STATE OF WASHINGTON
DEPARTMENT OF HEALTH
SECRETARY OF HEALTH

In the Matter of **DAYBREAK YOUTH SERVICES - SPOKANE** License No. RTF.FS.00001010 License No. BHA.FS.60873305 Respondent	**No. M2022-552 (lead)** **M2022-553** Consolidated **AMENDED NOTICE OF INTENT TO SUSPEND**

Pursuant to RCW 43.70.115, the Office Director for the Department of Health Office of Community Health Systems, which includes the Residential Treatment Facilities Program and Behavioral Health Agencies Program (collectively, "Programs"), on designation by the Secretary, having authority to regulate Residential Treatment Facilities (RTFs) under chapters 71.12 RCW and 246-337 WAC, and having authority to regulate Behavioral Health Agencies (BHAs) under chapters 71.05, 71.24, and 71.34 RCW and 246-341 WAC, hereby provides Amended Notice of Intent to Suspend License No. RTF.FS.00001010 and BHA License No. BHA.FS.60873305. 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 Programs are sub-units of the Department of Health (Department) with authority to license and regulate RTFs and BHAs. The Programs' authority to license and regulate RTFs is found at RCW 71.12 and WAC 246-337. The Programs' authority to license and regulate BHAs is found at RCWS 71.05, 71.24, 71.34 and WAC 246-341. This authority includes authority to review all records and interview all RTF and BHA patients and staff.

1.2 On June 28, 1984, the State of Washington issued Daybreak Youth Services – Spokane (Daybreak-Spokane), located at 628 S Cowley St., Spokane, WA 99202, license no. BHA.FS.60873305 to operate as a behavioral health agency (BHA or agency). Daybreak-Spokane's license is active in renewal.

1.3 On January 1, 2005, the State of Washington issued Daybreak Youth Services – Spokane, located at 628 S. Cowley Street, Spokane, WA 99202, license no. RTF.FS.00001010 to operate as an RTF. Daybreak-Spokane's RTF license is currently active.

1.4 Daybreak-Spokane is behavioral health facility providing co-occurring disorder treatment services to youth. In addition to being required to comply with state licensing laws, Daybreak-Spokane must also comply with 42 USC § 290dd-2 and 42 CFR 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 Daybreak-Spokane, 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 Programs are authorized by law to regulate the activities of Daybreak-Spokane. Daybreak-Spokane is therefore permitted to allow the Programs to review, copy, remove, download, or forward patient records so long as the Programs agree in writing to comply with the conditions outlined in 42 CFR § 2.53(b)(1).

Case Nos. 2022-1206, 2022-1233, 2022-4047, and 2022-4048

1.6 On or about February 10, 2022, the Programs assigned an investigation of Daybreak-Spokane to Investigator Deborah (Deb) Duke (Investigator Duke). The investigation (case nos. 2022-1206 and 2022-1233) were based on a report from Department of Children, Youth and Families Child Protective Services (DCYF/CPS) regarding concerns of serious staff-to-patient boundary violations by a staff person at Daybreak–Spokane, Staff Member A. In March 2022 the Programs received a second complaint from the Spokane Police Department regarding the same staff-to-patient boundary violations, and this investigation (case nos. 2022-4047 and 2022-4048) was subsequently assigned to Investigator Duke. As part of its investigations, the Programs informed Daybreak-Spokane in writing that they would comply with the conditions in 42 CFR § 2.53(b)(1) to protect Part 2 covered records and information obtained from Daybreak-Spokane.

1.7 Carl Gordon was hired by Daybreak-Spokane as a skills coach in November 2021. Mr. Gordon's duties included daily contact with minor female patients at Daybreak-Spokane.

1.8 During employment at Daybreak-Spokane, Carl Gordon allegedly engaged in inappropriate contact and boundary violations with minor female patients. The conduct started on or around Mr. Gordon's start date with Daybreak-Spokane, and included, but was not limited to:

A. A visit to Daybreak-Spokane on or about December 8, 2021 to "hang with the girls," i.e., minor patients at Daybreak-Spokane, on Carl Gordon's day off. This visit resulted in counseling by Daybreak-Spokane.

B. A grievance filed by Patient 2 on December 29, 2021 with Daybreak-Spokane detailing Mr. Gordon hugging Patient 2 and using "prison sign language" to say he loved her.

C. A report on or about January 19, 2022 that Carl Gordon engaged with Patient 1 via Mr. Gordon's personal social media account.

D. Asking patients for hugs and talking to them about their bodies. When rebuffed by a patient who did not want to be hugged, Mr. Gordon became confrontational.

E. Sharing lunch trays with patients.

F. Telling patients that grievances had been filed against him by patients.

G. Telling a patient that an implant in her arm was "disgusting."

H. "Slut-shaming" patients by commenting about their clothing choices.

1.9 In response to patients' grievances regarding Mr. Gordon's alleged misconduct, Mr. Gordon allegedly engaged in retaliation and bullying against minor female patients.

1.10 Following reports of Carl Gordon's alleged behavior and concerns with the quality of care and/or management and oversight at Daybreak-Spokane, the Idaho Department of Health and Welfare suspended all referrals to Daybreak.

1.11 Daybreak-Spokane initiated an internal investigation regarding Carl Gordon's alleged misconduct. Though this internal investigation showed a concerning

pattern of misconduct, the conclusion of the investigation was that Mr. Gordon had not violated Daybreak-Spokane's code of ethics. Mr. Gordon remained employed by Daybreak-Spokane and had continued access to minor patients.

1.12 Daybreak-Spokane did not report any of the above complaints or concerns, or subsequent complaints and concerns, regarding Mr. Gordon to the Programs.

1.13 The Programs conducted their first on-site investigative visit to Daybreak-Spokane on or about March 8-9, 2022. Daybreak-Spokane was cooperative during this visit and provided the Programs access to Mr. Gordon's training records and improvement plan. The Programs conducted a second on-site investigative visit to Daybreak-Spokane on or about April 11-12, 2022, during which the Programs interviewed Carl Gordon. Daybreak-Spokane was cooperative during this investigative visit, as well.

1.14 On or about May 9, 2022, the Programs met virtually with members of Daybreak's management team to discuss the next steps in the Programs' investigations. During this meeting, the Programs requested access to, or copies of, the complete patient records for specified patients; access to all grievances filed against Carl Gordon; all supervision notes related to Mr. Gordon; and assistance with scheduling additional Daybreak-Spokane staff interviews. At this meeting, Investigator Duke probed Daybreak-Spokane on why patient and staff complaints about Mr. Gordon were not reported to the Programs.

1.15 Between May 9 and May 24, 2022, Ms. Duke had several email exchanges with Daybreak-Spokane trying to arrange staff interviews, as well as follow-up requests for records. Daybreak-Spokane did not provide the Programs with all of the information the Programs requested. Additionally, Daybreak-Spokane did not facilitate staff interviews or patient interviews. As a result of Daybreak-Spokane's non-responsiveness to the Programs' investigative requests, on or about May 24-25, 2022, Program investigators went on-site to Daybreak-Spokane to continue to investigate Daybreak-Spokane's responses to the alleged misconduct by Carl Gordon and any related, alleged staff misconduct.

