DRAFT FINDINGS OF FACT AND CONCLUSIONS OF LAW
PREPARED BY SENIOR DWELLING, INC.

October 14, 2014

Appeal No. 18820 of Senior Dwelling, Inc., pursuant to 11 D.C.M.R. § 3112.2, 14 D.C.M.R., § 1407.1, and D.C. Code § 6-641.07(f), from the Zoning Administrator's Notice to Revoke the Certificates of Occupancy for two rooming houses operating at 223 and 225 56th Place NE, Washington, D.C. 20019 (Square 5248, Lots 112 and 113).

HEARING DATE: September 23, 2014
DECISION DATE: October 21, 2014

ORDER GRANTING APPEAL

This appeal was submitted to the Board of Zoning Adjustment ("**Board**" or "**BZA**") on June 20, 2014 by Senior Dwelling, Inc. ("**Appellant**"). The appeal challenges the Zoning Administrator's ("**ZA**") Notice to Revoke Certificates of Occupancy ("**Notices**"), served on Appellant on April 21, 2014 based on the allegation that Appellant's rooming houses, located at 223 and 225 56th Place NE ("**223**" and "**225**," respectively) (Square 5248, Lots 112 and 113), were not being operated as provided for in the certificates. The ZA alleges 223 and 225 are being operated as community residence facilities ("**CRF**") or assisted living residences ("**ALR**"). DCRA also served Appellant with a Notice to Revoke Licenses with respect to Appellant's rooming house licenses earlier this year, relying on the same allegations that the rooming houses were operated as a CRF. That proceeding is stayed, pending the outcome of the BZA matter.

Based on the evidence of record, including the extensive prehearing submissions, testimony received at the public hearing, and posthearing submissions of evidence, and for the reasons set forth below, the Board grants the appeal, and the Appellant will maintain its Certificates of Occupancy.

PRELIMINARY MATTERS

Notice of Public Hearing

The Office of Zoning scheduled a hearing on September 23, 2014. In accordance with 11 DCMR §§ 3112.13 and 3112.14, the Office of Zoning mailed notice of the hearing to the

Appellant, ANC 7C (the ANC in which the property is located), the property owner, and DCRA. (Exhibits 9-11.[1])

Parties

Appellant in this case is Senior Dwelling, Inc., the owner of two residential properties located at 223 and 225 56th Place NE that are licensed as rooming houses in the District and also have valid Certificates of Occupancy as rooming houses. DCRA is the Appellee, as the "person" whose administrative decision is the subject of the instant appeal, pursuant to 11 DCMR § 3199.1(a)(2). The decision or determination is BZA's decision to revoke Appellant's Certificates of Occupancy for rooming houses at 223 and 225. The alleged zoning errors were the Zoning Administrator's determinations regarding the use of the property, namely, based on a December 3, 2013 DCRA investigation, the Zoning Administrator concluded that 223 and 225 were not being used as rooming houses in which residents were renting rooms and using common areas, but rather, were being operated as CRFs under DC Code § 44-501, because the houses "provide[d] a sheltered living environment for individuals who desire or need such an environment because of their physical, mental, familiar, social, or other circumstances, and who are not in the custody of the Department of Corrections," or ALRs under D.C. Code § 44-102.01, because the residences allegedly "combine[d] housing, heath, and personalized assistance, in accordance to individually developed service plans, for the support of individuals who are unrelated to the owner or operator of the entity." The Zoning Regulations define a CRF as "a residential facility for persons who have a common need for treatment, rehabilitation, assistance, or supervision in their daily living." 11 DCMR § 199. Ms. Rosemary Ogbenna is the Resident Director of 223 and 225, and sole owner of Senior Dwelling, Inc. The ANC was also automatically a party in the case, but did not file anything in connection with this appeal.

Pre-Hearing Submissions

The Board received prehearing materials from the Appellant on September 9, 2014, pursuant to 11 DCMR § 3112.10 (Exhibits 12-13). Appellant submitted a revised witness list on September 12, 2014 (Exhibit 14). DCRA submitted prehearing materials for the Board's consideration on September 16, 2014 (Exhibits 15-15H). DCRA later supplemented its materials with the testimony of Joy Cottman on September 19, 2014 and an affidavit from Matthew Le Grant, the Zoning Administrator, on September 22, 2014 (Exhibits 16 and 17).

Appellant's Case

The Appellant argued that 223 and 225 are operating as rooming houses, not CRFs. The Resident Manager of 223 and 225, Rosemary Ogbenna, previously owned and operated CRFs, from approximately 2001 to 2008, and is still in contact with the nursing and rehabilitation

[1] Unless otherwise noted, all exhibits reference the record in Appeal No. 18820.

centers, who currently refer her residents that are independent and able to care for themselves. Appellant contends this history clouded the issue and has caused DCRA to investigate her rooming houses since both 223 and 225 were established in 2009, assuming she is still operating a CRF. Appellant argued that Ms. Ogbenna interviews every resident, to ensure they are capable of living independently in her rooming houses, with limited assistance from home health aides ("**HHA**"). Appellant maintains that Ms. Ogbenna's primary goal is to provide affordable housing for low-income residents.

