OAH 22-1800-37865

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HUMAN SERVICES

In the Matter of the Appeal by James L. Noske, and the Rose Ann Brutger and James L Noske Adult Foster Care/HCBS	**FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION**

The above-entitled matter came before Administrative Law Judge Christa L. Moseng for a hearing on July 6, 7, and 8, 2022. The parties filed written closing arguments on August 5, 2022, and the record closed on that date.

James L. Noske, Noske Law Firm, appeared on behalf of James L. Noske, and the Rose Ann Brutger and James L Noske Adult Foster Care (together, Appellants). Leaf McGregor, Assistant Attorney General, appeared on behalf of the Minnesota Department of Human Services (Department).

At hearing, the Department's exhibits 1–61, and Appellants' exhibits 100–116, 119–129, 131–140,[1] 141–145, and 147–160, were admitted into the record. On August 9, 2022, Appellant filed a Motion to Supplement Record by Adding Two Exhibits, which is addressed by separate order.

STATEMENT OF THE ISSUES

1. Did the Department properly determine that Appellants were each responsible for maltreatment of three vulnerable adults by emotional abuse under Minn. Stat. §§ 626.557, subds. 9c(b) and (c), and 626.5572, subds. 2(b)(2) and 15 (2020).

2. Did the Department properly determine that Appellants were each responsible for maltreatment of three vulnerable adults by neglect under Minn. Stat. § 626.557, subd. 17 (2020).

3. Did the Department properly disqualify Appellant Noske based on recurring maltreatment, under Minn. Stat. §§ 245C.02, subd. 16, and 245C.15, subd. 4 (2020)?

[1] Proposed exhibits marked 140-1 and 140-2 were among those not admitted.

4. Did Appellant Noske meet the burden of proof to demonstrate he does not pose a risk of harm to clients under Minn. Stat. § 245C.22, subd. 4 (2020), such that his disqualification must be set aside?

5. Did the Department correctly determine that Rose Ann Brutger and James L Noske Adult Foster Care committed the three licensing violations related to the maltreatment as set forth in the August 13, 2021, Determination of Maltreatment, Disqualification from Direct Contact, Failure to Report Maltreatment, and Order of License Revocation (Revocation Order),[2] pursuant to the applicable law or rule cited for each violation?

6. Did the Department correctly determine Rose Ann Brutger and James L Noske Adult Foster Care failed to report maltreatment under Minn. Stat. §§ 626.557, subd. 3 and 245A.65, subd. 1 (2020)?

7. Did the Department properly revoke Appellants' Home and Community-Based Service License (1069512) and Adult Foster Care License (1045923) based on the maltreatment determinations and the license holders' disqualifications, as detailed in the Revocation Order pursuant to Minn. Stat. § 245A.07, subds. 1 and 3 (2020)?

SUMMARY OF RECOMMENDATION

The Judge respectfully recommends that, because:

1. the Department properly determined that Appellants were each responsible for maltreatment of three vulnerable adults by emotional abuse;

2. the Department properly determined that Appellants were each responsible for maltreatment of M.K. by neglect, but did not properly determine that Appellants were responsible for maltreatment of D.M or S.R. by neglect;

3. the Department properly disqualified Appellant Noske based on recurring maltreatment;

4. Appellant Noske did not demonstrate that he does not pose a risk of harm to clients;

5. the Department correctly determined that the Ann Brutger and James L Noske Adult Foster Care committed the three licensing violations;

6. the Department correctly determined that the Rose Ann Brutger and James L Noske Adult Foster Care failed to report maltreatment; and

7. the Department properly revoked Appellants' licenses based on the maltreatment determinations and the license holders' disqualifications;

[2] Exhibit (Ex.) 1.

the Commissioner of the Department of Human Services (Commissioner) should **MODIFY** the August 13, 2021, Determinations of Maltreatment, Disqualifications from Direct Contact, Failure to Report Maltreatment, and Order of License Revocation to strike the determinations of maltreatment by neglect of S.R. and D.M., and **AFFIRM AS MODIFIED**.

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

FINDINGS OF FACT

Background

1. Appellants provide home and community-based services (HCBS) and adult foster care (AFC) services at 1206 Heritage Drive, Waite Park MN 56287, under license numbers 1069512 (HCBS) and 1045923 (AFC).[3] Appellants' adult foster care license is overseen by Stearns County Human Services.[4]

2. At the times relevant to this proceeding, Rose Ann Brutger and James L. Noske were the sole license holders and controlling individuals of Rose Ann Brutger and James L Noske Adult Foster Care (Facility).[5] Appellant Noske remains a license holder and authorized agent of the Facility.[6]

3. At the times relevant to this proceeding, three vulnerable adults resided at and received services from Appellants at 1206 Heritage Drive, and were under the direct care and supervision of Brutger and Noske.[7]

4. On April 16, 2021, the Department issued an Order of Temporary Immediate Suspension of the licenses at issue.[8] The licenses remain temporarily suspended pending a final order.

5. Brutger was subject to, and did not appeal, the Department's Revocation Order. This appeal is brought by James Noske and the Facility.

The Facility

6. The Facility provides housing and services in a split-level, single family home.[9]

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[3] *Id*. at 1.
[4] Testimony (Test.) of Christine Schwinghammer.
[5] Test. of Jason Pehler.
[6] *Id*.; Ex. 1; Ex. 19 (Investigative Strategy Report) at DHS Exs. p 166.
[7] Test. of James Noske.
[8] Revocation Order at 8.
[9] Test. of J. Noske; Exs. 119-3, 122-1 and 128-1.

7. The upstairs of the home has a kitchen, living room, and two bedrooms for service recipients residing there.[10]

8. The downstairs of the home has a room that serves as both a bedroom and an office for Noske, and a bedroom for a service recipient.[11] The downstairs bedroom/office contains a medication safe and a security monitoring system.[12]

9. Security cameras are located in the kitchen/dining area, in the living room, and in the basement.[13] The cameras provide sound and video that could be viewed and recorded using the monitoring system in the bedroom/office.

10. According to Michael Hagstrom, the security system's maintainer, the security system's audio quality was "sufficient to the needs of the business."[14]

Vulnerable Adults

11. M.K. has been diagnosed with cerebral palsy and dementia.[15] M.K. requires 24-hour support needs 1-on-1 assistance with daily activities.[16] M.K. lacks awareness of his own safety.[17]

12. M.K. is missing a muscle on the bottom of his foot.[18] As a result, M.K. is unsteady on his feet, is prone to falling, and requires assistance to safely ascend or descend stairs.[19]

13. M.K. wears orthotic braces to facilitate safer walking.[20] M.K. requires assistance to put on his braces properly.[21]

14. M.K. experiences bladder and bowel incontinence.[22]

15. As of a June 2020 assessment, M.K.'s health was in decline and his ambulatory and dementia-related challenges have been increasing over time.[23]

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[10] Exs. 125-1, 125-2, 127-1, and 127-2.
[11] Test. of J. Noske; Exs. 119-2, 126-1, and 126-2.
[12] Test. of J. Noske.
[13] Test. of M. Hagstrom; Exs. 119-2–4; *see* Ex. 155 (video taken from a camera located in the kitchen/dining area).
[14] Test. of M. Hagstrom.
[15] Ex. 25, 572–80 (M.K.'s Community Support Plan (CSP)) at 6; Ex. 20 at DHS Exs. p. 399.
[16] M.K.'s CSP at 6.
[17] M.K.'s CSP at 5.
[18] M.K.'s CSP at 5.
[19] Test. of J. Noske; M.K.'s CSP at 5; Test. of Casha Daudinot.
[20] M.K.'s CSP at 5
[21] Test. of C. Daudinot; Test. of Cheryl Rae Sixx.
[22] M.K.'s CSP at 5.
[23] M.K.'s CSP at 5–6.

