IN THE SUPREME COURT OF IOWA

No. 17-1650

Linn County Case No. CVCV0085106

ROMOKE OLUTUNDE,
Plaintiff-Appellant,
v.,

IOWA DEPARTMENT OF HUMAN SERVICES,
CHARLES M. PALMER, DIRECTOR
Defendants-Appellees.

APPEAL FROM THE IOWA DISTRICT COURT JUVENILE DIVISION IN AND FOR LINN COUNTY
THE HONORABLE PATRICK R. GRADY, JUDGE

APPELLEE'S RESISTANCE TO APPLICATION FOR FURTHER REVIEW

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PROOF OF SERVICE AND CERTIFICATE OF FILING

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STATEMENT OF THE FACTS

The Defendant-Appellees accepts the statement prepared by the Applicant.

RESISTANCE TO APPLICATION FOR FURTHER REVIEW

COMES NOW the Defendant-Appellee, Iowa Department of Human Services, and pursuant to Iowa R. App. P. 6.1103(2), resists the Application for Further Review filed under the above-noted heading. In support of said Resistance, it is stated:

1. This Application represents the final stages of judicial review of an administrative determination that the Applicant-Appellant committed adult abuse.

2. The Defendant-Appellee Department of Human Services prevailed at all levels below, except before the Administrative Law Judge, who did not concur that adult abuse had occurred.

3. The main issue presented on appeal was whether the Applicant, Romoke Olutunde, was properly identified as a caretaker who committed adult abuse. The case does not present significant legal issues as the facts it presents are significantly different from those of *Mosher*, the controlling precedent in the area cited by the Applicant. *Mosher* involved the question of whether a competent adult could be said to have been financially exploited by a caretaker

after he left the facility where the caretaking had occurred. This case involved a severely disabled individual who did not receive proper medication *while in the facility in question*. She was never competent, before, after, or during her stay in the facility.

4. The Applicant makes much of the fact she was the owner and director of the facility in question, not a direct care worker. However, Defendant-Appellee Department was *not*, in this case, attempting to expand the purview of the adult abuse laws so as to generally reach the owners and management of care facilities.

5. Rather, the Department found that under the unique facts of this case, the Applicant Romoke and her husband, Soji, had to be identified as caretakers of the dependent adult, as neither they nor the Department could accurately identify someone more directly responsible for the care of the adult in question. The Applicant and her husband ran the facility in such a manner that the employees of the facility came and went in a matter of months and they were the only individuals who could be said to have been the dependent adult's caretaker over the time period in question. The husband, Soji, has not appealed the finding against him.

6. This is, therefore, not a good case in which to explore when the owners or management of a care facility may be said to be caretakers of

dependent adults within the meaning of the adult abuse laws. Such a case, presumably, would involve owners or management who could identify individuals under them who would admit to being more directly responsible for the adults' care.

WHEREFORE, it is requested that the Application for Further Review be denied as the case is too factually unique to present legal issues of broad import that would be productively resolved by this court.

ARGUMENT

I. THE COURT OF APPEALS WAS CORRECT IN AFFIRMING THE DISTRICT COURT DETERMINATION THAT THIS CASE WAS NOT CONTROLLED BY OR INCONSISTENT WITH THE *MOSHER* DECISION

The Applicant disagrees with the Defendant-Department's application of the term "caretaker" to her. Caretaker is defined by statute. Iowa Code section 232B.2(1)2017). The interpretation of statutes is ultimately up to the courts. However, the DHS has the discretion to interpret the laws pertaining to adult abuse, and their interpretations are entitled to deference. *Mosher v. Department of Inspections and Appeals,* 671 N.W.2d 501, 509-510 (Iowa 2003) (also dealing with an interpretation of the term "caretaker").

