

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HEALTH

In the Matter of Unity Health Care, Class F
Home License No. 352187 and Unity
Home Care, Inc., Class A Professional
Home Care License No. 353694

**FINDINGS OF FACT,
CONCLUSIONS OF LAW,
AND RECOMMENDATION**

The above-captioned matter came before Administrative Law Judge Perry Wilson for hearing on September 23-26, November 18-21, December 15-18, 2014, and January 12-16, 26-30, February 2-6, March 24-27, 30, and April 1-2, 2015 at the Minnesota Office of Administrative Hearings in St. Paul, Minnesota.

Audrey Kaiser Manka, Assistant Attorney General, and Cody Zustiak, Assistant Attorney General, appeared on behalf of the Minnesota Department of Health (Department). Lateesa T. Ward, Ward & Ward, appeared on behalf of Licensee, Unity Health Care, Inc. and Unity Home Health Care, Inc. (collectively Unity or Licensee).

STATEMENT OF THE ISSUES

1. Did the Department properly revoke the Class F license and refuse to renew the Class A license of Unity pursuant to Minn. Stat. § 144A.461, subd. 3 (2014) for failing to comply with Minnesota law and rules?
2. Did the Department properly impose conditions on Unity's home care licenses in October 2011, pursuant to Minn. Stat. § 144A.46, subd. 3 (2014)?
3. Did the Department properly impose fines in connection with a June 2013 survey that found Unity repeatedly violated Minn. Stat. § 144A.44, subd. 1(2) (2014); Minn. R. 4668.0810, subp. 6, .0815, subp. 2 (2013)?

SUMMARY OF RECOMMENDATION

The Administrative Law Judge concludes that:

1. The Department properly revoked the Class F license and properly refused to renew Unity's Class A license pursuant to Minn. Stat. § 144A.461, subd. 3 for its failure to comply with Minnesota law and rules. The Administrative Law Judge respectfully recommends that these decisions be **AFFIRMED**.

2. The Department properly imposed conditions on Unity's home care licenses in October 2011, pursuant to Minn. Stat. § 144A.46, subd. 3. The Administrative Law Judge respectfully recommends that this decision be **AFFIRMED**.

3. The Department properly imposed fines in connection with a June 2013 survey that found Unity repeatedly violated Minn. Stat. § 144A.44, subd. 1(2); Minn. R. 4668.0810, subp. 6, .0815, subp. 2. The Administrative Law Judge respectfully recommends that this decision be **AFFIRMED**.

Based on the submissions of the parties and proceedings in this matter, and for the reasons set forth in the Memorandum below, the Administrative Law Judge issues the following:

FINDINGS OF FACT

1. Unity was licensed by the Department to operate a Class F home care agency in 2007. Unity also held a Class A home care license issued by the Department.¹

2. Unity owns four houses that are registered by the Department as housing with services establishments (HWS) pursuant to Minn. Stat. ch. 144D (2014). These HWS are known as the Dr. Thomas H. Johnson Housing with Services. Beth Balenger, through her ownership of Unity, is the owner, primary contact, agent, and president of the four HSWs.² The HSWs are all located in close proximity to each other in Minneapolis, Minnesota.³

3. Ms. Balenger served as Unity's administrator until January 2012, when Paulette Wilson became administrator.⁴

4. The Department is empowered by state law to monitor and inspect home care providers.⁵ During these inspections, called surveys of providers, the Department representatives typically make an on-site visit and observe staff and clients, review documents, and conduct interviews.⁶ Surveyors do not review the care provided to all home care clients, but review the care provided to clients identified through a sampling process.⁷ Correction orders are issued if violations of applicable statutes or rules are found on an initial survey, and a time period is specified in which the violation must be corrected. The Department follows up at a later time to see whether the violation has been corrected. Those follow-up visits typically are narrower in scope because the follow-up survey looks at whether the licensee has corrected the violation.⁸ Once a time period to correct is given, if the violation is not corrected on the follow-up survey, the Department

¹ Transcript (T.) at 2434.

² Department Exhibit (Ex.) 3.

³ Department Exs. 4-7.

⁴ T. 2433-35.

⁵ Minn. Stat. § 144A.45, subd. 2 (2014).

⁶ T. at 167.

⁷ T. at 173-74.

⁸ T. at 69-70.

does not give an additional time to correct the violation.⁹ The Department conducts maltreatment investigations through its Office of Health Facility Complaints (OHFC).¹⁰ Surveys and compliance are conducted by the Department's Home Care and Assisted Living Program (HCALP).¹¹

5. The Department conducted surveys of Unity's facility in 2011, 2012, and 2013. Each survey resulted in a report that lists the results of the survey. The structure of each report is a series of correction orders.¹² The correction orders each have a tag number that refers to the statute or rule the Department has concluded provides the basis for the correction order.¹³ The correction order sets forth the applicable language from each statute or rule cited, and then provides the observations made during the survey that form the factual basis supporting the issuance of the correction order.¹⁴ There can be multiple correction orders issued under each tag number.¹⁵

A. May 2011 Survey and Correction Orders

6. The Department conducted a survey of Unity between May 24 and 27, 2011 (May 2011 Survey).

7. As a result of the May 2011 Survey, the Department issued an immediate correction order to Unity on May 26, 2011, in connection with the administration of insulin to Client B1.¹⁶ The Immediate Correction Order was based on Unity's failure to comply with Minn. Stat. § 144A.44, subd. 1(2),¹⁷ which mandates that clients receive care in compliance with accepted medical and nursing standards.¹⁸

8. The factual basis for the Immediate Correction Order was that Unity failed to consult client B1's doctor when B1's glucose levels became so elevated that the level did not register on the glucometer. B1 did not respond to the maximum dosage of insulin set forth in B1's doctor's orders. Unity staff also administered additional insulin to B1, over and above that provided for in the doctor's orders, without a doctor's order.¹⁹

9. On June 2, 2011, the HCALP division of the Department conducted an on-site monitoring visit and found that Unity had complied with the immediate correction order regarding the administration of insulin to B1.²⁰

⁹ *Id.*

¹⁰ See Department Ex. 12.

¹¹ See, e.g., Department Ex. 10.

¹² See, e.g., Department Ex. 11.

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ Department Ex. 9

¹⁷ *Id.*

¹⁸ Department's Ex. 99 at MDH 004076.

¹⁹ Department Ex. 9; T. 321-4.

²⁰ Department Ex. 34, MDH 000692.

10. On May 27, 2011, the Department's HCALP division issued an 88 page Correction Order to Unity involving Unity's violation of 23 rules or laws identified during the May 2011 Survey.²¹ The violations found by the Department were as follows:

- A. Minn. Stat. § 144A.44, subd. 1(2) (Tag 0030); failure to provide care and services pursuant to a suitable and up-to-date care plan, and subject to accepted medical or nursing standards for one of one client related to diabetes care (B1); two of two clients with injuries (B2 and A1); one of one client with a narcotics overdose (A1); one of one client with a suprapubic catheter (A1); two of two clients were not assessed for use of bed rails (A1 and A2); one of one client with wound care (A2); one of two clients on a bowel program (A2); and failure to ensure infection control protocols were implemented (B4 and B1);
- B. Minn. Stat. § 144A.44, subd. 1(14) (2014) (Tag 0090); failure to treat a home care client with respect for two of four clients whose care was reviewed (A2 and B3);
- C. Minn. Stat. § 144A.46, subd. 5(b) (2014) (Tag 0187); failure to ensure that one employee reviewed (AA), who was disqualified from providing direct client care, but who was employed by Unity under a variance, was acting in compliance with the terms of that variance;
- D. Minn. Stat. § 626.557, subd. 3 (2014) (Tag 0605); failure to immediately file a complaint with the common entry point regarding one of one client, who reported missing money and had an unexplained wound to his foot (A1);
- E. Minn. Stat. § 626.557, subd. 14(b) (2014) (Tag 0732); failure to have individualized abuse prevention plans for three of four clients reviewed (A1, B1, and B2);
- F. Minn. R. 4668.0040, subp. 2²² (2013) (Tag 1420); failure to ensure that the complaint/grievance process contained the required components and failure to implement the process by not informing one of one client of his right to complain about missing money (A1);

²¹ Department Ex. 11.

