NO. 103,983-2

SUPREME COURT OF THE STATE OF WASHINGTON

AKBERET TEKLE,

Petitioner,

v.

STATE OF WASHINGTON DEPARTMENT OF SOCIAL AND HEALTH SERVICES,

Respondent.

ANSWER TO PETITION FOR REVIEW

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I. INTRODUCTION

The Department of Social and Health Services Board of Review (Board) found that Akberet Tekle (Ms. Tekle) neglected Carl, a vulnerable resident of her adult family home, when she left him unattended in a wheelchair. Carl exited the home unsupervised at night, without clothes on his lower body, and wheeled across a cul-de-sac onto the front yard of a neighboring home where he fell to the ground, scraping his knees, in the below-freezing weather. The Board determined that Ms. Tekle had committed an "act or omission" resulting in neglect because she failed to provide adequate supervision to prevent Carl's elopement, even though she knew Carl had sought to exit the home before and that he needed high levels of supervision. The Board also found that Ms. Tekle's actions constituted a serious disregard of consequences that put Carl in clear and present danger because she should have known a substantial likelihood existed that Carl would try to elope should he be unsupervised

for any significant period, and that her failure to properly care for and supervise Carl put him in danger.

The Court of Appeals affirmed the Board's decision, finding in an unpublished opinion that the Board correctly applied the neglect provision of the Abuse of Vulnerable Adults Act (AVAA), that the findings of fact and conclusions of law were supported by substantial evidence, and that the Board did not misapply or misinterpret the law. It also found that the Department of Social and Health Services' (Department) actions were not arbitrary or capricious and that Ms. Tekle's due process rights were not violated.

Ms. Tekle again raises several of these issues in her request to have this Court review the Court of Appeals decision. But there are no grounds for review. The Court of Appeals decision conformed to applicable precedent and does not conflict with any published appellate decision. Nor does Ms. Tekle show how the Board's proper application of the neglect standard raises

an issue involving substantial public interest that should be determined by this Court. The petition should be denied.

II. ISSUE PRESENTED FOR REVIEW

Was the Board's finding that Ms. Tekle neglected Carl in accordance with controlling law and supported by substantial evidence?

III. STATEMENT OF THE CASE

A. The Department of Social and Health Services Cited Ms. Tekle for Neglect of Carl, a Vulnerable Adult

Ms. Tekle is the owner and operator of Orchard's Family Home (Orchard's), an adult family home. Agency Record (AR) at 161. An adult family home is a long-term care facility that provides room and board, personal care, and special care for up to six residents. RCW 70.128.010(1). An adult family home must be licensed by the Department, and is subject to Department regulations, inspections, and investigations. *See generally* chapter 70.128 RCW. As owner and operator, Ms. Tekle is

responsible for ensuring that Orchard's followed all applicable regulations. WAC 388-76-10015.

1. Carl was severely disabled and required 24-hour supervision for all activities of daily living and in the event of an evacuation

Carl was admitted to Orchard's in September 2019. AR at 161. Prior to his admission, Carl had an assessment and negotiated care plan completed, which indicated he suffered from numerous ailments, including dementia without behavioral disturbances and Alzheimer's disease. AR at 161, 303, 310.

Ms. Tekle participated in creating Carl's negotiated care plan and signed it on September 12, 2019. AR at 161, 302-24. According to that plan, "24-hour supervision is required to assist [Carl] with all activities of daily living. Schedule, meals, medications, and finances must be provided for him. He can complete some self-care tasks with set up, repeated cueing, and assistance. He requires accompanying for safety to walk to a safe area in the event of an emergency evacuation." AR at 162, 310. Although "exit-seeking" was not indicated as an issue in his

negotiated care plan, Carl was known by Ms. Tekle and others to seek to exit Orchard's through the back door and into the fenced yard, where he believed he was caring for "his chickens." AR at 162, 322.

