

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HEALTH

In the Matter of the Revocation of the
Class A Professional Home Care
Agency License and Class F Provider
License Issued to Mayfair Home
Health Services, Inc.

**FINDINGS OF FACT,
CONCLUSIONS AND
RECOMMENDATION**

This matter came on for hearing before Administrative Law Judge Kathleen D. Sheehy on March 11-12, 2008, at the Office of Administrative Hearings. The OAH hearing record closed following the receipt of post-hearing submissions from the parties on April 22, 2008.

Jocelyn F. Olson, Assistant Attorney General, 1200 Bremer Tower, 445 Minnesota Street, St. Paul, MN 55101, appeared on behalf of the Minnesota Department of Health (the Department).

Julie Osemeka, 6019 West 39th Street, St. Louis Park, MN 55416, appeared without counsel on behalf of Mayfair Home Health Services, Inc. (Licensee or Mayfair).

STATEMENT OF THE ISSUE

Should Mayfair's Class A Professional Home Care Agency License and Class F Home Care Provider License be revoked on the grounds that the owner and manager is disqualified, operated the facilities in violation of numerous home care agency statutes and rules, and performed acts detrimental to the health and safety of its clients?

The Administrative Law Judge concludes the licenses should be revoked.

FINDINGS OF FACT

1. The Department first licensed Mayfair Home Health Services in 2002 to operate as a Class A Professional Home Care Agency.^[1]

2. Under a Class A license, a provider may provide home care services in a client's place of residence, such as the client's home or a residential center.^[2]

3. Mayfair's most recent Class A license was effective April 22, 2007 to April 28, 2008.^[3]

4. The business address of Mayfair's Class A home care agency is: 1710 Douglas Drive, Suite 104, Golden Valley, MN 55422. The Golden Valley

location was a business office from which employees were sent out to other locations to provide care to clients.^[4]

5. The Department also licensed Mayfair in 2002 to operate as a Class F Home Care Provider.^[5]

6. Under a Class F license, a provider may provide nursing services, delegated nursing services, and other services performed by unlicensed personnel solely for residents of “housing with services” establishments registered under Minn. Stat. ch. 144D.^[6] Generally speaking, a “housing with services” establishment is an establishment providing sleeping accommodations to one or more adult residents, at least 80 percent of which are 55 years of age or older, and offering or providing, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services.^[7]

7. Mayfair’s most recent Class F license was effective April 22, 2007 to April 28, 2008.^[8]

8. The business address of Mayfair’s Class F facility is: 6019 West 39th Street, St. Louis Park, MN 55416. The St. Louis Park location was a residential facility where four clients lived and received services.^[9]

9. Julie Osemeka is the president, administrator, and 100 percent owner of Mayfair. She also worked as a personal care attendant for Mayfair.^[10]

Maltreatment Determination and Disqualification of Julie Osemeka

10. On May 11, 2007, following an investigation under the Vulnerable Adults Act, the Department of Health’s Office of Health Facility Complaints (OHFC) determined that Ms. Osemeka was responsible for neglect of a vulnerable adult by failing to obtain immediate medical attention for a Mayfair client with a traumatic brain injury who sustained second- and third-degree burns to 20 percent of his body during a scalding shower.^[11]

11. On July 11, 2007, the Department of Health sent Ms. Osemeka a letter notifying her of its finding of maltreatment and of her right to seek reconsideration of the finding.^[12] The letter also notified Ms. Osemeka that the OHFC had provided DHS with a copy of the maltreatment finding and that DHS would determine whether she was disqualified from having access to or direct contact with people served by her facility. The letter stated that DHS would contact her directly with its determination and that if she were disqualified she would be informed of her right to seek reconsideration of the disqualification.^[13]

12. On July 23, 2007, Ms. Osemeka filed a request for reconsideration of the maltreatment finding.^[14] By letter dated August 7, 2007, Arnold Rosenthal, Director of the OHFC, notified Ms. Osemeka that after reviewing her request, he determined that the maltreatment finding was proper and would not be changed. Mr. Rosenthal further notified Ms. Osemeka that if she wished to request a fair hearing on the maltreatment determination, she must submit a written request to the Department of Health within 30 days.^[15] Ms. Osemeka did not request a hearing on the maltreatment determination.^[16]

13. On July 23, 2007, DHS sent Ms. Osemeka a letter notifying her that it was in receipt of the finding that she was responsible for maltreatment of a vulnerable adult and that DHS had determined the maltreatment was “serious” under licensing laws and disqualified her from any position allowing direct contact with persons receiving services from programs licensed by DHS or the Department of Health.^[17] This letter further informed Ms. Osemeka that she could seek reconsideration of her disqualification by submitting a request for reconsideration to DHS within 30 days of receipt of the letter, and that if she failed to seek reconsideration, Mayfair would have to immediately remove her from any position allowing direct contact with or access to persons receiving services.^[18]

14. Ms. Osemeka did not request reconsideration or otherwise challenge the correctness of the information relied upon to disqualify her.^[19]

15. On Friday, August 24, 2007, DHS mailed to Ms. Osemeka a letter notifying her that because she had failed to seek reconsideration within 30 days, she could not work in any position allowing contact with or access to persons receiving services from Mayfair.^[20]

16. On Tuesday, August 28, 2007, Ms. Osemeka met with Arnold Rosenthal to discuss the August 24th letter she had received from DHS. In a letter confirming their meeting, Mr. Rosenthal reiterated that Ms. Osemeka was disqualified and could not have direct contact with or access to the clients receiving services at Mayfair. Mr. Rosenthal also requested assurance from Ms. Osemeka that there would be sufficient staff at Mayfair to provide necessary care given her disqualification.^[21]

17. Ms. Osemeka provided care to clients at the St. Louis Park facility through August 28, 2007.^[22] On August 29, 2007, she was present at Mayfair’s business office in Golden Valley when Department staff arrived to conduct a survey.^[23]

August 2007 Surveys of Mayfair

18. On August 29-31, 2007, the Department conducted a survey at Mayfair’s Golden Valley and St. Louis Park locations. Ms. Osemeka explained to surveyors at the Golden Valley office that all of Mayfair’s Class A clients were receiving services at Mayfair’s Class F licensed facility in St. Louis Park. In fact, Mayfair did have one Class A client who was receiving home care services from Mayfair in her home in Roseville, Minnesota.^[24]

