OAH 22-1800-38540

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HUMAN SERVICES

In the Matter of the Appeal by Victoria Yeboah Adult Foster Care/HCBS of the Order of License Revocation	**FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION**
License No. 1103749 (Home and Community-Based Services) License No. 1092850 (Adult Foster Care)	

The above-entitled matter came before Administrative Law Judge Christa L. Moseng for a hearing on March 27, March 29, and April 10, 2023. The Department submitted written closing arguments on April 28, 2023. Appellant submitted written closing arguments on May 1, 2023. The record closed on May 1, 2023.

João C.J.G. de Medeiros, Assistant Attorney General, appeared on behalf of the Minnesota Department of Human Services (Department). Max A. Keller, Keller Law Offices, appeared on behalf of Victoria Yeboah (Appellant).

STATEMENT OF THE ISSUES

1. Did the Department properly revoke Appellant's Adult Foster Care (AFC) license because Appellant's primary residence was away from the physical location of the foster care license, under Minn. Stat. § 245A.03, subd. 7(a) (2020)?

2. Did the Department correctly determine that Appellant committed the 18 licensing violations as set forth in detail in the June 30, 2022, Order of License Revocation (Revocation Order), pursuant to the applicable law cited for each violation?

3. Did the Department correctly determine that the Appellant knowingly withheld relevant information or provided false and misleading information related to compliance with licensing rules and laws under Minn. Stat. § 245D.07, subd. 3(a)(3) (2020)?

4. Did the Department properly revoke Appellant's AFC and Home and Community-Based Services (HCBS) licenses based on the licensing violations detailed in the Revocation Order, under Minn. Stat. § 245A.07, subds. 1 and 3 (2020)?

SUMMARY OF RECOMMENDATION

Because (1) Appellant's primary residence was away from the physical location of the Adult Foster Care license; (2) Appellant committed the licensing violations identified in the Revocation Order and their nature, severity, and chronicity supports revocation; and, (3) Appellant's licenses are subject to sanction for her lack of candor in violation of Minn. Stat. § 245A.07, subd. 3(a)(3), the Judge respectfully recommends that the Commissioner **AFFIRM** the June 30, 2022, Order of License Revocation.

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

FINDINGS OF FACT

1. Appellant provides AFC and HCBS services at 2306 38th Street, Moorhead, under license numbers 1092850 (AFC) and 1103749 (HCBS).[1] Appellant has been licensed since 2018.[2] On June 25, 2019, Appellant requested to change the service location to 2306 38th Street South, in Moorhead.[3]

2. 2306 38th Street is a 5-bedroom, 3-bathroom, home.[4]

3. Appellant was licensed to serve four vulnerable adults at 2306 38th Street, Moorhead, MN 56560, and on January 31, 2022, four vulnerable adults resided there and received services from Appellant.[5]

4. Clay County Social Services (Clay County) is the licensing agency responsible for oversight of Appellant's AFC services.[6] The Department is the licensing agency providing oversight of Appellant's HCBS services.[7]

5. On January 31, 2022, Krista Hastings and Elizabeth Schiefelbein, Senior Licensors, conducted a licensing review of Appellant's provision of HCBS licensed services on behalf of the Department.[8]

6. Also on January 31, 2022, Frances Davenport, Clay County Adult Foster Care Licensor, conducted a licensing visit to determine compliance with AFC licensing rules and statutes.[9]

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[1] Testimony (Test.) of Frances Davenport; Test. of Krista Hastings; Ex. 1 (Revocation Order).
[2] Test. of F. Davenport; Exhibit (Ex.) 49 at 326.
[3] Ex. 49.
[4] Ex. 49 at 326; Test. of F. Davenport; Test. of Victoria Yeboah. This finding excludes a sixth bedroom in the basement, because the identified room lacks a window or other second exit. Test. of V. Yeboah.
[5] Test. of F. Davenport; Test. of V. Yeboah. This report refers to four service recipients as P1, P2, P3, and P4, corresponding to their identity in the Revocation Order's Non-Public Identification Key. Ex. 2.
[6] Test. of F. Davenport.
[7] Test. of K. Hastings; Test. of Mary Kelsey.
[8] Test. of Krista Hastings.
[9] Test. of F. Davenport.

7. On June 30, 2022, the Department issued an Order of License Revocation, revoking Appellant's AFC and HCBS licenses. The Department concluded that revocation of Appellant's licenses was appropriate based on the Commissioner's evaluation of the program and because: (1) Appellant did not reside at the program as required for the program's operation; (2) Appellant failed to comply with applicable laws and rules; and, (3) Appellant knowingly withheld or gave false and misleading information to the Department.[10]

8. Appellant appealed the Order by correspondence dated July 7, 2022, which the Department received on July 8, 2022.[11]

Appellant's AFC and Primary Residence

9. On May 1, 2021, Appellant's AFC license was renewed for at 2306 38th Street to serve a capacity of four recipients.[12] In her AFC license application, she listed herself and two children as family members.[13]

10. On January 31, 2022, Ms. Davenport observed circumstances that she regarded as "odd" and inconsistent with the setting being primarily a "family setting." This led her to doubt that Appellant primarily resided at the facility. These observations included an insufficient number of bedrooms for Appellant and her family, notes and instructions intended for staff, and staff refrigerators.[14] Davenport left "with an overwhelming feeling" that Appellant resided elsewhere.[15]

11. Upon further investigation, Ms. Davenport learned that Appellant's children resided at another address: 4556 12th Street South, in Moorhead. Davenport also learned during her investigation that Appellant filed a Petition for Harassment Restraining Order in Clay County District Court on May 14, 2021. The petition requests an order requiring the Respondent in that proceeding to "stay away from where [I] live" and provides 4556 12th Street South as Appellant's home address.[16]

12. On February 1, 2022, Ms. Davenport wrote an email to Appellant, and asked if she lives with her children at 4556 12th Street South.[17] Appellant responded that she lives at 2306 38th Street and maintains the other address for the children to live with her mother.[18] However, in a telephone conversation with Ms. Davenport, Appellant stated that she sleeps where her children reside and she only sometimes sleeps at 2306 38th Street.[19]

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[10] Ex. 1 (Revocation Order).
[11] Ex. 3.
[12] Ex. 51.
[13] Test. of F. Davenport.
[14] Test. of F. Davenport; *See* Exs. 53–59.
[15] Ex. 49 at 327.
[16] Ex. 47.
[17] Ex. 29 at 327.
[18] *Id*.
[19] Test. of F. Davenport; Ex. 49 at 327.