Applicant-Appellant essentially makes two "caretaker" arguments on this appeal. In addition to her substantial evidence argument in Division II, she argues that she was not a caretaker insofar as the term was interpreted in

Mosher v. Department of Inspections and Appeals, *supra*. It is respectfully submitted, however, that as the District Court correctly found (App. 1554), *Mosher* is inapplicable to this case. *Mosher* dealt with the alleged financial exploitation of a resident in a facility by a facility employee after the resident had left that facility. By that time, the resident had begun to function in the world on his own. *Id.* at 511-512. Additionally, he had apparently been mentally competent while still in the facility. *Id.* at 516-519. Thus, there were numerous factors suggesting that the employee was not in a caretaker role when the alleged financial exploitation occurred, factors including the adult's level of functioning and the fact that the adult no longer resided in the facility where he would be under the control of the employee

By comparison, J.N. was never competent before, during or after her placement at All Ages Care. She could never handle her own affairs and certainly could not administer her own medication. She could not even count it. (App. 1482, Admin. Rec. 1434). She was *at* the facility when the abuse or neglect occurred. She was there through the arrangements of the Olutundes, pursuant to the representations made by the admissions director employed, supervised and trained by them. (App. 1483-1484, Admin. Rec. 1435-1436). J.N. was under their control and could not fend for herself.

She was not in the same position as the independently functioning adult in *Mosher*.

The report was founded as to the owner and operator in this case, not because such individuals would be a caretaker in every case or even in most cases, but because, given the unique facts presented here, with transient employees passing through the facility at a rapid pace, the Olutundes were the only ones in the facility who could be said to be responsible for J.N.'s care, or lack thereof, during the time she was there. They ran the facility in such a manner that a direct ongoing caretaker for J.N. other than themselves could not be identified. The direct care employees and their supervisor were hired and then left the facility in the months surrounding J.N.'s four-month stay there (App. 451-462, Admin. Rec. 421-432). It appears that the lines of authority were so confusing that the employee may not have known they were responsible for J.N. The supervisor of the direct care workers appeared not to know she was in charge of J.N.'s house. (App. 447-449, Admin. Rec. 417-419). *Her* supervisor, E.S., appeared not to know that she did not know. (App. 1478-1479, Admin. Rec. 1430-1431). If the Olutundes, including Romoke, were not caretakers at that facility, then J.N. had no caretaker while there, and the chaos in which she lived could generate no reports.

It is important that this type of situation does generate a report and the importance of this type of case with regard to someone like J.N. cannot be over-emphasized. The caretaker concept should not be defined so narrowly that those having the actual responsibility for the care of people like J.N. evade scrutiny. J.N. was severely mentally retarded. (App. 1483, Admin Rec. 1435). She could barely speak. She could not write or read. (App. 1482, Admin. Rec. 1434). Her parents were no longer living. She had no legal guardian. (Admin Rec. 1434). Her out-of-state brother was only her power of attorney. (App. 1482, Admin Rec. 1434). The only ones available to protect J.N. in this scenario were the adult protective system triggered by a 235B report and her case manager. The case manager did her job. She pulled J.N. from the All Ages Care facility because of what happened to her there. (App. 1486, Admin Rec. 1438). The DHS adult protective system had to file a report so this did not happen again to J.N. or to similarly situated individuals. This was apparently considered by the neighbors residing next to one of the All Ages Care homes. They confronted the DHS investigator who had arrived at the home after it had been shut down and described the chaos that surrounded it. The indicated the police were constantly summoned to the residence and that the residents appeared to be out of control, and to have not received their medications. (App. 1479, Admin.

Rec.1431). The neighbors expressed concern that the Olutundes might open another home as they did not appear qualified to operate such a facility. (App. 1075-1076, Admin. Rec. 1045-1046). In short, they recognized the protective value of having reports on file.

