imposition of conditions described above at Finding of Fact 109. It cited violations of:

- * WAC 388-76-620 (failing to provide appropriate services and care by not adequately supervising the woman who wandered out into the cold and becoming hypothermic as described above);
- * WAC 388-76-675 (failing to log and report this development and injury incident);
- * WAC 388-76-595 (failing to have a current assessment for a resident in the resident's file);
- * WAC 388-76-61070 and WAC 388-76-61550 (failure to update an assessment and negotiated care plan based on a change in the resident's condition);
- * WAC 388-76-640 (failure to document medications taken on an as needed basis);
- * WAC 388-76-765 (failure to ensure that fire drills were conducted and logged every two months);
- * WAC 388-76-770 (failure to ensure toxic substances, to wit, a bottle of 409 cleaner, were stored in a place inaccessible to residents).

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March 14, 2003 Statement of Deficiencies/Annual Inspection

133. On March 14, 2003, DSHS, through Ms. Wells, completed a Statement of Deficiencies for the 18210 home based on findings from an unannounced annual inspection conducted on March 12, 2003 and March 14, 2003. Exhibit 3. (This Statement of Deficiencies supported the ultimately rescinded fine notice.) It cited violations of:

- * WAC 388-76-64055 (failure to document the daily medication log when a resident refused medication on March 11, 2003);
- * WAC 388-76-64015 and WAC 388-76-635 (administering medication without a nurse delegation).

Corrections

134. A number of the citations were corrected by the Muresans. A few were never cited again, most were.

CONCLUSIONS OF LAW

APPLICABLE LAW

Jurisdiction.

1. There is jurisdiction to hear and decide this matter pursuant to Washington Administrative Code (WAC) 388-76-710, Revised Code of Washington (RCW) 70.128.160, RCW 43.20.205 and Chapter 34.12 RCW.

Governing Laws and Regulations

2. These proceedings are governed by WAC 388-76-710, Chapter 34.05 RCW, and Chapter 388-02 WAC. WAC 388-76-710(4).

Burden and Standard of Proof.

3. None of the governing laws or regulations assign the burden of proof. This issue was not raised by the parties. It is inferred from the statutory assignment of duties associated with the licensure of Adult Family Homes to DSHS that DSHS bears the burden of proof. The standard of proof is a preponderance of the evidence. WAC 388-02-0485.

Scope of Issues for Hearing.

4. WAC 388-76-705 authorizes DSHS to take actions against licensees for violations of the Minimum Licensing Requirements (MLRs). WAC 388-76-705(1)(a). A licensee may request an adjudicative hearing before an Office of Administrative Hearings (OAH) ALJ to

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contest any DSHS decision to take action or impose a remedy under that section. WAC 388-76-710(3) and (4). Requests for hearing must be made within 28 days of the adverse action. WAC 388-76-710. Actions and remedies which may be contested in an administrative hearing are denial of an application, imposition of conditions on a license, imposition of civil penalties, stop placement, suspension, revocation. WAC 388-76-705(3)(a). The ALJ hears and decides the issues *de novo* (anew, not as a review of DSHS's decision). WAC 388-02-0215. Further, the litigation of previously litigated issues is barred by the law of *res judicata* and/or collateral estoppel; determinations made by other judges about other allegations are final.

In this case, the issues for hearing are whether the allegations in the revocation notice, dated June 9, 2003, as amended July 8, 2003, more likely than not occurred, whether they constitute violations of the MLRs and whether revocation is the appropriate remedy.

The request for hearing on the fine notice, dated June 4, 2003, must be dismissed as DSHS has rescinded its adverse action based on the violations.

Evidence

5. With some exceptions, evidence is admissible if it is relevant and reliable. RCW 34.05.452 (1). Orders are entered pursuant to WAC 34.05.461. To support a Finding, admitted evidence must meet the standards of RCW 34.05.461 (4).

The findings in this case are based primarily on evidence which would be admissible in a civil trial. To the extent that any findings are based on hearsay, the hearsay is determined to be reliable. Further, basing a finding on such evidence does not abridge the Muresans' opportunities to confront witnesses and rebut evidence. They chose not to call any of the persons whose hearsay statements were presented at hearing. They were on notice that the hearsay statements would be presented by DSHS through the revocation notice, the incorporated Statement of Deficiencies, DSHS's witness list and its exhibit list. They did not rebut through their own or other witnesses' testimony many of the hearsay statements offered by DSHS. Finally, much of the Muresans' own evidence supported the hearsay evidence offered by DSHS.

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PURPOSE OF MINIMUM LICENSING REQUIREMENTS

6. The legislature has articulated the intent and purpose of the laws and regulations governing the operation of AFHs at RCW 70.128.005 and RCW 70.128.007 which provide, in pertinent part, as follows:

The legislature finds that many residents of community-based long-term care facilities are vulnerable and their health and well-being are dependent on their care givers. The quality, skills, and knowledge of their care givers are the key to good care....

The legislature finds that the state of Washington has a compelling interest in protecting and promoting the health, welfare, and safety of vulnerable adults residing in adult family homes. The health, safety, and well-being of vulnerable adults must be the paramount concern in determining whether to issue a license to an applicant, whether to suspend or revoke a license, or whether to take other licensing actions.

RCW 70.128.005.

The purposes of this chapter are to:

(1) Encourage the establishment and maintenance of adult family homes that provide a humane, safe, and residential home environment for persons with functional limitations who need personal and special care;

(2) Establish standards for regulating adult family homes that adequately protect residents;

...

(4) Provide for appropriate care of residents in adult family homes by requiring that each resident have a care plan that promotes the most appropriate level of physical, mental, and psychosocial well-being consistent with client choice[.]

RCW 70.128.007(1), (2) and (4).

The rules adopted pursuant to these statutes are found at WAC chapter WAC 388-76. WAC 388-76-535. They are entitled Minimum Licensing Requirements. That is, they establish minimum, not aspirational, standards for operating an AFH and providing care to residents.

VIOLATIONS

Resident rights/discharge requirements

7. WAC 388-76-60000(1) provides:

Under RCW 70.129.005 long-term care facility residents should have the opportunity to exercise reasonable control over life decisions.

RCW 70.129.110(1) and (3)(a) and (b) provides:

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- (1) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:
 - (a) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
 - (b) The safety of individuals in the facility is endangered;
 - (c) The health of individuals in the facility would otherwise be endangered;
 - (d) The resident has failed to make the required payment for his or her stay; or
 - (e) The facility ceases to operate.
-
- (3) Before a long-term care facility transfers or discharges a resident, the facility must:
 - (a) First attempt through reasonable accommodations to avoid the transfer or discharge, unless agreed to by the resident;
 - (b) Notify the resident and representative and make a reasonable effort to notify, if known, an interested family member of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand[.]

The Muresans' failure to notify LM's representative and get permission for her transfer from one AFH to the other is a violation of these laws. It is also noted that the reason for the transfer, to allow admission of another resident to the licensed home, is not a permissible reason for transfer. Mr. Muresan cannot circumvent the law with language in a contract, even if it includes the provision he asserts it did, which it does not. See Findings of Fact # 87 and #88.

On September 14, 2002, the Muresans received a consultation regarding resident rights including the right to control their own environment. See Finding of Fact # 122. They were therefore aware, at the very least, that moving a resident without permission would violate the resident's rights.

Resident Assessment

8. WAC 388-76-61020(1) through (5) and (8) through (10) provides:

The current written assessment must contain specific information regarding the resident applicant. If, despite the best efforts of the person conducting the assessment, an element of the required assessment information is not available, the effort to obtain the information must be documented with the assessment. At a minimum, the assessment must include:

- (1) Recent medical history;
- (2) Current prescribed medications, and contraindicated medications (including, but not limited to, medications that are known to cause adverse reactions or allergies);
- (3) Medical diagnosis by a licensed medical professional;

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- (4) Significant known behaviors or symptoms that may cause concern or require special care;
- (5) Evaluation of cognitive status in order to determine the individual's current level of functioning. This must include an evaluation of disorientation, memory impairment, and impaired judgment;
- ...
- (8) Social, physical, and emotional strengths and needs;
- (9) Functional abilities in relationship to activities of daily living including: Eating, toileting, ambulating, transferring, positioning, specialized body care, personal hygiene, dressing, bathing, and management of own medication;
- (10) Preferences and choices regarding daily life that are important to the person (including, but not limited to, such preferences as the type of food that the person enjoys, what time he or she likes to eat, and when he or she likes to sleep)[.]

The Muresans' failure to ensure complete and accurate assessments for NC and EN as described in detail in Findings of Fact #100 through #103 constitutes a violation of this regulation. Failure to have complete assessments leads to deficient care plans and results in less than optimal care for residents at best or, worse, dangerously inadequate or incorrect care. This is of special concern for residents as vulnerable as those in the Muresans' care.

On October 12, 1999, DSHS cited and on December 16, 1999, DSHS provided a consultation to the Muresans on this very issue. Ms. Wells also had numerous informal conversations with them about the importance of complete assessments and the value of using trained professionals and standard DSHS forms (whether required as they are for medicaid clients or not).

Daily Medication Log

9. WAC 388-76-64055(1) (2) and (5)(a) provide:
 - (1) The provider must ensure that every resident (unless WAC 388-76-64015(2) applies) has a daily medication log that includes the following information:
 - (a) A listing of all prescribed and OTC medications, the frequency, and the dosage; and
 - (b) The time the medication is scheduled to be taken by the resident.
 - (2) The provider must ensure that the person who assisted or administered prescribed or OTC medication to the resident initials the daily medication log within one hour after the medication was taken or refused.

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(3) The provider must ensure that if the prescribed or OTC medication is taken outside the scheduled time, the time the medication was taken must be recorded on the medication log.

(5) When the prescribing practitioner makes a change to any current medications, the provider must:

(a) Ensure that the change and the date of the change are immediately documented on the daily medication log;

The Muresans' repeated failures to promptly, completely and accurately maintain their residents' daily medication logs as detailed in Findings of Fact #80 through 84 constitute a violation of this regulations. Failure to maintain accurate daily medication logs put residents at great risk of being over-medicated, under-medicated or otherwise incorrectly medicated.

The Muresans were cited on October 12, 1999, September 25, 2001, January 15, 2002 and March 14, 2003 for similar deficiencies. Their licensors also had numerous conversations with them about the importance of these requirements.

Mr. Muresan's cavalier approach to the maintenance of these records and stubborn refusal to comply with the regulations despite repeated discussions eliminates any confidence that he would ever comply with this very important regulation.

Medication Administration/Nurse Delegation

10. WAC 388-76-64015 (4) provides:

(4) Medication administration is required when a resident cannot safely perform independent self-administration or self-administration with assistance. Medication administration must be performed by a practitioner as defined in chapter 69.41 RCW or by nurse delegation (WAC 246-840-910 through 246-840-970), unless performed by a family member or surrogate decision maker as defined in RCW 7.70.065.

The Muresans' administration of medications to EN and NC as detailed in Findings of Fact #89 through 94, without nurse delegation, from February 19, 2003 through at least May 28, 2003, constitutes a violation of this regulation.

Mr. Muresan's defense is not persuasive.

The language of DSHS's March 15, 2003 letter could certainly have been clearer, even if attached regulations should have made it clear to an experienced provider that

medication administration requires nurse delegation. However, Mr. Muresan's claimed reliance on his interpretation of this letter does not explain his failure to have nurse delegation in place between February 19, 2003 and March 15, 2003.

Further, as of at least March 14, 2003, when he was cited for administering medications without nurse delegation, he was on notice that his interpretation was wrong. His claimed reliance on his correct interpretation and his efforts to prevail on this issue by arguing up the chain of command as he did with the CPR disagreement is also unpersuasive as he received a letter from the Director of Residential Care Services on May 22, 2003 confirming that his interpretation was wrong, and he continued to administer medications without a delegation through at least May 28, 2003.

Finally, awaiting a change in rule based on personal preference is not a defense to failing to comply with a clear regulation, which WAC 388-76-64015(4) is, while it is still in place.

Administration of medications without nurse delegation places residents at serious risk of harm especially where, as here, some of the medications must be applied to the eye, some are to be administered "as needed," which requires some idea of when to administer, and some require crushing and administering to a person with swallowing difficulties.

Again, Mr. Muresan's cavalier attitude about following the rules which are in place and his disingenuous claim of relying on a March 15, 2003 letter when he lost his delegation almost one month before eliminates any confidence that he would comply with this very important regulation in the future.

Reporting Requirements

11. WAC 388-76-675(2), (3)(a) and (b) provide:
 - (2) The provider shall keep a log of injuries and accidents to residents.
 - (3) When there is a significant change in a resident's condition, or a serious injury, trauma, or death of a resident, the provider shall immediately notify:
 - (a) The resident's family, surrogate decision maker, physician and other appropriate professionals, and other persons identified in the negotiated care plan; and
 - (b) The case manager, if the resident is receiving services paid for fully or partially by the department.

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The Muresans' failure to report AD's pressure sores, bruises and abrasion to her doctor and failure to log the bruises and abrasion constitute violations of this regulation. See Findings of Fact #56 through 64. Their failure to notify LS's doctor or her DSHS case manager of the decline in her condition over at least a 3-week period constitutes a violation of this regulation. See Findings of Fact #68 through 71. And although not addressed in DSHS's factual allegations as a basis for a violation of this regulation, the Muresans' failure to report LM's pressure sore and perineum rash to her doctor is also a violation of this regulation. See Findings of Facts #65 through # 67.

Failure to comply with this regulation created risks and actual harm associated with delay in getting necessary care and treatment for AD, LS and LM. AD's pressure sores deteriorated over the several days that the Muresan's were told to call the doctor and failed to do so. LS's condition had deteriorated from the time of her assessment on March 11, 2003 to May 30, 2003 to the point where she needed to be hospitalized as soon as the doctor finally saw her on, it is noted, a previously scheduled visit, not one made as a result of a report from the Muresans. LM's condition led to a substantiated finding of abuse.

911 Decision Making

12. WAC 388-76-690(2)(a) provides:

-
- (2) The provider or resident manager shall:
- (a) Immediately contact the local emergency medical services in the event of a resident medical emergency regardless of any order, directive, or other expression of resident wishes involving the provision of medical services[.]

The Muresans' procedure of allowing their residents' decision makers to determine whether 911 should be called in the event of an emergency is a violation of this regulation and creates a risk of serious harm to the residents. See Finding of Fact #86.

Evacuation Plans

13. WAC 388-76-76510(2) provides:

- (2) The resident's preliminary service plan (WAC 388-76-61030) and negotiated care plan (WAC 388-76-61500) must identify the resident's level of evacuation capability ...

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The Muresans' failure to identify NC's, AZ's and JB's level of evacuation capability in their preliminary service plan is a violation of this regulation. See Findings of Fact #104 through #106. Contrary to Mr. Muresan's position, it is the provider's responsibility to ensure the completion of the required preliminary service plan and negotiated service plan, both of which are essential to providing care to and, in this case, the safety of, his residents. WAC 388-76-61030 and WAC 388-76-61500.

Safety/Water Temperature

14. WAC 388-76-770(5) provides:

(5) Water temperature does not exceed one hundred twenty degrees Fahrenheit at fixtures used by residents, such as tub, shower, and lavatory facilities[.]

The Muresans' failure to ensure that the water used by the residents did not exceed 120 degrees Fahrenheit on May 29, 2003 constitutes a violation of this regulation. See Finding of Fact #107.

On that day the temperature was 127.6 degrees Fahrenheit. This placed residents at risk for thermal burns.

On December 4, 1998, February 14, 2001 and September 25, 2002, the Muresans were cited for allowing the temperature of the residents' water to exceed 120 degrees Fahrenheit. The installation of a device which cools the water as it runs is not helpful. The point is to never have water which exceeds 120 degrees Fahrenheit coming out of the faucets at all.

Provider Suitability

15. WAC 388-76-560(7) provides:

(7) A provider shall have the understanding, ability, emotional stability and physical health suited to meet the emotional and physical care needs of vulnerable adults.

Mr. Muresan's aggressive promotion of his unproven and eccentric health care theory, his insistence on pushing for the reduction of medications prescribed by doctors for seriously ill people even in the face of clear disagreement with residents' doctors or family members, his continued over-dressing of his residents despite instructions to stop by family members and nurses, his inability to respect anyone else's point of view, his argumentative and

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hostile temperament, his skewed interpretation of reality and his refusal to comply with the MLRs, all as detailed specifically at Findings of Fact #17 through 19, #31 through 54 and indirectly in many of the other Findings, are frightening characteristics for a care giver for anyone, let alone the elderly vulnerable persons who reside in AFHs, and render him completely unsuitable to be an AFH provider.

Ms. Muresan's unsuitability appears to relate only to her association with and the apparent domination of the operation of their AFH by Mr. Muresan.

Provision of Service and Care

16. WAC 388-76-620(1), (4)(a), (b), and (c) and (5) provide:

(1) The provider shall ensure that the resident receives necessary services and care to promote the most appropriate level of physical, mental, and psychosocial well-being consistent with resident choice.

...

(4) The provider shall ensure that resident services are delivered in a manner and in an environment that:

(a) Promotes maintenance or enhancement of each resident's quality of life;

(b) Promotes the safety of all residents; and

(c) Reasonably accommodates the resident's individual needs and preferences, except when the health or safety of the resident or other residents would be endangered.

(5) The provider shall ensure that appropriate professionals provide needed services to the resident based upon the resident's assessment and negotiated care plan.

The Muresans violated this regulation for all of the reasons stated in the preceding Conclusions and based on Mr. Muresan's improper transfer of AD on May 29, 2003 (Finding of Fact #72) and on June 4, 2003 (Finding of Fact #73), the resulting injures therefrom (Finding of Fact # 74), and the Muresans' neglectful treatment of AD's grooming and quality of life (Findings of Fact #95 through # 99).

REMEDIES

17. WAC 388-76-705 provides, in relevant part, as follows:

(1) The department may take one or more of the actions listed in subsection (3)(a) of this section in any case in which the department finds that an adult family home provider has:

(a) Failed or refused to comply with the applicable requirements of chapters 70.128 and 70.129 RCW or of this chapter;

...

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(2)(a) For failure or refusal to comply with any applicable requirements of chapters 70.128 and 70.129 RCW or of this chapter, the department may provide consultation and shall allow the provider a reasonable opportunity to correct before imposing remedies under subsection (3)(a) unless the violations pose a serious risk to residents, are recurring or have been uncorrected.

(b) When violations of this chapter pose a serious risk to a resident, are recurring or have been uncorrected, the department shall impose a remedy or remedies listed under subsection (3)(a). In determining which remedy or remedies to impose, the department shall take into account the severity of the potential or actual impact of the violations on residents and which remedy or remedies are likely to improve resident outcomes and satisfaction in a timely manner.

(3)(a) Actions and remedies the department may impose include:

-
- (ii) Imposition of reasonable conditions on a license, such as correction within a specified time, training, and limits on the type of residents the provider may admit or serve;
- (iii) Imposition of civil penalties of not more than one hundred dollars per day per violation
- (iv) Suspension or revocation of a license; or
- (v) Order stop placement.
- ...

See also RCW 70.128.160.

The suspension referenced at WAC 388-76-706(2)(b)(iv) is an immediate ("Summary") suspension and is authorized by RCW 70.128.100 when conditions at an AFH constitute an "imminent danger to residents." See also RCW 43.20A.205(2)(b).

18. The appropriate remedy in this case is unquestionably summary suspension and revocation. The violations posed serious risks and caused actual harm; many of the most egregious ones are repeat violations. DSHS has worked with the Muresans since 1997 to help them come into compliance with the minimum standards set by regulation. The Muresans have been unable and, at least in Mr. Muresan's case, unwilling, to meet and maintain compliance with the minimum standards. And, Mr. Muresan is defiantly unwilling to acknowledge his deficits and in fact insists on his superiority in the determination of what is good for his residents. There is no hope that remedies short of revocation will result in a good outcome for the residents of the 18210 home.

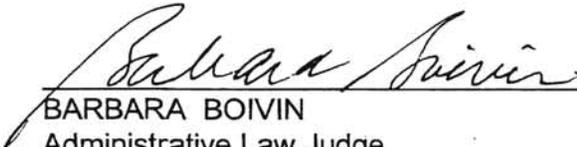
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DECISION AND ORDER

1. The hearing request on The Notice of Imposition of Civil Fine is DISMISSED for lack of jurisdiction as the Notice was rescinded.

2. DMMD violated several Minimum Licensing Requirements. Several of the violations were repeat violations and/or posed a serious risk to their residents. License number 390100 for the AFH at 18210 30th Avenue N.E., Seattle, Washington, is therefore REVOKED.

SERVED on the date of mailing.


BARBARA BOIVIN
Administrative Law Judge

BB:bb/jfk

Enclosure(s)

cc: David and Maria Muresan (DBA D M M D Adult Family Home), Appellants
Daphne Huang, AAG, Department Representative
Joyce Pashley Stockwell, Program Administrator
Janice Schurman, Program Administrator

NOTICE TO PARTIES

This decision becomes the final administrative decision unless a party files a petition for review. A petition must be received within 21 calendar days of the mailing date of this decision at the Board of Appeals. A petition form and instructions are attached.

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[affirmed]

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES, BOARD OF APPEALS

PETITION FOR REVIEW OF INITIAL DECISION

SEE INFORMATION ON BACK

Print or type detailed answers. Add more pages if needed. You may use your own form.

Name(s) [please print]

Docket Number

Client ID or "D" Number

Mailing Address

City

State

Zip Code

(_____) _____

(Area Code) Telephone Number

Please explain why you want the initial decision or order changed. Try to be specific. For example, tell us:

- ▶ Why you think that the decision is wrong (why you disagree with it).
- ▶ If the findings of fact are wrong, based on what was presented at the hearing.
- ▶ How the decision should be changed.

I ask for a review of the initial decision because. . .

Check
I sent a copy to
every other party

I have attached _____(number) pages.

Signature

Date

Deadline: Received on or before 21 days from mail date of Initial Decision

Mail to: Board of Appeals
PO Box 45803
Olympia, WA 98504-5803

STATE OF WASHINGTON, DEPARTMENT OF SOCIAL AND HEALTH SERVICES

BOARD OF APPEALS

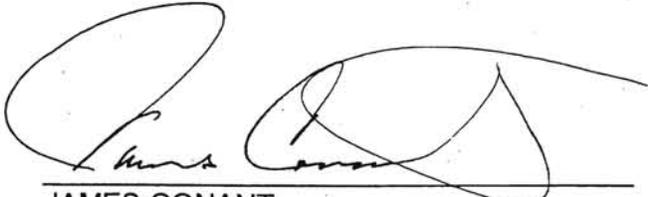
In Re:) Docket No. 06-2003-L-1154
)
 DAVID & MARIA MURESAN) ORDER DENYING REQUEST
 DBA DMMD ADULT FAMILY HOME CARE) FOR REVIEW
 18204 30th Avenue NE)
 Seattle, WA 98155)
)
 Appellants) Adult Family Home License

MAILED
MAR 18 2004
 DSHS
 BOARD OF APPEALS

The Office of Administrative Hearings served an Initial Decision on December 31, 2003. The Board of Appeals received a request for review on March 12, 2004, more than 51 days later. The request was not filed within the legal deadline.

IT IS ORDERED that the request for review is denied. The hearing decision or order is the final administrative decision.

Mailed on March 18, 2004.



 JAMES CONANT
 Review Judge

Attached: Reconsideration/Judicial Review Information
 Legal Authority: RCW 34.05.464; WAC 388-02-0580

Copies have been sent to: David & Maria Muresan, Appellants
 Daphne Huang, AAG, Seattle AGO, Department Representative
 Joyce Stockwell, Program Administrator
 Janice Schurman, Program Administrator

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 OFFICE OF ATTORNEY GENERAL
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 MAR 19 2004
 DSHS-AASA
 Residential Care Services



ADULT FAMILY HOME CARE

18204 30th Ave NE Seattle WA 98155. Ph. & Fax (206) 367 0818

RECEIVED

MAR 12 2004

DSHS BOARD OF APPEALS

To: Board of Appeals

(P O Box 45803, Olympia, WA 98504-5803)

Case # 06-2003-L-1154

David Muresan, Provider of DMMD-1 AFH at 18210. license #390100

To: Daphne Huang, (Aty Gen Office TB-14, 900 4th Ave Ste 2000 Seattle, WA 98164-1012)

Today is 2-10-04

Request for Appeal (for revoked license)

The deadline for this appeal was Jan-21st-04. I did not appeal this decision because DSHS requested me not to. I ask you to review the DSHS request and if you find it incorrect, please accept my appeal and give me about 20 days to prepare this appeal, based on the 40 pages Initial decision.