16. M.K.'s Community Support Plan (CSP), effective from August 1, 2020, to July 21, 2021, states the following:

- [M.K.] has cognitive impairments due to a mild intellectual disability which requires 24 hour support.[24]

- Personal Security: [M.K.] is mentally and physically unable to have the judgment to cope, make appropriate decision or take action in a changing environment or potentially harmful situation. [M.K.] requires a 24-hour Plan of Care to assure his health and safety in the community. His AFC provider stated that he always needs to have eyes on him. There is a baby monitor in his room. He requires 1:1 assistance with activities. He is at risk of self-neglect and is a vulnerable adult who is at risk of neglect, abuse or exploitation by others.[25]

17. M.K.'s Coordinated Services and Supports Plan (CSSP),[26] effective from August 1, 2020, to July 21, 2021, states the following:

- [M.K.] starts his day by waking up at 6 am.[27]
- Providers will work with [M.K.] on identified goals while ensuring his health and safety at all times.[28]
- Providers will ensure all staff working with [M.K.] are able to work with and meet his needs.[29]
- [M.K.] lives in foster care where his health and safety needs are met by the staff and providers.[30]
- [M.K.] should have staff accompany him or be nearby while he is working in the event of a fall this would allow him to get assistance right away.[31]

18. M.K.'s CSSP provides that the Facility would address M.K.'s needs for "Home Management, Cognitive and Behavior Supports, Self-Direction, Supportive Services, Health Related/Medical, Personal Security, Personal Assistance, Communications, Quality of Life."[32]

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[24] M.K.'s CSP at 6.
[25] *Id*.
[26] Ex. 25 at DHS Exhibits p. 581–93 (M.K.'s CSSP).
[27] M.K.'s CSSP at 1.
[28] M.K.'s CSSP at 4.
[29] *Id*.
[30] M.K.'s CSSP at 11.
[31] M.K.'s CSSP at 12.
[32] M.K.'s CSSP at 8.

19. S.R. has been diagnosed with anxiety, obsessive-compulsive disorder, Tourette syndrome, and developmental disabilities.[33] S.R. can complete most daily life activities without assistance but requires prompts or cues.[34] S.R. has poor physical coordination and has difficulty with household tasks and cutting food.[35] S.R. also has a history of struggling with spending and impulse buying.[36] S.R. has a representative payee managing S.R.'s finances.[37] The Facility provided S.R. staffing availability 24 hours a day in order to maintain quality of life and improve skills.[38]

20. D.M. has been diagnosed with schizophrenia, anxiety disorder, obsessive-compulsive disorder, depression, developmental disabilities, and had a history of seizures.[39] D.M. could complete most daily life activities without assistance, though the Facility provided 24-hour supervision and support to D.M., and provided assistance with medications.[40]

Reports Alleging Maltreatment

21. On March 10 and 11, 2021, the Department received reports from the Minnesota Adult Abuse Reporting Center (MAARC) alleging that:

- Noske would "holler and cuss" at M.K.[41]
- During a community fair in 2019, Noske left the vulnerable adults to go have drinks; when it was time to leave neither Noske nor M.K. could be immediately located.[42]
- Noske pays S.R. to complete Noske's cleaning tasks and sends S.R. to get groceries.[43]
- There have been incidents of Noske appearing disoriented, intoxicated, or under the influence of drugs and Brutger must resume care/supervision of the vulnerable adults.[44]
- Noske left M.K. alone to dry off after a shower and M.K. fell in the bathtub.[45]

[33] Ex. 26, DHS Exs. p. 594–604 (S.R.'s CSP) at 7.
[34] *See, generally,* S.R.'s CSP at 6.
[35] S.R.'s CSP at 6.
[36] S.R.'s CSP at 7.
[37] *Id*.
[38] Ex. 26, DHS Exs. p. 605–15 (S.R.'s CSSP) at 9.
[39] Ex. 24, DHS Exs. p 544–54 (D.M.'s CSP) at 7.
[40] *See* D.M.'s CSP at 6; Ex. 24, DHS Exs. p. 555–71 (D.M.'s CSSP) at 12.
[41] Ex. 5 at DHS Exhibits p. 48 (MAARC Report 375234789) and DHS Exhibits p. 54 (MAARC Report 375232900).
[42] The "allegation detail" section of reports #375232900 and #375234789 states that Noske could not be immediately located. *Id*. The same section of report #375063969 states that the Facility's co-owner had to go find M.K. Ex. 5 at DHS Exhibits p. 63 (MAARC Report 375063969). The Investigation Report states, "when it was time to leave [Noske] could not be located and the co-owner had to locate [M.K.]" Ex. 15 at DHS Exhibits p. 153, 157.
[43] *Id*.
[44] *Id*.
[45] Ex. 6 at DHS Exhibits p. 63 (MAARC Report 375063969).

- Noske took a nap while on duty and before Noske woke up, M.K. went outside unattended. Brutger returned to the facility, noticed that M.K. was not at the facility, and had to look for M.K.[46]
- Noske failed to prevent M.K. from urinating in his bed by not attending to M.K. in a timely fashion or maintaining M.K.'s schedule.[47]
- Noske was under the influence of an intoxicant on an occasion when he was supposed to drive vulnerable adults to church.[48]
- Noske paid service recipients to provide care or exercise to M.K., and to perform cleaning responsibilities assigned to Noske.[49]

22. DHS received additional MAARC reports on March 11, 2021, alleging maltreatment by Noske against M.K., S.R., and D.M.[50]

23. On April 12, 2021, DHS received additional reports that Noske had threatened and intimidated staff, and that he had been intoxicated while at the facility.[51]

24. A single incident can result in multiple similar reports to MAARC from different reporters.[52] A single report to MAARC can result in multiple similar MAARC Reports pertaining to different involved vulnerable adults.[53]

25. On March 11, 2021, Waite Park Police Investigator Abraham Salber began investigating MAARC report number 375063969.[54]

Waite Park Police Investigation

26. During the Waite Park Police Department investigation, Investigator Salber interviewed S.R. and D.M. in separate interviews.[55]

27. D.M. told Salber that Noske and Brutger would argue in front of residents, and that Noske would yell at M.K.[56] According to D.M.'s statement to Salber:

- Noske once left the residence to travel to Avon, leaving only D.M. and S.R. to care for M.K.

- M.K. left the house unattended while Noske was sleeping.

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[46] *Id*.
[47] *Id*.
[48] *Id*.
[49] *Id*.
[50] Exs. 7, 8, and 9.
[51] Ex. 10 at DHS Exhibits p. 109.
[52] Test. of Abraham Salber.
[53] Test. of A. Salber; Investigative Report at DHS Exhibits p. 249.
[54] Ex. 29 (Investigative Report).
[55] Investigative Report, Exs. 30 (S.R. Interview), and 31 (D.M. Interview).
[56] Investigative Report at DHS Exhibits p. 252; Ex. 61.