Mayfair’s Class F license

19. On August 29-31, 2007, Mayfair had four clients residing in its St. Louis Park Class F home care facility. All four clients had complex care needs including tracheostomies requiring suctioning, tube feedings, insulin dependent diabetes, open wounds, colostomy, indwelling urinary catheters, nebulizer treatments, methicillin resistant staphylococcus, and seizures. In addition,

client's #2 and #3 were quadriplegics and totally dependent for care, and all four clients required the use of wheelchairs.^[25]

20. Based on its findings during the survey of Mayfair's Class F licensed facility, the Department issued a Correction Order identifying 38 violations.^[26] Many of the most serious violations cited in the Correction Order were based on Mayfair's failure to have a registered nurse (RN) conduct periodic supervision of staff and clients, as required by the statutes and rules governing the licenses.^[27] The records suggest that there had been no RN on Mayfair's staff for many months. When interviewed on August 29, 2007, the owner stated that Mayfair's registered nurse had been on leave for about two months and that a new RN would be starting soon.^[28]

21. The violations that occurred at Mayfair's Class F facility and that are identified in the Correction Order are described below:

Advertising

22. In an advertising flyer, Mayfair claimed to provide "24-hour skilled nursing . . . in a luxurious and quiet environment," and "skilled nursing services by Registered Nurses (RNs), Licensed Practical Nurses (LPNs)." During the inspection, Department staff found no evidence of 24-hour skilled nursing. There was no evidence that a registered nurse was providing any services to the clients, and only one LPN was observed to be working during the three days and two nights of the survey.^[29] In addition, the surveyors found the facility to be dirty (rather than luxurious) with missing sheet rock, a broken toilet, no toilet paper in the bathroom, and sticky fly paper hanging above the kitchen sink.^[30]

Client Notifications

23. Mayfair failed to provide a copy of the Minnesota Home Care Bill of Rights to each of the four current clients and failed to give each of these clients written notice regarding the process for filing complaints about Mayfair or its staff.^[31]

24. At the hearing, Mayfair offered into evidence documents that purported to be Admission Agreements for some of Mayfair's residents. These documents included acknowledgements signed by the residents of having received the Minnesota Home Care Bill of Rights.^[32] None of these documents were in the clients' records when Department staff reviewed them during the August 29-31, 2007 survey.^[33] None of them are original documents, and all of them contain modifications made in ink (names and dates) superimposed on otherwise photocopied documents. Some of them contain irregularities that suggest names and/or signatures were cut and pasted into the document from other sources.^[34]

Adequacy, Training, Supervision and Screening of Staff

25. Mayfair did not have adequate staff available to provide services to clients. On August 30-31, 2007, employee C worked the day, evening and night shift. When Department staff arrived at the facility at 7:30 a.m. on August 31, 2007, employee C was still there and appeared to be extremely fatigued. Similarly, the same LPN was observed to be on site during the day and evening shifts on August 29-31, 2007.^[35]

26. Mayfair failed to ensure that three of its unlicensed employees had tuberculosis screenings prior to having direct contact with clients. There was no evidence of the screenings in the employees' records, and Mayfair presented no evidence of tuberculosis screenings for these employees at the hearing.^[36]

27. Mayfair failed to maintain a current job description for one of its management employees. During the survey, employee B identified himself as "management" and stated he was hired to do "computer stuff." When asked by Department staff if he had a job description, employee B stated that he did not know and could not access the computer to see if a job description was maintained there.^[37]

28. Mayfair failed to ensure that employees who provided direct care received orientation to home care requirements before providing home care services. Mayfair also failed to show that its unlicensed staff satisfied the training requirements for performance of delegated medical or nursing procedures, including medication administration. According to Mayfair's own records, employees C, D and E provided delegated procedures to Mayfair's clients including suctioning, indwelling urinary catheter care, and colostomy care. There was no documentation in the personnel records of these employees that they were trained by a registered nurse to perform these cares or had demonstrated competency to a registered nurse before performing these cares.^[38] Likewise, there was no evidence that these employees had completed training for medication administration.^[39]

29. During the hearing, Mayfair offered into evidence documents purporting to be orientation sign-off sheets, competency evaluation checklists, and certificates of training for several Mayfair employees.^[40] None of these documents were in the employees' records when Department staff reviewed the employee records during the August 29-31, 2007 survey.^[41]

30. During the survey, Department staff copied a "Staff Orientation Outline & Sign-Off" sheet for one employee that contained only the employee's first name, signature, and date; none of the training topics were checked to indicate successful completion of training.^[42] During the hearing, however, Ms. Osemeka offered an orientation outline and signoff form, purportedly for that same employee. The form contained modifications made in ink—the employee's first and last name, position, date, and check marks to indicate successful completion of training—superimposed on an otherwise photocopied document.^[43] In addition, the employee signatures on the two forms are different.^[44]

31. Ms. Osemeka also offered into evidence three “Home Health Aide Medication Competency Evaluation” forms that purport to be for three different Mayfair employees.^[45] The competency evaluation forms are copies of the exact same document indicating the employees demonstrated competency in the listed areas, with employee names, dates, and slightly different test scores written in ink on an otherwise photocopied page. In addition, she offered certificates of completion of continuing education on medication administration for two employees that are clearly photocopies of the same document, with different employee names written in ink on the otherwise photocopied document.^[46]

32. Mayfair failed to ensure that a registered nurse supervised unlicensed personnel who performed services for three clients that required supervision. For example, client #3 had a diagnosis of quadriplegia, diabetes mellitus, and had an indwelling urinary catheter, tracheostomy, colostomy, and open areas. He began receiving services at Mayfair on January 23, 2007. His record indicated that cares were completed by unlicensed staff and an LPN. The record lacked evidence of supervisory visits by a registered nurse or monitoring visits by an LPN. Similarly, the record for client #4, who had a diagnosis of morbid obesity, diabetes, and cellulitis with open areas, indicated that services were provided by unlicensed personnel. Client #4 began receiving services at Mayfair on June 29, 2005, but his record contained only two supervisory notes signed by a registered nurse.^[47]

33. Mayfair failed to ensure that there was a policy to communicate up-to-date information to a registered nurse regarding the training and qualifications of available staff to determine the appropriateness of delegating tasks. When Department staff asked the LPN who she would call to communicate changes in clients’ conditions, she stated that she would call the owner (who is not a registered nurse). The LPN also stated that she did not know where to find a phone number for a registered nurse employed by Mayfair.^[48]

34. Mayfair failed to submit a background study for one management employee (B). When interviewed on August 29, 2007, the owner stated that employee B was hired to take over the management of the home care agency. The DHS background study unit verified on September 5, 2007, that it had not received a completed background study form for employee B.^[49]

Care and Services

35. Mayfair failed to ensure that care and services were provided according to accepted medical or nursing standards for its four current clients.