²² The Minnesota Legislature revised the statutes applicable to Home Health Facilities in 2013, effective in 2014. See Chapter 108, Article 11, 2013 Minn. Laws. This statutory revision also resulted in the repeal of many of the Department's rules cited in the correction orders issued to Unity from 2011 to 2013. This report preserves the citations to the rules, as issued by the Department in the correction orders, to preserve continuity, even though these rules were later repealed. These rules and statutes were admitted into evidence as Department Exhibits 99 and 101. Unless otherwise indicated, citations are to these statutes and rules.

- G. Minn. R. 4668.0065, subp. 1 (2013) (Tag 1475); tuberculosis screening (AA, AB, and BC). The Department issued this correction order after the Initial Survey, but withdrew it at the time of the hearing;
- H. Minn. R. 4668.0065, subp. 3 (2013) (Tag 1485); failure to complete in-service training about infection control techniques annually (BB);
- I. Minn. R. 4668.0805, subp. 1 (2013) (Tag 6040); failure to ensure that four of four staff members who provided direct care completed the orientation to home care requirements before providing services to clients (AA, AB, BB and BC);
- J. Minn. R. 4668.0810, subp. 6 (Tag 6090); failure to ensure that four of four clients whose records were reviewed contained documentation of significant events regarding diabetic management, documentation of injuries, and care and treatment of wounds (A1, A2, B1 and B2);
- K. Minn. R. 4668.0815, subp. 2 (Tag 6110); failure to complete a reevaluation of four of four clients reviewed who had a change in condition (A1, A2, B1 and B2);
- L. Minn. R. 4668.0815, subp. 4 (2013) (Tag 6120); failure to ensure that the service plan contained all of the necessary components for four of four clients reviewed (A1, A2, B1 and B2);
- M. Minn. R. 4668.0825, subp. 2 (2013) (Tag 6155); failure to conduct nursing assessments to develop a service plan for one client related to mobility, and to another client related to diabetic monitoring (A1 and B1);
- N. Minn. R. 4668.0825, subp. 4 (2013) (Tag 6165); failure to ensure that three of four unlicensed staff who performed delegated nursing procedures received training and demonstrated competency; failure of the registered nurse to provide specific written instructions for performing the procedure (AA, AB and BB);
- O. Minn. R. 4668.0835, subp. 2 (2013) (Tag 6200); failure to ensure that four of four unlicensed staff whose records were reviewed had successfully completed training and had passed a competency evaluation for providing direct client care and were qualified to provide home care services (AA, AB, BB and BC);
- P. Minn. R. 4668.0855, subp. 4 (2013) (Tag 6290); failure to ensure that two of two unlicensed staff whose records were reviewed had successfully completed training and passed a competency evaluation for medication administration (AA and BB);

- Q. Minn. R. 4668.0855, subp. 6 (2013) (Tag 6300); failure to ensure that one of one unlicensed staff whose record was reviewed assisted with insulin administration within the limitations of the rule (BB);
- R. Minn. R. 4668.0855, subp. 7 (2013) (Tag 6305); failure to ensure that two of two unlicensed staff, who were observed administering medications, were trained and competent to perform the delegated task (AB and BB);
- S. Minn. R. 4668.0855, subp. 9 (2013) (Tag 6315); failure to ensure that there was adequate and complete documentation of medication assistance for two of four clients whose records were reviewed (A1 and A2);
- T. Minn. R. 4668.0860, subp. 2 (2013) (Tag 6330); failure to ensure physician's orders were obtained for one of one client who received sliding scale insulin and one of one client who received enemas and wound care (B1 and A2);
- U. Minn. R. 4668.0865, subp. 2 (2013) (Tag 6380); failure to complete a medication; failure to complete a medication assessment and determine functional status for one of one client whose care was reviewed (A1);
- V. Minn. R. 4668.0865, subp. 3 (Tag 6385); failure to ensure that medications were adequately secured in one of two HWS sites and failure to ensure that a system was in place to control narcotics (B2); and
- W. Minn. R. 4668.0865, subp. 5 (2013) (Tag 6395); failure to ensure that legend drugs were in the original container with identifying information on the container for one of one client whose medications were reviewed (A1).

11. The Department orally advised Unity of the correction orders it issued as a result of the May 2011 Survey in an exit interview that was conducted on May 27, 2011.²³ In addition, the Department sent Unity a letter dated August 17, 2011, that contained the correction orders issued after the May 2011 Survey.²⁴ The correction orders sent in August 2011,²⁵ specified the time for correction of each tag, and all tags were to be corrected within the time periods specified in the tags.²⁶

²³ Department Ex. 31 at MDH 000516, T. at 210-1.

²⁴ Department Ex. 10.

²⁵ See, e.g., Department Ex. 11.

²⁶ The delay in the mailing of the May 2011 correction orders to August 2011 was caused by a shutdown of Minnesota government functions during that period.

12. With the exception of the Tag 030 for the lack of bed rail assessments, Unity did not contest the tags issued as a result of the May 2011 survey during the hearing.²⁷ Unity admits that there were no bed rail assessments, as found by the Department, but contests the legal basis for its obligation to provide bed rail assessments. The bed rail assessment issue is addressed in the Conclusions of Law set forth below.

13. The Department's Office of Health Facility Complaints (OHFC) conducted a maltreatment investigation at Unity in the spring of 2011. As a result of that investigation, the Department issued three licensing orders dated May 23, 2011, and required Unity to correct those orders within 14 days.²⁸ The May 23, 2011 orders were issued for the following violations:

- A. Minn. Stat. § 144A.44, subd. 1(2) (Tag 0030); failure to ensure that care and services were provided in accordance with a suitable and up-to-date plan of care for two of two clients related to toileting and range of motion (ROM) exercises;
- B. Minn. Stat. § 626.557, subd. 3 (Tag 0605); failure to immediately report alleged maltreatment to the common entry point for one client; and
- C. Minn. R. 4668.0815, subp. 4 (Tag 6120); failure to ensure that the content of the service plan were complete for two of two clients.

14. On September 19, 2011, a Department OHFC investigator visited Unity and determined that Unity had corrected the licensing orders issued by OHFC on May 23, 2011.²⁹ Because the licensing orders issued by the OHFC section of the Department involved violations of the same laws and rules as those issued by the HCALP section of the Department during the May 2011 Survey, the Department supervisor instructed the HCALP Surveyor to not review the licensing orders issued after the May 2011 Survey under Tag 0030 during the October 2011 Survey.³⁰

B. October 2011 Survey and Conditional License

15. Between September 29 and October 7, 2011, a follow-up survey was conducted by the Department at Unity to determine whether correction orders issued on May 27, 2011, were corrected (October 2011 Survey). Follow-up surveys typically are narrower than full surveys and only examine the deficient conditions found in the preceding survey.³¹ The Department did not check to see if the violations written at the May 2011 Survey under Minn. Stat. §§ 144A.44, subd. 1(2) (Tag 0030), 626.557, subd. 3 (Tag 0605); Minn. R. 4668.0815, subp. 4 (Tag 6120) were corrected for the reason noted in Finding 14.

²⁷ See Unity's Proposed Findings of Fact, Conclusions of Law and Recommendations at pp. 4-5.