The reasons for my action are:

1. The DSHS letter dated April-28-03 requested me, in order to rent my house, to someone else to open an Adult Family Home, like my daughter, I have to release the court appeal for that house. *Quote from that letter:* "Please provide a letter from David Muresan releasing his court appeal for this location. We can not license two persons at the same address. (That letter is attached)

2. The above request is illegal and represents an Obstruction of Justice because:

3. An AFH provider with a revoked license has two possibilities, a) to rent the house to someone else until all appeals will be done. b) To sell the house and not to work in this business any more. In this case no appeals.

4. Due to a long period of time necessary for all appeals (approximate 3 years), the provider with a revoked license can not pay the mortgage without enough income. The only option is 2a, which is blocked by DSHS.

4. The DSHS request is also erroneous because: a) a provider with revoked license does not enjoy the advantages of a license during appeals, to be considered having license. b) in the event that that provider will get back the license through appeals and someone else started a new AFH in that house, then one of them will relinquish the license.

Please accept my appeal and my daughter to be allowed to open an AFH.

I faxed this material to: 1. Board of Appeal Fax. # 1-360-664-6187.
2. Daphne Huang, DSHS #206-464-5136

Appellant. David Muresan

000-85



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND DISABILITY SERVICES ADMINISTRATION
PO Box 45600 • Olympia, WA 98504-5600

CERTIFIED MAIL

NOTICE OF INCOMPLETE ADULT FAMILY HOME APPLICATION

April 28, 2003

Maria Cameron
18204 30th Ave Ne
Seattle, WA 98155

Dear Maria Cameron:

Your application for an Adult Family Home license, received in this office on March 17, 2003, is incomplete. Please complete the following items:

- Please provide the \$100.00 application fee.
- Please provide a letter from David Muresan releasing his court appeal for this location. We can not license two persons at the same address.
- #8 Provide a mailing address or mark N/A.
- #20 Provide the requested information or mark N/A.
- #46 You must mark "Yes" and provide the requested information. Our tracking system indicates that you are the resident manager of DMMD Adult Family Home.
- #58 Provide the requested information.
- #59 Provide the requested information.
- #61-67 Provide the requested information.
- Provide the missing highlighted information on page 11.
- The attestation you have provided is not acceptable. We do not accept attestations from family members for family members. I have enclosed a blank form for your use.

As outlined in the Adult Family Home Requirement WAC 388-76-550(11) License Application, "the department shall not commence review of an incomplete license application, and incomplete applications shall become void sixty days following the department's written request for additional documentation or information to complete the application."

Your completed application must be received in this office by **June 27, 2003** or your application will become void, and \$50 will be refunded to you. Please return your completed application to the Business Analyst Applications Unit, Attention: Amy Robertson, PO Box 45600, Olympia, WA 98504-5600. If you have any questions, please call me at (360) 725-2420.

Sincerely,

Amy Robertson, Business Analyst
Business Analyst Applications Unit
Residential Care Services



To whom it may concern,

I, David Mureson declare that I will not continue the appeal process in the license revocation, for the address: 18210 30th Ave NE, LFD, for which Maria Cameron applied for AFH license.

1-07-04. David Mureson



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Budget, Fiscal, & Contracts

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*Faxed 1-6-05
to HM*

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BEFORE THE WASHINGTON STATE OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES

In Re:

DAVID & MARIA MURESAN
APPELLANTS

Docket Nos. 02-2003-L-0860
05-2004-L-1507
05-2004-L-1744

ORDER GRANTING SUMMARY JUDGMENT

A. PROCEDURAL HISTORY

1. This order pertains to three adverse licensing actions taken by the Department of Social and Health Services (DSHS) against the above named Appellants David and Maria Muresan.
2. Docket Number 02-2003-L-0860 is an appeal from the denial of David and Maria Muresan's application to operate an adult family home located at 1578 South Crestview Drive, Camano Island, WA. The license denial letter was issued February 4, 2003, and based on Washington Administrative Code (WAC) 388-76-560(9)(a). Appellants David and Maria Muresan filed an appeal of that license denial on February 10, 2003.
3. Docket Number 05-2004-L-1507 is an appeal from the DSHS denial of David Muresan's application to operate an adult family home located at 1473 South Crestview Drive, Camano Island, WA. The license denial letter was issued by DSHS on May 11, 2004. The denial action was based upon WAC 388-76-560(9). David Muresan filed an appeal of that license denial on May 18, 2004.
4. Docket Number 05-2004-L-1744 is an appeal from the revocation of an adult family home license held by David and Maria Muresan for the adult family home located at 1473 South Crestview Drive, Camano Island, WA. The basis for the revocation

EXHIBIT # 8

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DSHS/AASAIRCS
Director's Office

action is WAC 388-76-560(9). Appellants David and Maria Muresan filed an appeal of that revocation action on May 19, 2004.

5. On September 3, 2004, by stipulation and agreement of the parties, the three administrative appeals identified above were consolidated for future proceedings.

6. A prehearing conference was conducted November 15, 2004, and a prehearing order was issued November 18, 2004. Pursuant to the order, DSHS was to prepare a new motion for summary judgment on the consolidated appeals on or before December 10, 2004. Appellants David and Maria Muresan were given until December 24, 2004 to file a written response to the DSHS motion. Further, either party was allowed to request that an oral argument on the DSHS motion for summary judgment be scheduled.

7. On November 22, 2004, David Muresan filed a conditional Motion for Oral Argument as follows:

Your Honor. Based on your Pre-hearing Order, I ask for Oral Argument.

1. I ask all the deficiencies DSHS will present for these three cases, to be debated in hearings and **I ask for permission the [sic] examine and cross-examine the DSHS workers who wrote those deficiencies and the Enforcement Officer who approved them.**

2. If you do not agree with my request in point one, and if you intend or are required to use WAC 388-76-550[sic](9), to uphold the DSHS denial, I do not see any reason to have an oral argument nor **Mr. Majors to present any deficiency or reference to any deficiency in his Motion for Summary Judgment.**

8. The undersigned Administrative Law Judge interprets Mr. Muresan's Request for Oral Argument to be conditioned upon the non-use of WAC 388-76-560 to affirm the DSHS denial. Since DSHS has requested summary judgment based upon WAC

388-76-560(9), the undersigned interprets Mr. Muresan's motion for oral argument to apply only if the DSHS summary judgment motion is denied.

9. On December 9, 2004, DSHS filed a Motion for Summary Judgment, and a supporting memorandum. The legal authority relied upon for the summary judgment motion is WAC 388-02-0215(2)(c) and (2)(j); WAC 388-02-0220; WAC 388-76-560(9)(a); and WAC 10-08-135.

10. On December 13, 2004, Appellant David Muresan filed a Motion Against Summary Judgment and a response to the DSHS memorandum in support of the summary judgment motion. In the response, Mr. Muresan renewed his request for oral argument stating:

Your Honor. Based on your Pre-hearing Order, I ask for Oral Argument.

I ask all the deficiencies DSHS will present for these three cases to be debated in hearings and I ask for permission the [sic] examine and cross-examine the DSHS workers who wrote those deficiencies and the Enforcement Officer who approved them.

11. It is presumed that the deficiencies to which Mr. Muresan refers are the deficiencies relied upon by DSHS in revoking the Muresan's adult family home license for a facility located at 18204 30th Avenue NE, Seattle, WA (Seattle AFH #1), and revoking a second adult family home license held by the Muresans for a facility located at 18210 30th Avenue NE, Seattle, WA (Seattle AFH #2).

B. PRIOR LICENSE REVOCATIONS

12. David and Maria Muresan's license to operate an adult family home at Seattle AFH #1 was revoked by DSHS in a notice issued April 19, 2002. The Muresans requested an administrative hearing to contest the license revocation. The hearing on their

appeal was conducted May 23, 2002 and an Initial Decision was issued July 22, 2002, reversing the license revocation. DSHS filed a petition for review of the Initial Decision, and on December 6, 2002, a DSHS review judge issued a Review Decision and Final Order reversing the Initial Decision, and reinstating the revocation of the Muresan's license for Seattle AFH #1. Mr. and Mrs. Muresan's petition for reconsideration was denied by the DSHS review judge on December 23, 2002. There is no dispute about these facts.

13. The Appellants filed a petition for judicial review in King County Superior Court of the DSHS Review Decision and Final Order. The King County Superior Court denied the petition on July 30, 2003. Appellants thereafter appealed the Superior Court order to the Court of Appeals. That appeal was denied by a court commissioner for the Court of Appeals on December 4, 2003. On January 12, 2004, a three judge panel of the Court of Appeals denied Appellants' motion to modify the commissioner's decision. Mr. Muresan filed a further petition for review to the Washington State Supreme Court. The State Supreme Court denied Mr. Muresan's petition for review on September 8, 2004. These facts are also undisputed.

14. David and Maria Muresan's license to operate an adult family home at Seattle AFH #2 was revoked by DSHS on July 8, 2003. The Muresans requested an administrative hearing to contest the suspension and revocation of their license to operate Seattle AFH #2. A hearing on the request was conducted November 3 through November 5, 2003. An Initial Administrative Decision was issued December 31, 2003. Pursuant to WAC 388-02-0525, the Initial Decision became final on January 21, 2004. Appellant David Muresan filed a petition for review of the Initial Decision with the DSHS Board of Appeals

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on March 12, 2004. The request for review was denied by a DSHS review judge as untimely on March 18, 2004. No further appeal was taken. These facts are also undisputed.

C. CONCLUSIONS OF LAW

15. The DSHS regulations under which adult family homes are licensed and operated are set forth in Chapter 388-76 WAC. Each of the adverse actions in these consolidated cases (two denials and one revocation) were taken under WAC 388-76-560(9), which provides in relevant portion:

(9) The department shall deny, suspend or revoke a license if any of the following people have a history of significant noncompliance with federal or state regulations in providing care or services to vulnerable adults or children:

- *An applicant/provider,
- *A resident manager,
- *A partner of the entity,
- *An officer of the entity,
- *A director of the entity,
- *A managerial employee of the entity,
- *An entity representative, or
- *An owner of five percent or more of the entity.

The department shall consider, at a minimum, the following as a history of significant noncompliance requiring denial of a license:

(a) Revocation or suspension of a license for the care of children or vulnerable adults...

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16. There is no dispute that David and Maria Muresan have had two adult family home licenses revoked. Both revocations were appealed through the administrative process. The appeal of the license revocation for Seattle AFH #1 was litigated to the level of the Washington State Supreme Court. In denying Mr. Muresan's petition for review on September 8, 2004, the Supreme Court affirmed the DSHS revocation of the Muresan's license to operate Seattle AFH #1. No further appeal of that revocation is available within the Washington State judicial system and it must be considered to be final.

17. The DSHS revocation of Mr. and Mrs. Muresan's license to operate Seattle AFH #2 was affirmed by an Administrative Law Judge on December 31, 2003, following a contested hearing. The Initial Decision issued by the Administrative Law Judge became a final DSHS administrative decision on January 21, 2004. DSHS dismissed a subsequent petition for review as untimely, and no judicial appeal therefrom was taken within the time allowed under RCW 34.05.542. The revocation of the Appellant's license to operate Seattle AFH #2 has therefore also become final, with no further appeal possible under Washington State law.

18. Under WAC 388-76-560(9), revocation or suspension of a license for the care of vulnerable adults constitutes, by definition, "...a history of significant noncompliance...". Under that same regulation, DSHS is required to deny or revoke the license of persons who "...have a history of significant noncompliance with federal or state regulations in providing care or services to vulnerable adults...".

19. Appellant David Muresan continues to take issue with the revocation of his licenses to operate Seattle AFH #1 and Seattle AFH #2. He believes he was denied

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an opportunity to question witnesses and to present the evidence he wanted to in his appeal of those license revocation actions. He would like to re-litigate those previous revocations in this current challenge to the adverse actions taken against his license to operate the two Camano Island adult family homes.

20. The undersigned Administrative Law Judge is without any authority to change the outcomes of the prior revocation actions. Even though Mr. Muresan may consider the appeal process to have been flawed, his opinion does not change the fact that the appeals of both Seattle adult family home license revocations have been carried to their ultimate legal conclusion within the Washington State Administrative and Judicial Review process. Any evidence Mr. Muresan may now wish to present concerning those prior revocation actions is irrelevant to the issues before the undersigned Administrative Law Judge concerning the Camano Island homes.

21. The denial and revocation actions taken against Mr. and Mrs. Muresan's license applications, and the existing license, pertaining to the Camano Island adult family homes were based exclusively upon the prior revocation of their licenses to operate the Seattle adult family homes. The reasons for those prior revocation actions are not material in the cases before this tribunal. What is material is that Mr. and Mrs. Muresan have a history of significant noncompliance with Washington state regulations in providing care to vulnerable adults. Because of this history of significant noncompliance, DSHS is required to deny or revoke their license applications and licenses.

22. Washington Administrative Code 10-08-135 provides:

WAC 10-08-135 Summary judgment. A motion for summary judgment may be granted and an order issued if the written record shows that there is

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no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law.

23. It is concluded that there is no genuine issue as to any material fact in this case, and that DSHS is entitled to judgment as a matter of law. As Mr. Muresan has acknowledged in paragraph 2 of his Motion for Oral Argument filed November 22, 2004, there is no reason in this case to schedule an oral argument. The license revocations at issue under Docket 02-2003-L-0860 and 05-2004-L-1744, and the license application denial at issue under Docket Number 05-2004-L-1507, must be affirmed pursuant to WAC 388-76-560(9).

//////

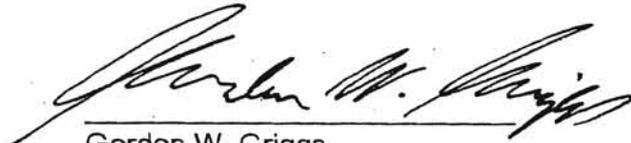
//////

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D. INITIAL ORDER ON SUMMARY JUDGMENT

24. The DSHS motion for summary judgment filed December 9, 2004 is granted. The February 4, 2003 adult family home license denial under appeal in Docket Number 02-2003-L-0860, the May 11, 2004 adult family home license denial under appeal in Docket Number 05-2004-L-1507, and the May 11, 2004 adult family home license revocation under appeal in Docket Number 05-2004-L-1744 are all affirmed, pursuant to WAC 388-76-560(9).

SERVED on the date of mailing.



Gordon W. Griggs
Administrative Law Judge
Office of Administrative Hearings

A copy was sent to:

David & Maria Muresan, Appellant
Joyce Pashley Stockwell, Program Admin
Janice Schurman, Program Admin
Scott Majors, Assistant Attorney General

NOTICE TO PARTIES: THIS ORDER BECOMES FINAL ON THE DATE OF MAILING UNLESS WITHIN 21 DAYS OF MAILING OF THIS ORDER A PETITION FOR REVIEW IS RECEIVED BY THE DSHS BOARD OF APPEALS, PO BOX 45803, OLYMPIA, WA 98504-5803. A PETITION FORM AND INSTRUCTIONS ARE ENCLOSED.

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STATE OF WASHINGTON, DEPARTMENT OF SOCIAL AND HEALTH SERVICES

RECEIVED

BOARD OF APPEALS

FEB 14 2005

DSHS/AASA/RCS
Director's Office

In Re:

) Docket No. 02-2003-L-0860
) 05-2004-L-1507
) 05-2004-L-1744

DAVD AND MARIA MURESAN
DMMD ADULT FAMILY HOME

) REVIEW DECISION AND FINAL ORDER

MAILED

Appellant

) Adult Family Home License

FEB 11 2005

DSHS
BOARD OF APPEALS

I. NATURE OF ACTION

1. The Department denied the Appellants' applications for two adult family home licenses and revoked one of the Appellants' adult family home licenses. The Appellants requested a hearing to contest the Department's denial and revocation actions. The Department filed a Motion for Summary Judgment. Administrative Law Judge Gordon W. Griggs issued an Order Granting Summary Judgment on December 30, 2004, denying the Appellants' application for two adult family home licenses and revoking the Appellants' adult family home license.

2. The Appellant filed a Petition for Review of the Initial Decision on January 5, 2005. The Petition stated:

Please review the administrative decision in the following cases:

- Case # 02-2003-L-0860
- # 05-2004-L-1507
- # 05-2004-L-1744

I attach the "ORDER GRANTING SUMMARY JUDGMENT" (first and last page), dated 12-30-04.

Reason for Hearing.

The base of refusing to listen these cases, was the final judgment of the case #06-2003-L-1154, which was an injustice and I ask for permission to have a copy of the Hearing Report and then to do a thoroughly presentation of the facts.

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*campus
Mail to
RA & FM
3-8-05*

3. The Department filed a Response to the Appellant's Petition for Review of the Initial Decision on January 10, 2005. The Department's Response stated:

COMES NOW the Department of Social and Health Service, Division of Residential Care Services (DSHS) to respond to the petition for review filed by David and Maria Muresan as follows:

There were no disputed issues of material fact as to the basis for DSHS's actions in the above matters. Because these are two final orders revoking adult family home licenses previously held by David and Maria Muresan, DSHS was mandated by WAC 388-76-560(9) to take the actions challenged herein. The prior revocations were fully litigated by the Muresans, and they are barred by the doctrine of collateral estoppel from relitigating those matters in this forum. Thus, ALJ Griggs committed no error when he granted DSHS's motion for summary judgment. DSHS's factual and legal arguments in support of the motion for summary judgment are set forth in the DSHS Memorandum in Support of Motion for Summary Judgment previously filed with the Office of Administrative Hearings in Everett, Washington, and incorporated herein by reference.

II. FINDINGS OF FACT

The Initial Decision did not contain Findings of Fact. The undersigned enters the following eight Findings of Fact based on the procedural history section of the Initial Decision. These facts were not contested by either party.

PRIOR LICENSE REVOCATIONS

1. The Department previously issued two licenses to the Appellants to operate two adult family homes in Seattle, Washington.

2. David and Maria Muresan's license to operate an adult family home at 18204 30th Avenue NE, Seattle, WA (Seattle AFH #1) was revoked by DSHS in a notice issued April 19, 2002. The Muresans requested an administrative hearing to contest the license revocation. The hearing on their appeal was conducted May 23, 2002, and an Initial Decision was issued July 22, 2002, reversing the license revocation. DSHS filed a Petition for Review of the Initial Decision, and on December 6, 2002, a DSHS review judge issued a Review Decision and Final Order reversing the Initial Decision, and reinstating the revocation of the Muresan's

license for Seattle AFH #1. Mr. and Mrs. Muresan's petition for reconsideration was denied by the DSHS review judge on December 22, 2002.

3. The Appellants filed a petition for judicial review in King County Superior Court of the DSHS Review Decision and Final Order regarding Seattle AFH #1. The King County Superior Court denied the petition on July 30, 2003. Appellants thereafter appealed the Superior Court order to the Court of Appeals. That appeal was denied by the court commissioner for the Court of Appeals on December 4, 2003. On January 12, 2004, a three judge panel of the Court of Appeals denied Appellants' motion to modify the commissioner's decision. Mr. Muresan filed a further petition for review to the Washington State Supreme Court. The State Supreme Court denied Mr. Muresan's petition for review on September 8, 2004.

4. David and Maria Muresans's license to operate an adult family home at 18210 30th Avenue NE, Seattle, WA (Seattle AFH #2) was revoked by DSHS on July 8, 2003. The Muresans requested an administrative hearing to contest the suspension and revocation of their license to operate Seattle AFH #2. A hearing on the request was conducted November 3 through November 5, 2003. An Initial Administrative Decision was issued December 31, 2003. Pursuant to WAC 388-02-0525, the Initial Decision became final on January 21, 2004. Appellant David Muresan filed a petition for review of the Initial Decision with the DSHS Board of Appeals on March 12, 2004. The request for review was denied by a DSHS review judge as untimely on March 18, 2004. No further appeal was taken.

CURRENT APPEAL

5. The Appellants applied to the Department for a license to operate an adult family home at 1578 South Crestview Drive, Camano Island, WA. The Department denied the Appellants' application for an adult family home license. The denial notice was issued

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February 4, 2003, and cited WAC 388-76-590(9). The Appellants filed an appeal of that license denial on February 10, 2003 and the appeal was assigned to docket number 02-2003-L-0860.

6. Mr. Muresan applied to the Department for a license to operate an adult family home at 1473 South Crestview Drive, Camano Island, WA. The Department denied Mr. Muresan's application for an adult family home license. The denial notice was issued on May 11, 2004, and cited WAC 388-76-590(9). Mr. Muresan filed an appeal of that license denial on May 18, 2004, and the appeal was assigned to docket number 05-2004-L-1507.

7. The Appellants held a license for an adult family home at 1473 South Crestview Drive, Camano Island, WA. The Department revoked the Appellants' adult family home license in a notice of revocation dated May 11, 2004, which cited WAC 388-76-560(9). The Appellants filed an appeal of that license denial on May 19, 2004, and the appeal was assigned to docket number 05-2004-L-1744.

8. The Department filed a Motion for Summary Judgment, asking the ALJ to uphold all three Department actions based on the fact that the Appellants' licenses for Seattle AFH #1 and #2 were previously revoked.

III. CONCLUSIONS OF LAW

1. **Jurisdiction for Review-** For cases in which an Appellant requests a hearing after November 15, 2002, a Review Judge may only review the types of cases listed in WAC 388-02-0125(4). WAC 388-02-0600(1). The list of cases subject to review includes cases involving "Adult family home licenses under chapter 388-76 WAC." WAC 388-02-0215(4)(a). Therefore, jurisdiction exists to review the Initial Decision and issue the final agency order.

2. **Scope of Review-** In adult family home licensing matters, the undersigned's authority is the same as the ALJ's with the exception that the undersigned is required to consider the ALJ's ability to observe the witnesses. WAC 388-02-0600(1)(a).

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3. **Findings of Fact-** Although the Initial Decision contained a detailed recitation of the history of this case, the Initial Decision did not identify specific Findings of Fact.

WAC 388-02-0520(3) states that all Initial Decisions must include Findings of Fact. Therefore, the undersigned has entered eight Findings of Fact based on the information in the Initial Decision's procedural history. The facts contained therein were not contested by either party.

4. **Denial and Revocation-** WAC 388-76-560(9) states that the Department shall deny or revoke a license if an applicant or provider has "a history of significant noncompliance with federal or state regulations in providing care or services to vulnerable adults or children." WAC 388-76-560(9) further states that the revocation or suspension of a license for the care of children or vulnerable adults is sufficient to satisfy the definition of "a history of significant noncompliance." This rule is clear, unambiguous, and absolute. If a provider has previously had a license revoked or suspended, then the Department is not permitted to issue a license to that provider.

5. Based on WAC 388-76-560(9)(a), the sole question in this matter is whether the Appellants have previously had a license to care for vulnerable adults revoked. If the Appellants have previously had a license revoked, then they are not entitled to another license. That is the end of the analysis. The circumstances of the previous revocation do not matter to the outcome of the case. The only relevant fact is the revocation itself.

6. In this case, the Appellants have had two adult family home licenses revoked. The dates of the previous revocations do not matter. The procedural histories of the previous revocations do not matter. The factual bases for the previous revocations do not matter. The sole relevant piece of information is the fact that the Appellants have had previous adult family home licenses revoked.

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7. Because the Appellants have had two previous adult family home licenses revoked, the Department was required to deny the Appellants' two new applications and to

revoke the Appellants' existing license. WAC 388-76-560(9)(a) does not leave the Department any discretion. Therefore, the Department's actions are upheld.

8. The use of summary judgment was appropriate in this case because there was no genuine issue as to any material fact. Although the Appellant states in his Petition for Review that he wants to "do a [thorough] presentation of the facts," there is only one material fact in this case. There is no reason to address any of the circumstances underlying the revocation actions because the Department's decision in this case was based on the revocation actions themselves. Nothing the Appellants could say in oral argument or testimony could change the fact that the Appellants have had two adult family home licenses revoked.

9. The Appellants' two applications for adult family home licenses shall be denied and the Appellants' existing adult family home license shall be revoked because the Appellants have a history of significant noncompliance with federal or state regulations in providing care or services to vulnerable adults or children.

The procedures and time limits for seeking reconsideration or judicial review of this decision are in the attached statement.

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IV. DECISION AND ORDER

1. The Appellants' application for an adult family home license for 1578 Crestview Drive shall be denied pursuant to WAC 388-76-560(9).
2. Mr. Muresan's application for an adult family home license for 1473 South Crestview Drive shall be denied pursuant to WAC 388-76-560(9).
3. The Appellants' adult family home license for 1473 South Crestview Drive shall be revoked pursuant to WAC 388-76-560(9).

Mailed on February 11, 2005.