1.16 During prior investigations predating the Programs' investigations arising out of the allegations about Carl Gordon, Daybreak-Spokane had provided Program

investigators with access to, or copies of, complete patient records. During the May 24-25, 2022 investigative visit, Daybreak-Spokane allowed the Programs to review parts of three (3) patients' records, but Daybreak refused Program investigators access to the complete patient records. Programs also requested copies of all grievances or complaints regarding Carl Gordon, and received only one (1) in response to this request. The Programs also asked to interview patients. This request was refused. Program investigators left the facility due to a lack of cooperation by Daybreak-Spokane, which prevented access to evidence requested in the investigation.

1.17 On or about May 26, May 27, June 2, and June 22, 2022, Daybreak-Spokane, through counsel, stated that it intended to cooperate with the Programs' investigation. However, the stated intent to cooperate came with caveats. The communications indicated that Daybreak-Spokane questioned the scope of the Programs' investigation and how the Programs' request for access to records and information was compatible with Part 2.

1.18 The Programs directly addressed Daybreak-Spokane's questions regarding the Programs' investigations. On July 7, 2022, the Programs sent Thomas (Tom) Russell, Daybreak CEO, an investigative request letter, outlining the purpose of the Programs' investigation; the scope of the Programs' investigation; the information to which the Programs required access in order to conduct its investigation; and the Programs' legal authority to conduct the investigation. In this letter, the Programs, in writing, again reiterated its commitment to abide by Part 2, specifically listing the conditions identified at 42 CFR § 2.53(b)(1). The letter informed Daybreak the Programs would be re-initiating its investigation on July 13, 2022.

1.19 On July 13, 2022, Investigator Duke emailed Daybreak CEO Mr. Russell and Daybreak employee Sandra Skok, notifying them the Programs was continuing the investigation of cases regarding allegations of inappropriate staff behaviors at Daybreak-Spokane. Investigator Duke requested the following information, which was needed to move the investigation forward:

- Copies of all complaints and grievances regarding any allegations of inappropriate staff behaviors, including any behaviors that made patients feel uncomfortable, from July 1, 2021 to the present.

- A staff list with job titles and scheduling information, such as shifts and days each person works. Ms. Duke noted the Programs intended to be on-site for staff interviews.
- The entire patient records for five (5), specifically identified patients.

1.20 On July 14, 2022, Daybreak, through counsel, responded to the Programs' July 13, 2022 email. Daybreak agreed to provide the Programs' investigators access to two hundred eighty (280) pages of documents and access to a "small number of employees necessary for DOH to conduct the review" described in the Department's July 7, 2022 letter. However, Daybreak objected to parts of Investigator Duke's investigative request, arguing it was overly broad. Moreover, Daybreak declined to provide Investigator Duke all of the patient records requested, arguing the request was inconsistent with Part 2.

1.21 On July 18, 2022, Program investigators arrived at Daybreak-Spokane to continue their investigation on-site. The Programs' on-site investigation plan was to obtain and/or review patient records, interview staff, and interview patients receiving services at Daybreak-Spokane on July 18 and 19. The Programs' investigative plan was within the scope of its investigative authority and did not conflict with Part 2.

1.22 On July 18, 2022, the Programs met with Daybreak-Spokane to attempt to obtain the information and records it needed. The same day, Daybreak CEO Mr. Russell emailed Investigator Duke to document a conversation they had regarding the investigation. The email indicated the Programs and Daybreak agreed about the scope of the investigation, and Daybreak would provide the Programs with the patient records the Programs requested and would arrange staff interviews. However, Mr. Russell stated the Department could not interview patients without receiving their written consent, and suggested the Programs' and Daybreak's attorneys discuss the contents of a written consent.

1.23 On July 18, 2022, the Programs interviewed Director of Nursing Becky Pulito, Mental Health Therapist Samantha Brown, and Admissions Manager Amanda Kerr. Daybreak CFO Richard Reathaford and Daybreak Talent Acquisition Specialist Sachelle McKenna attended the interviews. During the interviews, Mr. Reathaford interjected, attempted to control the scope of the questioning, answered for an interviewee, and would not allow interviewees to respond to questions he believed

were, in his words, “he-said, she-said” questions. Moreover, the Programs did not receive any of the patient records it requested and were not allowed to interview patients, purportedly because of Part 2 restrictions.

1.24 On July 19, 2022, Program investigators arrived at Daybreak-Spokane at 6:15 AM. The Programs’ plan for the day was to conduct staff interviews, interview patients, and review or obtain patient records. The Programs’ July 19 investigation unfolded as follows:

1.24.1 The Programs first attempted to interview Team Leader Nyneave Beach, with Mr. Reathaford and Ms. McKenna present. Shortly after the Programs began the interview, Mr. Reathaford interrupted, directing Nyneave Beach to only answer questions related to policies, procedures, and processes. Ms. Beach appeared confused, and stated that she couldn’t answer the questions without using “he-said, she said” information. Ms. Beach proceeded to answer questions about select Daybreak processes and the interview concluded, but Ms. Beach was unable to answer all of the Programs’ questions due to Mr. Reathaford’s interference.

1.24.2 The next Daybreak staff member the Programs interviewed was Skills Coach Jessica Rose. Mr. Reathaford and Ms. McKenna were present. Mr. Reathaford again interrupted the Programs’ interview, arguing the scope of the interview was limited to discussing policies and procedures only, which truncated the interview.

1.24.3 The Programs next attempted to interview Skills Coach Joseph Avila. Mr. Reathaford and Ms. McKenna were present. The Programs asked Mr. Avila a question about staff-to-patient interactions that could make a patient feel uncomfortable. At this question, Mr. Reathaford interrupted and became confrontational with the Programs. Mr. Reathaford argued that Mr. Avila could not answer the question because it called for speculation, asking how would Daybreak staff know what made a patient uncomfortable. Mr. Reathaford also argued the questions were outside the scope of the investigation. Mr. Reathaford instructed Mr. Avila to answer questions only about policies and procedures, again making a thorough interview impossible.

1.24.4 The next Daybreak staff member the Programs attempted to interview was Substance Use Disorder Professional Danica Skalski. Mr. Reathaford and Ms. McKenna were present. Mr. Reathaford interrupted the interview, and directed Ms. Skalski to answer questions about policies and procedures only.

1.24.5 After the interview with Ms. Skalski, Investigator Duke spoke to Mr. Reathaford about his conduct during the interviews. Investigator Duke informed Mr. Reathaford that his ongoing interference with and interruption of interviews was inappropriate, and that staff must be allowed to answer the questions asked without his interference. Mr. Reathaford stated it was his role to ensure the Programs stayed within what Daybreak perceived to be the proper parameters of the investigation. Mr. Reathaford told Investigator Duke she was being misleading to Daybreak staff, and she made them feel uncomfortable.

1.24.6 At about 11:00 AM, the Programs' investigative manager emailed Mr. Reathaford and instructed him to stop interfering with the Programs' interviews.