In its investigation, the Department attempted to identify those responsible for J.N.'s direct care and to interview them. This task was rendered difficult by the facility's inability to confirm who these employees were (App. 1478-1479, Admin. Rec. 1430-1431), and the employees' inability or unwillingness to show up for interviews regarding the allegations. (App. 1443-1453, 1477-1478, 1480, Admin. Rec. 1413-1423, 1429-1430, 1432). By way of example, R.S., was identified by the Olutundes as being the staff person in charge of the residence in which J.N. was assigned. (App. 448-449, 1477, Admin. Rec. 418-419, 1429). As such, she would have presumably been in charge of overseeing the administration of J.N.'s medications, and would have had information on whether that was done properly or not. Unfortunately, she not only denied any improper care of J.N., she even denied having been the supervisor of her residence, leaving the investigator with no one she could identify as J.N.'s direct caretaker. (App. 1478-1479, Admin. Rec. 1430-1431). Accordingly, the investigator's only possible course of action was to investigate those whom she *knew* had

the responsibility for J.N.'s care. This is what she did. While it is common for allegations of adult abuse or neglect to be denied by their facility caretaker, it is not common for facilities to be unable to identify who the direct adult caretaker was. This is why the Defendant-Appellee Department disagrees with the Applicant's contention that this case presents issues about the degree to which owners and managers may be investigated as caretakers in adult abuse investigations. It does not present these issues because it is unlikely that this extreme type of factual scenario exists with other owners and managers on a widespread basis.

To rule that Romoke Olutunde cannot be held to be a caretaker in this matter would be to effectively reward the facility for being so poorly run that a more direct caretaker could not be identified or located. Under such a ruling, a facility capable of assigning responsibility for a dependent adult's care to an individual, and making that individual available for interviews would be subject to adult protective investigations, but a facility such as All Ages Care, would actually escape this consequence by virtue of their placing dependent adults in the care of transient crews who move on before any investigation takes place. The Respondent-Appellees would advocate for an interpretation of the law which recognizes that society cannot place dependent adults in environments in which no one acknowledges

responsibility for their care. The Department submits that when owners and managers cannot produce staff that admit to having cared for an individual, they are the ones that should be deemed to have failed their caretaking duties.

J.N. was placed in All Ages Care, began missing her medication, lost weight, and ultimately had to be transferred to a different facility by her case manager. (App. 1486, Admin. Rec. 1438). She was at All Ages Care because she could not care for herself and the facility had represented they could care for her. (App. 1483-1486, Admin. Rec. 1435-1436). Those in charge of the facility, including the Applicant, could not care for her and frequently could not definitively identify anyone who would admit responsibility for caring for her. The responsibility for this state of affairs was the Olutundes', who were responsible for the staffing, care assignments, and training at All Ages Care. (App. 138, 434, 454, Admin. Rec.108, 404, 424). The haphazardness of care assignments led to the poor care of J.N. Staff could not have been properly trained. Soji Olutunde testified that it took three to six months to train staff, (App. 455-456, Admin. Rec. 425-426) which was troubling given that he also testified that virtually everyone responsible for J.N.'s care, including the supervisors, had been hired roughly the same time J.N. had arrived at the facility and thus did not have time to

obtain that training. (App. 447-448, Admin. Rec. 417-418). The Olutundes were responsible for this state of affairs and should therefore be deemed to have been responsible for care for J.N. at the time in question. By operating a facility in which employees came and went at a rate so fast they could not possibly be trained properly, the Olutundes put at risk any residents of the facility needing care such as the consistent administration of medication. J.N. was such a resident and did not receive medication necessary to maintain her life or health. That her medication was vital was established by the testimony of a doctor. (App. 372-378, Admin. Rec. 342-348).

Adult abuse Reports are founded because a problem has occurred with the manner in which a dependent adult has been cared for and that problem needs to be recorded. It is respectfully submitted that a limited definition of caretaker does not protect dependent adults because such a limitation would preclude the founding of abuse reports where such a founding would be of use to society. Such reports facilitate the identification of victims or potential victims of abuse. Iowa Code section 235B.4(1). A founded report can then be used as evidence in whatever legal action is necessary to protect the subject dependent adult. Adult abuse reports are of importance to more than just the adults subject to them. Such reports determine who can work in a healthcare facility. Iowa Code section 135C.33 (2017). Such reports

determine who will care for the isolated, disabled and the vulnerable. Adult abuse reports appear to have been used in the Medicaid action that shut this facility down. (App. 436-437, 463-464, 1066, Admin. Rec. 406-407, 433-434, 1036).Technical arguments in which one narrowly defines the parameters of adult protective laws are not consistent with the overall goal of protecting dependent adults.

