

STATE OF MINNESOTA  
OFFICE OF ADMINISTRATIVE HEARINGS  
FOR THE DEPARTMENT OF HUMAN SERVICES

In the Matter of the Appeal by New Horizon  
Academy of Determination of Maltreatment  
and Order to Pay a Fine

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

This matter came before Administrative Law Judge James E. LaFave for an evidentiary hearing on October 7, 2014. The hearing was held at the Office of Administrative Hearings, 600 North Robert Street, St. Paul, MN 55101.

Marsha Eldot Devine, Assistant Attorney General, appeared on behalf of the Minnesota Department of Human Services (Department). Jonathan Geffen, Arneson & Geffen, PLLC, appeared on behalf of Respondent New Horizon Academy (Licensee or NHA).

**STATEMENT OF THE ISSUES**

1. Did the Department properly determine that the Licensee NHA as a facility, was responsible for the maltreatment by neglect of a minor child pursuant to Minn. Stat. § 626.556, subd. 2(f)(1) and (2) (2014)? Specifically, on November 20, 2013, was NHA culpable of neglect when, unbeknownst to NHA, a child gave cereal which contained peanuts to a child with a known peanut allergy, and is the faculty responsible for failing to protect the child from conditions that seriously endangered his physical health?

2. If NHA was responsible for maltreatment, did the Department properly imposed a fine of \$1,000 pursuant to Minn. Stat. § 245A.07, subd. 3(c)(4) (2014)?

**SUMMARY OF RECOMMENDATIONS**

The Administrative Law Judge concludes that the Department has failed to show, by a preponderance of the evidence, that the Licensee was responsible for the maltreatment by neglect of a four-year-old child. Therefore, the Administrative Law Judge recommends that the Commissioner of the Department of Human Services (Commissioner) reverse the finding of maltreatment, and vacate the Order to Pay a Fine.

Based on the evidence in the hearing record, the Administrative Law Judge makes the following:

## FINDINGS OF FACT

### NHA's Policies and Procedures

1. The Licensee, NHA, operates a child care center located at 8547 Edinburgh Center Drive, Brooklyn Park, Minnesota.<sup>1</sup> The Brooklyn Park facility is one of 60 programs run by NHA in Minnesota.<sup>2</sup>

2. NHA recognized that food allergies have grown exponentially over the past ten years.<sup>3</sup> Starting in 2004, NHA stopped serving food that contained peanuts in their facilities and also began training their staff on food allergies.<sup>4</sup>

3. NHA strives to have a peanut free environment.<sup>5</sup> It does not knowingly serve peanut products.<sup>6</sup> Under NHA's policy, no peanuts or peanut products should be served or kept in the kitchen or classroom cupboards.<sup>7</sup> Because of the risk of peanut allergies, staff at NHA are specifically warned to be alert to cakes, cookies, and other treats parents bring to the centers for special occasions.<sup>8</sup>

4. It is also NHA's policy to discourage parents or students from bringing outside food into their facilities.<sup>9</sup>

5. There is no statute, rule, or Department licensing requirement that mandates a facility be peanut free or that bans parents or students from bring food into a licensed facility.<sup>10</sup>

6. NHA published the *New Horizon Academy Peanut Allergy Facts*, which describes peanut allergies and how to treat them.<sup>11</sup>

7. It is NHA's policy to post a sign on the door of the classroom of any student who has a food allergy.<sup>12</sup> In this case, a sign was posted on the door of the classroom which stated: "Attention! This room has peanut allergies."<sup>13</sup>

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<sup>1</sup> Exhibit (Ex.) 1 at 3.

<sup>2</sup> Testimony (Test.) of Chad Dunkley.

<sup>3</sup> *Id.*

<sup>4</sup> *Id.*

<sup>5</sup> Test. of Naomi Kolodziejczyk; Ex. 103 at 6, Ex. 105.

<sup>6</sup> Ex. 6 at 3.

<sup>7</sup> Ex. 105.

<sup>8</sup> *Id.*

<sup>9</sup> Test. of N. Kolodziejczyk.

<sup>10</sup> Test. of Alice Percy.

<sup>11</sup> Ex. 104.

<sup>12</sup> *Id.*

<sup>13</sup> Ex. 12 at 60.