13. At the evidentiary hearing, Appellant testified that she spent "most" nights at 2306 38th Street but not every night.[20]

14. To support her claim that 2306 38th Street was her primary residence on January 31, 2022, Appellant provided:

a. A 2019 Certificate of Rent Paid identifying Victoria Yeboah as a renter of 2306 38th Street through December 31, 2019;[21]

b. 2019 Federal and State tax returns dated February 14, 2020;[22]

c. Undated mail addressed to her and her children at 2306 38th Street;[23]

d. Utility bills addressed to her at 2306 38th Street and dated August and September 2022;[24]

e. A bill for cable and internet services during the month of June.[25]

f. A first-quarter report card addressed to the parent/guardian of her daughter for September 8, 2020, through November 6, 2020.[26]

g. A "borrower application form" for the Federal Paycheck Protection Program dated January 8, 2021, listing 2306 38th Street as the business address for Glory Care Living;[27]

15. Two former AFC residents, Devin Fredrick and Patrick Harling testified to the frequency that Appellant was at 2306 38th Street at night.[28] Fredrick testified that Appellant was there at night "every now and then."[29] Harling testified that she was there at night "sometimes."[30]

16. A relative of a former resident testified that "one time," when she was at 2306 38th Street in the evening, Appellant came to take a resident where the resident wanted to go.[31]

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[20] Test. of V. Yeboah.
[21] Ex. 101.
[22] Ex. 102.
[23] Ex. 104 at 1–3.
[24] Ex. 104 at 4–5.
[25] Ex. 104 at 7. The entire bill is not included and the year is not apparent on the exhibit.
[26] Ex.104 at 8.
[27] Ex. 111.
[28] Test. of Devin Fredrick; Test. of Patrick Harling.
[29] Test. of D Fredrick
[30] Test. of P. Harling.
[31] Test. of Judy Hoffbeck.

Licensing Violations

17. During her licensing review visit, Ms. Hastings observed the following:

a. a calendar kept in a common area in the facility had detailed personal, service, health and/or medical information for service recipients;[32]

b. a document posted in the common area titled "HOUSE RULES" which provided "DUE TO THE COVID PLEASE LIMIT FRIENDS VISIT PER 1" and "NO OUTING OR FRIENDS AFTER 11PM."[33]

c. a memo to staff which provided "PLEASE NOTE NO OUTING AFTER 10PM UNLESS EMERGENCY SITUATION" and "PLEASE ALWAYS NOTIFY VICKY WITH SUCH ISSUES AT HOME."

18. In connection with the January 31, 2022, licensing site visit, Ms. Schiefelbein conducted a review of Appellant's records.[34]

19. With respect to Appellant's staff training and orientation:

a. Appellant documented certain required staff training had been provided by a "case worker," but upon a request for the identity of the trainer or the training curriculum, Appellant could provide neither;[35]

b. Appellant documented certain staff training provided "online" or by a "website" but upon a request for additional information, Appellant was unable to substantiate the training provider or the curriculum for the training;[36]

c. Appellant documented completing certain staff orientation training more than 60-days after the start date;[37]

d. Appellant's annual training record reflected an incorrect hire date and documented that the training was not completed annually;[38]

e. Appellant documented training provided by outside providers on policies and procedures that Appellant would have created for her own programs;[39]

[32] Test. of K. Hastings; Ex. 52.
[33] Test. of K. Hastings, Ex. 53.
[34] Test. of Elizabeth Schiefelbein.
[35] Test. of E. Schiefelbein; Ex. 40 at 281–83.
[36] Test. of E. Schiefelbein; Ex. 41 at 284.
[37] Test. of E. Schiefelbein; Ex. 40.
[38] Test. of E. Schiefelbein; Ex. 41.

f. Appellant documented staff received certain training before the training was required by law;[40]

g. Appellant used the 2020 revision of a form to document training as far back as 2018;[41]

20. A Coordinated Service and Support Plan (CSSP) is a document developed by a service recipient's case manager which summarizes the services and supports a person will receive, who will provide them, and the person's goals.[42] A CSSP Addendum is a document prepared by a license holder based upon the CSSP.[43] Appellant was required to, and did, prepare support plan addenda for P1, P2, P3 and P4.[44]

21. To the extent that there is a conflict between a CSSP and a CSSP Addendum, the CSSP controls.[45]

22. With respect to Appellant's provision of services:

a. Appellant had not prepared individualized medication setup, administration, or assistance policies for service recipients based on their CSSP and CSSP addenda,[46] and had not trained staff on individualized plans;[47]

b. Appellant's Incident Response, Reporting, and Review Policy provides that incident reports would include certain information, but Appellant's incident report forms did not provide space for the required information;[48]

c. Two incident reports concerning P3 did not document whether or when Appellant reported the incident to P3's case manager;[49]

d. Appellant did not annually review P1's individual abuse prevention plan;[50]

e. P1 required intensive support services, but: Appellant's 45-day planning meeting did not include a discussion of how technology might be used to meet the person's desired outcomes; Appellant

[39] Test. of E. Schiefelbein.
[40] Test. of E. Schiefelbein.
[41] Test. of E. Schiefelbein; Ex. 40.
[42] Test. of K. Hastings; *See* Ex. 19; Minn. Stat. § 245D.02, subd. 4b (2020).
[43] Test. of K. Hastings; *See* Exs. 15 –18, 20; Minn. Stat. § 245D.02, subd. 4c (2020).
[44] Exs. 15 –18, 20.
[45] Test. of K. Hastings.
[46] Test. of E. Schiefelbein.
[47] Test. of E. Schiefelbein.
[48] Test. of E. Schiefelbein; Ex. 21 at 4–5; Exs. 22–24.
[49] Test. of K. Hastings; Exs. 23 and 24.
[50] Test. of K. Hastings; Ex. 26.