- Noske had paid her to help M.K. exercise, prepare for a nap, and to change M.K.'s undergarments while Noske was the only staff person in the Facility and he remained in his office.[57]

28. S.R. told Salber that:

- Noske had D.M. watch M.K. while Noske remained in his office in the basement, and had paid her $20 to do so.
- Noske had D.M. change M.K.'s undergarments.
- That D.M. last took care of M.K. about 1 ½–2 months prior to the interview.
- Noske had sworn and been verbally abusive to him, M.K., and Brutger.
- There were times when M.K. had called for help and Noske would not check on M.K. until "a few minutes later."
- S.R. believed that staff used a baby monitor to monitor M.K. during sleeping hours, and that Noske would turn the monitor down or off because Noske did not want to be disturbed.
- On multiple occasions, M.K. had fallen and Noske was not in the same room, including an occasion when M.K. fell in the shower.
- Noske had asked S.R. to retrieve D.M.'s medications from the medication safe using a key.[58]

29. At Salber's interview of S.R., S.R. read responses to some of Salber's questions from notes.[59] S.R. did not refer to notes when describing Noske swearing at clients, or when describing the last time D.M. took care of M.K.[60]

30. Salber noted that, based on his observations, M.K. "appeared to have the cognitive level of a 3–5 year-old."[61]

31. On March 23, 2023, Tiffany Thompson, Central Minnesota Child Advocacy Center, conducted a forensic interview of M.K.[62] M.K. told Thompson that Noske is "not nice" to anyone at the house and tells people, including Brutger and M.K., to "shut up."[63]

[57] Investigative Report at DHS Exhibits p. 252–53; Ex. 61.
[58] Investigative Report at DHS Exhibits p. 253–54; Ex. 61.
[59] Ex. 61 at 12:07–22:13.
[60] Ex. 61 at 12:59–13:15, 19:13–19:56, 21:19–21:39.
[61] Investigative Report at DHS Exhibits p. 255.
[62] Ex. 45; Ex. 46 (M.K. Interview).
[63] M.K. Interview at 8:04–8:27, 9:20–9:34, 13:46–14:09, 38:30–39:22, 39:50–40:17.

According to M.K., Noske has yelled at Brutger and told Brutger to "go to hell."[64] M.K. told Thompson that Noske does not take his time when putting on M.K's braces.[65] M.K. described every other person at the Facility as "nice."[66] M.K. did not address whether D.M. provided him care.[67]

32. During the forensic interview, M.K. often changed the subject when asked to discuss something unpleasant.[68] M.K. appeared likely to have memory difficulty[69] and to be confused about events in his day.[70]

33. Salber also took statements from Brutger, Cody Lingl (Facility overnight staff), Abigayle Thompson (Facility staff), Jean Rae Bergstrom (former Facility staff), and Stephen K. (M.K.'s guardian).[71] Their statements were consistent in expressing general concern about Noske's care of the vulnerable adults at the facility, and in their descriptions of specific allegations.[72]

34. Salber spoke with Noske on April 5, 2021.[73] Noske admitted to sometimes turning down M.K.'s baby monitor and that M.K. had left the house without assistance when only Noske and M.K. were at the home.[74] Noske denied other allegations of maltreatment.[75] Salber did not believe that Noske took the allegations seriously.[76]

35. Noske told Salber that "you don't let [M.K.] walk up the stairs without being there . . . Basically, you know, just have your eyes or ears on him all the time."[77]

Specific Incidents Involving M.K.

36. On one occasion M.K. left the house by himself while Noske was in the living room.[78] The amount of time that M.K. was unsupervised on this occasion is unknown, but Noske estimates that M.K. was outside unattended "10 to 15 seconds" before Noske found him.[79] Noske has variously described the place where he found

[64] M.K. Interview at 20:40–21:15, 39:50–40:26.
[65] M.K. Interview at 36:40–37:57.
[66] *See, generally*, M.K. Interview.
[67] M.K. Interview at 20:10–20:39.
[68] *See, e.g.,* M.K. Interview at 8:29–9:11; 9:17–10:34, 35:24–36:00; 37:57–38:12, 39:26–39:30.
[69] *See, generally*, M.K. Interview.
[70] M.K. Interview at 34:45–35:16.
[71] Investigative Report at DHS Exhibits p. 249.
[72] *See* Investigative Report at DHS Exhibits p. 249–59; Exs. 38, 41, 43, 46, 51, and 58.
[73] Investigative Report at DHS Exhibits p. 258.
[74] *Id*.
[75] *Id*.
[76] Test. of A. Salber.
[77] Ex. 56 at 11:55–12:57; Ex. 20 at DHS Exhibits p. 420.
[78] Test. of J. Noske.
[79] Test. of J. Noske.

M.K. after leaving the house as "near the neighbor's house,"[80] and "west of the driveway by a flowerbed" on Facility Property.[81]

37. M.K. could only have reached the locations outside the house that Noske described finding M.K. by descending stairs.[82]

38. Facility staff use a baby monitor to monitor M.K. overnight and identify occasions that M.K. may require care, particularly related to M.K.'s incontinence.[83] At times, M.K. would experience incontinence 3, 4, or 5 times overnight.[84]

39. Noske has turned M.K.'s baby monitor down or off at night while Noske was on-duty.[85]

40. On more than one occasion Noske disregarded that M.K. required care overnight—multiple staff members told investigators that they found M.K. in bed and soaked or saturated in urine after not being taken to the restroom or changed overnight by Mr. Noske.[86]

41. On February 1, 2021, while Noske was on-duty, M.K. fell into the shower.[87] Noske had left M.K. alone to dry off and dress after completing a shower, and M.K. fell.[88] The fall caused bruising on M.K.'s shoulder blade.[89]

Chores Assigned to Vulnerable Adults

42. D.M. complained to staff that Noske made her do chores.[90] D.M.'s CSP documents a "decrease in motivation or interest" in doing chores, which included "housekeeping tasks."[91]

43. Noske had D.M. do his work and paid her for doing so.[92] Bergstrom told Investigator Salber that the Facility maintained a chore book for employees, and that D.M. signed the chore book.[93]

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[80] Investigative Report at DHS Exhibits p. 258.
[81] Test. of J. Noske.
[82] Test. of J. Noske.
[83] Test. of J. Noske; Test. of C. Daudinot; M.K.'s CSP at 6.
[84] Ex. 56 at 16:51–17:19.
[85] Ex. 56 at 18:46–19:24; Ex. 29 at DHS Exhibits. p. 631; Statement of S.R.
[86] Test. of Tabitha Halverson; Test. of Jason Pehler; Ex. 39 at DHS Exhibits p. 661; Ex. 20 at 414.
[87] Test. of J. Noske; Ex. 100-57.
[88] Test. of J. Noske.
[89] Test. of Grace Martagon.
[90] Test. of G. Martagon.
[91] D.M.'s CSP at 6.
[92] Test. of T. Halverson; Ex. 43 at 11:11–12:29; Ex. 20 at DHS Exs. p. 410.
[93] Ex. 43 at 11:11–12:29; Ex. 20 at DHS Exs. p. 410.

44. Noske and Brutger both asked S.R. to obtain groceries for the Facility.[94]

April 10, 2021, Incident

45. On April 10, 2021, near 11 p.m., Waite Park Police Officers Deschepper, Lehmkuhl, and Zaboj responded to a call that an employee was intoxicated at the Facility.[95] The officers arrived to find Brutger at the doorway, who directed them to Noske in the Facility's basement.[96] Noske appeared to be intoxicated to a degree that Officer Lehmkuhl believed that "it would not be reasonable at all for him to work with vulnerable adults."[97] Noske blew a .210 on a portable breath test.[98]

46. Abigayle Thompson and Tabatha Halverson were present at the Facility when the Officers arrived.[99] Thompson was originally scheduled to work on April 10 from 8 a.m. until 8 p.m.[100] Thompson told Officer Lehmkuhl that Noske had arrived at 8 p.m. to relieve her.[101] She left the Facility when Noske relieved her, but returned upon Brutger's request.[102]

47. Noske was originally scheduled to be on duty on April 10, 2021.[103] That night, Brutger claimed to Officer Lehmkuhl that Noske was supposed to be on duty.[104] While at the Facility, Officer Lehmkuhl reviewed the schedule and noted that "it did appear that Noske did take his name off [the schedule] with whiteout."[105] There is no record evidence that Noske's name was removed from the schedule before Noske relieved Thompson.