8. Signs, such as those posted by NHA outside of the classroom notifying people a student has an allergy, are not mandated by statute, rule, or Department licensing requirements.<sup>14</sup>

9. As required by law,<sup>15</sup> NHA developed a “Child Care Center Risk Assessment and Risk Reduction Plan.”<sup>16</sup> By law, the plan must identify risks to the children served by the center and develop procedures to minimize the identified risks.<sup>17</sup>

10. In addressing the risk of feeding children food to which they are allergic the NHA plan states:

Upon enrollment parent are required to fill out forms (NH121 and NH121a) with regard to their child’s allergies and to notify New Horizon Academy if there are any changes to their child’s allergies going forward. In each classroom there is a posting, including the child’s photo, indicating which children are currently affected by allergies and a complete description of the same. All staff are trained on the risk of harm posed by feeding children foods to which they are allergic:

- Daily Education, Day 2-Health (NH550)
- Center Orientation (NH547)
- 2011 DHS Alert
- Substitute Orientation (NH523)<sup>18</sup>

11. As part of its investigation in this case the Department reviewed NHA’s risk reduction plan.<sup>19</sup> There was no finding by the Department that NHA’s risk reduction plan was insufficient or that it needed to be upgraded.<sup>20</sup>

12. In conformity with the law and its risk reduction plan, NHA staff posted the picture of each child, including the child in question, affected by an allergy and a description of that allergy, in each classroom.<sup>21</sup>

13. NHA’s Health and Safety Committee developed an Introduction to Food Allergy and Special Food Needs Guidelines and Procedures at New Horizon Academy.<sup>22</sup>

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<sup>14</sup> Test. of A. Percy.

<sup>15</sup> See Minn. Stat. § 245A.66, subd. 2 (2014).

<sup>16</sup> Ex. 15.

<sup>17</sup> Minn. Stat. § 245A.66, subd. 2.

<sup>18</sup> Ex. 15 at 94.

<sup>19</sup> Test. of A. Percy.

<sup>20</sup> *Id.*

<sup>21</sup> Test. of A. Percy; Ex. 12.

<sup>22</sup> See Ex. 100.

14. NHA trained its staff to recognize that certain allergens may be hidden.<sup>23</sup> Staff were trained on the preparing, cooking, serving, and storing of food as it relates to allergies.<sup>24</sup>

15. The Department, from time to time, issues alerts to highlight areas where the Division of Licensing has seen injury or harm to children, and to offer suggestions on prevention.<sup>25</sup> NHA train their staff on the alerts issued by the Department.<sup>26</sup> In 2009 and 2011, the Department issued an alert on allergies.<sup>27</sup>

16. There is an orientation for parents of children enrolled at NHA.<sup>28</sup> At the orientation, parents are told of NHA's policies, including that NHA strives to be peanut free and that parents are discouraged from bringing food into the facility.<sup>29</sup>

17. At the orientation parents are given the handbook which contains all of NHA's policies.<sup>30</sup> As explained at the orientation and as described in the handbook, families are expected to notify NHA regarding any food allergies their children may have.<sup>31</sup>

### **NHA Experienced Aide Latterran Gross and Her Training**

18. Latterran Gross is an experienced aide and has been working at NHA for six-and-a-half years.<sup>32</sup> Ms. Gross was working in the pre-4 classroom on the day in question.<sup>33</sup>

19. Employees of NHA are given an extensive five day training program.<sup>34</sup> The training program teaches NHA's employees the company's policies and procedures.<sup>35</sup> Each employee is given the *Employee Education Manual*, which details NHA's policies.<sup>36</sup> In addition, employees of NHA are given a one hour training course every year to review NHA's risk reduction plan.<sup>37</sup>

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<sup>23</sup> Ex. 101.

<sup>24</sup> *Id.*

<sup>25</sup> See Ex. 116.

<sup>26</sup> Test. of Latterran Gross.

<sup>27</sup> Ex. 116.

<sup>28</sup> Test. of N. Kolodziejczyk.

<sup>29</sup> *Id.*

<sup>30</sup> *Id.*

<sup>31</sup> *Id.*, Ex. 106.

<sup>32</sup> Test. of L. Gross.

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

<sup>35</sup> Test. of N. Kolodziejczyk; Ex. 103 at 6.

<sup>36</sup> See Ex. 107.

<sup>37</sup> Ex. 119.