Client #3 has a diagnosis of quadriplegia and diabetes. On August 30, 2007, a surveyor observed the LPN giving client #3 his blood sugar check supplies, but not offering or attempting to perform the blood sugar check for him. Department staff observed the LPN watching television while client #3 checked his own blood sugar, using his teeth to hold the instrument because he could not use his hands. Department staff also observed client #3 draw up and administer his own insulin using his teeth and the heels of his hands to hold the

syringe. Client #3 stated that he started administering his own insulin because no one checked on him at Mayfair, which caused the timing of his insulin injections to be irregular and resulted in him feeling sick and shaky.^[50]

Client #3 requires foot care for wounds on his heels. On August 30, 2007, Department staff observed an open area slightly larger than an eraser on the back of client #3's right foot just above the heel by the tendon. Department staff observed the LPN change client #3's dressings without looking at the wound and potentially contaminating the wound with blood from a towel. When asked who last changed client #3's dressings, the LPN stated that the owner had changed the dressings about two weeks previously.^[51]

In addition to quadriplegia and diabetes mellitus, client #3 has a diagnosis of Methicillin resistant staphylococcus aureus (MRSA) and had an indwelling urinary catheter, colostomy and tracheostomy. On August 29-30, 2007, Department staff observed that the large collection canister on the suction machine in client #3's room was completely full of liquid with whitish sediment and particulate matter and had not been emptied in some time. Department staff also observed a Mayfair employee attempt to clean client #3's colostomy bag and stoma with water from a container that had previously been used to collect urine. The same employee (employee D) contaminated antibacterial ointment and lotion in client #3's room by touching both containers with gloved hands that had already touched drawers, tubing, and supplies.^[52]

Client #4 was dependent on agency staff for foot care because of physical limitations resulting from morbid obesity. Client #4 had been receiving skin care at least six days per week for the three weeks prior to July 19, 2007, when he was hospitalized for "chronic wounds/cellulitis and new athlete's foot with secondary maggots."^[53]

Mayfair also failed to ensure that services were provided according to nursing standards with respect to personal hygiene of clients. On August 30, 2007, Department staff observed that the shower area in the facility was dusty, and the bathtub was used to store equipment. Client #2 had a strong odor of urine on his person and in his room. There was no evidence in the nurse's notes that he had received a bath since he began receiving services from Mayfair on August 24, 2007. Client #3's toenails were very long and curling under the toe. The right big toe was black and purple. Client #3 stated that he was bathed two weeks previously, although there was no documentation of him having been bathed since before April 2007. Client #4 weighed in excess of 450 pounds and was wheelchair bound. The skin on his stomach was covered with black crustations about the size of a nickel. Client #4 stated that he did not receive baths or showers at Mayfair because it was difficult for him to fit into the shower and because he had open areas on his legs. He stated that agency staff was supposed to give him bed baths, but that "that just doesn't happen." Client #4 could not recall when staff had last assisted him to bathe. The agency bath list indicated that client #4 was to be bathed on Friday mornings in a shower chair with the assistance of one staff member. When interviewed on August 31, 2007,

employees C and D confirmed that client #4 was not bathed so that his wounds would not get wet.^[54]

36. Mayfair did not allow a client to refuse his anti-seizure medications, and instead sprinkled the medication on his food with each meal. There was no order in the client's record authorizing this practice.^[55]

37. Mayfair failed to treat a client with courtesy and respect. On August 31, 2007, Department staff observed the LPN behave in a disrespectful manner toward client #3. While changing the dressing on his feet, the LPN disregarded client #3's requests that she move the dressing down. When client #3 told the LPN, "you should do what I want," the LPN dropped his foot back onto the pillow stating, "I'm not putting up with this," and left the room for 45 minutes. When the LPN returned to the room, she did not speak to the client or look at him.^[56] In general, Department staff found the LPN to be flippant and rude when interacting with the Mayfair clients.^[57]

Client Records

38. Mayfair failed to have any records on the premises for six discharged clients (#6, #7, #8, #9, #10 and #11).^[58] Mayfair also failed to have complete client records for two of its four current clients. Client #2's record lacked physician's orders for his medications and treatments. Client #3's record also lacked physician's orders for his medications and treatments and lacked documentation relating to the services to be provided.^[59] Finally, in three of four clients' records, Mayfair failed to ensure that entries were authenticated with the name, date, and title of the person making the entry.^[60]

39. Mayfair failed to maintain complete medication records for three clients. On August 29, 2007, Department staff observed that clients #2, #3, and #4 had one-week supplies of their medications set out in "medi-set" containers (pill boxes). There was no documentation in the clients' records as to who had performed the weekly set-up of their medications. When interviewed, the LPN stated that she thought she had documented the medication set-up in each of the clients' records, but she was unable to find the documentation. In addition, documentation of medication administrations in clients' records lacked signatures, titles, and initials of all staff administering medications.^[61] By failing to document when medications were administered, Mayfair exposed clients to the risk of medication errors. There was no way for Mayfair staff to know by looking at a client record whether a medication had been given or not.^[62]

40. The records of three of the four current clients also lacked signed orders for medications and treatments. For example, there was no signed prescriber's orders for the 26 medications and treatments client #2 received. When interviewed by Department staff on August 29, 2007, the LPN indicated that she believed the list of medications from client #2's previous home care agency were adequate, but that she was working with the case manager to complete a chart of the prescriber's orders.^[63]

41. Mayfair failed to ensure that orders received by telephone were communicated to the registered nurse within one hour of receipt, and were immediately recorded in the client record. On August 29, 2007, the LPN administered 7.5 milligrams of Coumadin to client #4 at 8:20 p.m. A review of the client's record indicated that he had received 5 milligrams of Coumadin at 8:00 p.m. that same evening. There were no orders for either of these amounts of Coumadin in client #4's record. When questioned, the LPN stated that she had received the orders by telephone and had written them on a "sticky" note because she did not have time to document the orders in the client's record; however, the LPN was unable to find the note. The LPN also stated that she did not usually call a registered nurse regarding order changes or other client issues, and there is no evidence in the record that she reported these telephone orders to a registered nurse.^[64]

42. Mayfair failed to keep personal and medical information private for one of three current clients. During the survey, two clients mentioned to Department staff that client #3 was an illegal alien and that the owner was "carrying him as a charity case." When Department staff asked client #4 how he knew client #3's history, he said that he heard it from the owner of Mayfair.^[65]

