

STATE OF MINNESOTA  
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE COMMISSIONER OF HUMAN SERVICES

In the Matter of the Maltreatment  
Determination and Disqualification of  
Frank Jackson IV

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

A hearing in this matter came was conducted by Administrative Law Judge Steve M. Mihalchick on December 11 and 12, 2003, in Meeting Room 3 of the Clay County Family Service Center, 715 North 11<sup>th</sup> Street, Moorhead, MN. An additional day of hearing was held by telephone conference on December 23, 2003, to take the testimony of one witness. The transcript was filed February 17, 2004. The hearing record closed on April 5, 2004, upon receipt of the final post-hearing brief.

Frank Wesley Jackson III, Attorney at Law, 600 Lafayette East, No. 1922, Detroit, MI 48226, and Emily Wilson, Hammarback, Dusek & Associates, 215A South 4<sup>th</sup> Street, P.O. Box 14145, Grand Forks, ND 58208, appeared for Frank Jackson IV (Appellant). Theresa Meinholz Gray, Assistant Attorney General, 900 NCL Tower, 445 Minnesota Street, St. Paul, MN 55101, appeared for the Department of Human Services (the Department).

**NOTICE**

This Report is a recommendation, not a final decision. The Commissioner of Human Services will make the final decision after a review of the record. The Commissioner may adopt, reject, or modify these Findings of Fact, Conclusions, and Recommendations. Under Minn. Stat. § 14.61, the final decision of the Commissioner shall not be made until this Report has been made available to the parties to the proceeding for at least ten days. An opportunity must be afforded to each party adversely affected by this Report to file exceptions and present argument to the Commissioner. Parties should contact Kevin Goodno, Commissioner, Department of Human Services, 444 Lafayette Road, St. Paul, MN 55155 to learn the procedure for filing exceptions or presenting argument.

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. The record closes upon the filing of exceptions to the report and the presentation of argument to the Commissioner, or upon expiration of the deadline for doing so. The Commissioner must notify the parties and the Administrative Law Judge of the date on which the record closes.

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

## **STATEMENT OF ISSUES**

Whether Appellant engaged in acts constituting maltreatment under Minn. Stat. § 626.5572, subd. 2(b)(3), when, on three occasions, he tied or held the ends of the shirtsleeves of vulnerable adults thereby restricting the use of their hands and arms, or whether such acts were the provision of program services, health care, or other personal care services done by Appellant in good faith in the interests of the vulnerable adults.

The Administrative Law Judge finds that the acts were not done in good faith in the interests of the vulnerable adults and concludes, therefore, that such acts did constitute recurring maltreatment.

Whether Appellant poses a risk of harm to the vulnerable adults he wishes to serve so that his disqualification for the recurring maltreatment should not be set aside under Minn. Stat. § 245A.04, subd. 3b(b).

The Administrative Law Judge finds that he does pose a risk of harm to the persons to be served and concludes that his disqualification for the recurring maltreatment should not be set aside.

Based upon the proceedings herein, the Administrative Law Judge makes the following:

## **FINDINGS OF FACT**

### **The East Grand Forks Community Services Program**

1. The East Grand Forks Community Services Program (the Facility or EGF-CSP) is a state-operated group home in East Grand Forks, Minnesota. It was opened June 30, 2000. The EGF-CSP was created as part of the state's Community Services Program – State Operated Community Services (CSP-SOCS or CSP) begun in the early 1990s to move developmentally disabled persons out of large institutions and into small community-based group homes.<sup>[1]</sup> At all times relevant here, the EGF-CSP operated under supervision from managers at the Fergus Falls Regional Treatment Center.<sup>[2]</sup>

2. Since it opened, EGF-CSP has been home to four developmentally disabled adult males who had previously resided together in a unit at the Fergus Falls Regional Treatment Center. These residents, also known as clients, will be referred to as VA1, VA2, VA3, and VA4, the same identifiers that were used in the Investigative Memorandum referred to below.<sup>[3]</sup>

## Treatment of Residents

3. Due to their vulnerability, treatment of residents by staff and others at the group homes is tightly governed by Department rules and CSP-SOCS policies. Staff is trained in those rules and policies. Chief among the rules is Minn. R. 9525.2700–9525.2810, collectively known under the Department’s former numbering scheme as “Rule 40.”<sup>[4]</sup> Rule 40, which is specifically authorized and required by Minn. Stat. § 245.825, subd. 1, governs the use of aversive<sup>[5]</sup> and deprivation procedures<sup>[6]</sup> with persons who have mental retardation or a related condition.<sup>[7]</sup>