Orchard's had an alarm on the front door that sounded when someone walked through, and Carl's bed was fitted with a bedside alarm that would alert the caregiver on duty if Carl tried to exit the bed. Verbatim Report of Proceedings (RP) Volume (Vol.) I, February 14, 2022, at 37, 73-74; RP Vol. II, February 18, 2022, at 129-30. When Ms. Tekle installed the front door alarm, she tested it near the front door. RP Vol. II at 129-30. Ms. Tekle did not test the alarm to determine whether it could be heard elsewhere in the home. RP Vol. II at 146.

2. Carl exited Orchards and was outside in freezing weather for about twenty minutes before a neighbor found him screaming for help

On November 30, 2019, the Department's Adult Protective Services Division (APS) received an intake report by Samantha Boyer (Ms. Boyer), who lived in a house across the

cul-de-sac from Orchard's, that at 5:30 a.m., a vulnerable adult was found outside screaming. AR at 278-79. On that morning, it was below freezing and dark where Orchard's is located. AR at 279, 333-36; RP Vol. I at 75. The intake report stated that the vulnerable adult had fallen out of his wheelchair and was on his knees, was wearing only a thin sweater without shoes or pants, and had multiple cuts and abrasions. AR at 278-79.

Ms. Boyer, who had recently moved in and was unfamiliar with Orchard's, reported she did not know where the man lives, but she knew there was a home at the edge of the cul-de-sac with a wheelchair ramp. RP Vol. I at 20. Ms. Boyer reported that when she knocked on the door to the home with the wheelchair ramp and asked the man who opened the door if someone worked there, the man replied, "Yes. She's sleeping." *Id*. Shortly after, Ms. Tekle came to the door dressed in pajamas. AR at 281; RP Vol. I at 20-21.

3. Orchard's nurse delegator conducted a medical evaluation of Carl and documented injuries to his body on December 4, 2019

Registered Nurse Linda Conrad (Nurse Conrad) was the Nurse Delegator[1] for Orchard's, and as such, she conducted 90-day assessments of residents, monitored the administration of residents' medication, and made sure the residents were stable and predictable. RP Vol. I at 36. About five days after the incident, on December 4, 2019, Nurse Conrad evaluated Carl at Orchard's. AR at 329-30. Regarding Carl's skin, Nurse Conrad noted, "skin thin with scattered scabs on legs." *Id.* She noted that Carl had a recent episode of agitation and anxiety and kicked the front door with his feet. *Id.*

Nurse Conrad later testified at the administrative hearing that she was familiar with Carl and at the time he moved into Orchard's he was very agitated and was constantly trying to exit

[1] Pursuant to RCW 18.79.260, registered nurses in Washington may contract privately or through the Department to provide nursing care and delegate specific nursing tasks to caregivers in certain community care settings, such as licensed adult family homes. *See also* WAC 246-840-910 to 970.

the house. RP Vol. I at 36-37. She testified that she had met Carl twice: once on September 12, 2019, and again on December 4, 2019. RP Vol. I at 46-47. She stated that it was her understanding that Ms. Tekle was aware of Carl's exit-seeking behavior, and she helped Ms. Tekle write Carl's negotiated care plan. RP Vol. I at 47-48.

The APS employee assigned to the investigation involving Ms. Tekle, Ashley Boyd (Investigator Boyd), testified at the hearing. AR at 282. Investigator Boyd testified that she also went to Orchard's on December 3, 2019, and spoke with Carl in his bedroom. *Id*. Investigator Boyd attempted to interview Carl, but Carl was not oriented to his location or the current date. *Id*.

Investigator Boyd also interviewed Ms. Tekle on December 3, 2019. Ms. Tekle reported that Carl was up all night and she stayed up all night with him. AR at 283. Ms. Tekle reported that on the morning of the incident, Carl had a bowel movement in his adult diaper and she helped him take it off and helped him into a wheelchair. *Id.* She stated that she then went to

start the water in the bathroom to warm it up, and approximately five minutes later, when she walked back into Carl's room, he was not there. *Id*.