Client Assessments and Evaluations

43. For each of Mayfair's four current clients, there was no evidence that a registered nurse conducted an individualized evaluation of client needs and established a written service plan for providing home care services.^[66] In addition, there was no evidence in the records of clients #2, #3 and #4 that a registered nurse conducted a nursing assessment of each client's functional status and need for medication administration.^[67]

44. For each of Mayfair's four current clients, there was also no evidence that a registered nurse assessed the clients' functional status and need for central medication storage, and developed a service plan for providing that service according to the clients' needs. All four clients received services, including central storage of medications.^[68]

45. Mayfair failed to ensure that an unlicensed employee reported to a registered nurse the administration of a pro re nata (PRN as needed) medication (Vicodin) to a client on August 1, 2007. The shift report for that date indicates that employee E administered Vicodin to a client, but there is no evidence that a registered nurse was notified that this medication was given.^[69]

46. Mayfair failed to implement a physician's order for one of its current clients. Client #3 had a physician's order dated February 20, 2007, for a "Podiatry eval for heel." There was no evidence that Mayfair scheduled the evaluation, that the evaluation took place, or that the client declined the referral for evaluation. When interviewed on August 30, 2007, client #3 stated that he never was seen by a podiatrist and that to his knowledge Mayfair had not made the ordered appointment. On that day, Department staff observed client #3 to have bilateral open areas on his heels and a spongy area on his left heel.^[70]

47. Mayfair failed to assess the four current clients for their susceptibility to abuse and potential to abuse other vulnerable adults. There was no evidence in the clients' records of vulnerability assessments and plans.^[71]

Control, Storage and Disposal of Medications

48. Mayfair failed to establish and maintain a medication control system. On August 30, 2007, Department staff noted that medications were set up incorrectly in the weekly "medi-set" containers (pill boxes) for three of the four current clients. For example, client #2 was missing two doses of Keppra in the Thursday and Friday slots of his container, client #3 had an extra tablet of Neurontin in two of the daily slots in his container, and client #4 had three extra medications in his pill container that could not be identified.^[72]

49. Mayfair failed to ensure that legend drugs prescribed for two clients were kept in their original container bearing the original prescription label. Mayfair also failed to ensure that all drugs were stored in locked compartments, and that schedule II medications were stored in separately locked compartments permanently affixed to the physical plant. During the survey, Department staff observed client medications in an unlocked refrigerator used by clients and staff, and schedule II drugs were stored in a locked metal box that was not permanently affixed to the physical plant. Mayfair also failed to ensure that unused portions of legend drugs were properly disposed of after clients were discharged from the facility. During the survey, Department staff discovered in Mayfair's central storage a box full of medications prescribed for six clients who were no longer receiving services from Mayfair.^[73]

Mayfair's Class A license

50. Except for one client, all of Mayfair's Class A clients were receiving home care services at Mayfair's Class F licensed facility in St. Louis Park. Based on the August 2007 survey, the Department issued a Correction Order identifying 28 violations relating to Mayfair's Class A license.^[74] Most of the facts underlying these violations are identical to those identified in the Correction Order relating to Mayfair's Class F licensed facility. These violations include misleading advertising, lack of adequate staff, failure to adequately train, screen or supervise unlicensed staff, failure to have complete client records, and failure to ensure that care and services were provided according to accepted medical or nursing standards for clients.^[75] The Department also identified violations of rules that are specific to Mayfair's Class A license. These violations are listed below.

51. Mayfair failed to establish written service agreements describing the services to be provided for each of its four current clients.^[76]

52. Treatment was not administered as ordered for one client. Client #3 was to receive weekly shampoos, a catheter change twice monthly, oxygen at bed time, heel wound cleaning and dressing, oxygen saturation rates checked every shift, oxygen tubing changed weekly, tracheostomy cares daily, suctioning every shift, catheter site care daily, colostomy care daily with bag emptied every

shift, and protective boots on at all times. There was no evidence of these treatments being administered as required.^[77]

53. The records for three of the four current clients lacked signed orders by the prescriber for medications and treatments administered.^[78]

54. Mayfair failed to renew orders at least every three months for two clients.^[79]

55. Mayfair failed to have records for one current client (#5) who received home care services in her home, and six discharged clients (#6, #7, #8, #9, #10 and #11).^[80] Mayfair also failed to have complete client records for two of its four current clients (#2 and #3).^[81]

56. Mayfair failed to establish and implement a quality assurance plan.^[82]

Resulting License Disciplinary Action

57. Based on its findings during the survey, the Department determined that the health and safety of Mayfair's clients were in imminent danger. On August 31, 2007, all four clients were removed from Mayfair's facility and admitted to Methodist hospital. Two of the clients remained at the hospital for an extended period of time. Hennepin County ultimately found new placements for all four clients.^[83]

58. As a result of the survey, the Department temporarily suspended Mayfair's Class A and Class F licenses for a 60-day period commencing September 5, 2007, and ending November 3, 2007. The notice of temporary suspension stated that, during the suspension period, the Department would be initiating the process to permanently revoke Mayfair's home care agency licenses.^[84] Mayfair requested a contested case hearing on the order of temporary suspension, but withdrew the hearing request shortly before the scheduled hearing date.^[85]

59. On October 1, 2007, the Department issued two sets of Correction Orders to Mayfair based on its findings during the survey. The Department also gave Mayfair written notice of its intent to revoke its Class A and Class F licenses on the grounds that Mayfair had violated statutes and rules relating to home care services and that Mayfair had performed acts detrimental to the welfare of its clients.^[86]

60. On November 6, 2007, the Department served Mayfair with a Notice and Order for Hearing. The hearing in this matter was originally scheduled for January 23, 2008.

61. On January 16, 2008, Ms. Osemeka (on behalf of Mayfair) requested a continuance of the hearing based on the ill health of her attorney, William Libby.

62. By Order dated January 17, 2008, the Administrative Law Judge granted Mayfair's request for a continuance, and the hearing was rescheduled to commence on March 11-12, 2008.

63. By letter dated March 3, 2008, William Libby withdrew as counsel for Mayfair.

64. At the beginning of the hearing on March 11, 2008, Ms. Osemeka requested another continuance in order to obtain new counsel. The Administrative Law Judge denied this request, and the hearing in this matter took place on March 11-12, 2008.

65. At the close of the hearing, the parties agreed to simultaneously submit post-hearing memoranda by April 2, 2008, and to submit any responsive memoranda by April 16, 2008.

