

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

In the Matter of the Appeal by Angela Khanai  
of the Determinations of Maltreatment,  
Orders of Disqualification, Order to Pay a  
Fine, and Orders of License Revocation

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

The above-entitled matter came before Administrative Law Judge Stephen D. Swanson for an evidentiary hearing on Angela Khanai's appeal from a Determination of Maltreatment and Order to Pay a Fine dated July 9, 2015; Determination of Maltreatment, Disqualification from Direct Contact, and Order of License Revocation dated August 25, 2015; and Supplemental Order of License Revocation dated September 11, 2015. The evidentiary hearing was held on December 8 and 9, 2015, at the Minnesota Office of Administrative Hearings, 600 North Robert Street, St. Paul, Minnesota; and on December 17, 2015, in a conference room of the Wright County Government Center, 10 2<sup>nd</sup> Street NW, Buffalo, Minnesota.

Marsha Eldot Devine, Assistant Attorney General, appeared on behalf of the Minnesota Department of Human Services (Department). The Licensee, Angela Khanai, appeared, and was represented by Christopher G. Anderson, Attorney at Law.

Exhibits 1-50 and Exhibit A were received in evidence. No other exhibits were offered. Kimberly Anderson, Stephanie Payne, Debra Jean Neubauer-Hoffman, Alyssa M. Dotson, and VA-1 testified on behalf of the Department. The Licensee did not testify and did not call any witnesses. Pursuant to Minn. Stat. § 14.60, subd. 2 (2014), and with the agreement of the parties, the Administrative Law Judge closed the hearing and sealed the exhibits and the hearing record.

The Administrative Law Judge requested that the parties submit post-hearing closing statements, and the record closed on January 22, 2016, the date of the filing of the closing statements.

**STATEMENT OF THE ISSUES**

1. Did the Department demonstrate, by a preponderance of the evidence, that the Licensee is responsible for the maltreatment by emotional abuse of one or more vulnerable adults on or about May 18, 2015?

2. If the Department demonstrated, by a preponderance of the evidence, that the Licensee is responsible for the maltreatment by emotional abuse of one or more vulnerable adults on or about May 18, 2015, did the Department properly issue a fine to the Licensee in the amount of \$1,000?

3. Did the Department demonstrate, by a preponderance of the evidence, that the Licensee is responsible for the maltreatment by neglect of one or more vulnerable adults regarding an incident or incidents occurring prior to June 25, 2015?

4. Did the Department demonstrate, by a preponderance of the evidence, that the Licensee is responsible for the maltreatment by neglect of a vulnerable adult on July 11, 2015?

5. Did the Department properly disqualify the Licensee for recurring maltreatment from direct contact with persons receiving services?

6. Did the Department demonstrate reasonable cause for the revocation of the Licensee's adult foster care licenses?

7. If the Department demonstrated reasonable cause for the revocation of the Licensee's adult foster care licenses, did the Licensee demonstrate, by a preponderance of the evidence, that she was in full compliance with the laws and rules the Department alleges she violated at the time that the Department alleges the violations of law or rule occurred?

### **SUMMARY OF RECOMMENDATION**

The Administrative Law Judge concludes that the Department has demonstrated, by a preponderance of the evidence, that the Licensee is responsible for the recurring maltreatment by emotional abuse and by neglect of one or more vulnerable adults, that the Licensee is properly disqualified from direct contact with persons receiving services, that the fine in the total amount of \$1,000 was properly issued, and that the Licensee's adult foster care licenses were properly revoked. Therefore, the Administrative Law Judge recommends that the Commissioner of the Department of Human Services enter a final disposition under Minn. Stat. § 626.557, subd. 9c (2014), that the reports of recurring maltreatment in this case are true, and order that the Licensee is disqualified from direct contact with persons receiving services, that the Licensee pay a fine in the amount of \$1,000, and that the Licensee's adult foster care and home and community based services licenses be revoked.

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

### **FINDINGS OF FACT**

1. The Licensee, Angela Khanai, doing business as Angela Khanai Adult Foster Care and Angel's Care, holds Adult Foster Care (AFC) License Number

1055713-1, and Home and Community Based Services (CS) License Number 1067131-1. The AFC license covers the physical space occupied by her program, and the CS license covers the adult foster care services provided by the program. Pursuant to these licenses, the Licensee operates an adult foster care program in her single family home located in Maple Lake, Minnesota. The licenses allow for a maximum of three vulnerable adults residing in the home. The Licensee is the sole caregiver in her program.<sup>1</sup>

2. The Licensee's home incorporates a split-level floor plan with living quarters on both the lower level and the upper level. Entrance through the front door is to a foyer with one set of stairs descending to the lower level, a second set of stairs ascending to the upper level, and a door leading to the attached garage. The front entry door is protected by a combination screen and storm door. At the end of the foyer, a door provides access to and egress from the stairs descending to the living quarters on the lower level. The door is equipped with a locking handle, and can be locked and unlocked from either side of the door by a key. If the door is locked, it cannot be opened from the stairs ascending from the living quarters without a key. Access to and egress from the living quarters on the lower level is also provided through a rear door leading to the backyard of the home.<sup>2</sup>