II. THE DEPARTMENT'S DETERMINATION THAT ROMOKE OLUTUNDE COMMITTED ADULT ABUSE WAS SUPPORTED BY SUBSTANTIAL EVIDENCE AS SHE WAS RESPONSIBLE FOR THE OPERATION OF THE WAIVER HOME IN SUCH A MANNER THAT J.N. WAS ADMITTED TO THAT HOME WITHOUT ADEQUATE PROVISION BEING MADE FOR MEDICAL CARE THAT J.N. DESPERATELY NEEDED AND J.N. SUFFERED BECAUSE OF THIS

This is an appeal from a finding of adult abuse. Normally, there are three elements that must be found to exist before a finding of an adult abuse can be made. There must be a dependent adult, a caretaker, and there must have been dependent adult abuse as that term is defined in the Iowa Code. 441 IAC 176.3(1). As to the first element, there is no question that the 55 year-old adult who was the subject of this case, J.N., was a dependent adult. She had moderate to severe Downs Syndrome and dementia and required a case manager. (App. 1482-1483, Admin. Rec. 1434-1435). She could not read or write, could barely speak, and required 24-hour care. (App. 1476,

1482-1483, Admin. Rec. 1428, 1434-1435). She could not administer her own medication. (App. 1482, Admin. Rec. 1434). At the time of relevance to this appeal, from late December 2013 to May of 2014, she resided at All Ages Care, a three-building waiver facility owned and operated by the Applicant-Appellant. (App. 127-129, Admin. Rec. 97-99).

In this Application, Appellant challenge that was shown that she was J.N.'s caretaker. She argues that it was not shown by substantial evidence that she was a caretaker. In *Mercy Health Center, A Division of Sisters of Mercy Health Corp. v. State Health Facilities Council*, 360 N.W.2d 808, 811-812 (Iowa 1985), the Court stated the following about the substantial evidence standard:

> Evidence is substantial if a reasonable person would find it adequate to reach the given conclusion, even if a reviewing court might draw a contrary inference. [citation]. Moreover, the fact that an agency might draw inconsistent conclusions . . . does not necessarily suggest its final conclusion is unsupported by substantial evidence [citation]. Although there was considerable evidence at variance with the agency decision there was substantial factual evidence to support it.

Because review is not de novo, the court must not reassess the weight to be accorded various items of evidence. *Aalbers v. Iowa Dept. of Job Service*, 431 N.W.2d 330, 334 (Iowa 1988). Weight of evidence remains

within the agency's exclusive domain. Under these circumstances great care must be taken by the reviewing court to avoid moving from the prescribed limited review into one that is de novo. *Burns v. Iowa Board of Nursing*, 495 N.W.2d 698, 699 (Iowa 1993).

Applicant-Appellant claims not to have been J.N.'s caretaker despite having admitted responsibility for caring for J.N. during the investigation (App 180, Admin. Rec. 1050) and in her testimony during the administrative appeal. (App. 167, Admin. Rec. 137). It is submitted there is little doubt that Romoke Olutunde, along with her husband Soji, was J.N.'s caretaker at the time in question. She owned the agency and was the agency's clinical director, as, unlike her husband, she had a medical background as a certified nursing assistant. (App. 443, 470, Admin. Rec. 413, 440). She trained, supervised and assigned J.N.'s caretakers and those who supervised them. (App. 138-139, Admin. Rec. 108-109). She occasionally provided direct care to J.N. herself. (App. 158-159, Admin. Rec. 128-129).