66. On April 2, 2008, the Department submitted its post-hearing memorandum.

67. On April 16, 2008, the Licensee submitted a post-hearing memorandum. Attached to the memorandum were three letters. The first letter purports to be from client #4; the second letter from the parent of client #2; and the third letter from a former Mayfair employee. The Licensee also submitted a document entitled "Appeal Request" dated October 5, 2007, addressed to DHS, and signed by Julie Osemeka. The first page concerns an appeal of the termination of the Licensee's Minnesota Health Care Programs provider number. The remaining three pages are an unsigned copy of portions of Ms. Osemeka's request for reconsideration of the maltreatment finding. Lastly, the Licensee submitted what appear to be portions of client records from 2005 including nursing assessments, admission agreements, and medication profiles.^[87]

68. On April 22, 2008, the Department filed a motion to strike the attachments filed with the Licensee's post-hearing submission.

69. The OAH hearing record closed with the filing of the Department's motion to strike on April 22, 2008.

Based upon these Findings of Fact, the Administrative Law Judge makes the following:

CONCLUSIONS

1. The Commissioner and the Administrative Law Judge have jurisdiction in this matter pursuant to Minn. Stat. §§ 14.50 and 144A.46 (3)(a) (2006).

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

3. The Department is charged with the licensing and regulation of "home care providers."^[88] A home care provider is an entity "regularly engaged in the delivery, directly or by contractual agreement, of home care services for a

fee.”^[89] Home care services include nursing services, personal care services, and other similar medical services and health-related support services.^[90]

4. Mayfair meets the statutory definition of a “home care provider” and has been licensed by the Department since 2002. State law prohibits a home care provider from operating in the state without a license.^[91]

5. The Commissioner of Health “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.”^[92] 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.^[93]

6. State law requires owners and managerial officials of home care agencies to undergo background studies to determine whether they are disqualified under Minn. Stat. Chapter 245C. Chapter 144A provides, in relevant part: “No person may be involved in the management, operation, or control of a [home care] provider, if the person has been disqualified under the provisions of chapter 245C.”^[94] In addition, a disqualified individual may not provide direct contact services, or have access to, persons receiving services from programs licensed by the Department.^[95]

7. Disqualification occurs if the results of the background study conducted by DHS show that the person studied has one or more of the disqualifying characteristics set forth in Minn. Stat. §§ 245C.14 and 245C.15. Among the disqualifying characteristics are convictions or admissions to certain crimes, or a determination that the subject of the study committed serious maltreatment of a minor or a vulnerable adult.^[96] “Serious maltreatment” means, among other things, maltreatment resulting in serious injury which reasonably requires the care of a physician.^[97]

8. A disqualified individual may submit a request for reconsideration of the disqualification.^[98] Unless an individual’s disqualification is set aside, the individual may not be involved in the management, operation, or control of a home care provider.^[99]

9. Ms. Osemeka is the owner and administrator of Mayfair, a home care provider. As such, she meets the definition of “owner” and “managerial official” set forth in Minn. Stat. § 144A.46, subd. 5(a) (2006).

10. Ms. Osemeka’s disqualification is based on the finding that she was responsible for substantiated maltreatment of a vulnerable adult. Although Ms. Osemeka sought reconsideration of the maltreatment finding, she did not request a fair hearing to appeal the determination after the Department affirmed the maltreatment finding. As a result, the maltreatment finding is conclusive.^[100]

11. Ms. Osemeka did not submit a request to DHS for reconsideration of her disqualification, and she did not request a hearing on whether the disqualification should be set aside. Consequently, Ms. Osemeka’s disqualification is conclusive.^[101]

12. A determination of substantiated maltreatment of a vulnerable adult that is serious maltreatment is a disqualifying offense under state law, which carries with it a seven-year disqualification period.^[102]

13. State law permits disqualifications to be set aside if the disqualified individual demonstrates that he or she does not pose a risk of harm to any person receiving services from a licensed program.^[103] Ms. Osemeka's disqualification has not been set aside.

14. Because Ms. Osemeka's disqualification has not been set aside, she is prohibited from being involved in the management, operation, or control of Mayfair or another provider.^[104]

15. The Department is required to inspect home care providers and to issue correction orders and assess civil penalties, as is necessary to ensure observance of state law.^[105]

16. State law provides that the Commissioner may suspend, revoke or deny renewal of a license "if the licensee, an owner or managerial official of the licensee . . . is in violation of, or during the term of the license has violated, any of the requirements of this chapter or Minnesota Statutes, sections 144A.43 to 144A.47."^[106]

17. The Department has the burden of proof to establish, by a preponderance of the evidence, that good cause exists for taking adverse against Mayfair's licenses.^[107]

18. The Department has established that Mayfair engaged in numerous and serious violations of statutes and rules relating to home care services and engaged in conduct detrimental to the welfare of Mayfair's clients.^[108]

19. The Department demonstrated that Mayfair:

- a. used false, fraudulent, or misleading advertising in the marketing of its services, in violation of Minn. R. 4668.0019.
- b. failed to provide clients or their representatives written copies of the home care bill of rights and written notice of complaint procedures, in violation of Minn. R. 4668.0030, subp. 2 and 4, and 4668.0040, subp. 2;
- c. failed to ensure that adequate staff was available to provide services to clients, in violation of Minn. R. 4668.0050, subp. 1;
- d. failed to ensure that employees had tuberculosis screenings, orientation to home care requirements, and training prior to having direct contact with clients, in violation of Minn. R. 4668.0065, subp. 1, Minn. R. 4668.0805, subp. 1, Minn. R. 4668.0825, subp. 4, Minn. R. 4668.0835, subp. 2, and Minn. R. 4668.0835, subp. 5;
- e. failed to provide a job description for one management employee, in violation of Minn. R. 4668.0070, subp. 3;