48. Brutger told Investigator Pehler that she put her name on the schedule because she "had to have a game plan" to care for the Facility's clients.[106] By April 10, 2021, Brutger believed that Noske should not be alone with the clients.[107]

Facility Policies

49. The Facility's Drug and Alcohol Policy was "reviewed or revised and authorized" by Noske on July 1, 2018.[108] The Drug and Alcohol Policy provides that "[i]t

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[94] Test. of J. Noske; Ex. 61.
[95] Ex. 32 at DHS Exhibits p. 644–647.
[96] Ex. 32 at DHS Exhibits p. 644.
[97] Ex. 32 at DHS Exhibits p. 646.
[98] *Id*.
[99] Ex. 32 at DHS Exhibits p. 645.
[100] Ex. 20 at DHS Exhibits p. 297.
[101] Ex. 36 at 2:22–2:31; Ex. 37 at DHS Exhibits p. 652.
[102] Ex. 36 at 1:32–2:22; Ex. 37 at DHS Exhibits p. 652; *see also* Investigative Strategy Report at 24.
[103] Ex. 20 at DHS Exhibits p. 297; Ex. 32 at DHS Exhibits p. 647.
[104] Ex. 32 at DHS Exhibits p. 647.
[105] Ex. 32 at DHS Exhibits p. 647. *But see* Ex. 35 (Thompson's Mar. 29 Statement to Salber) at 7:31–9:12 (Thompson telling Investigator Salber that Noske had been whiting out Bruger's name).
[106] Investigative Strategy Report at 22.
[107] Ex. 21 at DHS Exhibits pp. 466; 497; Ex. 12 at DHS Exhibits p. 126.
[108] Ex. 47 at DHS Exhibits p. 719 (Drug and Alcohol Policy).

is the policy of this DHS licensed provider (program) to support a workplace free from the effects of drugs, alcohol, chemicals, and abuse of prescription medications."[109] The policy further provides that:

> A. The consumption of alcohol is prohibited while directly responsible for persons receiving services, on our property (owned or leased) or in our vehicles, machinery, or equipment (owned or leased), and will result in corrective action up to and including termination.
>
> B. Being under the influence of . . . alcohol . . . in any manner that impairs or could impair an employee's ability to provide care or services to persons receiving services is prohibited and will result in corrective action up to and including termination.[110]

50. Noske created the Drug and Alcohol Policy by revising a sample policy obtained from the Department. He did so to meet requirements to obtain licenses under Minn. Stat. §§ 245A.001 –.75 and 245D.01 - .33 (2020).[111]

51. The Facility maintained a Safe Medication Assistance and Administration Policy (Medication Policy).[112] The Medication Policy was "reviewed or revised and authorized" by Brutger and Noske on July 28, 2017.

52. The Facility's medication administration policy provides, in relevant part, that when administering medication, staff must:

- Check the person's medication administration record (MAR);
- Prepare the medications as necessary; and
- Administer the medication or treatment the person according to the prescriber's order.[113]

53. Thompson told Investigator Salber that Noske failed to update the Medication Administration Record (MAR) for S.R. and as a result S.R. did not receive administration of a prescribed medication for several days.[114]

54. Thompson and Brutger told Investigators Salber and Pehler that Noske had administered medication without confirming that the medication was prepared

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[109] *Id*.
[110] *Id*.
[111] Test. of J. Noske.
[112] Ex. 47 at DHS Exhibits p. 711–16.
[113] Ex. 47 at DHS Exhibits p. 713.
[114] Thompson's Mar. 29 Statement to Salber at 11:41–12:37.

appropriately, and as a result administered the medication in a manner inconsistent with the prescription.[115]

The Department's Investigation

55. Investigator Jason Pehler conducted an investigation for the Department, and maintained an investigative strategy report during the course of the investigation.[116] Pehler's investigation incorporated the statements taken by Investigator Salber. Pehler personally interviewed Brutger, Bergstrom, Thompson, Christine Schwinghammer (Licensor, Stearns County Human Services), Tabatha McSwain (Facility staff), Grace Martagon (Personal Care Attendant), and Noske. Pehler was unable to contact two people that Noske suggested he interview: Sandra Kloss and Katie Salsburn.[117]

56. Investigator Pehler concluded that the statements of Brutger, Halverson, Thompson, Lingl, Bergstrom, Martagon, M.K., S.R., and D.M. consistently showed that Noske "demonstrated behavior that was inconsistent with that of a caregiver/provider in a licensed facility."[118] Upon a review of statements made during the investigation conducted by Investigator Salber, Pehler concluded that Noske's statement to Salber contradicted the statements of multiple other people.[119] Pehler further reasoned that "based on the number of persons who observed and/or had knowledge of the concerns reviewed in this investigation, it was determined that [Noske]'s account of the incidents was not credible."[120]

Maltreatment Determinations, Revocation Order, and Appeal

57. On August 13, 2021, the Department issued a report to Brutger and Noske containing determinations of maltreatment, disqualifications from direct contact, failure to report maltreatment, and an order of license revocation.[121] On the same day, the Department also issued a maltreatment investigation memorandum.[122]

58. The Department concluded that maltreatment was substantiated, and Rose Brutger, James Noske, and the facility were each responsible for the maltreatment.[123]

59. By a letter dated September 22, 2021, Noske appealed the August 13, 2021, order in its entirety.

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[115] *Id.*; Ex. 17 at 192.
[116] Ex. 19 (Investigative Strategy Report).
[117] Test. of J. Pehler; Investigative Strategy Report at 237.
[118] Ex. 3 at DHS Exs. p. 30.
[119] Test. of J. Pehler.
[120] *Id.*
[121] Revocation Order.
[122] Ex. 3 (Investigation Memo.).
[123] Revocation Order at 5.

Statements of Vulnerable Adults

60. After receiving notice of this contested case proceeding, S.R. and D.M. submitted signed, typewritten statements for consideration as part of the record.[124]

61. S.R. wrote:

> Living in the group home was a terrifying experience at times. When Mr. Noske was in the home he would yell at the clients, staff and Ms. Brutger calling us names and making threats. When Mr. Noske was in the house I would retreat to my room and lock the door hoping to not be targeted by him, I could hear him yelling at the other residents and staff which would cause my anxiety to escalate as I feared for their safety as well as my own.
>
> . . .
>
> My hope is that Mr. Noske is never able to harm another vulnerable adult again. No one should have to live with the fear that myself and my housemates endured.[125]

62. D.M. wrote that she experienced and witnessed abuse towards herself and other housemates. She stated that Noske would give her money to clean the house and tell her not to tell anyone. According to D.M., Noske had her help M.K. in the bathroom, change M.K.'s undergarment, and put M.K. to bed at night. D.M. also described knowledge of Noske yelling at M.K., calling M.K. names like "stupid," telling M.K. to "shut up," and leaving M.K. alone in the bathtub, where M.K. would fall. According to D.M., Noske "yelled a lot," and made threats. She stated that Noske "would be intoxicated while he was working and when he was in his office." D.M. stated that the experiences in the Facility negatively impacted her mental health and exacerbated her schizophrenia.[126]

63. Any material fact in the memorandum below, not stated in these findings of fact, is hereby adopted as such and incorporated by reference.

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

CONCLUSIONS OF LAW

1. The Administrative Law Judge and the Commissioner of Human Services have authority to consider this appeal under Minn. Stat. §§ 14.50, 245A.07, subd. 3(b), 245A.08, 260E.33 (2020), and Minn. R. 1400.8505 to .8612 (2021).