1.24.7 Investigator Duke and Mr. Reathaford spoke again about Mr. Reathaford's conduct during the interviews. Investigator Duke asked him to refrain from interrupting and interfering with interviews. Mr. Reathaford responded that he was doing what he was there to do, which was to prevent the Programs from exceeding Daybreak's perceived scope of the investigation. Mr. Reathaford stated he was directed to do this by Daybreak's attorney, David Smith. Investigator Duke asked Mr. Reathaford, "…to be clear, you're telling me that if you don't agree with the way things are said, you're going to say something?" Mr. Reathaford responded he would interrupt and that it was his role and obligation to do so. Mr. Reathaford stated, "I will not allow questions to deviate from policy and procedure," and for that reason he "politely re-directed staff when they were attempting to answer questions" and would continue to do so.

1.24.8 Mr. Reathaford's disruptive conduct and his promise to continue to disrupt the interviews obstructed and would continue to obstruct the flow of information. Such obstructive conduct compromised the reliability of the

staff interviews. For these reasons, the Programs determined that continuing staff interviews would not be fruitful.

1.24.9 The Programs again requested to interview Daybreak-Spokane patients. Daybreak denied this request, citing Part 2. Daybreak-Spokane's denial of access to interview patients prevents the Programs from understanding how Daybreak-Spokane staff behavior impacted patient treatment and safety.

1.24.10 Daybreak-Spokane provided the Programs two thousand, four hundred, fifty (2450) pages of hard-copy patient records prior to the Programs departing the facility on July 19. However, instead of providing the complete patient records as the Programs had requested, Daybreak provided only the records Daybreak deemed to be within the scope of the Programs' investigation.

Case Nos. 2023-1427and 2023-1428; 2023-2538 and 2023-2540; and 2023-2686 and 2023-2687

1.25 On or about January 31, 2023, the Department received a referral from the Department of Children, Youth and Families (DCYF) citing multiple allegations against Daybreak-Spokane, including that a staff member was "grooming" girls at the facility; staff members were being discouraged from making CPS (Child Protective Services) reports and told they were not mandatory reporters; child abuse and other issues were not being externally reported by Daybreak-Spokane; and complaints against staff were not being addressed by management. The Programs opened an investigation into this complaint in February 2023. This complaint was assigned case nos. 2023-1427 and 2023-1428.

1.26 On or about February 23, 2023, the Department received a complaint alleging that a Daybreak-Spokane staff member took patients to his residence, where he went inside and returned smelling of cannabis; that staff members are actively using illegal drugs and alcohol while on shift; and that staff are engaged in misconduct, including staff-to-patient boundary violations. This complaint was assigned case nos. 2023-2686 and 2023-2687.

1.27 On or about February 28, 2023, the Department received a complaint that Daybreak-Spokane staff allegedly made inappropriate comments about patients'

bodies, for example, commenting on their breasts; that a Daybreak-Spokane staff member slammed a patient to the ground; and that a staff member refused to provide patients their medications and gave patients the wrong medications and/or the wrong doses. This complaint was assigned case nos. 2023-2538 and 2023-2540.

1.28 Investigator Emely Lee was assigned to investigate these complaints.

Ongoing Failure to Cooperate

1.29 Between March 21, 2023, and March 23, 2023, the Programs conducted an on-site review of Daybreak-Spokane as part of the ongoing complaint investigations. Program investigators requested interviews with patients and staff, to begin March 21, 2023. Program investigators also requested that Daybreak-Spokane produce documents, to include, but not limited to patient, personnel, and other administration records.

1.30 During this on-site investigation, Daybreak-Spokane failed to cooperate with the Programs in the following ways:

1.30.1 Daybreak-Spokane did not make any patients available for interviews during the on-site review, as requested by the Programs.

1.30.2 Daybreak-Spokane did not produce patient lists, patient records, or the complete personnel records for Madison Taber, Steven Titus Jr., Sarah Robinson, Joseph Avila, or Trudy Frantz, as requested by the Programs.

1.30.3 Daybreak-Spokane did not make Thomas Russell or Cindi Hiday (Quality Improvement) available for interviews during the on-site review, as requested. The only reason provided was that they were "unavailable."

1.30.4 To date, Daybreak-Spokane has failed to provide the Programs with access to all requested records or to assist the Programs in conducting interviews with staff and patients. Daybreak-Spokane has explicitly denied the Programs access to patients and patient records.

Ongoing Pattern of Mismanagement

1.31 Daybreak-Spokane has repeatedly failed to adequately train and supervise staff. This pattern of conduct by Daybreak-Spokane and Thomas Russell has created a risk of harm and caused harm to patients.

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Madison Taber

1.32 Madison Taber was employed as a Skills Coach at Daybreak-Spokane from August 30, 2021, until May 2022, at which time she resigned voluntarily.

1.33 A Skills Coach provides, among other things, "monitoring, support, and coaching" to patients as part of the "inpatient team" in the co-occurring residential department. Skills Coaches report to a Team Leader and the Charge Nurse. A Skills Coach at Daybreak Youth Services must possess an agency affiliated counselor credential or have an application for the credential in process with the Department upon hiring.

1.34 On or about August 30, 2021, Madison Taber applied for an agency affiliated counselor credential with the Department. On November 8, 2021, the State of Washington issued Ms. Taber a credential to practice as an agency affiliated counselor. Ms. Taber's credential is currently expired but renewable.

1.35 Madison Taber reported to the Programs that she was "thrown into the deep end right off the bat" by Daybreak-Spokane and received "no direction from the company." Personnel records show that upon her hiring in August 2021, Daybreak-Spokane provided Ms. Taber with fifteen (15) minutes of training about ethics and "principles of conduct" as part of a set of twenty-two (22) online modules. Personnel records also show Ms. Taber completed only one (1) of six (6) pages of Daybreak-Spokane's "Floor Staff Orientation Program Checklist," indicating she did not receive training or demonstrate understanding about inventory, room, and personal searches, applying various policies, resolving conflict, professionalism, ethics, de-escalation, active listening, boundary setting, communication, documentation, and group facilitation, among other things. Completion of the checklist is required by Daybreak-Spokane's internal training policy. (The training policy also indicates upper management is to monitor and ensure compliance with training requirements.)

1.36 On October 7, 2021, Ms. Taber was confronted by staff about patient boundaries and "rumors" she was in a relationship with Patient 7 and had added Patient 7 on social media. Ms. Taber was counseled not to be in one-on-one situations with Patient 7. The next day, on October 8, 2021, Ms. Taber was observed outside alone with Patient 7. On October 16, 2021, Ms. Taber was observed spending one-on-one time with Patient 6 during what was meant to be structured time and then again at

"lights out" time. On October 25, 2021, Ms. Taber was observed hugging a patient for a long duration (about 30 seconds) and being halfway in the patient's bathroom at the time.

1.37 On November 2, 2021, Sandra Skok (Director of Mental Health) submitted a Critical Incident Report to Thomas Russell (her supervisor, agency administrator, and CEO of Daybreak) detailing allegations made by a patient that Madison Taber was in a relationship with Patient 6, was writing Patient 6 love letters, and was connected to several former patients on social media. Ms. Skok noted in the Critical Incident Report that "this also happened with [Patient 7] at the end of September first part of October." Ms. Skok concluded there appeared to be a pattern.