Ms. Tekle claimed that she immediately started looking for Carl inside the home, and then heard the doorbell. RP Vol. II at 134. Ms. Tekle noticed an individual she did not recognize at the door and saw Carl in his wheelchair on the sidewalk. RP Vol. II at 134-35. Once Ms. Tekle brought Carl back into the home, she stated that she checked his vitals and found them to be normal. AR at 140-41. Ms. Tekle claimed that she did not see any wounds or injuries on Carl. AR at 146. Regarding the front door alarm, Ms. Tekle later testified that she installed and tested it in early August 2019. RP Vol. II at 125-26. Ms. Tekle testified that she tested the alarm after she installed it, but she did not test the alarm to determine whether it could be heard elsewhere in the home. RP Vol. II at 146. She testified that she did not hear the front door alarm when Carl left Orchard's on November 30,

2019. RP Vol. II at 138. After the incident, Ms. Tekle determined that the front door alarm was set to a low volume level. *Id.*

B. The Department Determined that Ms. Tekle Neglected Carl, that She Failed to Report Carl Missing, and that She Failed to Actively Support Carl's Safety

Based on the APS investigation into the circumstances of Carl's absence from Orchard's, the Department issued a notice informing Ms. Tekle that it made a neglect finding against her under its authority in chapter 74.34 RCW. AR at 293-301. Specifically, APS found that Ms. Tekle, while acting as a paid caregiver, failed to provide Carl with necessary safety precautions and/or supervision, and as a result Carl was found outside in below freezing weather, had fallen out of his wheelchair, and was screaming for assistance. AR at 293-94. Due to Ms. Tekle's action or inaction, Carl required assistance by Ms. Boyer who heard the screams and came to help him. *Id*. APS concluded that, based on these events, Ms. Tekle more likely than not neglected Carl, a vulnerable adult. *Id.*

C. The Administrative Law Judge Affirmed the Department's Neglect Finding and Determined That the Department's Evidence was Credible, and the Board Affirmed

Ms. Tekle sought review at an administrative hearing. RP Vols. I-II. Following the hearing, the Administrative Law Judge (ALJ) affirmed the finding that Ms. Tekle neglected Carl. AR at 117-41. In finding the Department's evidence to be credible, the ALJ noted: "The Department witnesses have no apparent motivation to misstate the facts, and provided consistent, credible testimony. The accounts related in the Department's provided investigative file, entered as hearing exhibits, are credible, consistent, and with no apparent motivation to misstate the facts." AR at 128.

Regarding the testimony of Ms. Tekle and her husband, Habtom Negusse (Mr. Negusse), the ALJ stated:

> I do not find Ms. Tekle or Mr. Negusse to be credible witnesses as it relates to statements that seek to minimize or exclude Ms. Tekle from culpability regarding the Department's negligence allegations. They have motivation to misstate the

> facts in order to reverse the Department's finding of neglect against Ms. Tekle.
>
> *Id.*

The ALJ found that there was conflicting evidence regarding how long Carl was outside Orchard's. *Id*. Based on the record, the ALJ found that Carl was outside Orchard's for approximately twenty minutes, which includes the time it would have taken Carl to wheel himself from his bedroom to the front of Ms. Boyer's house, Ms. Boyer becoming aware of Carl, responding to his distress, and wheeling Carl back to Orchard's. AR at 129.

Ms. Tekle petitioned for review of the ALJ's Initial Order by the Board of Appeals, which affirmed the finding of neglect. AR at 1-39.

D. The Court of Appeals Rejected Ms. Tekle's Arguments on Appeal

Ms. Tekle sought judicial review of this final agency action before the Thurston County Superior Court. Clerk's Papers (CP) at 3-49. The superior court ordered that the matter

be directly transferred to the Court of Appeals. CP at 74-75. In an unpublished opinion, Division I of the Court of Appeals affirmed the Board's determination that Ms. Tekle neglected a vulnerable adult. *Tekle v. Dep't of Soc. & Health Serv.*, No. 86862-4-I, 2025 WL 522863 (Wash. Ct. App. Feb. 18, 2025).

