

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

In the Matter of the Appeal by Donna Bauman of Determination of Maltreatment, Order to Pay a Fine, and Order of Conditional License, and the Appeal by Siosaia Unga of Determination of Maltreatment

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

The above-entitled matter came before Administrative Law Judge Stephen D. Swanson for a consolidated evidentiary hearing on Donna Bauman's appeal from a Determination of Maltreatment, Order to Pay a Fine, and Order of Conditional License, dated September 18, 2015, and Siosaia Unga's appeal from a Determination of Maltreatment, dated September 18, 2015. The evidentiary hearing was held on February 9 and 10, 2016, at the Minnesota Office of Administrative Hearings, 600 North Robert Street, St. Paul, Minnesota.

Kelly L. Meehan, Assistant Attorney General, appeared on behalf of the Minnesota Department of Human Services (Department). Donna Bauman, the Licensee, and Siosaia Unga appeared and represented themselves.

Exhibits 1-25 and 100-105 were received in evidence. No other exhibits were offered. Debra Jean Neubauer-Hoffman and Tauna Louise Chavez testified on behalf of the Department. Donna Lee Bauman and Siosaia Langoia Unga testified on their own behalf and called Amy Lou Payne and Michelle Ann Hennes as 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 record closed on February 10, 2016.

STATEMENT OF THE ISSUES

1. Did the Department demonstrate, by a preponderance of the evidence, that the Licensee is responsible for the maltreatment by abuse of a vulnerable adult?
2. If the Department demonstrated, by a preponderance of the evidence, that the Licensee is responsible for the maltreatment by abuse of a vulnerable adult, did the Department properly issue a fine to the Licensee in the amount of \$1,000?
3. Did the Department demonstrate reasonable cause for the issuance of a conditional license?

4. If the Department demonstrated reasonable cause for the issuance of a conditional license, did the Licensee demonstrate, by a preponderance of the evidence that the Licensee was in full compliance with those laws or rules that the Department alleges the Licensee violated, at the time that the Department alleges the violations of law or rules occurred.

5. Did the Department demonstrate, by a preponderance of the evidence, that Siosaia Unga is responsible for the maltreatment by abuse of a vulnerable adult?

SUMMARY OF RECOMMENDATION

The Administrative Law Judge concludes that the Department has demonstrated, by a preponderance of the evidence, that the Licensee and Siosaia Unga are responsible for the maltreatment by abuse of a vulnerable adult, that the fine in the amount of \$1,000 was properly issued, that the Department demonstrated reasonable cause for the issuance of a conditional license, and that the Licensee failed to demonstrate, by a preponderance of the evidence, that she was in full compliance with those laws or rules that the Department alleges she violated at the time that the Department alleges the violations occurred. 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 report of maltreatment in this case is true as to both the Licensee and Siosaia Unga, that the Licensee pay a fine in the amount of \$1,000, and that the Licensee's adult foster care license be placed on conditional status for one year, beginning on September 18, 2015, subject to the conditions set forth in the Determination of Maltreatment, Order to Pay a Fine, and Order of Conditional License.

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

FINDINGS OF FACT

1. The Licensee, Donna Lee Bauman, doing business as Donna L. Bauman Adult Foster Care, holds Adult Foster Care License Number 1012206, and operates her adult foster care program in her home in Forest Lake, Minnesota.¹

2. Siosaia Langoia Unga is married to the Licensee and resides in her adult foster care home. He is not an employee of the Licensee's program. He has completed a background study undertaken by the Department. Subsequent to the investigation by the Department in this case, Mr. Unga completed some form of vulnerable adult training. Otherwise, his training is limited to instructions provided by the Licensee.

¹ Exhibit (Ex.) 1 at DHS 1; Testimony (Test.) of Donna Lee Bauman; Test. of Siosaia Langoia Unga; Test. of Debra Jean Neubauer-Hoffman.

Mr. Unga is from an island in Polynesia, and English is not his first language. His style of speech in English is forceful and very loud. Mr. Unga is a strong person.²

3. The vulnerable adult (VA) was born on November 13, 1931. The VA is legally blind, and able to discern only shapes and shadows, but not the identities of persons; is very hard of hearing; and suffers from severe peripheral neuropathy and severe anxiety. The VA cannot feel sensation in his hands and feet, and cannot eat without assistance. The VA suffers from spasms in one leg which cause the leg to involuntarily strike out. The VA suffers from dementia, is not always aware of activities occurring in the present, and is often not oriented to time and place. The VA remembers the first name of the Licensee, but does not remember Mr. Unga's name or the names of the staff persons employed by the Licensee. The VA is approximately six feet in height and weighs approximately 180 pounds. The VA is not ambulatory, and must be transported by wheelchair. The VA's Individual Abuse Prevention Plan (IAPP) provides that two persons be involved in the transfer of the VA to and from the wheelchair. The VA must be assisted in all areas of daily living. The VA has lived in the Licensee's present adult foster care home since 2010. The VA expresses pleasure when clean and well groomed. The VA retires to bed for the night at approximately 5:30 p.m.³