1.38 On or about November 4, 2021, Melissa (Missy) Boyd (Risk Management) initiated an investigation and interviewed one patient. (Records indicate she did not interview Patient 6 or the reporting patient at this time). This interviewed patient reported that Patient 6 had disclosed "something" was going on between Patient 6 and Ms. Taber, and Ms. Taber was writing Patient 6 love notes (although this patient had not seen any). This patient also reported that Ms. Taber told Patient 6 she loved her and gave Patient 6 hugs as she did with all patients. Ms. Taber denied the allegations, "wished someone had been direct with her the first time," was aware that there was a "problem," "understood the severity," and agreed to a performance improvement plan. No other interviews with patients or staff are noted in the investigation record. Daybreak-Spokane made a written determination that "the writing love letters from staff to patients" was not true. It was also noted that the "investigation process was not followed."

1.39 On November 12, 2021, Madison Taber and her supervisor, Steven Titus, signed a performance improvement plan (PIP) which was to last sixty (60) days, from November 3, 2021, to January 3, 2022.

1.40 According to Ms. Taber, she had not received regular, direct supervision prior to November 2021.

1.41 On November 27, 2021, a staff member observed Madison Taber spend time in a patient's room at midnight instead of finishing her shift and going home. Ms. Taber had to be told multiple times to go home. This staff member documented she intended to notify Steven Titus.

1.42 Steven Titus did not require Ms. Taber to complete the requirements of the PIP, which mandated regular, ongoing supervision meetings for the duration of the PIP. Instead, Mr. Titus prematurely ended the PIP on December 17, 2021.

1.43 On December 19, 2021, staff member Jessica Rose (a Team Lead) reported to upper-level managers and Steven Titus that a patient (roommate of Patient 6) reported a romantic, sexualized relationship between Patient 6 and Madison Taber, as follows:

1.43.1 Patient 6 was in a secret relationship with Madison Taber, who was the "love of her life."

1.43.2 Ms. Taber gave Patient 6 matching shoes.

1.43.3 Patient 6 was excited to go with Ms. Taber to a wedding in August.

1.43.4 Ms. Taber expressed a desire to snuggle, kiss, and fall asleep with Patient 6.

1.43.5 Ms. Taber masturbated while thinking of Patient 6.

1.43.6 Patient 6 knew Ms. Taber was on a corrective action plan and had weekly meetings to make sure Ms. Taber was "being appropriate."

1.43.7 Patient 6 believed it was important to keep all the information secret since she feared Ms. Taber might be fired.

1.44 Jessica Rose also reported she observed Patient 6 wearing Ms. Taber's oversized hoodie and that Ms. Taber asked Ms. Rose why Patient 6's roommate had wanted to talk to her.

1.45 Jessica Rose made a subsequent report to Sachelle McKenna (Human Resources) after another patient came forward expressing concerns about Ms. Taber's boundaries with patients. When Ms. Rose followed up about her report, Ms. McKenna told her she had "forgotten about it" but would look into it. Ms. Rose told Program investigators there was "no follow through addressing ongoing concerns for Madison Taber…."

1.46 On February 13, 2022, Madison Taber disclosed to two staff members that Patient 16 had given her a drawing which Ms. Taber had tattooed on her own body. This was then disclosed to at least one (1) patient.

1.47 In April 2022, Patient 17 reported to Michael Trotter (Risk Management) and Missy Boyd that Madison Taber often made her feel uncomfortable and became possessive over time. Patient 17 reported Ms. Taber had grabbed her and told her, "You are my [Patient 17] and I love you." (Ms. Taber later admitted to Ms. Trotter and Ms. Boyd she used the phrase "you are my Patient 17" and felt Patient 17 was "codependent.") Ms. Taber also demanded Patient 17 hug her and rubbed Patient 17's back in a "weird way." Ms. Taber also told Patient 17 she did not want Patient 17 to believe the lies other patients were telling about her (Ms. Taber). Patient 17 reported that staff member Danica Skalski was a witness to some of Ms. Taber's behavior and expressed to Patient 17, along with staff member Joseph Avila, that they understood what was happening because they had observed Ms. Taber's present and past conduct toward patients. Ms. Taber reportedly admitted to Ms. Skalski she was trying to turn other patients against Patient 17. Ms. Taber otherwise denied the allegations of boundary violations to upper management. Personnel records indicate no other interviews were conducted, and no other action was taken in response to the allegations.

1.48 During employment at Daybreak-Spokane, Madison Taber allegedly engaged in inappropriate contact and boundary violations with minor female patients. The conduct was internally reported by staff and patients and acknowledged by upper management. In addition to what is described above, this conduct included, but was not limited to:

A. Writing "I love you" and drawing hearts on Patient 16's body.

B. Holding hands with Patient 6 and another patient.

C. Sitting between Patient 6's legs and caressing Patient 6's hair.

D. Bullying a patient and admitting to inciting other patients to bully the patient.

E. Interfering with patients' treatment.

F. Staying after her shift to spend time with Patient 6 and Patient 16.

G. Expressing a desire to "finger" Patient 6's vagina.

H. Giving Patient 6 jewelry, including a necklace and ring.

1.49 After leaving employment at Daybreak-Spokane, Madison Taber admitted to a former coworker, Amber Nelson, that she had been in a romantic and sexual

relationship with Patient 6 while at Daybreak-Spokane. (Ms. Nelson told the Programs she does not know if they had sexual contact inside the facility.) Ms. Taber also stated that the relationship continued after both Ms. Taber and Patient 6 had departed from Daybreak-Spokane, until at least September 2022. Ms. Taber told Ms. Nelson she wished Patient 6 would overdose so that their relationship could end. After this conversation, Ms. Nelson reported what she knew to Sachelle McKenna and Missy Boyd. They told her it would be reported to the Department of Health. (The Department has no record of this occurring.) Patient 6 was later found dead at her mother's house. Madison Taber denies that she had a sexual relationship with any Daybreak-Spokane patients.

1.50 In October 2022, Rebecca Pulito (Director of Nursing) told Program investigators she had been aware of the ongoing complaints about Madison Taber having inappropriate and sexual relationships with patients. She was also able to identify the patients by name. According to staff member Sara Robinson, "everyone knew" about Ms. Taber and Patient 6's relationship.

1.51 Madison Taber's conduct and Daybreak-Spokane's failure to appropriately train, manage, and supervise Ms. Taber interfered with Patient 6's treatment.

1.52 Daybreak-Spokane staff and leadership had reasonable cause to believe that Ms. Taber had engaged in unprofessional conduct, including sexual misconduct and child abuse. Madison Taber's conduct was repeatedly reported to Daybreak-Spokane leadership by staff and patients. Multiple written complaints and grievances were made against Madison Taber, and allegations were discussed in staff meetings and in emails to Daybreak-Spokane leadership. Daybreak-Spokane leadership acknowledged that Madison Taber's conduct showed a pattern of boundary violations and child abuse. Yet, Daybreak-Spokane and its administrator failed to adequately address Madison Taber's conduct or perform thorough investigations according to their own investigation procedures.