²⁸ Department Ex. 12.

²⁹ Department Ex. 12, at MDH 023831.

³⁰ T. at 97 and 1177-8.

³¹ T. at 69-70; Department Ex. 103, at MDH 004230.

16. On October 7, 2011, the Department issued a 55 page set of correction orders, containing the following tags:³²

- A. Minn. Stat. Section 144A.44, subd. 1(2) (Tag 0030); failure to provide care and services pursuant to a suitable and up-to-date care plan and subject to accepted medical or nursing standards for one client who smoked while using oxygen (C1); three of three clients in the sample who received insulin (C1, A4, and A3) and one client who experienced a change in condition (A3);
- B. Minn. Stat. Section 144A.44, subd. 1(14) (Tag 0090); failure to treat a home care client with respect for one client (A3);
- C. Minn. Stat. Section 144A.44, subd. 1(15) (2014) (Tag 0095); failure to ensure that a home care client was free from physical and verbal abuse (C1);
- D. Minn. Stat. Section 626.557, subd. 3 (Tag 0605); failure to immediately file a complaint with a common entry point regarding C1, who smoked while using oxygen and who reported that she had been “hosed down” by the owner of the home care agency;³³
- E. Minn. Stat. Section 626.557, subd. 14(b) (Tag 0732); failure to have individualized abuse prevention plans for one of three clients in the sample reviewed;
- F. Minn. R. 4668.0810, subp. 1 (2013) (Tag 6065); failure to ensure that client records were maintained at the housing with services establishment where the services were provided;
- G. Minn. R. 4668.0810, subp. 6 (Tag 6090); failure to ensure that three of three clients whose records were reviewed contained documentation that was accurate, up-to-date, and available to all persons providing care for three of three clients whose records were reviewed (A3, C1, and A4) and that significant events were documented daily for one of those three clients (A3);
- H. Minn. R. 4668.0815, subp. 2 (Tag 6110); failure to ensure that a registered nurse had reviewed and revised a client’s evaluation and service plan for one of one client whose records were reviewed and who had a change in condition (A3);

³² Department Ex. 13.

³³ This tag is based on Unity’s failure to report the conduct underlying the maltreatment investigation of Beth Balenger discussed below.

- I. Minn. R. 4668.0815, subp. 4 (Tag 6120); failure to ensure that the service plan for one of one client contained all of the necessary components (A3);
- J. Minn. R. 4668.0825, subp. 4 (Tag 6165); failure to ensure that one of one employee whose files were reviewed had documentation that the employee (AE) had completed core training and successfully passed competency testing before assisting with a delegated nursing task;
- K. Minn. R. 4668.0835, subp. 2 (Tag 6200); failure to ensure that two of two unlicensed personnel had successfully completed the required training and were qualified to provide delegated nursing procedures (AE and AD);
- L. Minn. R. 4668.0855, subp. 4 (Tag 6290); failure to ensure that one of one unlicensed personnel was trained and competent to provide medication assistance (AE);
- M. Minn. R. 4668.0855, subp. 7 (Tag 6305); failure to ensure that one of one unlicensed personnel whose training was reviewed was competent to assist with insulin administration (AE) and failure to ensure that the registered nurse had specified in writing the instructions for insulin administration for two of two clients who received insulin administration (A3 and A4);
- N. Minn. R. 4668.0855, subp. 9 (Tag 6315); failure to ensure that there was adequate and complete documentation of medication administration as prescribed for three of three clients whose records were reviewed or medication administration was observed (C1, A2, and A4); and
- O. Minn. R. 4668.0865, subp. 2 (Tag 6380); failure to ensure an assessment of the client's functional status and the need for central storage of medication was completed and identified on the client's service plan for two of two clients whose service plans were reviewed (A2 and A3).

17. During the October 2011 Survey, the Department re-issued correction orders under Minn. Stat. §§ 144A.44, subd. 1(2), 626.557, subd. 3; Minn. R. 4668.0815, subp. 4, that previously had been found "corrected" on September 19, 2011 by OHFC, and found that 10 of the correction orders issued after the May 2011 Survey were not corrected.³⁴ In addition, the Department issued two correction orders for two new violations.³⁵

³⁴ Department Ex. 13.

³⁵ Department Exs. 8 and 13.

18. Despite the fact that Unity had failed to conduct bed rail assessments, there was no citation for Unity's failure to conduct assessments for the use of bedrails in the October 2011 Survey.³⁶

19. The Department did not review client records during the October 2011 Survey to determine whether Unity had completed nursing assessments for the use of bed rails for clients identified in the Initial Survey because that licensing order was written under Minn. Stat. § 144A.44, subd. 1(2) (Tag 0030), which had been found corrected by OHFC in September of 2011.³⁷

20. A serious violation of the Home Health Care law and rules was observed by the Department during the October 2011 Survey. On September 29, 2011, the Department representative noticed that Client A3 dropped a glass of water she was given and that a Unity staff member gave A3 insulin to self-administer when Client A3 appeared drowsy.³⁸ The representative asked staff to contact Unity's Director of Nursing (DON) about A3's condition. The DON said that she had noticed the client had "more drowsiness," but the DON did not check on A3 on September 29, 2011.³⁹

21. On September 30, 2011, the Department's representative returned to Unity and saw Client A3 sitting on the sofa with her head down, and Client A3 did not respond when the representative called her name.⁴⁰ Unity unlicensed staff told the representative that it took three staff members to get A3 up and dressed for the day, and that she had not had her blood sugar levels checked and her medications were not administered that morning.⁴¹ The representative instructed Unity staff to contact Unity's Registered Nurse (RN) because A3 needed to be evaluated immediately.⁴² Unity's License Practical Nurse (LPN) came to observe A3.⁴³ The LPN told the representative that Client A3 "plays possum,"⁴⁴ but she did call 911 and an ambulance arrived to take A3 to the hospital.⁴⁵ The LPN told the ambulance staff that A3 had behaviors where she "will not respond."⁴⁶ The representative called the hospital later in the day and was transferred to the intensive care unit (ICU) and spoke to the nurse who was assigned to care for A3.⁴⁷ The nurse in the ICU said that A3 was "a very sick lady."⁴⁸

22. Client A3's medical records contained a notation that one of Unity's unlicensed staff administered three units of sliding scale insulin to A3 on September 29, 2011, based on the doctor's order for sliding scale insulin, even though A3's blood sugar

³⁶ Department Ex. 13.

³⁷ T. 97.

³⁸ T. at 1187.

³⁹ T. at 1210-1.

⁴⁰ T. at 1211-2.

⁴¹ T. at 1213-4.

⁴² *Id.*

⁴³ T. at 1216-7.

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ T. at 1217.

⁴⁷ T. at 1218-9.

⁴⁸ *Id.*

was listed as 103.⁴⁹ The order for sliding scale insulin indicated no sliding scale insulin was to be administered if the blood sugar levels were below 151.⁵⁰ The staff person told the Department representative that she had not administered the sliding scale insulin, although she charted that she had administered sliding scale insulin.⁵¹ The Unity staff person testified at the hearing that she had given the sliding scale as charted on September 29, 2011.⁵²

23. The Department reviewed the deficiencies from the May 2011 Survey, the October 2011 Survey, the OHFC orders issued on May 23, 2011, as well as the OHFC revisit, correcting the May 23, 2011 order, and noted that while some violations had been corrected, there appeared to be an overall lack of compliance, and lack of follow-through. In addition, many of the actions by Unity's staff were detrimental to the welfare of Unity's clients.⁵³ The Department was also concerned about the observations made by the Surveyors during the surveys.⁵⁴ The Department decided to impose conditions on Unity's Class F and Class A licenses.⁵⁵

24. The conditional license issued on October 11, 2011⁵⁶ applied to both the Class F and Class A licenses, and required that Unity:

- A. cease providing home care services to all clients at the housing with services establishment located at two of its four locations upon the arrival of another home care provider, identified by Hennepin County, to take over the care of clients at those two locations;
- B. fully cooperate with the conditional license process and allow full access to the premises, supplies, medical and health equipment, and client records to a home provider identified by Hennepin County;
- C. provide the Department with a list of all clients living at the housing with services establishments, within twenty-four hours of receipt of the conditional license;
- D. hire an outside independent consultant at its cost who will visit on-site and in person to review, evaluate, and make recommended changes to Unity's practices to ensure that it will comply with state laws and regulations governing home care practices, and to submit weekly reports to the Department. Unity was to submit the name and qualifications of the consultant to the Department for approval;

⁴⁹ T. at 1191-2.