In its decision, the Court of Appeals found that the Board correctly applied the definition of "neglect" that has been used in *Woldemicael*, and other vulnerable adult cases, rather than the definition from child neglect cases such as *Brown*. *Tekle*, 2025 WL 522863, at *3-4. *Woldemicael v. Dep't of Soc. & Health Serv.*, 19 Wn. App. 2d 178, 494 P.3d 1100 (2021). *Brown v. Dep't of Soc. & Health Serv.*, 190 Wn. App. 572, 360 P.3d 875 (2015). Next, the court found that the Board's findings of fact and conclusions of law were both supported by substantial evidence and not erroneous, and that the Board did not misapply or misinterpret the law. *Tekle*, 2025 WL 522863, at *4-7. Finally, the court found that the Department's actions were not arbitrary or capricious because they were supported by sufficient

evidence, and therefore Ms. Tekle's due process rights were not violated and she received a hearing on the merits. *Id.* at *8.

Ms. Tekle now petitions this Court for discretionary review under RAP 13.4. Appellant Mot. at 1.

IV. ARGUMENT WHY REVIEW SHOULD BE DENIED

Ms. Tekle's petition for review should be denied because she has not met her burden to show this case meets the criteria for discretionary review. Ms. Tekle claims review should be granted pursuant to RAP 13.4(b)(2) and (4) because the Court of Appeals decision conflicts with other opinions of the Court of Appeals and because it presents a question of substantial public interest that should be determined by this Court.

Contrary to Ms. Tekle's argument, neither condition recognized by RAP 13.4(b)(2) or (4) is present, and thus review is not justified. Appellant Mot. at 12-13, 24-25. First, the decision below is not in conflict with any published decision of the Court of Appeals. Ms. Tekle asserts that the Court of Appeals erred by applying the statutory definition of neglect to this case;

however, Court of Appeals decisions since 2021 have recognized that the standard applied in *Woldemicael* and not *Brown* is the correct standard for in neglect cases involving the AVAA, chapter 74.34 RCW. *Woldemicael*, 19 Wn. App. 2d at 182. *Brown*, 190 Wn. App. 572.

Second, this appeal is particularized and fact-based and does not involve any issue of substantial public interest warranting review by this Court as required by RAP 13.4(b)(4). Ms. Tekle argues a finding of neglect impacts not only Ms. Tekle, but "scores of vulnerable adults and caregivers alike" such that Supreme Court review is necessary. Appellant Mot. at 17. While the Department recognizes the consequences of an abuse finding are undoubtedly significant for Ms. Tekle, that individual impact does not create an issue of substantial public interest warranting this Court's review. Instead, finalization of the neglect finding would accomplish the result intended by the Legislature: because substantial evidence supports the Board's finding that Ms. Tekle neglected a vulnerable adult, she should

not have access to vulnerable adults in the future. Thus, review should be denied under RAP 13.4(b)(4), because Ms. Tekle has failed to show a substantial issue of public interest.

Because Ms. Tekle has not satisfied any criteria under RAP 13.4(b), the Court should deny the petition for review.

A. The Court of Appeals Opinion is Consistent with Other Court of Appeals Cases Involving the Interpretation of Neglect Under the AVAA

The Court of Appeals interpreted and applied the definition of "neglect" in this case consistent with other Court of Appeals decisions addressing neglect in the context of the AVAA. Under RCW 74.34.020(15)(b)[2], "neglect" is "an act or omission by a person…with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety…"

///

[2] The Department's Response Brief and the Court of Appeals incorrectly cited to RCW 74.34.020(16).

Ms. Tekle argues that "neglect" should be construed narrowly, and that the Court of Appeals should have adopted the heightened standard under *Brown*, contending that "simple negligence is not enough." Appellant Mot. at 8. *Brown*, 190 Wn. App. 572. However, despite the similarities between the statutory definition of neglect of a vulnerable adult and the definition of neglect of a child applied in *Brown*, *Brown* has been clearly and consistently distinguished from cases involving vulnerable adults. *Tekle*, 2025 WL 522863; *Woldemicael*, 19 Wn. App. 2d at 182 (noting *Brown* is specific to child neglect cases). In so doing, courts have recognized that the relationship between a parent and minor child implicates the fundamental right to parent, whereas the relationship between a paid caregiver and a vulnerable adult within their care does not. *Woldemicael* 19 Wn. App. 2d at 182.