3. The upper level of the home contains a full kitchen, a bathroom, a living room, a dining room, an office, and two bedrooms. The lower level of the home contains two bedrooms equipped with entry doors, a living room with a television, a dining area with a refrigerator, a bathroom, a laundry room, and a locked medicine closet. The Licensee is the only person in the home with access to the medicine closet. The lower level bathroom is equipped with a toilet, a sink, a shower, and a medicine cabinet. The home is equipped with an electronic security system, including motion detectors. The Licensee uses the upper level as her residence. Vulnerable adults served by the Licensee's program use the bedrooms and facilities on the lower level and one of the bedrooms on the upper level.<sup>3</sup>

4. VA-1 is a female born on April 10, 1967. VA-1 suffers from a constellation of medical and mental health problems, including grand mal seizure disorder, bipolar disorder, borderline personality disorder, post-traumatic stress disorder, anxiety, depression, asthma, esophageal reflux, incontinence, insomnia, migraine headaches, pernicious anemia, chronic rhinitis, osteoarthritis, and post gastric bypass surgery complications. VA-1 is competent and not under guardianship. VA-1 is required to take a plethora of prescription medications daily to treat these problems. VA-1 is not able to take her medications as prescribed without supervision and assistance.<sup>4</sup>

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<sup>1</sup> Exhibit (Ex.) 1 at 4XX-a; Ex. 7; Testimony (Test.) of Alyssa M. Dotson; Test. of Stephanie Payne.

<sup>2</sup> Test. of Kimberly Anderson; Test. of S. Payne; Test. of VA-1; Ex. 4 at DHS 498, 502; Ex. 13 at DHS 375; Ex. 31 at DHS 225.

<sup>3</sup> Ex. 13 at DHS 375; Ex. 4 at DHS 497; Ex. 31 at DHS 225, 227, 228; Test. of K. Anderson; Test. of S. Payne; Test. of VA-1.

<sup>4</sup> Test. of S. Payne; Test. of VA-1; Ex. 10 at DHS 444, 449; Ex. 26 at DHS 168-172, 180; Ex. 30.

5. From March 13, 2015, to July 12, 2015, VA-1 was a recipient of services from the Licensee's adult foster care program and resided in the Licensee's adult foster care home. VA-1 was placed in the Licensee's adult foster care program to monitor her seizures, safety, and medication administration. VA-1's bedroom was on the lower level at all times pertinent to this case.<sup>5</sup>

6. The Licensee told VA-1 that she could not come to the upper level of the home because she was gross and stunk. The Licensee's comment caused VA-1 to "feel like an animal."<sup>6</sup>

7. VA-2 is a female born on May 5, 1981. VA-2 suffers from post-traumatic stress disorder-social phobia disorder, which impairs her intellectual functioning and mental health, her judgment, and her capacity to recognize reality, agoraphobia, and panic disorder. VA-2 is not under guardianship. VA-2 is required to take a plethora of prescription medications daily to treat her disorders. VA-2 is able to dress, bathe, and groom herself, to walk and use the toilet without assistance, and to prepare food and feed herself without supervision or assistance. VA-2 is not able to take her medications as prescribed without supervision and assistance.<sup>7</sup>

8. From May 8, 2015, to July 8, 2015, VA-2 was a recipient of services from the Licensee's adult foster care program and resided in the Licensee's adult foster care home. VA-2's bedroom was on the lower level.<sup>8</sup>

9. The Licensee did not want VA-1 and VA-2 to visit the upper level of her home without her permission and supervision. To preclude visits from VA-1 and VA-2, the Licensee occasionally locked the door at the top of the steps to the lower level residential area at night or when she was sleeping or absent from the home, thereby precluding VA-1 and VA-2 from leaving the lower level residential area through that door. On December 11, 2013, the Licensee adopted an Emergency Use of Manual Restraints Policy, which prohibits the use of seclusion for the purpose of eliminating behavior or for the convenience of staff. The locked door caused VA-1 to suffer fear, anxiety, and panic. The Licensee also placed a chair in the lower level residential area at night, instructing VA-1 and VA-2 not to pass by the chair, as movement beyond that point would trigger the security alarm motion sensor in the lower level living room. The chair and instructions precluded access by VA-1 and VA-2 to the refrigerator in the lower level at night.<sup>9</sup>

10. During the residence of VA-1 and VA-2 in the Licensee's home, the closing latch on the combination screen and storm door was broken and did not function. On several occasions, including on or about May 18, 2015, the Licensee, to prevent the door from banging, stretched a bungee cord from the broken latch to the

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<sup>5</sup> Test. of VA-1; Test. of Debra Jean Neubauer-Hoffman; Ex. 37 at DHS 3XX-a-3XX-c; Ex. 44 at DHS 277.

<sup>6</sup> Test. of VA-1.

<sup>7</sup> Test. of K. Anderson; Ex. 11 at DHS 459; Ex. 27 at DHS 186, 193-199, 205; Ex. 29.

<sup>8</sup> Test. of K. Anderson; Test. of S. Payne; Ex. 11 at DHS 468; Ex. 18 at DHS 85; Ex. 20 at DHS 127.