The nature of the operation of All Ages Care indicates that she and Soji should be found to have had primary responsibility for the care of J.N. Staff generally worked at All Ages Care for only a few months. (App. 444-453, Admin. Rec. 414-423). This was true of the staff that worked with J.N. (App. 444-448, 461-464, Admin. Rec. 414-418, 431-434). This included the

administrators as well as the front-line staff. (App. 445, Admin. Rec. 415). The person who had admitted J.N. in December, G.M., had a role that was, to some extent, the focus of the report. She was the one who did J.N's intake and the one who made assurances to the care manager that the facility could care for J.N., arrange for her medical care, and obtain her prescriptions through local providers. (App. 1483-1484, Admin. Rec. 1435-1436). But, by the time of the investigation, she had left the facility. (App. 470, Admin. Rec. 440). This left the Olutundes as responsible for keeping her promises, hiring a replacement, and maintaining the proper care for J.N. They were the only constant in J.N's care during the four months of her stay there, as the staff turned over almost completely during that time. (App. 446-448, 461-464, Admin. Rec. 416-418, 431-434). Appellant Romoke was the as sole owner and clinical director of the facility. (App. 433, 439, 443, Admin. Rec. 403, 409, 413). Soji was an administrator or manager. (App. 433, 438, Admin. Rec. 403, 408). He eventually had to vacate the facility due to his other abuse reports. (App. 437, 1480, Admin. Rec. 407, 1432). This left the Applicant-Appellant as solely responsible for the operation of the facility along with newly hired administrator, S.B. (App.434, 437-438, Admin. Rec. 404, 407-408). This in and of itself was somewhat problematic as S.B. seems to have limited qualifications for such a position. His previous

employment was working for a Christian services agency assigning youth to do projects for the elderly. (App. 182-183, Admin. Rec. 152-153). He did not have any degrees or relevant institutional experience (App. 177, Admin. Rec. 147) but, despite this, became "administrator" of the entire facility *within three or four weeks* of his employment by the agency. (App 178, Admin. Rec. 148). Though the facility only survived a few months after his January hire, he apparently remains there as driver, janitor and handyman. (App 177, Admin. Rec. 147).

Thus, within months of J.N's placement, the facility was operating with almost entirely new staff, staff without the qualifications to maintain her safely. The Applicant-Appellant seemed to be in charge of medical care in the place. She trained many of the staff in administering medications and was responsible for triaging incoming clients. (App. 138-139, 164-166, 187, Admin. Rec.108-109, 134-136, 157). Her qualification for this were her certification as a nurse's assistant, and, of course her status as CEO of the entire operation. (App. 468, Admin. Rec. 438). New staff were trained in administering medication by a video, though the precise nature of that video is not clear. (App. 139, 464-465, Admin. Rec. 109, 434-435). Though the Olutundes denied it, one of the few staff to talk to DHS maintained that she was administering medication the day she was hired. (App 1175-1177,

Admin. Rec. 1145-1147). It is not surprising therefore, that J.N, with her multiple medications that had to be obtained and administered at different times a day by different parties, did not receive the proper medication and suffered seizures and hospitalizations because of it.

"Caretaker" means a related or non-related person who has the responsibility for the protection, care, or custody of a dependent adult as a result of assuming the responsibility voluntarily, by contract, through employment, or by order of the court. Iowa Code section 235B.2(1) (2017) It is submitted that Appellant assumed care for J.N. by contract or through employment. The staff member who admitted J.N. was trained by Romoke who went back to doing aspects of her job when that staff member left. (App. 445, 470, Admin. Rec. 415, 440). The Olutundes took J.N. into their facility and placed her under the care of staff they hired and trained. By the time this adult abuse investigation occurred, virtually all of those staff had left the facility and J.N was under the care of newly hired staff. (App. 463-464, Admin. Rec. 433-434). The individuals as working in J.N.'s house all left. The party identified as the supervisor of the house, R.S., not only left, she even denied that she had in fact been assigned to that house. (App. 1477, Admin. Rec. 1429). She did not appear for a formal interview, nor did

anyone who worked under her in that particular house. (App. 1477-1478, 1480, Admin. Rec. 1429-1430, 1432).

