OAH 28-1800-39950

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HUMAN SERVICES

In the Matter of the Appeal by Little Sprouts LLC of the Amended Determination of Maltreatment and Order to Pay a Fine	**FINDINGS OF FACT, CONCLUSIONS OF LAW, RECOMMENDATION, AND ORDER TO SEAL**

License No. 1115945
Report Number 202310415

The above-entitled matter came before Administrative Law Judge Joseph C. Meyer for a hearing on August 20, 2024. The record closed on September 4, 2024, upon the filing of the parties' closing arguments.

Mara Sybesma, Assistant Attorney General, appeared on behalf of the Department of Human Services (Department). Erica Ann Tummers, Owner, appeared on behalf of Little Sprouts LLC (Appellant).

The Department's Exhibits 1 through 24 and the Appellant's Exhibit 100 were received. The Department moved to seal Exhibits 8, 10, 12, 14, 22, 23, and 24[1] and, at the hearing, the Appellant indicated that it did not object to the Department's motion.

STATEMENT OF THE ISSUES[2]

1. Did the Department correctly determine that the Appellant was responsible for maltreatment by neglect of two children pursuant to Minn. Stat. §§ 246E.03, subds. 12 & 15(a) (2024) and 260E.30, subd. 2(a) (2024)?

2. Did the Department correctly determine that the maltreatment of one of those children met the definition of "serious maltreatment," pursuant to Minn. Stat. § 245C.02, subd. 18 (2024)?

[1] Motion to Seal Exhibits (Aug. 13, 2024).
[2] The Notice and Order for Prehearing Conference and Hearing issued on April 16, 2024 also listed an alleged violation of Minn. Stat. § 245A.66, subd. 2(e) (2024) and Minn. R. 9503.0140, subp. 17 (2023) as an issue for this proceeding. At the hearing, the Department indicated that this issue was included in error in the Notice and Order for Prehearing Conference and Hearing, and that it was not seeking a determination in this proceeding with respect to whether the Department had correctly determined that the Appellant committed a licensing violation under these laws. Accordingly, the Administrative Law Judge makes no Conclusions of Law or Recommendations with respect to that issue.

3. Did the Department properly issue a $5,000 fine based on the determination that the Appellant was responsible for serious maltreatment, pursuant to Minn. Stat. § 245A.07, subd. 3(c)(4) (2024)?

SUMMARY OF RECOMMENDATION

Because the Department correctly determined that the Appellant was responsible for maltreatment by neglect of two children, and that the maltreatment of one child met the definition of "serious maltreatment," the Department properly issued a $5,000 fine to the Appellant. Thus, the Commissioner of Human Services (Commissioner) should **AFFIRM** the Amended Determination of Maltreatment and Order to Pay a Fine.

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

FINDINGS OF FACT

1. The Appellant operates a licensed child care center located at 708 Parkway Avenue, Eagle Lake, Minnesota, under license number 1115945.[3]

2. The Appellant's child care center includes two rooms for infants.[4] Each of these rooms contains a countertop.[5]

3. In a licensing review conducted on November 15, 2023, the Department observed no violations at the Appellant's child care center.[6]

4. Prior to December 11, 2023, the Appellant trained its staff on a procedure for warming breast milk for infants that consisted of using a microwave to heat a cup of water for two to three minutes, placing the heated water on a countertop in an infant room, and placing a bottle of breast milk into the heated water to warm it through convection.[7] Occasionally, staff members would place the cup of hot water on top of a towel or washcloth.[8]

5. The breast milk warming practice was not part of any written policy at the Appellant's child care center.[9]

[3] Exhibit (Ex.) 3 at 1 (Amended Determination of Maltreatment and Order to Pay a Fine) (Apr. 5, 2024).
[4] Ex. 17 (Floor Plan).
[5] Ex. 16 (Photograph of Countertop); Ex. 17.
[6] Ex. 100 (Review Report) (Nov. 15, 2023).
[7] Testimony (Test.) of Danielle Morrison; Test. of Erica Ann Tummers; Ex. 8 (Recording of Interview of Erica Tummers); Ex. 10 (Recording of Interview of Ava Gillmore); Ex. 12 (Recording of Interview of Amiya O'Brien); Ex. 14 (Recording of Interview of Jennifer Janzen).
[8] Test. of D. Morrison; Ex. 10; Ex. 12; Ex. 14.
[9] Test. of E. Tummers; Ex. 8.