<sup>9</sup> Test. of K. Anderson; Test. of VA-1; Ex. 2 at DHS 405, 406; Ex. 4 at DHS 500, 501; Ex. 5 at DHS 384, 385, 389, 393, 394; Ex. 8 at DHS 513-519; Ex. 20 at DHS 128.

handle of the entry door. The bungee cord inhibited access to or egress from the house through the front door.<sup>10</sup>

11. On May 20, 2015, the Department received a report that the front door to the Licensee's home was being secured by a bungee cord, making egress from the home difficult, and that the door at the top of the stairs leading to the lower level residential area was being locked by the Licensee while VA-1 and VA-2 were in the lower level residential area, precluding egress from the residential area by VA-1 and VA-2 through the door.<sup>11</sup>

12. Following an investigation of the report by a Department senior investigator, which included an unannounced visit to the Licensee's home on May 27, 2015, and interviews with the Licensee, VA-1, and VA-2, the investigator provided the Licensee with an opportunity to respond. The Licensee stated in writing on June 8, 2015, that policies and procedures were followed, that policies and procedures are adequate, that no additional training is required, that there were no other similar incidents, and that no further action is required as the door will be left open at all times.<sup>12</sup>

13. Following receipt of the Licensee's written response, the investigator issued an Investigation Memorandum on July 9, 2015, concluding that the actions of the Licensee in locking the door to the lower level residential area and using the bungee cord to secure the combination screen and storm door constituted substantiated maltreatment by emotional abuse of VA-1 and VA-2 by the Licensee and the facility, and that the maltreatment was neither serious nor recurring.<sup>13</sup>

14. Based upon the Investigation Memorandum, the Department issued a Determination of Maltreatment and Order to Pay a Fine dated July 9, 2015, determining that the Licensee had engaged in substantiated maltreatment (abuse) and ordering the Licensee to pay a fine in the amount of \$1,000, remove the lock from the door to the lower level residential area, and repair the combination screen and storm door.<sup>14</sup>

15. The Licensee was duly served with a copy of the Determination of Maltreatment and Order to Pay a Fine, and by letter dated July 29, 2015, from counsel, the Licensee duly appealed from the Determination of Maltreatment and Order to Pay a Fine.<sup>15</sup>

16. On June 26, 2015, the Department received a report that Ambien, a medication prescribed for VA-1, had been administered by the Licensee on June 25, 2015, to VA-2, who had not been prescribed the medication.<sup>16</sup>

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<sup>10</sup> Test. of K. Anderson; Test. of VA-1; Ex. 2 at DHS 404; Ex. 5 at DHS 384, 385, 393.

<sup>11</sup> Ex. 1.

<sup>12</sup> Test. of K. Anderson; Ex. 9.

<sup>13</sup> Test. of K. Anderson; Ex. 13.

<sup>14</sup> Ex. 14.

<sup>15</sup> Ex. 15 at DHS 359, 362; Ex. 16 at DHS 352.

<sup>16</sup> Test. of S. Payne; Ex. 17 at DHS 56, 58, 61, 62.

17. A senior investigator for the Department conducted an investigation, including an unannounced site visit on July 9, 2015, and interviews with the Licensee, VA-1, and VA-2. During the site visit, the investigator scanned all the records in the Licensee's possession regarding VA-1 and VA-2. The investigator collected the following records regarding VA-1: Medication Administration Record, Medication List, Adult Foster Care - Individual Resident Record, Adult Foster Care Physician Statements, Individual Abuse Prevention Plan, and Adult Foster Care Permission to Administer Medication. The investigator collected the following records regarding VA-2: Adult Foster Care - Individual Resident Record, Medication List, Medication Administration Record, Adult Foster Care Physician Statements, and Adult Foster Care New Placement Worksheet.<sup>17</sup>

18. By comparing the Medication Lists for VA-1 and VA-2 prepared by the Licensee with the Licensee's Medication Administration Records, the investigator determined that the Medication Administration Records for VA-1 and VA-2 did not record the administration of all the medications on the Medication Lists, and were incomplete and inaccurate on their face. During the site visit on July 9, 2015, the investigator pointed out the inadequacies in the Medication Administration Records, and gave the Licensee an opportunity to respond.<sup>18</sup>

19. The investigator obtained the pharmacy prescription records for VA-1 and VA-2. By comparing the pharmacy prescription records with the Medication Lists and the Medication Administration Records for VA-1 and VA-2, the investigator determined that several medications listed in the prescription records were not included by the Licensee in the Medication Lists.<sup>19</sup>

20. Ambien had been prescribed for VA-1, and not for VA-2. The medication was included in the pharmacy prescription records for VA-1, but did not appear in the Medication List for VA-1 prepared by the Licensee or in the Licensee's Medication Administration Record for VA-1.<sup>20</sup>

21. The Licensee did not administer VA-1's Ambien to VA-2.<sup>21</sup>

22. From the beginning of VA-1's and VA-2's residency in the Licensee's home, the Licensee knew from their Adult Foster Care Physician Statements and their Adult Foster Care - Individual Resident Records that the Licensee was responsible for the administration of prescription medications to VA-1 and VA-2. The Licensee recognized and accepted that responsibility, and adopted a written policy to ensure its full and proper implementation. The Licensee successfully completed four hours of "medical administration" public health training on August 28, 2014. VA-1 and VA-2 were

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<sup>17</sup> Test. of S. Payne; Exs. 20, 26, 27.

<sup>18</sup> Test. of S. Payne.

<sup>19</sup> *Id.*; Exs. 29, 30.

<sup>20</sup> Test. of S. Payne.