4. The Licensee's home incorporates a split-level floor plan with living quarters on both the lower level and the upper level. At all times relevant to these proceedings, the VA's bedroom was on the lower level, which also contains, among other rooms, a bathroom and a laundry room. At all times relevant to these proceedings, the bathroom on the lower level was equipped with a shower stall that included a seat built into the plastic casement surrounding the stall. The dining area and living room are located on the upper level of the home, and the VA is transferred to and from the lower level to the upper level by means of an electric chair lift. To use the chair lift, the VA must be transferred from the wheelchair to the chair lift and from the chair lift to the wheelchair.⁴

5. As a volunteer for the Licensee, Mr. Unga has been assisting the VA with a morning ritual for the past five years. The ritual involves the following activities, unassisted by the Licensee or program staff persons. Mr. Unga sits the VA up in bed; transfers the VA to the wheelchair by placing his arms around the VA's chest from the front and moving the VA to the wheelchair; transfers the VA from the wheelchair to the toilet by the same method; transfers the VA from the toilet to the wheelchair by the same method; transfers the VA from the wheelchair to a shower area by the same method; dresses the VA; transfers the VA to the wheelchair by the same method; transfers the VA from the wheelchair to the electric chair lift by the same method; and transfers the VA from the electric chair lift to the wheelchair by the same method.

² Test. of S. Unga; Test. of D. Bauman; Ex. 5 at DHS-24.

³ Test. of D. Bauman; Test. of S. Unga; Test. of D. Neubauer-Hoffman; Test. of Michelle Ann Hennes; Test. of Amy Lou Payne; Test. of Tauna Louise Chavez; Exs. 7, 8, 14 at DHS-77, 15, and 100.

⁴ Test. of D. Bauman; Test. of S. Unga; Test. of T. Chavez; Test. of D. Neubauer-Hoffman.

Mr. Unga has also assisted in the care of other male residents of the Licensee's adult foster care home.⁵

6. During transfers performed by Mr. Unga and performed by staff members of the Licensee's program, the VA suffers extreme anxiety from fear of being dropped or of falling. The VA can become out of control almost to the point of hyperventilation. The VA yells and screams, lashes out with his arms and legs, struggles, and attempts to grab the person performing the transfer behind the person's neck. To avoid being scratched, Mr. Unga wears a towel over the back of his neck while undertaking transfers of the VA.⁶

7. During transfers, the VA is often out of control and in danger of striking a hard surface or object with his arms and legs, or of falling from the wheelchair or the electric chair lift, thereby possibly suffering an injury. At such times, the VA is also a danger to persons near him.⁷

8. In order to control the actions of the VA during transfers performed by Mr. Unga, Mr. Unga tells the VA in a very forceful and loud voice to stop yelling, screaming, and striking out. At the same time, Mr. Unga attempts to reassure the VA by telling him that it is the same ritual every morning.⁸

9. The VA, at times, begins to slide down in the seat of the wheelchair and needs to be hoisted up and placed in a proper seated position. On at least two occasions, Mr. Unga attempted to accomplish this re-seating task by tipping the wheelchair backward on its rear wheels and moving the chair back and forth and from side to side in an effort to propel the VA back against the back of the seat. The VA responded to this maneuver with extreme agitation. The Licensee viewed these attempts and instructed Mr. Unga to discontinue the practice. Mr. Unga discontinued the practice.⁹

10. As his physical condition worsened, the VA experienced difficulty remaining seated on the plastic seat built into the shower surround. The Licensee contacted a medical supply company to obtain an apparatus known as a "shower buddie," an apparatus that allows a person to be secured in a chair and then inserted into the shower stall by pushing the chair into the stall on fixed rails. Through electronic research, the Licensee determined that the apparatus was not available for rental.¹⁰

11. The VA is under guardianship and receives financial support through a tribal band. The Licensee must obtain prior approval from the guardian and a tribal court for the expenditure of funds to purchase necessary equipment for the VA.

⁵ Test. of D. Bauman; Test. of S. Unga.

⁶ Test. of D. Bauman; Test. of S. Unga; Test. of M. Hennes; Test. of A. Payne; Test. of T. Chavez.

⁷ Test. of D. Bauman; Test. of S. Unga; Test. of M. Hennes; Test. of A. Payne; Test. of T. Chavez.

