BEFORE THE
DEPARTMENT OF SOCIAL SERVICES
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:

PAMELA THOMSEN dba THOMSEN LEARNING CENTER

(Preschool Facility), Respondent

CDSS No. 7722348101 (License Revocation)

PAMELA THOMSEN dba THOMSEN LEARNING CENTER

(Infant Facility), Respondent

CDSS No. 7722348101B (License Revocation)

PAMELA THOMSEN, Respondent

CDSS No. 7722348101D (Exclusion Action)

NICOLLE DANIELS, Respondent

CDSS No. 7722348101E (Exclusion Action)

In the Matter of the First Amended Statement of Issues Against:

PAMELA THOMSEN dba THOMSEN LEARNING CENTER

(School-Age Facility), Respondent

CDSS No. 7722348101C (Application Denial)

OAH No. 2023100672[1]

PROPOSED DECISION

Marion J. Vomhof, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference on April 15, 16, and 17, 2024.

Jennifer Kelly, Senior Staff Attorney, represented complainant, Kevin Gaines, Deputy Director of the Community Care Licensing Division (licensing) of the Department of Social Services (department), State of California.

Respondent Pamela Thomsen was present and represented herself and Thomsen Learning Center; Respondent Nicolle Daniels was present and represented herself.

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[1] On April 19, 2023, the department filed an Accusation and Statement of Issues, OAH Case No. 2023050565. On July 7, 2023, complainant's counsel, Joseph Zadeh, notified OAH that a settlement had been reached and included a partially executed stipulation. The matter was taken off calendar. However, the matter was not resolved and on August 8, 2023, the department filed a First Amended Accusation and Statement of Issues, OAH Case No. 2023100672.

Oral and documentary evidence was received. The record was closed, and the matter was submitted for decision on April 17, 2024.

PROTECTIVE AND SEALING ORDER

The names of minor children referred to in this matter are subject to a protective order. Any document received as evidence in this matter that contains the names of the minor children identified in the confidential names list (included in Exhibit 1, and included in the exhibits identified below shall be redacted before any disclosure to the public. No court reporter or transcription service shall transcribe the names of the children. Exhibits 1, 6 through 14, 16 through 21, 23, 27, 31, and 33, are subject to the sealing order. A reviewing court, parties to this matter, their attorneys, and a government agency decision maker or designee under Government Code section 11517, may review the sealed exhibits subject to this order, but the exhibits are protected from release to the general public, unless otherwise ordered by a court of competent jurisdiction.

FACTUAL FINDINGS

Jurisdictional Matters

1. The department is responsible for the licensing and operation of child day care centers.

2. Respondent Pamela Thomsen is licensed by the department to operate the Thomsen Learning Center, a child day care center for preschool children in

Ramona, California (preschool facility). The preschool facility was initially licensed on July 16, 2022.

3. Respondent Thomsen is licensed by the department to operate the Thomsen Learning Center, a child day care center for infants in Ramona, California (infant facility). The infant facility was initially licensed on July 16, 2022.

4. On July 19, 2022, respondent Thomsen submitted an application for a license to operate the Thomsen Learning Center, a child day care center for school-age children in Ramona, California (school-aged facility). On December 5, 2022, the department denied the application.

5. Respondent Nicolle Daniels is employed by respondent Thomsen as the director of the preschool facility and the infant facility (collectively referred to as facility or TLC.)

6. On August 8, 2023, Joseph Zadeh, Senior Staff Attorney, filed the First Amended Accusation and the First Amended Statement of Issues on behalf of complainant in his official capacity. The First Amended Accusation sought revocation of respondent Thomsen's licenses to operate the preschool facility and the infant facility, and exclusion of respondents Thomsen and Daniels from employment in, presence in, and contact with clients of, any facility licensed by the department or certified by a licensed foster family agency, or any resource family home, and from holding the position of member of the board of directors, executive director, or officer of the licensee of any facility licensed by the department, for the remainder of respondents' lives. The First Amended Statement of Issues sought denial of respondent Thomsen's application for a license to operate a school-age center.

7. In the First Amended Accusation, complainant alleged:

- Respondents Thomsen and Daniels aided, abetted, or permitted the violation of the applicable teacher-child ratios. (First Factual Allegation)

- Respondents Thomsen and Daniels aided, abetted, or permitted the violation of the personal rights of children in care. (Second Factual Allegation)

- Respondents Thomsen and Daniels aided, abetted, or permitted the violation of the rules governing health-related services. (Third Factual Allegation)

- Respondents Thomsen and Daniels aided, abetted, or permitted the violation of the applicable staff-infant ratios. (Fourth Factual Allegation)

- Respondents Thomsen and Daniels aided, abetted, or permitted the violation of the rules governing personnel records. (Fifth Factual Allegation)

- Respondents Thomsen and Daniels aided, abetted, or permitted the violation of the rules governing licensing reports. (Sixth Factual Allegation)

- On September 29, 2022, respondents Thomsen and Daniels failed to timely report to the department that Child No. 1 had sustained an injury while in the care of the preschool facility that required medical treatment. (Seventh Factual Allegation)

- Respondents Thomsen and Daniels aided, abetted, or permitted the violation of the rules governing teacher qualifications and duties. (Eighth Factual Allegation)

- From October 12, 2022, through December 5, 2022, respondents Thomsen and Daniels aided, abetted, or permitted the operation of the school-age facility as a child day care facility for school-age children without a valid license. (Ninth Factual Allegation)

- On August 8, 2022, and November 2, 2022, respondents Thomsen and Daniels aided, abetted, or permitted the care of 13 infants in the infant facility, which has a licensed capacity of 12 infants. (Tenth Factual Allegation)

- On July 27, 2023, respondents Thomsen and Daniels aided, abetted, or permitted five employees of the preschool facility and two employees of the infant facility to care for children without being immunized against influenza, pertussis, and/or measles. (Eleventh Factual Allegation)

- From January 16, 2023, through July 27, 2023, respondents Thomsen and Daniels aided, abetted, or permitted the preschool facility and infant facility to care for children without having the drinking water tested for lead contamination levels. (Twelfth Factual Allegation)

- On July 27, 2023, respondents Thomsen and Daniels aided, abetted, or permitted four employees of the preschool facility and five employees of the infant facility to care for children without completing mandated reporter training within the prior two years. (Thirteenth Factual Allegation)

- On July 27, 2023, respondents Thomsen and Daniels aided, abetted, or permitted three employees of the infant facility to care for children without completing a test for tuberculosis within one year prior to, or seven days after, their employment with the infant facility. (Fourteenth Factual Allegation)

- On July 27, 2023, respondents Thomsen and Daniels aided, abetted, or permitted food, including breast milk, to be brought into the infant facility without being labeled with the child's name and the date the food was brought into the infant facility. (Fifteenth Factual Allegation)

- Respondents Thomsen and Daniels engaged in conduct that is inimical to the health, morals, welfare, or safety of either an individual in or receiving services from the preschool facility or the infant facility, or the people of the State of California. (Sixteenth Factual Allegation).

8. Respondents Thomsen and Daniels timely filed Notices of Defense and this hearing followed.

Complaints

9. On August 2, 2022, the department received a complaint regarding the facility operating classrooms out of ratio and overcapacity, and for day care children using the restroom unattended. The complaint was investigated by department Licensing Program Analysts (LPAs) Patrick Ma and Selena Siao. The out-of-ratio claim was substantiated as a Type A violation and insufficient evidence was found regarding the unattended child claim.

10. On October 4, 2022, the department received an anonymous complaint, alleging that: the facility staff did not seek timely medical attention for an injury to a child in care; a staff member spoke inappropriately in front of children; a staff member handled an injured child in a rough manner; the facility did not follow reporting requirements; facility staff are not qualified; the facility does not conduct health checks upon day care children entering the facility, the facility does not have a sufficient

amount of sleeping equipment for day care children; and that the facility was out of ratio.

11. On October 5, 2022, the department received an anonymous complaint that a school-aged program was being operated at the facility without a license.

Testimony and Written Statement of Rozalynn (Ayala) Farley

12. Rozalynn Farley worked as a teacher at TLC "from the end of 2020" through September 30, 2022. Ms. Farley testified at hearing; her testimony was consistent with an undated written statement she provided to the department.

13. In September 2022, Ms. Farley was the lead teacher of the three-year-olds where she had 18 children and an aide with her most of the time. On September 29, 2022, she arrived at TLC about 7:45 a.m. She said that "emotions were high" that day because respondents were experiencing a loss in their family and all of the teachers were aware. About 9:30 a.m., Ms. Farley took her class to the playground along with her co-teacher Lauren. A volunteer named Alyssa joined them to observe the children for her college course. Ms. Farley was watching the children playing on their bikes when she saw one of her students (Child No.1) lose control and fall off her bike. Ms. Farley immediately ran over to her. Child No. 1 had one scrape on her left elbow and Ms. Farley "immediately noticed a bend in her left forearm" that was concerning. Ms. Farley, Lauren, and Alyssa rounded up the children so they could go inside and get an icepack for Child No. 1.