did not summarize such a conversation in P1's CSSP or CSSP Addendum; and, Appellant did not include a statement in any summary regarding any decision relating to the use of technology or any need for further research before a decision can be made;[51]

f. The following were not evident in Appellant's service recipient records:

i. progress or daily log notes for P1, P2, P3, or P4 in their respective service recipient records;

ii. a copy of P3's current coordinated service and support plan (CSSP) or that portion of the plan assigned to the license holder;

iii. a signed statement authorizing the license holder to act in a medical emergency when P4's legal representative cannot be reached or is delayed in arriving; or,

iv. an admission document for P4 that included P4's phone number.

23. There are three levels of responsibility that a license holder can be assigned relating to a service recipient's medication. They are: medication setup, medication assistance, and medication administration.[52] Each level of responsibility has its own documentation requirements.[53]

24. P1's CSSP addenda provided that Appellant would provide "medication assistance" for P1.[54] Appellant in fact provided P1 with "medication setup" for P1.[55] Appellant did not document the dates that staff provided medication setup or assistance for P1, and did not document the procedures for medication setup or assistance.[56]

25. P2's CSSP provided that P2 required "monitoring and assistance with medical/health needs, including assessing need for medical care and administration of medications."[57] P2 authorized Appellant to provide medication assistance but the signatures on the authorization are dated November 2021, and lack a specific date.[58] It is therefore not possible to use the authorization to determine when in November P2 authorized Appellant to provide medication assistance. P2's CSSP addendum indicated

[51] Test. of K. Hastings; Exs. 15 and 16.
[52] Test. of K. Hastings.
[53] Test. of K. Hastings.
[54] Ex. 15 at 165; Ex. 16 at 172.
[55] Test. of K. Hastings.
[56] Test. of K. Hastings.
[57] Ex. 17 at 179.
[58] Ex. 30.

"N/A" as the level of responsibility assigned to Appellant for P2's medication.[59] However, Appellant kept P2's medication and limited when P2 could take it.[60]

26. P3's CSSP addendum reflected that Appellant was responsible for P3's medication administration, including psychotropic medication.[61] Appellant did not document the target symptoms which the psychotropic medication was meant to alleviate on P3's CSSP addendum.[62]

27. P3 self-administered weekly injections of a medication which Appellant kept in a locked container.[63] A staff person came weekly on Tuesdays to retrieve the medication so P3 could administer the injection herself.[64] Appellant did not document the procedure for providing the medication to P3.[65]

28. P3's Medication Administration Record (MAR) reflected a change from "PRN" (as-needed) acetaminophen to three doses at 8 a.m., 4 p.m., and 8 p.m., which was not ordered but was requested by P3.[66] P3's MAR also documented stopping the administration of a medication on October 25, 2021, at P3's request, and followed by a subsequent order to change the medication's administration to the morning instead of the evening.[67]

29. P4's CSSP provided that P4 required "monitoring and assistance with medical/health needs, including assessing need for medical care and administration of medications."[68] P4's CSSP addendum reflected that Appellant was responsible for medication assistance for P4, and that staff would remind P4 to take her medications as prescribed.[69]

30. P4's MARs included two psychotropic medications.[70] P4's CSSP addendum indicated that Appellant was not administering the medication, because Appellant was providing medication assistance and not administration.[71]

31. On January 11, 2022, P4 was prescribed a medication for intermittent chest pain. The prescription provided that one tablet may be kept on P4's nightstand.[72]

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[59] Ex. 17 at 183.
[60] Test. of K Hastings.
[61] Ex. 18 at 193.
[62] *Id*.
[63] Test. of K. Hastings; Ex. 31 at 247.
[64] Test. of K. Hastings.
[65] *Id*.
[66] Test. of K. Hastings; Ex. 31 at 245.
[67] Test. of K. Hastings; Ex. 31 at 256.
[68] Ex. 19 at 206.
[69] Ex. 20 at 213.
[70] Test. of K. Hastings.
[71] Ex. 20 at 213.
[72] Ex. 36 at 269.

Appellant allowed P4 to keep the entire bottle of the medication in her room.[73] P4's January 2022 MAR did not reflect the prescription.[74]

32. Appellant did not document the procedures for staff to follow in order to satisfy the support-plan medication requirements of P1, P2, P3, or P4.[75]

33. P3 experienced health-related incidents on January 8 and January 21, 2022.[76] Appellant did not maintain documentation of whether or when the incident was reported to P3's case manager.[77]

34. Appellant had an obligation to review client medication administration records every three months.[78] Appellant did not identify medication administration errors that were apparent in the records during these reviews.[79]

35. Based upon the licensors' observations during the licensing review, the Department concluded that Appellant:[80]

a. knowingly withheld relevant information or provided false or misleading information related to compliance with licensing rules and laws, in violation of Minn. Stat. § 245A.07, subd. 3(a)(3);

b. did not provide and ensure the exercise and protection of the service recipient rights as required under Minn. Stat. § 245D.04, subds. 2 and 3 (2020);

c. did not report and maintain information about incidents for two persons whose records were reviewed (P2 and P3), as required under Minn. Stat. § 245D.06, subd. 1(b) (2020);

d. did not provide services as assigned in the coordinated service and support plan (CSSP) for two persons whose records were reviewed (P2 and P4), as required under Minn. Stat. § 245D.07, subd. 1;

e. for one person whose record was reviewed (P1), the license holder did not review an individual abuse prevention plan (IAPP) annually as required in Minn. Stat. § 245A.65, subd. 2 (2020);

f. did not meet service planning requirements for intensive support services for one person whose record was reviewed (P1), as required by Minn. Stat. § 245D.071, subd. 3(d) (2020);