⁸ Test. of D. Bauman; Test. of S. Unga; Test. of M. Hennes; Test. of A. Payne; Test. of T. Chavez.

⁹ Test. of D. Bauman; Test. of S. Unga; Test. of T. Chavez.

¹⁰ Test. of D. Bauman; Ex. 14 at DHS-78; Ex. 105.

Purchase of the apparatus required prior approval. The Licensee advised the VA's guardian and social worker that she was attempting to obtain the apparatus.¹¹

12. On July 21, 2015, the Department received a report that on or about the end of May or beginning of June 2015, Mr. Unga was rough with the VA during transfers; that on one specific occasion, Mr. Unga threw the VA onto a bed and ripped off the VA's clothes and diaper; and that on July 18, 2015, Mr. Unga put a towel over the VA's mouth and had his hand on the VA's neck when transferring the VA from the electric chair lift to the wheelchair.¹²

13. On or about July 24, 2015, the report was referred to a senior investigator for the Department, and the senior investigator began the investigation on July 27, 2015. The senior investigator made an unannounced visit to the Licensee's home on July 29, 2015. At the time of the visit, the senior investigator interviewed the Licensee, Mr. Unga, the VA, two other VAs residing in the home, and three staff persons employed by the Licensee. The senior investigator determined that the VA was not competent to provide accurate answers to her questions.¹³

14. From the site visit, which included a tour of the Licensee's home given by the Licensee, and the interviews, the senior investigator learned that Mr. Unga had been bathing the VA daily in the laundry room located on the lower level of the home for approximately four months prior to the visit.¹⁴

15. Beginning on or about April 1, 2015, the Licensee discontinued showering the VA in the lower level bathroom for the VA's safety. The Licensee acquired a commode equipped with four legs, adjustable as to length, a back rest, raised arms, and a toilet seat affixed to bars attached to the tops of the legs. The commode would not fit in the bathroom shower stall. At Mr. Unga's suggestion, the Licensee authorized Mr. Unga to bathe the VA daily in the laundry room on the lower level of the home, using the commode.¹⁵

16. The laundry room has an entry door, a cement floor, a washer and dryer, a water softener, a laundry sink, and a floor drain which accommodates two drainage pipes, one from the air conditioner and one from the water softener. There are two cat litter boxes located approximately three or four feet from the floor drain for use by the Licensee's two cats. When the entry door to the laundry room is closed, the cats can access the room through a swinging cat door located at the bottom of the entry door. The Licensee cleans the litter boxes daily.¹⁶

¹¹ Test. of D. Bauman.

¹² Test. of D. Neubauer-Hoffman; Ex. 4.

¹³ Test. of D. Neubauer-Hoffman; Ex. 4 at DHS-23; Ex. 5 at DHS-36 and -39; Exs. 9-16.

¹⁴ Test. of D. Neubauer-Hoffman; Ex. 9 at DHS-53; Ex. 10 at DHS-57; Ex. 14 at DHS-78.

¹⁵ Test. of D. Neubauer-Hoffman; Test. of D. Bauman; Test. of T. Chavez; Ex. 17 at DHS-157 and -160; Ex. 104.

¹⁶ Test. of D. Neubauer-Hoffman; Test. of D. Bauman; Ex. 17 at DHS-157; Ex. 104.

17. Mr. Unga followed the following procedure in bathing the VA in the laundry room. Mr. Unga placed the commode over the floor drain. He shut the laundry room door. He transferred the VA from the wheelchair to the commode seat. He used a bucket of warm soapy water to thoroughly clean the VA's body, wash the VA's hair, and shave the VA. He used a plastic scoop constructed from a milk jug to rinse the VA. He dressed the VA and brushed the VA's teeth. He then transferred the VA from the commode to the wheelchair.¹⁷

18. At an indeterminate date following the site visit by the senior investigator, Mr. Unga discontinued bathing the VA in the laundry room, and staff persons began giving the VA sponge baths in his bed. At an indeterminate date following the site visit, the shower buddie was installed in the lower level bathroom, and staff began bathing the VA in the shower.¹⁸

19. The senior investigator invited the Licensee to respond to the allegations of maltreatment. The Licensee provided a written internal review dated August 3, 2015, essentially denying the allegations of abuse, explaining Mr. Unga's style of communication with the VA, and stating that her policies and procedures are adequate and were followed and that no further action need be taken.¹⁹