⁵⁰ *Id.*

⁵¹ MDH Ex. 56, MDH 000877 and 000895 and T. at 1194.

⁵² T. at 3831-2.

⁵³ T. at 2667-8.

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ Department Ex. 14.

- E. submit a plan of action showing steps to be taken by Unity to assure compliance with all state laws and rules, including timelines and ways to monitor progress. The plan was to address how Unity would assure that each client's needs were being met according to an up-to-date individualized service plan consistent with accepted medical and nursing standards;
- F. meet with Department staff and Hennepin County staff to answer questions about practices, violations of law, and the written plan of action;
- G. not admit new clients during the period of the conditional license; and
- H. notify and disclose to each client, or the client's contact person, that the Department was taking action against Unity's home care licenses by providing a copy of the notice to the Department of Health.

25. The Department believed there was evidence of "imminent danger" and "serious health and safety risk" to Unity's clients found in the May 2011 and October 2011 Surveys.⁵⁷ The Department decided not to suspend Unity's license because that would have disrupted clients who lived in the other two HSW locations that did not have the same type or number of violations that the Department found at the two HWS locations it identified.⁵⁸

26. With the approval of the Department, Unity hired two home care consultants, Pathway Health Services (Pathway) and Homecare Consultants, to comply with the condition that it hire a consultant.⁵⁹ Unity terminated the consultant contract with Homecare Consultants on approximately November 23, 2011, but continued to work with Pathway into January 2012 when it hired a Pathway employee to serve as the interim director of nursing.⁶⁰

27. Representatives of Hennepin County were unable to locate a provider that would agree take over the care of Unity's clients at the two HWS locations identified in the conditional license⁶¹ and Unity indicated that it was willing to continue to care for clients at these locations.⁶² The Department then modified the conditions to allow Unity to provide services at all four of the HWS establishments during the term of the conditional license.⁶³

⁵⁷ T. at 5025-7.

⁵⁸ T. at 5036, Unity Ex. 78.

⁵⁹ T. at 2475-7.

⁶⁰ T. at 2482.

⁶¹ T. at 2668.

⁶² T. at 2682-83.

⁶³ *Id.*

28. Unity submitted a revised plan of action on December 2, 2011, and indicated that the plan would be implemented by December 31, 2011.⁶⁴

C. Maltreatment Finding as to Beth Balenger

29. In November of 2011, the Department investigated a claim of maltreatment at Unity arising from conduct of Beth Balenger and determined that maltreatment had occurred.⁶⁵

30. As a result of the maltreatment determination, contained in OHFC Report #HL23694008, the Department placed another condition on Unity's home care license. The new condition became effective January 1, 2012, and provided that Balenger not have "direct, face to face contact with any of the clients" of Unity.⁶⁶

31. Ms. Balenger appealed the maltreatment determination through a fair hearing, after which the Commissioner of the Minnesota Department of Health (Commissioner) upheld the maltreatment determination. Ms. Balenger then appealed that decision to the Hennepin County District Court. On December 11, 2014, the District Court affirmed the decision of the Commissioner, and on December 15, 2014, judgment was entered in favor of the Department.⁶⁷

D. Unity's Compliance Efforts

32. The Department conducted a monitoring survey at Unity in January 2012.⁶⁸ Unity was not in compliance with the home care law and rules.⁶⁹ No fines were issued after those surveys because the Department determined to impose conditions on Unity's license in October 2011, requiring Unity to hire a consultant that would be paid for by Unity, so Unity was incurring costs by paying for the consultant. The Department believed that issuing fines in addition to requiring the consultant was duplicative.⁷⁰

33. The Department, Unity, and Unity's consultant met weekly to discuss Unity's progress toward meeting its revised plan of correction,⁷¹ and the consultants provided the Department with weekly reports.⁷² These progress reports from the consultant indicated that Unity and the consultants were making progress in bringing Unity into compliance with applicable health care law and rules.⁷³

⁶⁴ Department Exs. 16 and 17.

⁶⁵ Department Ex. 18.

⁶⁶ *Id.* at MDH 022985-022986; T. at 2685.

⁶⁷ Department Ex. 110.

⁶⁸ Department Ex. 24.

⁶⁹ *Id.*

⁷⁰ T. at 2689.

⁷¹ Unity Ex. 81.

⁷² Unity Ex. 75.

⁷³ *Id.*

34. Unity made significant efforts and spent significant money and resources in its work to come into compliance with applicable health care law and rules.⁷⁴ Unity made genuine efforts to improve its processes and procedures.⁷⁵ These efforts included engaging a social worker to do risk assessments for each of its clients.⁷⁶ Unity hired additional staff and engaged in training of its existing staff.⁷⁷

E. March 2012 Survey, and License Revocation and Nonrenewal

35. After receiving correspondence from Unity's counsel stating that Unity was in compliance with health care law and rules,⁷⁸ the Department conducted a survey of Unity in March of 2012 to determine whether Unity was in compliance. On March 22, 2012, the Department issued a 41 page set of correction orders.⁷⁹ In the March 2012 Survey, the Department found the following violations:⁸⁰

- A. Minn. Stat. § 144A.44, subd. 1(2) (Tag 0030); failure to provide care and services pursuant to a suitable and up-to-date care plan, and subject to accepted medical or nursing standards for one of one client (B6) with a PICC line; failure to evaluate two of two clients with memory and mobility deficits who had bed rails (A2 and A6); and failure to ensure that range of motion exercises were being provided according to the care plans for two of two clients whose record and services were reviewed (A5 and A6);
- B. Minn. R. 4668.0810 (2013) (Tag 6090); failure to ensure that three of five clients reviewed (B6, A6, and B2) had accurate, up-to-date plans that were available to all persons responsible for assessing, planning, and providing assisted living home care services to those clients;
- C. Minn. R. 4668.0815, subp. 2 (Tag 6110); failure to complete a reevaluation for one of four clients whose records were reviewed (A6);
- D. Minn. R. 4668.0825, subp. 3 (2013) (Tag 6160); failure to ensure that three of three unlicensed personnel who provided direct care to clients possessed the knowledge and skills consistent with the complexity of the nursing task being delegated (unlicensed staff BA, AI, and AH);

⁷⁴ T. 4956-59.

⁷⁵ *Id.*

⁷⁶ T. 4958.

⁷⁷ T. 4964-65.

⁷⁸ Department Ex. 87.

⁷⁹ Department Ex. 26.

⁸⁰ *Id.*

- E. Minn. R. 4668.0825, subp. 4 (Tag 6165); failure to ensure that one of three employees observed performing delegated tasks was instructed by the registered nurse prior to performing the delegated nursing procedures and had demonstrated competency and/or the registered nurse had specified in writing the specific instructions for performing the procedures (unlicensed personnel BA);
- F. Minn. R. 4668.0855, subp. 7 (Tag 6305); failure to ensure that unlicensed personnel were instructed by the registered nurse before performing delegated nursing tasks of medication administration, and that they had demonstrated competency prior to performing the procedure for one of two employees observed during medication administration (unlicensed personnel BA); and
- G. Minn. R. 4668.0855, subp. 9 (Tag 6315); failure to ensure that there was adequate and complete documentation of medications administered as directed by the physician for one of three clients whose medication administration was observed (Client A5).