The Appellant also argued that, Ms. Ogbenna is very aware of the difference between a CRF and a rooming house, as she owned and operated several CRFs in the past. Ms. Ogbenna testified that she decided not to continue running CRFs because it was a time-consuming venture, she was in and out of the hospital with complications in her pregnancy, and certain residents in CRF's were problematic, with one even assaulting Ms. Ogbenna. Specifically:

(1) Appellant argued that the residents of 223 and 225 were diverse in that some required HHAs for some assistance with daily activities during the week and some residents did not require HHAs.

(2) Despite the fact that some of her referrals came from old nursing home contacts she knew when she was running the CRFs, as the Resident Director of 223 and 225, she interviewed each and every resident, and would not take on a resident if they were unable to live safely on their own.

(3) At no point did all the residents of 223 and 225 need assistance from HHAs, in fact, at most, six of eleven residents had HHAs.

(4) Even those individuals that did have HHA for assistance with some daily activities were able to live independently on their own.

(5) Appellant is not responsible for the residents' care in anyway, as Appellant operates a rooming house, or rooms for rent.

(6) Appellant does not provide meals at 223 or 225, although some rooming houses do and are permitted to provide meals to residents. In this case, some residents had aides cook for them.

(7) Ms. Ogbenna was listed as the responsible party because residents did not have phones, and the agency needed to be able to contact them. This information was put into the resident's record with the home care agencies before they came to live at 223 or 225, and was not subsequently updated by the home care agencies or the residents.

(8) Ms. Ogbenna conceded that some of the residents had HHAs from home care agencies, but testified that she did not work with these agencies, she did not

compensate the HHAs, and she did not oversee the HHAs work with the residents at 223 and 225.

(9) Senior Dwelling argued that DCRA had previously investigated Senior Dwelling in 2010, but found that Senior Dwelling was operating rooming houses. Senior Dwelling argued that its practices had not changed since that time.

At the hearing, the Appellant presented testimony from Rosemary Ogbenna, Senior Dwelling's owner, and from April Brent, formerly a Discharge Planner for St. Thomas Moore, a nursing and rehabilitation home, who referred residents to 223 and 225. Both Ms. Ogbenna and Ms. Brent testified in accordance with Appellant's factual claims and legal arguments. Ms. Brent in particular testified that she inspected Senior Dwelling's facilities and placed persons there whom she described as "walkie-talkies," that is, persons who were able to live independently.

Following the hearing, at the request of the Chairman, Appellant provided copies of the leases for the four remaining tenants of 223 and 225, with any identifying information redacted.

DCRA's Case

DCRA asserted that the appeal should be denied because Appellant was operating 223 and 225 as CRFs, not rooming houses. DCRA based this conclusion on the testimony and affidavit of Sharon Mebane (Exhibit 15A), the testimony and report of Roland Fallot (Exhibits 15C1 and 15C2), and the report of Kevin Meredith (Exhibit 15B). At the hearing, DCRA also presented evidence and testimony from Matthew Le Grant, the Zoning Administrator, who had not actually visited the premises. Specifically:

(1) Ms. Mebane testified that the Plans of Care ("**POC**"), provided by the home care agencies, for the residents at 223 and 225 listed some residents as having 24-hour care, and listed Ms. Ogbenna as their responsible person. She also testified that Ms. Ogbenna signed off on these POCs, but did not provide any evidence of this at the hearing.

(2) According to Ms. Mebane, six of Appellant's eleven residents had Ms. Ogbenna listed as their responsible person and those six also required 24-hour care. The POCs also allegedly stated that the residents were living in a group home or ALR. No evidence was provided that Ms. Ogbenna provided this information.

(3) Ms. Mebane testified that DOH's investigation of the home care agencies providing care at 223 and 225 indicated that residents were not receiving adequate care, however, Ms. Mebane did not present any evidence other than her own testimony, showing that Ms. Ogbenna or Appellant were responsible for the resident's care.

(4) Ms. Mebane concluded that those who did not receive HHAs were at risk, since HHAs shared services with them. However, there was no evidence in the record that the remaining five residents needed care. Those residents said they were self-sufficient, cooked their own meals, etc.

(5) Ms. Mebane testified that various home care agencies did not know that 223 and 225 were rooming houses, and were under the impression that the residents were at a group home, but was unable to provide anything other than her testimony and interview notes prepared by other DCRA officials that supported this statement. Similarly, Ms. Mebane testified the Veteran's Administration ("**VA**"), who placed residents at 223 and 225, pulled residents out when it found out that 223 and 225 were rooming houses, but provided no affidavit or statement from the VA to corroborate this allegation.