<sup>21</sup> *Id.*; Ex. 20 at DHS 120-122, 146.

not cognizant of all the medications prescribed for them and relied on the Licensee to administer all medications as prescribed.<sup>22</sup>

23. The Licensee kept VA-1's and VA-2's prescription medications in the locked medicine closet, and doled out daily supplies to be administered to VA-1 and VA-2 by the Licensee. The Licensee did not permit VA-1 and VA-2 to observe her as she prepared the daily supplies or to review their Medication Administration Records.<sup>23</sup>

24. The Medication List for VA-1 prepared by the Licensee did not include several medications prescribed for VA-1. The Medication Administration Record for VA-1 prepared by the Licensee did not include several medications prescribed for VA-1.<sup>24</sup>

25. The Medication List for VA-2 prepared by the Licensee did not include several medications prescribed for VA-2. The Medication Administration Record for VA-2 prepared by the Licensee did not include several medications prescribed for VA-2, and several medications from VA-2's Medication List.<sup>25</sup>

26. The Licensee did not prepare Medication Administration Records for each month that VA-1 and VA-2 resided in her home. She combined months on the same record sheet. The Medication Administration Records for VA-1 and VA-2 were incomplete, making it impossible to accurately determine when a particular prescription medication had been administered or whether all prescription medications were being administered to VA-1 and VA-2.<sup>26</sup>

27. The Licensee employed a practice of adding the unused portion of a prescription to the next prescription for the same drug without regard to expiration dates. The Licensee retained in the locked medicine closet and in an unlocked medicine cabinet accessible to VA-1 and VA-2 in the bathroom on the lower level prescription medications for vulnerable adults that no longer resided in her home, and bottles of medications with the labels removed.<sup>27</sup>

28. The Licensee failed to administer to VA-1 and VA-2 all the medications prescribed for VA-1 and VA-2.<sup>28</sup>

29. The investigator did not contact the Licensee to follow up on the investigator's concerns regarding the Licensee's medicine administration practices and record keeping. The investigator provided the Licensee with an opportunity to respond,

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<sup>22</sup> Ex. 23 at DHS 111; Ex. 24 at DHS 104-108; Ex. 26 at DHS 174, 178, 180; Ex. 27 at DHS 187, 196; Ex. 20 at DHS 114, 127-129, 143-146.

<sup>23</sup> Test. of S. Payne; Ex. 20 at DHS 114-118, 127-135.

<sup>24</sup> Test. of S. Payne; *compare* Ex. 30 at DHS 158-165 *with* Ex. 26 at DHS 168-172.

<sup>25</sup> Test. of S. Payne; *compare* Ex. 29 at DHS 148-154 *with* Ex. 27 at DHS 197-199, 205.

<sup>26</sup> Test. of S. Payne; Ex. 26 at DHS 168-171; Ex. 27 at DHS 197-199.

<sup>27</sup> Test. of S. Payne; Ex. 20 at DHS 114-118, 127-135; Ex. 31 at DHS 229, 230, 232-243; Ex. 40 at DHS 313.

<sup>28</sup> The facts set forth in Findings of Fact 24-26 support a reasonable inference that the Licensee failed to administer to VA-1 and VA-2 all the medications prescribed for VA-1 and VA-2.

and the Licensee responded to the initial report that had prompted the investigation. The Licensee stated in writing on July 20, 2015, that policies and procedures were followed, that policies and procedures are adequate, that no additional training is required, that there were no other similar incidents, and that no further action is required.<sup>29</sup>

30. Following receipt of the Licensee's written response, the investigator issued an Investigation Memorandum on August 25, 2015, stating that the investigation had covered both the initial report of the administration of Ambien to VA-2 and concerns regarding the Licensee's medicine administration practices and record keeping. The investigator found that the evidence did not support a determination that the Licensee had administered Ambien to VA-2, but did support a determination that the Licensee's medicine administration practices and record keeping constituted a failure to provide VA-1 and VA-2 with the care and services required for their physical and mental health. The investigator concluded that the Licensee had committed substantiated maltreatment by neglect, that the maltreatment was not serious, that the maltreatment was recurring, and that the Licensee was disqualified from direct contact with persons receiving services.<sup>30</sup>

31. Based upon the Investigation Memorandum, the Department issued a Determination of Maltreatment, Disqualification from Direct Contact and Order of License Revocation dated August 25, 2015, determining that the Licensee had engaged in substantiated maltreatment (neglect) and that the maltreatment was recurring, and disqualifying the Licensee from direct contact and revoking the Licensee's licenses.<sup>31</sup>

32. The Licensee was duly served with a copy of the Determination of Maltreatment, Disqualification from Direct Contact and Order of License Revocation, and by letter dated August 25, 2015, from counsel, the Licensee duly appealed from the Determination of Maltreatment, Disqualification from Direct Contact and Order of License Revocation.<sup>32</sup>

33. On June 16, 2015, the Licensee gave VA-1 a 60-day notice to leave her home. From the beginning of VA-1's residency in the Licensee's home, the Licensee knew from VA-1's Adult Foster Care - Individual Resident Record that because of VA-1's seizure disorder, the Licensee was responsible for always assisting and supervising VA-1 with toileting and bathing. From VA-1's Adult Foster Care New Placement Worksheet, the Licensee knew that VA-1 was unsteady on her feet, needed nighttime assistance with toileting, and was unable to safely and independently use the bathtub, shower, or toilet. Prior to July 11, 2015, VA-1 had fallen at least three times in the Licensee's home and she had informed the Licensee that she had fallen.<sup>33</sup>

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<sup>29</sup> Test. of S. Payne; Ex. 25.

<sup>30</sup> Test. of S. Payne; Ex. 33.

<sup>31</sup> Test. of S. Payne; Ex. 34.

<sup>32</sup> Test. of S. Payne; Ex. 36.

<sup>33</sup> Ex. 26 at DHS 173-176, 220; Ex. 40 at DHS 312, 321; Ex. 42; Ex. 44 at DHS 296, 298.