S. ANDREW GRACE
Review Judge

Attached: Reconsideration/Judicial Review Information

Copies have been sent to: DMMD Adult Family Home
David and Maria Muresan, Appellant
Scott Majors, AAG, Department's Representative
Joyce Pashley Stockwell, Program Administrator, MS: 45600
Janice Schurman, Program Administrator, MS: S53-4
Gordon W. Griggs, ALJ, Everett OAH

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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
BOARD OF APPEALS
**PETITION FOR RECONSIDERATION OF
REVIEW DECISION**

See information on back.

Print or type detailed answers.

NAME(S) (PLEASE PRINT)	DOCKET NUMBER	CLIENT ID OR "D" NUMBER	
MAILING ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE AREA CODE AND NUMBER			

Please explain why you want a reconsideration of the Review Decision. Try to be specific. For example, explain:

- Why you think that the decision is wrong (why you disagree with it).
- How the decision should be changed.
- The importance of certain facts which the Review Judge should consider.

I want the Review Judge to reconsider the Review Decision because...

PRINT YOUR NAME SIGNATURE DATE

<u>MAILING ADDRESS</u> BOARD OF APPEALS PO BOX 45803 OLYMPIA WA 98504-5803	<u>PERSONAL SERVICE LOCATION</u> Board of Appeals, DSHS Blake Office East Bldg 2nd Floor, W 4500 10th Ave SE, Lacey Washington
<u>FAX</u> 1-(360) 664-6187	<u>TELEPHONE (for more information)</u> 1-(360) 664-6100 or 1-877-351-0002

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RECONSIDERATION REQUEST

Page _____ of _____

If You Disagree with the Judge's Review Decision or Order and Want it Changed,
You Have the Right to:

- (1) Ask the Review Judge to reconsider (rethink) the decision or order (**10 day deadline**);
- (2) File a Petition for Judicial Review (start a Superior Court case) and ask the Superior Court Judge to review the decision (**30 day deadline**).

DEADLINE for Reconsideration Request - 10 DAYS: The Board of Appeals must **RECEIVE** your request within ten (10) calendar days from the date stamped on the enclosed Review Decision or Order. The deadline is 5:00 p.m. If you do not meet this deadline, you will lose your right to request a reconsideration.

If you need more time: A Review Judge can extend (postpone, delay) the deadline, but you must ask within the same ten (10) day time limit.

HOW to Request: Use the enclosed form or make your own. Add more paper if necessary. You must send or deliver your request for reconsideration or for more time to the Board of Appeals on or before the 10-day deadline (see addresses on enclosed form).

COPIES to Other Parties: You must send or deliver copies of your request and attachments to every other party in this matter. For example, a client must send a copy to the DSHS office that opposed him or her in the hearing.

Translations and Visual Challenges: If you do not read and write English, you may submit and receive papers in your own language. If you are visually challenged, you have the right to submit and receive papers in an alternate format such as Braille or large print. Let the Board of Appeals know your needs. Call 1-(360)-664-6100 or TTY 1-(360) 664-6178.

DEADLINE for Superior Court Cases - 30 DAYS: The Superior Court, the Board of Appeals, and the state Attorney General's Office must all **RECEIVE** copies of your Petition for Judicial Review within thirty (30) days from the date stamped on the enclosed Review Decision or Order. There are rules for filing and service that you must follow.

EXCEPTION: IF (and only if) you file a timely reconsideration request (see above), you will have thirty days from the date of the Reconsideration Decision.

Refer to the Revised Code of Washington (RCW), including chapter 34.05, the Washington Administrative Code (WAC), and to the Washington Rules of Court (civil) for guidance. These materials are available in all law libraries and in most community libraries.

If You Need Help: Ask friends or relatives for a reference to an attorney, or contact your county's bar association or referral services (usually listed at the end of the "attorney" section in the telephone book advertising section). Columbia Legal Services, Northwest Justice Project, the Northwest Women's Law Center, some law schools, and other non-profit legal organizations may be able to provide assistance. You are not guaranteed an attorney free of charge.

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STATE OF WASHINGTON, DEPARTMENT OF SOCIAL AND HEALTH SERVICES

BOARD OF APPEALS

In Re:)	Docket No. 02-2004-L-0175
)	
DMMD ADULT FAMILY HOME)	REVIEW DECISION AND FINAL ORDER
DAVID/MARIA MURESAN)	
18204 30 TH AVENUE NE)	
SEATTLE, WA 98155)	
)	
Appellants)	Adult Protective Services

MAILED
NOV 24 2004

DSHS
BOARD OF APPEALS

I. NATURE OF ACTION

1. The Department concluded that the Appellants neglected a vulnerable adult. The Appellants requested a hearing to contest the Department's neglect finding. Administrative Law Judge Susan K. Serko held a hearing on June 7-9, 2004, in response to the Appellants' request. The Administrative Law Judge (ALJ) issued the Initial Decision on August 16, 2004, upholding the Department's finding and concluding that the Appellants neglected a vulnerable adult.

2. The Appellants filed a Petition for Review of the Initial Decision on August 20, 2004. The Petition for Review stated:

I ask review of this Initial Decision based on the following facts.

This Initial Decision was not based on the facts in the record, but on the Collateral Estoppel, related with the license revocation for the license on the address 18210, issued as Initial Decision, on December 31- 2003, by the Judge Barbara Boivin.

The requirement #4 for an adjudication to be applied Collateral Estoppel, says 4. *The application of the doctrine does not work an injustice.* The Judge Susan K. Serko wrote on Initial Decision page 10 Quote "Therefore, each had an opportunity to defend his/herself and the *collateral estoppel* does not work an injustice because the parties had a full opportunity to litigate these factual issues. Thus *collateral estoppel* is applicable." Unquote.

When judge Susan K. Serko wrote initial decision the above statement, she did not know the following facts which proves that *collateral estoppel* does not apply in this case.

1. The judge Barbara Boivin did not allow me to question the Licensor and Field Manager. She said that the quotes from citation are inflammatory. This is against my

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DSHS/AASA
Home & Community Programs

constitutional right to examine witnesses. Please see the transcripts from that hearing or ask me to provide you with a selection from the tape, to prove my statement.

2. I did not continue with appeals **because DSHS ask me not to continue** or my daughter will not be able to apply for her own license for the same house. A annex the DSHS letter requesting that, and my letter to DSHS accepting their request, accepted by DSHS on Jan-09-04.

3. The Department filed a Response to the Appellants' Petition for Review on August 31, 2004. The Response stated:

COMES NOW, the Department of Social and Health Services, Region 4 Home and Community Services (hereinafter Department), by and through their attorney, Ree Ah Bloedow, to respond, pursuant to WAC 388-02-0590, to the Appellants' Petition for Review submitted on August 20, 2004. The Department respectfully requests that the Review Judge affirm Administrative Law Judge (ALJ) Susan K. Serko's Initial Decision of August 17, 2004 that DSHS has proven by a preponderance of the evidence that David and Maria Muresan, doing business as DMMD, neglected a vulnerable adult and that the findings of fact issued by Administrative Law Judge Barbara Boivin on December 31, 2003 preclude litigation of those issues in this matter.

I. BACKGROUND

Administrative Law Judge (ALJ) Susan K. Serko issued an Initial Decision (Decision) on August 17, 2004 holding (1) DSHS has proven by a preponderance of the evidence that Appellants neglected LM in the manner alleged and therefore DSHS' determination that David and Maria Muresan neglected a vulnerable adult should be affirmed and (2) the findings of fact issued by ALJ Barbara Boivin on December 31, 2003 preclude litigation of those issues in this pending matter. Appellants filed a Petition for Review on August 31, 2003, asserting, without citing any specific finding of fact or conclusion of law: "The collateral estoppel is not applicable." Appellants further state: "This Initial Decision was not based on the facts in the record but on the Collateral Estoppel related with the license revocation with the license on the address 18210, issued as Initial Decision, on December 31, 2003 by the judge Barbara Boivin." The "Initial Decision" in question is Initial Decision, Docket Nos. 06-2003-L-1154 and 06-2003-L-0967 issued by ALJ Barbara Boivin of December 31, 2003 ("December 2003 Decision"). The December 2003 Decision was related to Appellants license as an Adult Family Home provider where Appellant contested the notice of imposition of a civil fine, summary suspension, license revocation, and stop placement order issued by DSHS. See attached Initial Decision of December 31, 2003, Docket Nos. 06-2003-L-1154 and 06-2003-L-0967.

II. STATEMENT OF THE ISSUE

Whether the ALJ erred as a matter of law finding res judicata or collateral estoppel precludes Appellant from litigating the findings of fact issued by ALJ

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Barbara Boivin on December 31, 2003 as they relate to Appellants present appeal.

III. LEGAL AUTHORITY

A. JURISDICTION

The Board of Appeals has jurisdiction to hear this matter pursuant to the Revised Code of Washington (hereinafter RCW) 34.12.040 and 74.08.080 and Chapter 388-02 of the Washington Administrative Code.

B. STANDARD OF REVIEW

The review judge considers the request, the hearing decision, and record, before deciding if the decision may be changed.¹ The review judge, in most cases, only considers evidence given at the original hearing.² A review judge may only change the hearing decision if (a) There are irregularities, including misconduct of a party or misconduct of the ALJ or abuse of discretion by the ALJ, that affected the fairness of the hearing; (b) The findings of fact are not supported by substantial evidence based on the entire record; (c) The decision includes errors of law; (d) The decision needs to be clarified before the parties can implement it; or (e) Findings of fact must be added because the ALJ failed to make an essential factual finding. The additional findings must be supported by substantial evidence in view of the entire record and must be consistent with the ALJ's findings that are supported by substantial evidence based on the entire record.³

C. BURDEN OF PROOF

WAC 388-02-0480 provides, "The party who has the burden of proof is the party who has the responsibility to provide evidence to persuade the ALJ [Review Judge] that a position is correct." Appellant, as the petitioner, therefore bears the burden of establishing that the ALJ erred in finding collateral estoppel applicable to this matter.

IV. LEGAL ARGUMENT

A. THE ALJ CORRECTLY DETERMINED THAT RES JUDICATA OR COLLATERAL ESTOPPEL PRECLUDES APPELLANTS FROM LITIGATING FINDINGS OF FACT ISSUED BY ALJ BARBARA BOIVIN ON DECEMBER 31, 2003

According to WAC 388-02-0575, "A party must make the review request in writing and clearly identify the: (1) parts of the initial order with which the party disagrees; and (2) evidence supporting the party's position." (Emphasis added). The only part of the initial order Appellant clearly identifies as disagreeing with is "page 10 Quote. "Therefore, each had an opportunity to defend his/herself and

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¹ See WAC 388-02-0560.

² See WAC 388-02-0565.

³ See WAC 388-02-0600.

the *collateral estoppel* does not work an injustice because the parties had a full opportunity to litigate these factual issues. Thus *collateral estoppel* is applicable."⁴ Appellants' petition points to the fourth prong of collateral estoppel, "The application of the doctrine does not work an injustice," as unmet arguing:

"1. The judge Barbara Boivin did not allow me to question the Licensor and Field Manager. She said that the quotes from citation are inflammatory. This is against my constitutional right to examine witnesses. Please see the transcripts from that hearing or as me to provide you with a selection from the tape, to prove my statement.

2. I did not continue with appeals **because DSHS ask me not to continue** or my daughter will not be able to apply for her own license for the same house. A annex the DSHS letter requesting that, and my letter to DSHS accepting their request, accepted by DSHS on Jan-09-04."⁵

In determining whether application of the doctrine of collateral estoppel would work an injustice, the court in *Nielson v. Spanaway General Medical Clinic Et. Al.*, 135 Wn.2d 255, 956 P.2d 312 (1998), focused on "whether the parties to the earlier adjudication were afforded a full and fair opportunity to litigate their claim in a neutral forum." Here, Appellants exercised their right to request an administrative hearing to contest the revocation of their Adult Family Home license. A three-day hearing was held from November 3, 2003 through November 5, 2003 before ALJ Barbara Boivin. David Muresan represented himself and co-Appellant, Maria Muresan, of DMMD Adult Family Home Care. Both DSHS and Appellant submitted numerous exhibits, notably, Appellants' Exhibits A-E, F 1-4, 11-14, 16-39, H 14 through 28, and I were admitted into the record.⁶ Appellants also submitted notes from which Mr. Muresan testified as their closing argument as well as Mr. Muresan's opening statement in writing as part of Exhibit H (pp. 29-30).⁷ Appellants David and Maria Muresan testified on their own behalf. Appellants had the opportunity to cross-examine DSHS' six witnesses and to conduct direct examination of DSHS' three main witnesses despite having failed to list them as witnesses.⁸ The December 2003 Decision further explains that Appellants were not allowed to call the other DSHS witnesses as his own because "he had failed to provide any notice, the state objected and established potential prejudice, and Mr. Muresan failed to establish that he had any questions for the witnesses which would not be objectionable."⁹ With regard to Appellants limitation of questions, ALJ Boivin noted, "Mr. Muresan wished to ask more questions than he was allowed to ask of Ms. Dasher, Ms. Wells and Ms. Mikunas as most of his questions were objectionable on numerous grounds. Most were irrelevant, argumentative, assumed facts not in evidence, repetitive, called for speculation, were unclear, and, in general, better

⁴ Petition for Review

⁵ Petition for Review

⁶ Initial Decision of December 31, 2003 at 2.

⁷ Id.

⁸ Id. at 1.

⁹ Id. at 2.

characterized as statements rather than questions."¹⁰ Mr. Muresan further declined to submit any offer of proof for questions he was not allowed to ask DSHS witnesses.¹¹ As reflected in the December 2003 Decision, Appellants were afforded a full and fair opportunity to litigate their claim in a neutral forum. Moreover, if Appellants had any issue related to the December 2003 Decision Appellants should have exercised their right to appeal that decision by filing a timely request for further administrative or judicial review. As indicated in Finding of Fact 26, the December 2003 Decision became a final order pursuant to an Order Denying Request for Review based on a later request.¹² Appellant David Muresan testified at the hearing that he did not seek any further judicial or administrative review of the December 2003 Decision.¹³ Furthermore, Appellants did not state the basis of their decision not to seek further review or raise any issue as to the reason they chose not to seek further administrative or judicial review. With regard to the Appellants' second argument, there is no merit to Appellants' accusation that "DSHS asked me not to continue" [with an appeal to the December 2003 Decision] nor is it the subject of this appeal. As previously noted, Appellants appeal was denied as untimely and he testified that he did not seek any administrative or judicial review.

Appellants' Petition must fail because there is no legal support, nor does Appellant offer any, to show that collateral estoppel is applicable to this matter. Appellants' arguments are completely irrelevant to the issue of whether the application of collateral estoppel works an injustice to the Appellant or even if collateral estoppel was correctly applied in this matter. If anything, Appellants arguments appear to seek review of the December 2003 Decision under this review. There is no authority to do so.

V. CONCLUSION

Based on the foregoing reasons, the Review Judge should affirm the ALJ's decision that the findings of fact issued by ALJ Barbara Boivin on December 31, 2003 preclude litigation of those issues in this matter and that DSHS has proven by a preponderance of the evidence that Appellants neglected LM in the manner alleged and therefore DSHS' determination that David and Maria Muresan neglected a vulnerable adult.

4. The Appellants filed a Response to Issues Based on the Transcript document on October 4, 2004. The Response to Issues Based on the Transcript stated:

Based on the Initial Decision "Finding of Facts" this case contains the following allegations designed to make the case as neglect:

Issues

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¹⁰ Id.

¹¹ Id.

¹² Initial Decision of August 17, 2004 at 8.

¹³ Testimony of David Muresan.

1. Finding of Facts 7. LM Bruises Quote "LM received bruises when appellants transfer her between the 18210 home and the 18210 home." Unquote.
2. Finding of Facts 15. Medication Side Effects. Quote "Dr. Schenne issued a letter to David Muresan in response to appellants request to stop all medications." Unquote.
3. Finding of Facts 16. Layers of Clothing. Quote "On May 29, 03 Joanne Wells observed LM at one of appellants AFHs bundled in several layers of clothing." Unquote.
4. Finding of Facts 17. LM condition on the day of investigation. Quote "LM has left heel pressure ulcer,... left swollen ankle, and yeast infection" Unquote.
5. Finding of Facts 18. LM communication capability. Quote "LM was unable to answer Ms. Bizilia's question to whether LM felt to hot or not during Ms. Bizilia's examination of her May 30, 2003. LM acknowledged to Ms. Bizila that the area of redness on her thighs were painful and itchy." Unquote
6. Finding of Facts 20. Appellants requirements to report to doctor. Quote "Appellants were responsible to report to the doctor any changes in the residents situation." Unquote.
7. Finding of Facts 24. LM Yeast infection. Quote "Appellants were advised by the APS on May 30,2003 that is their responsibility to seek medical care for LM's yeast infection. " Unquote.
8. Finding of Facts 29. Roth's substantiation as neglect for provider. Quote "On June 17,2003. Ms. Ruth substantiated finding of neglect against the Appellants." Unquote.
9. Finding of Facts 30. heel broken open. Quote "On July 10, 2003, Robert McDonald, LM spouse brought LM to Stevens Hospital on the advice of LM's physician to receive treatment for her hell pressure ulcer which had now broken open." Unquote.
10. Finding of Facts 34. Three Licenses Revocation

Issues Analysis

1. Finding of Facts 7. LM bruises
 Quote "LM received bruises when appellants transfer her between the 18210 home and the 18210 home." Unquote. The above statement is licensior's Joanne Wells speculations. Our knowledge is that LM's bruises could happened when her husband, took her in the car, twice per week.

In the Dep. Ex. D-20, page 7, said: Quote "Call received from Bruce. He is unaware of any bruises but knows she has a shin from his father putting her into the car. Bruce state that since there are no guaranties that any AFHs are any

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good he is going to keep his mother at the Muresans for the time being. Bruce questions whether DSHS is being overzealous in this case." Unquote.

In this quote Bruce confirm our opinion about LM's bruises. Bruce was right that no other AFH is as good as ours, because we took care for LM 14 Months, and when she left our house she was OK.

LM died after 49 days in the another AFH, chosen for her by DSHS. Bruce also has a feeling that DSHS was interested in, making a case against us, to support their decision to revoke my second license. We heard the licenser Joanne Wells calling APS and saying: "Please do an investigation and come up with something."

In support of the above statement is the fact that the "official complaint" on which was based this investigation was made 4 days after the investigation, on 07-03-2003, as the Dep. Ex. D-24, page 1 says, Assignment date 07-03-2003, and the incident describe in Dep. Ex. D-24, page 2. is the description of the investigation instead of being the description of the incident alleged to be.

The incident called by the reporter Joanne Wells is presented in Finding of Facts 16. DSHS did not produce for hearings any complaint before the date of the investigation, as RCW 74-39A.060(5)(a) require.

2. Finding of Facts 15. Medication side effects. Quote "Dr. Schenne issued a letter to David Muresan in response to appellants request to stop all medications,' Unquote.

This statement is not accurate because I did ask to be discontinued only the medications with negative side effects, and not all medications. Dep. Ex. D-27, says: Quote "Please work with the doctor to remove any medication with negative side effects..." Unquote.

That was my duty to inform the doctor about the resident behavior after the medication administration. Although DSHS tried to say that I did force the doctor or family to remove the medications, was just a recommendation, because the admission contract allows me to ask the family to move the resident with 30 days notice, or I have to increase the cost of care due to medication's side effects. The doctor Schenne did not accept my recommendation.

After 38 days in the new AFH, LM's health declined considerable, as in Appellant Ex. B-3, the doctor Alina Urriola, wrote on 12-18-03. about LM, Quote "She has lost a lot of weight. She is less responsive, weaker, and unable to sustain her weight. She has been compliant with meds. D/c (discontinue) Laxis, Monpril and KCL." Unquote.

So, this doctor did discontinue 3 meds and when I did ask to discontinue them I was accused of neglect. I think that this is something personal and has nothing to do with the care for LM.

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In only 38 days we have a different LM. When she left our home she has normal weight, as the Appellant Ex. B-11, and B-12 show. The picture was taken on 9-3-2003 as the visiting nurse in Appellant Ex. B-10, says, Quote " Picture taken of wound by David, also myself and Lenore." Unquote.

LM died in the very next day, on 12-19-2003. after 49 days in the new AFH. I did ask the DSHS workers if they did verify if LM receives good care in the other AFH and the answer was no.

On Hearing report page 256 line 4, I did ask Barbara Bizilia, Quote "Did you investigate her care and death in that AFH?" Unquote. On line 6 is Barbara Bizilia's answers, Quote "I did not." Unquote.

3. Finding of Facts 16. Layers of Clothing.

Quote "On May 29, 03 Joanne Wells observed LM at one of appellants AFH's bundled in several layers of clothing." Unquote. Quote " On 5-29- 03, Joanne Wells observed LM at one of appellants AFHs bundled in several layers of clothing... leaning over one side of the chair" Unquote.

The cloths idea is used intensively by DSHS. LM had in that day two silk like blouses a cotton T-shirt and a fleece sweater. Licensor Joanne Wells found LM leaning over one side of the chair. This is a proof that LM did not have enough cloths on.

Based on our observations, when a resident is leaning on one side, is because some nerves responsible for her posture are affected by the environment temperature. Proper clothes and especially a scarf may solve the problem.

This problem has another side. In school we learn to dress older people very well. On Appellant Ex. A-5, under the title "Physical Health", says, Quote "Poor circulation can contribute to an older person's need for worm clothing and warmer room temperature Check that the thermostat is set properly. Encourage layers of clothing to provide the best insulation" Unquote.

On Hearing report page 255 line 8, I did ask Barbara Bizilia, Quote " Did they dress worm LM?" Unquote. On line 16, is Barbara Bizilia's answer, Quote "I don't know...I'm assuming not more than one or two." Unquote.

If, in that period, between first of November, when she was moved from our home, and 19 of December, when she died in the other AFH, LM was dressed in one or two layers of clothing, then here could be found the cause of her death.

If the resident do not have worm cloths on, and a worm hat on the head, then the brain is less and less responsive and will not cooperate even to open the mouth for foods. The legs will become numb and will not be able to stand. One week after LM left our house we saw her, and I was surprise that she lost a lot of weight. That was visible on her face.

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4. Finding of Facts 17. LM condition on the day of investigation; Quote "LM had left heel pressure ulcer,... left swollen ankle, and yeast infection." Unquote.

This statement is inaccurate because left swollen ankle was never present in the hearings. Finding of Facts 25 is the Dr. Schenne medical examination and was found: heel ulcer, diaper rash and yeast infection.

Diaper rash is always present to incontinent people. Barbara Bizilia ask for a flash light to find this diaper rash. The skin was not open and was not painful. We never had LM expressing any discomfort.

Yeast infection is not something visible. To detect yeast infection you have to be medical professional and not caregiver. I did ask the Dr. Schenne a few questions about yeast infection.

Dep. Ex. D-29, page 2, Dr. Schenne wrote: Quote "Yeast dermatitis. If she is incontinent. I do not think they are changing her frequently enough," Unquote.

On Hearing report page 148 line 12, I asked Dr. Schenne, Quote " How frequent a resident has to be changed to prevent yeast infection? Unquote. On line 18 is the Dr. Schenne answer, Quote " I cannot be specific." Unquote. On Hearing report page 149 line 1, I asked Dr. Schenne, Quote "Is it possible a resident who is not incontinent to get yeast infection? Unquote. On line 3 is Dr. Schenne answer, Quote "Anyone can get a yeast infection" Unquote.

If Dr. Schenne, as medical professional, does not know how often has to be changed an incontinent resident to prevent yeast infection, how can we know, as caregiver? What we know is every two hours, but that is not sure will prevent yeast infection, if even a non incontinent resident can develop yeast infection. Why? I think that Dr. Schenne was coerced by LM's husband to say what she said.

Heel pressure ulcer, We considered it a pressure sores in a normal process of healing. We did show it to family about two weeks before the investigation, and they did not consider to do anything. We did not call the doctor because was not an emergency and was not a significant change in her condition, the only situations when we have to bypass the family. In Finding of Facts 25 Dr. Schenne wrote. Quote "Her pressure ulcer, "that does not appear to be new" Unquote.

Three days after investigation Dr. Schenne noticed in her report on the Dep. Ex. D-29, page 2, Quote "will set up healthcare to evaluate and treat this ulcer." Unquote. Those note are not available to us and Dr. Schenne did not send or call us to instruct what to do.

On Hearing report page 147 line 4, I asked Dr. Schenne, Quote "Was that condition evaluated?" Unquote. On line 5 is the Dr. Schenne answer, Quote "As far as I know, yes, she did have a wound care come and evaluate her." Unquote.

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Nobody came to evaluate her between Dr. Schenne saw her and 7 -10-2003, when her wound was seen by doctors at the Steven Hospital. DSHS did not produce any documents that someone evaluated her ulcer in this period or

instructed us to do something. Dr. Schenne never called us. In Hearing report page 149 line 8, I asked Dr. Schenne, Quote "Have you ever had a conversation with me or other caregiver..." Unquote. On line 10 is the Dr. Schenne answer, Quote "No, I have not." Unquote. Then on line 11 I asked Dr. Schenne, Quote "Have you ever seen our facility? Again on line 12 Dr. Schenne answer, Quote "I have not seen your facility. Unquote.