Child No. 1 kept complaining that her arm was hurting. Ms. Farley does not have phone numbers for the parents, so she went to Amy King, the "second in command" at the facility. Ms. Farley showed Child No. 1's arm to Ms. King and told her

she was going to send a message to Child No. 1's mother on Brightwheel.[2] Ms. King instructed her to immediately locate respondent Daniels and have her call Child No. 1's parents. Ms. Farley brought Child No. 1 to respondent Daniels, explained what happened and showed her Child No. 1's arm. Respondent Daniels replied that she could not deal with this, and Child No. 1 was "over dramatic." Ms. Farley took Child No. 1 to respondent Thomsen who reprimanded her and said there was nothing wrong, and that she and respondent Daniels did not need any more issues. Ms. Farley messaged Child No. 1's mother through Brightwheel and explained that Child No. 1 had complained of arm pain and her arm was still hurting her. She never got a response from Child No. 1's mother.

Respondent Thomsen came into Ms. Farley's room and yelled at Ms. Farley in front of the children and other staff. Respondent Thomsen said Ms. Farley needed to "knock it off." Respondent Thomsen grabbed Child No. 1 by the wrist - the same arm with the scrape and "bump." She lifted the arm upwards and moved it around and said, "See, it's not broken." Ms. Farley observed pain on Child No. 1's face. Respondent Thomsen told Ms. Farley to "leave it alone."

14. Child No. 1's grandmother, Jenny Andrews, worked at TLC and was scheduled to arrive later that day, so Ms. Farley waited for her to arrive. Ms. Farley continued to comfort Child No. 1 and Lauren tried to direct the other children to keep playing. Ms. Farley photographed Child No. 1's arm and then saw how "misaligned" it was. She "knew it was serious." Child No. 1 did not want to eat and asked Ms. Farley to help her. Ms. Andrews arrived about 12:30 p.m. Ms. Farley asked her to call Child No.

[2] Brightwheel is an app that allows parents and teachers to communicate with each other about a child.

1's mother. Ms. Farley exchanged messages with respondent Daniels who told her to give Child No. 1 an icepack. Ms. Farley left work at the end of the children's naps. At that time Child No. 1 was with Ms. Andrews.

15. On September 30, 2022, Ms. Farley returned to TLC. Respondent Thomsen said she was not going to report the incident and if there were issues, Ms. Farley would be blamed. Ms. Farley told her, "I'm not going to work here," and she left the facility. Ms. Farley stated she was scared of respondent Thomsen because respondent Thomsen had berated her in front of the children. Ms. Farley asked Alyssa if she wanted to make a statement about what had happened and Alyssa said, "Yes." Ms. Farley prepared a witness statement that evening which she provided to the department; her statement was consistent with her testimony. Ms. Farley was interviewed by the department.

16. Respondents provided cots for children but many times there were not enough cots, so the smaller children used the cots and the older children laid on the floor. Children could bring a blanket if they wished. The school provided sheets for the cots but sometimes there were not enough clean sheets for the children. Ms. Farley said this was true during the entire time she worked at TLC.

Testimony of Jenny Andrews

17. Jenny Andrews is Child No. 1's grandmother. In August 2022, she began working at TLC as an aide in the infant room. She arrived at TLC about noon on September 29, 2022. She went into the toddler room, and when she was relieved, she went into Ms. Farley's room. Ms. Farley looked distraught and said that Child No. 1 got hurt and "they wouldn't let her contact anyone." Ms. Farley had taken a photo of Child No. 1's arm and sent it to Child No. 1's parents through Brightwheel. When Child No. 1

awoke from her nap, she told Ms. Andrews, "My arm doesn't work." Ms. Andrews contacted Child No. 1's parent and said that something looked wrong with Child No. 1's arm. Ms. Farley relayed that respondent Thomsen picked up Child No. 1's arm, wiggled it and dropped it. Ms. Andrews called her husband first, he called Child No. 1's mother, and Ms. Andrews was told that Child No. 1's father would pick up Child No. 1. At about 2:30 p.m., respondent Thomsen came to the room and asked how Child No. 1 was doing and said, "Maybe we should call the parents." Respondent Daniels left early that day due to the death in the family, and Ms. Andrews did not speak with her that day. Ms. Andrews was there when Child No. 1's father picked her. On October 1, 2022, Ms. Andrews told respondent Thomsen that she did not want to work at TLC anymore because she did not feel comfortable. She then received a text from respondents stating that they no longer needed her.

18. On cross-examination, Ms. Andrews was asked why she did not take Child No. 1 to the hospital. She responded that she was in shock, and she did not want to step on her daughter's toes.

Testimony of Symona Jean Andrews

19. Symona Andrews is Child No. 1's mother. Child No. 1 was three years old at the time of the incident; she is now five years old. She has not attended TLC since September 29, 2022. Symona A. works at her family's restaurant about 25 miles away from TLC, and Child No. 1's father works about 45 minutes away. Symona A. received a photo and a message on Brightwheel, stating that Child No. 1 fell on the bike and got a scratch, and that her arm was sore. She received no phone call from TLC even though they had cell phone numbers for her and Child No. 1's father. When her mother got to work and saw Child No. 1's arm, she called Symona A. and told her that someone should come and take her to the doctor. Symona A. did not have a car so

Child No. 1's father picked up Child No. 1 and took her to the emergency room. X-rays showed her left forearm bone was completely broken. She was unable to get a cast until three days later due to the swelling in her arm. Child No. 1 told her that she fell off her bike and her arm hurt really bad, and she doesn't want to go back to the school. At 8:41 p.m. on September 29, 2022, respondent Daniels sent Symona A. a Facebook message and asked how Child No. 1 was. Symona A. responded that Child No. 1 had a broken arm to which respondent Daniels replied that when she saw Child No. 1, she had a band aid. Several days later respondent Thomsen called her at work and asked how Child No. 1 was doing. Symona A. responded that she was going to get an attorney because her mother and Ms. Farley had told her "what happened." Symona A. was contacted by and spoke with licensing. When Child No. 1 began attending TLC, Symona A. signed a release for TLC to provide and obtain medical care for Child No. 1.

20. Symona A. acknowledged that her mother called her around lunchtime on the day of the incident, but she said, her mother was not calling on behalf of TLC.

Testimony of LPA Patrick Ma

21. Patrick Ma has been an LPA with licensing for almost four years. His duties include inspection and consulting on Title 22 regulations. The following information was obtained from his testimony and written reports, as well as other documents provided by the department.

22. Prior to becoming licensed, licensees must attend orientation training, which includes training on staffing, ratios, regulations, hazards, nutrition, how license is to be issued, responsible person, and personal rights training. Licenses are issued after a pre-licensing visit once all inspections are done and all required information is

received. A facility must specifically identify which rooms will be used for infant care and which will be used for preschool.

When a licensee in his caseload receives a complaint, LPA Ma investigates where he reviews documents, makes personal observations, conducts interviews, and makes findings. If he finds the allegation to be true or it rises to the level of a citation, he discusses with the licensee how the issue should be resolved. A Type A citation is issued where a child is placed in immediate danger; a Type B citation is issued when something poses a potential danger to a child.

23. TLC was first assigned to LPA Ma's caseload in August 2021. The facility has received numerous citations requiring follow-up inspections, and complaints that required investigation. TLC has an infant license with a maximum capacity of 12 and a preschool license with a maximum capacity of 59. In July 2022, TLC applied for a school-aged license which the department denied in December 2022. TLC is located in a two-story building, but only the lower level is licensed. TLC's licensee is respondent Thomsen. Respondent Daniels is the director. Her job is to oversee the facility and ensure that all regulations are met, including safety issues, care of the children and required reporting.

The following is a chronological summary of LPA Ma's visits to the facility beginning in August 2022:

24. On August 9, 2022, LPA Ma went to TLC with fellow LPA Selina Siao to investigate a complaint received by the department on August 2, 2022, regarding classrooms operating out of ratios and children in care left unattended in the bathroom. When his investigation was complete, LPA Ma provided respondents a copy of his written report which stated, in summary: (1) the facility's preschool room was

operating out of ratio because an aide, who was enrolled but had not yet completed the 12 Early Childhood Education (ECE) units to be a fully qualified teacher, and a volunteer, were caring for seven children. A Type B citation was issued; and (2) the infant room was operating out of ratio and over capacity because an aide, not yet a qualified teacher, and a volunteer, were caring for 13 infants where infant classroom ratio is 4:1 and the maximum capacity was 12. A Type A citation was issued. The allegation regarding children left unattended in the bathroom needed further investigation.

Respondent Daniels assured LPAs Ma and Saio that a qualified teacher would begin working at TLC on August 18, 2022.

25. On October 3, 2022, the department received an anonymous complaint alleging that: (1) the facility staff did not seek timely medical attention for a day care child's injury; (2) a facility staff member spoke inappropriately in front of day care children; (3) a staff member handled an injured day care child in a rough manner; (4) the facility did not follow reporting requirements; (5) facility staff are not qualified; (6) the facility does not conduct health checks upon day care children entering the facility; (7) the facility does not have a sufficient amount of sleeping equipment for day care children; and (8) the facility was out of ratio. The complaint was sent to LPA Ma for investigation.

26. On October 4, 2022, the department received an unusual incident report from the facility regarding an injury to Child No. 1, which occurred on September 29, 2022. Licensees are required to call the duty line and report the incident within 24 hours and submit an unusual incident report by the next business day.

27. On October 5, 2022, the department received a complaint that TLC was providing unlicensed care because an unapproved school-aged program was operating at the facility.

28. On October 12, 2022, LPA Ma and LPA Siao visited TLC and began their investigation of the October 3, 2022, complaint. LPAs Ma and Saio made multiple visits to the facility in connection with the investigation and follow-up. Based on their investigation, LPA Ma found that allegations 1, 2, 3, 4, and 8 were substantiated, allegations 5 and 6 were unsubstantiated, and allegation 7 was unfounded.