[73] Test. of K. Hastings.
[74] Ex. 35 at 268.
[75] Test. of K. Hastings.
[76] Ex. 23.
[77] *Id*.; Test. of K. Hastings.
[78] Test. of K. Hastings; Ex. 32.
[79] Test. of K. Hastings; Exs. 31–39.
[80] Ex. 1 at 2–18.

g. did not maintain service recipient records as required under Minn. Stat. § 245D.095, subd. 3(b) (2020);

h. did not maintain documentation on health needs as required under Minn. Stat. § 245D.05, subd. 1(b) (2020);

i. did not provide medication setup for P1 as required under Minn. Stat. § 245D.05, subd. 1a (2020);

j. did not provide medication administration for P2, P3 or P4, as required under Minn. Stat. § 245D.05, subd. 2 (2020);

k. did not obtain written authorization for medication administration for P2 as required under Minn. Stat. § 245D.05, subd. 2(b);

l. did not review medication administration records and report medication and treatment issues for P3 and P4 as required under Minn. Stat. § 245D.05, subd. 4;

m. did not meet the requirements for psychotropic medication use and monitoring for P3 and P4 as required under Minn. Stat. § 245D.051, subd. 1 (2020);

n. did not provide orientation training for three staff persons as required under Minn. Stat. § 245D.09, subd. 4 (2020);

o. did not provide orientation to individual service recipient needs to two staff persons, as required under Minn. Stat. 245D.09, subd. 4a(d) and (e);

p. did not provide annual training to one staff person, as required under Minn. Stat. § 245D.09, subd. 5 (2020);

q. did not maintain personnel records for three staff persons, as required under Minn. Stat. § 245D.095, subd. 5 (2020);

r. did not enforce policies and procedures, as required under Minn. Stat. 245D.11, subd. 2(7) (2020); and

s. failed to ensure that the designated coordinator provided supervision, support, and evaluation of activities and failed to ensure that the designated manager provided program management and oversight of the services provided by the license holder, in violation of Minn. Stat. § 245D.081 (2020).

36. The Department considered the nature, chronicity, and severity of the violations. It noted one repeat violation and that many of the identified violations were of a law or rule that concerns the health, safety, or rights of people served by the

program.[81] The Department considered the total number of identified violations as part of its analysis.[82] It wrote that it revoked Appellants AFC and HCBS licenses:[83]

> [b]ecause you changed your primary residence away from the physical location of the family adult foster care license that was issued during the moratorium on new foster care programs that are not the primary residence of the license holder; and, due to the serious and chronic nature of licensing violations and the conditions in the program, which impact the health and safety of persons served in your care[.]

37. Any conclusion of law more appropriately characterized as a finding 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, (2020), and Minn. R. 1400.8505 to .8612 (2021).

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

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

4. Appellant timely appealed the Revocation Order.

5. The Department has the initial burden to "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."[84] If the Department makes the required showing, the burden shifts to license holder to prove 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."[85]

6. Minn. Stat. § 245A.07, subd. 3(a)(1) provides that the Commissioner may suspend or revoke a license, or impose a fine, if a license holder fails to comply fully with applicable laws or rules.

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[81] Ex. 1 at 4–5.
[82] Test. of M. Kelsey.
[83] Ex. 1 at 18.
[84] Minn. Stat. § 245A.08, subd. 3(a) (2020).
[85] *Id*.

7. Minn. Stat. § 245A.03, subd. 7 (2020), requires the Commissioner to revoke an adult foster care license if the license holder changes the license holder's primary residence away from the physical location of the foster care license.

8. The Department had reasonable cause to conclude that the license holder changed her primary residence away from 2306 38th Street. Appellant did not meet her burden to show by a preponderance of the evidence that she was in full compliance with the requirement to maintain 2306 38th Street as her primary residence.

Licensing Violations

9. **Violation 1:**[86] A license holder is responsible for coordination of service delivery, and program management and oversight.[87] The license holder must designate a staff person to coordinate delivery and evaluation of services. The designated coordinator must provide supervision, support, and evaluation of activities that include: oversight of the license holder's responsibilities assigned in service recipients' CSSP and CSSP Addendum.[88] The license holder must ensure the designated coordinator is competent to perform the required duties.[89] The license holder must also designate a person to perform program management, who must maintain a current understanding of the licensing requirements, ensure the duties of the designated coordinator are fulfilled, and ensure staff competency.[90]

10. Appellant is the license holder, designated coordinator, and designated manager.

11. Appellant failed to comply with the requirements of Minn. Stat. § 245D.081 by failing to ensure the designated coordinator and the designated manager carried out their responsibilities under Minn. Stat. § 245D.081.

12. **Violation 2:** A license holder must ensure the exercise and protection of a service recipient's rights in the services provided by the license holder and as authorized by the recipient's CSSP.[91] Service recipients have the right to have health and medical information kept private.[92]

13. Because she did not keep residents' health and medical information private, Appellant did not provide and ensure the exercise and protection of the service recipient rights as required under Minn. Stat. § 245D.04, subds. 2 and 3.

14. **Violation 3:** A license holder must maintain information about and report incidents to the person's legal representative or designated emergency contact and

[86] As numbered in the Revocation Order.
[87] Minn. Stat. § 245D.081, subd. 1.
[88] *Id*. at subd. 2.
[89] *Id*.
[90] *Id*. at subd. 3.
[91] Minn. Stat. § 245D.04, subd. 1(4) (2020).
[92] Minn. Stat. § 245D.04, subd. 3(a)(1) (2020).

case manager within 24 hours of an incident occurring while services are being provided.[93]

15. Appellant did not maintain information about two incidents relating to P3 as required by Minn. Stat. § 245D.06, subd. 1(b).

16. **Violation 4:** A license holder must provide services as assigned in the support plan.[94]

17. Appellant did not provide medication administration assigned to Appellant in P4's CSSP, in violation of Minn. Stat. § 245D.07, subd. 1.