20. On September 18, 2015, the senior investigator issued an Investigation Memorandum, determining that there was a preponderance of the evidence that Mr. Unga maltreated the VA by offensively yelling at the VA, by roughly yanking off the VA's clothes, by placing his arm around the VA's neck and pulling the VA up in order to force the VA to sit up in the wheelchair, by tipping the wheelchair backwards on its rear wheels to force the VA to sit up in the wheelchair, and by placing a towel over the VA's mouth to force the VA to be quiet. The senior investigator also determined that the Licensee and Mr. Unga maltreated the VA by bathing him in the laundry room for a period in excess of four months; and that the Licensee maltreated the VA by witnessing and not intervening in Mr. Unga's maltreatment of the VA and by forcing the VA, against his desires, to go to bed by 6:00 p.m. each night. Based upon the accumulation of these instances of maltreatment, the senior investigator concluded that emotional abuse of the VA had occurred, and that the Licensee and Mr. Unga were responsible for the abuse. The senior investigator determined that the maltreatment was neither recurrent nor serious in that Mr. Unga's maltreatment was the result of a pattern of conduct, and medical attention for the VA was not required.²⁰

21. Based upon the Investigation Memorandum, the Department issued a Determination of Maltreatment, Order to Pay a Fine, and Order of Conditional License dated September 18, 2015, determining that the Licensee had engaged in substantiated maltreatment (abuse), ordering the Licensee to pay a fine in the amount of \$1,000, and placing the Licensee's adult foster license on conditional status for one year, beginning on September 18, 2015, subject to the following conditions: provide notice of the

¹⁷ Test. of S. Unga; Test. of T. Chavez; Test. of A. Payne.

¹⁸ Test. of S. Unga; Ex. 105.

¹⁹ Test. of D. Neubauer-Hoffman; Ex. 18 at DHS-83-85.

²⁰ Test. of D. Neubauer-Hoffman; Ex. 3.

conditional status to all residents and prospective residents; review and revise residents' care plans; complete at least six additional hours of approved training on caring for older adults and managing stress; and require Mr. Unga to complete the 12-hour training requirement for a new caregiver, including training on caring for older adults and managing stress.²¹

22. The Licensee was duly served with a copy of the Determination of Maltreatment, Order to Pay a Fine, and Order of Conditional License. By memorandum received by the Department on September 25, 2015, the Licensee duly appealed from the Determination of Maltreatment, Order to Pay a Fine, and Order of Conditional License.²²

23. By letter dated September 18, 2015, the Department advised Mr. Unga that the Department had entered a final disposition that he had committed substantiated maltreatment of a vulnerable adult. By letter dated September 28, 2015, Mr. Unga requested reconsideration of the final disposition. By letter dated November 18, 2015, the Department notified Mr. Unga that the Commissioner had affirmed the determination of maltreatment. By memorandum received by the Department on November 30, 2015, Mr. Unga duly appealed from the determination of maltreatment. The appeals of the Licensee and Mr. Unga were, by stipulation of the parties, consolidated for a contested case hearing.²³

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 and 245A.08 (2014).

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

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.²⁴

4. At a hearing pursuant to an appeal of an order to pay a fine and an order of conditional license, 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

²¹ Ex. 1.

²² Ex. 20.

²³ Exs. 2 and 21-23.

²⁴ Minn. Stat. § 626.5572, subd. 19 (2014).

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.²⁵

5. Minnesota Statutes section 245A.06 (2014) states in part:

Subdivision 1. Contents of correction orders and conditional licenses. (a) If the commissioner finds that the applicant or license holder has failed to comply with an applicable law or rule and this failure does not imminently endanger the health, safety, or rights of the persons served by the program, the commissioner may issue . . . an order of conditional license to the applicant or license holder. When issuing a conditional license, 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. The correction order or conditional license must state:

- (1) the conditions that constitute a violation of the law or rule;
- (2) the specific law or rule violated;
- (3) the time allowed to correct each violation; and
- (4) if a license is made conditional, the length and terms of the conditional license.

6. Minnesota Statutes section 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;

7. Minnesota Statutes section 245.04, subdivision 6 (2014), states:

Commissioner's evaluation. Before issuing, denying, suspending, revoking, or making conditional a license the commissioner shall evaluate

²⁵ Minn. Stat. § 245A.08, subd. 3(a).

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.

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

9. The VA is a "vulnerable adult," as that term is defined in Minn. Stat. § 626.5572, subd. 21(a)(1) (2014).

10. The Licensee was the VA's "caregiver," as that term is defined in Minn. Stat. § 626.5572, subd. 4 (2014).

11. Minnesota Statutes section 626.5572, subdivision 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 the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening

12. "Maltreatment" of a vulnerable adult includes "abuse."²⁶

13. The Department proved, by a preponderance of the evidence, maltreatment by the Licensee and Mr. Unga by emotional abuse during the period on or about April 1, 2015, through and including on or about July 29, 2015, caused by the Licensee's and Mr. Unga's conduct in bathing the VA daily on a commode in the laundry room, and not reporting the abuse.