29. Regarding the October 5, 2022, complaint of unlicensed care, during their initial investigation visit on October 12, 2022, LPAs Ma and Siao observed eight school-aged children in care, who stated their ages were between five to seven. LPAs Ma and Siao photographed the lobby area of the facility which revealed backpacks; and photographs from the second floor of the building revealed desks, lessons written on the board, and backpacks. The LPAs reviewed facility records on at least eight children, confirming they were each of school age. LPA Ma found that the allegation for unlicensed care was substantiated. On October 12, 2022, the department issued a cease and desist letter to the facility.

30. During the October 12, 2022, visit, other deficiencies were observed, and the facility was cited for failure to timely report Child No. 1's injury, being out of ratio in the toddler room with 11 children and one teacher, rather than two teachers, and staff files were missing TB screening, immunization records, and a current mandated reporter certificate.

31. On October 24, 2022, LPAs Ma and Siao visited the facility. They made a case management site inspection to ensure compliance with the Cease and Desist

Order. No one was at the front desk and LPAs were informed that respondent Daniels was upstairs with the kindergarteners. Upstairs they observed 15 school-aged children. Respondent Daniels said the children were kindergarten through second grade. Based on observations and interviews, the LPAs concluded that the facility had continued to conduct unlicensed school-aged program, despite the cease and desist order. A Type A citation was issued.

32. On October 24, 2022, LPAs Ma and Siao made a site inspection at the facility regarding the out of ratio issues. They found that room 1D, designated as the toddlers room, had 11 children with one teacher, instead of the required 6:1 ratio. A Type A citation was issued. Respondents wanted to split a room between toddler and two year olds. Based on the measurements they provided and the sink and bathroom requirements, this did not work

33. On November 2, 2022, LPAs Ma and Siao visited the facility to ensure compliance with the Cease and Desist Order. The LPAs observed respondent Daniels in the unlicensed second floor area with 16 school-aged children. Because this was a repeat violation, LPA Ma issued a civil penalty. The LPAs observed that the preschool was in ratio. The infant room had 13 infants with two staff, then a third staff person came in. The infant ratio is 4:1 and license capacity is 12, so the license was over capacity and out of ratio. The facility was required to post the two Type A violations.

34. On November 7, 2022, LPA Ma wrote about his concerns regarding the continuing violations at TLC and elevated this to his superiors.

35. On November 16, 2022, a Noncompliance Conference (NCC) was held at the department offices. In attendance were respondent Daniels, LPA Ma, Licensed Program Manager (LPM) Ana Chico, and Regional Manager Kimberly Hall. LPA Ma

stated that the purpose of the NCC is to help the licensee understand the items identified and review the circumstances with the goal of providing guidance for the licensee to get back in compliance while warning the licensee what will happen if this does not happen. They discussed the multiple violations under the current licenses and past violations at a previous location. At the end of the conference, respondent Daniels signed and agreed to more training for staff.

36. On February 14, 2023, LPA Ma and LPM Askew conducted an unannounced case management visit. Deficiencies observed included out of ratio in toddler room and staff missing health screening and/or mandated reporter records.

37. On July 27, 2023, LPA Ma and LPM Askew conducted an unannounced annual inspection. They observed various deficiencies including: a half filled syringe containing antibiotics was found in a small refrigerator in a preschool room; a teacher was alone in a classroom with 12 children and the teacher was not fully qualified because she only had proof that she had completed 9 units out of the required 12; five out of five staff files were missing immunizations; respondent Daniels was a teacher to meet ratio, but while she was teaching there was no one acting as facility director. She told LPA Ma that she thought she could no longer be the director due to legal issues.

38. On July 27, 2023, respondents were also cited for not having water tested to ensure no excess lead. By 2021 all facilities were required to test facility to make sure no excessive lead but they had not yet tested their water. This was a requirement at time of licensure (180 days from the time of licensing). Respondents were cited for missing four of five missing mandated reporting certificates and for no medical release from a preschool child to have medications at the facility.

39. LPA Ma still oversees the facility. Respondent Daniels has been the director the entire time. LPA Ma interviewed respondent Thomsen regarding complaints but otherwise he did not have much interaction with her. Most of his discussions were with respondent Daniels. Since July 2023, he has visited the facility "multiple" times. He has issued more deficiencies. He continues to have another LPA or LPM with him during these visits. Due to the manner in which respondents interacted with LPA Ma and other licensing staff, licensing decided that it would be best to have two individuals at each visit.

Testimony and Written Statement of Alyssa Uffens

40. Alyssa Uffens is a 2023 graduate of Palomar College with an associate degree in Adolescence and Child Development. The following information was obtained from a written statement she provided to the department as well as her testimony, which was consistent with the written statement. In the fall of 2022, she had a class assignment to observe children and she found it difficult to find in-person classes due to the COVID-19 pandemic. Respondent Thomsen said she could come to TLC and observe and then leave when she needed to. On September 21, 2022, she observed for a few hours. She enjoyed working with the kids and asked if she could volunteer and text when she was available. Respondents agreed. She asked if she needed any health screenings and was told she did not. On September 29, 2022, she sent a text to respondents and arrived about 9:30 a.m. She was told to go to the five and six-year old classroom upstairs. When she arrived, respondent Daniels was working in the classroom, so she asked about helping with the two or three-year olds. When she arrived at the classroom the children were outside, she went outside and introduced herself to Ms. Farley and told her she was a volunteer. Ms. Uffens had been there about 15 minutes when she noticed a child on a bike and then heard her cry. She

did not witness her fall. Ms. Farley ran to help the Child No. 1 and then told Ms. Uffens and another staff member named Lauren to go inside with the children as Child No. 1 was hurt. Ms. Uffens saw Child No. 1's arm and said to herself that the arm was broken.

41. Ms. Farley took Child No. 1 with her inside to get ice. Ms. Uffens and Lauren stayed with the other children as they played. It was now lunchtime and Child No. 1 said her arm was broken and she did not want to eat. Ms. Farley told Ms. Uffens that she tried to get help and was told this "was drama." Ms. Uffens thought this was not right, but she sat with the other children. Respondent Thomsen appeared in the doorway. Ms. Uffens heard "loud words" and heard respondent Thomsen say this was only "drama" and that the child was "fine." Respondent Thomsen kept saying "stop it" to Ms. Farley. Ms. Uffens could not believe this was happening in front of the children. Ms. Farley appeared very stressed. She had been told not to reach out to parents, but she did anyway. She used the "automated system," took a photo and sent it to Child No. 1's mom. About 10 minutes later, respondent Thomsen came back into the room, she was upset and walked toward the center of the room where Ms. Farley was with Child No. 1. Respondent Thomsen grabbed Child No. 1's arm and bent it up and then down, and said, "She's fine." Ms. Uffens said she was traumatized because she had worked with children enough to know this was not what should be happening in child care. It was now time for nap, and she realized that only about half of the children had cots and only a few had sheets and the sheets did not look very clean. Some of the children had no cot or a sheet, a few had blankets. Child No. 1 appeared to not have anything as she laid on her back on the hard floor with Ms. Farley's help. Child No. 1 kept saying that her arm was broken.

42. Ms. Uffens left about 1:45 p.m. She does not recall speaking to anyone else at TLC before she left. She did not return to TLC after this incident. Ms. Farley

asked for her number in case she needed it. When Ms. Uffens left TLC, she planned to report the incident as she is a mandated reporter, however, the next day Ms. Farley texted her and said that the arm was broken and asked if she would provide a written statement, which Ms. Uffens did. She was later contacted by a male from the department and spoke with him for about two hours.

Testimony of Selina Siao

43. Selina Siao has worked as an LPA in Licensing for 18 years. When investigating a complaint she gathers information, interviews all parties, including staff and care providers. She is required to know the applicable regulations and licensing requirements and must document what she reviews and personally observes. Respondents applied for a school-age license for Kindergarten through 8th grade. LPA Siao was supposed to complete an inspection and she had been ready to do so, but because of all of the violations at the facility, the department decided to put the application on hold.

44. TLC was not part of her caseload, but LPA Siao accompanied LPA Ma to the facility on several occasions because of the way the facility representative treated LPA Ma, which had occurred earlier at respondents' previous facility. She and LPA Ma went to the facility on August 9, 2022, to investigate a complaint for being out of ratio. LPA Ma was able to substantiate being out of ratio in the preschool and both out of ratio and overcapacity in the infant facility. Citations were issued for these violations.

LPA Siao accompanied LPA Ma on October 12, 2022, for another complaint of out of ratio and reporting issues. She toured the facility, reviewed rosters, and records, and took photos. LPA Siao was showed a photo she took of a school-aged classroom located in the upstairs of the facility. This is where the school age children were

observed. Another photo showed respondent Daniels teaching a class in this room. Once it was determined that these children were school age, because of their size and because she and LPA Ma spoke with them, a citation was issued on October 17, 2024, with eight allegations, two were substantiated at the time, the others required further investigation.

45. LPA Siao accompanied LPA Ma to the facility again on October 24, 2022, to make sure there was no longer an unlicensed school-age program, but they found it was continuing and respondent Daniels was with the children that day. On that visit they found that the preschool was out of ratio because there was one staff member with 11 kids in room 1D. When she and LPA Ma returned for a case management visit, the infant room was out of ratio with nine infants and two staff members. The infant program was cited.