(6) Ms. Mebane testified that Ms. Ogbenna signed admission records for the residents, but could not produce those records at the hearing. These records were maintained by the home care agencies. These records allegedly indicated that Ms. Ogbenna was responsible for the remaining 16 hours of care, after each HHA left for the day, but no evidence of this was received into the record. The home care agencies were each cited for violations, since Ms. Ogbenna was not actually providing that care. Ms. Mebane also concluded that since the admission records stated Ms. Ogbenna was the responsible person, meaning she was responsible for providing the rest of the 24-hour care. No evidence to support this was placed in the record.

(7) Ms. Mebane claimed Ms. Ogbenna signed the POCs for these residents, but no evidence of this was admitted into the record.

(8) Mr. Roland Fallot testified that "Mercy," or Ms. Mercy, was the resident director at 223 and 225, but there is no evidence in the record to support that statement. Mr. Fallot allegedly interviewed Mercy and she stated this was her title, but did not ask her about her job duties, and based his conclusion on the fact that she was preparing lunch when he interviewed her.

(9) Mr. Fallot could only remember talking to four residents, and only two of those he felt needed care, based on the fact that they were "confused" and took medications.

(10) Mr. Fallot did not fact-check the residents' testimony outside of talking with their HHAs. For example, he claimed that Ms. Ogenna received the residents' Social Security benefits, but did not check with Social Security or ask Ms. Ogbenna herself. Or some residents stated that Mercy cooked their meals or administered medication, but he did not ask Mercy that. He later stated that that same resident was confused, and stated Mercy administered medications, but was in fact referring to his HHA.

(11) Mr. Fallot testified that the residents of 223 and 225 who did receive assistance from HHAs, which was not everyone, required different levels of care, some needed help with bathing, some did not.

(12) A representative of T&N Reliable Nursing Care ("**T&N**"), Vera Oberg, purportedly told Mr. Fallot that some individuals could not care for themselves. Ms. Oberg was not present to testify and Mr. Fallot could not testify to what she actually said, and said it was more along the lines of the resident "needed somebody there."

(13) Matthew Le Grant, the Zoning Administrator testified that 223 and 225 were being operating not as rooming houses, but as community-based residential facilities. He based this conclusion on review the Certificates of Occupancy for 223 and 225 and reviewing the reports prepared by DOH and DCRA. Mr. Le Grant never visited the facilities himself, but based on a review of reports only, and no follow up with the investigators. He declared that the individuals living in 223 and 225 had a need for common care, based on a few individuals needing assistance with various daily activities.

DCRA presented testimony from Sharon Mebane, the Program Manager for the Department of Health's Intermediate Care Facilities Division under the Health Regulation License Administration. DCRA also presented testimony from Rolland Fallot, an investigator with DOH. Finally, Matthew Le Grant, the Zoning Administrator testified as a zoning expert for DCRA. Following the hearing, at the request of the Chairman, Appellee submitted clear copies of Exhibit 15B, page 2 and the POC's referred to by their witnesses during the hearing.

The Record

The Board deferred its decision on the merits of the case and closed the record, except to receive a list and clear copy of the photos of the signs on page 2 of Exhibit 15, the current leases for the residents of 223 and 225, and all Plans of Care referred to by DCRA in their testimony, and proposed findings of fact and conclusions of law from Appellant and DCRA to be filed by October 13, 2014. The Board scheduled the case for decision on October 21, 2014, at which time it will consider the merits of the case. Senior Dwelling submits that the Board should grant the appeal.

PROPOSED FINDINGS OF FACT

Administration of 223 and 225

1. Ms. Ogbenna, through Blessed Home, Inc., operated CRFs in the District from approximately 2001 through 2008.

2. Ms. Ogbenna decided to surrender CRF licenses because she was in the middle of a difficult pregnancy, was in and out of the hospital, and could not give the facilities the attention that they needed.

3. Ms. Ogbenna subsequently closed her CRF facilities and decided to apply for rooming house licenses for her properties.

4. Ms. Ogbenna began operating 223 and225 56th Place NE, Washington, D.C. 20019 (Square 5248, Lots 112 and 113) as rooming houses in 2009.

5. Certificates of Occupancy Nos. 169076 and 169061 permit 223 and 225 to be used as rooming houses.

6. 223 and 225 provide rooms for rent for residents. Each room at 223 and 225 is furnished with a television, bed, nightstand, and a dresser.

7. The leases show for rooms at 223 and 225 provide that residents are receiving a room, bathroom, and use of the common areas for the monthly rent. The lease does not make any mention of additional services.

8. Due to Ms. Ogbenna's history and contacts with nursing homes in the District, if an independent patient was being discharged, and the discharge nurse or social worker felt they were able to care for themselves for the majority of the time, they would sometimes refer the patient to Ms. Ogbenna.

9. Residents that were referred to 223 or 225 often did not have a home to return to because they either lost their home while in the hospital or their living situation changed such that they could not return to their homes upon discharge.