14. The Department failed to prove, by a preponderance of the evidence, maltreatment by the Licensee or Mr. Unga of the VA regarding all the other alleged incidents of abuse set forth by the Department in the Investigation Memorandum and

²⁶ Minn. Stat. § 626.5572, subd. 15 (2014).

the Determination of Maltreatment, Order to Pay a Fine, and Order of Conditional License.

15. 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 \$1,000.²⁷

16. The Department demonstrated reasonable cause for the imposition of a conditional license, and for the conditions prescribed by the conditional license.²⁸

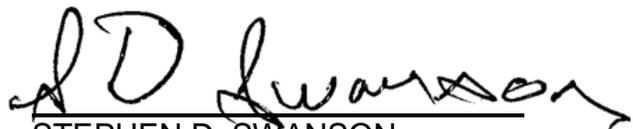
17. The Licensee failed to demonstrate, by a preponderance of the evidence that she was in full compliance with those laws or rules that the Department alleges the Licensee violated, at the time that the Department alleges the violations of law or rules occurred.²⁹

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 report of maltreatment in this case is true as to both the Licensee and Siosaia Unga, and order that the Licensee pay a fine in the amount of \$1,000, and that the Licensee's adult foster care license be placed on conditional status for one year, beginning on September 18, 2015, subject to the conditions set forth in the Determination of Maltreatment, Order to Pay a Fine, and Order of Conditional License.

Dated: March 3, 2016


STEPHEN D. SWANSON
Administrative Law Judge

Reported: Digitally Recorded
No Transcript Prepared

²⁷ Minn. Stat. §§ 245A.07, subd. 3(c)(4), 626.557, subd. 9c(c), (d) (2014).

²⁸ Minn. Stat. §§ 245A.04, subds. 6, 7(e)(1), 245A.07, subds. 1(a), 3(a)(1), (2), 245A.08, subd. 3(a) (2014).

²⁹ 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 64989, 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 several incidents of alleged maltreatment of the vulnerable adult (VA) by emotional abuse. The Department has established, by a preponderance of the evidence, one incident of maltreatment of the VA by emotional abuse. The Department has failed to establish, by a preponderance of the evidence, the other incidents of alleged maltreatment of the VA. The incidents will be reviewed in detail in Section III of this Memorandum.

Because much of the documentary evidence contains private medical information regarding the VA, 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 identify the VA or contain information that could readily lead to the identification of the VA, 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.³⁰

³⁰ 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. Law Applicable to Determination of Maltreatment by Emotional Abuse

The Department argues that the Licensee and Siosaia Unga maltreated the VA through emotional abuse. The Department does not argue that the VA was maltreated by physical abuse or by neglect.³¹

In the context of the allegations of maltreatment by emotional abuse in this case, the term, “abuse,” is defined by statute as follows:

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 the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening³²

Given the allegations in the present case, this definition of “abuse” can be synthesized to mean “conduct . . . which produces or could reasonably be expected to produce . . . emotional distress including . . . use of repeated or malicious oral . . . language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory [or] humiliating”

At once apparent from this definition is the decision by the legislature to incorporate a “reasonable person” standard in subsection (2). That decision was likely born of a concern that many vulnerable adults are not physically or mentally capable of articulating the emotional consequences of abuse, including, for example, feelings of disparagement, derogation, or humiliation. The adoption of an objective standard also recognizes that the application of a subjective standard would lead to the absurd result that the more disabled the vulnerable adult the more the vulnerable adult could be

³¹ While the Department introduced evidence that the VA’s IAPP provides that two persons be involved in the transfers of the VA into and out of his wheelchair, the Department does not argue that the unassisted transfers performed by Mr. Unga, standing alone, constituted neglect or abuse.

³² Minn. Stat. § 626.5572, subd. 2(b)(2).

emotionally abused.³³ Said another way, such a result would lead to “decreasing protection for increasingly vulnerable adults.”³⁴

The concern of the legislature is manifested in the present case. Here, the Department’s senior investigator concluded, following an interview with the VA, that the VA was not competent to understand and respond accurately to her questions, let alone articulate feelings regarding certain treatment, such as being bathed in the laundry room and being constantly spoken to in a very loud voice. While the VA was able to express fear and anxiety in the moment through such exclamations as “stop,” “oh, oh,” and “ouch,” the witnesses at the hearing were uniform in their testimony that when the VA talked, the VA talked about past, and not present events. For these reasons, the Administrative Law Judge has disregarded, in its entirety, the senior investigator’s interview with the VA.