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[124] Statement of S.R. (May 23, 2022); Statement of D.M. (May 19, 2022).
[125] Statement of S.R.
[126] Statement of D.M.

2. The Department has fulfilled all relevant procedural requirements of law or rule.

3. Appellants received due, proper, and timely notice of the basis for the agency's decision, and of the time and place of the hearing.

4. Appellants timely appealed the Revocation Order.

5. The Department's determinations concerning Brutger were not appealed and are therefore conclusive.

6. Vulnerable adults include persons at least 18 years of age who reside at a Department-licensed facility.[127]

7. M.K., S.R., and D.M. are vulnerable adults.

8. The vulnerable adults were notified of this contested case proceeding and informed of their right to submit a signed, written statement as required by Minn. Stat. § 626.557, subd. 21.

9. The Judge must consider the written statements of the vulnerable adults in deciding this appeal.[128]

10. Noske was a "caregiver," as defined in Minn. Stat. § 626.5572, subd. 4 (2020), for residents in the Facility.

Maltreatment Standard of Proof

11. The Department has the burden to prove by a preponderance of evidence that Appellant is responsible for maltreatment.[129]

12. A "preponderance of the evidence" means that the ultimate facts must be established by a greater weight of the evidence.[130] All of the evidence must lead one to believe that the claim is more likely true than not true.[131] If it is more likely than not that the facts support the Department's allegations, then the Department has met its burden. In contrast, if the evidence casting doubt on the Department's allegations is stronger and more persuasive, then the Department has failed to meet its burden. Under this standard, the Department maintains the ultimate burden of persuasion to prove that maltreatment occurred.

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[127] *See* Minn. Stat. § 626.5572, subd. 6(a) (defining facility), and subd. 21(a)(1) (defining vulnerable adult to mean any person at least 18 years of age and who is a resident of a facility).
[128] Minn. Stat. § 626.557, subd. 21 (2020).
[129] Minn. Stat. § 260E.30, subd. 1 (2020); Minn. R. 1400.8608.
[130] 4 Minnesota Practice, CIV JIG 14.15 (2020).
[131] *Id*.

Maltreatment by Abuse

13. Maltreatment includes abuse as defined by Minn. Stat. § 626.5572, subd. 2 (2020).[132]

14. Abuse includes conduct—other than accidental or therapeutic conduct—which produces or could reasonably be expected to produce emotional distress, including 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.[133]

15. Yelling at staff and residents in a licensed facility could reasonably be expected to produce emotional distress in service recipients diagnosed with anxiety.

16. Calling a developmentally disabled vulnerable adult "stupid" would be considered by a reasonable person to be disparaging.

17. The Department has shown by a preponderance of the evidence that Noske committed maltreatment of D.M. and S.R. by yelling at staff and residents in their presence.

18. The Department has shown by a preponderance of the evidence that Noske committed maltreatment by calling M.K. "stupid."

Maltreatment By Neglect

19. Maltreatment includes neglect as defined by Minn. Stat. § 626.5572, subd. 17 (2020).[134]

20. Neglect is defined as:

> (a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, 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

[132] Minn. Stat. § 626.5572, subd. 15 (2020).
[133] Minn. Stat. § 626.5572, subd. 2(b)(2).
[134] Minn. Stat. § 626.5572, subd. 15.

(2) which is not the result of an accident or therapeutic conduct.[135]

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, 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.

21. The Department has shown by a preponderance of the evidence that Noske committed maltreatment by allowing M.K. to descend stairs without reasonable and necessary supervision, and to leave the house unattended.

22. The Department has shown by a preponderance of the evidence that Noske committed maltreatment by allowing M.K. remain in bed while soaked in urine.

23. The Department has not shown by a preponderance of the evidence that Noske committed neglect of D.M. or S.R.

Recurring Maltreatment and Responsibility for Maltreatment

24. Under Minn. Stat. § 245C.02, subd. 16, "recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that the maltreatment occurred and that the subject was responsible for the maltreatment.

25. Upon a maltreatment determination involving a facility, Minn. Stat. § 260E.30, subd. 2(a) (2020), requires the Department to establish by a preponderance of the evidence whether the facility, an individual, or both, were responsible for the maltreatment.

26. When maltreatment is determined to have been committed by an individual who is also the facility license holder, both the individual and the facility must be determined responsible for the maltreatment.[136]

27. Because Noske is a Facility license holder, and because a preponderance of the evidence establishes that Noske committed at least two instances of maltreatment, including maltreatment by emotional abuse and maltreatment by neglect, both Noske and the Facility are responsible for maltreatment by emotional abuse, maltreatment by neglect, and recurring maltreatment.

[135] Minn. Stat. § 626.557, subd. 17.
[136] Minn. Stat. § 260E.30, subd. 4(c) (2020).

Disqualification

28. A person is disqualified from direct contact with persons receiving services licensed under Minn. Stat. §§ 245A.001 – .75 when a preponderance of the evidence substantiates that recurring maltreatment occurred and that the person was responsible for the maltreatment.[137]

29. Because the Department has met its burden to show that Noske was responsible for recurring maltreatment, Noske is disqualified from direct contract with service recipients.

30. The Commissioner may set aside a disqualification if an individual has demonstrated that he does not pose a risk of harm to a service recipient.[138] The individual has the burden of proof to establish a basis setting aside a disqualification.[139]

31. To determine whether the burden of proof for setting aside a disqualification has been met, the Commissioner must consider:

a. the nature, severity, and consequences of the event or events that led to the disqualification;

b. whether there is more than one disqualifying event;

c. the age and vulnerability of the victim at the time of the event;

d. the harm suffered by the victim;

e. vulnerability of persons served by the program;

f. the similarity between the victim and persons served by the program;

g. the time elapsed without a repeat of the same or similar event;

h. documentation of successful completion by the individual studied of training or rehabilitation pertinent to the event; and

i. any other information relevant to reconsideration.[140]

32. Under Minn. Stat. § 245C.22, subd. 3 (2020), any one of the nine factors in the risk of harm analysis may be considered determinative, and the statute requires that preeminent weight be given to the safety of the persons to be served by the program over the interests of the disqualified individual or applicant.

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[137] Minn. Stat. § 245C.15, subd. 4(b)(2).
[138] Minn. Stat. § 245C.22, subd. 4(a).
[139] Minn. Stat. § 245C.22, subd. 4(b).
[140] *Id*.

33. The following considerations weigh against setting aside Noske's disqualification: the repeated nature of the disqualifying event; the vulnerability of the victims at the time of the event; vulnerability of persons served by the program; the similarity between the victims and persons served by the program; the recency of the disqualifying event; and the absence of documentation of successful completion by the individual studied of training or rehabilitation pertinent to the event.

34. In light of the statutory considerations, Noske has not met his burden to show he does not pose a risk of harm to a service recipient.

Licensing Violations

35. When sanctioning a licensee, the Department has the burden to establish reasonable cause for 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 commissioner 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 or rules that the commissioner alleges the license holder violated, at the time that the commissioner alleges the violations of law or rules occurred.[141]

36. A license holder must develop program policies and procedures necessary to maintain compliance with licensing requirements, and must monitor implementation of policies and procedures by program staff.[142]

37. The Facility's Drug and Alcohol Policy prohibits the consumption of alcohol on Facility property.[143] The policy also prohibits "being under the influence of . . . alcohol . . . in any manner that impairs or could impair an employee's ability to provide care or services to persons receiving services."[144]

38. Noske violated the Drug and Alcohol Policy by consuming alcohol on Facility property.

39. Noske violated the Drug and Alcohol Policy by being under the influence of alcohol in a manner that could impair his ability to provide care or services.