Also the Finding of Facts 27 said, Quote MM did not receive any services from a home health visiting nurse between 6-3-2003 and 7-30th" Unquote. The above statement is a charge for us only if, we have been, instructed, by the doctor what to do, and we did nothing.

Dr. Schenne did talk with the family only, as Finding of Facts 30 said, Quote "On 7-10-2003 Robert McDonald, LM's spouse brought LM to Steven Hospital on the advice of LM's physician to receive treatment for her heel ulcer." Unquote.

5. Finding of Facts 18. LM communication capability. Quote "LM was unable to answer Ms. Bizilia's question to whether LM felt too hot or not during Ms. Bizilia's examination of her May 30, 2003. LM acknowledged to Ms. Bizilia that the area of redness on her thighs was painful and itchy." Unquote.

So, if LM was unable to answer Ms. Bizilia's question to whether LM felt too hot or not how could she process an information more complicated like, Is your area of redness on your thighs painful or itching? LM never expressed any discomfort.

6. Finding of Facts 20. Appellants requirement to report to a doctor. Quote "Appellant was responsible to report to the doctor any changes in the residents situation." Unquote.

This is not what the law says. We are responsible to report to doctor only emergency or significant changes. I did question DSHS witnesses about this subject. On Hearing report page 240 line 16, I asked Barbara Bizilia, Quote "Was that wound an emergency?" Unquote. On line 23 is Barbara Bizilia's answer, Quote "It wasn't an emergency" Unquote. and on line 18 Barbara Bizilia said, Quote "It was a significant change." Unquote. On Hearing report page 302 line 3, I asked Denise Roth, Quote "Why do you think we had to call a doctor for that heel wound?" Unquote. On line 8 is Denise Roth answer, Quote "I think it's a serious emergency situation." Unquote and on page 297 line 25 Denise Roth said, Quote "She was in the last stage of Alzheimer's, she was terminally ill" Unquote.

Bizilia said is significant change and Roth said is emergency. If we admit that the ulcer was significant change then after 6-3-2003, when Dr Schenne saw the resident we do not have anymore the responsibility to call the doctor. The condition of the wound did not change in this period, but on Hearing report page 242 line 17, Barbara Bizilia said, Quote "If something had been assessed to be a black eschar and you took her to the physician and the physician did nothing about it, then if it were me I'd take her to another physician." Unquote.

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Barbara Bizilia is a healthcare professional and we are not. No code support such a requirement, to take the resident to a second doctor, because no doctor will do nothing if something has to be done.

On Hearing report page 241 line 3, I asked Barbara Bizilia, Quote "Do you know if that change was positive or negative?" Unquote.

On line 5 is Barbara Bizilia's answer, Quote "I couldn't make the speculation because I hadn't seen it before." Unquote. On line 11, Barbara Bizilia said, Quote "What I was stating is .. a change from intact healthy skin." Unquote.

That is not what the code refer to significant change. Must by between two doctor visits. Otherwise we have to call the doctor every day until the heel ulcer is healed, because every day is a significant change with respect of intact skin.

If the LM condition was an emergency situation in the day of investigation, then the heel must be emergency also three days later, on 6-2-2003 when Dr. Schenne saw the heel. But Dr. Schenne did not considered as emergency, because did not hospitalize her, or to order a service for her right away.

7. Finding of Facts 24. LM yeast infection. Quote "Appellants were advised by the APS on May 30, 2003 that is their responsibility to seek medical care for LM's yeast infection." Unquote.

When Barbara Bizilia diagnosed the LM's yeast infection, in the same day LM's family contact the Dr. Schenne.

Hearing report page 146 line 16, 1 asked Dr. Schenne, Quote "You examined the client also on 5-30-2003?" Unquote. On line 17, Dr. Schenne said, Quote "I just talked with them. I did not examine her." Unquote. LM got some medication for her yeast infection.

8. Finding of Facts 29 Roth's substantiation as neglect for provider. Quote "On June,17,2003, Ms. Ruth substantiated finding of neglect against appellants." Unquote.

We have here two legal issues. One is the LM's son right to refuse any treatment and two, our responsibility to bypass the LM's son in emergency or significant changes.

Based on the previous discussions was not emergency, based on the Dr. Schenne inaction, and was not a significant change based an the fact that that wound was old, and Barbara Bizilia's definition of significant change is incorrect.

On Hearing report page 298 line 21, I asked Denise Roth, Quote "Can you as DSHS worker to force a resident's son to accept treatment or services?" Unquote. On 23 is Denise answer, Quote "Absolutely not." Unquote.

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But DSHS workers did create pressure on the son to move her from our AM, as Hearing report page 299 line 7 said, Quote "Judy feels LM should definitely be

moved and is requesting that we look for guardianship since the son would not move her." Unquote. On line 10 is my question to Denise Roth, Quote "Who is Judy?" Unquote. On line 11 is Denise Roth answer, Quote "I can't address it" Unquote.

On Hearing report page 231 line 13, I asked Barbara Bizilia, Quote "Isn't Judy, Judy Mickunas, the investigator." Unquote.

Barbara Bizilia on line 14, said Quote "Quite frankly I don't remember who Judy is." Unquote. On line 1,5 I asked Barbara Bizilia, Quote " Is there not a Judy in your service? Unquote. On line 16 is Barbara Bizilia answer "I don't know." Unquote.

Hearing report page 165 line 15, said, Quote "I recommended that she be moved to another adult family home." Unquote. On line 17, I asked Judith Mickunas, Quote " Do you agree with the above statement that she has to be moved from our home." Unquote. On page 166 line 2 Judith Mickunas answered. Quote "I don't agree or disagree." Unquote.

On Hearing report page 303 line 14, I asked the investigator Denise Roth, Quote "Without Barbara Bizilia would you substantiate LM's condition as neglect." Unquote. Her answer is in line 18, Quote "No..." Unquote.

9. Finding of Facts 30. heel broken open Quote "On July 10, 2003 Robert McDonald, LM spouse brought LM to Stevens Hospital on the advice of LM's physician to receive treatment for her heel pressure ulcer which had now broken open." Unquote.

I do not know who introduced the notion of broken heel but nobody have any knowledge about it. The hospital report in the day of surgery, 7-10-2003, wrote. Hearing report page 220 line 23, Quote "There is a chronic left foot ulcer that is not clearly infected." Unquote. On page 221, line 2, I asked Barbara Bizilia, Quote "Is the above the description of a broken heel?" Unquote. On line 9 is Barbara Bizilia's answer, Quote " It doesn't document here that it's broken open." Unquote.

If, the heel was broken open before the surgery, that means that the heel was healed or was better in the moment of surgery and maybe the surgery was not necessary. If the heel was broken open after the surgery, then any charges on us are incorrect, because the doctor open the heel during surgery.

10. Finding of Facts 34. Three Licenses Revocation

We had so far three licenses revoked and accused of neglect.

I mention that in 7 years, we had those licenses, we did not have a single complaint made or supported by residents or their families. All the complaints are made by DSHS workers. Even the enforcement officer Janice Shurman did a complaint, although she never saw that house, and did not have any call about an incident.

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The cause of this DSHS actions against us are related with our high professionalism in long term care.

You may find my opinion about care in my "Closing Arguments" on Hearing report Page 326 to 34

5. The Department filed a Reply to Appellants' Response to Issues Based on Transcript document on October 11, 2004. The Reply to Appellants' Response to Issues Based on Transcript stated:

COMES NOW, the Department of Social and Health Services, Region 4 Home and Community Services (hereinafter Department), by and through their attorney, Ree Ah Bloedow, to respond, pursuant to WAC 388-02-0590, to the Appellants' Response to Issues Based on the Transcript submitted on October 4, 2004. On October 8, 2004 the Department received a Notice of Document Received from the Board of Appeals along with a copy of Appellants' Response to Issues Based on the Transcript. The Department provides the following supplemental memorandum to the Department's Petition for Review in response to Appellants' Response to Issues Based on the Transcript. The Department respectfully requests that the Review Judge find that the ALJ did not err in Findings of Fact 7, 15, 16, 17, 18, 20, 24, 29, 30, or 34 and affirm Administrative Law Judge (ALJ) Susan K. Serko's Initial Decision of August 17, 2004 that DSHS has proven by a preponderance of the evidence that David and Maria Muresan, doing business as DMMD, neglected a vulnerable adult.

I. STATEMENT OF THE ISSUE

Whether the ALJ erred in Findings of Fact 7, 15, 16, 20, 24, 29, 30, or 34.

II. LEGAL AUTHORITY

A. JURISDICTION

The Board of Appeals has jurisdiction to hear this matter pursuant to the Revised Code of Washington (hereinafter RCW) 34.12.040 and 74.08.080 and Chapter 388-02 of the Washington Administrative Code.

B. STANDARD OF REVIEW

The review judge considers the request, the hearing decision, and record, before deciding if the decision may be changed.¹ The review judge, in most cases, only considers evidence given at the original hearing.² A review judge may only change the hearing decision if (a) There are irregularities, including misconduct of a party or misconduct of the ALJ or abuse of discretion by the ALJ, that affected the fairness of the hearing; (b) The findings of fact are not supported by

¹ See WAC 388-02-0600.

² See WAC 388-02-0565.

substantial evidence based on the entire record; (c) The decision includes errors of law; (d) The decision needs to be clarified before the parties can implement it; or (e) Findings of fact must be added because the ALJ failed to make an essential factual finding. The additional findings must be supported by substantial evidence in view of the entire record and must be consistent with the ALJ's findings that are supported by substantial evidence based on the entire record.³

C. BURDEN OF PROOF

WAC 388-02-0480 provides, "The party who has the burden of proof is the party who has the responsibility to provide evidence to persuade the ALJ [Review Judge] that a position is correct." Appellant bears the burden of establishing that the ALJ erred in Findings of Fact 7, 15, 16, 17, 18, 20, 24, 29, 30, or 34.

III. LEGAL ARGUMENT

APPELLANT FAILS TO ESTABLISH THAT FINDINGS OF FACT, AS RAISED BY APPELLANT, ARE NOT SUPPORTED BY SUBSTANTIAL EVIDENCE

The Initial Decision must be upheld because Appellant has failed to establish that the Findings of Fact 7, 15, 16, 17, 18, 20, 24, 29, 30, or 34 are not supported by substantial evidence based on the entire record.

Finding of Fact 7. Finding of Fact 7 is supported by substantial evidence as found in Exhibit 20 and David Muresan and Denise Roth's testimony. Appellant David Muresan's own testimony establishes that LM was moved throughout the time in question between the 18210 and 18204 home.⁴ Denise Roth's testimony along with her report, as found in Exhibit 20, further establishes that LM incurred bruising to her leg on at least one occasion when she was moved between the two homes.⁵ LM's bruised leg was also observed by LM's son, Bruce MacDonald, who reported to Ms. Roth that he had seen the bruise to LM's leg, "its' scabbed over and, quote, the Muresans know they have to, improve their operation."⁶ The ALJ did not err in Finding of Fact 7.

Finding of Fact 15. Finding of Fact 15 is supported by substantial evidence as found in Exhibits 27, 28, and B-2 and Dr. Jennifer Schenne and David Muresan's testimony. Appellant argues that he since he only intended to charge additional fees for those medications he deemed had negative side effects, not necessarily all of LM's medications, the ALJ erred in Finding of Fact 15. The record, however, shows that Appellants believed all of LM's medications caused negative side effects and that they intended to discontinue all of them. Appellants' letter states, "Pease work with the doctor to remove any medication with negative side effects for a full month. We will conclude if the resident functioning is better." (Emphasis added.) Appellant then lists all four medications (Monopril, Atenolol, Levoxyl, and Lasix) being prescribed to LM by her

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³ See WAC 388-02-0600.

⁴ Testimony of David Muresan, Vol. I, p. 62.

⁵ Testimony of Denise Roth, Vol. III, pp. 285-286.

⁶ Id.

physician.⁷ This letter was issued to LM's son, Bruce MacDonald, who consulted LM's physician on May 30, 2003. Dr. Schenne's progress note provides that "she also received a letter from the place stating that if they do not consider it possible to remove the medicine they will charge extra for each medicine with negative side effects."⁸ The record is clear that Appellants' not only demanded LM's family and primary physician stop all of her medications but elevated themselves to the status of a medical professional, capable of determining which of LM's medications should be discontinued, despite their admission that they did not have any training or expertise to determine whether a resident's medication should be changed.⁹ Appellants' comments regarding LM's health or medications in the adult family home (AFH) she was transferred to from Appellants' AFH of the quality of care provided by the receiving AFH is purely speculative and irrelevant to Finding of Fact 15. The ALJ did not err in Finding of Fact 15.

Finding of Fact 16. Finding of Fact 16 is supported by substantial evidence as found in Exhibit 18, Exhibit 20, and Joanne Wells' testimony. Joanne Wells' Adult Protective Services report to Ed Crouch, APS intake worker, states, "... I viewed this woman sitting in a large chair and appeared to be dozing. She was leaning awkwardly with one arm dangled over the arm of the chair. She was bundled in several layers of clothing on a very warm day..."¹⁰ (Emphasis added.) Joanne Wells also testified to her personal observation of LM on May 29, 2003, "... The caregiver opened the door and I - I then saw LM, which I recognized as LM, slumped over, like hanging out of the chair with one arm dropping and her head dropping, all bundled up..."¹¹ (Emphasis added.) Appellant misrepresents Barbara Bizilia's testimony with respect to how many layers of clothing LM was wearing on May 29, 2003. The portion of the record Appellant cites in reference to how LM was dressed was not in the AFH LM was transferred to, not Appellants' AFH.¹² Finally, Appellants' belief as to why he dressed LM in multiple layers of clothing is irrelevant to Joanne Wells' observation of how LM was dressed. The ALJ did not err in Finding of Fact 16.

Finding of Fact 17. Finding of Fact 17 is supported by substantial evidence as found in Exhibit 20 and Barbara Bizilia's testimony. Exhibit 20, pp. 4-5 is Barbara Bizilia's report from her home visit and examination of LM. Barbara Bizilia specifically describes LM's left heel pressure ulcer and yeast infection. Barbara Bizilia also testified extensively to her observations of LM on May 30, 2003.¹³ Denise Roth accompanied Barbara Bizilia to Appellants home on May 30, 2003 and describes LM's left ankle as swollen.¹⁴ Finding of Fact 17 is about Adult Protection Services' observations of LM on May 30, 2003 not about Dr. Schenne's examination of LM on June 2, 2003 or as Appellant contests, whether

⁷ Testimony of David Muresan, Vol. I, p. 74; Testimony of Dr. Jennifer Schenne, Vol. I, pp. 134-135; Exhibit 27.

⁸ Exhibit 28.

⁹ Testimony of David Muresan, Vol. I, p. 74.

¹⁰ Exhibit 18.

¹¹ Testimony of Joanne Wells, Vol. I, p. 106.

¹² Testimony of Barbara Bizilia, Vol. II, p. 254.

¹³ Testimony of Barbara Bizilia, Vol. II, pp. 190-198.

¹⁴ Exhibit 20 at 3.

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Appellants were neglectful in caring for LM. Nevertheless, Dr. Schenne testified that the Appellants neglected LM as demonstrated by LM's preventable pressure ulcer and yeast infection.¹⁵ The ALJ did not err in Finding of Fact 17.

Finding of Fact 18. Finding of Fact 18 is supported by substantial evidence in Exhibit 20 and Barbara Bizilia's testimony.¹⁶ Appellant has not offered any evidence to show that LM's responses to Barbara Bizilia's questions were did not occur. Finding of Fact 18 does not state, as Appellant concludes, "LM never express any discomfort." The ALJ did not err in Finding of Fact 18.

Finding of Fact 20. Finding of Fact 20 is supported by substantial evidence as found in Exhibit 14. Finding of Fact 20 is word-for-word Appellants' Admission policy as provided in Exhibit 14: Observation and reporting. DMMD will report to the doctor and family any change in the resident situation. Major changes will be recorded in a report."¹⁷ Although Appellant argues that the law provides "only emergency or significant changes must be reported to the doctor," Appellants' own Adult Family Contract and Admission policy provides otherwise. The ALJ did not err in Finding of Fact 20.

Finding of Fact 24. Finding of Fact 24 is supported by substantial evidence as found in Exhibit 20 and Barbara Bizilia's testimony. Appellant does not provide any contradictory evidence that they were not advised by Adult Protective Services on May 30, 2003 that it was their responsibility to seek medical care for LM's yeast infection and pressure ulcer.¹⁸ The ALJ did not err in Finding of Fact 24.

Finding of Fact 29. Finding of Fact 29 is supported by substantial evidence as found in Exhibits 20 and 22 and Denise Roth's testimony. Denise Roth clearly testified, as provided in her reports, that on June 17, 2003 she made a substantiated finding of neglect against Appellants for the reasons outlined in Finding of Fact 29.¹⁹ Appellants' argument regarding LM's son right to refuse treatment on behalf of his mother or whether LM should be moved from Appellants' AFH is irrelevant to Finding of Fact 29. Moreover, Appellants were notified by both Barbara Bizilia and Denise Roth that they held a duty of care separate from LM's family to ensure LM receive any necessary medical services.²⁰ The ALJ did not err in Finding of Fact 29.

Finding of Fact 30. Finding of Fact 30 is supported by substantial evidence as found in Exhibit 30, Stevens Hospital record of July 10, 2003 for LM's heel pressure ulcer. Exhibit 30, p. 5 provides under History of Present Illness, "This 85-year old female has had this problem with her heel for a number of weeks. She was seen by her family physician without much real change in her symptoms. According to her husband, the patient has Alzheimer's and is not able to verbally communicate. She is able to sit up and move around. She is

¹⁵ Testimony of Jennifer Schenne, Vol. I, pp. 141, 143, 145.

¹⁶ Exhibit 20 at 2-4; Testimony of Barbara Bizilia, Vol. II, pp. 191-192.

¹⁷ Exhibit 14 at 2.

¹⁸ Testimony of Barbara Bizilia, Vol. II, pp. 197-203.

¹⁹ Testimony of Denise Roth, Vol. III, p 286.

²⁰ Testimony of Barbara Bizilia, Vol. II, pp. 258-260; Testimony of Denise Roth, Vol. III, p. 282.

normally bedridden although she can sit up in a chair. She sees Dr. Schenne at Ballinger Clinic." Contrary to Appellants' assertion that there is some question as to whether LM's pressure heel had broken open by July 10, 2003 Stevens Hospital records provides otherwise. Stevens Hospital describes LM's "abnormal finding" as "1½ diameter open wound left heel with yellowish exudate. Left LE (lower extremity) swollen." (Emphasis added).²¹ The ALJ did not err in Finding of Fact 30.

Finding of Fact 34. Finding of Fact 34 does not state that Appellants have had three [adult family home] licenses revoked, nor it is the subject of this matter. Finding of Fact 34 recites findings, strictly limited to factual issues raised in this proceeding, from one of Appellants license revocations hearings. The issue of the applicability of collateral estoppel was previously addressed in the Department's Reply to Appellants Petition for Review. The ALJ did not err in Finding of Fact 34.

IV. CONCLUSION

Based on the foregoing reasons, the Review Judge should find that the ALJ did not err in Finding of Fact 7, 15, 16, 17, 18, 20, 24, 29, 30, or 34 and that DSHS has proven by a preponderance of the evidence that David and Maria Muresan, doing business as DMMD, neglected a vulnerable adult.

6. The Appellants filed a Response to Department's Reply document on October 18, 2004. The Response to Department's Reply stated:

I consider that in a court process everything must, be proved. I did come up with different people's way of thinking and acting: There are three ways of thinking:

1. Rational- Is objective, rational, can be proved or experimented. Nothing is a miracle. Every effect has a cause. It is used in science and must be used in official human relations. The thinker can see both sides equally.
2. Spiritual or Emotional- Is subjective, cannot be proved or experimented. It is designed to satisfy the person to whom the thinker is speaking. Everything could be a miracle. It is used in fine human relations and in religious activity. The thinker pays more attention to the other person's side.
3. Psychiatric or Dictatorial- Is subjective, cannot be proved or experimented. It is designed to satisfy the person who is speaking. The thinker's desire is the law. It is used in bellicose human relations. It is used by people having some chemical imbalance in their brain or having their brain too full of arrogance and power. Only the thinker's side counts.

I will try to prove in this presentation that APS's team, their representative and the hearing Judge did use the dictatorial way of thinking, characterized by not proving anything, just saying it, and being blind to other's side.

Initial Issues' analysis. And to Department Reply

²¹ Exhibit 30 at 4.

1. Finding of Facts 7. LM bruises Quote "LM received bruises when appellants transfer her between the 18210 home and the 18210 home." Unquote.

The above statement is licenser's Joanne Wells speculations. Our knowledge is that LM's bruises could happened when her husband, took her in the car, twice per week.

In the Dep. Ex. D-20, page7, said: Quote "Call received from Bruce. He is unaware of any bruises but knows she has a shin from his father putting her into the car. Bruce state that since there are no guaranties that any AFHs are any good he is going to keep his mother at the Muresans for the time being. Bruce questions whether DSHS is being overzealous in this case." Unquote. In this quote Bruce conform our opinion about LM's bruises.

Bruce was right that no other AFH is as good as ours, because we took care for LM 14 Months, and when she left our house she was OK.

LM died after 49 days in the another AFH, chosen for her by DSHS. Bruce also has a feeling that DSHS was interested in making a case against us, to support their decision to revoke my second license. We heard the licenser Joanne Wells calling APS and saying: "Please do an investigation and come up with something"

In support of the above statement is the fact that the "official complaint" on which was based this investigation was made 4 days after the investigation, on 07-03-2003, as the Dep. Ex. D-24, page 1 says, Assignment date 07-03-2003, and the incident describe in Dep. Ex. D-24, page 2. is the description of the investigation instead of being the description of the incident alleged to be.

The incident called by the reporter Joanne Wells is presented in Finding of Facts 16. DSHS did not produce for hearings any complaint before the date of the investigation, as RCW 74-39A.060(5)(a) require..

Department quotes: On Dep. Reply p3, says Quote, "Denise Ruth testimony establishes that LM incurred bruises to her leg at least one occasion when she was moved between the two homes" Unquote.

Denise Ruth testimony matched the citation made by her or her team. She said that bruises happened in at least one occasion. To know this for sure, as appeared here, she must have seen the incident and to describe it. Denise Ruth never testify that she saw the incident which resulted in LM bruises, or to give a reasonable explanation to the incident.

The transfer between the two homes was made in a wheelchair on a concrete driveway. How could that happen? Ruth did not explain. We also do not know, we can only speculate. What we know was that son knows that LM had a bruise from the husband car transfer.

000223

On Hearing report page 305 line 13, I ask Denise Ruth. Quote, "Do you have rules when and how to do an assessment as neglect?" On line 15, Denise Ruth answered, " We have a policy manual called Chapter 6. On line 16, I ask Denise Ruth. Quote, "Are you required to do pictures?" On line 17, Denise Ruth answered, "Not all the time, no"

If we accept first answer "Not of all the time," that means that sometime they are required to do picture, and for sure this case required to have pictures. If we accept first answer "no." then this is a mistake, because without picture they cannot prove the validity of the allegations.

On Hearing report page 305 line 18, I ask Denise Ruth. Quote "Are you required the family member or someone else who is not a DSHS worker to conform your findings?" On line 10, Denise Ruth answered, "No"

On Hearing report page 306 line 6, I ask Denise Ruth. Quote, "Are you required to see a wound more than once?" On line 7, Denise Ruth answered, "No"

If they do not have to see the progress of the care for resident, then they can assess as neglect everything, even a significant progress in resident condition, as is this case. On Hearing report page 308 line 14, I ask Denise Ruth. Quote, "Did you have any care for her after she was moved?" On line 15, Denise Ruth answered, "No" On line 18, I ask Denise Ruth. Quote, "What happened to her?" On line 114, Denise Ruth answered, "I heard that she expired"

LM was moved from DMMD AFH, due to neglect in Ramos AFH where LM died after 49 days. I mention that LM lived in DMMD AFH 14 Months and when she was moved, her weight was normal as appellant exhibit B-11 shows. The DSHS workers did not care for her, and she died due to their neglect by moving her and not care for her.

The ALJ did err this #7 because she accepted an unreasonable allegation as real fact. No one, other than those who did the allegation, testified. And no recording of any kind was made.

2. Finding of Facts 15. Medication side effects. Quote "Dr. Schenne issued a letter to David Muresan in response to appellants request to stop all medications." Unquote.