20. Employees are taught to be aware of food allergies and to know the steps to take if a child eats a problem food.<sup>38</sup> Employees are specifically trained on how to respond if a child has an allergic reaction.<sup>39</sup>

21. Before an NHA staff member is allowed to work in a classroom they must watch *It Only Takes One Bite/Alexander the Elephant*, a video on food allergies.<sup>40</sup>

22. In December of 2007, Ms. Gross completed NHA's five day training course.<sup>41</sup> The training specifically covered NHA's policies on striving to be a peanut free environment and discouraging people from bringing food into the classrooms.<sup>42</sup>

23. Ms. Gross watched the video *It Only Takes One Bite/Alexander the Elephant* and was trained on how to respond if a child consumes food to which the child was allergic.<sup>43</sup>

24. Ms. Gross received training on the Department's 2009 alert on allergies.<sup>44</sup> Ms. Gross also received training on the 2011 Department alert on allergies.<sup>45</sup>

25. In 2011, Ms. Gross completed NHA's five day training course for a second time when she returned from maternity leave.<sup>46</sup> The training again included a review of NHA's policies on striving to be a peanut free environment and to discourage people from bringing food into the classrooms.<sup>47</sup> As part of the training she also watched the video *It Only Takes One Bite/Alexander the Elephant*, and was again trained on how to respond if a child consumes food to which it was allergic.<sup>48</sup>

26. Ms. Gross testified that while she was trained to discourage food being brought into her classroom, if food was brought into the classroom, she would get rid of it.<sup>49</sup>

### **The Events of November 20, 2013**

27. Ms. Gross was working in the Pre-4 classroom the morning of November 14, 2013.<sup>50</sup> There was a sign on the door to the classroom which read "Attention! This room has peanut allergies."<sup>51</sup>

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<sup>38</sup> Ex. 107.

<sup>39</sup> Test. of L. Gross.

<sup>40</sup> Test. of N. Kolodziejczyk; Ex. 114.

<sup>41</sup> Test. of L. Gross; Ex. 113.

<sup>42</sup> *Id.*

<sup>43</sup> Test. of L. Gross; Exs. 113 - 114.

<sup>44</sup> Ex. 116.

<sup>45</sup> *Id.*

<sup>46</sup> Test. of L. Gross.

<sup>47</sup> *Id.*

<sup>48</sup> *Id.*

<sup>49</sup> *Id.*

<sup>50</sup> *Id.*

<sup>51</sup> Ex. 12 at 60.

28. "Steve," a student in the pre-4 class, was a four-year-old boy with peanut allergies.<sup>52</sup> "Steve" arrived around 8:00 that morning.<sup>53</sup>

29. "Sally", another student, entered the Pre-4 classroom with her grandmother ten minutes later.<sup>54</sup> Ms. Gross saw that "Sally" had a zip lock bag with her, but could not tell what the bag contained.<sup>55</sup> Ms. Gross asked the grandmother about the zip lock bag, but the grandmother just laughed.<sup>56</sup> Ms. Gross considered checking the bag, but it was very busy with parents who were dropping off other students.<sup>57</sup> Ms. Gross was responsible for greeting arriving students and writing down the parents' names as they came in.<sup>58</sup>

30. "Sally" went over to the table where "Steve" was playing with some magnetic toys.<sup>59</sup> There was cereal that contained peanuts in "Sally's" zip lock bag. She shared her cereal with "Steve."<sup>60</sup>

31. "Steve" immediately began crying.<sup>61</sup> Ms. Gross asked him what was wrong.<sup>62</sup> "Steve" told her he ate something with peanut butter.<sup>63</sup> Ms. Gross asked "Sally" for the cereal and threw it away.<sup>64</sup>

32. "Steve" began throwing up and his face started to swell.<sup>65</sup> Jenny Xiong, the lead teacher in the classroom, went and got an EpiPen® (epinephrine).<sup>66</sup> Ms. Gross grabbed the emergency handbook.<sup>67</sup>

33. Ms. Gross then administered the EpiPen® to "Steve" and gave him Benadryl.<sup>68</sup>

34. "Steve's" parents were called and the parents said they would take "Steve" to the hospital.<sup>69</sup> "Steve" responded well to the EpiPen® and Benadryl, but remained at the hospital for six hours for observation.<sup>70</sup>

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<sup>52</sup> Test. of L. Gross; Ex. 7 at 42.

<sup>53</sup> *Id.*

<sup>54</sup> *Id.*

<sup>55</sup> Test. of L. Gross.

<sup>56</sup> *Id.*

<sup>57</sup> *Id.*

<sup>58</sup> Ex. 7 at 43.

<sup>59</sup> Ex. 7 at p. 42.

<sup>60</sup> *Id.*

<sup>61</sup> Ex. 7 at p. 43.