34. On July 11, 2015, VA-1 suffered a bout of severe diarrhea and incontinence and awoke at approximately 1:30 a.m., with her body, hair, sleep ware, and bed linens covered with feces. VA-1 asked the Licensee for assistance in cleaning herself and changing the bed linens. The Licensee refused to assist VA-1 and told her to take a shower and to put the soiled bed linens and sleep ware in the shower. The Licensee did not provide clean bed linens to VA-1.<sup>34</sup>

35. On July 14, 2015, the Department received a report regarding the incident on July 11<sup>th</sup>. A senior investigator from the Department conducted an investigation, including an unannounced site visit on July 22, 2015, and interviews with the Licensee and VA-1. In response to the report, the Licensee stated in writing on August 19, 2015, that policies and procedures were followed, that policies and procedures are adequate, that no additional training is required, that there were no other similar incidents, and that no further corrective action is required.<sup>35</sup>

36. Following receipt of the Licensee's written response, the investigator issued an Investigation Memorandum on September 11, 2015, finding that the Licensee refused and failed to assist VA-1 in cleaning herself and changing her bed linens. The investigator concluded that the actions of the Licensee constituted substantiated maltreatment by neglect, that the maltreatment was not serious, that the maltreatment was recurring, and that the Licensee is disqualified from direct contact with persons receiving services.<sup>36</sup>

37. Based upon the Investigation Memorandum, the Department issued a Supplemental Order of License Revocation dated September 11, 2015, determining that the Licensee had engaged in substantiated maltreatment (neglect), disqualifying the Licensee from direct contact, and revoking the Licensee's licenses.<sup>37</sup>

38. The Licensee was duly served with a copy of the Supplemental Order of License Revocation, and by letter dated September 23, 2015, from counsel, the Licensee duly appealed from the Supplemental Order of License Revocation.<sup>38</sup>

## **CONCLUSIONS OF LAW**

1. The Administrative Law Judge and the Commissioner of Human Services have jurisdiction over this matter pursuant to Minn. Stat. §§ 14.50, 245A.08 (2014).

2. The Notice and Order for Prehearing Telephone Conference and Hearing, Amended Notice and Order for Prehearing Telephone Conference and Hearing, and Second Amended Order for Prehearing Telephone Conference and Hearing are proper in all respects, and the Department complied with all substantive and procedural requirements of law and rule.

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<sup>34</sup> Test. of VA-1; Ex. 37 at DHS 3XX-a; Ex. 40 at DHS 311, 312, 320.

<sup>35</sup> Test. of D. Neubauer-Hoffman; Exs. 37, 39, 40, 43.

<sup>36</sup> Test. of D. Neubauer-Hoffman; Ex. 47.

<sup>37</sup> Ex. 48.

<sup>38</sup> Ex. 50.

3. At a hearing pursuant to 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>39</sup>

4. At a hearing pursuant to an appeal of an order to pay a fine and an order of license revocation, 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 the license holder was in full compliance with those laws and rules at the relevant times.<sup>40</sup>

5. Minn. Stat. § 245A.07 (2014) states in part:

Subdivision 1. Sanctions; appeals; license. (a) In addition to making a license conditional under section 245A.06, the commissioner may suspend or revoke the license, impose a fine, or secure an injunction against the continuing operation of the program of a license holder who does not comply with applicable law or rule. When applying sanctions authorized under this section, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program.

. . .

Subd. 3. License suspension, revocation, or fine. (a) The commissioner may suspend or revoke a license, or impose a fine if:

(1) a license holder fails to comply fully with applicable laws or rules;

(2) a license holder . . . has a disqualification that has not been set aside . . . .

6. Minn. Stat. § 245.04, subd. 6 (2014), states:

Commissioner's evaluation. Before issuing, denying, suspending, revoking, or making conditional a license the commissioner shall evaluate information gathered under this section. The commissioner's evaluation shall consider facts, conditions, or circumstances concerning the program's operation, the well-being of persons served by the program, available consumer evaluations of the program, and information about the qualifications of the personnel employed by the applicant or license holder.

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<sup>39</sup> Minn. Stat. § 626.5572, subd. 19 (2014).

<sup>40</sup> Minn. Stat. § 245A.08, subd. 3(a).

7. The Licensee operates a “facility,” as that term is defined in Minn. Stat. § 626.5572, subd. 6(a) (2014).

8. VA-1 and VA-2 are “vulnerable adults,” as that term is defined in Minn. Stat. § 626.5572, subd. 21(a)(1) (2014).

9. The Licensee was VA-1’s and VA-2’s “caregiver,” as that term is defined in Minn. Stat. § 626.5572, subd. 4 (2014).

10. The Licensee holds a Home and Community Based Services license, and is subject to the HCBS Standards.<sup>41</sup>

11. Under the HCBS Standards, VA-1 and VA-2 had a right to be free from maltreatment and seclusion, and to have free access to and use of the common areas of the residence.<sup>42</sup>

12. Under the HCBS Standards, VA-1 and VA-2 were entitled to the accurate administration by the Licensee of their prescription medications and the accurate documentation by the Licensee of the administration of their prescription medications.<sup>43</sup>

13. Minn. Stat. § 626.5572, subd. 2 (2014), states in part:

Abuse. “Abuse” means:

. . . .

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

. . . .

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult . . . .

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<sup>41</sup> Minn. Stat. §§ 245D.01, .03 (2014).