Because there is no evidence in the record that suggests or reveals the VA’s understanding of, or emotional response to the alleged incidents of abuse, the Administrative Law Judge must apply the “reasonable person” standard.

For conduct to be considered emotional abuse, it must fall under the general provision in section 626.5572, subd. 2(b), defining “abuse,” in relevant part, as “conduct . . . which produces or could reasonably be expected to produce . . . emotional distress”³⁵ Conduct set forth, as non-inclusive examples, in subsections (1)-(4) of subdivision 2(b), would be considered “abuse” under the general provision of subdivision 2(b).³⁶

III. Alleged Incidents of Maltreatment by Emotional Abuse

(A) Emotional Abuse by Bathing the VA in the Laundry Room

The facts regarding the Licensee’s use of the laundry room to bathe the VA are largely not in dispute. For a period of approximately four months, which extended at least to the date of the senior investigator’s unannounced visit to the Licensee’s home, Mr. Unga bathed the VA daily in the laundry room on a commode.³⁷ The Licensee initiated this practice because the VA was slipping off the plastic seat in the bathroom shower stall, thereby placing his health and safety in danger. The laundry room had a

³³ *In re Kleven*, 736 N.W.2d 707, 711 (Minn. Ct. App. 2007).

³⁴ *Id.* In *Kleven*, the court held that Minn. Stat. § 626.5572, subd. 2(b), the general provision defining “abuse,” in relevant part, as “conduct . . . which produces or could reasonably be expected to produce . . . emotional distress,” is governed by a “reasonable person” standard. 736 N.W.2d 707, 711.

³⁵ *Kleven*, 736 N.W.2d 707, 711.

³⁶ *In re Appeal of Staley*, 730 N.W.2d 289, 298 (Minn. Ct. App. 2007).

³⁷ There is some dispute as to whether Mr. Unga used a transfer belt to secure the VA to the commode and whether Mr. Unga placed flip flops on the VA’s feet during the bathing process. The transfer belt and flip flops were not in evidence when the senior investigator observed the commode at the time of her site visit, but were in evidence at the time that the Licensee photographed the commode on an unidentified date subsequent to the visit. *Compare* Ex. 17 at DHS-157 *with* Ex. 104. This dispute is irrelevant because the use of the transfer belt and the flip flops, if they were used, would not change the Administrative Law Judge’s decision regarding the conduct of bathing the VA in the laundry room.

concrete floor and contained a laundry tub, washer and dryer, and a water softener. It also contained two cat litter boxes which were located three to four feet from the floor drain over which the commode was placed. Two drainage lines ran into the floor drain. Nothing else is known about the laundry room, except that it had an entry door.

As a very temporary solution, bathing the VA in the laundry room might have been an appropriate solution to protect the VA's health and safety until other appropriate showering arrangements could be made. But the evidence suggests that the Licensee did not view the solution as temporary. The Licensee testified that she located a shower buddie, an apparatus that permits the VA to be safely bathed in the bathroom shower, but that it took a very long time to obtain tribal court approval for the expenditure of the VA's money to acquire the apparatus and a long time to actually acquire and install the apparatus. This testimony lacks substance because the Licensee did not provide any hard evidence as to the date she located the apparatus, the date she contacted the VA's guardian to begin the tribal court approval process, the date that the tribal court approved the requested expenditure, the date that the apparatus was purchased, and the date that the apparatus was delivered and installed. Without such evidence, the Licensee's testimony that "it took a very long time" is of no value. In the view of the Administrative Law Judge, the Licensee permitted the temporary solution to become the norm.

The conduct of bathing the VA in the laundry room constitutes "treatment of a vulnerable adult," as that term is used in Minn. Stat. § 626.5572, subd. 2(b)(2).³⁸ Applying the "reasonable person" standard, the Administrative Law Judge concludes that a reasonable person would consider the conduct of being bathed daily for approximately four months in a laundry room on a commode disparaging, derogatory, and humiliating.

The Licensee and Mr. Unga argue that they did not intend, by the conduct, to abuse or harm the VA, but rather that they engaged in the conduct to ensure that he could be safely bathed. The Administrative Law Judge does not suggest that the Licensee and Mr. Unga intentionally or maliciously maltreated the VA. But intent is not the issue. The conduct of the Licensee and Mr. Unga "could reasonably be expected to produce . . . emotional distress" in a reasonable person.³⁹ Therefore, the conduct constitutes maltreatment by emotional abuse.⁴⁰

(B) Emotional Abuse by Speaking Loudly to the VA

The Department argues that Mr. Unga, with the knowledge of the Licensee, repeatedly abused the VA by yelling at him, in violation of Minn. Stat. § 626.5572, subd. 2(b)(2). In pertinent part, that section defines "abuse" as the "use of repeated or malicious oral . . . language toward a vulnerable adult . . . which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or

³⁸ See *Staley*, 730 N.W.2d 289, 298, 299.