The Court of Appeals in this case simply reiterated *Woldemicael*'s holding that the heightened standard in *Brown*, stemming from the unique parent-child relationship, does not

apply to vulnerable adult cases. *Tekle*, 2025 WL 522863, at *4 (citing *Woldemicael*, 19 Wn. App. 2d at 180-83). Contrary to Ms. Tekle's contention, however, the Court in this case did not suggest that simple negligence is enough for a neglect finding. Instead, the Court reiterated *Woldemicael*'s holding that "serious disregard requires *more than simple negligence*" under the definition of neglect appliable to cases under the AVAA. *Tekle*, 2025 WL 522863, at *4 (citing *Woldemicael*, 19 Wn. App. 2d at 182) (emphasis added). The court also emphasized that "hindsight may not be used to find neglect based solely on a bad outcome; the circumstances must be examined as a whole." *Id.*

Here, as the Court of Appeals held, the Board determined that Ms. Tekle's actions rose to the level of serious disregard because she should have known a substantial likelihood existed that Carl would try to elope if left alone for an extended period, and that could result in harmful consequences to Carl. *Id*. at 7. The Court of Appeals' conclusion that this rose to the level of neglect is entirely consistent with *Woldemicael*.

Ms. Tekle also argues that *Raven* necessitates Supreme Court review as an issue of first impression. Appellant Mot. at 17. *Raven v. Dep't of Soc. & Health Serv.*, 177 Wn.2d 804, 306 P.3d 920 (2013). While *Raven* may have addressed an issue of first impression at the time it was published, *Woldemicael* has since settled the issue of the appropriate standard to use in administrative findings of neglect involving vulnerable adults and their caregivers. *Raven*, 177 Wn.2d 804. *Woldemicael*, 19 Wn. App. 2d 178. Moreover, *Raven* is distinguishable because the individual involved was a guardian, unlike Ms. Tekle, who is an adult family home owner and caregiver of vulnerable adults. *Raven*, 177 Wn.2d 804. *Tekle*, 2025 WL 522863. As recognized by the Court of Appeals, the Board noted in its final order that while *Brown* was helpful in defining "neglect," the heightened standard does not apply in vulnerable adult neglect cases, and the Board applied the correct standard when analyzing neglect in Ms. Tekle's case. *Tekle*, 2025 WL 522863.

Ms. Tekle asserts that two unpublished Court of Appeals decisions support her claim that her conduct did not rise to the level of serious disregard: *Yan v. Pleasant Day Adult Family Home, Inc., P.S.,* No. 68976-2-I, 2013 WL 6633440 (Wash. Ct. App. Dec. 16, 2013) and *Ocak v. Dep't of Soc. & Health Serv.*, No. 56862-4-II, 2023 WL 3591175 (Wash. Ct. App. May 23, 2023). These are unpublished opinions with no precedential value, and the Court of Appeals decision specifically addressed both cases in its opinion to explain why the facts of those cases were distinguishable. *Tekle*, 2025 WL 522863.

As noted by the Court of Appeals, in *Yan,* the adult family home provider was not informed about the vulnerable adult's exit seeking behavior or that the adult was recommended to be placed in a facility providing a higher level of care. *Yan*, 2013 WL 6633440, at *2. Additionally, the provider explicitly told the resident's family they needed to find a new home for the resident after the resident repeatedly fell and eloped from the facility. *Id* at *7. In *Ocak*, the provider was the mother of a vulnerable adult,

she took numerous steps to prevent her son's elopement, and the court determined it would be against public policy to find family members accountable for neglect every time a developmentally delayed adult being cared for at home eloped. *Ocak*, 2023 WL 3591175, at *10.