6. On December 11, 2023, C1 and C2 were both in attendance at the Appellant's child care center.[10]

7. On December 11, 2023, at approximately 10:30 a.m., a staff member at the Appellant's child care center was warming a bottle of breast milk consistent with procedure described above.[11]

8. While the staff member removed a cup of hot water from the microwave and began placing it on a washcloth, C1 began to attempt to climb on the staff member's leg.[12]

9. The staff member attempted to move C1 from their leg and, in doing so, inadvertently pulled on the washcloth, spilling hot water onto C1 and C2.[13]

10. The Appellant's staff noticed that C1's skin turned red and began to blister and that C2's neck had a bright pink spot.[14]

11. C1's parents took to them to the Mayo Clinic Health System Mankato Emergency Department where C1 was diagnosed with second degree burns on their face and right arm.[15]

12. Medical staff at the Mayo Clinic transferred C1 to the burn unit at the Hennepin County Medical Center (HCMC).[16]

13. HCMC medical staff diagnosed C1 with second degree burns to their face, right arm, and trunk, covering five percent of their total body surface area.[17]

14. HCMC's treatment of C1 included debridement procedures performed while C1 was under sedation.[18]

15. C1 was discharged from HCMC on December 13, 2023.[19]

16. C2's parents also took them to the Mayo Clinic Health System Mankato Emergency Department where C2 was diagnosed with superficial/first-degree burns.[20]

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[10] Ex. 4 at 2 (Maltreatment Investigation Memorandum) (Mar. 15, 2024). C1 and C2 refer to children with the initials R.B. and R.S. C1 was 12 months old as of December 11, 2023. Ex. 23 at 6 (Mayo Clinic Records for C1) (Feb. 9, 2024). C2 was 11 months old as of December 11, 2023. Ex. 22 at 6 (Mayo Clinic Records for C2) (Jan. 3, 2024).
[11] Test. of D. Morrison; Ex. 14.
[12] Test. of D. Morrison; Ex. 12; Ex. 14.
[13] Test. of D. Morrison; Ex. 10; Ex. 12; Ex. 14.
[14] Test. of D. Morrison; Ex. 8; Ex. 10; Ex. 14.
[15] Ex. 23 at 6.
[16] Ex. 23 at 8.
[17] Ex. 24 at 4 (HCMC Records for C1) (Dec. 27, 2023).
[18] Ex. 24 at 76–77.
[19] Ex. 24 at 4.
[20] Ex. 22 at 6, 8.

17. After the incident, the Appellant began using a bucket that was attached to the counter with Velcro to prevent similar spills in the future.[21] Sometime after that, the Appellant began using waterless bottle warmers.[22]

18. On December 11, 2023, the Department began an investigation into whether C1 and C2's injuries were the result of maltreatment.[23]

19. On March 15, 2024, the Department issued a Determination of Maltreatment and Order to Pay a Fine which determined that the Appellant was responsible for maltreatment by neglect, that the maltreatment by neglect met the definition of serious maltreatment, and issued a $5,000 fine based on those determinations.[24]

20. The Appellant timely appealed the Department's March 15, 2024 order on March 22, 2024.[25]

21. On April 5, 2024, the Department issued an Amended Determination of Maltreatment and Order to Pay a Fine which corrected erroneous report and license numbers in the March 15, 2024 Order.[26]

22. Any Conclusion of Law more properly considered a Finding of act is incorporated herein.

23. Any portion of the accompanying Memorandum more properly considered to be a Finding of Fact is incorporated herein.

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 (Commissioner) have jurisdiction over this matter pursuant to Minn. Stat. § 14.50 and 260E.33 (2024).