This statement is not accurate because I did ask to be discontinued only the medications with negative side effects, and not all medications. Dep. Ex. D-27, says: Quote "Please work with the doctor to remove any medication with negative side effects..." Unquote.

That was my duty to inform the doctor about the resident behavior after the medication administration. Although DSHS tried to say that I did force the doctor or family to remove the medications, was just a recommendation, because the admission contract allows me to ask the family to move the resident with 30 days notice, or I have to increase the cost of care due to medication's side effects. The doctor Schenne did not accept my recommendation.

000224

After 38 days in the new AFH, LM's health declined considerable, as in Appellant Ex. B-3, the doctor Alina Urriola, wrote on 12-18-03. about LM, Quote "She has lost a lot of weight. She is less responsive, weaker and unable to sustain her weight. She has been complaint with meds. D/c (discontinue) Laxis. Monopril and KCL. Unquote.

So, this doctor did discontinue 3 meds and when I did ask to discontinue them I was accused of neglect. I think that this is something personal and has nothing to do with the care for LM.

In only 38 days we have a different LM. When she left our home she has normal weight, as the Appellant Ex. B-11, and B-12 show. The picture was taken on 9-3-2003 as the visiting nurse in Appellant Ex. B-10, says, Quote " Picture taken of wound by David, also myself and Lenore." Unquote.

LM died in the very next day, on 12-19-2003 after 49 days in the new AFH. I did ask the DSHS workers if they did verify if LM receives good care in the other AFH and the answer was no.

On Hearing report page 256 line 4, I did ask Barbara Bizilia, Quote "Did you investigate her care and death in that AFH?" Unquote. On line G is Barbara Bizilia's answers, Quote "I did not." Unquote.

Department quotes: On Dep. Reply p4, says: Quote, "Appellant intended to discontinue all of them" "The record is clear that appellant not only demanded LM's family and primary physician stop all her medication but elevated themselves to the status of medical professional capable of determining which of the LM's medication should be discontinued" Unquote. This inflammatory quote proves that the APS workers are more interested in the provider than they are about the resident LM.

Appellant Ex. D-10, showed all the LM's medications on 8-31-02 when LM was moved in our AFH (DMMD), They are 11 medications. Appellant Ex. D-9, showed the web-MD side effects Information's, and contained 4 medications. This exhibit was not accepted, although the accuracy of it could be easily verified. So I annex it here. The provider did suspect those medications because the description of the side effect matches the LM's behavior.

No facts proves that I elevated myself at the status of Medical professional. But the facts proves that I am a care professional. because: 1. I did notice that LM had a unnatural behavior after she took meds and had a more natural behavior in the morning, when the artificial molecules contained in the meds were absorbed by the body. I also observed that her brain functioning is better in the morning, and was less responsive after a while after meds administration. 2. The doctor Schenne did not pay any attention to my concern about meds' side effects, but the doctor Alina Urriola, one day before LM died, did discontinue 3 of LM's meds, exactly those I considered as having side effects. 3. Dr. Schenne did never speak with me or to see our facility, so she was totally blind to LM's abnormal behavior. 000225

The ALJ did err this #15 because no testimony was made in the hearing to prove that my concern about LM's suffering, or abnormal behavior, after meds' administration is not true. My concern was legitimate and APS's must pay attention to it. This is a resident's right and a APS's duty.

3. Finding of Facts 16. Layers of Clothing. Quote "On May 29, 03, Joanne Wells observed LM at one of appellants AFHs bundled in several layers of clothing." Unquote. Quote "On 29- 43, Joanne Wells observed LM at one of appellants AFHs bundled in several layers of clothing ... leaning over one side of the chair." Unquote. The cloths idea is used intensively by DSHS. LM had in that day two silk like blouses a cotton T-shirt and a fleece sweater.

Licenser Joanne Wells found LM leaning over one side of the chair. This is a proof that LM did not have enough cloths on.

Based on our observations, when a resident is leaning on one side, is because some nerves responsible for her posture are affected by the environment temperature. Proper clothes and especially a scarf may solve the problem.

This problem has another side. In school we learn to dress older people very well. On Appellant Ex. A-S, under the title "Physical Health", says, Quote " Poor circulation can contribute to an older person's need for worth clothing and warmer room temperature... Check that the thermostat is set properly. Encourage layers of clothing to provide the best insulation." Unquote.

On Hearing report page 255 line 8, I did ask Barbara Bizilia, Quote "Did they dress worm LM?" Unquote. On line 16, is Barbara Bizilia's answer, Quote "I don't know. ...I'm assuming not more than one or two." Unquote.

If, in that period, between first of November, when she was moved from our home, and 19 of December, when she died in the other AFH, LM was dressed in one or two layers of clothing, then here could be found the cause of her death.

If the resident do not have worm cloths on, and a worm hat on the head, then the brain is less and less responsive and will not cooperate even to open the mouth for foods. The legs will become numb and will not be able to stand. One week after LM left our house we saw her, and I was surprise that she lost a lot of weight. That was visible on her face.

Department quotes: On Dep. Reply p 5, says: Quote "She (LM) was bundled in several layers of clothing" Unquote,

For residents with dementia, who cannot choose their clothes, the provider has authority to chose the clothes for that resident.

The ALJ did err this #16 because nobody presented in the hearing or in any other materials attached to the file, that provider has not full authority to choose the LM's clothing, or any instructions how many layers to have on: I mention that two layers were silk like blouses.

00022b

I mention that I did have negative interactions with LM's husband about LM's clothing, but never with the son, who has the power of attorney. If you need details about LM's husband mental disability or his aggressiveness, I can provide you a taped conversation with him, in which he threatens to kill me, if I will ever put a scarf around the LM's neck. Unfortunately DSHS licensor did work with the father to crate this case. On Hearing report page 115 line 22, I ask the licensor Joanne Wells, Quote, " Do you find LM's husband. a reasonable person?" Unquote. On page 116 line 1, licensor Joanne Wells answered, Quote, " he's as reasonable as David is" Unquote.

4. Finding of Facts 17. LM condition on the day of investigation. Quote "LM had left heel pressure ulcer,... left swollen ankle, and yeast infection." Unquote.

This statement is inaccurate because left swollen ankle was never present in the hearings. Finding of Facts 25 is the Dr. Schenne medical examination and was found: heel ulcer, diaper rash and yeast infection,

Diaper rash is always present to incontinent people. Barbara Bizilia ask for a flash light to find this diaper rash. The skin was not open and was not painful. We never had LM expressing any discomfort.

Yeast infection is not something visible. To detect yeast infection you have to be medical professional and not caregiver. I did ask the Dr. Schenne a few questions about yeast infection..

Dep. Ex. D-29, page 2. Dr. Schenne wrote: Quote "Yeast dermatitis. If she is incontinent. I do not think they are changing her frequently enough," Unquote.

On Hearing report page 148 line 12, I asked Dr. Schenne, Quote "How frequent a resident has to be changed to prevent yeast infection? Unquote. On line 18 is the Dr. Schenne answer, Quote " I cannot be specific." Unquote. On Hearing report page 149 line 1, I asked Dr. Schenne, Quote "Is it possible a resident who is not incontinent to get yeast infection? Unquote. On line 3 is Dr. Schenne answer, Quote "Anyone can get a yeast infection" Unquote.

If Dr. Schenne, as medical professional, does not know how often has to be changed an incontinent resident to prevent yeast infection, how can we know, as caregiver? What we know is every two hours, but that is not sure will prevent yeast infection, if even a non incontinent resident can develop yeast infection. Why?

Heel pressure ulcer, We considered it a pressure sores in a normal process of healing. We did show it to family about two weeks before the investigation, and they did not consider to do anything. We did not call the doctor because was not an emergency and was not a significant change in her condition, the only situations when we have to bypass the family.

In Finding of Facts 25 Dr. Schenne wrote. Quote "Her pressure ulcer, "that does not appear to be new" Unquote.

000227

Three days after investigation Dr. Schene noticed in her report on the Dep. Ex. D-29, page 2, Quote "will set up healthcare to evaluate and treat this ulcer." Unquote. Those notes are not available to us and Dr. Schenne did not send or call us to instruct what to do.

On Hearing report page 147 line 4, I asked Dr. Schenne, Quote "Was that condition evaluated?" Unquote. On line 5 is the Dr. Schene answer, Quote "As far as I know, yes, she did have a wound care come and evaluate her." Unquote.

Nobody came to evaluate her between Dr. Schene saw her and 7-10-2003, when her wound was seen by doctors at the Steven Hospital. DSHS did not produce any documents that someone evaluated her ulcer in this period or instructed us to do something. Dr. Schenne never called us. In Hearing report page 149 line 8, I asked Dr. Schenne, Quote "Have you ever had a conversation with me or other caregiver. .." Unquote. On line 10 is the Dr. Schene answer, Quote "No, I have not." Unquote. Then on line 11 I asked Dr. Schene, Quote "Have you ever seen our facility? Again on line 12 Dr. Schene answer, Quote "I have not seen your facility." Unquote.

Also the Finding of Facts 27 said, Quote "LM did not receive any services from a home health visiting nurse between 6- 3- 2003 and 7- 30th" Unquote.

The above statement is a charged for us only if, we have been instructed, by the doctor what to do, and we did nothing.

Dr. Schene did talk with the family only, as Finding of Facts 30 said, Quote "On 7- 10 - 2003 Robert McDonald, LM's spouse brought LM to Steven Hospital on the advice of LM's physician to receive treatment for her heel ulcer." Unquote.

Department quotes: On Dep. Reply, p6 says: Quote, "LM's left ankle was swollen" "Dr. Schenne testified that the Appellants neglected LM as demonstrated by LM's preventable pressure ulcer and yeast infections" Unquote, Dep. Ex. D-30, page 3, Quote "The left ankle is swelled more than the right"

This is not a statement to prove that the providers are responsible about it, because is not conformed that that ankle has a situation at the level of illness, and during the visit Barbara Bizilia never showed us that ankle. She has to do a picture of that ankle to prove the severity of it.

To accuse us that the pressure ulcer is our fault, when the father took her twice per week, and forced her in the car is not correct. We do not know when that pressure ulcer started. Most possible was an accident, most possible when she was forced to walk to the car. Never in the hearings was the idea that we are responsible for that pressure ulcer, but only for not healing it or calling the doctor. I mention that LM had a history of skin cancer.

000228

The APS's concept that any red spot or diaper rash for an incontinent resident is a proof of neglect, is not reasonable because that will invite to say that the senior people must be totally healthy in AFHs, regardless of age or condition.

I think that pressure ulcer and yeast infections are preventable but not with the care DSHS are allowing us to do. We can heal any pressure ulcer or swollen body by dressing that resident worm, but that is considered by DSHS as abusive, and they revoked my licenses because of that. Moreover I believe that all infectious diseases are preventable and curable. And that was also used by DSHS against us.

Also good nutrition is important, but when I did call the doctor and I said that the resident do not cooperate in opening the mouth to eat or is yelling for ours after medications and we cannot provide in that period any care, and the resident cannot stand safely after medication and is shaking and we cannot toilet her, which might contribute to dipper rash or yeast infection, DSHS did revoke our second license, because they wrote, "I do not know the difference between medication side effects and medical symptoms"

The ALJ did err this #17 because we were charged with things which are beyond our rights given by DSHS or our possibilities.

5. Finding of Facts 18. LM communication capability Quote "LM was unable to answer Ms. Bizilia's question to whether LM felt hot or not during Ms Bizilia's examination of her May 30, 2003. LM acknowledged to Ms. Bizilia that the area of redness on her thighs were painful and itchy. Unquote.

So, If LM was unable to answer Ms. Bizilia's question to whether LM felt too hot, how could she process an information more complicated like, Is your area of redness on your thighs painful or itching? LM never express any discomfort.

Department quotes: On Dep. Reply p6, says: Quote "Appellants has not offered any evidence that LM's response to Barbara Bizilla questions did not occur" Unquote,

This statement has a reverse one: " Barbara Bizilia has never offered any evidence that LM's response to her question did occur" I am not allowed to record any conversations with DSHS staff. They must do it, if they want to use those facts in a court against us, or to ask us to do, which I could do. The ALJ did err this #18 because this is an unproved allegation.

6. Finding of Facts 20. Appellants requirements to report to doctor. Quote "Appellant was responsible to report to the doctor any changes in the residents situation." Unquote.

This is not what the law says. We are responsible to report to doctor only emergency or significant changes. I did question DSHS witnesses about this subject.

000229

On Hearing report page 240 line 16, I asked Barbara Bizilia, Quote " Was that wound an emergency? "Unquote. On line 23 is Barbara Bizilia's answer, Quote " It wasn't an emergency" Unquote. and on line 18 Barbara Bizilia said, Quote " It was a significant change." Unquote.

On Hearing report page 301 line 3, I asked Denise Roth, Quote " Why do you think we had to call a doctor for that heel wound?" Unquote. On line 8 is Denise Roth answer, Quote "I think it's a serious emergency situation" Unquote and on page 297 line 25 Denise Roth said, Quote " She was in the last stage of Alzheimer's, she was terminally ill" Unquote.

Bizilia said is significant change and Roth said is emergency. If we admit that the ulcer was significant change then after 6-3-2003, when Dr Schenne saw the resident we do not have anymore the responsibility to call the doctor. The condition of the wound did not change in this period, but on Hearing report page 242 line 17, Barbara Bizilia said, Quote "If something had been assessed to be a black eschar and you took her to the physician and the physician did nothing about it, then if it were me I'd take her to another physician." Unquote.

Barbara Bizilia is a healthcare professional and we are not. No code support such a requirement, to take the resident to a second doctor, because no doctor will do nothing if something has to be done.

On Hearing report page 241 line 3, I asked Barbara Bizilia, Quote "Do you know if that change was positive or negative?" Unquote.

On line 5 is Barbara Bizilia's answer, Quote "I couldn't make the speculation because I hadn't seen it before." Unquote. On line 11, Barbara Bizilia said, Quote "What I was stating is .. a change from intact healthy skin" Unquote.

That is not what the code refer to significant change. Must be between two doctor visits. Otherwise we have to call the doctor every day until the heel ulcer is healed, because every day is a significant change with respect of intact skin.

If the LM condition was an emergency situation in the day of investigation, then the heel must be emergency also three days later, on 6-2-2003 when Dr. Schenne saw the heel. But Dr. Schenne did not consider as emergency, because did not hospitalize her, or to order a service for her right away.

Department quotes; On Dep. Reply p6, says Quote, "Appellants argue that only emergency or significant change must be reported to doctor. " Unquote.

Is this possible, the APS's representative, Mrs. Bloedow not to have access to those rules, or she is not interested at all to see those rules.

WAC 388-76-675(3) says " ...a significant change in the resident condition" On Dep. Exhibit D-13 page 6, says Quote, "When to report. Report any changes or concerns you have to a resident's family member" We did that. The ALJ did err this #20 because did not consider the rules.

000230

7. Finding of Facts 24. LM yeast infection. Quote "Appellants were advised by the APS on May 30, 2003 that is their responsibility to seek medical care for LM's yeast infection." Unquote.

When Barbara Bizilia diagnosed the LM's yeast infection, in the same day LM's family contact the Dr. Schenne.

Hearing report page 146 line 16, I asked Dr. Schenne, Quote "You examined the client also on 5-30-2003?" Unquote. On line 17, Dr. Schenne said Quote "I just talked with them. I did not examine her." Unquote. LM got some medication for her yeast infection.

Department quotes: On Dep. Reply p 7, says: Quote, "Appellant does not provide any evidence that they were not advised by APS on May-30-2003 that it was their responsibility to seek medical care for LM." Unquote.

The opposite is true. "APS did not provide any evidence if they did advise provider on May-30-2003 about their responsibility to seek medical care for LM, and what specific to do." APS do not have a written advise they gave us or a recorded statement.

In the very same day the family called the doctor and two days later, on 6-2-03 Dr. Schenne did see LM. After the doctor saw a resident we do not have to do anything if the condition of that resident does not change significantly. This was here the case.

The ALJ did err this #24 because did not consider the rules and the common sense.

8. Finding of Facts 29 Roth's substantiation as neglect for provider. Quote "On June 17, 2003 Ms. Ruth substantiated finding of neglect against appellants." Unquote.

We have here two legal issues. One is the LM's son right to refuse any treatment and two, our responsibility to bypass the LM's son in emergency or significant changes.

Based on the previous discussions was not emergency, based on the Dr. Schenne inaction, and was not a significant change, based on the fact that that wound was old, Barbara Bizilia's definition of significant change is incorrect. On Hearing report page 298 line 21, I asked Denise Roth, Quote "Can you as DSHS worker to force a resident's son to accept treatment or services?" Unquote. On 23 is Denise answer, Quote "Absolutely not." Unquote.

But DSHS workers did create pressure on the son to move her from our AFH, as Hearing report page 299 line 7 said, Quote "Judy feels LM should definitely be moved and is requesting that we look for guardianship since the son would not move her." Unquote. On line 10 is my question to Denise Roth, Quote "Who is Judy?" Unquote. On line 11 is Denise Roth answer, Quote "I can't address it" Unquote.

000231

On Hearing report page 231 line 13, I asked Barbara Bizilia, Quote "Isn't Judy, Judy Mickunas, the investigator." Unquote.

Barbara Bizilia on line 14, said Quote "Quite frankly I don't remember who Judy is." Unquote. On line 15 I asked Barbara Bizilia, Quote "Is there not a Judy in your service? Unquote. On line 16 is Barbara Bizilia answer "I don't know." Unquote.

Hearing report page 165 line 15, is written, Quote "I recommended that she be moved to another adult family home." Unquote. On line 17, I asked Judith Mickunas, Quote "Do you agree with the above statement that she has to be moved from our home." Unquote. On page 166 line 2, Judith Mickunas answered. Quote "I don't agree or disagree." Unquote.

On Hearing report page 303 line 14, I asked the investigator Denise Roth, Quote "Without Barbara Bizilia would you substantiate LM's condition as neglect. Unquote. Her answer is in line 18, Quote "No..." Unquote.

Department quotes: On Dep. Reply p7, says: Quote, "Appellants' argument regarding LM's son right to refuse treatment on behalf of his mother or whether LM should be moved from Appellants' AM is not relevant." Unquote.

If the above statement is true then, why are the residents right? Does not APS protect the residents' rights? The LM's son has the legal right to decide when and if his mother has to be seen by doctor. LM was continue supervised by providers and family, and was not in any danger in DMMD-AFH, as APS alleged.

Has the son no right to decide which care is good for his mom? APS did move LM from DMMD-AFH and she died in 49 days under the APS protection. The ALJ did err this #29 because was ignored the resident's rights.

9. Finding of Facts 30. heel broken open Quote "On July 10, 2003 Robert McDonald, LM spouse brought LM to Stevens Hospital on the advice of LM's physician to receive treatment for her heel pressure ulcer which had now broken open." Unquote.

I do not know who introduced the notion of broken heel but nobody have any knowledge about it. The hospital report in the day of surgery, 7-10-2003, wrote, Hearing report page 220 line 23, Quote "There is a chronic left foot ulcer that is not clearly infected." Unquote. On page 221, line 2, I asked Barbara Bizilia, Quote "Is the above the description of a broken heel?" Unquote. On line 9 is Barbara Bizilia's answer, Quote "It doesn't document here that it's broken open." Unquote.

If, the heel was broken open before the surgery, that means that the heel was healed or was better in the moment of surgery and maybe the surgery was not necessary. If the heel was broken open after the surgery, then any charges on us are incorrect, because the doctor open the heel during surgery.

000232

Department quotes: On Dep, Reply p7; says Quote, "Stevens Hospital provides ...She was seen by her family physician without much real change in her symptoms." "Appellants' assertion that there is some question as to whether LM's pressure heel ulcer had broken open by July 10-03 Stevens Hospital record provides otherwise.... 1.5 diameter open wound. Unquote. This is a statement that LM's condition did not change significantly. So after Dr. Schenne saw LM on 6-02-03 we did not have to do anything.

The statement "open Wound" does not appear to be equal with "heel-broken-open" The term broken refers to an event between the Dr. Schenne visit, on 6-2-04 and 7-10-04, when LM was brought to hospital, but nobody knows when.

The citation on appellant exhibit C-1 clearly says, "There was not follow up until her heel broke open" This says that the reason she was brought to Stevens Hospital was that the heel situation deteriorated significantly, and the heel broken open so LM has to go to doctor. Otherwise what was the motive to bring LM to hospital? This is not presented anywhere in the record. LM's heel situation did not change, to justify a new doctor call, and Dr. Schenne did recommend to family to take LM to hospital without to have a deterioration in her conditions or without even see her again. If we will look at the e-mail between APS and Dr Schenne we may find the answer, which might be, "APS insisted to be LM taken to hospital" Why? APS has to answer.

Now I wish to present you what happened after the hospital did remove the heel ulcer scab, or eschar or crust, which cover and protect a wound to heal. App. Ex. B-16. Is a picture of (Lenore McDonald), LM.

Fig 2. shows the wound after two month of continue medical treatment. The wound was worse than in the day of investigation. Fig. 1. The whole heel appeared infected and the leg was swollen. The visiting nurse let the leg necked and David Muresan did not intervene at all, being afraid to complicate even further his situation. Two Months after the surgical removal of the wound scab, on 9-3-03, DM decided to intervene, for the sake of Lenore, no mater what will happen to him. He did place two thick socks and shoes on her legs. In three weeks only, the wound was completely healed, as the Fig. 4, and the 9-26-03 visiting nurse notes in App. Ex. B-10 says. The leg was not any more swollen, as the Fig. 5 shows.

The ALJ did err this #30 because were ignored the facts.

10. Finding of Facts 34. Three Licenses Revocation

We had so far three licenses revoked and accused of neglect. I mention that in 7 years, we had those licenses, we did not have a single complaint made or supported by residents or their families. All the complaints are made by DSHS workers. Even the enforcement officer Janice Shurman did a complaint, although she never saw that house, and did not. have any call about an incident.

000233

The cause of this DSHS actions against us are related with our high professionalism in long term care.

You may find my opinion about care in my "Closing Arguments" on Hearing report page 326 to 334

II. FINDINGS OF FACT

The undersigned has reviewed the recorded transcript of the hearing, the documents admitted as exhibits, the Initial Decision, the Petition for Review, and determines that the Initial Findings of Fact must be amended. As explained below, many of the Initial Findings of Fact have been deleted because they were not relevant to the precise issue in this case. Several essential Findings of Fact have been added to resolve the precise issue in this case. The additional Findings of Fact appear in italics below. WAC 388-02-0600(2); RCW 34.05.464(8).

1. Appellants obtained a license from Department of Social and Health Services ("DSHS") to operate an adult family home ("AFH") on September 5, 1997. Exhibit 1.

2. Appellants own and operate the DMMD Adult Family Home, an AFH care business with three homes, two located in Seattle, Washington, and a third located in Camano Island, Washington.

3. The AFH located at 18210 - 30th Ave. NE in Seattle, Washington ("home") was a licensed AFH from September 5, 1997, until revoked by the Office of Administrative Hearings (OAH) Decision issued December 31, 2003.

4. The AFH located at 18204 - 30th Ave. NE in Seattle, Washington ("18204 home") was a licensed AFH from July 2000 until revoked by a Board of Appeals Review Decision issued December 26, 2002. The King County Superior Court and the State of Washington Court of Appeals (Division I) upheld the decision to revoke Appellants' license to operate that home on June 30, 2003, and December 4, 2003, respectively.

5. The 18204 home and the 18210 home are located adjacent to each other.

6. Appellants both completed the Fundamentals of Caregiving, a comprehensive 000234 training, to be licensed as AFH providers in December 1998. David Muresan completed the

Fundamentals of Caregiver training again in July 2002 and Maria Muresan completed the Fundamentals of Caregiver training again in August 2002. Exhibits 3, 34, and 35.

7. On August 22, 2002, Appellants became LM's paid caregivers and received \$2,500.00 per month in exchange to provide room, personal care services, and other services as identified in the Adult Family Care Contract to LM. Exhibit 14. *LM lived in both the 18204 home and the 18210 home.*

8. LM was born on February 11, 1918. Her medical conditions include CVA (cerebrovascular accident or stroke) with swallowing difficulty, dementia, Alzheimer's, hypertension, and visual change. Exhibit 15.

9. LM was prescribed several medications including Atenolol, Lasik, ASA, Levothyroxin, Monopril, calcium carbonate, Tylenol, and Immodium. LM's physician ordered her medications to be crushed due to her inability to swallow. Exhibit 15.

10. LM suffered from serious cognitive and mental impairments including disorientation, wandering, anxiety, memory, impairment, impaired judgment hallucinations, and aphasia (unable to speak). Exhibit 17.