<sup>62</sup> *Id.*

<sup>63</sup> *Id.*

<sup>64</sup> *Id.*

<sup>65</sup> *Id.*

<sup>66</sup> *Id.*

<sup>67</sup> *Id.*

<sup>68</sup> *Id.*

<sup>69</sup> Test. of L. Gross.

<sup>70</sup> *Id.*

35. "Steve" returned to NHA for class the next day.<sup>71</sup>

36. NHA staff did not see "Sally" bring food into the classroom, nor did staff see "Sally" share her cereal with "Steve."<sup>72</sup>

37. The Department conceded that NHA's staff followed their training and "Steve's" allergy plan in reacting to "Steve's" allergic reaction. and that the NHA staff responded properly in this case.<sup>73</sup>

38. After the incident, NHA conducted an internal investigation.<sup>74</sup> Mr. Gross was interviewed as part of that investigation.<sup>75</sup> Ms. Gross told NHA's internal investigators that she did not see what was in "Sally's" zip lock bag and that she did not see "Sally" share her food with "Steve."<sup>76</sup>

39. Any findings of fact contained in the following Memorandum are adopted as such.

### CONCLUSIONS OF LAW

1. The Administrative Law Judge and the Commissioner of Human Services are authorized to consider an appeal of a maltreatment determination and the fine assessed for violating the child care licensing rules, pursuant to Minn. Stat. §§ 14.50, 245A.07, subd. 3(c)(1); .08; 626.556 (2014).

2. The Notice and Order for Prehearing Conference and Hearing is proper in all respects and the Department complied with all substantive and procedural requirements of law and rule. This matter is, therefore, properly before the Commissioner and the Administrative Law Judge.

3. At a hearing of an appeal from a determination of maltreatment order, the Department has the burden to prove by a preponderance of the evidence that an act that meets the definition of maltreatment occurred.<sup>77</sup>

4. At a hearing of an appeal of an order to pay a fine, the Department may demonstrate reasonable cause for the action taken by submitting statements, reports, or affidavits to substantiate the allegations that the license holder failed to comply fully with applicable law or rule. If the Department demonstrates that reasonable cause existed, the burden of proof shifts to the license holder to demonstrate by a preponderance of the evidence that it was in full compliance with those laws and rules at the relevant times.<sup>78</sup>

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<sup>71</sup> Test. of L. Gross; Ex. 7 at 44.

<sup>72</sup> Test. of A. Percy; Test of L. Gross; Ex. 7.

<sup>73</sup> Test. of A. Percy.

<sup>74</sup> *Id.*

<sup>75</sup> Test. of L. Gross.

<sup>76</sup> *Id.*

<sup>77</sup> Minn. Stat. § 626.5572, subd. 19 (2014).

<sup>78</sup> Minn. Stat. § 245A.08, subd. 3(a).

5. The term, “reasonable cause,” means “there exist specific articulable facts or circumstances which provide the commissioner with a reasonable suspicion that there is an imminent risk of harm to the health, safety, or rights of persons served by the program.”<sup>79</sup>

6. The term “neglect” in the Maltreatment of Minors Act is defined in part as either:

(1) failure by a person responsible for a child’s care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child’s physical or mental health when reasonably able to do so;

(2) failure to protect a child from conditions or actions that seriously endanger the child’s physical or mental health when reasonably able to do so . . . .”<sup>80</sup>

7. When a child, without the knowledge of NHA staff, brings food from home that contains peanuts and shares that food with another child with a known peanut allergy, even though the allergy endangers that child’s physical health, it does not meet the definition of maltreatment by neglect under the Maltreatment of Minors Act.

8. Minn. Stat. § 245A.04, subd. 14 (2014), requires facilities to develop program policies and procedures necessary to maintain compliance with licensing requirements, provide training to staff, document the provision of this training, and monitor the implementation of policies and procedures by staff.

9. Child care facilities must also ensure that every staff person completes orientation training, including the center’s philosophy, child care program, and procedures for maintaining health and safety and handling emergencies and accidents; specific job responsibilities; the behavior guidance standards in Minn. R. 9503.0055 (2013); and the reporting responsibilities before starting their assigned duties.<sup>81</sup>

10. The Department failed to establish by a preponderance of the evidence that NHA breached its duty to develop program policies and procedures necessary to maintain compliance with licensing requirements in violation of Minn. Stat. § 245A.04, subd. 14.

11. The Department also failed to establish by a preponderance of the evidence that NHA failed to provide training to staff relating to its food allergy policies, or failed to monitor the implementation of those policies in violation of Minn. Stat. § 245A.04, subd. 14.