46. LPA Siao visited TLC again on November 2, 2022, and found them caring for 16 school age children. A citation was issued plus a civil penalty for failure to cease operations, as requested previously. She went to TLC another time to ensure the preschool was within ratio and it was. She does not recall going to the facility again.

47. On cross-examination, LPA Siao explained the only reason for the frequent visits to the facility was because of the citations or ongoing issues that needed to be resolved. The timeline of the visits change if there is an issue with an immediate danger to children or to require the facility to stop operating given the Cease and Desist Order. LPA Siao explained that the difference between a complaint and case management is that when a complaint is received, the investigation must begin within 10 days. Case management varies as to how often a visit is needed. The LPA notifies the facility the reason for a visit. They also try to investigate all pending

issues with that facility at the same visit. LPA Siao recalls being told that these children were in a homeschool pod.

Testimony of Kimberly Hall

48. Kimberly Hall has been a regional manager in the child care division of licensing for almost five years. She was previously a LPM and an LPA. As regional manager, she manages three other managers. Ms. Hall's duties as a regional manager include to summarize concerns with a facility and to make recommendations, and review and decide how to proceed. Ms. Hall is Renesha Askew's manager and Ms. Askew is LPA Ma's manager.

Ms. Hall has never been to the facility. The facility compliance plan was initiated in late October of 2022. After reviewing the summaries of the plan, she made her own recommendations. Prior to making comments, she reviewed the history and citations issued to the facility. She decided to move forward with revocation of the license. She attended a noncompliance conference with respondent Daniels on November 16, 2022. These conferences are held to meet with licensees and try to find a plan to bring them into compliance before other administrative action. A licensee is required to be present. Here respondent Daniels was present; respondent Thomsen was not.

The discussion included a general review of the Type A citations that had been issued, concerns about citations, and a candid conversation with respondent Daniels regarding her role. Respondent Daniels shared information about the facility. They agreed to a plan with the understanding that respondent Daniels would share the information with respondent Thomsen and submit documents that were agreed upon. Respondent Daniels signed the noncompliance conference document.

Respondents have not complied with the plan. The goal is to bring them into compliance without further citations. There were additional citations after the NCC, which showed that they were not following the plan.

There was a letter that was handwritten by respondent Thomsen but brought to the conference by respondent Daniels, which Ms. Hall understood was respondent Thomsen's statement for why she did not appear. Ms. Hall explained to respondent Daniels that respondent Thomsen should have attended the meeting because she is the licensee and respondent Daniels, as the director, should have remained at the facility.

Ms. Hall signed the denial letter for respondents' application for a school-age license. The basis of the denial was respondents' continued operation of the school age "program" when they knew a license had not been granted.

49. On cross-examination Ms. Hall stated she recalled telling respondent Daniels that licensing is there to help her/licensees. She recalls telling respondent Daniels that there is a technical support program (TSP). Information regarding this program was provided to respondent Daniels during the meeting. She also recalls telling her that the person that would be assisting her would be someone other than LPA Ma.

At the NCC, Ms. Hall told respondent Daniels that she could withdraw her application for the school-age license and give parents notice to find alternative care. This did not happen. Facility visits are based on the compliance of the facility. If there are no problems, visits are usually once per year. If there are a lot of compliance issues or more unusual incident reports, then there will be more visits. Some issues require a visit, and others may be resolved with a phone call.

Testimony of Renesha Askew

50. Renesha Askew has been employed by licensing as an LPM since 2019. She supervises LPAs and accompanies them in the field if needed. Prior to this position she was an LPA for six years. She oversees the LPA when a complaint is filed. She assigns the complaint to an LPA and reviews the completed investigations. LPM Askew is familiar with respondents and TLC because respondents were assigned to LPA Ma, who she supervises. She has been to the facility, and she assisted LPA Ma when needed. She communicated with respondents in person and through email.

51. LPM Askew responded to an email from respondents requesting to split the toddler room in half. LPM Askew said, "No," but she provided alternatives. She also responded to other issues. She was concerned with respondents tone the tone of contacts with LPA Ma.

The Facility Compliance Plan is created when a facility is showing serious signs of violations. Based on the citation history and the visit history, LPM Askew recommended moving forward with denial of the application, revoking the existing two licenses, and excluding respondents.

Regarding the application denial, over the course of various visits to the facility, licensing staff observed respondents providing child care for school age kids without a license. On October 12, 2022, licensing gave them a Cease and Desist Order, yet respondents continued to operate. The application took as long as it did because of the continued complaints and citation history. Licensing was concerned with respondents operating a third group when they were not able to care for the first two groups

Ratio violations are concerning because this is how you ensure the safety of children in care. Repeated violations cause concern for the health and safety of children. Licensing is also concerned because of the blatant disregard for violations, the sheer number of violations, and that no steps were made to clear violations or to become or remain compliant.

Personal rights violations are serious because children in care have the right to be treated with dignity. Grabbing a child's injured arm could reinjure the arm and could cause pain and distress to the child. Yelling to reprimand a teacher in front of children and creating an intimidating and toxic environment violates the personal rights of those observing the conduct, including children in care and the staff.

After the NCC, respondents agreed to do several things. They have not been in compliance with this plan. LPM Askew accompanied LPA Ma to several visits at the facility and other LPAs did as well. This is not usually done but here, due to the nature of violations and the tone and the way LPA Ma was treated by respondents she thought someone else should be there. Respondents were aggressive, and offensive in tone in response to licensing staff when they arrived. The licensee stayed upstairs, licensing staff only spoke with respondent Daniels who would soften up and be pleasant.

52. On cross-examination, respondent Daniels asked why they were not told on October 5, 2022, that the school-age license had not been issued. LPM Askew stated that licensing did tell respondents that the school-age license had not been issued. She recalled that the toddler option was removed.

Respondents' Evidence

TESTIMONY OF RESPONDENT THOMSEN

53. Respondent Thomsen has been working in child care for 42 years. She has never wanted to be the director; she has always wanted to teach. She opened the current facility 21 months ago and they have had 19 visits by LPA Ma. Once they received approval for the new facility, they moved in quickly and started to unpack, but five days later, LPA Ma came with a complaint of not watching children in the bathroom. The complaint came from another childcare in Ramona. In mid-September there was a contest that selects the best day care in town - TLC won in 2022. Within days, she received another complaint.

On September 29, 2022, she arrived at work and told her staff that her father-in-law had passed away. She was working with the mortuary throughout the day and "took on a new role." At 10:45 a.m., Ms. Farley came to her asking if Child No. 1's arm was broken. She told Ms. Farley to put ice on the arm and make sure to put this on Brightwheel. Ms. Farley proceeded to go around the building asking each teacher if the arm was broken. She told Ms. Farley to "sit down" and contact the family. Ms. Farley put ice on the arm and Child No. 1 ate lunch. Jenny Andrews arrived and took care of Child No. 1. She was in charge of Child No. 1 until the parents arrived. Ms. Andrew's said that her daughter could not come but the child's father was on his way. Respondent Thomsen did not know if the arm was broken but she had noticed bowing on Child No. 1's arms and legs. She asked if Ms. Andrew's would take Child No. 1 to find out if the arm was broken. Ms. King reported that Child No. 1's father arrived about 5:00 p.m. Ms. Andrews could have taken Child No. 1, but she said that she did not feel comfortable doing so. Respondents decided "that if Ms. Andrews could not take care of her own granddaughter, she could not work here." Ms. Farley got upset

and “started screaming” that she was going to get me, and she was aggressive in front of the children. They had problems with Ms. Farley from July through September 2022 because she wanted to be the lead and did not want to be a team player. Respondents decided that Ms. Farley was “way out of control” and needed some time to “go home and get healthy.”

Respondent Thomsen reached out to Child No. 1’s mother and learned the arm was broken. The next day they wanted to report the incident, but licensing had “changed the rule regarding calling . . ..” They immediately mailed the notice and explained what had happened. LPA Ma showed up and started asking questions. “He came about every day for weeks.”

TLC had applied for a school-aged license in July 2022 and had been told that licensing would come for an inspection. TLC signed an agreement with a home school pod. They “wanted to go through licensing in case we wanted to do after school care.” LPA Ma scheduled an appointment to visit and an appointment for an inspection in September. The inspection time changed. They found out that Ms. Farley did not put out bedding for the children’s naps.

In November 2022, they were asked to meet with Ms. Hall. They asked LPA Ma if one of them could write a letter instead and he said that would be fine. After the meeting, respondent Daniels told her they were “on a program to be watched and monitored.” After being involved for 42 years “licensing had never been this bad.” They obtained a private school affidavit in December 2022. On February 14, 2023, LPA Ma came for an inspection for “being out of ratio but we knew that we were not.” The problem was that “we had asked for a toddler option but had never received it.”

In August 2023, "We knew we had to be our best advocate." Respondents started sending employees to earn their units "to be better employees." In September 2023, they "were having a hard time because of LPA Ma's visits." They had moved in quickly and needed time to put everything away, but they could not do this because LPA Ma was always there. He wrote them up multiple times for the same things and he never gave them a chance to fix the problem. LPA Ma never once offered to help, he only accused them of violations. They have never done anything to harm a child. "A lot of this got blown out of proportion." Respondent Thomsen said, "At this time we feel like we have to protect ourselves from LPA Ma."

The first 21 months "were bumpy" and they received no help from licensing. After the pandemic, "licensing never got back to helping." She believes the problems were due to a lack of communication "partly on us, mostly on licensing." During the past five months they have finally been able to do better. "We dialed things back." They have a good staff, they disposed of one of the classrooms, and sent two teachers for training to become directors.