11. On September 9, 2002, LM's primary physician, Jennifer Schenne, M.D., completed a Resident Assessment of LM. LM's assessment determined that she was totally dependent on her care givers for all of her personal care needs including personal hygiene, dressing, bathing, toileting, eating, mobility/transfer, positioning, communication, medication administration, body care, travel/shopping and exiting in an emergency. Exhibits 16 and 17.

12. LM's service plan provided that her caregivers would meet all of her personal care needs as provided in her assessment. Exhibit 17.

13. On May 29, 2003, Joanne Wells observed LM at one of Appellants' AFHs bundled in several layers of clothing on a very warm day. LM appeared to be dozing, leaning 000235 awkwardly over one side of her chair and unable to reposition herself independently. LM's

caregiver was unable to reposition LM alone because LM required two people to reposition LM. Ms. Wells was concerned that LM was receiving all of her medications and whether LM had received proper notice of change in homes, as LM was being moved back and forth between the 18204 home and the 18210 home. Exhibit 18; Exhibit 20; Testimony of Joanne Wells. *Ms. Wells notified the Department's Adult Protective Service (APS) of her concerns and APS initiated an investigation of alleged neglect of LM.*

14. On May 30, 2003, APS nurse investigator, Barbara Bizilia, examined LM. Ms. Bizilia observed LM with four layers of clothing on including two cotton knit long sleeve shirts, a sweater, a fleece jacket and a hat. LM wore incontinent briefs and sweat pants on her lower half. LM had one heavy sock and a slipper on her left foot and wore nothing on her right foot. LM's axillary temperature was 98.6 degrees Fahrenheit. LM had left heel pressure ulcer that was round blank dried eschar approximately 2.5 cm in diameter, left swollen ankle, and yeast infection to her perineum area and thighs. Exhibit 20; Testimony of Barbara Bizilia.

15. *During Ms. Bizilia's visit on May 30, 2003, the Appellants told Ms. Bizilia that they had notified LM's son about the pressure ulcer approximately one week prior to May 30, 2003. LM's son had not asked the Appellants to take any action to address the pressure ulcer. The Appellants had not notified LM's doctor about the pressure ulcer and the Appellants had not taken LM to see her doctor. Ms. Bizilia informed the Appellants that it was their responsibility to seek medical treatment for LM's pressure ulcer despite LM's son's failure to do so. Ms. Bizilia informed the Appellants that they would need a home health nurse to treat LM's pressure ulcer. Exhibit 20, p. 3; Transcript (Tr.), p. 199.*

16. On June 2, 2003, LM's son and husband took LM to see her primary care physician, Jennifer Schenne, D.O. *Dr. Schenne observed the pressure ulcer on LM's left heel, which was approximately one inch in diameter. Dr. Schenne did not believe that LM's pressure sore would heal on its own. Dr. Schenne believed that the sore on LM's heel needed more* 000236

aggressive treatment. Tr, p. 141. Dr. Schenne ordered a home health nurse to treat LM's left heel pressure ulcer. Dr. Schenne told LM's husband that LM needed a home health nurse to treat her pressure sore. Exhibit 29. Based on the evidence in the record, it is not clear whether Dr. Schenne or LM's family members ever told the Appellants that Dr. Schenne had ordered home health nurse services for LM's pressure sore.

17. On June 17, 2003, APS made a substantiated finding of neglect against Appellants based upon the Muresans' (1) failure to seek necessary medical care and treatment for LM's pressure ulcer, yeast infection, and perineum rash; (2) bundling of LM in multiple layers of clothing without regard for season, ambient temperature, and the wishes of LM decision makers, appearance or medical contraindications; (3) demands to LM's family to discontinue her medication although contradictory to LM's physician; and (4) transferring LM between the 18210 home and the 18204 home for their convenience, disregarding LM's basic resident and civil rights and causing injuries to LM including on at least one occasion bruising. Exhibits 20, 22. *There is no evidence in the record to indicate that the Appellants were notified of this substantiated finding of neglect. At the time the Department made the substantiated finding against the Appellants on June 17, 2003, the subject of a substantiated APS finding did not have a right to a hearing to contest the finding.*

18. *Throughout the month of June 2003, LM did not receive any services from a home health agency to treat the pressure sore on her heel. LM's son instructed the Appellants to keep the heel sore dry and to use Neosporin. Exhibit 25, pp. 2-3.*

19. *At the beginning of July 2003, the sore on LM's heel "opened up." In response to the change in the condition of LM's heel sore, Ms. Muresan told LM's son to take LM to see the doctor. The Appellants did not follow up with LM's son and did not know if LM's son had taken LM to the doctor. Exhibit 25, p. 2. The Appellants did not contact LM's doctor.*

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20. On July 2, 2003, another Department investigator, Ms. Mickunas, came to the Appellants' home to investigate an allegation that the Appellants were providing care in an unlicensed home. During this visit, Ms. Mickunas talked to the Appellants about LM's heel sore. Ms. Muresan stated that she did not like the way LM's wound looked and that the wound sometimes smelled bad. Exhibits 23, 24; Tr., p. 162. Ms. Mickunas did not see LM's heel sore on July 2, 2003, because Ms. Mickunas did not have any authority to examine a resident in an unlicensed home. Ms. Mickunas asked the Appellants if they had notified LM's doctor about the deterioration of LM's sore and the Appellants said they had not notified LM's doctor. Tr., p. 162. Based on her conversation with the Appellants on July 2, 2003, Ms. Mickunas notified APS that she was concerned about LM's well-being. On July 3, 2003, APS initiated a second investigation of alleged neglect of LM. Exhibit 24.

21. On July 10, 2003 Robert MacDonald, LM's spouse, brought LM to Stevens Hospital on the advice of LM's physician to receive treatment for her heel pressure ulcer which had now broken open. LM received a physical examination that revealed a pressure ulcer to her left foot. LM's pressure ulcer was debrided with "a dark, necrotic eschar removed. A small amount of continued debridement of dead soft tissue was removed and tolerated well." Exhibit 30. Stevens Hospital ordered home health services for the treatment of LM's sore. The hospital contacted the Visiting Nurse Service and asked the Visiting Nurse Service to contact LM's husband to set up services for LM. Exhibit 30, p. 7.

22. On July 12, 2003, the Visiting Nurse Service began coming to the Appellants' home two times per day to provide care for LM's pressure sore.

23. On July 16, 2003, APS investigator Barbara Bizilia came to the Appellants' home to investigate the second allegation of neglect of LM. Ms. Muresan reported to Ms. Bizilia that the home health care services had begun four days earlier. Ms. Muresan also reported to 000238

Ms. Bizilia that LM's wound had opened up several weeks before and that the Appellants had reported the change to LM's son. Exhibit 25, p. 3.

24. On November 7, 2003, Ms. Bizilia completed her investigation. APS determined that the neglect allegation was substantiated against LM's son and against the Appellants. Exhibit 25, p. 2.

25. On January 23, 2004, DSHS notified Appellants that Adult Protective Services substantiated a finding that they neglected a vulnerable adult. Exhibit 31. The finding notice sent by APS stated:

This incident occurred during a visit by APS to your home on the 17th of July 2003. I had informed you during a previous APS visit on May 30th that the AV needed to have immediate medical attention to a large black area of skin breakdown on her heel. A physician saw her on June 2nd and home health was ordered. For some reason this was not started and you did not follow up on appropriate care for this potentially serious skin problem. The AV's son had a duty to care for the AV but you had a responsibility to the AV as well to ensure her health and safety. There was no medical follow up until her heel broke open and she was seen by a doctor again on 7/10/2003 at Steven's Hospital. When Home Health was started on 6/12/2003 the nurse had serious concerns about the AV's quality of care.

The Notice also informed the Appellants that they had a right to request a hearing to contest the substantiated finding. Exhibit 31.

26. On January 29, 2004, the Office of Administrative Hearings received David Muresan's request for an administrative hearing to contest DSHS's substantiated finding of neglect against Appellants. Exhibit 32.

27. On March 15, 2004, Appellants requested an administrative hearing for Maria Muresan and requested that the findings against both Appellants be addressed at the hearing scheduled. Exhibit 33.

III. CONCLUSIONS OF LAW

1. **Jurisdiction for Review-** For cases in which an Appellant requested a hearing 000239 after November 15, 2002, a Review Judge may only review the types of cases listed in WAC 388-02-0125(4). WAC 388-02-0600(1). The list of cases subject to review includes

cases involving "Placement of personal aides providing self-directed care on a state registry under RCW 74.39A.050(9) and WAC 388-71-0150 and 388-71-0155; where a hearing was requested under WAC 388-71-0116, a finding of abuse, abandonment, neglect or financial exploitation of a vulnerable adult by alleged perpetrators other than personal aides; or, where a hearing was requested under WAC 388-71-01235, a substantiated finding of abandonment, abuse, financial exploitation or neglect of a vulnerable adult by an alleged perpetrator." WAC 388-02-0215(4)(e); see WSR 03-23-113; WSR 04-07-090; WSR 04-15-056. Therefore, jurisdiction exists to review the Initial Decision and issue the final agency order.

2. **Scope of Review-** In a proceeding involving Adult Protective Services (APS) findings, the Review Judge may change an Initial Decision only if a party shows one of the following: irregularity affecting the fairness of the hearing; Findings of Fact that are unsupported by substantial evidence in the record; a need for additional consistent Findings of Fact based upon substantial evidence in the record; an error of law; or a need for clarification in order to implement the decision. WAC 388-02-0600(2).

2. **Subject Matter Jurisdiction-** As an initial matter, the undersigned must determine whether there is authority to adjudicate the issues in this case. This authority to adjudicate is also known as subject matter jurisdiction. The issue of subject matter jurisdiction is particularly important in the administrative process because administrative agencies do not have general or inherent powers. As the Washington State Supreme Court has explained:

[A]dministrative agencies are creatures of the Legislature, without inherent or common-law powers and, as such, may exercise only those powers conferred by statute, either expressly or by necessary implication.... The power of an administrative tribunal to fashion a remedy is strictly limited by statute.

Skagit Surveyors & Eng'rs v. Friends of Skagit County, 135 Wn.2d 542, 558, 958 P.2d 962 (1998).

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While [an administrative] agency has some discretion in interpreting ambiguous statutes, it may not alter or amend an act, and its interpretation must be within the framework and policy of the statute.

Burlington Northern Inc. v. Johnston, 89 Wn.2d 321, 326, 572 P.2d 1085 (1977) (internal citations omitted). Thus, the ALJ and the undersigned must have explicit authority in either statute or rule in order to proceed with adjudication.

3. Washington courts have ruled that the issue of subject matter jurisdiction cannot be waived and can be raised at any time. *J.A. v. Dep't of Soc. & Health Servs.*, 120 Wn. App. 654, 657, 86 P.3d 202 (2004). "Even in the absence of a contest, where there is a question as to jurisdiction, [the] court has a duty to itself raise the issue." *Riley v. Sturdevant*, 12 Wn. App. 808, 810, 532 P.2d 640 (1975). Without subject matter jurisdiction, a court or administrative tribunal may do nothing other than enter an order of dismissal. *Inland Foundry Co. v. Spokane County Air Pollution Control Auth.*, 98 Wn. App. 121, 124, 989 P.2d 102 (1999). The undersigned has an obligation to address the issue of subject matter jurisdiction before proceeding with review.

4. In the case of substantiated APS findings, the explicit authority to adjudicate comes from a Department rule. On October 31, 2003, the Department adopted WAC 388-71-0116, which states:

Can an alleged perpetrator who is not a personal aide challenge an APS finding of abuse, abandonment, neglect or financial exploitation? (1) An alleged perpetrator of abuse, abandonment, neglect or financial exploitation of a vulnerable adult, other than a personal aide, may request an administrative hearing under chapter 34.05 RCW and chapter 388-02 WAC to challenge a substantiated APS finding made on or after October 1, 2003.

This emergency rule became effective on October 30, 2003. See WSR 03-22-053. This emergency rule was re-adopted on February 23, 2004, and June 25, 2004. See WSR 04-06-039; WSR 04-14-013. On October 22, 2004, the Department adopted a permanent rule that took the place of former WAC 388-71-0116. Current WAC 388-71-01235 states:

Can an alleged perpetrator challenge an APS finding of abandonment, abuse, financial exploitation or neglect? An alleged perpetrator of abandonment, abuse, financial exploitation or neglect may request an administrative hearing to challenge a substantiated initial finding made by APS on or after the effective date of this rule. 000241

Read together, the Department's rules grant a right to a hearing to challenge all substantiated APS findings entered on or after October 1, 2003. The authority of the ALJ and the undersigned is similarly limited to findings entered on or after October 1, 2003. No statute or Department rule grants the subject of a substantiated APS finding a right to a hearing to contest a finding that was entered prior to October 1, 2003.

5. **Jurisdiction to Address the June 17, 2003, Neglect Finding-** The Department first entered a finding of neglect against the Appellants on June 17, 2003. The June 17, 2003, neglect finding was based on four actions:

(1) failure to seek necessary medical care and treatment for LM's pressure ulcer, yeast infection, and perineum rash; (2) bundling of LM in multiple layers of clothing without regard for season, ambient temperature, and the wishes of LM decision makers, appearance or medical contraindications, (3) demands to LM's family to discontinue her medication although contradictory to LM's physician; and (4) transferring LM between the 18210 home and the 18204 home for their convenience, disregarding LM's basic resident and civil rights and causing injuries to LM including on at least one occasion bruising.

Exhibits 20, 22. The Appellants were not notified of the June 17, 2003, APS finding because the Department was not required to notify APS finding subjects in June 2003.

6. As explained above, the right to contest an APS finding applies only to APS findings made on or after October 1, 2003. Neither the ALJ nor the undersigned has subject matter jurisdiction over any APS finding that was entered before October 1, 2003. The Department's first neglect finding in this matter is not subject to appeal because it was entered more than three months before the right to hearing came into effect.

7. In its Prehearing Brief, the Department waived "any jurisdictional limits to the pre-October 1, 2003, substantiated finding of neglect made on June 17, 2003." Department's Prehearing Brief, p. 10. However, the Department did not have any authority to waive jurisdictional limits and the ALJ did not have any authority to accept such a waiver. As explained above, Washington courts have ruled that the issue of subject matter jurisdiction cannot be waived and the court has a duty to itself raise the issue. *J.A. v. Dep't of Soc. &*

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Health Servs., 120 Wn. App. 654, 657, 86 P.3d 202 (2004); *Riley v. Sturdevant*, 12 Wn. App. 808, 810, 532 P.2d 640 (1975); *Inland Foundry Co. v. Spokane County Air Pollution Control Auth.*, 98 Wn. App 121, 124, 989 P.2d 102 (1999). The Department's waiver of the jurisdictional issue does not resolve the jurisdictional defect inherent in the appeal of the first APS finding. Because the finding was entered prior to October 1, 2003, the ALJ and the undersigned do not have any jurisdiction over the first APS finding.

8. The Initial Decision erroneously adjudicated the June 17, 2003, neglect finding without any authority to do so. The undersigned has deleted all of the Initial Findings of Fact that addressed the four actions that formed the basis for the June 17, 2003, substantiated finding. This decision will not address the Appellants' failure to obtain treatment prior to June 2, 2003, the bundling of clothing, the request to discontinue medications, and the transfer between houses. The undersigned does not have any authority to address these four actions because they were part of a finding that is not subject to appeal.

9. **November 7, 2003, Finding-** The Department substantiated the second finding of neglect against the Appellants on November 7, 2003. Because this finding was entered after October 1, 2003, and because the Appellants filed a timely appeal, the ALJ and the undersigned do have jurisdiction over the second finding.

10. The notice of the second substantiated finding stated:

This incident occurred during a visit by APS to your home on the 17th of July 2003. I had informed you during a previous APS visit on May 30th that the AV needed to have immediate medical attention to a large black area of skin breakdown on her heel. A physician saw her on June 2nd and home health was ordered. For some reason this was not started and you did not follow up on appropriate care for this potentially serious skin problem. The AV's son had a duty to care for the AV but you had a responsibility to the AV as well to ensure her health and safety. There was no medical follow up until her heel broke open and she was seen by a doctor again on 7/10/2003 at Steven's Hospital. When Home Health was started on 6/12/2003 the nurse had serious concerns about the AV's quality of care.

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Exhibit 31. This is the precise issue that is before the undersigned. The sole question in this case is whether the Appellants' failure to obtain additional care for LM between June 2, 2003,

and July 12, 2003, amounts to neglect. The other issues discussed during the hearing, such as the events that took place prior to June 2, 2003, are not before the undersigned because they were not part of the January 23, 2004, Notice.

11. **Collateral Estoppel-** The Initial Decision concluded that the Findings of Fact from the December 31, 2003, Initial Decision revoking the Appellants' adult family home license were entitled to preclusive effect in this decision under the doctrine of collateral estoppel. This Conclusion is erroneous because the time period at issue in the December 31, 2003, Initial Decision is different than the time period at issue in this case.

12. The December 31, 2003, Initial Decision addressed the Department's Notice of Revocation of the Appellants' adult family home license, which was dated June 9, 2003. Therefore, the December 31, 2003, Initial Decision addressed events that took place prior to June 9, 2003. By contrast, this decision addresses only the events that took place between June 2, 2003, and July 12, 2003. The December 31, 2003, Initial Decision did not address the time period between June 2, 2003, and July 12, 2003, because this time period took place after the Department's revocation. The December 31, 2003, Initial Decision does not contain any Findings of Fact or Conclusions of Law that address the sole issue in this case-- the Appellants' alleged failure to obtain medical treatment for LM's pressure sore after June 2, 2003.

13. As explained in the Initial Decision, there are four requirements for the application of the doctrine of collateral estoppel. The first requirement is "The issue decided in the prior adjudication is identical with the one presented in the second action." See Initial Conclusion of Law 2. In this case, the issue decided in the prior adjudication is not identical to the issue presented in this action. The issue decided in the prior adjudication was the Appellants' actions before June 9, 2003. The issue to be decided in this case is the Appellants' actions after June 2, 2003. Therefore, the requirements for collateral estoppel are not present and the doctrine of collateral estoppel does not apply. The undersigned has deleted the

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Findings of Fact about the December 31, 2003, Initial Decision because they have no relevance to the issue of whether the Appellants' obtained medical care for LM after June 2, 2003.

14. **Initial Findings of Fact-** The undersigned has deleted numerous Initial Findings of Fact that addressed issues that were not contained in the January 23, 2004, Notice. The undersigned has also added numerous Findings of Fact regarding the treatment of LM's heel sore between June 2, 2003, and July 10, 2003. These additional Findings of Fact are essential to resolve this matter because the Initial Decision contained insufficient information about the period between June 2, 2003, and July 10, 2003. These additional Findings of Fact are supported by substantial evidence in the hearing record. WAC 388-02-0600(2).

15. **Neglect Finding-** Having concluded that there is jurisdiction to address the November 2003 neglect finding, there is precisely one issue in this case: Did the Appellants' failure to obtain medical care for LM's heel sore between June 2, 2003, and July 10, 2003, rise to the level of neglect? The relevant definition of neglect appears in RCW 74.34.020(9):

"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 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.

16. There was very little information in the record about the time period between June 2, 2003, and July 10, 2003. During their testimony, the Appellants were never asked about care provided between June 2, 2003, and July 10, 2003. For example, the Appellants were not asked if they knew about Dr. Schenne's home health order, the Appellants were not directly asked about the progress of LM's wound after June 2, 2003, and the Appellants were not asked why they did not follow up with additional services when LM's sore deteriorated in June and July 2003. Dr. Schenne also testified. However, Dr. Schenne was not asked how or to whom she transmitted her order for home health services. Dr. Schenne was not asked

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whether she followed up on her order for home health services. LM's family members did not testify during the hearing, so there is no way of knowing whether they knew about the need for home health services. There is also no way of knowing what conversations, if any, LM's family had with the Appellants and when these conversations took place. After three days of testimony, the witnesses only mentioned the time period between June 2, 2003, and July 10, 2003, a handful of times. The Initial Decision contained two brief Findings of Fact that addressed this time period. Therefore, the undersigned has attempted to recreate the events of this time period primarily from the exhibits in the record

17. There can be no question that LM's health and welfare were in danger from June 2, 2003, and July 10, 2003. LM's treating physician had determined on June 2, 2003, that LM had a sore that was not going to heal on its own. LM's primary care physician had also determined that LM needed the services of a home health nurse to treat her heel sore.¹ However, LM did not begin to receive the services of a home health nurse until July 12, 2003, almost six weeks later. During these six weeks, LM was at risk because she was not receiving a service that her doctor had determined was vital for her health. Therefore, the next question is whether the Appellants were responsible for the fact that LM did not receive additional treatment from June 2, 2003, through July 10, 2003.

18. Based on the preponderance of the evidence in the record, the Appellants were at least partially responsible for the fact that LM did not receive additional treatment from June 2, 2003, through July 10, 2003. While the Appellants are correct that there was no evidence in the record to prove that the Appellants were ever notified of Dr. Schenne's June 2, 2003, order for home health treatment, that is not the end of the analysis. Even if the Appellants were not directly notified of Dr. Schenne's June 2, 2003, order, the Appellants

¹ The Appellants' arguments that LM did not actually need wound care, and that the wound care made LM's wound worse, are without merit. Dr. Schenne, a licensed physician, determined that home health care was a medically necessary service and there was no competent medical evidence in the record to challenge this prescription.

should have taken additional steps to obtain treatment for LM. This conclusion is based on three factors. First, the Appellants should have obtained additional treatment because Ms. Bizilia specifically told the Appellants on May 30, 2003, that LM would require home health services to treat her heel sore. Tr., p. 199. Ms. Bizilia's comment notified the Appellants that the sore on LM's heel was serious and that significant interventions would be required in the future. The Appellants should have asked more questions after the June 2, 2003, appointment with Dr. Schenne to find out what services were required for LM's health and well-being. When LM's son told the Appellants to simply use Neosporin, the Appellants knew that this plan was inadequate because Ms. Bizilia had already told the Appellants that home health services were necessary for the wound.

19. Second, the Appellants should have obtained additional treatment because LM's heel sore continued to deteriorate in June and July 2003. For example, Ms. Muresan observed that LM's sore "opened up" at the beginning of July 2003. Exhibit 25, p. 2. Mrs. Muresan told Ms. Mickunas on July 2, 2003, that she did not like how the wound looked and that the wound sometimes smelled bad. Tr., p. 162. The Appellants notified LM's son but did not even follow up to find out if LM had been taken to the doctor. Exhibit 25, p. 2. Despite their responsibility to ensure that LM received the services necessary for her health and well-being, the Appellants did not even attempt to obtain additional services as LM's wound deteriorated.

20. Third, the Appellants should have obtained additional treatment because the Appellants knew that they had an independent responsibility to ensure that LM received necessary care. During the June 2003 investigation, the Department investigators clearly explained to the Appellants that they were responsible to ensure that all of LM's needs were met, regardless of the actions of LM's son. Tr., p. 199. When LM's heel sore kept deteriorating and LM's son did not take any action, the Appellants had a responsibility to step in. The Appellants should have been aware of this independent responsibility because the Department

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investigators had just explained it to the Appellants days earlier during the first investigation. Had the Appellants called Dr. Schenne even one time during the month of June 2003 as LM's sore was deteriorating, LM would have begun receiving her medically necessary home health services and this case could have been avoided. The Appellants argued that they were required to follow the instructions of LM's son, even if this placed LM at risk. This argument is not correct. As the Department representatives explained to the Appellants in June 2003, the Appellants were required to exercise independent judgment and to provide all of the services necessary for LM's health and well-being. The Appellants were not required or permitted to follow the instructions of LM's son when those instructions clearly placed LM's health at risk.

21. In sum, the Appellants argued that their sole obligation was to ensure that LM's son knew that LM had a sore. The Appellants did not believe that they had any obligation to further assess LM's needs or to follow up with LM's son or to contact LM's doctor. The Appellants believed that after they notified LM's son about the sore, the sore was no longer their problem. This argument is not correct. The Appellants had a responsibility to ensure that LM received the care that was necessary for her health and well-being. The Appellants knew that LM required home health care based on Ms. Bizilia's instruction. The Appellants knew that they had an independent obligation to assess and address LM's needs based on Ms. Bizilia's instruction. The Appellants also knew that LM's sore continued to deteriorate in the months of June and July based on Ms. Muresan's observations. Despite all of this knowledge, the Appellants failed to take any action to ensure that LM received the services required to treat and heal her sore. The Appellants' passive approach to LM's care posed a clear and present danger to LM's health. Therefore, the Appellants neglected LM and the Department's finding is upheld.

22. Initial Conclusions of Law 1, 3, 4, 5, 6, and 7 are adopted as Conclusions in this decision. RCW 34.05.464(8). The undersigned has considered the Initial Decision, the Petition

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for Review, and the entire record or the documents submitted by the parties. Any arguments in the Petition for Review that are not specifically addressed have been duly considered but are found to have no merit or to not substantially affect a party's rights.

