STATE OF WASHINGTON
DEPARTMENT OF HEALTH
SECRETARY OF HEALTH

In the Matter of **DAYBREAK YOUTH SERVICES – BRUSH PRAIRIE** License No. RTF.FS.60722961 Respondent	**No. M2023-435** **NOTICE OF INTENT TO SUSPEND**

Pursuant to RCW 43.70.115, the Office Director for the Department of Health Office of Community Health Systems (Department), which includes the Residential Treatment Facilities Program (Program), on designation by the Secretary, having authority to regulate Residential Treatment Facilities (RTFs) under chapters 71.12 RCW and 246-337 WAC, hereby provides Notice of Intent to Suspend License No. RTF.FS.60722961. This Notice will take effect and become a Final Order, without further notice, twenty-eight (28) days after receipt, absent a timely request for an adjudicative proceeding. This Notice is based on the following findings of fact and conclusions of law.

1. FINDINGS OF FACT

1.1 The Program is a sub-unit of the Department with authority to license and regulate RTFs. The Program's authority to license and regulate RTFs is found at RCW 71.12 and WAC 246-337, and includes authority to review all records and interview all RTF clients and RTF staff. RCW 71.12.500 through .530.

1.2 On May 16, 2017, the state of Washington issued Daybreak Youth Services – Brush Prairie (DYS – Brush Prairie), located at 11910 NE 154th Street, Brush Prairie, WA 98606 (Daybreak), license no. RTF.FS. 60722961 to operate as a residential treatment facility (RTF). DYS – Brush Prairie's license is currently active.

1.3 DYS – Brush Prairie is operated by Daybreak Youth Services (Daybreak), a nonprofit corporation, which also operates a licensed and certified BHA and licensed RTF in Spokane, Washington (DYS – Spokane). A number of employees administer and oversee both DYS – Brush Prairie and DYS – Spokane including, but not limited to, the Chief Executive Officer, the Risk Management Coordinator, and Human Resources.

There are also a number of employees who work from an assigned location, such as DYS – Brush Prairie.

1.4 In addition to being required to comply with state licensing laws, Daybreak must also comply with 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2 (Part 2).

1.5 Part 2 is a federal law that protects the confidentiality of substance use disorder (SUD) records and information in the possession of Part 2 covered programs, such as DYS - Brush Prairie, and in the possession of other lawful holders. In general, Part 2 prohibits Part 2 covered programs from disclosing Part 2 covered records and information without patient consent. However, Part 2 permits Part 2 covered programs to disclose Part 2 covered records and information to state agencies "authorized by law to regulate the activities of the Part 2 program." 42 CFR § 2.53(b)(2)(i). The Program is authorized by law to regulate the activities of DYS - Brush Prairie. DYS - Brush Prairie is therefore permitted to allow the Program to review, copy, remove, download, or forward patient records so long as the Program agrees in writing to comply with the conditions outlined in 42 CFR § 2.53(b)(1).

Kathryn Reinmuth (Reinmuth) and Patient #9

1.6 On July 25, 2022, the Program received a complaint alleging that Daybreak – Brush Prairie may have violated WAC 246-16-270 and RTF incident reporting rules when it terminated the employment of Reinmuth for committing boundary violations with a former patient of DYS – Brush Prairie, Patient #9. An investigation was authorized, and the Program assigned the investigation (case no. 2022-8554) to Program Investigator Emely Lee (Investigator Lee). As part of its investigation, the Program informed DYS - Brush Prairie in writing that the Program would comply with the conditions in Part 2 to protect covered records and information obtained from DYS – Brush Prairie.

1.7 Patient #9 received services from DYS – Brush Prairie as part of two (2) treatment episodes. The first treatment episode occurred between approximately May 4, 2021, and July 8, 2021. The second treatment episode occurred between approximately September 8, 2021, and October 13, 2021. At all times relevant to the facts below, Patient #9 was a minor.

1.8 While admitted to DYS – Brush Prairie, Patient #9 had frequent contact with Reinmuth, including disclosing to Reinmuth that Patient #9 was raped by a teacher.

Reinmuth was employed by DYS – Brush Prairie as a Skills Coach between approximately October 26, 2020, and April 1, 2022. Based on DYS – Brush Prairie's job description for the Skills Coach position, Reinmuth was responsible for, among other things: monitoring, coaching, and documenting patient behavior; supervising recreational activities for patients; serving as a role model for appropriate behavior; and continually attempting to develop solid relationships with all patients in order to build trust. Reinmuth held an active registration as an Agency Affiliated Counselor while employed at DYS – Brush Prairie.

1.9 On or about March 13, 2022, DYS – Brush Prairie staff received a phone call from Patient #9. During this phone call, Patient #9 reported they had been in communication with Reinmuth since being discharged, and that Reinmuth had been communicating with another patient of DYS – Brush Prairie outside of the facility. Patient #9 reported the conduct of Reinmuth had triggered a manic episode due to past trauma when Patient #9 had been raped by a teacher. DYS – Brush Prairie staff who received Patient #9's phone call informed DYS – Brush Prairie's risk-management team, including Melissa "Missy" Boyd (Boyd) and Michael Trotter (Trotter), of this phone call.

1.10 On or about March 14, 2022, Trotter had a telephone conversation with Patient #9's parents. During this conversation, Patient #9's parents reported that, since being discharged from DYS – Brush Prairie, Patient #9 had been communicating with Reinmuth via cellphone and social media. These communications included discussions of a sexual nature, Reinmuth's marital issues, and Reinmuth's disclosure of romantic feelings for Patient #9 as well as for another patient who received services at DYS – Brush Prairie.