³⁹ Minn. Stat. § 626.5572, subd. 2(b).

⁴⁰ Minn. Stat. § 626.5572, subds. 2(b)(2), 15.

threatening.” To meet this definition, the oral language must be either repeated or malicious.⁴¹

Mr. Unga’s first language is not English. When he speaks in English, he normally uses a very loud and forceful voice. The VA is subject to many transfers into and out of his wheelchair each day. Because the VA suffers from severe peripheral neuropathy, is legally blind, and is very hard of hearing, the VA is afraid of being dropped or of falling, and becomes extremely anxious and agitated during the transfers. At those times, the VA strikes out with his arms and legs and becomes a danger to himself and others.

When Mr. Unga is performing a transfer, and the VA becomes anxious and agitated, Mr. Unga attempts to calm and control the VA by speaking to him in a loud and forceful voice. The Department failed to establish that Mr. Unga, in these efforts to calm and control the VA, employed “malicious” language, which has been defined by the Court of Appeals to be “conduct . . . carried out with evil intent,” evoking a “desire to harm others or see others suffer.”⁴² While not “malicious,” the oral language was “repeated” by Mr. Unga, and therefore meets the definitional requirement of Minn. Stat. § 626.5572, subd. 2(b)(2).

While persons with normal hearing might not appreciate being repeatedly spoken to in the way Mr. Unga spoke to the VA, the evidence in this case is clear that all oral communication with the VA by everyone at the Licensee’s home must be in a very loud voice. During transfers, it is absolutely essential to the protection of the VA’s health and safety, and the safety of others around him, that every effort be made to reassure and calm the VA to convince him to accept the transfer and not fight it. As a general rule, oral communication, if successful, is preferred over physical control and restraint. In this case, given the VA’s medical problems, all oral communication had to be in a loud and forceful voice. The Court of Appeals has reasoned that each of the subsections of Minn. Stat. § 626.5572, subd. 2(b), including subsection (2), require “egregious conduct” to rise to the level of “abuse.”⁴³ The use of loud and forceful language to protect the health and safety of a vulnerable adult cannot, without more, be considered “egregious conduct.”⁴⁴

The Department has failed to establish, by a preponderance of the evidence, that Mr. Unga abused the VA by repeatedly speaking to him in a loud and forceful manner.

⁴¹ *Staley*, 730 N.W.2d 289, 298.

⁴² *Id.*

⁴³ *Id.* at 299.

⁴⁴ The use of loud and forceful oral language to calm and control a vulnerable adult to protect the vulnerable adult’s health and safety could be considered “therapeutic conduct,” as that term is defined in Minn. Stat. § 626.5572, subd. 20 (2014), because it represents “the provision of program services . . . [or] health care . . . done in good faith in the interests of the vulnerable adult.” As such, it would not be considered abuse under Minn. Stat. § 626.5572, subd. 2(b).

(C) Other Alleged Incidents of Maltreatment by Emotional Abuse

In the Department's Investigation Memorandum, the senior investigator cites additional alleged incidents of maltreatment of the VA by emotional abuse: (1) an incident in May 2015 of rough treatment by Mr. Unga of the VA when Mr. Unga allegedly yanked off the VA's clothing and diaper; (2) an incident when Mr. Unga allegedly attempted to re-seat the VA in the wheelchair by placing his arm around the VA's neck and pulling the VA up to an upright seated position in the wheelchair; (3) an incident when Mr. Unga placed a towel over the VA's mouth to stifle the cries of the VA; (4) two incidents when Mr. Unga attempted to re-seat the VA in an upright seated position in the wheelchair by tilting the wheelchair back on its back legs and moving the wheelchair from side to side; and (5) the practice of forcing the VA to go to bed for the night by 6:00 p.m.

The evidence regarding alleged incidents (1)-(3) is highly conflicting.⁴⁵ The Department has failed to establish, by a preponderance of the evidence that the incidents occurred.

Mr. Unga admitted to incident (4), but the evidence shows that he discontinued the practice upon being told by the Licensee that it was upsetting to the VA and to discontinue the practice. The Department has failed to establish, by a preponderance of the evidence, that the two incidents of tipping the VA's wheelchair back to encourage the VA to sit up straight in the chair constituted maltreatment by emotional abuse.

The evidence established that the VA was put to bed by 6:00 p.m. each night. There was testimony that the VA wished to go to bed at that hour and that headphones and a television were available to the VA.⁴⁶ There is insufficient evidence in the record to support a finding of fact regarding the desires of the VA.⁴⁷ In the final analysis, the Department has failed to establish, by a preponderance of the evidence, that the practice of putting the VA to bed by 6:00 p.m. constitutes maltreatment by emotional abuse.