<sup>42</sup> Minn. Stat. §§ 245D.02, subd. 29; .04, subd. 3(a)(3), (4), (b)(3) (2014).

<sup>43</sup> Minn. Stat. § 245D.05, subds. 1, 1a, 2 (2014).

14. Minn. Stat. § 626.5572, subd. 17 (2014), states in part:

Neglect. "Neglect" means:

(a) The failure or omission of a caregiver to supply a vulnerable adult with care or services, including but not limited to . . . health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to . . . health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult . . . .

15. "Maltreatment" of a vulnerable adult includes "abuse" and "neglect," as above defined.<sup>44</sup>

16. The Department proved, by a preponderance of the evidence, maltreatment by the Licensee of both VA-1 and VA-2 by emotional abuse on or about May 18, 2015, caused by the Licensee's actions in locking and secluding VA-1 and VA-2, against their will, in the living quarters on the lower level of the facility, and by denying them free access and use of the common living quarters on the upper level of the facility.

17. Because the Licensee was both the person who committed the maltreatment and the facility license holder, the Department properly imposed a fine in the amount of \$1,000.<sup>45</sup>

18. The Department proved, by a preponderance of the evidence, maltreatment by the Licensee of both VA-1 and VA-2 by neglect during the period prior to June 25, 2015, caused by the Licensee's failure to administer to VA-1 and VA-2 all medications prescribed for VA-1 and VA-2, and to fully and accurately document the administration of prescription medications to VA-1 and VA-2.

19. The Department proved, by a preponderance of the evidence, maltreatment by the Licensee of VA-1 by neglect on or about July 11, 2015, caused by

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<sup>44</sup> Minn. Stat. § 626.5572, subd. 15 (2014).

<sup>45</sup> Minn. Stat. §§ 245A.07, subd. 3(c)(4); 626.556, subd. 10e(j); 626.557, subd. 9c(c), (d) (2014).

the Licensee's refusal of a request by VA-1 to assist her in cleaning herself and changing her bed linens following a bout of severe diarrhea.

20. The incidents of the Licensee's maltreatment of VA-1 and VA-2 by abuse and neglect were "recurring."<sup>46</sup>

21. The Department properly disqualified the Licensee from direct contact with persons receiving services.<sup>47</sup>

22. The Department demonstrated reasonable cause for the revocation of the Licensee's adult foster care and home and community based services licenses.<sup>48</sup>

23. The Licensee failed to demonstrate, by a preponderance of the evidence, that she was in full compliance with applicable laws and rules at the times of the incidents of maltreatment.<sup>49</sup>

Based upon these Conclusions of Law, and for the reasons explained in the accompanying Memorandum, the Administrative Law Judge makes the following:

### RECOMMENDATION

IT IS RECOMMENDED that the Commissioner of the Department of Human Services enter a final disposition under Minn. Stat. § 626.557, subd. 9c, that the reports of recurring maltreatment in this case are true, and order that the Licensee is disqualified from direct contact with persons receiving services, that the Licensee pay a fine in the amount of \$1,000, and that the Licensee's adult foster care and home and community based services licenses be revoked.

Dated: February 19, 2016



STEPHEN D. SWANSON  
Administrative Law Judge

Reported: Digitally Recorded  
No Transcript Prepared

<sup>46</sup> Minn. Stat. § 245C.02, subd. 16 (2014).

<sup>47</sup> Minn. Stat. §§ 245C.14, subd. 1(a)(3); .15, subd. 4(b)(2) (2014).

<sup>48</sup> Minn. Stat. §§ 245A.04, subds. 6, 7(e)(1); .07, subds. 1(a), 3(a)(1), (2); .08, subd. 3(a) (2014).

<sup>49</sup> Minn. Stat. § 245A.08, subd. 3(a).

## 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 (2014), 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 (2014). 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 (2014), 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

### I. Introduction

The present case involves three separate and distinct incidents of alleged maltreatment, two involving both vulnerable adults, and one involving only VA-1. The Department has established, by a preponderance of the evidence, that all three incidents occurred, and that the maltreatment was committed by the Licensee. The evidence is persuasive. The Licensee did not testify or call any witnesses, but her statements to Department investigators are part of the record.

Because much of the documentary evidence contains private medical information regarding the two vulnerable adults, the Administrative Law Judge, pursuant to Minn. Stat. § 14.60, subd. 2, and with the agreement of the parties, closed the hearing and placed the exhibits and the hearing record under seal. Because this report does not contain significant private information or identify the vulnerable adults, and because the Commissioner of the Department of Human Services may incorporate all or part of the report by reference in her final disposition, the report is not placed under seal.<sup>50</sup>

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<sup>50</sup> The final disposition of the Commissioner will be classified as public data under the Minnesota Government Data Practices Act. Minn. Stat. § 13.46, subd. 4(b)(1)(ii) (2014).

## II. Maltreatment Determinations

### (A). Emotional Abuse by Seclusion and Denial of Access

The Licensee did not want the two vulnerable adults housed on the lower level of her split-level home to have access to or use the common areas, including the full kitchen and bathroom, on the upper level, where she maintained her living quarters. To this end, the Licensee occasionally locked the door from the lower level when one or both of the vulnerable adults were on the lower level, thereby preventing them from accessing the foyer and ascending the stairs to the upper level. She also used her security system as a deterrent to leaving the lower level by placing a chair in the hallway on the lower level and instructing the vulnerable adults to not pass by the chair, as movement beyond the chair would be detected by a motion sensor and trigger the security system alarm.