Joseph Avila

1.53 On or about April 5, 2021, Daybreak-Spokane hired Joseph Avila as a Skills Coach. In his application for employment, Mr. Avila disclosed he had been a gang leader in a powerful prison gang, served over twenty-five (25) years in prison, had abused drugs, and had been through ten treatment centers. Daybreak-Spokane

conducted a background check, the results of which did not reflect this information. There is no evidence Daybreak-Spokane inquired further about the discrepancy but instead accepted a signed disclosure form from Mr. Avila stating he had never been convicted of a crime against persons or a crime related to drugs.

1.54 Personnel records show Mr. Avila did not complete Daybreak-Spokane's required "Floor Staff Orientation Program Checklist." Additionally, no documentation exists in his personnel record received by the Programs that Mr. Avila completed the online module training, as required by Daybreak's policy, or that he received all training required by regulation, including, for example, an overview of the agency's policies and procedures, reporting unprofessional conduct to appropriate authorities, the process for resolving patient concerns, cultural competency, violence prevention, and the prevention and control of communicable disease.

1.55 Personnel records show that Mr. Avila was found by Daybreak-Spokane to have repeatedly given gifts to patients, which included going into the agency on his days off to do so, between July and December 2021. Subsequently, a performance improvement plan (PIP) was initiated. However, records show it was never started or completed. The PIP was set to last sixty (60) days, from December 29, 2021, to February 27, 2022, and was to Include close monitoring, reviewing the code of ethics policy, and weekly supervision. The PIP was never signed by Mr. Avila or his supervisor, Steven Titus. Mr. Titus did not make any periodic review notes on the form, nor is there any indication a member of upper management monitored, reviewed, or signed the incomplete PIP.

1.56 Staff member Amber Nelson reported to Sachelle McKenna and Missy Boyd that Mr. Avila took a patient into the facility clothing closet for pajamas and told the patient to "turn around so I can make sure your butt looks good." According to Ms. Nelson, "nothing was done about Joe," and he was promoted after she reported this (and other concerning conduct) to upper management.

1.57 On December 29, 2021, staff member Sarah Robinson filed a complaint against Mr. Avila after multiple staff members witnessed him engage in threatening conduct toward another co-worker, Danika Skalski. Mr. Avila told Ms. Robinson, "I have never been disrespected so much in my life. Last time someone disrespected me like

that, I stabbed them in the throat." Mr. Avila then made several stabbing motions toward his neck.

1.58 During a follow-up meeting with Daybreak-Spokane leadership on January 17, 2022, Mr. Avila denied making the stabbing motion and disclosed that he had been charged with murder and acquitted in 1999, was charged with aggravated murder (and/or conspiracy to commit murder), pled guilty to racketeering and drug charges, picked up another federal charge in 2008, and spent time in multiple prisons. Daybreak-Spokane retained Mr. Avila for an additional year, until February 1, 2023, even though they had reason to believe his criminal background check was incomplete, he had falsified his criminal conviction disclosure form, and he had committed serious crimes against persons and drug-related crimes.

Kevin Horn

1.59 On August 22, 2022, Daybreak-Spokane hired Kevin Horn as a Skills Coach. His application and resume show he had no experience working with youth or in treatment-like settings. Mr. Horn was issued an agency affiliated counselor credential on September 9, 2022.

1.60 Daybreak-Spokane's personnel record for Mr. Horn does not contain a copy of a counselor credential (which was issued September 9, 2022) or a Washington State Patrol Background check, both of which are required by regulation.

1.61 On or about August 25, 2022, patients began filing complaints against Mr. Horn for body shaming and glorifying gangs. In September 2022, a supervisor noted his professionalism fell below expectations. In December 2022, Mr. Horn was found to have yelled at patients, stating he was not going to "let little girls disrespect" him. Mr. Horn took pictures of patients on his personal phone and argued with patients to the point of needing to be separated from them. Staff members also reported Mr. Horn for being visibly sexually aroused in the presence of patients and for making comments to female patients that he had "pimped out other girls."

1.62 On January 26, 2023, Mr. Horn drove patients to his house where he introduced patients to his dogs which behaved aggressively. Mr. Horn entered his house and then exited smelling strongly of marijuana, after which he continued to drive patients around. Mr. Horn shared personal details about his life, including telling patients he was allowed to have sex with women other than his wife. Staff member

Mariah Rock reported the conduct internally, and when she followed up with the Charge Nurse Trudy Frantz, Ms. Frantz said Mr. Horn had a different story. Ms. Rock noted that during this exchange, Ms. Frantz smelled strongly of alcohol and appeared flushed. Ms. Rock reported to the Programs that she was terminated one (1) week later by Ms. Frantz. Ms. Frantz and Sachelle McKenna were both unresponsive to her subsequent questions about the reasons for her firing.

1.63 Mr. Horn's personnel records do not indicate that Daybreak-Spokane placed Mr. Horn on a PIP, provided additional formal training, increased supervision, or put Mr. Horn on administrative leave at any time. Mr. Horn continued to work at Daybreak-Spokane until February 14, 2023, at which time he was terminated. His termination letter indicates he was terminated for "concerns around patient safety" and policy violations related to the conduct described above.

1.64 Department records show that between January 1, 2021, and May 10, 2023, Daybreak-Spokane did not externally report any current or former employees to the Department for unprofessional conduct, to include, but not limited to, Madison Taber, Joseph Avila, and Kevin Horn.

Suppression of External Reporting

1.65 Daybreak-Spokane leadership engaged in a pattern of conduct, to include, policy, practice, and training, which suppressed external reporting to DCYF/CPS, law enforcement, and the Department.

1.66 Daybreak-Spokane failed to ensure that the agency's mandatory reporting policies and procedures were consistent with state law and regulations, to include, but not limited to, RCW 26.44.

Policy Definitions

1.66.1 According to BHA WAC 246-341-0420(13)(a) a "critical incident" is defined as a "serious or undesirable outcome that occurs in the agency," including, but not limited to, "allegations of abuse, neglect or exploitation."[1]

[1] The specific provisions of the Washington Administrative Code (WAC) cited herein are the provisions which were in effect from July 1, 2021, until May 1, 2023.

1.66.2 The definition of "critical incident" in Daybreak-Spokane's "Critical Incident and Sentinel or Adverse Event" Policy (hereafter, "Critical Incident Policy" or policy) addresses abuse and neglect, as follows: "Alleged abuse or neglect of an individual receiving services that is of a serious or emergency nature, by any employee, volunteer, licensee, contractor, or another individual receiving services; …." Exploitation is not mentioned.

1.66.3 Per RCW 26.44.020(1), "Abuse or neglect means sexual abuse, sexual exploitation, or injury of a child by any person under circumstances which cause harm to the child's health, welfare, or safety, excluding conduct permitted under RCW 9A.16.100; or the negligent treatment or maltreatment of a child by a person responsible for or providing care to the child. An abused child is a child who has been subjected to child abuse or neglect as defined in this section." (Notably, Daybreak-Spokane's policy allows for child/patient-on-child/patient abuse (see *supra*), which is consistent with the language of "any person" in this section.)

1.66.4 Per RCW 26.44.020(19), "Negligent treatment or maltreatment means an act or a failure to act, or the cumulative effects of a pattern of conduct, behavior, or inaction, that evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to a child's health, welfare, or safety, …."