1.11 In addition, Patient #9's parents reported to Trotter that on or about February 24, 2022, Reinmuth drove to see Patient #9 perform in a high school musical production. After the production, Reinmuth drove Patient #9 to an Airbnb that Reinmuth was staying at, and Reinmuth asked Patient #9 if they would stay overnight. After a number of hours together at the Airbnb, Reinmuth drove Patient #9 home. The next morning, Reinmuth took Patient #9 to a restaurant for breakfast and back to the Airbnb where they stayed for a number of hours.

1.12 On or about March 16, 2022, one of Patient #9's parents provided information to Trotter about another DYS – Brush Prairie patient that Reinmuth was reported to have communicated with outside of the facility.

1.13 On or about March 16, 2022, Patient #9's mother provided Trotter with screenshots of Instagram messages sent between Patient #9 and Reinmuth. These screenshots included messages sent by Reinmuth stating that Patient #9 was "unforgettable" and asking whether Patient #9 ever had "romantic feelings" for Reinmuth.

1.14 On or about March 23, 2022, DYS – Brush Prairie staff interviewed Reinmuth about the allegations involving Patient #9. Reinmuth denied having any communication or contact with Patient #9 since their discharge from DYS – Brush Prairie.

1.15 On or about March 25, 2022, DYS – Brush Prairie staff interviewed Patient #9. During the interview, Patient #9 stated Reinmuth provided her phone number and Instagram to Patient #9 when they were discharging from DYS – Brush Prairie. Patient #9 also reported Reinmuth attended their high school musical production and that after the production, Reinmuth drove Patient #9 to an Airbnb Reinmuth was staying at. While at the Airbnb, Patient #9 reported Reinmuth's body language was "inappropriate" and Reinmuth was "scooting closer to me like she wanted to cuddle". After a number of hours together, Reinmuth drove Patient #9 home. The next morning, Reinmuth and Patient #9 spent a number of hours together.

1.16 On or about March 28, 2022, Patient #9's mother provided Trotter with Patient #9's cellphone records. The cellphone records allegedly documented communication between Patient #9's cellphone and Reinmuth's cellphone.

1.17 On or about March 29, 2022, DYS – Brush Prairie staff interviewed Reinmuth a second time. During the interview, Reinmuth admitted to communicating with Patient #9 after they had discharged from DYS – Brush Prairie. Reinmuth also admitted to attending Patient #9's high school musical production and taking Patient #9 to breakfast the day after the production. Reinmuth denied driving Patient #9 to the Airbnb Reinmuth was staying at.

1.18 On or about March 31, 2022, DYS – Brush Prairie terminated Reinmuth's employment effective April 1, 2022. The termination letter stated that Reinmuth had

been dishonest with DYS – Brush Prairie during an interview on or about March 23, 2022, and had violated Daybreak's Code of Ethics and Conduct policy by communicating with a former patient.

1.19 DYS – Brush Prairie did not report Patient #9's complaint or Reinmuth's termination of employment to the Department until June 10, 2022. DYS – Brush Prairie is required by law to report incidents to the Department that involve serious or undesirable outcomes by the next business day, such as the incident involving Patient #9 and Reinmuth. DYS – Brush Prairie is also required by law to report to the Department when an individual, licensed by the Department, is terminated from employment because they have engaged in unprofessional conduct or harmed a patient or have placed a patient at unreasonable risk of harm, such as the incident involving Patient #9 and Reinmuth. Rather than submit this information timely, it was not until approximately June 10, 2022, that DYS – Brush Prairie submitted a report as required by Section 4.6 of a Stipulated Findings of Fact, Conclusions of Law and Agreed Order entered *In the Matter of Daybreak Youth Services – Brush Prairie*, Case No. M2018-844 and M2018-845. During an interview with the Program's investigator, Thomas Russell (Russell), Chief Executive Officer (CEO) of Daybreak, stated DYS – Brush Prairie was not mandated by law to report Patient #9's complaint and Reinmuth's termination of employment to the Department but because DYS – Brush Prairie wanted the Program to be aware of this information it chose to submit the information as part of its report submitted on or about June 10, 2022.

1.20 As part of the Program's investigation, Patient #9 reported that when Patient #9 and Reinmuth were at the Airbnb Reinmuth was staying at, Patient #9 touched Reinmuth's breasts, Reinmuth touched Patient #9's genitalia, and that Patient #9 and Reinmuth kissed and hugged each other. Patient #9 also reported to the Program that the incidents involving Reinmuth negatively impacted Patient #9's mental health immensely and caused them to deteriorate and seek mental health treatment. Further, Patient #9 reported to the Program and DYS – Brush Prairie that the incidents with Reinmuth resembled how they felt when they were raped by a teacher.

1.21 Although DYS – Brush Prairie received reports directly from Patient #9 and Patient #9's parents that Reinmuth had allegedly had contact with another patient of DYS – Brush Prairie, DYS – Brush Prairie did not initiate an internal investigation

specific to the allegations in these reports. Instead, as part of conducting the investigation related to Reinmuth and Patient #9, DYS – Brush Prairie simply asked Reinmuth whether she had contacted any other patient of DYS – Brush Prairie outside of the facility, and asked Patient #9's parents if they knew the name of the other patient. Patient #9 provided some information to DYS – Brush Prairie employees during an interview but those comments were unprompted and not offered because DYS – Brush Prairie employees asked.

1.22 On or about November 9, 2022, Investigator Lee also made a request for copies of any internal investigations conducted by Risk Management or Human Resources involving professional misconduct and/or boundary violations by staff for the last twelve (12) months. On or about November 15, 2022, DYS – Brush Prairie responded to this request, through its attorney, by stating that the term "professional misconduct" was undefined, and thus vague and ambiguous. Opting to use the definition of "unprofessional conduct" in RCW 18.235.130 (a statute that applies to a range of non-health care business and not to BHAs or RTFs), DYS – Brush Prairie asserted that there have been no incidents of unprofessional conduct reported to DYS – Brush Prairie. DYS – Brush Prairie then stated it had previously disclosed all documents related to "boundary" violations to Investigator Deborah Duke (Duke) as part of a separate investigation and that Investigator Lee should obtain the records from Investigator Duke because it would be too burdensome and expensive for DYS – Brush Prairie to produce them.