In her Determination of Maltreatment, Order to Pay a Fine, and Order of Conditional License, the Commissioner adds, as an additional alleged incident of maltreatment, an incident when Mr. Unga permitted the VA to remain in the bathroom unsupervised. This incident was not pursued by the Department during the hearing, and the Department has failed to establish, by a preponderance of the evidence, that the incident occurred.

⁴⁵ Compare testimony of T. Chavez with Testimony of S. Unga and D. Bauman.

⁴⁶ Test. of D. Bauman.

⁴⁷ For the reasons stated above, the Administrative Law Judge has disregarded information provided by the VA to the Department's senior investigator.

IV. Sanction Determinations

(A) Fine

Based upon the determination of maltreatment by emotional abuse, the Commissioner 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) Order of Conditional License

In her Determination of Maltreatment, Order to Pay a Fine, and Order of Conditional License, the Commissioner ordered that the Licensee's license to provide adult foster care be placed on conditional status for one year beginning September 18, 2015, subject to the following conditions: provide notice of the conditional status to all residents and prospective residents; review and revise residents' care plans; complete at least six additional hours of approved training on caring for older adults and managing stress; and require Mr. Unga to complete the 12-hour training requirement for a new caregiver, including approved training on caring for older adults and managing stress.

At the hearing, the Department demonstrated reasonable cause for the imposition of a conditional license, and for the conditions prescribed by the conditional license.⁴⁸ By bathing the VA in the laundry room on a commode for approximately four months, the Licensee and Mr. Unga committed substantiated maltreatment by emotional abuse. They failed to report the abuse, and thereby violated Minn. Stat. § 626.557 (2014). Therefore, the Commissioner was authorized by law to issue an order of conditional license.⁴⁹

When issuing a conditional license, the Commissioner 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."⁵⁰ By definition, maltreatment of a vulnerable adult is a severe violation of the law.⁵¹ In the present case, given the fact that the maltreatment continued daily for approximately four months, the violation can be considered chronic. The violation directly affected the right of the VA to be protected against maltreatment by the Licensee.

When issuing a conditional license, the Commissioner must set forth the length and terms of the conditional license. Here, the length of the conditional license is one year, a reasonable period of time, and the terms are appropriate and reasonable. Because the Licensee allowed the practice of bathing the VA in the laundry room to

⁴⁸ Minn. Stat. § 245A.08, subd. 3(a).

⁴⁹ Minn. Stat. § 245A.06, subd. 1(a).

⁵⁰ *Id.*; Minn. Stat. § 245A.04, subd. 6.

⁵¹ See Minn. Stat. § 626.557, subd. 1, setting forth the public policy of protecting vulnerable adults from maltreatment.

continue for an extended period of time, it is appropriate that the Licensee receive additional approved training on caring for older adults and managing stress. Because Mr. Unga lives in the Licensee's adult foster care home and has a lengthy history of assisting the Licensee as a volunteer in the care of male residents of the home, it is appropriate that the Licensee require Mr. Unga to complete the 12-hour training requirement for a new caregiver, including approved training on caring for older adults and managing stress.

Because the Department demonstrated that reasonable cause existed for the imposition of a \$1,000 fine and the issuance of a conditional license, the burden of proof shifted to the Licensee to demonstrate, by a preponderance of the evidence, that the Licensee was in full compliance with those laws or rules that the Department alleges the Licensee violated, at the time that the Department alleges the violations of law or rules occurred.⁵² The Department established, by a preponderance of the evidence, that the Licensee and Mr. Unga committed maltreatment of a vulnerable adult by emotional abuse and failed to report the abuse. The Licensee did not demonstrate that she was in compliance with the Minnesota Vulnerable Adults Act at the time the abuse occurred.⁵³

V. Conclusion

The Department has established, by a preponderance of the evidence, that the Licensee and Mr. Unga committed maltreatment against a vulnerable adult by emotional abuse. The imposition of the \$1,000 fine is required by law, and the Department has established that the issuance of a conditional license is an appropriate sanction in this case.

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⁵² Minn. Stat. § 245A.08, subd. 3(a).

⁵³ Minn. Stat. § 626.557. Of course, proof, by a preponderance of the evidence, by the Department of a violation of the Minnesota Vulnerable Adults Act and proof, by a preponderance of the evidence, by a licensee of compliance with the Act, when considering the same conduct, are mutually exclusive. Therefore, the shifting burden provision set forth in Minn. Stat. § 245A.08, subd. 3(a), is of no consequence in the present case.