10. Some residents that were referred to 223 and 225 did not need any care, and some residents referred by nursing homes needed some level of assistance for some activities of daily living. These residents were no longer in need of medical care, however, they were provided with the option of having home health care and a HHA. The resident was free to decide if they wanted to continue receiving the service.

11. Ms. Ogbenna conducts an assessment of potential residents at the nursing home prior to accepting a resident at 223 or 225. Ms. Ogbenna would not accept a resident who was severely ill or presented a danger to themselves.

12. When an individual is discharged from a nursing home, the home notifies the District of Columbia Office of the Healthcare Ombudsman (Legal Services for the Elderly). Because the Department of Health saw residents were still being discharged to Ms. Ogbenna's homes,

the Department of Health began sending DOH officials to survey Ms. Ogbenna's properties, including 223 and 225.

13. DOH investigators started coming to 223 and 225 in 2009 and 2010. Several reports were prepared in January 2010, after interviews with the residents of 223 and 225, stating that 223 and 225 were operating as rooming houses.

14. Ms. Ogbenna testified that 223 and 225 currently have four residents total. All residents are able to live independently. Two of the current residents are in their 40s and work. The remaining two residents received assistance from HHAs on a limited basis, but are able to live independently.

15. In June 2012, an active and independent resident was rushed to the hospital. After he was taken to the hospital, it came to Ms. Ogbenna's attention that the resident had been closing his vents in his room, causing the room to heat up. The resident later died. This incident lead to a DOH investigation. There was no evidence presented that this incident was related to Appellant or Ms. Ogbenna, or that this resident was in Ms. Ogbenna's care.

16. In 2013, Ms. Ogbenna took on another active resident in his 50's who had been discharged, but had a drinking problem. His family would not take him back due to his issues with alcohol. The resident assured Ms. Ogbenna that his alcohol issues were under control so she decided to take him in. He periodically stayed with his family for days at a time. When Ms. Ogbenna had not seen the resident for a few days, she started asking the other residents if they had seen him. Nobody had seen him. Ms. Ogbenna found the resident passed out in his room. This resident in fact had passed away. There was no evidence presented that this incident was related to Appellant or Ms. Ogbenna, or that this resident was in Ms. Ogbenna's care.

17. 223 and 225 currently have a total of four residents. Two of the residents have jobs and work outside. One resident is in his 50s, and does not work, but likes to be at home. The last resident is an elderly woman in her 80s who mostly stays at home. Only two of the four have home health aides.

18. Ms. Ogbenna gets calls for all types of patients, but will not take on a patient that is too ill or cannot function independently because she offers no services, and 223 and 225 are only rooming houses. Ms. Ogbenna provides rooms for her residents, but no services. She cannot accept anyone into 223 or 225 who needs care around the clock.

19. Ms. Ogbenna at Senior Dwelling has some of the same referral sources she had when she was operating as a CRF under the name Blessed Home, however, she does not represent Senior Dwelling's facilities as a CRF and is clear that she can only take on residents that are able to live independently.

20. Appellant also receives referrals from other sources, for residents that are not in need of any home health care.

21. Appellant received referrals from nursing homes like St. Thomas Moore. The Discharge Planner there, April Brent, who was a licensed practical nurse ("LPN") responsible for discharging patients safely back in to the community, would contact Ms. Ogbenna looking for a room for rent for these residents. She visited 223 and 225, and understood them to be rooming houses, or rooms for rent.

22. Patients that were discharged to 223 and 225 were high functioning patients, or in Ms. Brent's words, "walkie-talkies." These were high functioning patients that could carry out activities of daily living on their own and did not need much if any assistance.

23. As a precaution, every patient discharged from St. Thomas Moore was discharged with a HHA. If the HHA felt that after working with and observing the patient, they were not safe to be on their own, the HHA was supposed to call adult protective services. This was a benefit allowed under Medicare and Medicaid, and it was St. Thomas Moore's practice to always refer patients being discharged to agency that provided home health care.

24. Often patients needed some limited assistance upon discharge, such as physical therapy, or someone to help them bathe until they were fully recovered. That was why a HHA was matched up with each patient that was discharged.

25. Ms. Brent also referred some of her patients to CRFs and assisted living facilities ("**ALR**"). These patients needed extensive care post-discharged, such as wound care, or were incontinent. Ms. Brent would not discharge these types of patients to 223 or 225, since they were not independent and capable of taking care of themselves.

26. There are nurses at 223 and 225 every day for two of the four residents. In the past, at most, nurses came to 223 and 225 to provide care for six out of eleven patients.

27. Nurses stay with their patients for a set number of hours each day. After their shift is done, the resident is able to take care of themselves until the next time the nurse arrives. There are no residents that need round the clock care.