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<sup>79</sup> *Id.*

<sup>80</sup> Minn. Stat. § 626.556, subd. 2(f)(1) and (2).

<sup>81</sup> Minn. Stat. § 245A.40, subd. 1.

12. Information about food allergies of children attending the facility must be available in the area where food is prepared or served to children with allergies. All staff providing care to the child must be informed of the allergy.<sup>82</sup>

13. It was NHA's policy to post the allergy/food restriction list in its kitchen and in all of the classrooms.

14. On November 20, 2013, a copy of the list of children with food allergies was posted in the kitchen of the pre-4 classroom at NHA, in conformity NHA's policy.

15. The Department failed to establish by a preponderance of the evidence that NHA breached its duty to make information about food allergies of children attending the facility available in the area where food is prepared or served to children with allergies in violation of Minn. R. 9503.0145, subp. 6 (2013).

16. When determining whether the facility or individual is responsible for determined maltreatment in a facility, or whether both are responsible, the investigating agency shall consider at least the following mitigating factors:

(1) whether the actions of the facility or the individual caregivers were according to, and followed the terms of, an erroneous physician order, prescription, individual care plan, or directive; however, this is not a mitigating factor when the facility or caregiver was responsible for the issuance of the erroneous order, prescription, individual care plan, or directive or knew or should have known of the errors and took no reasonable measures to correct the defect before administering care;

(2) comparative responsibility between the facility, other caregivers, and requirements placed upon an employee, including the facility's compliance with related regulatory standards and the adequacy of facility policies and procedures, facility training, an individual's participation in the training, the caregiver's supervision, and facility staffing levels and the scope of the individual employee's authority and discretion; and

(3) whether the facility or individual followed professional standards in exercising professional judgment.<sup>83</sup>

17. The Department failed to demonstrate by a preponderance of the evidence that NHA breached its duty to monitor the implementation of its policies and procedures relating to food allergies, failed to adequately train staff on its food allergy and transitioning policies and procedures, and failed to adequately document any training it did provide to staff.

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<sup>82</sup> Minn. R. 9503.0145, subp. 6 (2013).

<sup>83</sup> Minn. Stat. § 626.556, subd. 10e(i).

18. The Department failed to demonstrate by a preponderance of the evidence that NHA was responsible for maltreatment of "Steve" on November 20, 2013, in violation of Minn. Stat. § 626.556, subd. 2(f)(1) and (2).

19. Minnesota Statutes section 245A.07, subdivision 3(c)(4), provides that the Commissioner may assess a fine of \$1,000 for each determination of maltreatment of a child under section 626.556 for which the license holder is determined responsible.

20. Since there was no maltreatment, the Department's assessment of a \$1,000 fine under the terms of Minn. Stat. § 245A.07, subd. 3(c)(4), and should be vacated.

21. These Conclusions of Law are reached for the reasons set forth in the attached Memorandum, which is hereby incorporated into these Conclusions by reference.

Based upon the foregoing Conclusions of Law, and for the reasons set forth in the accompanying Memorandum, the Administrative Law Judge makes the following:

### RECOMMENDATION

IT IS HEREBY RECOMMENDED:

That the Department's determination that NHA was responsible for maltreatment of a child be **REVERSED** and that the Order to Pay a Fine be **VACATED**.

Dated: November 6, 2014

s/James E. LaFave  
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JAMES E. LAFAVE  
Administrative Law Judge

Reported: Digitally Recorded  
No Transcript Prepared

## NOTICE

This Report is a recommendation, not a final decision. The Commissioner of Human Services (the Commissioner) will make the final decision after a review of the record. Under Minn. Stat. § 14.61, the Commissioner shall not make a final decision until this Report has been made available to the parties for at least ten calendar days. The parties may file exceptions to this Report and the Commissioner must consider the exceptions in making a final decision. Parties should contact Debra Schumacher, Administrative Law Attorney, PO Box 64998, St. Paul, MN 55164, (651) 431-4319 to learn the procedure for filing exceptions or presenting argument.

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 Administrative Law Judge of the date the record closes. 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. In order to comply with this statute, the Commissioner must then return the record to the Administrative Law Judge within ten working days to allow the Judge to determine the discipline imposed.

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

## MEMORANDUM

On November 20, 2013, unbeknownst to NHA, "Steve" a four-year-old child with a known peanut allergy, ate cereal which contained peanuts. The cereal was provided by a classmate. After eating the cereal, "Steve" had an allergic reaction. He cried, began vomiting and his face swelled. The staff at NHA immediately administered an EpiPen® and gave "Steve" Benadryl. "Steve" was taken to the hospital where he was observed for six hours and then sent home.