Thus, Appellant's argument that she was not a caretaker for J.N. is made herein without being able to produce anyone who admits to having been in that capacity. It is submitted that she was responsible for this scenario, being the sole owner of the facility and by operating the facility in such a manner that more direct caretakers came and went, and clients like J.N. were cared for by a transitional crew who could not possibly master the skills necessary to care for her. As founder, owner and clinical director of the facility in which J.N. was placed, the Applicant should have been able to identify persons hired by her who would admit to having been in charge of J.N.'s care. This she could not do. Her duties as J.N.s caretaker may have largely consisted of placing J.N. in the care of people who would properly care for her, but she failed in that duty.

J.N. did not receive the care necessary to maintain her life and health. She did not receive proper medication, specifically medication to treat her acid reflux and her seizure disorder. In the main incident focused upon in the report, J.N. attended a day program or "Day Hab" at another facility while at All Ages Care. (App. 1476, Admin. Rec. 1428). She was transported there by bus. It was important that her medication follow her

there as she took medicine throughout the day. In a meeting it was established that the medication would have to be transported through the driver of the bus that took her to the facility. (App. 342-344, Admin. Rec. 312-314). If it were placed in her backpack, she might eat it with adverse consequences to her health. (App. 1477, Admin. Rec. 1429). Despite this, the medicine was sent in her backpack anyway. (App. 342, Admin. Rec. 315). This was admitted by the new administrator. (App. 194-195, Admin. Rec. 164-165). Additionally, because the day facility had not yet been not authorized to administer her medication, All Ages Care staff were to travel to the other facility and administer the medication. All Ages Care staff failed to show up when they were supposed to administer medication. (App. 339-340, Admin. Rec. 309-310). This even occurred on the day of the meeting held to establish the transition protocol. (App. 1483, Admin. Rec. 1437). Their records on the matter were confusing and tend to confirm that J.N. did not get her meds. (App. 483-485, 694-697, Admin. Rec.453-455, 664-667). As stated in the review request in the administrative appeal:

> Neither her case manager, Angela Albers, nor the admitting people at the day perceived her to have received the proper medication, and both thought it was being inappropriately transported. Stephanie Bawek of the day-program felt that it was clear from the bubble packs that J.N. did not receive her medication. Dr. Timothy Volk testified as to the harm that could occur upon such a failure. Thus, the Department established the immediate and potential danger associated with

> the Appellant's failure to see that J.N.'s medications were properly administered.
>
> (App. 42, Admin. Rec. 12).

Assuming that J.N. was deprived of proper medication in the chaotic environment of All Ages Care, one might expect her health to suffer. This did, in fact, happen. J.N.'s condition deteriorated while at All Ages Care. After arrival at the agency's house, J.N. began to lose weight according to her case manager. According to her case manager she lost 66 pounds between her arrival in late December 2013 and departure roughly four months later. (App. 1486, Admin. Rec. 1438). After her arrival, she began having seizures and going to the hospital frequently (App. 1483-1485, Admin. Rec. 1435-1437). This was not consistent with her history. (App. 1478, 1485, Admin. Rec. 1430, 1437). This was consistent with the erratic administration of her medicine. (App. 1483-1485, Admin. Rec. 1435-1437). Her case manager testified that she did not have seizures unless she did not get her medication. (App. 1485, Admin. Rec. 1437). The increase in seizures and hospitalizations started in January of 2014, soon after her December 27, 2013 admission to All Ages Care. Shortly thereafter she began to have her first seizures in almost a year. (App. 1485, Admin. Rec. 1437).

The chaotic conditions at All Ages Care were a contributing factor in her neglect. J.N. had lost her previous placement in Grinnell due to its closure. (App. 1483, Admin. Rec. 1435). Her case manager looked for a new placement, found All Ages Care, and met with that agency about J.N.'s admission. (App. 1483-1484, Admin. Rec. 1435-1436).The facility, or, specifically its admissions director, "G. M", met with the case manager and was given instructions for J.N.'s care, along with her prescriptions. (App. 1483-1484, Admin. Rec. 1435-1436). The understanding was that the facility would then be responsible for refilling the prescriptions with local providers. (App. 1484, Admin. Rec. 1436). However, "G.M.", the party who admitted J.N., soon ceased her employment with the agency, (App. 445, 470, Admin. Rec. 415, 440) as did virtually everyone else working there. (App. 142, 447-448, Admin. Rec.112, 417-418). It was difficult to locate employees of the facility who would admit responsibility for J.N. J.N. was placed in a house which was allegedly supervised by R.S. R.S. denied this, but otherwise would not talk to the DHS. Neither would two employees under her. (App. 1477, 1480, Admin. Rec. 1429, 1432). The facility hired the two new management officials in January and February of 2014. E.S. appeared to have assumed responsibility for obtaining J.N.'s prescriptions, but according to the day-hab staff, did not seem to take his duties seriously.