40. The Facility failed to implement its Drug and Alcohol Policy.

41. Service recipients have a right to be free from maltreatment and the right to be treated with courtesy and respect.[145]

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[141] Minn. Stat. § 245A.08, subd. 3.
[142] Minn. Stat. § 245A.04, subd. 14.
[143] Drug and Alcohol Policy.
[144] *Id.*
[145] Minn. Stat. § 245D.04, subd. 3(a)(3), (6).

42. By yelling at M.K., telling him to shut up, and calling him stupid, Noske deprived M.K. of the right to be treated with courtesy and respect.

43. The Facility failed to ensure the exercise and protection of service recipient's protection-related rights, including the right to be free from maltreatment and the right to be treated with courtesy and respect.

44. Under Minn. Stat. § 245D.05, subd. 2(b), if responsibility for medication administration is assigned to the license holder by a coordinated service and support plan or coordinated service and support plan addendum, the license holder must implement medication administration procedures to ensure a service recipient takes medications and treatments as prescribed.

45. For a license holder providing intensive support services, the medication or treatment must be administered according to the license holder's medication administration policy and procedures required by Minn. Stat. § 245D.11, subd. 2(3).

46. The Facility's medication administration policy requires that, when administering medication, staff must:

a. Check the person's medication administration record (MAR);

b. Prepare the medications as necessary; and

c. Administer the medication or treatment the person according to the prescriber's order.

47. The Department had reasonable cause to cite the Facility for failing to implement its medication administration policy because multiple staff observed or reported knowledge of Noske failing to administer medications according to the Facility's medication administration policy. The Facility has not shown that it was in full compliance with the requirement to implement its medication administration policy.

Failure to Report Maltreatment

48. Minn. Stat. § 245A.65, subd. 1, requires license holders serving vulnerable adults to establish and enforce written policies and procedures relating to suspected or alleged maltreatment.

49. A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated must immediately report the information to the entity responsible for receiving such reports.[146]

[146] Minn. Stat. §§ 626.557, subd. 3; 626.5572, subd. 5 (2020).

50. "Mandated reporter" includes a professional engaged in the care of vulnerable adults.[147]

51. Because facility staff, including an administrative staff person, had knowledge of maltreatment, but did not make a report as required, the Department has met its burden to establish violations of Minn. Stat. § 245A.65, subd. 1 and Minn. Stat. § 626.557, subd. 3.

License Revocation

52. Under Minn. Stat. § 245A.07, subd. 1(a), the Commissioner may revoke a license when a license holder does not comply with applicable law or rule, upon consideration of 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.

53. The Commissioner has established reasonable cause for the Order of Revocation.

54. Appellants have not demonstrated that they were in full compliance with the laws or rules that the commissioner alleges Appellants violated, at the time that the commissioner alleges the violations of law or rules occurred.

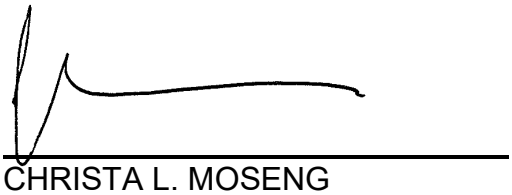
55. Any conclusion of law more appropriately characterized as a finding of fact is hereby adopted as such and incorporated by reference.

Based upon these Conclusions of Law, and for the reasons explained in the accompanying Memorandum, which is incorporated herein by reference, the Administrative Law Judge makes the following:

RECOMMENDATION

Based upon these Findings of Fact and Conclusions of Law, the Administrative Law Judge recommends that the Commissioner **MODIFY** the August 13, 2021, Determinations of Maltreatment, Disqualifications from Direct Contact, Failure to Report Maltreatment, and Order of License Revocation to strike the determinations of maltreatment by neglect of S.R. and D.M., and **AFFIRM AS MODIFIED**.

Dated: October 28, 2022



CHRISTA L. MOSENG
Administrative Law Judge

Reported: Digitally Recorded
No transcript prepared

[147] Minn. Stat. § 626.5572, subd. 16 (2020).

NOTICE

This Report is a recommendation, not a final decision. The Commissioner of the Department of Human Services (Commissioner) will make the final decision after a review of the record. Under Minn. Stat. § 14.61 (2022), 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 Administrative Law Office staff at DHS_AdminLaw@state.mn.us 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 (2022). 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 to be imposed.

Under Minn. Stat. § 14.62, subd. 1 (2022), the Commissioner is required to serve a final decision upon each party and the Administrative Law Judge by first class mail or as otherwise provided by law.

MEMORANDUM

I. Introduction

Appellant James Noske contests the Department's determinations that he is responsible for maltreatment by emotional abuse and maltreatment by neglect of vulnerable adults at his facility. Also at issue are the Department's determinations that Noske is disqualified from direct contact with service recipients, and that the Facility committed licensing violations relating to Facility policies and the statutory requirement to report maltreatment.

In his closing argument, Noske makes a number of new arguments seeking the inclusion of testimony and other evidence in the guise of argument, and exclusion of evidence under the rules of evidence.[148] To the extent that Noske offers evidence and evidentiary arguments that were not timely offered or raised and addressed during the hearing, they must be rejected as untimely.

[148] *See, e.g.,* James Noske's Closing Argument at 4 (claims concerning the contents of videos that were not offered or admitted into the record), 10 (arguing for the exclusion of evidence under Minn. R. Evid. 1003), and 24 (arguing for the exclusion of evidence under Minn. R. 1400.8607).

II. Credibility and Reliability

To the extent not otherwise expressly discussed, the Judge's relative credibility determinations may be inferred from the Findings, above, and analysis, below. The Judge makes the following express credibility and reliability determinations for purposes of clarity.

The testimony of Tabatha Halverson is generally credible and more reliable than conflicting testimony or evidence. Halverson's versions of events remained consistent from statements made to investigators to her testimony, and she was careful to distinguish direct personal knowledge from things she was told. Noske points to a single occasion that Halverson contradicted herself,[149] which she credibly explained.[150]

The Judge considers reliable Facility staff statements to investigators concerning Noske's acts and omissions at the facility, particularly those that concern finding M.K. soaked in urine and consistent descriptions of Noske's at-work behavior. At the time of these statements, staff knew that there was a penalty for making a false report of maltreatment because Noske hung a reminder of the penalty in the Facility for staff to see.[151] Some skepticism is warranted for statements from Brutger to investigators, but to the extent that her statements were corroborated by Halverson's testimony or multiple other statements by staff or vulnerable adults, they are reliable.

The written statements from D.M. and S.R. submitted to the court are credible and reliable. They were drafted after leaving the Facility, and therefore less likely to be the subject of undue influence than statements they made during the investigation. The Judge did not give great weight to the portions S.R's statement to Investigator Salber when he was clearly reading from notes. The portions of S.R.'s statement that were not read from notes are corroborated by other reliable evidence.

The Judge did not give much weight to testimony by Noske in circumstances where it is contradicted or called into question by reliable evidence—particularly where he described material events when there were no witnesses (such as when he worked alone overnight), or where his conduct was only witnessed by a vulnerable adult. Noske's testimony in these instances was less persuasive than the weight of conflicting, reliable evidence.

III. Analysis

This analysis will consider first the Department's maltreatment-related determinations, then Noske's disqualification, and finally the citations for licensing violations.

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[149] James Noske's Closing Argument at 11.
[150] Test. of T. Halverson.
[151] Test. of J. Noske; Ex. 47 at DHS Exhibits p. 720.