Alicia Stowe (Stowe) and Patient #10

1.23 On or about February 8, 2023, the Program received a second complaint alleging a counselor (Stowe) employed at DYS – Brush Prairie was arrested for having a sexual relationship with Patient #10. This second complaint (case no. 2023-2056) was authorized for investigation. The investigation was initially assigned to Investigator Lee before being re-assigned to Investigator Suzanne Todd (Investigator Todd). As part of its investigation, the Program informed DYS - Brush Prairie in writing that the Program would comply with the conditions in Part 2 to protect covered records and information obtained from Daybreak.

1.24 Patient #10 received services from DYS-Brush Prairie for approximately two (2) or three (3) months at the end of 2020, and again from approximately

January 2021 to March 17, 2021. At all times relevant to the facts below, Patient #10 was a minor.

1.25 While admitted to DYS - Brush Prairie, Patient #10 had frequent contact with Stowe. Stowe was employed by DYS - Brush Prairie as a Skills Coach between approximately May 2020, and February 10, 2022. Based on DYS – Brush Prairie's job description for the Skills Coach position, Stowe was responsible for, among other things: monitoring, coaching, and documenting patient behavior; supervising recreational activities for patients; serving as a role model for appropriate behavior; and continually attempting to develop solid relationships with all patients in order to build trust. Stowe held an active registration as an Agency Affiliated Counselor while employed at DYS-Brush Prairie.

1.26 During March 2021, Stowe initiated and engaged in sexual contact, including sexual intercourse, with Patient #10 on multiple occasions. The sexual contact between Stowe and Patient #10 occurred within DYS - Brush Prairie's facility and while Patient #10 was still receiving inpatient services from DYS - Brush Prairie. Patient #10 did not report this sexual contact to any of DYS – Brush Prairie's staff.

1.27 Stowe continued to have sexual contact, including sexual intercourse, with Patient #10 after Patient #10 was discharged from DYS – Brush Prairie. Patient #10 reported to the Program and to law enforcement that Stowe would contact Patient #10 to arrange a meeting, travel to Patient #10's location, book a hotel room, and then Patient #10 would travel to the hotel themselves or Stowe would pick up Patient #10 and transport them to the hotel. Once at the hotel, Patient #10 and Stowe would engage in sexual contact, including sexual intercourse. This occurred on multiple occasions. Patient #10 did not report this sexual contact to any staff of DYS – Brush Prairie.

1.28 Stowe's employment with DYS - Brush Prairie was terminated on February 10, 2022, due to excessive absences and failing to use proper call out procedures.

1.29 On or about February 18, 2022, the Clark County Sheriff's Office received a report stating Stowe and Patient #10 had been texting each other and arranged to meet at a hotel. On or about February 25, 2022, a Clark County Sheriff's Office deputy called DYS - Brush Prairie to discuss the incident with management. A DYS - Brush

Prairie staff person indicated that someone in risk management or the executive office would return the deputy's call. David Smith (Smith), Daybreak's attorney, returned the deputy's call later in the day. The deputy summarized the investigation for Smith, provided the identities of the individuals involved, and explained what type of information was needed by the deputy from Daybreak. Smith then informed the deputy that he would speak with Daybreak's leadership and that a report would need to be filed with the Department.

1.30 Subsequent to the communication with the Clark County Sheriff's Office, DYS - Brush Prairie did not file a report with the Department, nor did DYS – Brush Prairie conduct an internal investigation of the encounters between Stowe and Patient #10. During an interview on March 22, 2023, Melissa "Missy" Boyd (Boyd), DYS – Brush Prairie's Risk Management Coordinator, reported to Program investigators that DYS – Brush Prairie did not conduct any internal investigation based on the communication with the deputy because DYS – Brush Prairie was only provided limited or no information from the deputy. This is contrary to the deputy's report of the conversation with Smith, which indicates the deputy provided the identity of the individuals involved as well as a summary of the investigation.

1.31 Approximately twelve (12) months after the communication with the Clark County Sheriff's Office, DYS – Brush Prairie did conduct an internal investigation based on a media report that detailed the encounters between Stowe and Patient #10. During an interview on March 22, 2023, Boyd informed Program investigators that DYS – Brush Prairie's internal investigation resulted in findings that "couldn't determine anything necessarily", except that Stowe had used her key fobs in multiple doors of the facility on a specific day. Boyd further stated that these findings were provided to the Clark County Sheriff's Office, but that Boyd did nothing else internally in response to the investigation other than file it. During the same interview, Boyd was unable to articulate, in her position as Risk Management Coordinator, what, if any, quality improvement efforts were undertaken in response to the incidents involving Stowe and Patient #10 other than the internal investigation.

1.32 Investigator Todd also made a request for quality improvement documentation, including copies of internal investigations, which would demonstrate

what action DYS – Brush Prairie took in response to the incidents involving Stowe and Patient #10, but DYS – Brush Prairie did not provide any.

LaRae Swope (Swope), Abdul Conteh (Conteh), and Patient #11

1.33 While conducting the investigation of the second complaint (case no. 2023-2056) the Program became aware of allegations that another counselor at DYS – Brush Prairie (Swope) had engaged in sexual contact with Patient #11 within DYS – Brush Prairie's facility and while Patient #11 was admitted to DYS – Brush Prairie. Specifically, Smith informed the Program on or about March 21, 2023, that Daybreak was served with a complaint for damages related to Swope and Patient #11 on or about March 10, 2023.