2. The Department has complied with all substantive and procedural requirements of law and rule and this matter is properly before the Administrative Law Judge and the Commissioner.

[21] Ex. 8; Ex. 10; Ex. 12; Ex. 14; Ex. 21 at 14 (Little Sprouts Employee Handbook).
[22] Ex. 8; Ex. 12; Ex. 14; Ex. 16.
[23] Test. of D. Morrison.
[24] Ex. 1 (Determination of Maltreatment and Order to Pay a Fine) (Mar. 15, 2024).
[25] Ex. 2 (Appeal) (Mar. 22, 2024).
[26] Ex. 3.

3. The Department has the burden to prove by a preponderance of the evidence that the Appellant is responsible for maltreatment of a child.[27]

4. Maltreatment includes neglect.[28]

5. Neglect includes the failure by a person responsible for a child's necessary care required to provide for the child's physical health or fails to protect a child from conditions or actions that seriously endanger the child's physical health when reasonably able to do so.[29]

6. The Appellant stipulated at the hearing that it was responsible for maltreatment by neglect with respect to C1 and C2.

7. Serious maltreatment includes maltreatment by neglect which reasonably requires the care of a physician.[30]

8. The Appellant stipulated at the hearing that its maltreatment constituted serious maltreatment with respect to C1.

9. The Commissioner may impose a fine against a license holder who does not comply with applicable law or rule.[31]

10. The Commissioner may demonstrate 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.[32]

11. When deciding whether to issue a fine, the Commissioner shall consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program.[33]

12. The fine for serious maltreatment is $5,000.[34]

13. As the Appellant stipulated that it was responsible for serious maltreatment, the Department issued the statutorily prescribed fine, and the nature, chronicity, or severity of the violation and the effects of the violation on the health, safety, or rights of

[27] Minn. Stat. § 260E.30, subd. 1 (2024); Minn. R. 1400.8608 (2023).
[28] Minn. Stat. § 260E.03, subd. 12(2) (2024).
[29] Minn. Stat. § 260E.03, subd. 15(a)(1–2) (2024).
[30] Minn. Stat. § 245C.02, subd. 18(a).
[31] Minn. Stat. § 245A.07, subd. 3(a)(1) (2024).
[32] Minn. Stat. § 245A.08, subd. 3(a) (2024).
[33] Minn. Stat. § 245A.07, subd. 1(a) (2024).
[34] Minn. Stat. § 245A.07, subd. 3(c)(4)(ii).

persons served by the Appellant support the decision to issue a fine, the Department has demonstrated reasonable cause for its decision to issue a $5,000 fine.

14. As the Appellant stipulated that it was responsible for serious maltreatment, the Appellant has not shown by a preponderance of the evidence that it was in compliance with the laws or rules that the Commission alleged it to have violated.

15. The Minnesota Health Records Act broadly prevents the disclosure of health records of a person who received health care from a provider.[35]

16. Exhibits 8, 10, 12, 14, 22, 23, and 24 are health records, and should be sealed in order to prevent their disclosure and to protect the privacy interests of C1 and C2.

17. Any Finding of Fact more properly considered to be a Conclusion of Law is incorporated herein.

18. Any portion of the accompanying Memorandum more properly considered to be a Conclusion of Law is incorporated herein.

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

RECOMMENDATION

Because the Department correctly determined that the Appellant was responsible for maltreatment by neglect of C1 and C2, and that the maltreatment met the definition of "serious maltreatment," the Department properly issued a $5,000 fine to the Appellant. Thus, the Commissioner should **AFFIRM** the Amended Determination of Maltreatment and Order to Pay a Fine.

ORDER

The Department's Motion to Seal is **GRANTED**. Exhibits 8, 10, 12, 14, 22, 23, and 24 are **SEALED**.

Dated: October 17, 2024

JOSEPH C. MEYER
Administrative Law Judge

Reported: Digitally Recorded
No transcript prepared

[35] Minn. Stat. § 144.293, subd. 2 (2024).