18. **Violation 5:** A license holder must implement an abuse prevention plan according to Minn. Stat. § 245A.62, subd. 2 (2020).[95] A license holder must review program abuse prevention plans annually.[96]

19. Appellant did not review the program abuse prevention plan of P1 annually, in violation of Minn. Stat. §§ 245A.62, subd. 2(a)(5) and 245D.071, subd. 2 (2020).

20. **Violation 6:** A license holder must conduct a 45-day planning meeting for recipients requiring intensive support services that includes a discussion of how technology might be used to meet the person's desired outcomes. The support plan or support plan addendum must include a summary of this discussion. The summary must include a statement regarding any decision that is made regarding the use of technology and a description of any further research that needs to be completed before a decision regarding the use of technology can be made.[97]

21. Because Appellant either did not discuss with P1 how technology might be used to meet P1's desired outcomes, or did not summarize the discussion and provide the necessary statement relating to a decision regarding the use of technology, Appellant violated Minn. Stat. § 245D.071, subd. 3(d).

22. **Violation 7:** A license holder must maintain a record of current services provided to each person on the premises where the services are provided or coordinated. The service recipient records must include (among other things):

a. an admission form with the recipient's telephone number, medication administration procedures;

b. a signed statement authorizing the license holder to act in a medical emergency when the person's legal representative, if any, cannot be reached or is delayed in arriving;

[93] Minn. Stat. § 245D.06, subd. 1(b).
[94] Minn. Stat. § 245D.07, subd. 1.
[95] Minn. Stat. § 245D.071, subd. 2 (2020).
[96] Minn. Stat. § 245A.62, subd. 2(a)(5) (2020).
[97] Minn. Stat. § 245D.071, subd. 3(d).

c. medication administration procedures;

d. a medication administration record documenting the implementation of the medication administration procedures;

e. the person's current support plan or that portion of the plan assigned to the license holder; and

f. progress or daily log notes that are recorded by the program.[98]

23. Appellant's service recipient records for P3 and P4 failed to include required information, in violation of Minn. Stat. § 245D.95, subd. 3(b) (2020).

24. **Violation 8:** If responsibility for meeting the person's health service needs has been assigned to the license holder in the support plan or the support plan addendum, the license holder must maintain documentation on how the person's health needs will be met, including a description of the procedures the license holder will follow to provide medication setup, assistance, or administration.[99]

25. Appellant did not maintain documentation including a description of the procedures the license holder will follow to provide medication setup, assistance, or administration of P1, P2, P3, or P4, as required by Minn. Stat. § 245D.05, subd. 1(b).

26. **Violation 9:** A license holder is responsible for meeting health service needs assigned in the support plan.[100] When a license holder is assigned a medication setup or when a medication setup is required as part of a medication assistance or administration, the license holder must document: dates of setup, name of medication, quantity of dose, times to be administered, and route of administration at time of setup; and, when the person will be away from home, to whom the medications were given.[101]

27. Appellant did not document medication setup for P1, in violation of Minn. Stat. § 245D.05, subd. 1a.

28. **Violation 10**: When a license holder is assigned to perform medication administration, the license holder must implement medication administration procedures to ensure a person takes medications as prescribed.[102] The license holder must ensure the following information is documented in the person's medication administration record (MAR):

a. the information on the current prescription label or the prescriber's current written or electronically recorded order or prescription that includes the person's name, description of the medication or treatment to be provided, and the frequency and other information

[98] Minn. Stat. § 245D.95, subd. 3(b).
[99] Minn. Stat. § 245D.05, subd. 1(b).
[100] Minn. Stat. § 245D.05, subd. 1a.
[101] Minn. Stat. § 245D.05, subd. 1a(b).
[102] Minn. Stat. § 245D.05, subd. 2(b)(1).

needed to safely and correctly administer the medication or treatment to ensure effectiveness;[103]

b. notation of any occurrence of a dose of medication not being administered or treatment not performed as prescribed, whether by error by the staff or the person or by refusal by the person, or of adverse reactions, and when and to whom the report was made; and,[104]

c. notation of when a medication or treatment is started, administered, changed, or discontinued.[105]

29. Because Appellant did not document the frequency and other information needed to safely and correctly administer a medication for P2; did not include current prescription information on P3's MAR; did not ensure that P3 or P4 took medication as prescribed; and on several occasions failed to note occurrences of a dose not being administered, Appellant violated Minn. Stat. § 245D.05, subd. 2.

30. **Violation 11**: A license holder must obtain written authorization from a person or the person's legal representative to administer medication or treatment.[106]

31. The Department had reasonable cause to conclude that Appellant violated Minn. Stat. § 245D.05, subd. 2(b)(2), because the P2's signed medication administration authorization did not include a date. Because Appellant did not meet the burden to show that the authorization was obtained before administering medication to P2, Appellant violated Minn. Stat. § 245D.05, subd. 2(b)(2).

32. **Violation 12**: When assigned responsibility for medication administration, the license holder must ensure that the information maintained in the medication administration record is current and is regularly reviewed to identify medication administration errors.[107] The reviews must occur at least every three months.[108]

33. Because Appellant's reviews of P3's and P4's medication records did not identify medication administration errors, Appellant did not comply with the requirements of Minn. Stat. § 245D.05, subd. 4.

34. **Violation 13**: When a person is prescribed a psychotropic medication and the license holder is assigned responsibility for administration of the medication in the person's support plan or the support plan addendum, the license holder must document a description of the target symptoms that the psychotropic medication is to alleviate.[109]

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[103] Minn. Stat. § 245D.05, subd. 2(c)(1).
[104] Minn. Stat. § 245D.05, subd. 2(c)(5).
[105] Minn. Stat. § 245D.05, subd. 2(c)(6).
[106] Minn. Stat. § 245D.05, subd. 2(b)(2).
[107] Minn. Stat. § 245D.05, subd. 4.
[108] *Id*.
[109] Minn. Stat. § 245D.051, subd. 1(b)(1).