1.34 Patient #11 received services from DYS - Brush Prairie between approximately September 17, 2021, and November 24, 2021. At all times relevant to the facts below, Patient #11 was a minor.

1.35 While admitted to DYS - Brush Prairie, Patient #11 had frequent contact with Swope. Swope was employed by DYS - Brush Prairie as a Skills Coach between approximately July 2021, and November 30, 2021. Based on DYS – Brush Prairie's job description for the Skills Coach position, Swope was responsible for, among other things: monitoring, coaching, and documenting patient behavior; supervising recreational activities for patients; serving as a role model for appropriate behavior; and continually attempting to develop solid relationships with all patients in order to build trust. Swope had a pending registration as an Agency Affiliated Counselor while employed at DYS - Brush Prairie.

1.36 During Patient #11's first week at DYS – Brush Prairie, Swope started to appear around Patient #11 more often and initiated conversations that gave, what Patient #11 described to Program investigators as, "weird signals". Swope also questioned Patient #11 on their personal life and asked whether Patient #11 had ever had a romantic relationship with an older woman.

1.37 While Patient #11 was admitted to DYS – Brush Prairie, on at least two (2) occasions, Swope initiated sexual contact with Patient #11 without Patient #11's consent within DYS – Brush Prairie's facility, specifically in a restroom out of view of any camera. During one of these encounters, another patient was in the bathroom and observed what happened. According to Patient #11's report to Program investigators,

this caused Swope to “freak out” and tell the other patient not to tell anyone about what they observed. Patient #11 told Program investigators they felt scared that if they did not do what Swope wanted them to do then they “could be blackmailed or there would be consequences.”

1.38 Swope also engaged in nonconsensual sexual contact with Patient #11 during an outing from DYS – Brush Prairie. Patient #11 reported that Swope stated Patient #11 should sit in the back of the van with them, or else Swope would hurt Patient #11. Patient #11 could only describe the incident to Program investigators as worse than the incidents in the bathroom.

1.39 Swope also wrote notes to Patient #11 confessing her love and detailing her sexual intentions and desires. Patient #11 showed one of the notes to Conteh, another Skills Coach employed at DYS – Brush Prairie, because Patient #11 felt like they could trust Conteh. Patient #11 reported to Program investigators that Conteh tried to “make it seem cool” that Patient #11 had an older woman doing sexual things with them. Conteh returned the note to Patient #11. The note was later ripped up by Patient #11 at the request of Swope.

1.40 Patient #11 also told Program investigators they felt a lack of privacy at DYS – Brush Prairie due to the cameras in the bathroom and that they felt uncomfortable being in the bathroom when a staff member, usually of the opposite gender, was present.

1.41 Patient #11 was discharged from DYS – Brush Prairie on November 24, 2021. Conteh gifted Patient #11 an Xbox game when they were discharged. During an interview with Program investigators, Patient #11’s mother commented that the gift “seemed weird and felt inappropriate.” Additionally, Swope kept in contact with Patient #11 through social media. Patient #11 stopped contacting Swope because they felt like it was not right.

1.42 DYS - Brush Prairie terminated Swope on November 30, 2021, over “concerns around professional and personal boundaries with Daybreak clients”. Swope’s termination letter indicates that she gave out her personal cell phone number to a discharging client, informed the client it was okay to contact her, asked other parties to keep this information a secret, and answered her personal cell phone while on shift and in front of three patients. DYS-Brush Prairie did not report Swope’s

unprofessional conduct and termination of employment to the Department until the Program investigators' on-site investigative visit on March 21, 2023. This is despite the fact that current law requires DYS – Brush Prairie to report incidents to the Department that involve serious or undesirable outcomes by the next business day, such as the incidents that resulted in Swope's termination. DYS – Brush Prairie is also required by law to report to the Department when an individual, licensed by the Department, is terminated from employment because they have engaged in unprofessional conduct or harmed a patient or have placed a patient at unreasonable risk of harm, such as the incidents resulted in Swope's termination.

1.43 Program investigators also made a request for quality improvement documentation, including copies of internal investigations, which would demonstrate what, if any, action DYS – Brush Prairie took in response to the incidents involving Swope and Patient #11, but DYS – Brush Prairie did not provide any.

1.44 The incidents involving Reinmuth, Stowe, and Swope evidence an inability of DYS – Brush Prairie to provide a safe environment for the patients it serves and an inability to safeguard patients against violations of their individual participant rights including, but not limited to, being treated with respect and dignity, and receiving services in an environment that is free of exploitation.

Internal and External Reporting, and Staffing

1.45 While conducting investigations at DYS – Brush Prairie of the second complaint (case no. 2023-2056), Program investigators observed a disturbing trend that staff at Daybreak Youth Services were actively discouraged by supervisors and members of Daybreak leadership from making, and failed to make, required reports to external agencies, such as the Department and the Department of Children and Youth Services – Child Protective Services (DCYF/CPS); were misinformed by Daybreak leadership and Daybreak's attorney about their status as mandatory reporters; were coached by Daybreak leadership on how and when to answer questions posed by Program investigators; and did not have their grievances taken seriously by Daybreak leadership. Examples of the foregoing include, but are not limited to, the following:

A. Program investigators spoke with Fawn Hughes (Hughes), a former Skills Coach at DYS – Brush Prairie, regarding her experience at DYS-Brush Prairie while employed during the summer of 2022.

Hughes informed Program investigators that after providing contact information for the Program's investigators to a current staff member, the current staff member replied stating that current staff members cannot speak to the Program and that Daybreak's attorney was handling it all.