The Court of Appeals instead likened the facts of this case to those in *Kabbae*, where the court affirmed a finding of neglect after a caregiver at an adult family home left three vulnerable adults, who required 24-hour supervision, unattended for at least 20 minutes. *Kabbae v. Dep't of Soc. & Health Serv.*, 144 Wn. App. 432, 192 P.3d 903 (2008). *Tekle*, 2025 WL 522863. As the Court of Appeals noted, despite knowing Carl suffered from dementia and had eloping tendencies, Ms. Tekle left him unattended long enough for him to exit the house in the dark, minimally clothed, in freezing temperatures, where he was alone for about 20 minutes. *Tekle*, 2025 WL 522863. Ms. Tekle should have known a substantial likelihood existed that Carl would try to elope if left alone for an extended period without

effective systems in place to monitor his movements, and her conduct was in serious disregard of the potential, harmful consequences to Carl's health, safety, or welfare. *Id.*

Ms. Tekle argues that the fact that *Woldemicael* and the decision below did not discuss this Court's decision in *Kim*, suggests this Court should review the matter. *Kim v. Lakeside Adult Family Home*, 185 Wn.2d 532, 374 P.3d 121 (2016). *See* Appellant Mot. at 21-22. Ms. Tekle contends that it was error for the Court of Appeals not to "account for this Court's reasoning in *Kim,*" which she argues "clearly supports the application of *Brown* to an AVAA neglect case." Appellant Mot. at 22.

However, *Kim* does not discuss *Brown*, let alone address the appropriate standard for neglect to be used in the AVAA context. Rather, *Kim* concerned whether the AVAA's mandatory reporting provision created an implied private cause of action for failure to report abuse. *Kim*, 185 Wn.2d at 542. In conducting that analysis, the Court was guided by its previous conclusion that the Abuse of Children Act (ACA), RCW 26.44, implies a

cause of action against mandatory reporters who fail to report suspected child abuse. *Kim*, 185 Wn.2d at 542-47. However, nothing about *Kim* suggests that each statutory provision in the AVAA must be construed identically to those in the ACA. Ms. Tekle also points to *Pal*, an unpublished decision issued prior to *Woldemicael*, but that case rejected a provider's argument that "the Board's failure to apply the standard of neglect articulated in *Brown* requires reversal." *Pal v. State*, No. 50660-2-II, 2019 WL 1048268, at *10 (Wash. Ct. App. Mar. 5, 2019). The decision below is entirely consistent with *Woldemicael* and other published Court of Appeals cases holding that the neglect definition in the AVAA does not incorporate the heightened standard in the child abuse context set forth in *Brown*. Review under RAP 13.4(b)(2) is not warranted.

B. The Application of RCW 74.34.020(15) in This Case Does Not Present an Issue of Substantial Public Interest

This case does not present an issue of substantial public interest that should be determined by this Court under

RAP 13.4(b)(4), because the Court of Appeals properly applied the statutory definition of neglect of a vulnerable adult under RCW 74.34.020(15), APS lacks authority to modify the effects of a final finding under chapter 74.34 RCW, and Ms. Tekle has exercised her right to and has received adequate due process.

Ms. Tekle asserts this case presents an issue of substantial public interest because review will prevent unnecessary litigation and confusion in the future and a finding of neglect is professionally disqualifying for the individual involved. Appellant Mot. at 13. The analysis of neglect of a vulnerable adult used by the Court of Appeals' is consistent with prior case law interpreting this issue. *Crosswhite v. Dep't of Soc. & Health Serv.*, 197 Wn. App. 539, 551, 389 P.3d 731 (2017); *Brown v. Dep't of Soc. & Health Serv.*, 145 Wn. App. 177, 180-81, 185 P.3d 1210 (2008). As discussed above, the decision of the Court of Appeals in this case is unpublished, it is fact-specific, and it analyzes the correct standard for neglect cases involving vulnerable adults and paid caregivers. Therefore, it will not lead

to unnecessary litigation and confusion and does not present an issue of substantial public interest.

Second, currently, nothing in statute specifically authorizes APS to limit the effects a final finding under chapter 74.34 RCW has on Ms. Tekle, or any person who is placed on it. APS has asked the Legislature on multiple occasions to create such a process as the Legislature did for individuals with final findings of child neglect following the Washington Supreme Court's decision in *Fields*, or to specifically authorize the Department to promulgate rules establishing how and when the effects of a final finding should expire, the Legislature has not seen fit to do so. *Fields v. Dept. of Early Learning*, 193 Wn.2d 36, 434 P.3d 999 (2019). Although this Court held in *Romero* that RCW 74.39A.056(3) authorizes the Department to remove individuals from the vulnerable adult abuse registry, Division I held, much more broadly, in *Garcia*, that even a database containing prior agency decisions constitutes a "registry" under RCW 74.39A.056(2), and that provider