36. Among the Unity clients whose medical care was found to be subject to a correction order during the March 2012 Survey were:

- A. Client B6 who returned to Unity from the hospital with a PICC line inserted in his vein for use in administration of antibiotics. Once back at Unity, B6 was given a shower by Unity staff without a watertight covering on the PICC line, which permitted the line to migrate and become wet. There were no instructions issued to Unity staff on how to properly deal with B6's PICC line.⁸¹ Unity admitted this tag was correct.⁸²
- B. Client A6 did not have a nursing assessment of the need for bed rails that were in use for him at Unity. Unity admitted this tag was correct.⁸³
- C. Client A6 did not receive proper range of motion exercises.⁸⁴ A6 was the same client who was the subject of a licensing order issued to Unity by OHFC in May 2011, for failure to provide range of motion exercises to A6 and another client.⁸⁵ Unity admitted this tag was correct.⁸⁶

⁸¹ T. at 1347-55, MDH Ex. 89.

⁸² T. at 2490-2491.

⁸³ T. at 2491.

⁸⁴ Department Ex. 53.I, MDH 001853; T. at 220-3 and 5287-8.

⁸⁵ MDH Ex. 12, MDH 009319, 009338-9.

⁸⁶ T. at 2495.

- D. By Unity's admission, Client A5 did not receive proper range of motion exercises.⁸⁷ This was caused because Unity's staff was not properly trained in the administration of these exercises.⁸⁸
- E. Unity staff permitted client A6's leg to drag when transporting A6 by wheel chair.⁸⁹
- F. Numerous other, less significant, deficiencies were also found by the Department, including deficient oral care, eating and swallowing care, and speech therapy of client A6.⁹⁰

37. The Department requested that the Minnesota Board of Nursing investigate Unity's nurses, as well as Judi Van Hauer, regarding errors while she was director of nursing.⁹¹ The Board of Nursing interviewed them all,⁹² but did not discipline anyone.

38. Unity did not provide care to clients under its Class A license in 2012.⁹³

39. Between January and March 2012, Hennepin County reviewed and was satisfied with Unity's facilities and extended Unity's contract with the County through 2013.⁹⁴ This review did not examine Unity's compliance with applicable health care law and rules.⁹⁵

40. In May 2012, there was confusion between Unity, the Minnesota Department of Human Services, and the Department as to the status of Unity's Class F license.⁹⁶ While this confusion was resolved, for a time, Unity was not paid by the Department of Human Services because it incorrectly believed that Unity did not have a valid Class F license.⁹⁷ Eventually, Unity was paid by the Department of Human Services.⁹⁸

41. By letter dated May 22, 2012, the Department notified Unity that it was revoking Unity's Class F Home Health Care License because of the findings in the May 2011, October 2011, and March 2012 Surveys that Unity had committed numerous violations of the home health care laws and rules.⁹⁹ The Department also revoked Unity's

⁸⁷ T. at 2513.

⁸⁸ Unity Ex. 127, MDH 001851.

⁸⁹ T. at 5308

⁹⁰ See Department Ex. 8.

⁹¹ Department Exs. 91-96.

⁹² *Id.*

⁹³ T. 5222.

⁹⁴ Unity Ex. 61; T. 3508-13.

⁹⁵ T. 3528.

⁹⁶ Unity Ex. 153; T 4012-17.

⁹⁷ *Id.*

⁹⁸ T. 5224.

⁹⁹ Department Ex. 27.

license because it failed to comply with law and rules by February 14, 2012 as required by the Conditional License issued to Unity on October 11, 2011.¹⁰⁰

42. The Department also provided notice to Unity that it was not renewing Unity's Class A license because the effect of the revocation of the Class F license and the operation of law meant that Unity's owners could not operate a Class A facility after the revocation of the Class F license.¹⁰¹

43. Unity's counsel sent a letter requesting a contested case hearing on June 6, 2012.¹⁰²

44. Blaine White Pine and River Birch Residence were Class F licensees.¹⁰³ Both entities were the subject of surveys, correction orders, and, in the case of River Birch Residence, license revocation.¹⁰⁴

45. No evidence was offered to show the race of the owners of Blaine White Pine and River Birch Residence.

F. June 2013 Survey

46. In June 2013, the Department again surveyed Unity and found the following violations:¹⁰⁵

- A. Minn. Stat. § 144A.44, subd. 1(2) (Tag 0030); failure to provide care and services pursuant to a suitable and up-to-date care plan, and subject to accepted medical or nursing standards for three of four clients who were reviewed (B6, A1, and A7);
- B. Minn. R. 4668.0810, subp. 6 (Tag 6090); failure to ensure that significant events and other information necessary to provide care and services were documented for three of four clients with skin conditions (B6, A1, and A7);
- C. Minn. R. 4668.0815, subp. 2 (Tag 6110); failure to evaluate the care and services pertaining to the wound care for one of four clients (A1);
- D. Minn. R. 4668.0855, subp. 2 (2013) (Tag 6280); failure to ensure that a registered nurse had completed a medication assessment for one of three clients whose records were reviewed (A1).

45. On July 26, 2013, the Department issued fines to Unity in the amount of \$250 for the violation of Minn. Stat. § 144A.44, subd. 1(2); a \$100 fine for the violation of

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² Department Ex. 28.

¹⁰³ See Unity Exs. 160 and 161.

¹⁰⁴ *Id.*

¹⁰⁵ Department Ex. 77.

Minn. R. 4668.0810, subp. 6; and a \$250 fine for the violation of Minn. R. 4668.0815, subp. 2.¹⁰⁶ These fines were based on the results of the June 2013 Survey, which found Unity had not corrected the conditions cited in previous correction orders.¹⁰⁷

CONCLUSIONS OF LAW

1. The Commissioner and the Administrative Law Judge have jurisdiction in this matter pursuant to Minn. Stat. §§ 14.50, 144A.46 (3)(a) (2014).

2. The Department gave proper notice of the hearing and all relevant procedural requirements of law and rule have been fulfilled.

3. Unity received due, proper, and timely notice of the basis for the agency's decision, and of the time and place of the hearing. This matter is, therefore, properly before the Commissioner and the Administrative Law Judge.

4. The Department is charged with the licensing and regulation of "home care providers." A home care provider is an entity "regularly engaged in the delivery, directly or by contractual agreement, of home care services for a fee."¹⁰⁸ Home care services include nursing services, personal care services, various types of therapies, home management services, and other similar medical services and health-related support services.¹⁰⁹

5. Unity meets the statutory definition of a "home care provider" and has been licensed by the Department since 2007.¹¹⁰

6. Home care licenses are issued for a period of one year and may be renewed upon submission of application renewal forms and the renewal fee.¹¹¹

7. The Commissioner "may refuse to grant or renew a license, or may suspend or revoke a license, for violation of statutes or rules relating to home care services or for conduct detrimental to the welfare of a consumer."¹¹² Prior to any suspension, revocation, or refusal to renew a license, the home care provider is entitled to notice and the opportunity for a contested case hearing.¹¹³

8. The Department inspects home care providers and issues correction orders and assesses civil penalties, as is necessary to ensure observance of state law in accordance with Minn. Stat. § 144.653, subds. 5-8 (2014), for violations of Minn. Stat. §§ 144A.43-.47 (2014) or the rules adopted under those sections.