35. Because Appellant failed to maintain documentation that included a description of the target symptoms that the psychotropic medications of P3 or P4 were used to alleviate, Appellant violated Minn. Stat. § 245D.051, subd. 1(b)(1).

36. **Violation 14**: A license holder who supervises direct support staff must, within 60 days of hire, provide and ensure completion of orientation sufficient to create staff competency for direct support staff that combines supervised on-the-job training.[110] The statute prescribes certain orientation topics, including basic first aid.[111]

37. The Department had reasonable cause to conclude that Appellant failed to ensure completion of orientation within 60 days of hire for SP3, because SP3's orientation record failed to record the name of the instructor for basic first aid orientation and the curriculum of the training could not be verified. Appellant did not show that she was in full compliance with Minn. Stat. § 245D.09, subd. 4 at the time of the alleged violation.[112]

38. **Violation 15**: Before having unsupervised direct contact with a person served by the program, or for whom the staff person has not previously provided direct support, or any time certain plans or procedures specified in the statute are revised, the staff person must review and receive orientation to individual service recipient needs.[113] The required review includes instruction on medication setup, assistance, or administration procedures established for the person when assigned to the license holder.[114]

39. Because Appellant did not document medication administration procedures for service recipients, the Department had reasonable cause to conclude that Appellant failed to ensure SP2 and SP3 reviewed and received instruction on medication administration procedures established for service recipients whose medication administration was assigned to Appellant, in violation of Minn. Stat. § 245D.09, subd. 4a(d). Appellant did not show she had fully complied with Minn. Stat. § 245D.09, subd. 4a(d) at the relevant times.

40. **Violation 16**: A license holder must provide annual training to direct support staff on topics specified in Minn. Stat. § 245D.09, subd. 4(3)–(11).[115]

41. The Department had reasonable cause to conclude that Appellant did not provide annual training to direct support staff because Appellant's annual training record failed to record the name of the instructor and the curriculum for the training could not

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[110] Minn. Stat. § 245D.09, subd. 4.
[111] *Id*.
[112] The Department argued that Appellant, herself, was required to complete orientation within 60 days of her start date in 2018. However, the orientation requirement in Minn. Stat. § 245D.09, subd. 4, does not apply to a license holder who does not supervise any direct support staff. The Department did not establish that Appellant had support staff in 2018 or another basis for applying the requirement to Appellant.
[113] Minn. Stat. § 245D.09, subd. 4a.
[114] Id. at 4a(d).
[115] Minn. Stat. § 245D.09, subd. 5.

be verified. Appellant did not show she had fully complied with Minn. Stat. § 245D.09, subd. 5.

42. **Violation 17:** A license holder must maintain a personnel record for each employee to document and verify staff qualifications, orientation, and training that includes "the name of the trainer or instructor."[116]

43. Appellant did not maintain personnel records in the manner required by Minn. Stat. § 245D.095, subd. 5, because training documentation did not include the name of the trainer or instructor.

44. **Violation 18:** A license holder must establish policies and procedures that promote health and welfare, including a procedure for the review of incidents and emergencies and a record-keeping system for the incident and emergency reports. The license holder must conduct a review of incident reports. Incident reports must include a determination of whether corrective action is necessary based on the results of the review.[117]

45. Appellant established and maintained a policy for incident response, reporting, and review. However, Appellant failed to enforce the policy by failing to maintain required information, or to document a determination of whether corrective action was necessary based on the results of the required review, in violation of Minn. Stat. § 245D.11, subd. 2 (2020).

46. The Department had reasonable cause to determine that Appellant committed the 18 violations set forth in the Revocation Order.

47. Minn. Stat. § 245A.07, subd. 3(a)(3), provides that the Commissioner may suspend or revoke a license, or impose a fine, if a license holder knowingly withholds relevant information from or gives false or misleading information during an investigation or regarding compliance with applicable laws or rules.

48. Appellant knowingly withheld relevant information or gave false or misleading information to the Department relating to (1) the license holder's primary residence and (2) staff training.

49. Minn. Stat. § 245A.07, subd. 1(a), requires the Department to 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 when determining what sanction to impose.

50. The nature, chronicity, and severity of the proven violations support revocation of Appellant's AFC and HCBS licenses.

[116] Minn. Stat. § 245D.095, subd. 5(a)(2).
[117] Minn. Stat. § 245D.11, subd. 2.

51. The Department had reasonable cause to issue the June 30, 2022, Revocation Order. Appellant did not meet the burden to show by a preponderance of the evidence that it was in full compliance with the laws and rules cited.

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

RECOMMENDATION

The Judge respectfully recommends that the Commissioner **AFFIRM** the June 30, 2022, Order of License Revocation.

Dated: July 27, 2023

CHRISTA L. MOSENG
Administrative Law Judge

Reported: Digitally Recorded
No transcript prepared

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

The Department issued an order revoking Appellant's Adult Foster Care and Home and Community-Based Services licenses based upon violations of law and rule, Appellant's lack of candor to the Department regarding compliance, and because Appellant did not maintain the Adult Foster Care location as her primary residence. Appellant contests the Department's decision to revoke the licenses.

II. Burden of Proof

The Department has the initial burden to "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."[118] If the Department makes the required showing, the burden shifts to license holder to prove 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."[119]

III. Analysis

The Department maintains that Appellant's failure to maintain the AFC as her primary residence justifies revocation of the AFC license, and that the violations of law and rule provide an independent basis for revocation of both licenses. Appellant argues that her licenses should not be revoked because the result is disproportionate; because the requirement to maintain a primary residence at the AFC is unenforceably vague; and, because one of the identified violations did not occur. This Memorandum will first analyze the sufficiency of the AFC primary residence issue for revocation of the AFC license, and then the law and rule violations' sufficiency to support both revocations.