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 (2024), 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 (2024). 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 (2024), 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

The material facts in this matter are not in dispute. A staff member at the Appellant's child care center placed a cup of hot water on a washcloth on a counter in order to warm breast milk. While the staff member was doing this, a child began climbing on the staff member's leg, causing the staff member to inadvertently spill the hot water on two children, causing second degree burns on one of the children. The questions to be addressed here are (1) whether the Appellant was responsible for maltreatment by neglect of C1 and C2; (2) whether, with respect to C1, the alleged maltreatment constituted serious maltreatment; and, if so (3) whether the Department properly issued a $5,000 fine to the Appellant.

The Appellant stipulated that it was responsible for maltreatment by neglect with respect to C1 and C2. The record supports the Appellant's stipulation. Hot water poses a risk to the physical health of young children and, by using a process that involved cups of hot water near the edge of a counter where young children are present, the Appellant failed to protect the children in the child care center from that risk.

The Appellant also stipulated that, with respect to C1, the maltreatment constituted serious maltreatment. This stipulation is also supported by the record. C1 suffered burns significant enough to reasonably require the care of a physician, including multiple days in a burn unit and debridement procedures.

The sole disputed issue is whether the Department properly issued a $5,000 fine as a sanction for the serious maltreatment. The Department considered the nature, chronicity, and severity of the violation and the effects of the violation on the health, safety, and rights of persons served by the Appellant.[36] The violation exposed two children to water hot enough to cause serious burns and resulted in a multiple day hospital stay for one of those children. Thus, the nature and severity of the violation, and the effect on the health and safety of children served by the Appellant establish that the Department had reasonable cause to issue a fine to deter licensed providers from similar conduct in the future. As the Appellant stipulated that it was responsible for maltreatment by neglect and that the maltreatment constituted serious maltreatment, the Appellant has not shown by a preponderance of the evidence that it was in full compliance with the laws and rules it was alleged to have violated.

The Appellant argues that (1) a $5,000 fine would present a significant financial hardship[37] and (2) that the Department failed to identify any concerns with the process for heating breast milk prior to the incident.[38] While the Department can serve as a resource for child care centers, ultimately the responsibility to provide for the health and safety of the children in the Appellant's care rests with the Appellant and its staff. Absent any evidence that the Department specifically approved the bottle warming procedure, concerns about what the Department could or should have done to prevent the incident do not relieve the Appellant of its responsibility to protect children in its care. With respect to the financial hardship, the Administrative Law Judge does not take the Appellant's concern lightly. Five thousand dollars is a lot of money for a small business. That said, the Department reasonably chose to issue a fine instead of more restrictive sanctions, such as suspension or revocation.[39] Five thousand dollars is a statutorily prescribed amount for a fine issued for serious maltreatment. Thus, upon establishing that the decision to issue a fine was proper, the Department has also demonstrated that the amount of the fine was correct.

The incident at issue in this proceeding did not arise from malice, intentionality, or even recklessness. It was a simple act of inadvertence. But, as the Appellant stipulated, that is sufficient to establish serious maltreatment under the law. It is important to note that, after the incident, the Appellant promptly developed and distributed new procedures to prevent similar incidents from occurring in the future. Further, the staff member who spilled the water, in their interview with the Department, exhibited sincere remorse for the incident and demonstrated concern for the well-being of C1.[40] This Report should not be read as concluding that the incident was anything more than a regrettable mistake.

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[36] Test. of Maggie Hanson.
[37] Appellant Closing Letter (Aug. 27, 2024).
[38] Test. of E. Tummers.
[39] Minn. Stat. § 245A.07, subd. 1 (2024).
[40] The Department concluded that, due to the process in place for warming breast milk, the Appellant was responsible for maltreatment by neglect. The Department did not, however, determine that any staff member who followed the procedure (including the one who spilled the water) was individually responsible for maltreatment. Test. of D. Morrison.

Because the Department established that it properly issued a $5,000 fine, the Commissioner should **AFFIRM** the Amended Determination of Maltreatment and Order to Pay a Fine

J.C.M.