Respondent Thomsen said that the last 19 months "have been mishandled." "It went past the line and laws and [LPA Ma] made it personal." They have asked if LPA Ma could be replaced. The supervisors have always been professional, but not LPA Ma. He has never offered to help. He only told them what they did wrong, never what they had done right. She asked Ms. Hall to be put "on the program to be monitored" and that LPA Ma not be involved.

54. On cross examination respondent Thomsen acknowledged that, from October 2022 through 2023, all violations for which TLC was cited were witnessed by LPA Ma and another person from licensing.

Respondent Thomsen was asked how licensing could help with various issues that have resulted in violations. Regarding record issues, she said, "they need to give us more time. We were constantly on the firing squad - never enough time." TLC's documents were in order before the move in July 2022. She knows some of the rules and regulations, but it was 10 years ago when she took the classes. She knows she is required to follow licensing's rules "but not if they are gray." The rules are constantly changing and "we are trying to keep up." Regarding ratios, she has reminded her staff that they cannot leave a room without telling someone and being replaced.

Only respondent Daniels attended the NCC. Respondent Thomsen wrote a letter explaining that they wanted someone to be at the facility that day. TLC began caring for school age children after three failed attempts for inspection and after they had signed a contract with Classical Academy. They stopped when they were told to do so.

Respondent Thomsen was asked if she believed that "educating children trumps licensing rules." She responded, "no," but they were brushed off and not told the truth. If they had known how long it would take for the school-aged license, they would have gotten a private school affidavit sooner. The department can be assured that they will comply going forward because they have made "drastic changes" which they have had to do on their own. When asked if she takes responsibility for anything, respondent Thomsen replied, "We as a family took on more than we could handle. I have always said that we took blame for what we did."

TESTIMONY OF RESPONDENT DANIELS

55. Respondent Daniels has been working in child care for 20 years. She had her own home day care, worked at a different day care, and then opened a facility with respondent Thomsen. They moved into the current facility in July 2022. She had been

an assistant director, and she took on director responsibilities about five years ago. LPA Ma made her feel "less than." LPA Ma told her that she needed to be a director or be a teacher.

On the day of the incident she recalls Ms. Farley bringing Child No. 1 to her. Child No. 1 said her arm hurt and pointed to a scrape. Respondent Daniels said to put a band aid on it, ice it, and notify her parents. Ms. Farley texted her that she was having a hard time figuring out what to do with Child No. 1 and that Ms. Andrews would be there soon. Respondent Daniels texted her mom later that day and learned that Child No. 1's arm was broken. She is sorry about Child No. 1's arm and she learned from the mistake.

This was the first time she had to file an unusual incident report. She read the directions, which said to notify the department and mail the form, so she mailed the form. She has tried to learn and grow in her job, and to do research and make changes as needed. She is delegating some of her director duties. She said, "I feel that we were too emotionally invested from the beginning and I took every negative thing way too much to heart."

Regarding the "toddler option," she honestly thought it was optional and that it could be changed. She now understands that it is a "yes" or "no" decision. If she had known there would be such a delay in the school-aged application she would have completed the private school affidavit earlier.

Respondent Daniels said that the NCC was "one of the longest nights of my life." She then learned about the TSP program and she asked if she could have someone other than LPA Ma do inspections. She discussed this with respondent Thomsen but nothing ever came of the program.

Respondent Daniels said that it seems ridiculous to have 19 visits from licensing in 21 months. She tried to ask questions of licensing "to make the visits useful." She did ask for clarification on the toddler option and had a nice conversation with LPA Ma and Nancy D. from licensing.

56. On cross-examination, respondent Daniels stated that she attended training on licensing laws and regulations. She is aware that she cannot be counted as a teacher while at the same time being director of the facility. She understands she is required to find a replacement in her absence. Amy King and Collette Thomsen oversee the private school which is upstairs in the day care center.

On September 29, 2022, respondent Daniels left the facility due to personal issues and respondent Thomsen was in charge thereafter. Respondent Daniels believes there was a breakdown in communication. When Ms. Farley asked her for advice, respondent Daniels told her to call through Brightwheel. Ms. Farley sent a message to Child No. 1's parents through Brightwheel at about 10:00 a.m. When respondent Daniels saw Child No. 1's arm, she could not tell if the arm was broken and she could not tell if Child No. 1 was in distress. Respondent Daniels believes that if LPA Ma were not involved, the facility would not have received all the citations it received. She believes that "Selina (Siao) would have helped."

Character References

57. Respondents provided 12 character reference letters. The authors were parents, friends, and members of respondents' community, and most had known respondent Thomsen for more than 20 years.

Parents described respondent Thomsen as having a good moral character, being trustworthy and charitable. Another parent wrote that respondent Thomsen

taught three of her children, and she "treated the children as if they were her own." A parent wrote that respondent Thomsen is "dedicated and personable," and "an amazing teacher and mentor" for his children and others.

Friends described respondent Thomsen as "a woman of integrity with an incredible moral compass" and a caring, patient, compassionate, and dedicated teacher. Another wrote that she had a "heart and passion for children."

Several members of the Ramona community wrote that respondent Thomsen is very involved in the community, she is loved and respected and has a "great reputation for love and attention to children." A real estate agent in her community wrote that respondent Thomsen has an excellent reputation as a child care provider in Ramona.

Only two authors mentioned the possible loss of respondents' license, making the other letters of limited weight.

Complainant's Rebuttal Testimony

58. In rebuttal, Ms. Hall stated that during the past 10 years no laws have changed regarding personal rights, incident reports, and required records for the facility or for children. A director may fill in to relieve a teacher or temporarily fill in, but this should not be common practice.

Ms. Hall met with respondent Daniels at the NCC, which was held on November 16, 2022, in a conference room at the licensing office. The facility history and the citations issued were reviewed with respondent Daniels. She was given a timeframe of 10 days within which to withdraw her application. On December 5, 2022, the school-

age application was denied because no withdrawal was filed and respondents continued to provide unlicensed care.

TSP is a program where former LPAs go to a facility and work with the director and licensee to provide consultation and training regarding Title 22. The offer of TSP was made to respondent Daniels at the NCC and she said she would think about it. All she had to do was tell licensing that she wanted to be part of the program. The unlicensed care continued. When she considered the program later it was no longer an option.

59. In rebuttal, Ms. Askew stated that the toddler option was granted for room 1D. At no time did respondents ask for help and were told "no." In a meeting with respondents months after the NCC, respondent Daniels let Ms. Askew know that she was interested in the TSP program, but by then it was too late because the administrative action had already begun.

While respondents said they were operating a "homeschool pod" in the upstairs area of the facility, they were providing unlicensed child care. The visits to the facility were in proportion to the number of complaints and plans of correction for deficiencies observed.

LEGAL CONCLUSIONS

Jurisdiction

1. This matter arises under the California Child Day Care Facilities Act, Health and Safety Code section 1596.70 et seq., which governs the licensing and operation of child day care centers. Regulations governing the licensing and operation

of child day care centers are contained in California Code of Regulations, title 22, section 101151 et. seq.

Burden and Standard of Proof

2. In a proceeding to revoke a license, the burden is on complainant to show a basis to revoke the license by a preponderance of the evidence. (Health & Saf. Code, § 1596.887.)

3. In a proceeding to obtain a license (or license expansion), the burden is on respondent to show by a preponderance of the evidence that the license should be granted. (Health & Saf. Code, § 1596.887.)

4. In a proceeding to prohibit a person from being present in department-licensed facilities and from being a member of the board of directors, an executive director, or an officer of a licensee, the burden of proof is on complainant and the standard of proof is a preponderance of the evidence. (Health & Saf. Code, §1596.8897, subd. (e); Health & Saf. Code, § 16519.6, subd. (l).)

Applicable Code Sections

5. Health and Safety Code section1596.856 provides that if the department finds that an applicant is not in compliance with this act or the regulations promulgated under this act, the department shall deny the applicant a license.

6. Pursuant to Health and Safety Code section 1596.885, the department may deny an application for or suspend or revoke any license or registration issued under the Act on the following grounds:

(a) Violation by the licensee, registrant, or holder of a special permit of this act or of the rules and regulations promulgated under this act.

(b) Aiding, abetting, or permitting the violating of this act or of the rules and regulations promulgated under this act.

(c) Conduct which is inimical to the health, morals, welfare, or safety of either an individual in or receiving services from the facility or the people of this state.

7. Health and Safety Code section 1596.955, subdivision (a), provides that the department shall develop guidelines and procedures to permit licensed child day care centers serving preschool age children to create a special program component for children between 18 months to three years of age. This optional toddler program shall be subject to the following basic conditions:

(1) An amended application is submitted to and approved by the department.

[¶] . . . [¶]

(3) A ratio of six children to each teacher is maintained for all children in attendance at the toddler program. An aide who is participating in on-the-job training may be substituted for a teacher when directly supervised by a fully qualified teacher.

(4) The maximum group size, with two teachers, or one fully qualified teacher and one aide, does not exceed 12 toddlers.

(5) The toddler program is conducted in areas separate from those used by older or younger children. Plans to alternate use of outdoor play space may be approved to achieve separation.

(6) All other regulations pertaining to preschool age children are complied with.

8. Health and Safety Code section 1596.7995, subdivision (a)(1), provides that commencing September 1, 2016, a person shall not be employed or volunteer at a day care center if he or she has not been immunized against influenza, pertussis, and measles. Each employee and volunteer shall receive an influenza vaccination between August 1 and December 1 of each year.