The procedures and time limits for seeking reconsideration or judicial review of this decision are in the attached statement.

IV. DECISION AND ORDER

The Department proved that the Appellants neglected a vulnerable adult in June and July 2003. The Department's January 23, 2004, finding of neglect is affirmed.

Mailed on November 24 , 2004.



S. ANDREW GRACE
Review Judge

Attached: Reconsideration/Judicial Review Information

Copies have been sent to: DMMD Adult Family Home, Appellant
David and Maria Muresan
Ree Ah Bloedow, Department Representative
Lori Melchiori, Program Administrator, MS: 45600
Susan K. Serko, ALJ, Seattle OAH

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RICHARD D. JOHNSON,
Court Administrator/Clerk

The Court of Appeals
of the
State of Washington
Seattle
98101-4170

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February 16, 2006

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900 4th Ave Ste 2000
Seattle, WA, 98164-1012

APS FINDINGS

CASE #: 56798-5-1
David Muresan, Appellant t v. DSHS, Respondent

Counsel:

Enclosed please find a copy of the commissioner's ruling entered in the above case today. Please note that "[a] ruling or decision granting a motion on the merits is subject to review as provided in rule 17.7", RAP 18.14(i), and that the motion to modify must be "filed in the appellate court not later than 30 days after the ruling is filed." RAP 18.8.

Appellant is advised that "failure to file a motion to modify terminates appellate review." **State v. Rolax**, 104 Wn.2d 129, 135-36, 702 P.2d 1185 (1985).

Sincerely,



Richard D. Johnson
Court Administrator/Clerk

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emp

EXHIBIT # 11

WJF
ONE
2-21-06

several medical conditions with mental and cognitive problems including dementia, Alzheimer's, disorientation, hallucinations, impaired judgment, and inability to speak. She was totally dependent upon her care givers for all of her personal needs.

On May 30, 2003, Barbara Bizilia, an investigator for the Department, observed that L.M. had a left heel pressure ulcer that was round blank dried eschar approximately 2.5 cm in diameter, a swollen ankle, and a yeast infection. Muresan told Bizilia that he had notified L.M.'s son about the pressure ulcer approximately one week prior to May 30, 2003. L.M.'s son had not asked Mureson to take any action to address the pressure ulcer. Mureson had not notified L.M.'s doctor about the pressure ulcer and had not taken LM to see her doctor. Bizilia informed Mureson it was his responsibility to seek medical treatment for the pressure ulcer despite L.M.'s son's failure to do so. Bizilia informed Mureson that he would need a home health nurse to treat L.M.'s pressure ulcer.

On June 2, 2003, L.M.'s son and husband took L.M. to see her primary care physician. The doctor observed the pressure ulcer was approximately one inch in diameter. The doctor was concerned that the ulcer would not heal without aggressive treatment and told L.M.'s son and husband that L.M. required a home health nurse to treat the pressure sore. It is not clear if the doctor, L.M.'s son or husband told Muresan that the doctor had ordered home health nurse services for L.M.'s pressure sore.

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Throughout the month of June, L.M. did not receive any services from a home health agency to treat the pressure sore on her heel. L.M.'s son told Muresan to keep the heel sore dry and use Neosporin.

At the beginning of July 2003, the sore on L.M.'s heel "opened up." (Exhibit 25 includes an investigator's notation that on July 16, 2003, Ms. Muresan told the investigator that "the heel had been stable until a couple of weeks ago when it opened up.") In response to the change in the condition of the sore, Ms. Muresan told L.M.'s son to take L.M. to see the doctor, but the Muresans did not follow up with L.M.'s son and they did not know if L.M.'s son had taken L.M. to the doctor. The Muresans did not contact L.M.'s doctor.

On July 2, 2003, another Department investigator inquired about the condition of L.M.'s heel sore. The investigator testified that Ms. Muresan told the investigator that "she didn't like the way the wound looked and that it sometimes smelled." The investigator asked whether Muresan had notified L.M.'s doctor about the deterioration of L.M.'s sore and the Muresans said they had not notified L.M.'s doctor.

On July 10, L.M.'s husband took L.M. to a hospital on the advice of L.M.'s physician. Medical records reveal that "[t]he pressure ulcer was debrided with a dark, necrotic eschar removed. A small amount of continued debridement of dead soft tissue was removed and tolerated well." The hospital contacted the visiting nurse service, and L.M. began receiving treatment from a visiting nurse.

The Department determined that Muresan had neglected a vulnerable adult. Muresan requested an administrative hearing and the Administrative Law

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Judge concluded that Muresan neglected a vulnerable adult including among other violations, the failure to provide L.M. medical care for her pressure ulcer, yeast infection and perineum rash. The Board of Appeals upheld that decision, with the review judge making some additional findings of fact. The superior court upheld the Department. Muresan appeals.

CRITERIA FOR GRANTING A MOTION ON THE MERITS TO AFFIRM

RAP 18.14(e)(1) provides:

A motion on the merits to affirm will be granted in whole or in part if the appeal or any part thereof is determined to be clearly without merit. In making these determinations, the . . . commissioner will consider all relevant factors including whether the issues on review (a) are clearly controlled by settled law, (b) are factual and supported by the evidence, or (c) are matters of judicial discretion and the decision was clearly within the discretion of the trial court or administrative agency.

Applying these criteria in light of State v. Rolax,¹ the commissioner determines that the issue presented is clearly without merit.

DECISION

Under the Administrative Procedures Act, an administrative agency decision is reviewed on the record before the administrative agency, and the appellant has the burden of demonstrating the invalidity of the administrative decision.² Challenged factual findings by the administrative agency are affirmed on judicial review if supported by evidence that is substantial when viewed in light of the whole record before the court, and substantial evidence is a sufficient quantity of evidence to persuade a fair-minded person of the truth or correctness

¹ 104 Wn.2d 129, 702 P.2d 1185 (1985).

² RCW 34.05.570; Thurston County v. Cooper Point Ass'n, 148 Wn.2d 1, 7, 57 P.3d 1156 (2002).

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of the order.³ Issues of law are reviewed de novo and for mixed questions of law and fact, the reviewing court determines the law independently, then applies it to the facts as found by the agency.⁴ An argument will not be considered on appeal if it is inadequately briefed.⁵

Muresan does not cite any legal authority in his brief and focuses upon the factual challenge that "[t]he condition of the heel could not be proved as deteriorating, between June 2, 2003 and July 10, 2003, because nobody saw LM in that period, and we noticed an improvement for LM's heel condition. The accusation of neglect is false."

Essentially the same argument was presented to the Board of Appeals and the review judge acknowledged that the Muresans were not asked during their testimony if they knew the primary care physician had ordered home health care, they were not directly asked about the progress of L.M.'s wound after June 2, 2003, and they were not asked why they did not follow up with additional services when L.M.'s sore deteriorated in June and July 2003. But the review judge concluded that L.M.'s health and welfare were in danger from June 2, 2003 to July 10, 2003, because L.M. was not receiving health care ordered by her physician. The review judge concluded that the Muresans were "at least partially responsible". Even though there was no evidence that the Muresan's were ever directly notified that the physician had ordered home health care, Ms. Bizilia specifically told the Muresans that L.M. required home health services,

³ Thurston County, 148 Wn.2d at 8.

⁴ Hamel v. Employment Sec. Dep't, 93 Wn. App. 140, 145, 966 P.2d 1282 (1998).

⁵ Bohn v. Cody, 119 Wn.2d 357, 368, 832 P.2d 71 (1992).

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they thus knew the condition was serious and they knew that the son's directive to use Neosporin clearly was not the equivalent of home health services.

Muresan asserts that there is no evidence that L.M.'s pressure sore deteriorated between June 2 and July 12, 2003. But at the very least, the investigator's note establishes that in early July 2003, Ms. Muresan observed that the wound had "opened up" and she told an investigator in July that she did not like how the wound looked and it sometimes smelled bad. Further, the hospital records reveal that in July the sore had to be debrided with dead tissue removed. To the extent that Muresan contends there was no obligation to inform the physician because L.M.'s son had a power of attorney and he was making decisions regarding L.M.'s health care, the investigators told the Muresan's on May 30, that they had the responsibility to ensure that L.M.'s medical needs were met and that they could not rely upon having told the son that L.M. had a sore.

There is evidence in the record supporting the determination that the Muresan's knew the condition of the sore was deteriorating during June and July and they ignored the information they had been given by the investigator in June that L.M. required home health care and that they were responsible to inform her physician of the deterioration of her heel sore. Muresan cites no legal authority that he was excused from informing L.M.'s physician when the sore deteriorated and "opened up" in early July.⁶

⁶ RCW 74.34.020(9) defines neglect to include the failure to provide the goods and services that maintain the physical health of a vulnerable adult. WAC 388-76-675(3) sets forth the obligation of an adult family home provider to inform the resident's physician if there is a "significant change" in the resident's condition.

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CONCLUSION

There is no showing that the findings are not supported by substantial evidence, that the determination of neglect of a vulnerable adult was arbitrary or capricious, or that there was any error of law. The criteria for a motion on the merits to affirm have been satisfied. Now, therefore, it is hereby

ORDERED that the motion on the merits is granted and the decision of the trial court is affirmed.

Done this 16th day of February, 2006.



Court Commissioner

2005 FEB 16 AM 9:09

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IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION ONE

DAVID and MARIA MURESAN,)
)
 Appellants,)
)
 vs.)
)
 DEPARTMENT OF SOCIAL AND)
 HEALTH SERVICES FOR THE STATE)
 OF WASHINGTON,)
)
 Respondent.)

No. 56798-5-1

ORDER DENYING
MOTION TO MODIFY

*APS
pending
of neglect*

David Muresan, appellant, has moved to modify the commissioner's February 16, 2006 ruling granting a motion on the merits to affirm. We have considered the motion to modify under RAP 17.7 and have determined that it should be denied.

Now, therefore, it is hereby

ORDERED that the motion to modify is denied.

Done this 2nd day of May, 2006.

COPY RECEIVED
FEB 03 2010
OFFICE OF ATTORNEY GENERAL
EVERETT

Becker, J.

Dwyer, J.
Green

RECEIVED
MAY 04 2006
OFFICE OF THE ATTORNEY GENERAL
DSHS SEATTLE

EXHIBIT # 12

2006 MAY -2 AM 11:48
FILED
COURT OF APPEALS DIVISION ONE
STATE OF WASHINGTON
58

Adult Family Home License Application

SECTION 1 - INFORMATION ABOUT THE PROPOSED ADULT FAMILY HOME

1. NAME OF PROPOSED ADULT FAMILY HOME <p style="text-align: center; font-size: 1.2em;">DIAMOND</p>					
2. STREET ADDRESS 1578 S. Crestview Dr.		CITY Island	COUNTY Island	STATE WA	ZIP CODE 98282
3. MAILING ADDRESS (IF DIFFERENT FROM ABOVE) 1496 S. Crestview Dr.		CITY Island	STATE WA	ZIP CODE 98282	
4. TELEPHONE NUMBER 360-387-0571	5. CELL PHONE NUMBER	6. FAX NUMBER 360-387-0571			

Physical address for applicant (if the applicant is not living at the address for the proposed adult family home).

7. ADDRESS	CITY	STATE	ZIP CODE
------------	------	-------	----------

You must notify the department if the above address changes.

SECTION 2 - LANDLORD INFORMATION

8. Does the individual applicant/entity representative own this home? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "no" is checked above:	
9. NAME OF LANDLORD <p style="text-align: center; font-size: 1.2em;">DAVID MURESAN - PROVIDER</p>	
10. LANDLORD'S ADDRESS	CITY STATE ZIP CODE
11. Will the landlord take an active interest in the operation of the adult family home by charging rent as a percentage of the business, providing management services, providing care to residents or have any other involvement in the adult family home? <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 3 - UNITED BUSINESS IDENTIFIER (UBI) NUMBER AND FEDERAL EMPLOYER IDENTIFICATION NUMBER (EIN)

The following numbers are required for the license application. For information on getting these numbers, see the application instructions.

12. APPLICANT'S UBI NUMBER <p style="font-size: 1.2em;">601-369-136</p>	13. APPLICANT'S EIN NUMBER <p style="font-size: 1.2em;">91-1635601</p>
--	---

SECTION 4 - ENTITY

Fill out this section ONLY if an entity is applying for the license. An entity is a corporation, partnership, or limited liability company (LLC). If you are applying as an individual, mark the N/A box and go to section 6.

N/A (I am applying as an individual)

14. LEGAL NAME OF ENTITY (NAME LISTED ON THE EIN AND UBI)	15. TELEPHONE NUMBER	16. FAX NUMBER
17. MAILING ADDRESS	CITY	STATE ZIP CODE

SECTION 5 - INDIVIDUALS AFFILIATED WITH APPLICANT (FOR ENTITIES ONLY)

Fill out this section ONLY if an entity (a corporation, partnership, or limited liability company (LLC)) is applying for the license. If you are applying as an individual, skip this section and go to section 6.

N/A (I am applying as an individual)

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Complete the following table for all Owners, Officers, Directors, and Managerial Employees of the entity. List percentage of ownership for all stockholders with 5% or greater ownership. If you need more space, provide it on a separate page and attach it to this application.

NAME OF PERSON	TITLE OR POSITION	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YYYY)	PERCENT OWNERSHIP

SECTION 6 - INDIVIDUAL APPLICANT/ENTITY REPRESENTATIVE

The individual applicant or the entity representative must complete this section. An entity representative is the person designated by the entity as responsible for the daily operation of the proposed adult family home

18. NAME OF INDIVIDUAL APPLICANT OR ENTITY REPRESENTATIVE (LAST, FIRST, MIDDLE)
 MURESAN DAVID

19. NAME OF INDIVIDUAL APPLICANT OR ENTITY REPRESENTATIVE AS IT APPEARS ON BIRTH CERTIFICATE (LAST, FIRST, MIDDLE)
 MURESAN DAVID

20. DATE OF BIRTH
 03/03/1945

21. SOCIAL SECURITY NUMBER

22. E-MAIL ADDRESS
 davidmuresan@wavecable.com

23. TELEPHONE NUMBER IF NOT LIVING IN THE PROPOSED AFH
 N/A

24. ADDRESS IF NOT LIVING IN THE PROPOSED AFH
 N/A

CITY STATE ZIP CODE

SECTION 7 - SPOUSE OR STATE REGISTERED DOMESTIC PARTNER

25. Do you have a spouse or State Registered Domestic Partner (SRDP)? Yes No

26. Do you want your spouse or State Registered Domestic Partner to be listed on the license for this proposed adult family home? Yes No

- Notes:
- If you checked "yes" to the question immediately above, both you and your spouse or SRDP must meet all licensing requirements.
 - Couples considered legally married under Washington state law may not apply for separate licenses for each spouse.
 - State Registered Domestic Partners may not apply for separate licenses for each SDRP.
 - To be included as a SRDP, both the applicant and SRDP co-applicant must be registered with the Office of the Secretary of State, Corporations Division. For information about State Registered Domestic Partners, see www.secstate.wa.gov.

Complete below whether or not the spouse or SRDP is to be listed on the license.

27. NAME OF SPOUSE OR STATE REGISTERED DOMESTIC PARTNER (LAST, FIRST, MIDDLE)
 N/A

28. NAME OF SPOUSE OR STATE REGISTERED DOMESTIC PARTNER AS IT APPEARS ON BIRTH CERTIFICATE (LAST, FIRST, MIDDLE)
 N/A

29. DATE OF BIRTH

30. SOCIAL SECURITY NUMBER

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SECTION 8 RESIDENT MANAGER INFORMATION

This section is to be completed for the person who will be the resident manager of the proposed adult family home.

- Every adult family home application must list a resident manager for the proposed adult family home.
- A resident manager is a person employed or designated by the provider or entity representative to manage the adult family home.
- The resident manager can be the applicant, co-applicant, or other qualified person. However, a person cannot be a resident manager for more than one adult family home.
- If our records show that the person you have listed as a resident manager for this proposed adult family home is currently a resident manager for another adult family home, your application will be considered incomplete and you will be asked to designate another qualified person to be the resident manager of your proposed adult family home.

31. NAME OF RESIDENT MANAGER (LAST, FIRST, MIDDLE)

MURESAN DAVID

32. NAME OF RESIDENT MANAGER AS IT APPEARS ON BIRTH CERTIFICATE (LAST, FIRST, MIDDLE)

MURESAN DAVID

33. DATE OF BIRTH

March/03/1945

34. SOCIAL SECURITY NUMBER

SECTION 9 MINIMUM QUALIFICATIONS

Please mark with an "X" in the table below that documentation is provided with this application to verify that each of the following people meets the minimum qualifications:

- Individual applicant
- Spouse co-applicant or state registered domestic partner co-applicant,
- Entity representative, and
- Resident Manager

Include copies of the required documentation for each person. For the educational requirements (in "a" through "f" below), only one piece of proof is required.

	INDIVIDUAL APPLICANT	SPOUSE CO-APPLICANT OR STATE REGISTERED DOMESTIC PARTNER CO-APPLICANT	ENTITY REPRESENTATIVE	RESIDENT MANAGER
Has a United States high school diploma or general education development certificate, or any English translated government document of the following: a. Successful completion of government approved public or private school education in a foreign country that includes an annual average of one thousand hours of instruction a year for twelve years, or no less than twelve thousand hours of instruction (which is the equivalent of grades 1-12 in the U.S.). If so, you must include a copy of the diploma (foreign language and English translation) and proof of the required number of hours (foreign language and English translation).	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Graduation from a foreign college, foreign university, or United States accredited community college with a two-year diploma, such as an Associate's degree; If so, you must include a copy of the diploma (foreign language and English translation).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	INDIVIDUAL APPLICANT	SPOUSE CO-APPLICANT OR STATE REGISTERED DOMESTIC PARTNER CO-APPLICANT	ENTITY REPRESENTATIVE	RESIDENT MANAGER
c. Admission to, or completion of course work at a foreign or United States accredited college or university for which credit were awarded; If so, you must include a copy of the transcript(s) of credits (foreign language and English translation).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Graduation from a foreign or United States accredited college or university, including award of a Bachelor's degree; If so, you must include a copy of the diploma (foreign language and English translation).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Admission to, or completion of postgraduate course work at a United States accredited college or university for which credits were awarded, including award of a Master's degree; If so, you must include a copy of the transcript(s) of credits.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Successful passage of the United States board examination for registered nursing or any professional medical occupation for which college or university education was required. If so, attach a copy of the license. Note: This does <u>not</u> include a Certified Nursing Assistant.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has completed at least three hundred and twenty hours of successful direct care experience obtained after age eighteen to vulnerable adults in a licensed or contracted setting before operating or managing a home. Note: This information will be verified.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a valid cardiopulmonary resuscitation (CPR) certificate as required in Chapter 388-112 WAC. This training is usually provided by the American Heart Association and the Red Cross but there may be other training entities. An on-line course does not meet this requirement. Copy both sides of the card/certificate if two sides are completed.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a valid first-aid card or certificate as required in Chapter 388-112 WAC. First aid is usually done at the same time as CPR. Copy both sides of the card/certificate if two sides are completed.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has had tuberculosis (TB) screening test to establish tuberculosis status. TB screening consists of two tests done and read at different times. Consult with your local health department if you have questions. See WAC 388-76-10265 through 10310.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has completed Basic or Modified Fundamentals of Caregiving Training. If you meet the requirements of WAC 388-112-0105, you may take the modified basic training instead of basic training.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has completed the 48 Hour Administrator Training class for adult family homes.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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NOT REQUIRED

SECTION 10 SPECIALTY TRAINING

35. Check one:

- I do not intend to admit and care for residents with dementia, mental illness and/or developmental disabilities. If you check this box, please go to Section 11.
- I intend to admit and care for residents with dementia, mental illness and/or developmental disabilities. If you check this box or decide that you want to admit and care for residents with dementia, mental illness and/or developmental disabilities, the individual applicant, spouse co-applicant or state registered domestic partner co-applicant, entity representative, and resident manager must have the required manager "specialty" training. **Attach the appropriate specialty training certificates described below for each person and for each type of specialty training.**

TYPE OF SPECIALTY TRAINING	INDIVIDUAL APPLICANT	SPOUSE CO-APPLICANT OR STATE REGISTERED DOMESTIC PARTNER CO-APPLICANT	ENTITY REPRESENTATIVE	RESIDENT MANAGER
<u>Dementia Specialty Training</u> – the specialty training certificate must show the class was for "manager" dementia specialty training. If the class occurred before July 2002, the certificate MUST show that the person completed the 20 hour "dementia caregiving specialty training" class.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Mental Health Specialty Training</u> – The specialty training certificate must show the class was for "manager" mental health specialty training. If the class occurred before July 2002, the certificate must show that the person completed the 20 hour "mental health caregiving specialty training class.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Developmental Disability Specialty Training.</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 11 PREVIOUS LICENSING OR CONTRACTING EXPERIENCE

36. Has any person or entity named in this application ever owned, held an interest in, managed, or held a license for an adult family home, boarding home, nursing home, or other business providing services to children, vulnerable adults, or persons with mental illness or developmental disabilities? Yes No

If "yes", provide the information below for each person or entity in this application: (Attach additional pages if needed)

37. NAME OF PERSON <i>DAVID MAURESAN</i>	38. FACILITY LICENSE TYPE <i>ATH</i>	39. NAME OF FACILITY <i>DMMD-1,2,3</i>
40. FACILITY CITY AND STATE <i>SEATTLE</i>	41. POSITION HELD <i>MANAGER</i>	42. DATES HELD <i>1997-2003</i>
43. NAME OF PERSON	44. FACILITY LICENSE TYPE	45. NAME OF FACILITY
46. FACILITY CITY AND STATE	47. POSITION HELD	48. DATES HELD
49. NAME OF PERSON	50. FACILITY LICENSE TYPE	51. NAME OF FACILITY
52. FACILITY CITY AND STATE	53. POSITION HELD	54. DATES HELD <i>000263</i>

55. Has any person or entity named in this application ever held a contract to provide services to children, vulnerable adults, or persons with mental illnesses or developmental disabilities? Yes No

If "yes", provide the information below for each person or entity in this application: (Attach additional pages if needed)

NAME OF PERSON	TYPE OF CONTRACT	STATE	DATES HELD
DAVID MAURESAN	CAREGIVER - DSHS	WA	1997-2003

56. Has any person or entity named in this application now or previously been under investigation by a professional licensing agency, Division of Licensing Resources, a state licensing or contracting agency, Division of Children and Family Services, Child Protective Services, Adult Protective Services or the police for any disciplinary action or for abuse, neglect, exploitation or misappropriation of property of any person? Yes No

57. Has any person or entity named in this application now or previously been denied a contract, license or license renewal to operate a facility providing care to adults or children? Yes No

58. Has any person or entity named in this application been certified, licensed or contracted with to provide care or services to adults or children, and:

- had such certification or license revoked, suspended, suspended with stay, enjoined, or imposed with conditions, civil fine or stop placement? Yes No
- had a Medicaid or Medicare provider agreement revoked, cancelled, suspended or not renewed? Yes No
- relinquished or returned such certification or license; or did not seek the renewal of certification or license when notified by the state agency of initiation of denial, suspension, cancellations, or revocation of certificate, license, or contract? Yes No

If the answer is "yes", to any of the above questions (numbers 56 - 58) you must provide the following on a separate sheet of paper and attach it to this application:

- Name of the individual;
- Effective date of license or certification;
- Date of action taken;
- Type of action taken;
- Name and address of facility;
- Name and address of agency that took the action; and
- Circumstances.

See explanations to #11

SECTION 2 - BACKGROUND INFORMATION

List below and attach a completed Background Authorization form for the following:

- Individual Applicant
 - Individual Applicant's Spouse or State Registered Domestic Partner
 - Entity Owners, Partners, Officers, Directors, and Managerial Employees (Includes all members of a corporation)
 - Entity Representative
- Resident Manager
 - Landlord of the proposed adult family home if they will live, work, volunteer, or otherwise have unsupervised access to residents in the adult family homes.
 - Persons age 11 or older who currently or who will live, work, volunteer, or otherwise have unsupervised access to residents in the adult family home.

You can print out the Background Authorization form from: www.dshs.wa.gov/msa/bccu/bccu-forms.htm

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Do not complete Background Authorizations for other children age 10 or under.
Do not include residents.

Background Authorization forms must have ALL blanks filled in or the license application will be returned without action.

Results from a Background Inquiry are not accepted.

Note: If you do not include background authorization forms for anyone listed above, the department will return the application as incomplete and will not proceed with licensing activities until the background authorizations have been provided.