employment bans created in RCW 74.39A.056(2) are required by statute, not Department regulation, are permanent, and require legislative action to change. *Garcia v. Dep't of Soc. and Health Serv.,* 10 Wn.App.2d 885, 451 P.3d 1107 (2019); *Romero v. Dep't of Soc. and Health Serv.*, 30 Wn.App.2d 323, 544 P.3d 1083 (2024). According to *Matter of Arnold*, "one division [of the Court of Appeals] is not bound by the decision of another division" and "[s]tatewide agencies and other entities cannot choose to ignore a published judicial decision." *Matter of Arnold*, 190 Wn.2d 136, 154, 410 P.3d 1133 (2018). Thus as APS understands *Garcia*, even if it removes a person from the APS registry, that would not alleviate the requirements of RCW 74.39A.056(2), and APS has no authority to limit the effect of that statute. Insofar as Ms. Tekle does not believe a neglect finding should be the basis for permanent placement on the registry in the vulnerable adult context as required by RCW 74.39A.056(2), that argument is best left to the Legislature.

Third, Ms. Tekle received all the process she was due: she received notice of the neglect finding and requested an administrative hearing. At the administrative hearing, she was represented by counsel, she called and cross-examined witnesses, presented documentary evidence, and testified herself. After the hearing, Ms. Tekle, through counsel, appealed the initial order to the Board and successfully sought and obtained review by the Court of Appeals.

Ms. Tekle points to the consequences of her placement on the Vulnerable Adults Abuse Registry, which would prevent her from unsupervised access to vulnerable adults or children in the future. Appellant Mot. at 13-14. Although permanent placement on a vulnerable adult registry limits Ms. Tekle's future opportunities in her chosen career, she had access to and used significant procedural protections before the neglect finding became final. While the Department recognizes the significant consequences for Ms. Tekle, placement on the Vulnerable Adults Abuse Registry is the result intended by the Legislature in cases

such as these: because substantial evidence supported the Board's finding that Ms. Tekle neglected a vulnerable adult, she should not have access to vulnerable adults in the future to ensure their safety from harmful actions such as abuse or neglect at the hands of their caregivers. *See* RCW 74.39A.056(2).

The petition for review should be denied because the decision of the Court of Appeals amounts to an individualized analysis of neglect of a vulnerable adult, which is specific to Ms. Tekle's individual interest as a paid caregiver and provides no significant issue of substantial public interest that this Court should decide. Ms. Tekle has failed to meet her burden to show review should be granted under RAP 13.4(b)(4).

V. CONCLUSION

This Court should deny Ms. Tekle's petition for discretionary review because she has failed to satisfy the requirements of RAP 13.4(b). The decision below does not conflict with other published Court of Appeals decisions involving the definition of neglect under RCW 74.34.020(15)(b),

and the Court of Appeals undertook a thorough, fact-specific analysis of the Board's decision that does not raise a question of substantial public interest requiring Supreme Court determination.

This document contains 4,872 words, excluding the parts of the document exempted from the word count by RAP 18.17.

RESPECTFULLY SUBMITTED this 18th day of April, 2025.

NICHOLAS W. BROWN
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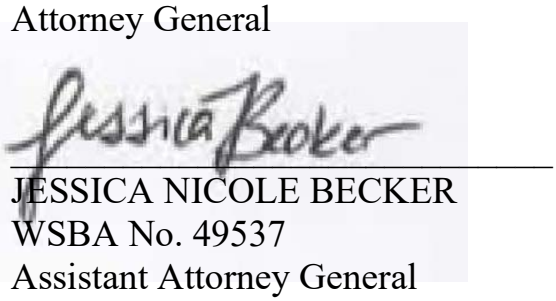

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PROOF OF SERVICE

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

DATED this 18th day of April, 2025, at Olympia, Washington.

Chelsea DeWeese

CHELSEA DEWEESE
Legal Assistant

WASHINGTON STATE ATTORNEY GENERAL'S OFFICE

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