28. Ms. Ogbenna did have one resident who was in a wheelchair at one time. During his stay with her, she hired a person to be at the property at night, in the event that there was any type of emergency. Appellant was not obligated to do this, and did not have a responsibility this resident to do so, but did so to make sure he would be okay in the event of an emergency. That resident is no longer with Ms. Ogbenna and there was never a 24-hour staff member at 223 or 225.

29. Ms. Ogbenna has never represented to any nursing home that she has 24-hour care or services at 223 or 225.

30. At times, Ms. Ogbenna has been listed a point of contact for residents of 223 and 225, specifically with the home care agencies, because when the resident initially moves in, they usually don't have a phone or any means to receive calls from or make calls to doctors and nurses. The nursing home usually asked Ms. Ogbenna to do so when discharging a resident to 223 or 225.

31. Appellant is the payee for two of the residents' Social Security Benefits. This is permitted by Social Security, and Ms. Ogbenna provided Social Security with her rooming licenses for 223 and 225 before getting approved as the payee for some of her residents. In the past, Appellant has been the payee for a maximum of six residents.

32. Because nurses and residents use the kitchen, and due to cleaning issues at 223 and 225, Appellant posted signs at the properties, instructing HHAs to clean the kitchen after cooking for any residents. Senior Dwelling also posted general rules and regulations applicable to all persons. This led Appellant to post signs related to the HHAs schedules in the common areas so that the HHAs would be held accountable for the messes they made in the common areas.

33. Appellant did not oversee meal preparation at 223 and 225. Some residents had their meals prepared by HHAs.

DOH and DCRA Investigations

34. Ms. Mebane admittedly testified regarding investigation and facts that pre-dated her time with DOH, as far back as 2008.

35. Ms. Mebane also oversees home care agencies, and investigated all three home care agencies involved in providing services at 223 and 225. In that investigation, she reviewed the plans of care ("POC") for the residents that had HHAs through the agencies. Six of Appellant's eleven residents had Ms. Ogbenna listed as their responsible person and those six also required 24-hour care. The POCs also allegedly stated that the residents were living in a group home or ALR. Ms. Mebane found various regulatory violations with the home health agencies.

36. During Ms. Mebane's investigation of the home care agencies, she visited each agency and examined their records.

37. Ms. Mebane's review found that some residents that did not have HHAs in fact needed HHAs, and did not have 24-hour supervision.

38. There was no evidence that the remaining five residents, out of eleven, needed care. Those residents said they were self-sufficient, cooked their own meals, etc.

39. Ms. Mebane testified that her office contacted the Veteran's Administration ("VA"), who were placing residents at 223 and 225. They did not know Appellant ran a rooming house, and thought they were discharging patients to a CRF. They removed their patients shortly thereafter. There is no evidence that Ms. Ogbenna indicated to VA 223 and 225 were CRFs.

40. Ms. Mebane testified that Ms. Ogbenna signed admission records for the residents, but could not produce those records at the hearing. These records were maintained by the home care agencies. These records allegedly indicated that Ms. Ogbenna was responsible for the remaining 16 hours of care, after each HHA left for the day, but no evidence of this was received into the record. The home care agencies were each cited for violations, since Ms. Ogbenna was not actually providing that care.

41. Ms. Mebane also concluded that since the admission records stated Ms. Ogbenna was the responsible person, that meant she was responsible for providing the rest of the 24-hour care. No evidence to support this was placed in the record.

42. Ms. Mebane claimed Ms. Ogbenna signed the POCs for these residents, but no evidence of this was admitted into the record.

43. Ms. Ogbenna was listed as the responsible party because residents did not have phones, and the agency needed to be able to contact them.

44. DOH's investigation of the home care agencies providing care at 223 and 225 indicated that residents were not receiving adequate care.

45. Ms. Mebane concluded that those who did not receive HHAs were at risk, since HHAs shared services with them. There is no evidence of this in the record.

46. Mr. Fallot testified that Ms. Mercy was a resident director at 223 and 225, but there is no evidence in the record to support that. Mr. Fallot allegedly interviewed Ms. Mercy and she stated this was her title, but did not ask her about her job duties, and based his conclusion on the fact that she was preparing lunch when he interviewed her.

47. Mr. Fallot could only remember talking to four residents, and only two of those he felt needed care, based on the fact that they were "confused" and took medications.

48. Mr. Fallot did not fact-check the residents' testimony outside of talking with their HHAs. For example, he claimed that Ms. Ogenna received the residents' Social Security benefits, but did not check with Social Security or ask Ms. Ogbenna herself. Or some residents stated that Mercy cooked their meals or administered medication, but he did not ask Mercy that. He

later stated that that same resident was confused, and stated Mercy administered medications, but was in fact referring to his HHA.

49. Mr. Fallot stated that residents required different levels of care, some needed help with bathing, some did not. He did note that no one seemed to be doing dishes.