B. Danica Skalski (Skalski), a former Substance Use Disorder Professional at DYS – Spokane, reported that Daybreak provided several trainings on reporting. During a training facilitated about the summer of 2021, Smith, Daybreak's attorney, informed staff, including skills coaches, team leads, and Substance Use Disorder Professional (SUDPs) counselors, they were not mandated reporters. Skalski expressed her confusion about how and why she would be exempt from her mandated reporting requirements. Skalski received no guidance for her concern.

C. Skalski also said that, before being interviewed by Program investigators as part of another investigation, Daybreak leadership made comments to her beforehand that made her feel anxious, uncomfortable, and limited in what she could say. Skalski also said, Daybreak's leadership informed staff they could speak to the Program only if risk management approved the contact, and that, if staff received a call from the Program, they should immediately inform risk management. Skalski also informed Program investigators that Daybreak leadership told staff that the Program was trying to obstruct Daybreak providing services to clients.

D. Sara Robinson (Robinson), a former Substance Use Disorder Professional at DYS – Spokane, stated she had received the same training conducted by Smith, in which she was told that SUDPs are not mandatory reporters. After the training, she became very upset and worried about what that meant for her independent license. Robinson reported that risk management was to decide when an incident was reportable. Nothing ever came from complaints reported to risk management and, from Robinson's perspective, risk management was

unhelpful. Robinson also reported that, during an on-site investigation in July 2022, Daybreak staff were told they were not allowed to interview with Program investigators and that, if they did, a member of Daybreak's leadership must be present.

E. Robinson also reported to Program investigators that, after reviewing one of Robinson's progress notes about a client reporting sexual assault by another client, Angela Ball (Ball), Substance Use Disorder Clinical Director, instructed Robinson to change the wording and said, "[i]f the Department of Health did an investigation, they would want to know why we didn't report this." Ball told Robinson she wanted her to replace "sexual assault" with "an uncomfortable encounter with another client." Robinson also told Program investigators that, prior to writing the progress note, she had reported the incident to Ball and Sandra Skok (Skok), Mental Health Director.

F. Meghan Chapman (Chapman), a former Skills Coach and back-up Team Lead at DYS – Spokane, reported to Program investigators that Daybreak leadership had informed employees that, if they were assaulted by patients, they were not permitted to report this to law enforcement or they would be fired. Chapman also reported that Daybreak leadership informed staff that, if they had concerns about staff and patient relationships, then that should be reported to Team Leads and not to outside entities, such as DCYF/CPS, law enforcement, or the Department.

G. Jessica Rose (Rose), a former Team Lead at DYS – Spokane, reported that Daybreak leadership repeatedly told her that she was not a mandated reporter. Rose also reported that a Daybreak staff member stated that if Rose is interviewed by Program investigators, she should only give short answers and basic information, putting Rose in a position where she had to decide between sharing critical information with Program investigators or continuing to be employed. Additionally, Rose was instructed not to report anything on her own or to call 911. Rose stated that staff were instructed to call American

Medical Response (AMR) if problems arose. AMR was called so many times that eventually they asked Daybreak to stop calling them.

H. Amber Nelson (Nelson), a former Skills Coach at DYS - Spokane, reported to Program investigators that she reported concerning actions by staff members to upper management, but they were all ignored, including reports of staff boundary violations with clients. Nelson continued that Skills Coaches and Team Leads were told by Daybreak that they were not allowed to report to external entities, such as the Department; that they were not mandatory reporters; and there would be repercussions for not following Daybreak's reporting structure.

I. Rebecca "Becky" Pulito, a former Director of Nursing, told Program investigators that she would not be surprised to hear many staff, including counselors, felt they were not regarded as mandatory reporters.

1.46 This conduct creates serious risks that, among other things, allegations of professional boundary violations will not be adequately investigated, which puts DYS – Brush Prairie patients at risk of harm and prevents external agencies, such as the Department and DCYF/CPS, from fulfilling statutorily mandated duties of investigating such incidents to hold those responsible accountable.

1.47 DYS – Brush Prairie is responsible for ensuring that it is sufficiently staffed with qualified employees to ensure adequate treatment services and facility security. DYS – Brush Prairie failed to do so, which created risks to the health and safety of both clients and employees. For example, during an interview with Program investigators, Hughes reported DYS – Brush Prairie was routinely understaffed and that the best people worked three (3) x twelve (12) hour shifts that "take so much out of them."

On-Site Investigative Visit November 7 – 8, 2022

1.48 As part of its investigation of the first complaint (2022-8554), the Program conducted an on-site investigative visit at DYS – Brush Prairie on or about November 7 – 8, 2023. The on-site investigative visit of DYS – Brush Prairie was conducted by Investigator Lee and Investigator Julie Marshall (Investigator Marshall).

1.49 Upon arrival, Investigator Lee and Investigator Marshall were directed to Boyd as DYS – Brush Prairie's point-of-contact. Once directed to Boyd, Investigator

Lee and Investigator Marshall made a number of routine investigative requests, such as requesting patient records, personnel records, and interviews with patients and employees. Although designated as the point-of-contact, Boyd repeatedly stated she could not give any information to Investigator Lee or Investigator Marshall unless approved by Smith, Daybreak's attorney, and that all questions related to the complaint be directed to Russell, Daybreak's CEO, or Smith. This immediately created delays in processing routine investigative requests made by Investigator Lee and Investigator Marshall.

1.50 During the on-site investigative visit, Investigator Lee and Investigator Marshall were denied access to requested patient records, a patient census, patient interviews, personnel records, and other DYS – Brush Prairie records, such as grievances. These are all investigative requests fulfilled routinely as part of an on-site investigative visit while the Program investigators are on-site.