59. NAME OF PERSONS AGE 11 OR OLDER (Attach additional sheets of paper if needed)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	RELATIONSHIP TO APPLICANT
DAVID MURESAN	03/03/1945		N/A

60. List below any person named in this application that was or is currently employed by the State of Washington.

NAME OF PERSON	JOB TITLE/AGENCY NAME	DATES OF EMPLOYMENT WITH THE STATE OF WASHINGTON (MONTH/YEAR)
If none, check here <input checked="" type="checkbox"/> N/A		

61. List below any person named in this application whom is over the age of 18 and has lived in another state in the past three years. Also, contact the application unit at 360-725-2420 regarding the out-of-state background check process before you submit this application.

NAME OF PERSON	OUT OF STATE ADDRESS	DATES LIVED IN OTHER STATE(S) (MONTH/YEAR)
If none, check here <input checked="" type="checkbox"/> N/A		

62. List any person named in this application who is over the age of 18 and has lived in another country in the past three years.

NAME OF PERSON	COUNTRY	DATES LIVED IN OTHER COUNTRY (MONTH/YEAR)
If none, check here <input checked="" type="checkbox"/> N/A		

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SECTION 13 - FINANCIAL ASSESSMENT INFORMATION

Answer this section for the individual applicant, spouse co-applicant or state registered domestic partner co-applicant, entity applicant, entity representative, resident manager, partners, officers, directors or managerial employees of the entity, and owner of 5% or more of the entity. Place an "x" in the appropriate "yes" or "no" boxes below. Attach additional sheets of paper if needed.

63. Have you ever filed for bankruptcy? Yes No

If "yes", provide the following:

NAME OF THE INDIVIDUAL <i>DAVID MAURESAN</i>	WHAT TYPE OF BANKRUPTCY WAS FILED? <i>CHAPTER -11</i>	DATE FILED <i>10/6/2005</i>	DATE CONCLUDED <i>2007</i>
NAME OF THE INDIVIDUAL	WHAT TYPE OF BANKRUPTCY WAS FILED?	DATE FILED	DATE CONCLUDED

64. Have any judgments ever been filed against you or the entity? Yes No

If "yes", provide the following:

NAME OF THE INDIVIDUAL	DATE OF JUDGMENT	COUNTY AND STATE
DESCRIBE THE CIRCUMSTANCES <i>See attached material</i>		

SECTION 14 - CONSENT TO RELEASE AND/OR USE CONFIDENTIAL INFORMATION

The individual applicant, spouse, or state registered domestic partner co-applicant, entity representative, entity's officers, director or owner, and resident manager must each sign this section.

I consent to the release and use of confidential information about me within the Department of Social and Health Services (DSHS) for purposes of licensing. I grant permission to DSHS and any agency, division, office, or the police to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or by computer, mail, or hand delivery.

I am aware that the department is required to respond to requests for disclosure of information from the public. The department may only withhold information if a specific disclosure exemption exists. (RCW 42.56, Chapter 388-01 WAC).

Completion of this form allows the use and sharing of confidential information within DSHS and with the individual applicant or entity representative for application processing purposes. DSHS may disclose and receive confidential information from outside agencies, divisions, offices and/or the police.

This consent is valid for as long as I am the person named in this application. A copy of this form is valid for my permission to release and use this information.

NAME OF INDIVIDUAL APPLICANT <i>DAVID MAURESAN</i>	SIGNATURE <i>[Signature]</i>	DATE <i>06/23/2009</i>
NAME OF SPOUSE OR STATE REGISTERED DOMESTIC PARTNER	SIGNATURE	DATE
NAME OF ENTITY REPRESENTATIVE	SIGNATURE	DATE
NAME OF OFFICER, DIRECTOR, OWNER OF 5% OR MORE OF THE APPLICANT:	SIGNATURE	DATE
NAME OF OFFICER, DIRECTOR, OWNER OF 5% OR MORE OF THE APPLICANT:	SIGNATURE	DATE
NAME OF OFFICER, DIRECTOR, OWNER OF 5% OR MORE OF THE APPLICANT:	SIGNATURE	DATE
NAME OF OFFICER, DIRECTOR, OWNER OF 5% OR MORE OF THE APPLICANT:	SIGNATURE	DATE
NAME OF OFFICER, DIRECTOR, OWNER OF 5% OR MORE OF THE APPLICANT:	SIGNATURE	DATE
NAME OF RESIDENT MANAGER	SIGNATURE	DATE

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SECTION 5 - CERTIFICATION

I certify, under the penalty of perjury under the laws of the State of Washington and by my signature, that the information provided in this application and all additional documents and forms required for licensure of an adult family home are true, complete, and accurate. I understand that the department may obtain additional information, verification and/or documentation related to my answers or information.

I certify that the applicant, spouse co-applicant, or State Registered Domestic Partner co-applicant, entity representative, and resident manager are at least 21 years of age or older.

Copies of all documents needed to verify the items in this application are attached, and original documents will be readily available for the licenser.

I understand that failure to accurately answer or fully complete the questions on this application may result in denial of the application, termination of a license, or other sanctions as allowed by law.

I understand that the department may check the credit of the corporation or business and its principals; obtain a credit report; and verify any responses provided. The department will use such information and may disclose this information to other parts of the department as appropriate. The department may define some or all of such information as public information and also disclose this information to third parties when requested according to law to the extent that such information is not exempt from such disclosure by state or federal law.

I understand and agree that the information I give to the department will be used to verify the information in this application. Any information I give to the department may be used by the department for this purpose.

I understand that if I am licensed to operate more than one adult family home that the department will perform an individual credit history check per WAC 388-76-10035.

I understand that if my application for an adult family home license is denied, I may request an administrative fair hearing within 28 days of receiving the denial letter from DSHS.

I have read Chapters 70.128, 70.129, 74.34 RCW, and 388-76, 388-112, and 388-110 WAC, and any other applicable laws and rules.

If/when I am licensed:

- I understand that any resident manager I employ must meet the requirements of RCW 70.128.120 and WAC 388-76-10130.
- No residents receiving care and service in the adult family home will be subject to discrimination on the basis of race, color, national origin, gender, age, religion, creed, marital status, disabled or Vietnam veteran's status, or the presence of any physical, mental, or sensory disability.
- If any residents need delegated care, I will make sure that the care is delegated by a registered nurse, according to state law and rules.
- I will use the approved floor plan and will not change the use of any room until the local building inspector, if required, and the Residential Care Services field office have reviewed and approved the changes.
- I will not exceed the approved capacity of the adult family home, and will contact the Residential Care Services field office before making any capacity changes.

I certify and declare under penalty of perjury under the laws of the State of Washington that the information in this application and all of the supporting documents are true and correct to the best of my knowledge.

SIGNATURE OF APPLICANT OR ENTITY REPRESENTATIVE AUTHORIZED TO COMPLETE THIS APPLICATION

PRINT NAME *MURRESAN DAVID*

DAYTIME TELEPHONE NUMBER
(760) 360-387-0571

DATE
June-23-2009

CITY AND STATE WHERE SIGNED
Camano Island - WA

Signature of Spouse Co-Applicant or State Registered Domestic Partner Co-Applicant (only complete this area if the Spouse or State Registered Domestic Partner is also applying to be licensed for this proposed adult family home).

PRINT NAME
HIA.

DAYTIME TELEPHONE NUMBER

SIGNATURE
[Signature]

DATE
June-23-2009

CITY AND STATE WHERE SIGNED

000268



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND DISABILITY SERVICES ADMINISTRATION
PO Box 45600 * Olympia, WA 98504-5600

September 9, 2009

CERTIFIED MAIL
(7007 1490 0003 4301 3024)

COPY RECEIVED

SEP 15 2009

OFFICE OF ATTORNEY GENERAL
EVERETT

David Muresan
1578 Crestview Drive
Camano Island, Washington 98282

License Application #ANW0077946

ADULT FAMILY HOME LICENSE DENIAL

Dear Mr. Muresan:

This letter constitutes notice of the decision of the Department of Social and Health Services, Residential Care Services, to deny your application for an adult family home license. This denial is being taken under authority of Chapter 70.128 of the Revised Code of Washington (RCW) and Chapter 388-76 of the Washington Administrative Code (WAC).

This action is based upon the following:

WAC 388-76-10120(3)(a)(f) License –Must be denied.

(3) The department must deny a license if the department finds that the applicant or the applicant's spouse, domestic partner, or any partner, officer, director, managerial employee or majority owner of the applying entity:

(a) Has a history of significant noncompliance with federal or state laws or regulations in the provision of care or services to children or vulnerable adults;

(f) Is listed on a state registry with a finding of abuse, neglect, financial exploitation, or abandonment of a minor or vulnerable adult;

In making a determination as to whether to grant an adult family home license, the department must consider information on the application, other documents and information the department deems relevant which may include but is not limited to inspections and complaint investigation findings in each facility or home in which the applicant provided care and services to vulnerable adults and the applicant's credit history. WAC 388-76-10115(2)(3)(a)(b).

Upon review of information provided with your current application for an adult family home license and a review of your history as a licensed adult family home provider, the department has concluded that you have a significant history of noncompliance with state laws and regulations in the provision of care to vulnerable adults in your three adult family homes. You had licenses to

000269



EXHIBIT # 14



three adult family homes revoked and multiple courts affirmed the Department's decision to revoke those licenses.

In addition you are also listed on the state registry with a finding of abuse of a vulnerable adult.

To summarize:

You and Maria Muresan were licensed as co providers for DMMD 1 adult family home located at 18204 30th Ave NE, Seattle WA, license #524000. In April 2002 Revocation of that license was initiated. That revocation was upheld by Board of Appeals on December 23, 2002. Washington State Superior Court affirmed the revocation. Washington State Court of Appeals, Washington State Supreme Court and the US Supreme Court refused to hear your appeals thus upholding the revocation.

You and Maria Muresan were licensed as co providers for DMMD AFH located at 18210 30th Ave NE, Seattle WA, license #391000. In June 2003 that license was summary suspended and revoked. That action was upheld by Board of Appeals on March 23, 2005.

You and Maria Muresan were licensed as co providers for DMMD 3 adult family home located at 1473 S Crestview Dr., Camano Island WA, license #512600. That license was revoked on May 11, 2004. The revocation of that license was upheld by Board of Appeals on February 11, 2005.

In 2003 Adult Protective services made a substantiated finding of neglect of a vulnerable adult in your care against you and Maria Muresan. That finding was also upheld on appeal.

The above findings mandate the department deny your application for an adult family home license.

Based upon the findings above, your current application for an adult family home license is denied.

If you wish to contest this decision, you may do so by requesting an administrative hearing. The Office of Administrative Hearings must receive your written request within twenty-eight (28) calendar days of receipt of this notification. A copy of this letter must be included with your request.

Send your request to:

Office of Administrative Hearings
PO Box 42489
Olympia, Washington 98504-2489

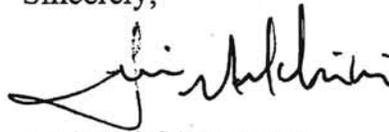
000270

If you do not request an administrative hearing within twenty-eight days of receiving this letter, this denial action will become final and you will have no further opportunity to appeal this decision.

You are advised that operating an unlicensed adult family home is against the Revised Code of Washington 70.128, and the Adult Family Home Minimum Licensing Requirements, WAC 388-76. Operation of an unlicensed adult family home could subject you to civil/criminal penalties.

If you have any questions, please contact Janice Schurman, at (360) 725-2581.

Sincerely,



Lori Melchiori, Ph.D.
Assistant Director
Residential Care Services

cc: Janice Schurman, Adult Family Home Compliance Specialist
Field Manager, Region 3 Unit B
Regional Administrator, Region 3
HCS Regional Administrator, Region 3
DDD Regional Administrator, Region 3
Area Agency on Aging, AAA-NW
Joanna Giles, Assistant Attorney General
LTC Ombudsman
Larry Yokoyama, Medicaid Fraud Control Unit
Medicaid Fraud Unit
John Ficker, HCS

000271



State of Washington
 DEPT OF SOCIAL & HEALTH SERVICES
 AGING AND DISABILITY SERVICES
 PO Box 45600
 Olympia WA 98504-5600

RETURN SERVICE REQUESTED

CERTIFIED MAIL™



7007 1490 0003 4301 3024

UNITED STATES POSTAGE
 \$ 05.54
 MAILED FROM ZIP CODE 98504

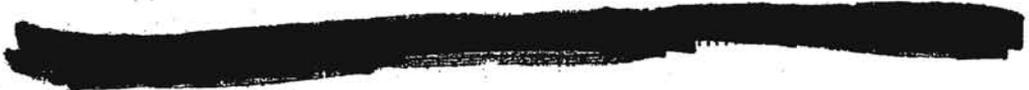
UNCLAIMED

9/11 - Gate
9-16

Mailing

4916 S. Castville Drive
SEP 30 2008
Dom Mailroom

David Muresan



000272

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For delivery information visit our website at www.usps.com

OFFICIAL USE

420E T0E4 E000 094T 2007

Postage	\$
Certified Fee	
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	\$

Postmark
Here

Sent To *David Muresan*
Street, Apt. No.,
or PO Box No. *David Case Act*
City, State, ZIP+4 *License Denial*

PS Form 3800, August 2006

See Reverse for Instructions

000273

PLACE STICKER AT TOP OF ENVELOPE TO THE RIGHT
OF THE RETURN ADDRESS, FOLD AT DOTTED LINE

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY
<ul style="list-style-type: none">■ Complete Items 1, 2, and 3. Also complete Item 4 if Restricted Delivery is desired.■ Print your name and address on the reverse so that we can return the card to you.■ Attach this card to the back of the mailpiece, or on the front if space permits.	<p>A. Signature <input type="checkbox"/> Agent <input checked="" type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) C. Date of Delivery</p>
<p>1. Article Addressed to:</p> <p>David Muresan 1578 Crestview Drive Camano Island, WA 98282</p>	<p>D. Is delivery address different from Item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input checked="" type="checkbox"/> No</p> <p>3. Service Type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>
<p>2. Article Number (Transfer from service label)</p>	<p>7007 1490 0003 4301 3024</p>

002714



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND DISABILITY SERVICES ADMINISTRATION
PO Box 45600 * Olympia, WA 98504-5600

September 9, 2009

CERTIFIED MAIL
(7007 1490 0003 4301 3024)

October 21, 2009

CERTIFIED MAIL
(7007 1490 0003 4301 3550)

AMENDED FOR ADDRESS
Amended text written in bold italics

COPY RECEIVED
OCT 23 2009
OFFICE OF ATTORNEY GENERAL
EVERETT

David Muresan
1496 S Crestview Drive
Camano Island, Washington 98282

License Application #ANW0077946

ADULT FAMILY HOME LICENSE DENIAL

Dear Mr. Muresan:

This letter constitutes notice of the decision of the Department of Social and Health Services, Residential Care Services, to deny your application for an adult family home license. This denial is being taken under authority of Chapter 70.128 of the Revised Code of Washington (RCW) and Chapter 388-76 of the Washington Administrative Code (WAC).

This action is based upon the following:

WAC 388-76-10120(3)(a)(f) License -Must be denied.

(3) The department must deny a license if the department finds that the applicant or the applicant's spouse, domestic partner, or any partner, officer, director, managerial employee or majority owner of the applying entity:

- (a) Has a history of significant noncompliance with federal or state laws or regulations in the provision of care or services to children or vulnerable adults; 098275
- (f) Is listed on a state registry with a finding of abuse, neglect, financial exploitation, or abandonment of a minor or vulnerable adult;



EXHIBIT # 15



In making a determination as to whether to grant an adult family home license, the department must consider information on the application, other documents and information the department deems relevant which may include but is not limited to inspections and complaint investigation findings in each facility or home in which the applicant provided care and services to vulnerable adults and the applicant's credit history. WAC 388-76-10115(2)(3)(a)(b).

Upon review of information provided with your current application for an adult family home license and a review of your history as a licensed adult family home provider, the department has concluded that you have a significant history of noncompliance with state laws and regulations in the provision of care to vulnerable adults in your three adult family homes. You had licenses to three adult family homes revoked and multiple courts affirmed the Department's decision to revoke those licenses.

In addition you are also listed on the state registry with a finding of abuse of a vulnerable adult.

To summarize:

You and Maria Muresan were licensed as co providers for DMMD 1 adult family home located at 18204 30th Ave NE, Seattle WA, license #524000. In April 2002 Revocation of that license was initiated. That revocation was upheld by Board of Appeals on December 23, 2002. Washington State Superior Court affirmed the revocation. Washington State Court of Appeals, Washington State Supreme Court and the US Supreme Court refused to hear your appeals thus upholding the revocation.

You and Maria Muresan were licensed as co providers for DMMD AFH located at 18210 30th Ave NE, Seattle WA, license #391000. In June 2003 that license was summary suspended and revoked. That action was upheld by Board of Appeals on March 23, 2005.

You and Maria Muresan were licensed as co providers for DMMD 3 adult family home located at 1473 S Crestview Dr., Camano Island WA, license #512600. That license was revoked on May 11, 2004. The revocation of that license was upheld by Board of Appeals on February 11, 2005.

In 2003 Adult Protective services made a substantiated finding of neglect of a vulnerable adult in your care against you and Maria Muresan. That finding was also upheld on appeal.

The above findings mandate the department deny your application for an adult family home license.

Based upon the findings above, your current application for an adult family home license is denied.

000275

If you wish to contest this decision, you may do so by requesting an administrative hearing. The Office of Administrative Hearings must receive your written request within twenty-eight (28)

David Muresan
October 21, 2009
Page 3

calendar days of receipt of this notification. A copy of this letter must be included with your request.

Send your request to:

Office of Administrative Hearings
PO Box 42489
Olympia, Washington 98504-2489

If you do not request an administrative hearing within twenty-eight days of receiving this letter, this denial action will become final and you will have no further opportunity to appeal this decision.

You are advised that operating an unlicensed adult family home is against the Revised Code of Washington 70.128, and the Adult Family Home Minimum Licensing Requirements, WAC 388-76. Operation of an unlicensed adult family home could subject you to civil/criminal penalties.

If you have any questions, please contact Janice Schurman, at (360) 725-2581.

Sincerely,

Handwritten signature of Jaye Ashley Stockwell in cursive script.

for
Lori Melchiori, Ph.D.
Assistant Director
Residential Care Services

cc: Janice Schurman, Adult Family Home Compliance Specialist
Field Manager, Region 3 Unit B
Regional Administrator, Region 3
HCS Regional Administrator, Region 3
DDD Regional Administrator, Region 3
Area Agency on Aging, AAA-NW
Joanna Giles, Assistant Attorney General
LTC Ombudsman
Larry Yokoyama, Medicaid Fraud Control Unit
Medicaid Fraud Unit
John Ficker, HCS

000277

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

David Muresan
 1496 Crostview Drive
 Camano Island, WA
 98282

2. Article Number
(Transfer from service label)

7007 1490 0003 4301 3550

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X *[Signature]*

- Agent
- Addressee

B. Received by (Printed Name)

[Signature]

C. Date of Delivery

10/27/01

D. Is delivery address different from item 1? Yes

If YES, enter delivery address below: No

3. Service Type

- Certified Mail
- Registered
- Insured Mail
- Express Mail
- Return Receipt for Merchandise
- C.O.D.

4. Restricted Delivery? (Extra Fee)

Yes

CERTIFIED MAIL RECEIPT

(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com

OFFICIAL USE

055E T064 E000 0641 2002
7007 1490 0003 4301 3550

Postage	\$
Certified Fee	
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	\$

Postmark Here

Sent To

David Muresan

Street, Apt. No., or PO Box No.

City, State, ZIP+4

Provided for address - license denial

PS Form 3808, August 2006

See Reverse for Instructions

000278



STATE OF WASHINGTON
 DEPARTMENT OF SOCIAL AND HEALTH SERVICES
 N95-2 • PO Box 24847 • Seattle WA 98124-0847

RECEIVED
 SEP 07 2010
 OAH SEATTLE

1/23/2004
 Certified Mail

Maria and David Muresan
 18210 30th Ave. N.E.
 Seattle, Wash. 98155

Dear Mr and Mrs Muresan:

The Department of Social and Health Services' Adult Protective Services program (DSHS APS) recently investigated a report of possible mistreatment of a vulnerable adult (Case ID# 38502). Based on this investigation, APS has determined that you neglected a vulnerable adult. As specified in RCW 74.34, neither the name of the victim nor the reporter may be disclosed to you.

This incident occurred during a visit by APS to your home on the 17th of July 2003. I had informed you during a previous APS visit on May 30th that the AV needed to have immediate medical attention for a large black area of skin breakdown on her heel. A physician saw her on June 2nd and home health was ordered. For some reason this was not started and you did not follow up on appropriate care for this potentially serious skin problem. The AV's son had a duty to care for the AV but you had a responsibility to the AV as well to ensure her health and safety. There was no medical follow up until her heel broke open and she was seen by a doctor again on 7/10/ 2003 at Steven's Hospital. When Home Health was started on 7/12/2003 the nurse had serious concerns about the AV's quality of care.

These actions met the definition of neglect as documented in RCW 74.34.020: Neglect means a pattern of conduct or inaction by a person with a duty to care to provide the goods and services that maintain the physical or mental health of a vulnerable adult.

At this time, you have a right to request an administrative hearing to challenge the department's determination as described in RCW 34.05 and WAC 388-02. You must request the hearing in writing within 30 calendar days of receiving this notice letter. Your request must be addressed to:

Office of Administrative Hearings
 PO Box 42489
 Olympia, WA 98504-2489

000279

16 4
 EXHIBIT D-31, p. 1 of 2



As stated in WAC 388-02-0105, you should provide enough information in your written request for the Office of Administrative Hearings to identify you and the DSHS action, including:

- Your name, address and phone number;
- A brief explanation of why you disagree with the finding of the investigation by Adult Protective Services;
- Any assistance you need, including a foreign or sign language interpreter or any accommodation for a disability.

If you request a hearing, it will be scheduled at a geographic location near you and a time convenient to you. An attorney may represent you at the hearing at your own expense. If the judge does not uphold the department's finding then Adult Protective Services will change the finding to unsubstantiated and correct the investigation record consistent with the order of the judge.

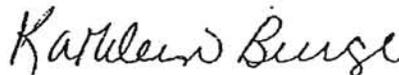
If you do not request a hearing, the department's finding will become permanent and your name will be forwarded to the DSHS Background Check Central Unit.

If you do request a hearing and the judge upholds the department's finding, it will become the permanent finding and your name will be forwarded to the DSHS Background Check Central Unit.

If the APS finding becomes permanent, state law may prevent you from being employed in a position that involves the care of vulnerable adults or children or unsupervised access to vulnerable adults or children. If the information is requested from APS or the DSHS Background Check Central Unit, DSHS may disclose the substantiated finding and your identity.

If you have questions about this notice you may call me at (206) 341-7665.

Sincerely,



Kathleen Burge, Supervisor/Program Manager
Adult Protective Services
Home and Community Services

000200

c: APS Case Record

EXHIBIT D-16, P. 2 of 4



ADULT PROTECTIVE SERVICES

ABUSE REGISTRY

Abuse Registry ID: 1161

NAME

Last Name:*+	Muresan
First Name:*+	David
Middle Name:+	
DOB:+	03/03/1945
SSN:+	
Gender:+	Male
Business Entity Name:*	
Name Status:	Investigated name

INFO

APS Case ID:	29311
Region Number:*	4
Date Provided to BCCU:	08/07/2006
BCCU Confirmation Date:	08/08/2006
Abuse Registry Status:	BCCU Submit
BCCU Retract Date:	
Retract Reason:	
BCCU Resubmit Date:	
Final Finding:	
Notes:	
Input:	

000281

EXH 0-16, P304

08/10/2006 Updated: 08/10/2006 04:41 PM

* Indicates Required Field

+ BCCU Submitted Field (Name and DOB required, SSN and Gender optional)

[Return to Search](#)

000202

NO. 69303-4-I

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

DAVID MURESAN,

Appellant,

v.

DECLARATION OF
SERVICE

WASHINGTON STATE
DEPARTMENT OF SOCIAL AND
HEALTH SERVICES,

Respondent.

I affirm under penalty of perjury of the laws of the State of Washington that the following is true and correct to my best knowledge and belief:

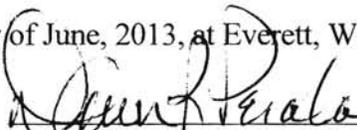
1. My name is Dawn R. Perala and I am employed as a paralegal for counsel for respondent.

2. On **June 3, 2013**, I sent via legal messenger and/or regular US Mail a true and accurate copy of Brief of Respondent to the following persons:

Court of Appeals, Division I
One Union Square
600 University Street
Seattle, WA 98101

David Muresan
1496 S. Crestview Dr.
Camano Island, WA 98282

DATED this 3 day of June, 2013, at Everett, Washington.


Dawn R. Perala, Paralegal

2013 JUN -4 AM 9:43
COURT OF APPEALS DIV I
STATE OF WASHINGTON