50. A representative of T&N, Vera Oberg, told Mr. Fallot that some individuals could not care for themselves. Ms. Oberg was not present to testify. However, he could not testify to what she actually said, and said it was more along the lines of the resident "needed somebody there."

Zoning Administrator's Review

51. Matthew Le Grant testified that in his opinion, 223 and 225 were being operating not as rooming houses, but as community-based residential facilities. He based this conclusion on review the Certificates of Occupancy for 223 and 225 and reviewing the reports prepared by DOH and DCRA. Mr. Le Grant never visited the facilities himself, but based on a review of reports only, and no follow up with the investigators, he declared that the individuals living in 223 and 225 had a need for common care, based on a few individuals needed assistances with various daily activities.

PROPOSED CONCLUSIONS OF LAW

1. The Board is authorized by the Zoning Act, D.C. Official Code § 6-641.07(f), to hear and decide appeals **"**by any person aggrieved, or organization authorized to represent such person, or by any officer or department of the government of the District of Columbia or the federal government affected, by any decision of the Inspector of Buildings granting or refusing a building permit or granting or withholding a certificate of occupancy, or any other administrative decision based in whole or in part upon any zoning regulation or map adopted under this subchapter. . . . There shall be a public hearing on appeal." (11 DCMR §§ 3100.2, 3200.2.) In an appeal, the Board may reverse or affirm, in whole or in part, or modify the decision appealed from. (11 DCMR § 3100.4.)

2. Based on the findings of fact, the Board is persuaded by the Appellant that an error occurred in the decision of the ZA to revoke its Certificates of Occupancy for rooming houses at 223 and 225. DCRA failed to show that Appellant was in fact operating CRFs pursuant to the zoning regulations, meaning the ZA committed an error based on the Zoning Regulations in deciding to revoke the Certificates.

3. The Zoning Regulations define a "rooming house" as a "building or part therefore that provides sleeping accommodations for three (3) or more persons who are not members of the immediate family of the resident operator or manager, and in which accommodations are not

under the exclusive control of the occupants. A rooming house provides accommodations on a monthly or longer basis." 11 DCMR § 199. Ms. Ogbenna testified that there is a common kitchen and living room area in each residence. The rooms are furnished by Appellant, and include a bathroom. The residents are not members of Ms. Ogbenna's immediate family.

4. Senior Dwelling's facilities thus fall within the definition of rooming houses under the DCMR.

5. DCRA concedes that 223 and 225 appear to fit the definition of a rooming house, but make the circular argument that 223 and 225 cannot be rooming houses because "[i]f an establishment is a community based residential facility as defined [by the Zoning Regulations], it shall not be deemed to constitute any other use permitted under the authority of these regulations," therefore, 223 and 225 cannot be rooming houses for zoning purposes because they are CRFs. 11 DCMR § 199.

6. In its prehearing submission and at the public hearing, DCRA failed to show that 223 and 225 are being operated as CRFs, not rooming houses.

7. At the public hearing, the DCRA alleged that 223 and 225 were actually being run as CRFs, not rooming houses, because they are both "residential facilit[ies] for person who have a common need for treatment, rehabilitation, assistance, or supervision in their daily living." See 11 DCMR § 199.

8. DCRA failed to present evidence that all the residents at 223 and 225 had a common need for treatment, and at most were able to show that at one time, six of eleven residents had HHAs, but could not show that even these residents had a common need for "treatment, rehabilitation, assistance, or supervision in their daily living." See 11 DCMR § 199.

9. The residents at Senior Dwelling did not have a common need for treatment, as some required some care, and some did not, and thus Senior Dwelling's facilities at 223 and 225 are not CRF's.

10. DCRA put on witnesses who could testify to violations on behalf of the home care agencies that sent HHAs to 223 and 225 to work with some of the residents there, but did not present any evidence that Appellant or Ms. Ogbenna in any way oversaw or were responsible for the HHAs work or the residents' care at 223 and 225. DCRA failed to show that 223 and 225 are operating as CRFs, and Appellant's Certificates should not be revoked.

11. Based on the Findings of Fact, the Board concludes that the Zoning Administrator and DCRA improperly decided that Appellant's Certificates should be revoked.

12. Based on the evidence and testimony of Appellant's witnesses, the Board finds that 223 and 225 are not operating at CRFs, because 223 and 225 are not "residential facilit[ies] for

person who have a common need for treatment, rehabilitation, assistance, or supervision in their daily living." See 11 DCMR § 199. The residents of 223 and 225 have varying levels of care, and Appellant is not running 223 and 225 to provide services to residents, but is rather providing a room for residents.

Additional Findings and Conclusions

Appellant has set forth findings and conclusions above that support its appeal on the issue of whether Appellant's facilities at 223 and 225 were properly licensed as rooming houses. Appellant addresses related issues below, which also support Appellant's appeal.