1.66.5 Per CPS WAC 100-30-0030, "Child abuse or neglect means the injury, sexual abuse, or sexual exploitation of a child by any person under circumstances which indicate that the child's health, welfare, or safety is harmed, or the negligent treatment or maltreatment of a child by a person responsible for or providing care to the child. An abused child is one who has been subjected to child abuse or neglect as defined in this section."

1.66.6 The definition of child abuse and neglect in Daybreak-Spokane's Critical Incident Policy requires the infliction of a physical injury on a child by other than accidental means, causing death, disfigurement, more than temporary skin bruising, impairment of physical or emotional heath, or loss or impairment of any bodily function; creating a substantial risk of physical harm or a child's bodily functioning; attempting, committing, or allowing any sexual

offense against a child as defined in Washington's criminal code (with examples); committing cruel or inhumane acts regardless of observable injury (with examples); assaulting or criminally mistreating a child as defined by Washington's criminal code; failing to provide food, shelter, clothing supervision, or healthcare necessary to a child's health and safety; engaging in actions or omission resulting in injury or creating a substantial risk to, the physical or mental health or development of a child; or failing to take reasonable steps to prevent the occurrence of the preceding actions.

Required Conduct

1.66.7 Per RCW 26.44.030(1)(a), "When any practitioner, … registered or licensed nurse, [or] social service counselor…has reasonable cause to believe that a child has suffered abuse or neglect, he or she shall report such incident, or cause a report to be made, to the proper law enforcement agency or to the department [DCYF] as provided in RCW 26.44.040." Subsection (b) directs supervisors to report the conduct of employees.

1.66.8 RCW 26.44.040 requires "an immediate oral report" by "telephone or otherwise to proper law enforcement agency or the department [DCYF] and, upon request, must be followed by a report in writing," which must contain certain facts, if known.

1.66.9 Daybreak's Critical Incident Policy requires reporting suspected or confirmed child abuse or neglect (as defined by their policy) to DCYF/CPS. Known facts may be disclosed to CPS, but disclosure is not required. Reports to DCYF/CPS "will be made" by the CEO, Quality Resource Director, or their designee and must be "consistent with federal and state confidentiality requirements" (and "Patient Confidentiality Policy and Procedure). Additionally, disclosures must be reviewed for "legal appropriateness."

1.66.10 Per Daybreak-Spokane's policy, any staff member who "observes or believes that a critical incident… has occurred" (which includes abuse and neglect as defined in the policy) must immediately notify their supervisor who, in turn, will notify the Quality Resources Director (or CEO if Director is unavailable). The individual making the report will submit the

designated form to an internal "Quality Resources" email address, with the assistance of their supervisor, if possible. Quality Resources will consult with the CEO and Legal to determine the next steps.

1.66.11 Daybreak's Critical Incident Policy also requires the reporting of "critical incidents" to the Department of Health within one (1) business day "consistent with federal and state confidentiality statutes and regulations and Daybreak policy and procedures," (and the "Patient Confidentiality Policy and Procedures"). Reports to the Department "will be made" by the CEO, Quality Resources Director or their designee, and disclosures will be reviewed for "legal appropriateness."

1.66.12 In her October 2022 interview with the Programs, Rebecca Pulito noted that although there were policy changes around the time she left Daybreak-Spokane, during her time at the facility, patient-on-patient incidents, including assaults, would be addressed in treatment with the patient's counselor, and more "serious" conduct would be reported to Risk Management. Staff conduct would be discussed with the staff member's supervisor for "coaching," and more serious concerns would be reported to Risk Management and Human Resources who would handle the investigation. With respect to external reporting, she stated that "all events went through Risk Management."

1.66.13 Sandra Skok (Mental Health Director) and Angela Ball (SUD Clinical Supervisor) confirmed that unwanted physical or sexual contact by staff toward patients would be a report to Risk Management or Thomas Russell. In the case of a patient reporting abuse or neglect by parents, a counselor would do the reporting to CPS or confirm it had been reported.

1.66.14 On May 14, 2021, following a third-party's report of abuse at Daybreak-Spokane, DCYF/CPS documented concerns in a written assessment of Daybreak-Spokane. These concerns included, but were not limited to, Daybreak-Spokane failing to report child safety related matters per WAC requirements, failing to timely notify parents of involved minor children, failing to provide sufficient information to guardians, and conducting their own investigations.

1.67 Daybreak-Spokane leadership failed to correctly train employees to report abuse, neglect, and exploitation to CPS or law enforcement agencies. Credentialed staff were repeatedly told they were not mandatory reporters.

1.67.1 Danica Skalski (SUDP) reported to Program investigators that she attended a training in the summer of 2021 for all mental health counselors, SUD counselors, and case managers at Daybreak-Spokane. At the training, they were told by the facility's attorney (in the presence of Michael Trotter and Sandra Skok) that they were not mandated reporters. Sara Robinson, another SUDP, confirmed she was also trained by Daybreak-Spokane that she and others in her role were not mandated reporters.

1.67.2 Ms. Skalski also reported that employees were regularly reminded of the "reporting restrictions" for clinical staff, which included skills coaches, team leads, mental health counselors, and SUD counselors. Other staff members reported the same: Daybreak-Spokane leadership and management "repeatedly" told credentialed employees they were not mandated reporters and should report concerns to a counselor, not to external entities.

1.67.3 Amber Nelson told Program investigators that Skills Coaches and Team Leads were told by Daybreak-Spokane leadership they were not allowed to report to outside entities such as the Department of Health, DCYF/CPS, or law enforcement. There were many staff members who had concerns about this but felt they put their jobs at risk by discussing those concerns. Sandra Skok told staff members they were not mandatory reporters and warned there would be repercussions for failing to follow the internal reporting structure and reporting externally.

1.67.4 Staff members were aware of many incidents of patients engaging in non-consensual sexual acts against other patients, yet staff members were told by Thomas Russell and other Daybreak-Spokane leadership that such conduct was not reportable and "children can't abuse children." When asked about child-on-child assaults, Rebecca Pulito confirmed that sexual encounters between patients were viewed by Daybreak-Spokane as consensual because the patients are all close in age. Such incidents would be reported to

Risk Management and likely documented as "treatment interfering behavior" for counseling.

1.68 Daybreak-Spokane leadership and staff repeatedly failed to externally report allegations of child abuse committed by parents and patients. These failures to report created serious risks of harm and serious harm to patients, to include, but not limited to:

1.68.1 In May of 2021, two (2) patients engaged in forcible sexual contact with a third patient who was sleeping. The facility required counseling staff to reach out to the patients' juvenile probation officers. Melissa Boyd reported to the Programs that a patient's roommate "…placed a pencil in between the cheeks of her rear end under her pajamas. With the pencil sticking out, [a patient] grabbed it, pushed on it, and moved it around…." Daybreak-Spokane did not externally report this to DCYF/CPS or law enforcement. This incident was reported to DCYF/CPS by a third party, and DCYF/CPS attempted to investigate. However, they were unable to complete the investigation because "investigators were repeatedly denied access to assess the risk and safety of individuals involved. Despite numerous attempts by DCYF, Daybreak withheld the full names [of] collateral sources, full names of alleged subjects/staff, video footage and facility documentation."