- f. failed to have complete records for two of the four current clients, and six of six discharged clients at the facility, in violation of Minn. R. 4668.0810, subps. 1 and 6;
- g. failed to ensure that entries in client records were authenticated with the name, date, and title of the person making the entry, in violation of Minn. R. 4668.0810, subp. 5;
- h. failed to ensure that a registered nurse conducted an individualized evaluation of the client's needs and established a written service plan for four of the four current clients, in violation of Minn. R. 4668.0815, subp. 1;
- i. failed to ensure that there was a policy to communicate information to the registered nurse regarding the training and qualifications of available staff to determine the appropriateness of delegating tasks, in violation of Minn. R. 4668.0825, subp. 5;
- j. failed to ensure that a registered nurse supervised unlicensed personnel who performed services that required supervision for three clients, in violation of Minn. R. 4668.0845, subp. 2;
- k. failed to ensure that a registered nurse conducted a nursing assessment of the client's functional status and need for medication administration for three clients, in violation of Minn. R. 4668.0855, subp. 2;
- l. failed to ensure that a registered nurse delegated medication administration only to unlicensed persons who were qualified to provide delegated nursing services and had completed training for medication administration for three current unlicensed employees, in violation of Minn. R. 4668.0855, subp. 3;
- m. failed to ensure that a registered nurse instructed unlicensed persons in the correct procedure for medication administration for three current unlicensed employees, in violation of Minn. R. 4668.0855, subp. 4;
- n. failed to ensure that unlicensed personnel reported the administration of pro re nata (PRN as needed) medication to a registered nurse for one unlicensed employee, in violation of Minn. R. 4668.0855, subp. 5;
- o. failed to maintain complete medication records for three clients, in violation of Minn. R. 4668.0855, subp. 9;
- p. failed to ensure that there were signed orders for medications and treatments for three of four current clients, in violation of Minn. R. 4668.0860, subp. 2;
- q. failed to ensure that orders received by telephone were communicated to the registered nurse within one hour of receipt

and were immediately recorded or placed in the client's record for one of four clients, in violation of Minn. R. 4668.0860, subp. 7;

- r. failed to implement an order within 24 hours for one of two current clients, in violation of Minn. R. 4668.0860, subp. 8;
- s. failed to ensure that a registered nurse assessed the clients' functional status, need for medical storage, and developed a service plan for providing that service according to the clients' needs for four current clients, in violation of Minn. R. 4668.0865, subp. 2;
- t. failed to store, control and dispose of medications (legend and schedule II drugs) properly, in violation of Minn. R. 4668.0865, subps. 3, 5, 8 and 9, and Minn. R. 4668.0870, subp. 3;
- u. failed to ensure that care and services were provided according to accepted medical or nursing standards for four clients, in violation of Minn. Stat. § 144A.44, subd. 1(2);
- v. failed to allow the resident to refuse treatment for one client who chose not to take his medications, in violation of Minn. Stat. § 144A.44, subd. 1(5);
- w. failed to provide the right to have personal and medical information kept private for one of three current clients, in violation of Minn. Stat. § 144A.44, subd. 1(11);
- x. failed to treat clients with courtesy and respect for two of four current clients, in violation of Minn. Stat. § 144A.44, subd. 1(14);
- y. failed to ensure that a background study was conducted for one management employee, in violation of Minn. Stat. § 144A.46, subd. 5(b);
- z. failed to ensure that clients were assessed for their susceptibility to abuse and potential to abuse other vulnerable adults for four of the current clients, in violation of Minn. Stat. § 626.557, subd. 14(b);
- aa. failed to establish a written service agreement for four of the current clients and one client who lived in the community, in violation of Minn. R. 4668.0140, subp. 1;
- bb. failed to ensure that treatments were administered as ordered for one of the current clients, in violation of Minn. R. 4668.0150, subp. 2;
- cc. failed to ensure that there were signed orders for medications and treatments for three of the four current clients in violation of Minn. R. 4668.0150, subp. 3, and that orders were renewed at least every three months for two clients, in violation of Minn. R. 4668.0150, subp. 6;

- dd. failed to have records for one current client and six discharged clients, in violation of Minn. R. 4668.0160, subp. 1, and failed to have complete records for two of four current clients, in violation of Minn. R. 4668.0160, subp. 6; and
- ee. failed to establish and implement a quality assurance plan, in violation of Minn. R. 4668.0180, subp. 9.

20. Because the owner and manager of Mayfair is disqualified and the disqualification has not been set aside, because of Mayfair's numerous and serious violations of statutes and rules relating to home care services, and because of conduct detrimental to the welfare of Mayfair's clients, the Commissioner's revocation of Mayfair's Class A Professional Home Care Agency license and Class F Home Care Provider license is appropriate and warranted.

21. The Department's motion to strike Mayfair's extra-record evidence is granted in part. The Administrative Procedure Act and rules of the Office of Administrative Hearings require that this decision be based exclusively on the testimony and evidence presented at the hearing.^[109] Accordingly, the attachments to the post-hearing memorandum and the client records submitted therewith (identified in Finding No. 67) are not received into the evidentiary record and were not considered by the Administrative Law Judge in reaching this decision. These documents will, however, be marked separately and maintained in the record as an offer of proof.

Based upon the above Conclusions of Law, the Administrative Law Judge makes the following:

RECOMMENDATION

The Administrative Law Judge recommends that the revocation of Mayfair's Class A Professional Home Care Agency License and Mayfair's Class F Home Care Provider License be AFFIRMED.

Dated: May 14, 2008

s/Kathleen D. Sheehy

KATHLEEN D. SHEEHY
Administrative Law Judge

Reported: Digitally Recorded
No transcript prepared

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, and Recommendations. Under Minn. Stat. § 14.61, 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 Dr. Sanne Magnan, Commissioner, Minnesota Department of Health, 625 Robert Street North, P.O. Box 64975, St. Paul, MN 55164-0975, 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. 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, 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

Ms. Osemeka contends that she should be permitted to challenge the maltreatment determination in this proceeding, as it is the basis for her disqualification, which is in turn a partial basis for the proposed revocation. The Department's OHFC found that one of Mayfair's clients was neglected in January 2007 by both the personal care attendant who provided direct care to the client and by Ms. Osemeka. The attendant neglected the client by leaving him in the shower, despite her awareness of fluctuating water temperatures; and Ms. Osemeka neglected the client by failing to send him to the emergency room immediately after identifying the client's multiple severe burns. The attendant contacted Ms. Osemeka at about 9:00 a.m. the morning of the incident to inform her of the burns. Ms. Osemeka maintained that she followed Mayfair's policy by contacting the client's physician and following his direction to dress the burns with gauze and continue to monitor and observe him for several hours.^[110] When an LPN arrived at the facility at about 12:45 p.m., the LPN instructed her to call 911 and send the client to the hospital. At about 1:45 p.m., the client arrived at the emergency room in serious condition, with second- and third-degree burns on his hand, lower abdomen, penis, scrotum, bilateral thighs, and his back. The burns were red with open blisters, and the client was moaning in pain. He required wound excisions and skin grafting. His physician informed investigators that the client would have experienced extreme pain from the burns and should have gone to the hospital immediately.^[111] When contacted in the course of the maltreatment investigation, the physician denied having received a phone call from Ms. Osemeka "indicating the severity and extent" of the burns.^[112] During the hearing, Ms. Osemeka offered an affidavit from the physician confirming that

she had telephoned him, but not addressing whether the information she had provided to him adequately described the severity or extent of the client's burns.^[113]