1.51 Investigator Lee and Investigator Marshall were permitted to conduct a tour of DYS – Brush Prairie, but exposure to patients and the milieu environment was controlled and limited by Russell and Boyd. Boyd also asked Investigator Lee and Investigator Marshall before the tour started whether the purpose of the tour was "just for fun?"

1.52 Investigator Lee and Investigator Marshall were permitted by DYS – Brush Prairie to interview some employees but were expected to agree to have interviews recorded before they could be conducted. This demand was made by DYS – Brush Prairie minutes before the first interview was meant to commence and created a delay in the interviews being conducted. The situation also resulted in Smith aggressively and repeatedly demanding that Investigator Lee admit to refusing to being recorded.

1.53 Although DYS – Brush Prairie did fulfill some requests made as part of the on-site investigative request, DYS – Brush Prairie refused to permit Investigator Lee and Investigator Marshall to interview current patients, citing concerns about compliance with Part 2, and continued to refuse to provide Investigator Lee and Investigator Marshall with requested records if those records had previously been provided to another investigator employed by the Department. However, the records

provided to other investigators employed by the Department were requested as part of completely separate investigations.

On-Site Investigative Visit March 21 – 23, 2023

1.54 As part of its investigation of the second complaint (2023-2056), the Program conducted an on-site investigative visit at DYS – Brush Prairie on or about March 21 – 23, 2023. The on-site investigative visit of DYS – Brush Prairie was conducted by Investigator Todd and Investigator Marshall.

1.55 On or about March 21, 2023, Investigator Todd and Investigator Marshall arrived at DYS-Brush Prairie and provided Boyd with a packet including the complaint investigation notice, a records request letter, and copies of WACs pertinent to the investigation. The notice explained that the Program would comply with the conditions in Part 2 to protect covered records and information obtained from DYS – Brush Prairie. The records request letter explained that the investigation had to do with allegations of staff sexual misconduct with patients and with a failure of facility systems to ensure patient safety. The records request letter also requested patient records, personnel files of employees at DYS – Brush Prairie, quality improvement process documents, lists of current/former patients and employees of DYS – Brush Prairie, interviews with employees of DYS – Brush Prairie, and interviews with current patients admitted to DYS – Brush Prairie. The types of records and interviews requested by Investigator Todd and Investigator Marshall are routinely requested without issue at other RTFs as part of an onsite investigative visit, and are typically provided during the on-site visit. Additionally, Investigator Todd and Investigator Marshall provided the investigation packet to Boyd because Russell, DYS – Brush Prairie's Administrator, was reportedly unavailable and DYS – Brush Prairie did not identify who was delegated the responsibilities of the administrator in the administrator's absence. Although designated as a point of contact, Boyd was not delegated the responsibilities of the administrator because Boyd reported she could not fulfill any of Investigator Todd's or Investigator Marshall's requests until authorized by Russell, who was reportedly unavailable, and Smith.

1.56 On March 21, 2023, Investigator Todd requested to start the investigation by interviewing patients. Boyd indicated that she would need to speak to Russell and Smith before allowing Investigator Todd and Investigator Marshall the opportunity to

interview patients. Boyd later confirmed with Investigator Todd and Investigator Marshall that DYS – Brush Prairie would not be providing any requested documents or scheduling any interviews of patients or employees until authorized by Smith. Additionally, Investigator Todd and Investigator Marshall were initially informed that a number of staff would not be made available for interviews because they were named on a witness list for an adjudicative proceeding involving DYS – Spokane. At approximately 3 pm, Investigator Todd and Investigator Marshall left the facility due to a lack of cooperation by DYS – Brush Prairie.

1.57 On March 22, 2023, Investigator Todd and Investigator Marshall returned to DYS – Brush Prairie to continue their on-site investigative visit. Boyd informed Investigator Todd and Investigator Marshall that there had been no change in status and that DYS – Brush Prairie would not be fulfilling any of the Program's requests until authorized by Smith. Around noon, Investigator Todd and Investigator Marshall checked-in with Boyd about scheduling interviews. Boyd informed Investigator Todd and Investigator Marshall that DYS – Brush Prairie had an all-staff meeting between 12 pm and 2 pm and that Boyd would be unavailable because she was presenting at the meeting. However, Boyd could not say what she was to present because Russell had the agenda for the meeting. Investigator Todd and Investigator Marshall had previously been informed that Russell would be unavailable during the duration of the investigative on-site visit. Around 3 pm, Investigator Todd and Investigator Marshall were permitted to interview Boyd. Investigator Todd and Investigator Marshall then left for the day.

1.58 On March 23, 2023, Investigator Todd and Investigator Marshall returned to DYS – Brush Prairie to continue their on-site investigative visit. DYS – Brush Prairie permitted Investigator Todd and Investigator Marshall to interview Sachelle McKenna, Human Resource Generalist; Angela Ball, Substance Use Disorder Clinical Director; and Sandra Skok, Mental Health Director.

1.59 On March 23, 2023, Investigator Todd and Investigator Marshall were also permitted by DYS – Brush Prairie to tour the facility with Boyd. Boyd showed Investigator Todd and Investigator Marshall the West Wing patient recreation room where Investigator Todd and Investigator Marshall had to inquire as to who was a staff member and who were patients. Investigator Todd and Investigator Marshall were then

shown a bathroom, bedroom, living room area, staff office, and the nurse's office in the West Wing. Boyd and the investigators moved to the East Wing, where they observed a room used for patient calls. Boyd offered that phone calls were "monitored" by DYS – Brush Prairie employees. The group then observed a bathroom, and Investigator Todd requested to view the angle of the camera in the bathroom. Boyd stated she would have to ask other people before giving the investigators access to the camera view. After obtaining the approval, Boyd granted access to view the angle of the camera in the bathroom.