A. Maltreatment Determinations

The Department argues that Noske and the Facility were responsible for maltreatment by emotional abuse, maltreatment by neglect, and recurring maltreatment. Noske argues that the Department did not meet its burden to establish that maltreatment occurred. For the reasons discussed below, the Department has met its burden to establish that Noske committed multiple instances of maltreatment.

i. Maltreatment by Abuse of M.K., D.M., and S.R.

Maltreatment by abuse includes conduct that produces emotional distress and disparaging conduct.[152] The Department has met its burden to show that Noske engaged in both.

Many allegations in D.M. and S.R.'s May 2022 written statements are too general, taken by themselves, to support a maltreatment determination. However, both D.M. and S.R., and others, consistently described experiencing and witnessing conduct by Noske that could reasonably be expected to produce emotional distress in the vulnerable adults. Noske yelled at staff and residents while in the presence of two vulnerable adults diagnosed with anxiety. Noske threatened retaliation against Brutger and other staff in the presence of D.M. and S.R., which caused fear in the vulnerable adults that Noske would retaliate against them if they truthfully complained of maltreatment.

These experiences negatively affected D.M. and S.R.'s mental health while they experienced them. They continue to affect D.M. and S.R. over a year later. Noske also called M.K. disparaging names, including "stupid." The Department has met its burden to establish maltreatment by abuse of the three vulnerable adults.

ii. Maltreatment by Neglect of M.K.

Maltreatment by neglect includes the failure or omission by a caregiver to supply a vulnerable adult with care, services, or necessary supervision.[153] The Department has met its burden to show that Noske was a caregiver who failed to supply care, services, or necessary supervision to M.K.

M.K.'s fall in the shower constitutes an instance of maltreatment by neglect. M.K.'s CSP states that he needs "24 hour support." M.K.'s CSSP documents that M.K. is a fall risk. M.K. fell in the bathroom while at work on multiple occasions, going back to 2019.[154] Noske left M.K. unattended after a shower, and M.K. fell. According to Noske, he followed M.K. out of the bathroom and M.K. returned to the bathroom after Noske went to the kitchen. Because Noske was not aware of M.K.'s needs or activities, Noske failed to provide reasonably necessary supervision.

[152] Minn. Stat. § 626.5572, subd. 15.
[153] Minn. Stat. § 626.5572, subd. 17.
[154] Ex. 102-1 to 102-8.

M.K.'s absconding from the house unattended constitutes an instance of maltreatment by neglect. Noske's testimony about how long M.K. was outside the house unattended is both unreliable and, ultimately, immaterial. His estimate of how long M.K. was unattended outside is uncorroborated and self-serving. But the amount of time M.K. was unattended need not be established to conclude that M.K.'s absconding from the Facility without supervision constituted neglect because (1) M.K.'s CSP required M.K. have 24-hour support, and (2) M.K. could not leave the facility without descending stairs, and M.K. requires a person to assist him to use the stairs safely.

Noske argues that he could not have foreseen M.K. falling in the bathroom or attempting to leave the house, and that his supervision was adequate because he met the standard of supervision in Minn. Stat. § 245D.02, subd. 33b. These arguments are unpersuasive. Noske acknowledged that M.K. always needed eyes or ears on him. Supervision includes, among other things, "awareness of the person's needs and activities[.]"[155] In both instances, Noske lacked awareness of M.K.'s needs or activities.

Additionally, it is more likely than not that M.K.'s lack of awareness of his own personal safety renders any amount of unsupervised time outside the facility an omission of reasonably necessary supervision. Noske admits allowing M.K. to leave the facility unattended, which M.K. could only do by traversing stairs alone. Noske thereby failed to supply M.K. with services reasonable and necessary for M.K.'s physical health and safety. He did so as a result of a pattern of inattentiveness, not as an isolated or inadvertent accident.

Noske's decisions to ignore or turn down the volume on the baby monitor and to allow M.K. to sleep in, on occasion, resulted in instances of maltreatment by neglect. These decisions were, more likely than not, for Noske's convenience and resulted in omissions of reasonably necessary care or services for M.K. On more than one occasion, Noske allowed M.K. to remain in bed while saturated with urine.

Noske attempts to rebut evidence that he allowed M.K. to remain in bed saturated with urine by pointing to testimony of people who did not observe such occasions, to evidence that other staff allowed this to occur, and to the absence of evidence of physical symptoms of neglect. This evidence does not contradict, disprove, or overcome credible witness statements that he failed to provide reasonably necessary supervision, care, and services to M.K. at least twice. Noske's omissions resulted in a urine soaked M.K. being discovered by other Facility staff. These constituted instances of maltreatment by neglect.

Noske argues, incorrectly, that there is no evidence that M.K. requires supervision while sleeping, and argues that the baby monitor was neither required by any of M.K.'s care plans nor an approved method for ensuring M.K. received necessary sleep-related care. It is true that the baby monitor was neither required nor expressly approved for the provision of care. However, Facility used the baby monitor as a tool to

[155] Minn. Stat. § 245D.02, subd. 33b.

ensuring that M.K. received necessary care and services, including 24-hour support. The Facility allowed staff to sleep during overnight shifts because staff relied on the baby monitor to interrupt their own sleep when necessary to provide M.K. care. Noske's decision to turn down or disregard the baby monitor while on-duty overnight caused Noske to fail to provide necessary care.

Finally, Noske argued that he used the security camera system to monitor M.K. while sleeping, which can be monitored from Noske's bedroom/office. However, the security camera system did not have a camera or other recording device inside M.K.'s bedroom or near M.K.'s bedroom door. There is not a preponderance of credible evidence to establish that Noske could or did, in fact, use the security system to adequately monitor M.K. and determine that M.K. needed bed-related care or services.[156] It is more likely than not that the security system was not suited or adequate for this purpose, and that Noske chose not to avail himself of the method that Facility staff ordinarily relied on—the baby monitor—because Noske wanted to sleep.

iii. Maltreatment by Neglect of D.M. and S.R.

The Department also concluded that Noske neglected S.R. and D.M. by causing them to perform supervision, care, or other tasks for which staff was responsible. The Department points to claims by S.R. and D.M. that Noske paid them to perform tasks that would be staff's responsibility. The Department reasoned that requiring a vulnerable adult to, in effect, provide their own care constitutes neglect.

Noske denies paying D.M. to care for M.K. and denies that S.R. handled medication. However, Noske admitted to having vulnerable adults do household chores, and that vulnerable adults would get paid for doing "a little extra" around the Facility.[157] Several people observed that Noske, as Bergstrom put it, "doesn't do anything" at the Facility.[158] Besides her statements during and after the police and Department investigations into maltreatment, D.M. contemporaneously complained to staff that Noske made her do chores.[159]

Based upon the entire record, it is more likely than not that Noske coerced or enticed D.M. to perform services for his advantage that she would not otherwise have performed.[160] Abuse includes the act of "coercing, or enticing a vulnerable adult against

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[156] The Judge infers from the testimony of Michael Hagstrom—the security system's maintainer—that the security system's audio was adequate to meet the business's needs as a security system, but not for the purpose of monitoring M.K. for care needs while M.K. was in his bedroom.

[157] Ex. 56 at 23:34–24:24. *See also* Ex. 152 at 7:04 to 7:40 (D.M.: "Because 'member all the times you paid me to help you out?" Noske: "Yeah.").

[158] Ex. 43 at 11:11–12:26. *See also, e.g.,* Test. of T. Halverson (Noske "stayed in the basement"); Ex. 59 at 8:01–9:02 (Halverson statement to Salber that Noske "wants to be there and get paid but he doesn't want to work"); Ex. 38 at 5:09–6:11 (Lingl statement to Salber regarding Noske that "when he comes into work it's more less in my opinion it seems like he's there but he's not there."); Ex. 61 at 4:57–5:32 (D.M. statement to Salber that Noske is usually in his office).