Administration of 223 and 225

At the public hearing, Ms. Ogbenna conceded she at one time ran several CRFs in the District of Columbia, but that given the level of care needed for the residents of a CRF and her health conditions and time constraints, she voluntarily surrendered her licenses in 2009, and closed all CRFs she operated. Ms. Ogbenna explained that she owned several properties and had mortgage payments on each, so she looked for another way to generate income and keep her residential properties. She decided to apply for rooming house licenses for 223 and 225 in 2009. Ms. Ogbenna testified that each room in 223 and 225 was fully furnished, with a bathroom, and each resident had full access to the common kitchen and living areas. Ms. Ogbenna testified that she received referrals from contacts that knew she was operating rooming houses and also from her contacts at the nursing homes that used to refer her residents when she operated CRFs. Ms. Ogbenna made it clear that the referrals she received from the nursing homes were different than the referrals she used to take on as a CRF. When taking residents on that were being discharged from a nursing home, Ms. Ogbenna would go to the nursing home prior to discharge, and meeting with the potential resident and the discharge planner. Ms. Ogbenna testified that she would make sure that each resident of 223 and 225 were fully functioning and independent, and able to live safely on their own.

Ms. April Brent, a licensed nurse practitioner and former Discharge Planner at St. Thomas Moore, a nursing home that referred residents to 223 and 225, corroborated this testimony. Ms. Brent worked with St. Thomas Moore from 2010 to early 2014, and during that time, she testified that she regularly referred "walkie-talkies," or high functioning, independent patients to 223 and 225 upon discharge. Ms. Brent also testified in all discharge situations, no matter what patient's level of functioning was, Ms. Brent would exercise the patient's benefits under Medicare or Medicaid, and refer the patient to home care agencies for HHAs. The number of hours approved depended on the patient's condition upon discharge, and not all patients decided to continue the services after leaving St. Thomas Moore. Ms. Brent testified that she was the Discharge Planner for all patients at St. Thomas Moore, so she often referred patients to CRFs and ALRs. She testified that she was clear on what constitutes a CRF or ALR. She testified that the patients she discharged to CRFs were not able to function independently, and

were in need of twenty-four hour care. Ms. Brent testified that she visited 223 and 225 prior to discharging any of her patients to either residence and she described 223 and 225 as providing "rooms for rent." Ms. Brent testified that if a patient was in need of extensive care such as wound care or incontinent patients, she would not refer them to 223 or 225.

Ms. Ogbenna testified that she never had 24-hour staff. At one time, she testified she did have a "night sitter" for one resident who was in a wheelchair. She testified that during his stay with her, she hired a person to be at the property at night, in the event that there was any type of emergency. She testified that she was not obligated to do this, and did not have a responsibility to this resident to do so, but did so to make sure he would be okay in the event of an emergency. The resident has subsequently moved out.

Because there were several residents with HHAs, and because both HHAs and residents had access to and used to common areas, Ms. Ogbenna testified that she ran into problems with cleanliness, specifically in the kitchen areas. Because of this, Ms. Ogbenna testified that she created signs regarding rules for cleanup, addressing both the HHAs and the residents. Ms. Ogbenna testified that she did not oversee the HHAs, but because the residents were complaining about the mess, she wanted to hold the HHA's accountable for cleaning up their mess. Photos of some of the signs were included in Kevin Meredith's report. The Chairman asked DCRA to produce clearer pictures of the signs, and DCRA subsequently did so (Exhibit ___). A review of the signs shows that the signs were meant to address situations where the HHAs were not cleaning the kitchen or common areas after using them. Specifically, the sign reading "Nursing Aide Grouping Category," was meant to hold the HHAs assigned to residents accountable for their messes in the common areas and kitchen.

Review of Leases

The Board subsequently reviewed the leases for the current residents of 223 and 225 submitted by Appellant. The leases show that the rooms at 223 and 225 were simply rooms for rent and the monthly rent did not include any additional services (Exhibit ___).

Allegations of Inadequate Care by the Home Care Agencies

DCRA provided documents and testimony that the home care agencies were in violation of laws and regulations that applied to them, but failed to show any connection between these violations and Appellant. For example, Ms. Mebane testified regarding numerous DOH investigations of 223 and 225, as well as Ms. Ogbenna's previous CRF facilities. Ms. Mebane read straight from an affidavit prepared for her by counsel for DCRA during the hearing. Ms. Mebane testified to investigations that admittedly predated her time with DOH.

Ms. Mebane did testify that she visited 223 and 225 twice, and in doing so, identified numerous practices by the HHAs that violated regulations, however, she failed to draw any

connection between the failure to provide adequate care by the HHAs and Ms. Ogbenna or Appellant. All three agencies that provided HHAs to some residents at 223 and 225 were subsequently investigated and fined. Ms. Mebane testified that she personally investigated all three agencies, visited the agencies, and examined their records. DCRA provided a Statement of Deficiencies and Plan of Correction for one home care agency, T&N Reliable Nursing Care ("**T&N**") naming numerous violations and bad practices on behalf of T&N, however, neither Ms. Mebane's testimony nor the documents show that Appellant or Ms. Ogbenna were responsible for providing care to the residents at issue.