After careful examination of the relevant statutes, the Administrative Law Judge has concluded that the maltreatment determination and the disqualification are conclusive and not subject to challenge in this proceeding, because Ms. Osemeka failed to request a hearing on the maltreatment determination and she failed to seek reconsideration of the disqualification decision. And because Ms. Osemeka is disqualified and her disqualification has not been set aside, she cannot manage or operate a home health care agency. Ms. Osemeka is, for all intents and purposes, Mayfair Home Health Services. The record reflects that she is the sole owner, operator, and management official having the responsibility for ongoing management or direction of Mayfair's policies, services, or employees. Revocation of Mayfair's license is accordingly appropriate pursuant to Minn. Stat. §§ 144A.46, subs. 3(a) and 5(a).

The Department argued in its post-hearing memorandum that Mayfair committed a separate and independent violation of Minn. Stat. § 144A.46, subd. 5(a), by failing to remove Ms. Osemeka from her role as manager and operator of the agency after receiving notice of her disqualification. Unlike the case cited in the post-hearing memorandum,^[114] however, the Department did not order Mayfair to immediately remove Ms. Osemeka from her managerial position, nor did it notify Ms. Osemeka that her disqualification prohibited her from being involved in the management, operation, or control of Mayfair. Instead, the August 24, 2007, letter from DHS informed Ms. Osemeka only that she was disqualified from any position allowing direct contact with or access to persons receiving services; Mr. Rosenthal's letter of August 28, 2008, said the same thing. When surveyors arrived on August 29, 2007, Ms. Osemeka was working in the Golden Valley office. In the absence of any notice that she could no longer be involved with the management or operation of Mayfair, her presence in the Golden Valley office that day does not establish an independent violation of Minn. Stat. § 144A.46, subd. 5(a).

The Administrative Law Judge has also concluded that the Department failed to prove one of the allegations of abuse cited in the Correction Order, which alleged that Mayfair failed to prevent the physical abuse of Client #3.^[115] This citation was based on a conversation between a surveyor and Client #3, who reported that an LPN had tried to choke him three to four months prior to the survey. The LPN denied harming Client #3 and told the Department that she had been on a leave of absence during the relevant time period and had only recently returned to the facility. She also loudly maintained that Client #3 was a liar. This evidence is insufficient to establish by a preponderance of the evidence that Mayfair failed to ensure Client #3's right to be free from physical abuse, in violation of Minn. Stat. § 144A.44, subd. 1(15). It is more appropriately viewed as additional evidence that staff failed to treat Client #3 with courtesy and respect, as required by Minn. Stat. § 144A.44, subd. 1(14).

The Licensee concedes, as she must, that there were many violations of statutes and rules relating to homecare services. She argues that she is willing to correct these violations and that Mayfair should be given another chance to demonstrate its compliance before revocation would be appropriate. The Department has presented overwhelming evidence that Mayfair engaged in numerous and serious violations of statutes and rules relating to home care services and engaged in conduct detrimental to the welfare of Mayfair's clients. The findings reflect that the Licensee did not have adequate staff and employed untrained and unsupervised individuals to provide services to seriously disabled clients. As a result, care and services were not provided according to accepted medical or nursing standards. Clients were not bathed, medications were not given, and wound dressings were not changed as frequently as required. In addition, the Licensee failed to maintain client and employee records, failed to observe proper control and storage of medications, and in at least one instance, failed to submit a background study for a management employee.

Moreover, the Administrative Law Judge has concluded that much, if not all, of the documentary evidence offered by Mayfair to show compliance with some of the rules was fabricated, and that Ms. Osemeka cannot be trusted either to maintain proper records or to tell the truth when questioned about her compliance with these requirements.^[116] Even absent the maltreatment determination and disqualification of Ms. Osemeka, the Administrative Law Judge concludes that the record would compel the revocation of Mayfair's license based on the pervasive nature of the serious violations found during the survey.

Ms. Osemeka further maintains that had she been permitted to enter the St. Louis Park facility during the survey, she would have been able to find many of the documents missing from staff and client files. The record reflects that Ms. Osemeka was in telephone contact with staff members in St. Louis Park during the survey and that one of the surveyors spoke to her outside the St. Louis Park facility and asked about the missing records. Ms. Osemeka told the surveyor that she would look for the records and fax them to the Department, but none were ever received.^[117] Furthermore, the Department asked for these documents in discovery before the hearing, and they were not provided. The law requires that licensees maintain specific client records for each client; it also requires that client records be readily accessible to personnel authorized to use them and that revocation may be an appropriate sanction if a licensee destroys or makes unavailable any records or other evidence relating to the licensee's compliance with statutes and rules.^[118] Ms. Osemeka had many opportunities to provide the missing documents to the Department, and her disqualification did not prevent her from responding to the allegations in the Correction Orders.

The evidence presented at the hearing fully supports the Department's proposed action to revoke Mayfair's Class A Professional Home Care Agency License and its Class F Home Care Provider License. The Administrative Law Judge recommends that the revocation of Mayfair's licenses be affirmed.

K.D.S.