9. The department is authorized to exclude a person from being a member of the board of directors, an executive director, or an officer of a licensee, and from employment at, or presence in, and from having any contact with, clients of any facility licensed by the department, if that person has violated or permitted a violation any statutes or regulations pertaining to child day care centers (Health & Saf. Code, § 1596.8897, subd. (a)(1); or engaged in conduct inimical to the health, morals, welfare, or safety of either an individual in or receiving services from the facility or the people of the State of California. (Health & Saf. Code, § 1596.8897, subd. (a)(2).)

10. Health and Safety Code section 1596.8662, subdivision (b)(1), provides that on or before March 30, 2018, a person who, on January 1, 2018, is a licensed child

day care provider, administrator, or employee of a licensed child day care facility shall complete the mandated reporter training provided pursuant to paragraphs (2) and (3) of subdivision (a), and shall complete renewal mandated reporter training every two years following the date on which he or she completed the initial mandated reporter training.

Applicable Regulations

11. California Code of Regulations, title 22, section 101212, subdivision (d), provides:

> Upon the occurrence during the operation of the child care center of any of the events specified in (d)(1) below, a report shall be made to the Department by telephone or fax within the Department's next working day and during its normal business hours. In addition, a written report containing the information specified in (d)(2) below shall be submitted to the Department within seven days following the occurrence of such event.
>
> (1) Events reported shall include the following:
>
> [¶] . . . [¶]
>
> (B) Any injury to any child that requires medical treatment.
>
> (C) Any unusual incident or child absence that threatens the physical or emotional health or safety of any child.
>
> [¶] . . . [¶]

12. California Code of Regulations, title 22, section 101216, subdivision (g)(1), requires that good physical health shall be verified by a health screening, including a test for tuberculosis (TB), performed by or under the supervision of a physician not more than one year prior to or seven days after employment or licensure.

13. California Code of Regulations, title 22, section 101223, subdivision (a)(1) to (a)(3), states:

> (a) The licensee shall ensure that each child is accorded the following personal rights:
>
> (1) To be accorded dignity in his/her personal relationships with staff and other persons.
>
> (2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.
>
> (3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse or other actions of a punitive nature including but not limited to, interference with functions of daily living including eating, sleeping or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.

14. California Code of Regulations, title 22, section 101226, subdivision (e), provides that in centers where the licensee chooses to handle medications, all prescriptions and nonprescription medications shall be kept in a safe place

inaccessible to children. (*Id.* at subd.(e)(1)(A).) Prescription medications must be administered in accordance with the label directions as prescribed by the child's physician and the licensee shall obtain written approval and instructions from the child's authorized representative. (*Id.* at subd. (e)(3)(B).)

15. California Code of Regulations, title 22, section 101427, subdivision (j), requires that bottles, dishes and containers of food brought by the infant's authorized representative shall be labeled with the infant's name and the date the item was brought into the facility.

16. Assembly Bill (AB) 2370, Chapter 676, Statutes of 2018, requires all licensed child care centers (CCCs) constructed before January 1, 2010, to test their water (used for drinking and food preparation) for lead contamination before January 1, 2023, and then every five years after the date of the first test. For child care center licenses issued after July 1, 2022, the licensee shall test their water for lead within 180 days of licensure pursuant to Written Directives section 101700 (PIN 21-21.1-CCP).

Evaluation

17. Respondent Thomsen has been involved in child care for 42 years; Respondent Daniels has been involved for 20 years. At the time of this hearing, respondent Thomsen had been a licensee for about ten years and respondent Daniels had been a director for about five years, so in these roles each has attended orientation(s), been advised of and worked with department rules and regulations, met with licensing during visits to their facility, and attended various trainings, yet respondents' conduct revealed that they were not able to follow these rules and regulations or that they did not comprehend the importance of doing so.

Respondents' facility had repeated incidents of being out of ratio in classrooms, of being overcapacity, of having nonqualified teachers in classrooms, and of failing to maintain required documentation. They insisted that licensing was not willing to work with them, but when asked what licensing could do regarding missing documentation, respondent Thomsen stated that licensing needed to give them more time. Respondent Daniels was overwhelmed with her responsibilities as director and often being a teacher as well. She was the teacher for the unlicensed school-age program. Respondents did not seem to understand the department requirement that there must always be a director in charge, and that director cannot also be teaching in a classroom.

This first complaint was received in August 2022, soon after the infant and preschool licenses were issued. Respondents asserted that that this complaint, as well as the anonymous complaint received on October 4, 2022, were filed by child care "competitors" in the Ramona area. No evidence was provided to confirm the source of either complaint but regardless of the source, the department has a duty to thoroughly investigate each complaint. LPA Ma's investigation also revealed unqualified teachers, and classrooms that were out of ratio and over capacity,

On September 29, 2022, Child No. 1's arm was injured while she was playing at the facility. Ms. Farley credibly testified that she put ice on the arm, reached out to both respondents - the licensee and the director of the facility - and both dismissed her, stating that she and/or the child were being over dramatic and they did not have the time to deal with this issue. It is understandable that this may have been a difficult day for respondents who had suffered the loss of a family member, however, this does not excuse them from their responsibilities for the children in their care, even for a short period of time. Ms. Farley and Ms. Uffens testified that respondent Thomsen

grabbed Child No. 1's arm and reprimanded Ms. Farley in front of other staff and in front of children in care. Neither respondent notified Child No. 1's parents or confirmed that the parents had been notified promptly so that prompt medical care could be provided. At the end of the day, the licensee is fully responsible for each child in care and for all that occurs within a facility.

At the conclusion of their investigation into the October 3, 2022, complaint, LPAs Ma and Siao were able to substantiate five of eight allegations. LPAs Ma and Siao then investigated the complaint that respondents were providing unlicensed care, and this allegation was substantiated. Respondents acknowledged that they were in fact providing care for school-aged children without having been licensed to do so. Respondents attempted to justify their conduct by stating that they had already signed an agreement with Classical Academy, that it was taking licensing too long to complete their inspections, and that respondents were providing a needed service to these children and their parents. It was not until December 5, 2022, that respondents obtained a private school affidavit.

Respondents believed that LPA Ma was out to get them and that it had become "personal" with him. They repeatedly expressed their frustration that he spent so much time at their facility - 19 visits in 21 months. What they did not seem to understand is that when a complaint is filed, LPA Ma is required to investigate and determine whether the allegations can be substantiated. If during that investigation he observes other violations, he is required to document these violations and monitor them, along with the other substantiated allegations. He is required to continue to visit the facility or contact the facility until all matters have been resolved. As in the case of respondents' unlicensed care of school-aged children, when the facility repeatedly

ignored licensing's Cease and Desist Order, additional monitoring and visits were needed.

Respondent Thomsen failed to attend the NCC. She provided a letter stating that she was not attending so that someone would be present at TLC that day. Respondent Daniels stated she was alone on one side with all of licensing on the other side against her. Respondent Thomsen's absence from the NCC spoke volumes on her failure to understand the significance of the meeting or her role at TLC.

Throughout the hearing, respondents failed to fully take responsibility for their repeated violations of certain regulations, and their failure to follow various department rules and regulations. They provided excuses for their conduct and the violations that occurred during 2022 and 2023, including that: they moved too quickly and did not have time to organize their files; the complaints were filed by disgruntled competitors; they operated the school-aged program without a license because licensing was too slow, they had already signed a contract and they were filling a need in the community; and licensing provided no assistance but instead, LPA Ma was out to get them.

Respondent Thomsen said it best when she stated, "We as a family took on more than we could handle." The repeated violations and the failure of respondents to either fully comprehend the necessity of complying with department regulations or to accept responsibility for their conduct does not provide the department with the assurance it needs to grant an additional license or to allow respondents to retain their existing licenses. Based on this record as a whole, nothing less than the revocation of respondent Thomsen's infant and preschool licenses and the exclusion of respondents Thomsen and Daniels from department licensed facilities shall assure public protection.

Cause for Discipline

FIRST FACTUAL ALLEGATION: TEACHER-CHILD RATIOS

18. Complainant established by a preponderance of the evidence that respondents Thomsen and Daniels aided, abetted, or permitted the violation of the applicable teacher-child ratios, in violation of Health and Safety Code sections 1596.885, subdivision (a) and (b), 1596.8897, subdivision (a)(1), 1596.95, and 1596.955, subdivision (a)(3), and California Code of Regulations, title 22, section 101216.3, subdivision (a), when:

A. On February 14, 2023, nine children were supervised by one teacher in a room at the preschool facility designated for the care of toddlers.

Finding: On a February 14, 2023, during an unannounced case management visit to the facility, LPA Ma and LPM Askew observed that in room ID, the toddler room, nine children were being supervised by one teacher, instead of the required 6:1 ratio, which poses a potential health and safety risk to the persons in care. A Type B citation was issued.

B. On December 5, 2022, 28 children were supervised by two staff members at the preschool facility.

Finding: On December 5, 2022, during an unannounced case management visit to the facility, LPA Ma and LPM Askew observed that there were 28 children in room 1A with two staff members. The required teacher-child ratio is one teacher visually observing and supervising no more than 12 children in attendance. A Type B citation was issued.

C. On October 12, 2022, 11 children were supervised by one teacher in a room at the preschool facility designated for the care of toddlers.