After conducting an investigation of the incident, the Department determined that NHA was responsible for maltreatment of "Steve" because it had an obligation to protect "Steve" when it was reasonably able to do so. The Department determined that NHA did not enforce NHA's policies of striving to be peanut free and of discouraging people from bring food into the facility. The Department claimed that Ms. Gross saw there was food in "Sally's" zip lock bag. It asserted Ms. Gross did not take steps to determine what was in the bag and to throw out the contents if it was contraband.

NHA argues it was in full compliance with the statues and rules governing its license. NHA maintains it has been at the forefront of addressing topic of allergies. NHA has developed and implemented policies that go far beyond what is required by the Department. NHA noted that its staff has extensive training on food allergies and on

how to respond to allergic reactions. It argues this training was exemplified in the professional manner in which the NHA staff responded to “Steve’s” allergic reaction.

## **Maltreatment**

The term “neglect” in the Maltreatment of Minors Act is defined in relevant part as either:

- (1) failure by a person responsible for a child’s care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child’s physical or mental health when reasonably able to do so; [or]
- (2) failure to protect a child from conditions or actions that seriously endanger the child’s physical or mental health when reasonably able to do so . . . .<sup>84</sup>

The fact a child with a known peanut allergy eats cereal laced with peanuts and has an allergic reaction, by itself, does not meet the definition of neglect. The Department is required to demonstrate the facility failed to either provide for a child’s physical health or failed to protect the child’s physical health when it is able to do so.

The Department claims that when “Sally” entered the classroom the morning of November 20, 2013, Ms. Gross saw there was food in the zip lock bag. The Department bases this claim on an interview Ms. Gross gave to Department investigators.<sup>85</sup> Ms. Gross however, corrected herself moments later in the interview when she stated “I didn’t know it was cereal. When she (“Sally”) walked in, I saw the baggie.”<sup>86</sup>

Ms. Gross testified very credibly at the hearing that she only saw the zip lock bag and not what was in it. This testimony was consistent with the version of events she gave to NHA’s internal investigators shortly after the incident. The facts in the record do not support the Department’s contention that Ms. Gross saw food was being brought into the class and that she failed to act to protect the health and safety of the children.

The Department also claims that NHA committed neglect when it failed to enforce its policies on discouraging people from bringing food into the classrooms and its policy of striving to be peanut free.

The Department points to interviews with other staff, who stated that from time to time NHA staff allowed food to be brought into the classrooms.<sup>87</sup> That argument fails on two grounds. First, those staff members were not present when “Sally” brought the zip lock bag into the classroom. Second, the only NHA staff member present at the time

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<sup>84</sup> Minn. Stat. § 626.556, subd. 2(f)(1) and (2).

<sup>85</sup> See Ex. 7 at 42.

<sup>86</sup> Ex. 7 at 43.

<sup>87</sup> Ex. 6 at 35; Ex. 8 at 50.

“Sally” arrived testified she did not see food being brought into the classroom. The argument that food may have been allowed at other times is irrelevant when, as in this case, NHA staff did not knowingly allow food to be brought into the classroom.

Child care facilities are required to develop policies and procedures necessary to maintain compliance with licensing requirements, provide adequate training to employees, document the provision of that training, and monitor implementation of its policies and procedures.<sup>88</sup> Here, NHA’s policies and procedures exceed what is required by statute and rule. The evidence showed that NHA staff were thoroughly trained on those policies and procedures. The success of that training was demonstrated by the NHA’s staff response when “Steve” suffered the allergic reaction.

In determining whether a facility is responsible for maltreatment, the Department is required to consider certain mitigating factors including the adequacy of the facility’s policies and procedures, the training on those policies and procedures, and an individual’s participation in that training.<sup>89</sup> While the Department did not find fault with NHA’s policies and procedures, there is no evidence to suggest the Department considered NHA’s policies, procedures, or staff training as mitigating factors in arriving at the maltreatment determination.

Based upon the record as a whole, the Administrative Law Judge concludes that the Department has failed to establish by a preponderance of the evidence that NHA should be held responsible for the alleged maltreatment of “Steve” on November 20, 2013.

Accordingly, the maltreatment determination should be reversed and the \$1,000 fine assessed against NHA should be vacated.

**J. E. L.**

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<sup>88</sup> See Minn. Stat. § 245A.04, subd. 14.

<sup>89</sup> Minn. Stat. § 626.556, subd. 10e(i).