A. Revocation of the AFC license is required under Minn. Stat. § 245A.03, subd. 7(a).

The Legislature established a moratorium on adult foster care licenses issued for a physical location that will not be the primary residence of the license holder for the entire period of licensure.[120]

The Department had reasonable cause to conclude that Appellant's primary residence was not 2306 38th Street on January 31, 2022. Clay County's Adult Foster Care Licensor observed circumstances that led her to doubt that Appellant primarily resided at the facility. The facility did not have enough bedrooms to house four service

[118] Minn. Stat. § 245A.08, subd. 3(a).
[119] *Id*.
[120] Minn. Stat. § 245A.03, subd. 7(a).

recipients, Appellant, and her children. There were staff refrigerators and instructions for staff, the nature of which left the licensor "with an overwhelming feeling" that Appellant resided elsewhere. The licensor investigated further and found additional reasons to believe that Appellant resided at a different address, including that her children live at another address and a May 2021 court filing by Appellant indicating a different home address. Then, in a telephone conversation Appellant told the Licensor that she only sleeps at 2306 38th Street sometimes.

Because the Department met its burden, it is Appellant's burden to show by a preponderance of the evidence that 2306 38th Street was Appellant's primary residence on January 31, 2022. The strongest evidence that Victoria Yeboah's primary residence was 2306 38th Street, at the relevant time, is her own testimony. However, Appellant's testimony that she slept at the facility most nights contradicts what she told Ms. Davenport in their telephone conversation during Ms. Davenport's investigation. Appellant's testimony is therefore given little weight and is insufficient on its own to establish the fact of Appellant's primary residence. The record lacks substantial evidence to corroborate the testimony.

Other evidence offered to support Appellant's claim that 2306 38th Street was her primary residence does not speak to the location of Appellant's primary residence at the relevant time. The tax records and report card are from 2020. The utility bills are from August and September 2022. Although the utility bills are addressed to her, personally, in light of evidence that Appellant commingled business and personal funds, the utility bills shed little light on Appellant's place of residence in February 2022.[121]

Testimony of Appellant's witnesses tended to support the Department's conclusion. Two former AFC residents testified that Appellant was at 2306 38th Street at night only "sometimes" or "every now and then." A relative of a former resident noted that Appellant made a special trip to be at 2306 38th Street in the evening, suggesting that the address was not where Appellant generally spent her evenings.

The AFC facility had five bedrooms—four for residents and one for "staff." Appellant did not offer evidence of who served as overnight staff in January or February 2022. Such information could have informed the record considerably more than any of the residence-related documentary evidence than Appellant provided.

Appellant's children reside at another address, where Appellant's mother also lives. An Otter Tail County social worker advocated to Clay County that Appellant's license be changed to a corporate license, which would allow the AFC to continue operating regardless of Appellant's primary residence. In May of 2021, Appellant declared to Clay County District Court, under penalty of perjury, a home address other than 2306 38th Street. Taken as a whole, the greater weight of the evidence supports a conclusion that, at the relevant time, Appellant's primary residence was not 2306 38th Street.

[121] Test. of V. Yeboah.

Appellant argues that the statute's "primary residence" requirement is undefined and "unconstitutionally vague" and that revocation is excessive.[122] To the extent that Appellant's constitutional argument is a facial challenge to the statute, this tribunal lacks jurisdiction to consider the argument.[123] Considered on an as-applied basis, the argument fails.

The phrase "primary residence" appears some 30 times in various statutes, for purposes such as mortgage lending,[124] wild and scenic river protection,[125] an interstate compact relating to medical licensure,[126] vehicle registration,[127] cold-weather protections for utility service,[128] and child custody arrangements.[129] But no statute defines the phrase. The legislature has provided that, where it has not acquired a special meaning, terms such as "primary residence" must be construed according to their common and approved usage.[130]

"'Residence' is defined in the dictionary to mean the 'place in which one lives; a dwelling.'"[131] "The word 'primary' is defined as '[f]irst or highest in rank or importance; principal.'"[132] The greater weight of the evidence does not support a conclusion that 2306 38th Street was the highest-ranked or principle place where Appellant lived on January 31, 2022.[133]

The moratorium plainly requires revocation if the license holder changes the license holder's primary residence away from the physical location of the foster care license.[134] The Legislature has therefore determined that revocation is the appropriate result under such a circumstance and the Commissioner does not have discretion to do otherwise. Appellant argues that this result is harsh. Any harshness, however, is consistent with a legislative intent to maintain the moratorium and ensure that family adult foster care occurs in the intended setting. AFC regulators rely on licensees to act according to relevant law and to be truthful about issues affecting their license.[135] The

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[122] Appellant's Closing Argument (May 1, 2023) at 2–3.
[123] *See Neeland v. Clearwater Memorial Hospital*, 257 N.W.2d 366, 368 (Minn. 1977) (stating that an administrative tribunal proceeding lacks subject matter jurisdiction to consider a constitutional issue).
[124] Minn. Stat. § 47.20, subd. 6a (2020).
[125] Minn. Stat. § 103F.321, subd. 3 (2020).
[126] Minn. Stat. § 147.38, art. 4(a)(1) (2020).
[127] Minn. Stat. § 168.10, subd. 1 (2020).
[128] Minn. Stat. § 216B.096, subd. 2(k) (2020).
[129] *See, e.g.,* Minn. Stat. § 518.183 (2020).
[130] Minn. Stat. § 645.08; *See In re the Marriage of Suleski v. Rupe*, 855 N.W.2d 330, 335 (Minn. Ct. App. 2014) (applying this canon of construction to construe the meaning of "primary residence" in a family law context upon a determination that the phrase is not expressly defined by a relevant statute).
[131] *Schisel v. Schisel*, 762 N.W.2d 265, 269 (Minn. Ct. App. 2009), *citing The American Heritage Dictionary of the English Language* 1535 (3d ed. 1992)
[132] *Suleski v. Rupe*, 855 N.W.2d at 335, *citing The American Heritage Dictionary of the English Language,* 1398–99 (5th ed. 2011)
[133] Appellant specifically argues that the standard must specify "how many nights she is required to stay there," in order to satisfy her right to due process. However, in this case, Appellant failed to meet the burden to satisfy *any* reasonable standard.
[134] Minn. Stat. § 245A.03, subd. 7(a).
[135] *See* Ex. 1 at 2 ("Because [] Clay County and DHS are unable to provide continuous oversight of licensed facilities, they must rely on license holders to be truthful and forthcoming.").

threat of revocation incentivizes licensees to avoid circumstances that support reasonable doubts about the license holder's primary residence.