1.60 After the tour, DYS – Brush Prairie permitted Investigator Todd and Investigator Marshall to interview Lance Anders, Psychiatric Nurse Practitioner, an employee not on the DYS – Brush Prairie request list. This concluded the on-site investigative visit and resulted in a significant number of routine requests made by Investigator Todd and Investigator Marshall being partially or completely unfulfilled by DYS – Brush Prairie:

A. Investigator Todd and Investigator Marshall requested to interview patients beginning on March 21, 2023. DYS – Brush Prairie refused to permit Investigator Todd and Investigator Marshall to interview current patients citing concerns about compliance with Part 2.

B. Investigator Todd and Investigator Marshall requested to interview employees of DYS – Brush Prairie beginning on March 21, 2023, depending on staff availability. This request specifically identified eleven (11) staff members for interviews. DYS – Brush Prairie only made four (4) of these employees available for interviews over the three (3) days Investigator Todd and Investigator Marshall were on-site. DYS – Brush Prairie also made available another employee who was not originally requested to be interviewed by Investigator Todd and Investigator Marshall. The employees Investigator Todd and Investigator Marshall were able to interview used scripted language, were non-responsive and evasive, and demonstrated an inability to answer questions about facility processes. For example, Boyd and McKenna, the Risk Management Coordinator and Human Resources Generalist, respectively, were not able to identify what training is

provided to DYS – Brush Prairie employees on professional boundaries or discuss what a boundary violation might look like. Additionally, DYS – Brush Prairie provided a schedule of interviews for employees after Investigator Todd and Investigator Marshall had left the facility and did not coordinate with Investigator Todd and Investigator Marshall before establishing this schedule.

C. Investigator Todd and Investigator Marshall requested a list of all current patients that included patient admit date, and a list of patients that were admitted in January 2021 through March 2021, August 2021 through September 2021, and June 2022 through July 2022. DYS – Brush Prairie failed to provide this information.

D. Investigator Todd and Investigator Marshall requested a list of all staff currently employed at DYS – Brush Prairie. DYS – Brush Prairie failed to provide this information.

E. Investigator Todd and Investigator Marshall requested a list of all staff terminated from employment at DYS – Brush Prairie since July 2022. DYS – Brush Prairie did provide this information to Investigator Todd and Investigator Marshall while they were on-site.

F. Investigator Todd and Investigator Marshall requested patient records for two (2) named patients. DYS – Brush Prairie failed to provide Investigator Todd and Investigator Marshall access to the Patient's records at DYS – Brush Prairie.

G. Investigator Todd and Investigator Marshall requested the complete personnel files for ten (10) employees. DYS – Brush Prairie provided partial personnel files for eight (8) employees and failed to provide a personnel file for two (2) employees. Partial personnel files that were received by Investigator Todd and Investigator Marshall did not contain information and documents required by law or rule, such as Washington State Patrol background checks.

H. Investigator Todd and Investigator Marshall requested a number of quality improvement process documents. DYS – Brush Prairie provided one (1) internal investigation involving Julie Nitteberg-Bryson,

but provided no other quality improvement process documents that were requested.

I. Investigator Todd and Investigator Marshall requested a number of specified policies and procedures. DYS – Brush Prairie did provide this information to Investigator Todd and Investigator Marshall while they were on-site.

J. Investigator Todd and Investigator Marshall requested job descriptions for the skills coach position, team lead position, and van/transport position. DYS – Brush Prairie did provide this information to Investigator Todd and Investigator Marshall while they were on-site.

1.61 DYS – Brush Prairie's lack of cooperation meant Investigator Todd and Investigator Marshall were unable to complete routine activities during an on-site investigative visit. The obstruction and refusal to fully cooperate with the Program's complaint investigation process have resulted in Program investigators being unable to fully assess and evaluate possible system deficiencies that affect patient safety, including staff boundary violations (emotional, physical, and sexual). The inability to conduct thorough complaint investigations has created adverse conditions and perpetuated system failures related to patient safety through ongoing exposure to problematic staff.

1.62 Where Program Investigators were able to obtain information from DYS – Brush Prairie, employees demonstrated a highly unusual lack of knowledge about matters their positions at DYS – Brush Prairie would suggest their involvement in, an almost complete deferral to DYS – Brush Prairie's attorney to a level that amounted to DYS – Brush Prairie's attorney acting as the Administrator's designee, and a disregard of the seriousness of the alleged conduct DYS – Brush Prairie's employees were involved with. For example, when Boyd was interviewed by Program investigators regarding the incidents involving Reinmuth and Stowe, Boyd's immediate focus in response to questions was not on how DYS – Brush Prairie could engage in a quality improvement process in relation to these incidents, but instead was on the fact that Reinmuth's conduct occurred outside of the DYS – Brush Prairie facility and that there did not appear to be a "pattern necessarily." As an additional example, DYS – Brush Prairie staff had to obtain the approval of Daybreak's attorney before

engaging in nearly every investigative step. This led to obstruction in the evidence gathering process, including obstructing investigator interviews, observations, and document review. DYS – Brush Prairie's administrator is responsible for day-to-day operations at the facility, including responding to investigations. The facility role of the administrator was effectively delegated to Daybreak's attorney, who determined how the facility would respond to Program investigator requests for interviews, observations, and document review. Daybreak's attorney obstructed the evidence gathering process, which resulted in Program investigators being unable to assess and evaluate information in the manner of the Program's choosing. This practice places patients at immediate risk by preventing the Program from promptly and fully assessing the risk of staff violating professional boundaries, including sexual boundaries, with underage patients.

2. CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Department makes the following Conclusions of Law:

2.1 The Secretary of Health, acting through his designee, has jurisdiction over the licensee, DYS – Brush Prairie, and over the subject matter of this proceeding under chapters 71.12 RCW and 246-337 WAC.