1.68.2 A patient reported sexual abuse by their father to Amber Nelson, a Skills Coach at Daybreak-Spokane, which she reported to the patient's counselor, "Sarah." Ms. Nelson told Program investigators the counselor did not report it to DCYF/CPS, and the patient discharged back to her father. Daybreak-Spokane records show that in June 2022, a supervision session was held between Sara Robinson and Angela (Angie) Ball (SUD Clinical Director), noting they discussed a patient's recent report that her father was "having sex with her." They discussed reporting this to Risk Management. There is no indication they made an external report.

1.68.3 Sara Robinson reported to Program investigators that after reviewing one (1) of her progress notes about a patient reporting sexual assault by another patient, Angela Ball instructed Ms. Robinson to change the wording, telling Ms. Robinson, "If the Department of Health did an investigation, they

would want to know why we didn't report this." Ms. Ball told Ms. Robinson she wanted her to replace "sexual assault" with "an uncomfortable encounter with another patient." Ms. Robinson also told Program investigators that prior to writing the progress note, she had reported the incident to Ms. Ball and Sandra Skok.

1.69 Daybreak-Spokane leadership and staff repeatedly failed to externally report allegations of child abuse committed by staff members. These failures to report created serious risks of harm and serious harm to patients. Daybreak-Spokane leadership and staff had reasonable cause to believe and externally report the following allegations:

1.69.1 Chris McDanel told patients who had been sexually abused and trafficked that none of them had a legitimate excuse for not being virgins anymore. On another occasion he told Patient 12 to get on her knees and "ask him for it." Chris McDanel also forced a patient to get on her knees and beg for water. One of the patients (Patient 12) who filed an internal grievance against Mr. McDanel asked for a meeting with Risk Management and the CEO but was reportedly told that they did not talk to patients. Patient 12 reported to the Programs that she saw Missy Boyd and Michael Trotter in the facility and asked them about the grievances, to which they replied they did not know what Patient 12 was talking about.

1.69.2 Kevin Horn yelled at patients, glorified gangs, engaged in body-shaming, took pictures of patients with his personal phone, told patients he "pimped" other girls out, took patients to his house and exposed them to aggressive dogs, and smelled of marijuana and drove patients around.

1.69.3 Joe "Martin" "groomed" patients and had a sexual relationship with a patient.

1.69.4 Tony Bernal confused patients' medications, refused to give patients their medications, commented on a patient's breasts and nipples, and appeared to intentionally knock a patient down by slamming into a door, which caused the patient to have a seizure. Patient 13 reported to the Programs that staff did not call for an ambulance or otherwise take the patient for medical care.

Multiple grievances were filed by patients against Mr. Bernal. Patient 13 was told by “the person in charge” that she was a liar and patients were making things up.

1.69.5 Macy (last name unknown) used cocaine in the facility bathroom, bragged to patients that she used substances while at work, and bragged to patients about her sugar daddy.

1.69.6 Trudy Frantz was intoxicated while working.

1.69.7 Madison Taber engaged in sexual misconduct as defined in WAC 246-16-100.

1.69.8 Carl Gordon “groomed” patients, had at least one (1) patient’s drawings tattooed on his body, used prison sign language to tell Patient 2 he loved her, snuggled her, asked for hugs and communicated displeasure if she declined, and caused her to be bullied when she reported his conduct. Mr. Gordon also told patients, on at least one (1) occasion, that they looked like ‘whores.”

1.69.9 Staff member Danica Skalski was made aware of some of Carl Gordon’s conduct by one (1) of the patients she counseled (Patient 2). Ms. Skalski told Program investigators that her “instinct at the time was to report [her] concerns to Child Protective Services (CPS),” but Daybreak-Spokane employees were not allowed to do so without permission from Risk Management who, she noted, did not “have the knowledge to make that determination.” So, she reported her concerns to the patient’s social worker/guardian. Ms. Skalski also submitted a report to Risk Management (Missy Boyd and Michael Trotter) who disputed Ms. Skalski’s use of the word “grooming” to describe Mr. Gordon’s conduct. Ms. Skalski believed Mr. Gordon’s conduct to be consistent with grooming behaviors and explained to Ms. Boyd and Mr. Trotter why she had used that word in her report. After Ms. Skalski made this report, Thomas Russell (agency administrator) reportedly told her that the Department was coming after her provider credential because she did not report her concerns to CPS.

1.70 Department records show that between January 1, 2021, and May 10, 2023, twenty (20) complaints were filed against Daybreak Youth Services (to include Spokane, Vancouver, Brush Prairie BHAs/RTFs) by third parties or the Department. Of those twenty (20) complaints, DCYF/CPS referred seven (7) to the Department. Of

those seven (7) CPS referrals, all were against Daybreak-Spokane, and only one (1) of the underlying CPS reports had been made by a Daybreak-Spokane employee.

1.70.1 In that single case, the referrer/employee's stated purpose for the call was to have a patient removed from the facility. The patient had allegedly sexually assaulted five (5) other patients on or about April 10, 2021.

1.70.2 The referrer/employee would not provide further details about the assaults to CPS, including alleged victims' names; nor would they allow CPS or law enforcement to conduct investigations. A police officer who responded to the scene reported, "…the staff at Daybreak were extremely uncooperative. Despite the reported presence of multiple victims, witnesses, surveillance footage, and [the suspect patient], Daybreak would not allow me to conduct further interviews or gather evidence inside the facility." Daybreak's Risk Manager Michael Trotter "reiterated that Daybreak would not be cooperative."

1.70.3 Police officers later became aware that two (2) of the alleged victims, Patient 14 and Patient 15, contacted their parents over the phone. When a Daybreak-Spokane staff member heard them telling their parents about the incidents and their victimization, the staff member interrupted the phone calls and told the patients they could not tell their parents about the assaults. Patient 14 told police later that she believed the only way to get law enforcement involved was through her family.

1.71 Department records also show that between January 1, 2021, and May 10, 2023, Daybreak Youth Services (to include Spokane, Vancouver, and Brush Prairie BHAs/RTFs) self-reported to the Department twenty-five (25) times. Thirteen (13) were self-reports of positive COVID tests. Eleven (11) were self-reports of patient attempted suicides. One (1) was a report of patient-on-patient non-consensual physical contact with a pencil (see *supra*) resulting in a "precautionary" trip to the emergency room and a report to the patient's mother. Daybreak-Spokane has not reported any other incident, employee, or former employee for unprofessional conduct to the Department during the aforementioned time period.

1.72 Patient 12 reported to Program investigators, "While I was a client at Daybreak, I was never informed that I had the right to contact the Department of Health

to make a complaint. I didn't know that was a possibility and no one made me aware of that while I was at Daybreak."

Other Staffing and Safety Issues

1.73 Daybreak-Spokane, through its administration, is responsible for ensuring that Daybreak-Spokane is sufficiently staffed with qualified employees to ensure adequate treatment services and facility security. Daybreak-Spokane failed to do so, which created risks to the health and safety of both patients and employees.