[159] Test. of G. Martagon.

[160] There is no evidence that S.R. complained about being asked to get groceries.

the vulnerable adult's will to perform services for the advantage of another."[161] However, the Department did not determine or argue that Noske abused D.M. or S.R. by coercing or enticing them to perform services for the Facility. It argued only that paying D.M. and S.R. to perform work for the Facility constituted neglect.[162]

The Judge does not find persuasive the Department's reasoning that these facts satisfy the statutory criteria for neglect. Even accepting that Noske paid D.M. or S.R. to perform tasks on his behalf, or for the benefit of the Facility, the Department has not established that the instances constituted *neglect*. Paying clients to do Facility "chores" did not constitute neglect because D.M. and S.R. received necessary care and services. The Department has not shown by a preponderance of the evidence that Noske failed, omitted, or was responsible for the absence of services or necessary care for D.M. or S.R.

iv. Recurring Maltreatment

The Department has more than met its burden to establish that recurring maltreatment occurred. The Department need only prove more than one incident of maltreatment to establish recurring maltreatment.[163] It has done so.

The Department has also met its burden to establish that both Noske and the Facility were responsible for each instance of maltreatment discussed above and for recurring maltreatment. The Department must ordinarily consider mitigating factors when allocating responsibility for maltreatment to a facility, individual, or both.[164] However, when maltreatment is determined to have been committed by an individual who is also the facility license holder, both the individual and the facility must be determined responsible for the maltreatment.[165] Noske is a facility license holder. Accordingly, both the Facility and Noske are responsible for each proven instance of maltreatment, and for recurring maltreatment.

B. Disqualification

Because Noske was responsible for recurring maltreatment, the Department appropriately concluded that he is disqualified under Minn. Stat. § 245C.15, subd. 4(b)(2). Noske bears the burden to show that the disqualification should be set aside because he does not pose a risk of harm to people that he would serve.[166] He has not met the burden.

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[161] Minn. Stat. § 626.5572, subd. 2(d).
[162] Department's Closing Arg. (Aug. 5, 2022) at 21.
[163] Minn. Stat. § 245C.02, subd. 16.
[164] Minn. Stat. 260E.30, subd. 4 (2020).
[165] Minn. Stat. 260E.30, subd. 4(c)
[166] Minn. Stat. § 245C.22, subd. 4(b).

Noske has not established that any statutory factor[167] weighs in favor of setting aside his disqualification. Most notably, rather than attempt to show completion of rehabilitation or training pertinent to any maltreatment, Noske has denied responsibility.

Noske's overall lack of regard for M.K.'s physical and mental health and safety is well established in the record. Noske argued that every incident involving M.K. was not Noske's responsibility, should not be regarded as serious, or did not occur. However, there were multiple occasions where Noske's acts or omissions constituted maltreatment. Noske's inattentiveness or disregard of M.K.'s care needs constituted a pattern that gave rise to multiple instances of maltreatment. The Commissioner should not set Noske's disqualification aside.

C. Licensing Violations

The Department identified three licensing violations related to its maltreatment determinations: failure to implement the Facility's Drug and Alcohol Policy, failure to administer medications according to the Facility's Medication Administration Policy, and failure to ensure the exercise and protection of service recipients' protection-related rights. Noske has appealed all three cited violations. For reasons discussed in detail above, the Department has shown that the Facility did not protect the vulnerable adults' rights to be free from maltreatment and to be treated with courtesy and respect, as required by Minn. Stat. § 245D.04, subd. 3(a). For the reasons discussed below, the Department has also established the remaining two violations.

i. Drug and Alcohol Policy

Noske argues that the Facility's Drug and Alcohol Policy is only intended to apply to people directly responsible for providing care while on duty. He asserts that his intoxication while at the facility was not a violation because he was not on duty while intoxicated, and because he was in a private room in the facility. However, the relevant portions of the policy's express language relating to consumption of alcohol and intoxication do not limit their application to people directly responsible for providing care.

The Drug and Alcohol Policy's introductory language offers a guide for interpreting its effective provisions, stating that the purpose of the policy is to "support a workplace free from the effects of . . . alcohol[.]" The policy prohibits "being under the influence of . . . alcohol . . . in any manner that impairs or could impair an employee's ability to provide care or services to persons receiving services."[168] Paragraph B of the policy prohibits the consumption of alcohol "while directly responsible for persons receiving services, on our property (owned or leased) or in our vehicles, machinery, or equipment (owned or leased)."[169]

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[167] *See Id*. (listing the required considerations).
[168] Drug and Alcohol Policy.
[169] *Id*.

Noske's argument that the entirety of paragraph B of the policy should be read to apply only to on-duty employees is unpersuasive. Neither the express language of the policy nor any reasonable construction supports Noske's interpretation. The policy does not limit application of the "on our property" clause to on-duty employees.

The Drug and Alcohol policy should be construed in a manner consistent with its policy statement.[170] Allowing off-duty employees to consume alcohol on the premises would not support a workplace free from the effects of alcohol. Noske's preferred interpretation is therefore inconsistent with the policy's plain language and its stated purpose. The only reasonable construction of paragraph B prohibits employee consumption of alcohol while on Facility property.

Accordingly, by consuming alcohol on Facility property and by being under the influence of alcohol in a manner that could impair his ability to provide care or services, Noske violated the Facility's Drug and Alcohol Policy. The Department has met its burden to show that the Facility did not implement its own Drug and Alcohol Policy.

ii. Medication Administration Policy

The record supports a conclusion that the Facility failed to implement its medication administration policy. Multiple staff persons described various violations of the policy, including medications administered by unauthorized persons, failure to administer prescribed medication, and administration of medication despite not confirming that the medication has been prepared correctly. The Department had reasonable cause to cite the Facility for failing to implement its medication administration policy, and Noske has not demonstrated that the Facility was in full compliance with the requirement that the policy be implemented.

D. Failure to Report Maltreatment

The Department also cited Appellants for failure to report maltreatment. Overall, the record depicts a Facility where, by 2021, care of the vulnerable adults took a back seat to the interests of the Facility's co-owners. The record reflects maltreatment of vulnerable adults that went unreported by either Noske or Brutger until their business and interpersonal relationship had deteriorated to the point that each alleged maltreatment or other improper conduct committed by the other.[171] Multiple instances of maltreatment were not timely reported by Appellants. The citation for failure to report maltreatment is supported by the record.

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[170] Reading the Drug and Alcohol Policy as a whole, the Judge sees no ambiguity in its language. But to the extent the Drug and Alcohol Policy is ambiguous it should be construed strictly against Noske, who drafted the policy. *See, e.g., Lowry v. Kneeland*, 263 Minn. 537, 541 (Minn. 1962) ("It is elementary that if there is doubt as to its meaning it must be construed most strongly against the one who chose the language in drafting the instrument.").

[171] *See* Test. of J. Noske (alleging misconduct by Brutger).

IV. Conclusion

The Department has met its burden to establish multiple instances of maltreatment, recurring maltreatment, failure to report maltreatment, and license violations relating to implementation of facility policies and protection of service recipients' rights. The Department has also correctly determined that Appellants are responsible for the maltreatment and that Noske should be disqualified from direct contact with service recipients.

However, the Department did not establish that D.M. or S.R. experienced neglect. The Commissioner should therefore **MODIFY** the Department's Revocation Order to strike the determinations of maltreatment by neglect of D.M. and S.R., and **AFFIRM AS MODIFIED**.

C. L. M.