¹⁰⁶ Department Ex. 79.

¹⁰⁷ *Id.*

¹⁰⁸ Minn. Stat. § 144A.43, subd. 4 (Department's Ex. 99).

¹⁰⁹ *Id.*, subd. 3.

¹¹⁰ *Id.*, subd. 4.

¹¹¹ Minn. Stat. § 144A.46, subd. 1 (2014).

¹¹² Minn. Stat. § 144A.46, subd. 3(a).

¹¹³ *Id.*, subd. 3(b).

9. Pursuant to Minn. Stat. § 144.653, subd. 5, correction orders must “state the deficiency, cite the specific rule violated, and specify the time allowed for correction.” Minn. Stat. § 144.653, subd. 6, provides that if the deficiencies as outlined in the correction order are not corrected upon reinspection then a notice shall be issued assessing a penalty for each uncorrected deficiency with the amount of fines as established in various subparts of Minn. R. 4668 (2013).

10. Pursuant to Minn. Stat. § 144A.46, subd. 3(a), the Department may impose conditions on the license of a home care provider for violation of the health care law and rules. The Department properly imposed conditions on Unity’s license in October of 2011 as a result of the correction orders it issued to Unity in May and October of 2011.

11. Unity is entitled to a contested case hearing if it receives a notice assessing penalties and, if the request for a hearing is made within 15 days of the receipt of the notice of assessment pursuant to Minn. Stat. § 144.653, subd. 8.

12. The Department has the burden of proof to establish, by a preponderance of the evidence that a sufficient basis exists for the revocation of Unity’s Class F home care license and for the assessment of penalties arising out of uncorrected violation. Unity has the burden of proof to establish, by a preponderance of the evidence, the facts to support any affirmative defense.¹¹⁴

13. The Department established by a preponderance of the evidence that Unity engaged in numerous and serious violations of statutes and rules relating to home care services such that the Department may revoke Unity’s Class F Home Health Care License.

14. Examples of the violations that support the conclusion that the Department met its burden of proof are listed in Findings of Fact 10, 13, 16, 20, 21, 22, 29, 30, 31, 35, and 36.

15. Accepted nursing standards require that when Unity determines that the use of bed rails may be appropriate for a specific client, Unity must assess that client to determine whether use of bed rails is appropriate.¹¹⁵ This requirement is based on recommendations made by the United States Food and Drug Administration beginning in the year 2000.¹¹⁶ Unity failed to meet this standard when it did not conduct assessments of use of bed rails for its clients A2 and A6, after it was made aware of this requirement in the correction orders issued after the May 2011 Survey.

16. Minnesota law requires that residents in Unity’s facility be free of physical restraints imposed for purposes of convenience.¹¹⁷

¹¹⁴ Minn. R. 1400.7300, subp. 5 (2015).

¹¹⁵ Department Ex. 107.

¹¹⁶ *Id.*

¹¹⁷ Minn. Stat. § 144D.07.

17. Unlicensed personnel (ULP) may provide assisted living home care services if they meet the training requirements specified in Minn. R. 4668.0835, before 2013 and in Minn. Stat. § 144A.4795, subds. 3, 4, after enactment in 2013. ULP may perform delegated nursing services if they have satisfied the requirements of Minn. R. 4668.0835 (2013) and Minn. Stat. § 144A.4794, subd. 3(b) (2014), and an RN has delegated the nursing services to the ULP.¹¹⁸ ULP must be trained by an RN regarding core assisted living home care services and successfully demonstrate competency in the topics described in rule and statute, after 2013.¹¹⁹ ULP may only administer medication or assist with self-administration of medication in accordance with the training and delegation specified at Minn. R. 4668.0855 and Minn. Stat. § 144A.4795, subd. 7, and the delegation must be delegated by an RN in accordance with the requirements of Minn. R. 4668.0835 and .0855 or, after 2013, with Minn. Stat. § 144A.4795, subd. 7. Unity violated these requirements when it failed to have its ULP trained in medication administration by an RN, as set forth in Findings of Fact 10 N-R, 16 L-N, 21, and 22.

18. Unity, as the licensee, was responsible for compliance with the home care law and rules by its staff and contractors. Home care providers that contract to provide home care services through another business must require the contractor to comply with the home care law and rules.¹²⁰ The services provided by contractors are part of the services provided under Unity's home care license, and Unity is responsible for ensuring those services are in compliance with the home care law and rules.¹²¹

19. Minnesota Statutes section 144A.46, subdivision 3(f) provides in part:

Notwithstanding the provisions of paragraph (a), the commissioner shall not renew, or shall suspend or revoke the license of any home care provider which includes any individual as an owner or managerial official who was an owner or managerial official of a home care provider whose Minnesota license was not renewed or was revoked as described in paragraph (d) for five years following the effective date of the nonrenewal or revocation. The commissioner shall notify the home care provider 30 days in advance of the date of nonrenewal, suspension, or revocation of the license.

20. By operation of Minn. Stat. § 144A.46, subd. 3(f), once the Department establishes that it properly revoked Unity's Class F Home Health Care license, the Department is required to deny Unity's application for renewal of its Class A Home Health Care license.

21. Pursuant to Minn. Stat. § 144.653, subd. 5, the Department has authority to issue correction orders and specify the time allowed for correction. Minn. Stat. § 144.653, subd. 6, provides that, if the deficiencies outlined in the correction orders are not corrected

¹¹⁸ Minn. R. 4668.0825; Minn. Stat. § 144A.4795, subd. 4 (2014).

¹¹⁹ Minn. R. 4668.0840; Minn. Stat. § 144A.4795, subd. 7 (2014).

¹²⁰ Minn. R. 4668.0008, subp. 3; Minn. Stat. § 144A.4794, subd. 5 (2014).

¹²¹ Minn. Stat. § 144A.4795 (2014).

upon reinspection, then a notice shall be issued assessing the penalty for each uncorrected deficiency with the amount of the fines as established at Minn. R. 4668.0230. The Department established by a preponderance of the evidence that it properly issued fines in the amount of \$250 for the violation of Minn. Stat. § 144A.44, subd. 1(2); a \$100 fine for the violation of Minn. R. 4668.0810, subp. 6; and a \$250 fine for the violation of Minn. R. 4668.0815, subp. 2.

22. Unity failed to establish by a preponderance of the evidence that the Department discriminated against it on the basis of the race of its owner.

23. Unity failed to establish by a preponderance of the evidence that the Department manipulated the sanctions it imposed on Unity and the maltreatment finding against Beth Balenger so as to deprive Unity of its appeal rights.

24. Unity failed to establish by a preponderance of the evidence that the Department issued more serious sanctions against it based on the race of its owner than the Department issued to the entities named Blaine White Pine and River Birch Residence. Unity failed to prove the race of the ownership of Blaine White Pine and River Birch Residence.

25. Unity failed to establish by a preponderance of the evidence that the Department interfered with Unity's right to be paid for services by the Department of Human Services.

26. Unity failed to establish by a preponderance of the evidence that the Department manipulated its correction order process in order to terminate Unity's Class F license by improperly issuing multiple tags for the same violations and misstating the fact basis for the issuance of the correction orders (Unity referred to this allegation as "stretching tags").

27. The issues in this proceeding are not mooted as a result of the Department's finding that all tags issued to Unity have been corrected.

28. The Department gave proper and timely notice to Unity of the nonrenewal of its Class A license pursuant to Minn. Stat. § 144A.46, subd. 3(f).