1.74 Multiple staff members reported to Program investigators that working conditions at the facility were unsafe, chaotic, and unorganized. They reported the facility had chronic staffing shortages, high turnover, and a lack of supervision for both staff and patients. Staff members also reported the following:

1.74.1 They were not allowed to take breaks and were asked to sign fake break logs and agreements to give up their lunch breaks.

1.74.2 They were expected to work double and triple shifts, sometimes back-to-back, and were encouraged to work more than one hundred (100) hours per pay period.

1.74.3 They were not allowed to call law enforcement or press charges if they were assaulted by a patient, or they would be fired. Staff were assaulted by patients "more than a few times."

1.74.4 If assaulted, they were not allowed to seek medical treatment outside the facility during work.

1.75 Staff member Jessica Rose reported to Program investigators there was an incident of a patient harming herself and others; and while attempting to place the patient in hold, the patient bit Ms. Rose. She told the Programs, "The patient had bitten me so severely that I could not move while she was biting me, for risk of her tearing flesh from my arm if I tried to pull away." Meanwhile, the nurse practitioner walked away from the situation "because he did not know what to do." It took five (5) staff members to physically control the patient. The escalation caused another patient to begin banging their head against a wall. After the situation was under control, Sandra Skok would not allow Ms. Rose to leave the facility to have her bite wound treated. Instead,

Ms. Rose was instructed to take the second injured patient to urgent care (at which time she was able to have her wound addressed).

1.76 Staff member Megan Chapman intervened when one (1) patient charged their roommate. One (1) patient "threw her off multiple walls" and the other patient threw objects at her head. Ms. Chapman sustained torn ligaments in her shoulder but was forced to finish her shift before seeking medical attention.

1.77 Staff member Mariah Rock reported there was a riot on one side of the facility, during which patients "destroyed the floor, smashing furniture and destroying things." At the same time, a fight was escalating on the other side of the facility. Staff, including her Team Lead, "just got up and left, they walked out," leaving two (2) other new hires and two (2) Skills Coaches behind.

1.78 On January 19, 2022, Sara Robinson (SUDP) reported to her supervisor, Angela Ball, that she became aware on a Saturday that a patient had suicidal ideation with a plan to hang herself on Sunday. Ms. Robinson instructed Madison Taber and Steven Titus to put the patient on one-to-one supervision and to create a safety plan and protocol. When Ms. Robinson followed up later, she found out the patient had been taken off one-to-one supervision on Sunday and put back in group supervision because of staffing issues. She also learned the situation had not been staffed with a treatment team and safety plan had plan had not been completed until the next Tuesday.

2. CONCLUSIONS OF LAW

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

Residential Treatment Facility - Jurisdiction and Violations

2.1 The Secretary of Health, acting through his designee, has jurisdiction over the licensee, Daybreak Youth Services, 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 246-337; WAC 246-337-021(1)(b), (2), (6)(b), (f), (g), (h); WAC 246-337-045(1)(d), (2)(b), (3)(a), (b), (c), (e); WAC 246-337-050(1), (2)(a)-(e), (4), (5)(a), (7)(e), (f); WAC 246-337-055; WAC 246-337-065(5)(a); WAC 246-

337-075(1)(c), (d), (2)(a), (g), (5); WAC 246-337-080(2)(h); WAC 246-337-095(3); WAC 246-337-105(4)(a).[2]

2.3 The above violations demonstrate that Daybreak-Spokane has failed or refused to comply with chapters 71.12 RCW and 246-337 WAC.

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

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

Behavioral Health Agency - Jurisdiction and Violations

2.6 The Secretary of Health, acting through his designee, has jurisdiction over the licensee, Daybreak Youth Services, and over the subject matter of this proceeding under chapters 71.05, 71.24, 71.34 RCW, and WAC 246-341.

2.7 The Findings of Fact constitute violations of chapters RCW 71.05; RCW 71.24; RCW 71.34; WAC 246-341; WAC 246-341-0335(1)(a), (b), (c), (d), (e); WAC 246-341-0410(1)(a), (c), (4)(a), (b), (f); WAC 246-341-0420(9); WAC 246-341-0510(1)(a), (c), (f); WAC 246-341-0515(2); WAC 246-341-0600(1), (2)(d), (e), (f), (j); WAC 246-341-0605(3); and WAC 246-341-0650(4); WAC 246-341-1108(5)(a).[3]

2.8 The findings of fact constitute an immediate danger to the public health, safety, and welfare and requires emergency action, as authorized by WAC 246-341-0335(4).

2.9 The above violations demonstrate that Daybreak-Spokane has failed to comply with chapters 71.05, 71.24, 71.34 RCW, and WAC 246-341.

2.10 Daybreak-Spokane's failure to comply with chapters 71.05, 71.24, 71.34 RCW, and 246-341 WAC provides grounds for the Department to deny, suspend, revoke,

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[2] The specific provisions of the Washington Administrative Code (WAC) cited herein are the provisions which were in effect at the time of the alleged violations.

[3] The specific provisions of the Washington Administrative Code (WAC) cited herein are the provisions which were in effect at the time of the alleged violations.

or place on probation Daybreak-Spokane's license or specific program certifications under RCW 43.70.115, chapters 71.05, 71.24, 71.34 RCW, WAC 246-341-0335, and WAC 246-341-0605.

2.11 Daybreak-Spokane's failure to comply with chapters 71.05, 71.24, 71.34 RCW, and 246-341 WAC provides grounds for the Department to assess a fee under RCW 43.70.250, WAC 246-341-0335(5), and WAC 246-341-0605(5).

Right to Contest

2.12 Daybreak-Spokane 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.

2.13 Daybreak-Spokane has the right to contest a Department decision to deny, suspend, revoke, or place on probation its BHA 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 246-341-0335(3).

2.14 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.00001010, DAYBREAK YOUTH SERVICES – SPOKANE, is **SUSPENDED INDEFINITELY.** The **SUSPENSION** shall immediately be stayed for four (4) days after this Notice becomes a Final Order.

3.2 License No. BHA.FS.60873305, DAYBREAK YOUTH SERVICES – SPOKANE and associated certifications are **SUSPENDED INDEFINITELY.** The **SUSPENSION** shall immediately be stayed for four (4) days after this Notice becomes a Final Order.

3.2 Within four (4) days after the Amended Notice becomes a Final Order, Daybreak-Spokane shall comply with the following:

A. Stop all admissions of new patients to Daybreak-Spokane.

B. Safely and appropriately discharge or transfer all current patients of Daybreak-Spokane. 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, Daybreak-Spokane 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), Daybreak-Spokane 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 Daybreak-Spokane 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.

3.4 It is HEREBY ORDERED that a protective order in this case is granted. All healthcare information and non-conviction data contained in the Motion, Notice, and Declarations with attached exhibits, shall not be released except as provided in Chapter 70.02 RCW, Chapter 10.97 RCW, 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2, and any other applicable law, as authorized under RCW 34.05.446(1), and WAC 246-10-405(1) and (2).

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.**

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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: May 19, 2023.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
RESIDENTIAL TREATMENT FACILITIES PROGRAM

Ian Corbridge
Ian Corbridge (May 19, 2023 13:26 PDT)

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