These actions deprived the vulnerable adults of their right to be free from involuntary seclusion and their right to have free access to and use of the common areas of the residence, rights guaranteed by the HCBS Standards.<sup>51</sup> These actions also constituted maltreatment by emotional abuse.

In relevant part, emotional abuse is defined to mean:

conduct . . . which produces or could reasonably be expected to produce . . . emotional distress including . . . treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening . . . [and] use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult . . . .<sup>52</sup>

The actions of the Licensee fall squarely within this definition. She locked the door or used her security system to require the vulnerable adults to remain on the lower level, thereby preventing them from freely accessing the common areas on the upper level. Applying the reasonable person standard, the Licensee, through these actions, humiliated the vulnerable adults, confined them unreasonably, and involuntarily secluded them. VA-2 testified that this treatment by the Licensee caused her to suffer fear, anxiety, and panic. The Department has established, by a preponderance of the evidence, that the Licensee committed maltreatment by emotional abuse as to both of the vulnerable adults.

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<sup>51</sup> Minn. Stat. §§ 245D.02, subd. 29; .04, subd. 3(a)(4), (b)(3) (2014).

<sup>52</sup> Minn. Stat. § 626.5572, subd. 2(b)(2), (3).

**(B). Neglect by Failure to Properly Administer Prescription Medications**

Both vulnerable adults in this case suffered from severe medical and mental health problems, and were prescribed dozens of medications to treat those problems. From documents obtained from the Licensee, including VA-1's Adult Foster Care - Individual Resident Record, Adult Foster Care Physician Statements, and Adult Foster Care Permission to Administer Medication, and VA-2's Adult Foster Care - Individual Resident Record, Adult Foster Care Physician Statements, and Adult Foster Care New Placement Worksheet, and from the Licensee's statement to the Department investigator, it is clear that the Licensee knew that the vulnerable adults could not manage the administration of their prescription medications. The Licensee knew that she was responsible for the administration of prescription medications to the vulnerable adults, and she accepted that responsibility.

It is difficult to imagine a more important responsibility of an adult foster care licensee than the full and proper administration of prescription medications to a vulnerable adult who cannot administer his or her own medications. For that reason, under the HCBS Standards, VA-1 and VA-2 were entitled to the accurate administration by the Licensee of their prescription medications and the accurate documentation by the Licensee of the administration of those medications.<sup>53</sup>

In this case, the Licensee did neither. A comparison of the vulnerable adults' many prescriptions with the Medication Lists and Medication Administration Records prepared by the Licensee to document her medication administration responsibility reveals that many medications prescribed for the vulnerable adults were not included by the Licensee in their Medication Lists and not reflected in their Medication Administration Records. Simply put, the Medication Administration Records were incomplete and inaccurate to the point of making it impossible to determine if and when prescription medications were administered to the vulnerable adults by the Licensee.

The failure to administer prescription medications and the failure to properly document the administration of prescription medications constitutes maltreatment by neglect, which is defined, in relevant part, to mean:

The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to . . . health care . . . which is . . . reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult . . . .<sup>54</sup>

Based upon the facts that many of the medications prescribed for the vulnerable adults were not included in the Licensee's Medication Lists and Medication Administration Records, the Administrative Law Judge has drawn an inference that the Licensee failed

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<sup>53</sup> Minn. Stat. § 245D.05, subds. 1, 1a, 2.

<sup>54</sup> Minn. Stat. § 626.5572, subd. 17(a)(1).

to administer to the vulnerable adults all of their prescription medications.<sup>55</sup> Given the overwhelming documentary evidence and the absence of any testimony on the Licensee's part, the Administrative Law Judge deems this inference to be reasonable.

But putting aside the inference, the failure of the Licensee to thoroughly and accurately document the administration of the prescription medications, standing alone, constitutes neglect. The vulnerable adults could not know if they were receiving all their medications, as prescribed. The proper documentation of the administration of prescription medications is critical to the care provided to vulnerable adults, and is essential to ensure their health and safety. The Department has established, by a preponderance of the evidence, that the Licensee committed maltreatment by neglect as to both of the vulnerable adults.

**(C). Neglect by Refusal to Assist VA-1 to Clean Herself in the Shower**

The Licensee's refusal to assist VA-1 to clean herself and her bed after suffering incontinence and a severe bout of diarrhea during the night is shameful. The Licensee is operating a business; she is not a volunteer.

Moreover, that refusal constitutes maltreatment by neglect, which is defined, in relevant part, to mean:

The absence . . . of care or services . . . necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.<sup>56</sup>

The Licensee knew from VA-1's Adult Foster Care - Individual Resident Record that because of VA-1's seizure disorder, the Licensee was responsible for always assisting and supervising VA-1 with toileting and bathing. From VA-1's Adult Foster Care New Placement Worksheet, the Licensee knew that VA-1 was unsteady on her feet, needed nighttime assistance with toileting, and was unable to safely and independently use the bathtub, shower, or toilet.

The Licensee was responsible for the care of VA-1, including assisting VA-1 with bathing, in order to ensure that VA-1 did not fall. The physical safety of VA-1 depended upon this assistance. Yet, notwithstanding the obvious emotional strain upon VA-1 induced by awakening covered in feces, the Licensee refused VA-1's request for assistance in bathing and changing her bed linens. The Licensee's refusal placed the safety of VA-1 directly at risk. It also deprived her of the comfort she deserved in such a trying circumstance. The Department has established, by a preponderance of the evidence, that the Licensee committed maltreatment by neglect by refusing to assist VA-1.