At the hearing, Ms. Mebane testified that Ms. Ogbenna reviewed and signed off on the POCs, was named the responsible party for the residents receiving care, and also agreed in writing to provide care to the residents for the 16 hours that the HHAs were not with the patients. At the conclusion of the hearing the Chairman requested the POCs for each of the six residents that Ms. Mebane was referring to from DCRA. DCRA subsequently provided some POCs. The POCs provided did state Ms. Ogbenna as the contact person or responsible party, which Ms. Ogbenna addressed in her testimony. Since the rooms Appellant provided at 223 and 225 did not have a phone, the home care agencies asked Ms. Ogbenna if they could list her as a contact person for the residents, Ms. Ogbenna agreed. At no point did Ms. Ogbenna agree to be the "responsible person" for the residents. Ms. Ogbenna's signature does not appear anywhere on the POCs. The POCs do note that the residents require 24-hour care, but do not state that Ms. Ogbenna or any representative of Appellant is to provide any care for the residents.

Ms. Mebane testified that the home care agencies did not know that 223 and 225 were rooming houses, and in fact believed them to be CRFs. No evidence was presented that Ms. Ogbenna represented to any home care agency or nursing home that she was a CRF. No representative from T&N or any other home care agency providing care to residents of 223 or 225 were present the meeting to testify. If there was an error, the error is on the part of the agency providing the home care. It would seem that it would be the responsibility of the home care agency to check Appellant's licenses, certificates of occupancy, and other relevant documents if they were relying on Appellant or Ms. Ogbenna to provide any portion of the care provided for by the physician in the residents' POCs. Further, Ms. Ogbenna testified that she did not receive a POC from any resident upon receiving the resident into 223 or 225.

Ms. Mebane also testified that at most, six of the eleven residents at 223 and 225 at the time she was involved in investigating both residences were receiving assistance from HHAs. She testified that there was no evidence that the remaining five residents needed care, and that those residents were self-sufficient.

Ms. Fallot also testified for DCRA. Mr. Fallot was the author of one 2013 report discussing the findings of an investigation at 223 and 225. Mr. Fallot could not remember the details of his investigation, and asked if he could use his report. The Chairman denied this

request initially, and asked if Mr. Fallot could try to testify from memory initially. Mr. Fallot could only testify that five residents maximum received care from HHAs. Mr. Fallot testified that of these five individuals, each resident required different levels of care. Mr. Fallot testified that these individuals could not live independently because they were "confused" and "took medications." Mr. Fallot testified that he interviewed a woman in the kitchen, Mercy, who stated that she was the Resident Director of 223 and 225. Mr. Fallot testified that she was cooking at the time of interview, but he did not ask her any further questions such as her job description or what her job duties were as resident director. Mr. Fallot did not fact-check the resident's testimony outside of speaking with some of their HHAs. For example, in his report, he stated that one resident stated Mercy administered his medication, but also stated that the resident was referring to his HHA as Mercy, when that was not her name.

Based on the evidence submitted by DCRA, and the testimony of Ms. Mebane and Mr. Fallot, the Board cannot conclude that Appellant or Ms. Ogbenna were responsible for the care of the residents of 223 and 225. At most, DCRA has set out a case for why the home care agencies should be investigated and possibly suspended from doing business in the District, however, there is no evidence that Appellant compensated or organized the HHAs or received compensation from the home care agencies or any other organization for providing care to residents. Further, as stated above, a review of the leases submitted by Appellant shows that the rooms at 223 and 225 were simply rooms for rent and the monthly rent did not include any additional services (Exhibit ___).

Zoning Administrator's Review and Recommendation

Finally, the Zoning Administrator, Matthew Le Grant, testified that based on his review of the investigation reports and the certificates of occupancy for 223 and 225, 223 and 225 were in fact operating as rooming houses. Admittedly, Mr. Le Grant had not been to either facility. Mr. Le Grant testified that he based this conclusion off of the fact that five or six of the residents needed some assistance with daily living, so 223 and 225 must be a CRF. However, when questioned by the Chairman regarding the other residents at 223 and 225 at the time of investigation, Mr. Le Grant testified that he believed that "some individuals based on the reports that [he] reviewed would not need the level of care consistent with a community-based residential facility."

Based on Mr. Le Grant's opinion, the Board cannot conclude that the residents of 223 and 225 have a "common need for treatment, rehabilitation, assistance, or supervision in their daily living." See 11 DCMR § 199.

DECISION

Based on the findings of fact and conclusions of law, the Board concludes that the Appellant has satisfied its burden of proof with respect to the various claims of error regarding

the Zoning Administrator's decision to revoke Appellant's Certificates of Occupancy. Accordingly, it is therefore ORDERED that the appeal is GRANTED.