Finding: On October 12, 2022, during an unannounced case management visit to the facility, LPAs Ma and Siao observed that room 1D, designated for the toddlers component had 11 children being supervised by one teacher. This room was out of ratio as a ratio of 6:1 is required in the toddler program. This posed a potential health and safety risk to children in care and a Type B citation was issued.

SECOND FACTUAL ALLEGATION: PERSONAL RIGHTS

19. Complainant failed to establish by a preponderance of the evidence that respondents Thomsen and Daniels aided, abetted, or permitted the violation of the personal rights of children in care, in violation of California Code of Regulations, title 22, section 101223, subdivision (a)(2) and (a)(3), and Health and Safety Code sections 1596.8897, subdivision (a)(1) and (2), 1596.885, subdivisions (a) through (c), and 1596.95, when:

A. On multiple dates from September 2022 through October 2022 that are known to the respondents, but unknown to the complainant, children in the care of the preschool facility were placed on the carpet and floor to sleep without cots, floor mats, and/or sheets.

Finding: Ms. Farley testified that many times there were not enough cots so the smaller children used the cots and the older children laid on the floor, and that the school provided sheets for the cots but sometimes there were not enough clean sheets. On November 16, 2023, LPA Ma reported that as a result of his investigation, which included interviews with several children in care, he concluded that this

allegation was unfounded. LPA Ma's report and investigation were determined to be more credible than Ms. Farley's statements, and this allegation was not established.

20. Complainant established by a preponderance of the evidence that respondents Thomsen and Daniels aided, abetted, or permitted the violation of the personal rights of children in care, in violation of California Code of Regulations, title 22, section 101223, subdivision (a)(2) and (a)(3), and Health and Safety Code sections 1596.8897, subdivision (a)(1) and (2), 1596.885, subdivisions (a) through (c), and 1596.95, when:

B. On September 29, 2022, respondent Thomsen grabbed Child No. 1 by the arm. As a factor in aggravation, Child No. 1's arm was fractured and visibly injured at the time.

Finding: Ms. Farley and Ms. Uffens both credibly testified that they observed that Child No. 1's arm was injured and that they observed respondent Thomsen grab Child No. 1's arm. Based on licensing's investigation, on November 16, 2022, LPA Ma reported that licensing was substantiating "that staff handled an injured child in a rough manner."

C. On September 29, 2022, respondent Thomsen yelled at and verbally reprimanded a staff member in the presence of multiple children in care of the preschool facility.

Finding: Ms. Farley and Ms. Uffens both credibly testified that they observed respondent Thomsen speak inappropriately and yelled at Ms. Farley in front of day care children. Based on licensing's investigation, on November 16, 2022, LPA Ma reported that, regarding the above allegation, licensing was substantiating that staff

was “yelling to reprimand a teacher in front of children and creating an intimidating and toxic environment.”

THIRD FACTUAL ALLEGATION: HEALTH-RELATED SERVICES

21. Complainant established by a preponderance of the evidence that respondents Thomsen and Daniels aided, abetted, or permitted the violation of the rules governing health-related services, in violation of Health and Safety Code sections 1596.856, 1596.885, subdivisions (a) through (c). 1596.8897, subdivisions (a)(1) through (a)(2), and 1596.95, and California Code of Regulations, title 22, section 101226, subdivisions (c), (e)(1)(A), and (e)(3)(B), when:

A. On July 27, 2023, a syringe containing prescription medication for a child in care was stored in a refrigerator in the preschool facility where it was accessible to children.

Finding: On July 27, 2023, during an annual inspection of the facility, LPA Ma and LPM Askew observed a half filled syringe with pink antibiotics in a clear zip lock bag in a small refrigerator in preschool room 1B, which poses an immediate health, safety or personal rights risk to persons in care. Respondent Daniels identified the antibiotics were for Child No. 2, then quickly took it away and said she will place it in the "staff refrigerator.” Type A citation cited 101226, subdivision (e)(1)(A).

B. On July 27, 2023, the preschool facility stored a prescription medication for a child in care without label directions from the child's physician, and without written instructions from the child's authorized representative.

Finding: On July 27, 2023, during a record review as part of an annual inspection of the facility, LPA Ma and LPM Askew observed that a child was missing a medical

release for their antibiotics at the facility which poses a potential health, safely or personal rights risk to persons in care.

C. On September 29, 2022, respondents Thomsen and Daniels failed to ensure that Child No. 1 obtained emergency medical treatment for an injury Child No. 1 sustained while in the care of the preschool facility.

Finding: On October 12, 2022, during a visit to the facility to investigate a complaint received on October 4, 2022, LPAs Ma and Siao interviewed respondents and other staff members and determined that respondents failed to ensure that Child No. 1 obtained timely emergency medical treatment.

FOURTH FACTUAL ALLEGATION: STAFF-INFANT RATIO

22. Complainant established by a preponderance of the evidence that respondents Thomsen and Daniels aided, abetted, or permitted the violation of the applicable staff-infant ratios, in violation of Health and Safety Code sections 1596.856, 1596.885, subdivisions (a) and (b), 1596.8897, subdivision (a)(1), and 1596.95, and California Code of Regulations, title 22, section 101416.5, subdivision (b), when:

A. On February 14, 2023, nine infants at the Infant Facility were being cared for by two aides and one teacher who was not fully qualified.

Finding: On February 14, 2023, during a visit to the facility, LPA Ma observed that nine infants were being cared for in room 1E (infant room) by two aides and one teacher who was not fully qualified, when the required staff to infant ratio is 1:4. This poses a potential health and safety risk to the persons in care.

B. On November 2, 2022, 13 infants at the Infant Facility were being cared for by two teachers.

Finding: On November 2, 2022, during a visit to the facility, LPA Ma observed that 13 infants were being cared for in room 1E (infant room) by two teachers, where the staff to infant ratio is 1:4. This poses an immediate health and safety risk to children in care.

C. On October 24, 2022, nine infants at the Infant Facility were being cared for by two teachers.

Finding: On October 24, 2022, during an unannounced case management visit to the facility, LPAs Ma and Siao observed that nine infants were being cared for in room 1E (infant room) by two teachers, where the staff to infant ratio is 1:4. This poses an immediate health and safety risk to children in care.

FIFTH FACTUAL ALLEGATION: PERSONNEL RECORDS

23. Complainant established by a preponderance of the evidence that respondents Thomsen and Daniels aided, abetted, or permitted the violation of the rules governing personnel records, in violation of Health and Safety Code sections 1596.856, 1596.885, subdivisions (a) and (b), 1596.8897, subdivision (a)(1), and 1596.95, and California Code of Regulations, title 22, section 101217, subdivision (a), when:

A. On February 14, 2023, the infant facility failed to maintain a health screening report and/or mandated reporter documentation for three employees.

Finding: On February 14, 2023, during an unannounced case management visit, LPAs Ma and Siao conducted a file review of staff and observed that the infant facility failed to maintain a health screening report and/or mandated reporter documentation for three employees. This poses a potential health and safety risk to children in care.

B. On October 12, 2022, the preschool facility failed to maintain a health screening report, immunization record, and/or current mandated reporter documentation for two employees.

Finding: On October 12, 2022, during an unannounced visit to initiate an investigation for a complaint received on October 4, 2022, LPAs Ma and Siao observed that the facility had no documentation of TB screening, immunization records, and current mandated reporter certificates for two employees, which poses a potential health and safety risk to children in care.

SIXTH FACTUAL ALLEGATION: LICENSING REPORTS

24. Complainant established by a preponderance of the evidence that respondents Thomsen and Daniels aided, abetted, or permitted the violation of the rules governing licensing reports in violation of Health and Safety Code sections 1596.856, 1596.8595, subdivision (c)(1)(4) through (d)(1)(4), 1596.885, subdivisions (a) and (b), 1596.8897, subdivision (a)(1), and 1596.95, when:

A. On February 14, 2023, the infant facility failed to maintain an Acknowledgment of Receipt of Licensing Reports in the files of one child in care.

Finding: On February 14, 2023, during a visit to the facility, LPA Ma observed that an Acknowledgment of Receipt of Licensing Reports for a previously issued Type A citation was missing from one child's file. A Type B citation was issued.

B. On December 5, 2022, the infant facility failed to maintain an Acknowledgment of Receipt of Licensing Reports and/or Non-Compliance Conference Report in each child's files.

Finding: On December 5, 2022, during a visit to the facility, LPA Ma observed that Acknowledgment of Receipt of Licensing Reports for three previously issued Type A citations were missing from all children's files. A Type B citation was issued.

SEVENTH FACTUAL ALLEGATION: REPORTING REQUIREMENTS

25. Complainant established by a preponderance of the evidence that, on September 29, 2022, respondents Thomsen and Daniels failed to timely report to the department that Child No. 1 had sustained an injury while in the care of the preschool facility that required medical treatment, in violation of Health and Safety Code sections 1596.856, 1596.885, subdivisions (a) through (c), 1596.8897, subdivision (a)(1) and (a)(2), and 1596.95, and California Code of Regulations, title 22, section 101212, subdivision (d)(1)(B).

Finding: On October 12, 2022, during a visit to the facility to investigate a complaint received on October 4, 2022, LPAs Ma and Siao interviewed respondents and determined that the facility did not follow reporting requirements because Child No. 1 was injured on September 29, 2022, and was known by respondent Daniels to require medical attention on the same day, but a call was not made to the department within 24 hours. This poses a potential health and safety risk to children in care. A Type B citation was issued.