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<sup>55</sup> Finding of Fact 28.

<sup>56</sup> Minn. Stat. § 626.5572, subd. 17(b).

### **III. Sanction Determinations**

#### **(A). Fine**

Based upon the determination of maltreatment by emotional abuse, the Department imposed a fine in the amount of \$1,000. The Licensee does not contest the amount of the fine. Because the Licensee committed the maltreatment and is also the license holder, a fine in the amount of \$1,000 is mandated under Minn. Stat. § 245A.07, subd. 3(c)(4).

#### **(B). Disqualification from Direct Contact**

As part of its determination of maltreatment by neglect regarding the medication administration records, the Department determined that the maltreatment was recurring and disqualified the Licensee from direct contact with persons receiving services. Because of the earlier determination of maltreatment by emotional abuse and because that determination and the determination regarding the medication administration records were committed by the Licensee and applied to both vulnerable adults, the Department was correct in its determination of “recurring maltreatment,” as that term is defined in Minn. Stat. § 245C.02, subd. 16.

In turn, under Minn. Stat. § 245C.15, subd. 4(b)(2), recurring maltreatment requires a seven-year disqualification of the individual committing the maltreatment from direct contact with persons receiving services.

#### **(C). License Revocation**

Based upon the determinations of maltreatment by neglect, the Department revoked the Licensee’s adult foster care licenses. This action was justified and proper for the following reasons.

The recurring maltreatment by the Licensee violated the law and placed the health and safety of the vulnerable adults in danger. Therefore, license revocation was authorized pursuant to Minn. Stat. § 245A.07, subd. 3(a)(2). A lesser sanction was authorized as well. The question is whether the Department has demonstrated reasonable cause for the revocation.<sup>57</sup>

When applying authorized sanctions, the Commissioner, under Minn. Stat. § 245A.07, subd. 1(a), must “consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program.” Here, the maltreatment was committed against two vulnerable adults on two separate occasions, and against one of the vulnerable adults on a third occasion, all within a period of less than two months. The maltreatment was chronic.

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<sup>57</sup> Minn. Stat. § 245A.08, subd. 3(a).

Although not found by the Department to be “serious,” as that term is defined in Minn. Stat. § 245C.02, subd. 18 (2014), because medical attention was not required, the instances of maltreatment regarding the administration of prescription medications and regarding the refusal to assist VA-1 in the shower were, in the view of the Administrative Law Judge, “severe,” as that term is used in Minn. Stat. § 245A.07, subd. 1(a), because they placed the health and safety of the vulnerable adults in direct danger. Therefore, license revocation is appropriate in this case.

License revocation is the appropriate sanction for an additional reason. The Licensee is the sole caregiver in her program. She is now disqualified and cannot be re-licensed for seven years. License revocation in such circumstances is logical and is specifically contemplated by the provisions of Minn. Stat. § 245A.07, subd. 3(a)(2).

In conclusion, the Department has established that the revocation of the Licensee’s adult foster care licenses is warranted in this case. Given the recurring maltreatment committed by the Licensee, the well-being of vulnerable adults served by her program is seriously in doubt.<sup>58</sup> The Licensee failed to establish that she was in full compliance with the laws and rules the Department alleges she violated at the time that the Department alleges the violations of law or rule occurred.

#### **IV. Licensee’s Contentions**

The Licensee does not argue that her actions in this case were the result of “accident” or “therapeutic conduct,” as those terms are defined in Minn. Stat. § 626.5572, subs. 3, 20 (2014). Rather, she denies that she committed maltreatment and argues that there is no credible direct evidence to support the Department’s maltreatment determinations.<sup>59</sup> The Administrative Law Judge does not agree.

The Licensee’s argument ignores the extensive documentary evidence revealing her knowledge of the medical condition of the vulnerable adults, their inability to administer their own prescription medications, and her failure to properly administer those medications and to document their administration. Those records and the statements made to Department investigators provide sufficient evidence to sustain the determinations of maltreatment.

The Licensee argues further that the statements of the vulnerable adults given to Department investigators were not credible because the vulnerable adults are essentially not competent to report accurately. Both vulnerable adults are their own guardians. Their statements to investigators are consistent with the other evidence adduced in this case, including the statements given to investigators by the Licensee. There is nothing in the record to suggest that the vulnerable adults are not accurate reporters. VA-1 testified at the hearing. She was competent to testify and her testimony was reasonably consistent with prior statements she had given to

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<sup>58</sup> See Minn. Stat. § 245A.04, subd. 6.

<sup>59</sup> Letter of Christopher G. Anderson dated January 22, 2016.

investigators and with other evidence adduced during the hearing. The Administrative Law Judge finds that VA-1 was a credible witness and her testimony believable.<sup>60</sup>

## **V. Conclusion**

The Department has established, by a preponderance of the evidence, that the Licensee committed maltreatment against two vulnerable adults by emotional abuse on one occasion and neglect on a second occasion, and that the Licensee committed maltreatment by neglect against one vulnerable adult on a third occasion. The Department has established that the maltreatment was recurring and that the Licensee should be disqualified from direct contact with persons receiving services. The imposition of the \$1000 fine was required by law, and the Department has established that the revocation of the Licensee's adult foster care licenses is an appropriate sanction in this case.

**S. D. S.**

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<sup>60</sup> Test. of VA-1.