2.2 The Findings of Fact constitute violations of RCW 71.12.500; RCW 71.12.510; RCW 71.12.520; WAC 246-16-245(1)(g) and (2)(a); WAC 246-16-270(1)(a) and (2); WAC 246-337; WAC 246-337-021(1)(b) and (2); WAC 246-337-045(1)(d), (2)(b), (3)(a), (b), (c), and (e); WAC 246-337-048; WAC 246-337-050(1), (2), (4), (5)(a), and (7)(e) and (f); WAC 246-337-055; WAC 246-337-065(5), WAC 246-337-075; WAC 246-337-080(2)(h); and WAC 246-337-095(3).

2.3 The above violations demonstrate that DYS – Brush Prairie has failed or refused to comply with chapters 71.12 RCW and 246-337 WAC.

2.4 The findings of fact and above violations constitute an imminent threat to the health, safety, and welfare of DYS – Brush Prairie patients and are grounds for the Department to summarily suspend DYS – Brush Prairie's RTF license pending further proceedings. WAC 246-337-021(7).

2.5 DYS – Brush Prairie's failure to comply with chapters 71.12 RCW and 246-337 WAC provides grounds for the Department to deny, suspend, modify, or revoke DYS – Brush Prairie's RTF license under chapters 71.12, 43.70, and 34.05 RCW, chapter 246-10 WAC, and WAC 246-337-021(6).

2.6 DYS – Brush Prairie has the right to contest a Department decision to deny, modify, suspend, or revoke its RTF license by requesting an adjudicative proceeding within twenty-eight (28) days of receipt of the Department's decision. RCW 43.70.115, chapter 34.05 RCW, chapter 246-10 WAC, and WAC 246-337-021.

2.7 The Secretary may indicate when and under what circumstances an order may become an effective Final Order. RCW 43.70.115(2) and RCW 34.05.461.

3. NOTICE OF SUSPENSION

Based on the above Findings of Fact and Conclusions of Law, the Secretary, through his designee, enters the following:

3.1 License No. RTF.FS.60722961, DAYBREAK YOUTH SERVICES – BRUSH PRAIRIE, is **SUSPENDED INDEFINITELY**. The **SUSPENSION** shall immediately be stayed for four (4) days after this Notice becomes a Final Order.

3.2 During the four (4) day period that the summary suspension of License No. RTF.FS.60722961 is stayed, DYS – Brush Prairie shall comply with the following:

A. Stop all admissions of new patients to DYS – Brush Prairie.

B. Safely and appropriately discharge, or transfer all current patients of DYS – Brush Prairie. The movement of patients to an acute care hospital emergency department does not constitute a safe and appropriate discharge or transfer of a patient unless a patient is deemed to need emergency department services.

C. Within the first twenty-four (24) hours of the four (4) day period, DYS – Brush Prairie shall develop and provide a "Closure Plan" via email to Ian Corbridge, Director, Office of Community Health Systems, Ian.Corbridge@doh.wa.gov. The "Closure Plan" must contain the following:

i. Information pertaining to the patient census, acuity (deidentified information on primary diagnosis) and payor mix in table format on

the calendar day in which the Notice becomes a Final Order. For private pay patients (non-Medicaid or patients on Department of Children, Youth and Families contract), DYS – Brush Prairie must provide a list of patient names, name and contact information of legal guardian(s), and insurance companies responsible for care, if applicable.

ii. A plan for relocating patients ("Closure Transfer Plan") to appropriate care settings that offer similar services or services mandated based on court documents. The "Closure Transfer Plan" must take into consideration the most appropriate setting possible in terms of quality, services, and location, as available and determined appropriate by the patient care team after taking into consideration the patient's individual needs, choices, and interests. The plan must outline transportation resources DYS – Brush Prairie will use to support patient movement, and identify facilities who have agreed to receive patients.

iii. A plan for notifying patients, patient guardians, patient families, any surrogate decision makers of the patient, and insurance company (if applicable) of the license suspension. Notification shall include the intent to transfer a patient to another care facility and the name, location, and contact information of the facility a patient is transferred to, if appropriate.

iv. A strategy for referring patients who receive outpatient care under the facility license to other appropriate outpatient settings.

v. A plan for the preservation and transfer of medical records.

3.3 This Notice will become a **FINAL ORDER** without further notice twenty-eight (28) days from the date of receipt, absent a timely request for an adjudicative proceeding.

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4. REQUEST FOR AN ADJUDICATIVE PROCEEDING

If you wish to contest the Department's decision in this matter, you or your representative must, within **twenty-eight (28)** days of receipt of this decision, file a written request with the Department's Adjudicative Service Unit (ASU) in a manner that shows proof of the service on the ASU. Please use the enclosed form labeled "Application for Adjudicative Proceeding."

The mailing address is:
Department of Health
Adjudicative Service Unit
P.O. Box 47879
Olympia, WA 98504-7879

The physical address is:
Department of Health
Adjudicative Service Unit
310 Israel Road SE
Tumwater, WA 98501

A copy of the Department's decision must be attached to the Application for an Adjudicative Proceeding. **FILING SHALL NOT BE DEEMED COMPLETE UNTIL THE ASU ACTUALLY RECEIVES THE APPLICATION.**

You or your representative's **FAILURE** to submit an Application for an Adjudicative Proceeding within **twenty-eight (28)** days of receipt of this decision will constitute a waiver of the right to a hearing; the Department may decide this matter without you or your representative's participation and without further notice.

DATED: _____, 2023.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
RESIDENTIAL TREATMENT FACILITIES
PROGRAM

_____
IAN CORBRIDGE
DIRECTOR
OFFICE OF COMMUNITY HEALTH SYSTEMS
RESIDENTIAL TREATMENT FACILITIES
PROGRAM