Based on the Findings of Fact and Conclusions of Law, and for the reasons set forth in the accompanying Memorandum, the Administrative Law Judge respectfully makes the following:

RECOMMENDATION

The Administrative Law Judge recommends that the revocation of Unity's Class F Home Care Provider License and the denial of the application for the renewal of the license for Unity's Class A Home Care Provider License be **AFFIRMED**. The Administrative Law Judge recommends that the decision to impose conditions on Unity's licenses in October of 2011 be **AFFIRMED**. The Administrative Law Judge recommends that the assessment of fines in the amount of \$600.00 against the Unity arising out of uncorrected violations be **AFFIRMED**.

Dated: August 10, 2015

s/Perry Wilson

PERRY WILSON
Administrative Law Judge

NOTICE

This Report is a recommendation, not a final decision. The Commissioner of Health will make the final decision after a review of the record. The Commissioner may adopt, reject or modify the Findings of Fact, Conclusions of Law, and Recommendations. Under Minn. Stat. § 14.61 (2014), the final decision of the Commissioner shall not be made until this Report has been made available to the parties to the proceeding for at least ten days. An opportunity must be afforded to each party adversely affected by this Report to file exceptions and present argument to the Commissioner. Parties should contact Edward Ehlinger, Commissioner, Minnesota Department of Health, 85 East Seventh Place, P.O. Box 64975, St. Paul, MN 55164, to learn the procedure for filing exceptions or presenting argument.

If the Commissioner fails to issue a final decision within 90 days of the close of the record, this Report will constitute the final agency decision under Minn. Stat. § 14.62, subd. 2a (2014). The record closes upon the filing of exceptions to the Report and the presentation of argument to the Commissioner, or upon the expiration of the deadline for doing so. The Commissioner must notify the parties and the Administrative Law Judge of the date on which the record closes.

Under Minn. Stat. § 14.62, subd. 1 (2014), the agency is required to serve its final decision upon each party and the Administrative Law Judge by first class mail or as otherwise provided by law.

MEMORANDUM

A. Class F License Revocation

Minnesota Statutes section 144A.46 provides that the Department may revoke Unity's Class F license if it concludes that Unity has engaged in conduct that is in violation of the statutes and rules relating to home care services or for conduct that is detrimental to the welfare of the consumer. In its letter dated May 22, 2012, the Department explained that its decision to revoke Unity's Class F license was based on its findings in the May 2011 Survey, the October 2011 Survey, and the March 2012 Survey that Unity violated the home health care law and rules and because Unity failed to comply with applicable law and rules by February 14, 2012, as required by the October 11, 2011 Conditional License. The Department has the burden of proving by a preponderance of the evidence that its revocation of Unity's Class F license meets the standard set forth in Minn. Stat. § 144A.46. Based on a careful review of the record, the undersigned Administrative Law Judge has concluded that the Department's decision to revoke Unity's Class F license is supported by a preponderance of the evidence.

In *City of Lake Elmo v. Metropolitan Council*,¹²² the Minnesota Supreme Court stated the following regarding the preponderance of the evidence standard:

The preponderance of the evidence standard requires that to establish a fact, it must be more probable that the fact exists than that the contrary exists. *Netzer v. N. Pac. Ry. Co.*, 238 Minn. 416, 425, 57 N.W.2d 247, 253 (1953). If evidence of a fact or issue is equally balanced, then that fact or issue has not been established by a preponderance of the evidence. *Id.* The preponderance of the evidence standard is a higher standard than the substantial evidence standard set forth in section 14.69, which is the typical evidentiary standard applied by appellate courts when reviewing agency decisions.¹²³

In this case, the Department has satisfied this burden by showing that it satisfied the standard set forth in Minn. Stat. § 144A.46, subd. 3(a) which provides in part:

The commissioner may refuse to grant or renew a license, may suspend or revoke a license, or may impose a conditional license for violation of statutes or rules relating to home care services or for conduct detrimental to the welfare of the consumer.

A preponderance of the evidence in this case supports the Department's decision. The Department conducted four surveys of Unity's houses before it reached the decision to revoke the Class F license. The first survey in May of 2011 found a wide range of violations. The follow up survey in October found some improvements, but also new violations. At this point, the Department decided it needed to impose conditions on Unity's

¹²² 685 N.W.2d 1 (Minn. 2004).

¹²³ *Id.* at 4

license, including the condition that Unity hire a consultant to advise it on compliance with health care law and rules.

Unity spent significant time and resources working with its consultant and reporting compliance progress to the Department from October 2011 through February 2012. Improvements in the level of care delivered at Unity and its administrative structure were achieved during this period. Unfortunately, these efforts were not sufficient to bring Unity into full compliance.

The March 2012 survey, made at the invitation of Unity's counsel and based on Unity's belief that it was in compliance with health care law and rules, instead showed that Unity was still not in compliance. Unity's owner admitted on cross examination that a number of compliance issues found in the March 2012 survey were true.¹²⁴

There were serious violations of the health care law and rules that endangered the health and safety of Unity's clients. The most serious of these were the failure to deliver proper diabetes care to client A3,¹²⁵ and the failure to properly instruct Unity staff on how to care for client B6's PICC line discovered in the March 2012 survey.¹²⁶ Both situations resulted in dangerous conditions, clearly detrimental to the health and welfare of these clients.

The Department's decision to revoke Unity's Class F license is also supported by the results of the maltreatment investigation of Unity's owner Beth Balenger, which found that Ms. Balenger maltreated one of Unity's clients by spraying the client with a hose in order to force the client to take a shower.

The Department moved for partial summary disposition on the merits of Tag 095, which is based on a finding of maltreatment by Beth Balenger. Before the hearing began, the Administrative Law Judge denied this motion because there was no final judgment to support the third element of the doctrine of *res judicata*. After that ruling, during the course of the hearing, Hennepin County District Court Judge Philip Carruthers issued an Order Affirming Commissioner of Health's Determination of Maltreatment, dated December 12, 2014.¹²⁷ Judge Carruthers affirmed the finding of maltreatment and ordered the entry of judgment.¹²⁸ This judgment was the element missing from the Department's earlier motion. The four elements articulated by the Minnesota Supreme Court in *Brown-Wilbert Inc. v. Copeland Buhl & Co. P.L.L.P.*,¹²⁹ are now present and the Administrative Law Judge finds the maltreatment conclusively established by the operation of the doctrine of *res judicata*.

Overall, the Administrative Law Judge has concluded that the Department gave Unity a substantial period to achieve compliance and Unity failed to do so. The conclusion

¹²⁴ See Finding of Fact 36.

¹²⁵ See *id.* at 20-22.

¹²⁶ See *id.* 36A.

¹²⁷ Department Ex. 110.

¹²⁸ *Id.* at 1-2.

¹²⁹ 732 N.W.2d 209, 220 (Minn. 2007).

that Unity's Class F license should be revoked is supported by a preponderance of the evidence.

B. Class A License Nonrenewal

The Department's decision to revoke Unity's Class F license leads, by operation of law, to the conclusion that the Department's decision to not renew Unity's Class A license should also be affirmed.

Minnesota Statutes section 144A.46, subdivision 3(f) provides, in part that:

Notwithstanding the provisions of paragraph (a), the commissioner shall not renew, or shall suspend or revoke the license of any home care provider which includes any individual as an owner or managerial official who was an owner or managerial official of a home care provider whose Minnesota license was not renewed or was revoked as described in paragraph (d) for five years following the effective date of the nonrenewal or revocation.

Given that revocation of Unity's Class F license is supported by the record, this statute requires the Department to refuse to renew Unity's class A license, because Unity's owner is now subject to the operation of the statute.