Because the Department met its burden to show reasonable cause for revoking the license under Minn. Stat. § 245A.03, subd. 7(a), Appellant must demonstrate that it is more likely than not that 2306 38th Street was her primary residence. She failed to meet this burden. Revocation of her AFC license is therefore required.

B. Revocation is Warranted for the Proven Statute and Rule Violations.

The Revocation Order cited Appellant for 18 violations of statute and rule, and separately cited Appellant for withholding relevant information or for providing false or misleading information related to her compliance with licensing laws and rules. The Department concluded that the violations—in light of their nature, chronicity, and severity—established an independent basis to revoke Appellants HCBS and AFC licenses. Appellant argued that at least one violation was not fully proven and that the remaining violations were primarily "paperwork errors" that did not justify revocation.[136]

Appellants arguments are unavailing. The Department met its burden to show that it had reasonable cause to conclude that Appellant violated each law or rule identified in the Revocation Order, which then places the burden on Appellant to show that she was in full compliance with each law or rule, at the time of the alleged violation. She did not meet this burden, with one partial exception.

The cited violations can be broadly categorized as relating to (1) the provision of services and maintenance of records related to service provision,[137] and (2) program policies, training, and program and staff oversight.[138] Appellant accurately contends that many of the violations concern documentation. However, many violations directly concern the health, safety, or rights of service recipients, including arguably paperwork-related violations.

Service recipients have a right to have their health and medical information kept private. Appellant kept a calendar with residents' medical appointments and other medical information in a common area of the residence. In so doing, she did not ensure the protection of her residents' privacy rights.

Appellant simply did not provide services (or document that she provided them) as assigned to her by P1's CSSP. Appellant also failed to maintain accurate and complete medication records and failed to document procedures necessary to ensure that medication-related responsibilities assigned to Appellant were correctly carried out.

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[136] Appellant's Closing Argument (May 1, 2023) at 3–4. Appellant seemingly concedes at least some of the violations, arguing that Appellant should have had an opportunity to correct the "errors." *Id*. at 4.
[137] Licensing Violations 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 13, as identified in the Revocation Order at 6-14.
[138] Licensing Violations 1, 14, 15, 16, 17, and 18, as identified in the Revocation Order at 5–6 and 14–18.

The Revocation Order cites Appellant for violating Minn. Stat. § 245D.06, subd. 1(b), by failing to report and maintain information about incidents for two persons whose records were reviewed: P2 and P3. The statute requires a license holder to maintain information about and report incidents to the person's legal representative or designated emergency contact and case manager within 24 hours of an incident occurring while services are being provided. Appellant reported the incident concerning P2 and maintained the required information.[139] But Appellant did not show she maintained the necessary information with respect to two incidents involving P3. And the incident reports lacked other required information intended to ensure that incident-related oversights were caught and avoided in the future.

The staff training and oversight violations also indirectly relate to the health, safety, and rights of residents. The training requirements are intended to ensure service providers will adequately protect the health, safety, and rights of service recipients. Appellant's staff training documentation often failed to include the name of the trainer or instructor, instead documenting only "website" or "online." As a consequence, the Department could not verify that the training occurred or that it met statutory and rule requirements. Appellant did not show that she fully complied with the training-related statutes and rules that the Department alleged were violated.

To summarize, the Department met its burden to show reasonable cause to conclude that Appellant committed the law and rule violations that it identified in the Revocation Order. Appellant only met her burden to establish she had complied with the relevant law in one circumstance, and even then she did not show she fully complied with that same law on other occasions.

The number and nature of Appellant's violations weigh against dismissing them as mere "paperwork errors." Taken together, the nature, chronicity, and severity of the proven violations gave the Department reasonable cause to revoke both her AFC and HCBS licenses. The Department could reasonably conclude that these violations undermine its confidence that, if given a lesser sanction, Appellant would comply with licensing laws and rules or adequately protect the health, safety, and rights of service recipients in her care.

C. Appellant's Licenses are Subject to Sanction for Withholding Information or Giving False or Misleading Information

The Department may suspend or revoke a license, or impose a fine, if a license holder knowingly withholds relevant information from or gives false or misleading information regarding compliance with applicable laws or rules.[140]

In light of the multiple training documentation discrepancies; Appellant's failure to provide and inability to substantiate the trainer or curriculum for certain required trainings; and, Appellant's claim to have contemporaneously documented 2018 trainings on a form with a 2020 revision date, the Department had reasonable cause to conclude

[139] Test. of V. Yeboah; Ex. 131.
[140] Minn. Stat. § 245A.07, subd. 3(a)(3).

that Appellant either withheld relevant information or provided false or misleading information with respect to staff training and orientation.

Appellant also withheld relevant information and gave false or misleading information with respect to her primary residence. She told licensors on January 31, 2022, that she lived at 2306 38th Street, but did not inform the Department of a change in the composition in the household when she moved the children to another address or that she had claimed in a May 2021, court filing to live at another address, both of which were relevant for ascertaining her compliance with the AFC licensing moratorium.

The Department has established reasonable cause to sanction Appellant's licenses for her lack of candor in violation of Minn. Stat. § 245A.07, subd. 3(a)(3). Appellant did not show that she did not intentionally withhold training- and residence-related information, or that the training- and residence-related information she gave to the Department was neither false nor misleading.

IV. Conclusion

The Department has shown reasonable cause to revoke Appellants AFC and HCBS licenses. Appellant has not shown that she fully complied with the laws or rules the Department alleged that she violated, at the time the alleged violations of law or rule occurred. The Judge therefore respectfully recommends that the Commissioner **AFFIRM** the Revocation Order.

C. L. M.