(App. 1477, Admin. Rec. 1429). The case manager caught him lying about providing medication to J.N. at least once. (App. 1071, 1485, Admin. Rec. 1041, 1437). The DHS investigator smelled alcohol on his breath. (App. 1478, Admin. Rec.1430). S.B. was the youth services worker without a college degree described earlier, whose background was finding young people to do projects for the elderly—such as raking their lawns. (App. 182-186, Admin. Rec. 152-156). Neither he nor E.S. were in a position to place the facility on a footing where people like J.N. could properly be cared for.

It is submitted that the rapid turnover amongst employees contributed to J.N.'s poor care. J.N.'s case manager became concerned that J.N. was not receiving her medication at the facility, and became aware that three months into J.N.'s four month stay there, the prescriptions still had not been refilled. (App. 1485, Admin. Rec. 1437). These included prescriptions for a seizure disorder and J.N. began to have seizures. (App. 1478, 1485, Admin. Rec.1430, 1437) There were also problems transferring J.N.'s prescriptions to the day facility. (App. 1484-1485, Admin. Rec. 1436-1437). It was at this time that the meeting was held, at which the protocol for this was discussed. (App. 1478, 1484-1485, Admin. Rec. 1430, 1436-1437). It was decided that All Ages would send the medications with a bus driver, not in J.N.'s

backpack, and would travel there for the midday administration of the medication. Neither of these occurred regularly.

By April 22, 2014, Romoke Olutunde had become the person primarily in charge of the All Ages facility in which J.N. was placed. (App. 441-447, Admin. Rec. 411-417). Soji had been the subject of another abuse report and could no longer have any client contact according to the Iowa Medicaid Enterprise. (App. 436-441, Admin. Rec. 406-411). It appears that Romoke was not completely without qualification to at least work in this facility. She had some nurses training and both she and Soji had worked in other facilities. (App. 145, 435-436, Admin. Rec. 115, 405-406). That is where he obtained one of his other abuse reports. (App. 1087-1094, Admin. Rec. 1057-1064). However, she could not manage the facility and J.N. suffered the effects of inadequate care as the facility slipped into chaos. As stated previously, she lost 66 pounds during her stay there. (App. 1486, Admin Rec. 1438). Her hygiene suffered. (App. 1486, Admin. Rec. 1438). She was hospitalized at least three times, including once for dehydration. (App. 1484-1485, Admin. Rec. 1436-1437). She had to be removed from the facility which was eventually shut down. It is clear she had suffered abuse and neglect at the hands of the Applicant-Appellant.

CONCLUSION

The Application for Further Review should be denied as this is a factually unique case whose issues are unlikely to be revisited.

CONDITIONAL REQUEST FOR ORAL SUBMISSION

The Respondent-Appellees, Department of Human Services, request to be heard if oral argument is granted to the Applicant.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH TYPE-VOLUME LIMITATION, TYPEFACE REQUIREMENTS, AND TYPE-STYLE REQUIREMENTS

1. This Resistance to Application for Further Review complies with the type-volume limitation of Iowa R. App. P. 6.903(1)(g)(1) because this brief contains 5,082 words, excluding the parts of the brief exempted by Iowa R. App. P. 6.903(1)(g)(1).

2. This brief complies with the typeface requirements of Iowa R. App. P. 6.903(1)(e) and the type-style requirements of Iowa R. App. P. 6.903(1)(f) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in font Times New Roman 14.

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January 7, 2019