C. Evaluation of Unity's Claims of Race Discrimination

Unity argues that the Department's survey results, the conditional license, and the decision to revoke its Class F license should not stand because the Department discriminated against Unity on the basis of the race of its owner, who is African American. First, Unity asserts that the Department multiplied tags by issuing more than one tag based on the same Unity conduct. Unity also argues that the Department treated Unity differently than similarly situated Class F facilities owned by non-African American owned entities. Both of these claims start with the premise that Unity was treated differently than it would have been if it were owned not owned by an African American.¹³⁰ This legal requirement comes from race discrimination law and the United States Supreme Court's decision in *McDonnell Douglas Corp. v. Green*.¹³¹ Following *McDonnell Douglas*, the Minnesota Supreme Court decided, in *Hubbard v. United Press International*,¹³² to apply the legal criteria for discrimination analysis articulated in *McDonnell Douglas* to the Minnesota Human Rights Act.

The evidence in this case does not support Unity's claim that the Department multiplied tags to justify treating Unity differently than white-owned facilities. Unity emphasized the Department's use of the Bill of Rights set forth in Minn. Stat. § 144A.44 as the basis for a number of correction orders. The Department witnesses consistently testified that Department policy is to write tags based on the same facts for all violations of law and rule that are presented by each fact situation, including the Bill of Rights. Unity

¹³⁰ See, e.g., *Hubbard v. United Press International*, 330 N.W.2d 428, 441-42 (1983).

¹³¹ 411 U.S. 792 (1973).

¹³² 330 N.W.2d 428 (1983).

did not counter this testimony with evidence that the Department does not follow this approach. Therefore, Unity failed to prove this claim of discrimination by a preponderance of the evidence.

Similarly, the evidence does not support Unity's claim that the Department's enforcement process as to it, which included the issuance of correction orders, immediate correction orders, a conditional license and license revocation, was different for Unity than the process it followed for white-owned Class F license holders. The evidence presented by Unity focused onto Class F license holders, Blaine White Pine and River Birch.¹³³ There were a number of evidentiary issues that exist with this claim. First and most important, Unity did not offer evidence of the ownership of either entity. Therefore, the Administrative Law Judge has no basis for concluding that these are white-owned licensees. Second, any comparison is complicated by changes in the enforcement powers of the Department over time. For example the enforcement actions against River Birch began in 2006, while the first correction order was issued to Unity in 2011. Third, Unity offered no admissible evidence to show that Unity was similarly situated to River Birch and Blaine White Pine. Therefore, Unity failed to prove this claim of race discrimination by a preponderance of the evidence.

D. Nursing Board Evidence

The evidence showed that the Minnesota Board of Nursing interviewed each nurse who worked at Unity during the period 2011 to 2013, but none of them received any discipline from the Board. Unity argues that this shows the Department treated it differently because these nurses were responsible for the care that resulted in correction orders issued to Unity, but were not disciplined for that conduct. Unity's argument is flawed for two reasons. First, the Department and the Board of Nursing are separate entities that are charged with enforcing different statute and rules. There was no evidence showing that the care issues found at Unity would ordinarily have resulted in discipline issued by the Board of Nursing. Second, Unity is the licensee and is legally responsible for the care delivered in its facilities. So, the absence of discipline for the nurses does not show that Unity was unfairly treated.

E. Bed Rail Assessments

Unity argues that the Department's issuance of correction orders based on the absence of assessments for bed rails shows overreaching by the Department, and manipulation of the correction order process to make Unity appear noncompliant with the health care law and rules. Unity's argument is two-pronged. First, it argues that, as a Class F licensee, it was not obligated to perform bed rail assessments until 2012. Second, Unity argues that the Department intentionally refrained from issuing a correction order for the absence of assessments in October of 2011 in an effort to make Unity look noncompliant and to multiply the number of correction orders issued to Unity.

¹³³ Unity Exs. 160, 161, and 167.

The evidence showed bed rail assessments first became prevalent in 2000 when the United States Food and Drug Administration published standards for the assessment of bed rail use. The Department presented testimony indicating that bed rail assessments were required by nursing standards of care before May of 2011, when Unity received correction orders for the absence of bed rail assessments. A Department representative testified that she told Unity's administrator about the need for bed rail assessments in the exit interview after the May survey was completed. The correction orders received by Unity in August of 2011 for the May 2011 survey cited Unity for the absence of bed rail assessments. Unity's administrator testified that she understood that the use of bed rails required a doctor's order. There was also testimony that Class F facilities were not required to perform bed rail assessments, but that performing them is a best practice. On balance, the Administrative Law Judge finds that bed rail assessments were required of Class F facilities by nursing standards of care before the May 2011 correction orders, and that Unity's failure to perform the assessments or, at least raise the question of whether it was required to perform assessments when it received the correction orders in August 2011, is sufficient to support the issuance of a correction order.

The second issue is whether Unity should have received a correction order for the absence of bed rail assessments in October 2011 as a result of the follow up survey. This argument is a puzzling one. In essence, while arguing it received too many correction orders in general, here Unity argues that the failure by the Department to issue a correction order shows its malice towards Unity. The Department representative testified that the follow up survey process does not involve examination of medical records and, because that is where the assessments for bed rails would be, the follow up survey did not examine compliance by Unity. On balance, the Administrative Law Judge finds that Unity was on notice that bed rail assessments were required and that it failed to perform them, as found in the results of the March 2012 survey. The Department did not undertake to advise Unity on how to comply with the correction orders. That was the job of Unity's consultants. The conspiracy theory Unity advances about the October 2011 correction orders is unsupported by the evidence.

F. The Minnesota Department of Human Services Payment Issue

Unity argues that the Department interfered with the payment obligation between Unity and the Department of Human Services by providing misleading information about the status of Unity's licenses in order to put Unity out of business. The evidence showed that a staff member in the Department of Human Services consulted the Department's website and determined that Unity's Class F license had expired and refused to make payment for services Unity had rendered to its clients. As the evidence showed, after this initial refusal to pay, there was confusion between both departments as to the status of Unity's license. Eventually, Unity was paid for these services, with a delay of approximately two months. There was no evidence showing that the Department engaged in a deliberate effort to interfere with payment to Unity in an effort to put Unity out of business.

G. Mootness

Unity argues that this proceeding is moot and should be dismissed. The predicate for this argument is that the Department found Unity had corrected all existing tags in June of 2013, and that the goal of the Department's regulatory activities is compliance. Therefore, since Unity's compliance has been achieved this proceeding is moot.

As a matter of fact, Unity's argument is not supported by the record. The Department found violations of law and rule in the June 2013 Survey.

In *In re McCaskill*,¹³⁴ the Minnesota Supreme Court stated the issue of mootness arises when there is no longer an actual controversy between the parties.¹³⁵ In this case, even if there were no violations of law and rule found in the June 2013 Survey, there is an actual controversy between the Department and Unity over the revocation of Unity's Class F license and the refusal to renew Unity's Class A license. These actions were taken by the Department in 2012 and are not changed by Unity's subsequent claim to be in compliance in June of 2013. This proceeding is not moot.

H. Fines

Unity argues that the Department should have fined it after the October 2011 survey so it would have had the opportunity to appeal at an earlier point in the enforcement process. The Department's position is that it has discretion as to which enforcement tool to employ at which point in the process. Further, the Department explains that, having chosen to require Unity to hire a consultant as a part of the conditional license, imposing fines in addition would have imposed a financial hardship on Unity. The Administrative Law Judge agrees with the Department that it has the discretion under Minn. Stat. § 144A.46, subd. 3(a) to impose conditions on Unity's license. Nothing in this statute requires the Department to issue fines, as Unity argues. There was no evidence that the Department was trying to prevent Unity from appealing its licensing sanctions, but there was evidence that the Department considered whether its actions would permit Unity to appeal. The Administrative Law Judge finds that the Department's consideration of Unity's appeal rights is an appropriate part of its deliberative process.

P. M. W.

¹³⁴ 603 N.W.2d 326 (Minn. 1999).

¹³⁵ *Id.* at 327.