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- [1] Testimony of Jean Johnston.
- [2] Minn. R. 4668.0012, subp. 3(A)(1) (2007); Testimony of Sarah Peterson.
- [3] Ex. 3.
- [4] Test. of S. Peterson.
- [5] Ex. 4.
- [6] See Minn. Stat. § 144D.01 (2006); Test. of S. Peterson.
- [7] Minn. Stat. § 144D.01, subd. 4.
- [8] Ex. 4.
- [9] Test. of S. Peterson.
- [10] Exs. 5 and 6.
- [11] Ex. 8 at 5-8.
- [12] Ex. 8. The Department initially sent the letter on May 24, 2007, to Ms. Osemeka's former home address in Andover, Minnesota. The post office returned the letter to the Department as undeliverable, and on July 11, 2007, the Department re-sent the letter to Ms. Osemeka's home address in Shakopee, Minnesota.
- [13] Ex. 8 at 4.
- [14] Ex. 8 at 10-15.
- [15] Ex. 8 at 16.
- [16] Testimony of Julie Frokjer.
- [17] Ex. 7. DHS initially sent this letter on July 13, 2007, to Ms. Osemeka's former home address in Andover, Minnesota. The post office returned the letter to DHS on or about July 23, 2007, at which time DHS re-sent a copy of the July 13th letter to Ms. Osemeka's home address in Shakopee, Minnesota.
- [18] Ex. 7.
- [19] Test. of J. Frokjer; Ex. 7 at 7.
- [20] Ex. 7 at 7.
- [21] Ex. 9.
- [22] Ex. 10 at 70.
- [23] *Id.*
- [24] Test. of S. Peterson; Testimony of Lisa Jacobsen.
- [25] Test. of S. Peterson; Ex. 11 at 6 and 11.
- [26] Ex. 11.
- [27] See, e.g., Minn. R. 4668.0845.
- [28] Ex. 11 at 18.
- [29] Ex. 11 at 3-4.
- [30] *Id.*
- [31] Ex. 11 at 4-5.
- [32] Exs. A-E. Exhibits A and E are Admission Agreements for two clients who were living in the facility at the time of the survey; Exhibits B, C, and D are Admission Agreements for three clients who were not living at the facility at the time of the survey.
- [33] Test. of S. Peterson.
- [34] Exs. A-E.
- [35] Ex. 11 at 6-7.
- [36] Ex. 11 at 8.
- [37] Ex. 11 at 9.
- [38] Test. of S. Peterson; Ex. 11 at 9 and 14-18; Exs. 19 and 20.
- [39] Ex. 11 at 18-19.
- [40] Exs. F-L.
- [41] Test. of S. Peterson.

- [42] Ex. 19.
- [43] Ex. I.
- [44] *Compare* Ex. I with Ex. 19.
- [45] Exs. F-H.
- [46] Ex. L.
- [47] Ex. 11 at 16-17.
- [48] Ex. 11 at 15.
- [49] Ex. 11 at 35.
- [50] Ex. 11 at 27-28.
- [51] Ex. 11 at 29.
- [52] Ex. 11 at 30.
- [53] Ex. 11 at 29.
- [54] Ex. 11 at 32.
- [55] Ex. 11 at 33.
- [56] Ex. 11 at 34.
- [57] Test. of S. Peterson, L. Jacobsen, and N. Wood.
- [58] Ex. 11 at 9-12.
- [59] Ex. 11 at 11.
- [60] Ex. 11 at 10-11.
- [61] Ex. 11 at 20-21.
- [62] Test. of L. Jacobsen.
- [63] Ex. 11 at 21-22.
- [64] Ex. 11 at 22.
- [65] Ex. 11 at 33.
- [66] Ex. 11 at 13-14.
- [67] Ex. 11 at 18.
- [68] Ex. 11 at 23.
- [69] Ex. 11 at 19 -20.
- [70] Ex. 11 at 23.
- [71] Ex. 11 at 35-36.
- [72] Ex. 11 at 24-25; Ex. 10 at 67.
- [73] Ex. 11 at 25-27; Test. of S. Peterson.
- [74] Ex. 10.
- [75] Ex. 10.
- [76] Ex. 10 at 21.
- [77] Ex. 10 at 22.
- [78] Ex. 10 at 22-23.
- [79] Ex. 10 at 23.
- [80] Ex. 10 at 23.
- [81] Ex. 10 at 25.
- [82] Ex. 10 at 27.
- [83] Test. of S. Peterson.
- [84] Ex. 14.
- [85] *In the Matter of the Temporary Suspension of the Class A Professional Home Care Agency License and Class F Home Care Provider License Issued to Mayfair Home Health Services, Inc.*, OAH Docket No. 3-0900-19194-2.
- [86] Ex. 15.
- [87] One of the documents is an Admission Agreement for the same client identified in Ex. B, but it contains a different client signature, and the name of the nurse witness is different.
- [88] Minn. Stat. §§ 144A.43-.47 (2006) and Minn. R. Ch. 4668 (2007).
- [89] Minn. Stat. § 144A.43, subd. 4.
- [90] Minn. Stat. § 144A.43, subd. 3.
- [91] Minn. Stat. § 144A.46, subd. 1(a).
- [92] Minn. Stat. § 144A.46, subd. 3(a); *see also* Minn. R. 4668.0012 (15).
- [93] Minn. Stat. § 144A.46, subd. 3(a).
- [94] Minn. Stat. § 144A.46, subd. 5(a).

- [95] Minn. Stat. § 245C.14, subd. 1.
- [96] Minn. Stat. § 245C.15, subd. 4(b).
- [97] Minn. Stat. § 245C.02, subd. 18(a).
- [98] Minn. Stat. § 245C.21.
- [99] Minn. Stat. § 144A.46, subd. 5(a) (The statute provides, in relevant part: “No person may be involved in the management, operation, or control of a [home care] provider, if the person has been disqualified under the provisions of chapter 245C.”).
- [100] Minn. Stat. § 245C.29, subd. 1(3).
- [101] Minn. Stat. § 245C.29, subd. 2(a).
- [102] Minn. Stat. §§ 245C.15, subd. 4(b)(2); Minn. Stat. § 626.557.
- [103] Minn. Stat. § 245C.21, subd. 3(3).
- [104] Minn. Stat. § 144A.46, subd. 5(a).
- [105] Minn. Stat. §144A.45, subd. 2(a)(1), (2) and (4) (2006); Minn. R. Ch. 4668.
- [106] Minn. R. 4668.0012, subp. 15(A).
- [107] Minn. R. 1400.7300, subp. 5.
- [108] Minn. Stat. § 144A.46, subd. 3(a); Minn. R. 4668.0012, subp. 15.
- [109] Minn. Stat. § 14.60, subd. 2; Minn. R. 1400.7100, subp. 2 and 1400.7300, subp. 2.
- [110] Ex. 8 at 11-14. The investigation records reflect that there was no registered nurse available to assess the client at Mayfair. Ms. Osemeka contacted a registered nurse, who she described as a friend, for advice on how to respond to the burns. The nurse told investigators she advised Ms. Osemeka to call 911 and send the client to the emergency room.
- [111] Ex. 8 at 6-8.
- [112] Ex. 8 at 8.
- [113] Ex. M.
- [114] *In re Loving Care Nursing and Home Care Services*, OAH Docket No. 8-0900-17632-2, Findings of Fact, Conclusions and Recommendation (July 20, 2007).
- [115] See Ex. 10 at 65.
- [116] See Exs. A-L and 19-20.
- [117] Test. of S. Peterson.
- [118] See Minn. R. 4668.0160; 4668.0810; 4668.0012, subp. 15, Item I.