EIGHTH FACTUAL ALLEGATION: TEACHER QUALIFICATION AND DUTIES

26. Complainant established by a preponderance of the evidence that respondents Thomsen and Daniels aided, abetted, or permitted the violation of the rules governing teacher qualifications and duties, in violation of Health and Safety Code sections 1596.856, 1596.885, subdivisions (a) and (b), 1596.8897, subdivision

(a)(1), and 1596.95, and California Code of Regulations, title 22, section 101216.1, subdivisions (b) and (c), when:

A. On July 27, 2023, staff member Collette Thomsen, (respondent Thomsen's daughter) who was not a fully qualified teacher, cared for 12 children in the preschool facility.

Finding: On July 27, 2023, during a records review as part of an annual inspection of the facility, LPA Ma and LPM Askew observed that Collette was alone in classroom 1A (two year olds room) with 12 children, but Collette only had proof of completing nine ECE units (12 units are required). The facility was not within ratio as Collette was not qualified to be alone with children, which posed an immediate health, safety or personal rights risk to persons in care.

B. On August 9, 2022, seven children were cared for by a teacher's aide and a volunteer at the preschool facility that were not under the direct supervision of a qualified teacher.

Finding: On August 9, 2022, during an initial inspection for a complaint received on August 2, 2022, LPAs Ma and Siao observed that seven children in room 1D were being cared for by a volunteer and an aide who was enrolled by had not completed 12 ECE units so was not a qualified teacher. Therefore the classroom was out of ratio. This was a potential risk to the health and safety of children in care.

NINTH FACTUAL ALLEGATION: UNLICENSED CARE

27. Complainant established by a preponderance of the evidence that from October 12, 2022 through December 5, 2022, respondents Thomsen and Daniels aided, abetted, or permitted the operation of the school-age facility as a child day care

facility for school age children without a valid license, in violation of Health and Safety Code sections 1596.80, 1596.856, 1596.885, subdivisions (a) through (c), 1596.8897, subdivisions (a)(1) and (a)(2), and 1596.95, and California Code of Regulations, title 22, section 101161(a).

Finding: On October 12, 2022, LPAs Ma and Siao made an unannounced visit to initiate the investigation of a complaint received on October 5, 2022, that unlicensed care was being provided at the facility. The LPAs met with respondent Daniels and observed eight or more school age children in care at the time of the inspection who stated that their ages were between five and seven. Based on the observations and interviews with the children and respondent Daniels, the LPAs determined that TLC was conducting an unlicensed child care school-age program at the facility. Respondent Daniels was provided a cease and desist letter to stop operations by the end of the business day and was notified that continued unlicensed operation may result in civil penalties.

TENTH FACTUAL ALLEGATION: LIMITATIONS ON CAPACITY

28. Complainant established by a preponderance of the evidence that on August 8, 2022, and November 2, 2022, respondents Thomsen and Daniels aided, abetted, or permitted the care of 13 infants in the infant facility, which has a licensed capacity of 12 infants, in violation of Health and Safety Code sections 1596.856, 1596.885, subdivisions (a) and (b), 1596.8897, subdivisions (a)(1), and 1596.95. California Code of Regulations, title 22, section 101161, subdivision (a).

Finding: On August 8, 2022, during an initial inspection for a complaint received on August 2, 2022, LPAs Ma and Siao observed that 13 infants were being cared for in the infant room with a staff of three. It was determined that the infant facility was out

of ratio and over capacity because the total capacity under the license is 12 and the infant ratio is 4:1.

ELEVENTH FACTUAL ALLEGATION: IMMUNIZATION REQUIREMENTS

29. Complainant established by a preponderance of the evidence that on July 27, 2023, respondents Thomsen and Daniels aided, abetted, or permitted five employees of the preschool facility and two employees of the infant facility to care for children without being immunized against influenza, pertussis, and/or measles, in violation of Health and Safety Code sections 1596.856, 1596.885, subdivisions (a) through (c), 1596.8897, subdivisions (a)(1) and (a)(2), and 1596.95, and 1596.7995, subdivision (a)(1) and (c).

Finding: On July 27, 2023, during a records review as part of an annual inspection of the facility, LPA Ma and LPM Askew observed that five of five staff files were missing proofs of immunizations (Tdap, MMR), which poses/posed a potential health, safety or personal rights risk to persons in care.

TWELFTH FACTUAL ALLEGATION: LEAD CONTAMINATION TESTING

30. Complainant established by a preponderance of the evidence that on July 27, 2023, respondents Thomsen and Daniels aided, abetted, or permitted the preschool facility and the infant facility to care for children without having the drinking water tested for lead contamination levels, in violation of Health and Safety Code sections 1596.856, 1596.885, subdivisions (a) through (c), 1596.8897, subdivision (a)(1)

and (a)(2), 1596.95 and 1597.16, and Written Directives,[3] section 101700, subdivision (c)(1).

Finding: On July 27, 2023, during a records review as part of an annual inspection of the facility, LPA Ma and LPM Askew observed that the facility had not completed testing prior to their deadline in accordance with the Written Directives because the facility was licensed on July 16, 2022, and testing was due to be completed by January 16, 2023.

THIRTEENTH FACTUAL ALLEGATION: MANDATED REPORTER TRAINING

31. Complainant established by a preponderance of the evidence that on July 27, 2023, respondents Thomsen and Daniels aided, abetted, or permitted four employees of the preschool facility and five employees of the infant facility to care for children without completing mandatory reporter training within the prior two years, in violation of Health and Safety Code sections 1596.856, 1596.8662, subdivision (b)(1), 1596.885, subdivisions (a) through (c), and 1596.889, subdivisions (a)(1)(2) and (3).

Finding: On July 27, 2023, based on a records review during an annual inspection of the facility, LPA Ma and LPM Askew observed that four out of five staff

[3] Health and Safety Code section 1597.16, subdivisions (b)(3) authorizes the department to implement and administer the health and safety requirements related to lead exposure and testing through written instructions, until it adopts regulations under the Administrative Procedure Act. Written Directives issued by the department have the same force and effect as regulations contained in Title 22 of the California Code of Regulations.

records were missing current mandated reporter certificates, which poses a potential health, safety or personal rights risk to persons in care. A Type B citation was issued.

FOURTEENTH FACTUAL ALLEGATION: HEALTH SCREENING

32. Complainant established by a preponderance of the evidence that on July 27, 2023, respondents Thomsen and Daniels aided, abetted, or permitted three employees of the infant facility to care for children without completing a test for tuberculosis within one year prior to, or seven days after, their employment with the infant facility, in violation of Health and Safety Code sections 1596.856, 1596.885, subdivisions (a) through (c), 1596.8897, subdivisions (a)(1) and (a)(2), and 1596.95, and California Code of Regulations, title 22, section 101216, subdivision (g)(1).

Finding: On July 27, 2023, based on a records review during an annual inspection of the facility, LPA Ma and LPM Askew observed that three of five staff files were missing LIC 503 and/or negative TB proof, which poses a potential health, safety or personal rights risk to persons in care. A Type B citation was issued.

FIFTEENTH FACTUAL ALLEGATION: FOOD SERVICE

33. Complainant established by a preponderance of the evidence that on July 27, 2023, respondents Thomsen and Daniels aided, abetted, or permitted food, including breast milk, to be brought in the infant facility without being labeled with the child's name and the date the food was brought into the infant facility, in violation of Health and Safety Code sections 1596.856, 1596.885, subdivisions (a) through (c), 1596.8897, subdivisions (a)(1) and (a)(2), and 1596.95, and California Code of Regulations, title 22, section 101427, subdivision (j).

Finding: On July 27, 2023, during an annual inspection of the facility, LPA Ma and LPM Askew observed infant food including breast milk that was not labeled with the children's name or date the food was brought in. This poses a potential health, safety or personal rights risk to persons in care. A Type B citation was issued.

SIXTEENTH FACTUAL ALLEGATION: INIMICAL CONDUCT

34. Complainant established by a preponderance of the evidence that respondents Thomsen and Daniels engaged in conduct that is inimical to the health, morals, welfare, or safety of either an individual in or receiving services from the preschool facility or the infant facility, or the people of the State of California, when, as complainants established by a preponderance of the evidence, respondents engaged in the conduct detailed in the factual allegations one through 15 above. These incidents, discretely and collectively, constituted inimical conduct.

ORDER

1. The license of respondent Pamela Thomsen dba Thomsen Learning Center to operate the preschool facility is revoked.

2. The license of respondent Pamela Thomsen dba Thomsen Learning Center to operate the infant facility is revoked.

3. The application of respondent Pamela Thomsen dba Thomsen Learning Center to operate a school-age facility is denied.

4. Complainant's request that respondent Pamela Thomsen be prohibited, for the remainder of her life, from employment in, presence in, and contact with clients of, any facility licensed by the department or certified by a licensed foster family

agency, or any resource family home, and from holding the position of member of the board of directors, executive director, or officer of the licensee of any facility licensed by the department, until respondent successfully petitions for reinstatement pursuant to Government Code section 11522 is granted.

5. Complainant's request that respondent Nicolle Daniels be prohibited, for the remainder of her life, from employment in, presence in, and contact with clients of, any facility licensed by the department or certified by a licensed foster family agency, or any resource family home, and from holding the position of member of the board of directors, executive director, or officer of the licensee of any facility licensed by the department, until respondent successfully petitions for reinstatement pursuant to Government Code section 11522 is granted.

DATE: May 21, 2024

Marion J. Vomhof

MARION J. VOMHOF
Administrative Law Judge
Office of Administrative Hearings