4. Certain actions and procedures are prohibited by Rule 40, including anything that constitutes abuse or neglect under the Vulnerable Adults Act,<sup>[8]</sup> restricting normal access to a nutritious diet; corporal punishment; placing a person in seclusion; totally or partially restricting a person’s senses, with minor exceptions; denying or restricting a person’s access to equipment and devices such as walkers, wheelchairs, and hearing aides; and others.<sup>[9]</sup>

5. Certain other actions and procedures are exempted from the reporting requirements and restrictions of Rule 40; but they are only permitted if they are addressed in the client’s Individual Service Plan. One such action is the use of physical contact or a physical prompt to briefly redirect behavior, escort a person to safety, or to conduct a medical treatment or examination.<sup>[10]</sup> Such action is exempted to allow caregivers to use physical contact to deal effectively and naturally with intermittent and infrequent problems. However, physical contact or a physical prompt “may not be used to circumvent the requirements for controlling the use of manual restraint.”<sup>[11]</sup>

6. The third type of actions and procedures addressed by Rule 40 are “controlled procedures,” which are permitted, but controlled. The “controlled procedures” are exclusionary and room time out procedures; positive practice overcorrection; restitutive overcorrection; partially restricting a person’s senses; manual restraint; mechanical restraint; and deprivation of a positive reinforcer.<sup>[12]</sup> A

controlled procedure can be used only in an emergency or “when the controlled procedure is based upon need identified in the individual service plan and is proposed, approved, and implemented as part of an individual program plan.”<sup>[13]</sup> Such planning and documentation is referred to as “being authorized in a Rule 40 program,” or “having a Rule 40 program.”<sup>[14]</sup>

7. “Manual restraint” means physical intervention intended to hold a person immobile or limit a person’s movement by using body contact as the only source of physical restraint. The term does not mean physical contact used to: (1) facilitate a person’s completion of a task or response when the person does not resist or the person’s resistance is minimal in intensity and duration; (2) escort or carry a person to safety when the person is in danger; or (3) conduct necessary medical examinations or treatments.<sup>[15]</sup> In addition to the normal conditions on the use of other controlled procedures, additional requirements apply to the use of manual restraint: The person’s primary care physician must be consulted, the person must be released from the manual restraint at least ten minutes every hour, and efforts to lessen or discontinue the manual

restraint must be made at least every 15 minutes and noted in the person's permanent record.<sup>[16]</sup>

8. "Mechanical restraint" means the use of devices to limit a person's movement or hold a person immobile as an intervention precipitated by a person's behavior. The term does not apply to mechanical restraint used to treat a person's medical needs, to protect a person known to be at risk of injury resulting from lack of coordination or frequent loss of consciousness, or to position a person with physical disabilities in a manner specified in the person's individual program plan. The term does apply to, and Rule 40 does govern, mechanical restraint when it is used to prevent injury with persons who engage in behaviors, such as head-banging, gouging, or other actions resulting in tissue damage, that have caused or could cause medical problems resulting from the self-injury.<sup>[17]</sup> Use of a mechanical restraint has the same additional restrictions as use of a manual restraint, plus a requirement that a staff member remain with the person in certain circumstances.<sup>[18]</sup>

9. "Emergency use" of a controlled procedure is also strictly regulated. It is only allowed if the following conditions are met:

A. Immediate intervention is needed to protect the person or others from physical injury or to prevent severe property damage that is an immediate threat to the physical safety of the person or others.

B. The individual program plan of the person demonstrating the behavior does not include provisions for the use of the controlled procedure.

C. The procedure used is the least intrusive intervention possible to react effectively to the emergency situation.<sup>[19]</sup>

Moreover, the staff person who uses an emergency procedure must document that fact within three calendar days. That report must promptly be reviewed by a designated staff member, the case manager, and then an expanded interdisciplinary team which determines what modifications should be made to the existing individual program plan so as to not require the use of a controlled procedure in the future.<sup>[20]</sup>

10. SOCS-CSP has a Behavior Management Policy to provide direction to staff for treatment of "challenging behavior" by residents.<sup>[21]</sup> The Behavior Management Policy restates and explains Rule 40 in a more easily understood format. It provides a list of restricted/prohibited procedures, exempted procedures, and controlled procedures. Among the exempted procedures, it lists corrective feedback or prompts to assist a person performing a task and physical assistance when no physical resistance is encountered. Also exempted is, "Use of control procedure when medical staff has taken control of the patient for the purpose of conducting medical examinations or administrating [sic] medical treatment." The Behavior Management Policy lists controlled procedures as well, stating, "The following procedures are controlled procedures and must be sanctioned by the appropriate personnel prior to implementation."

11. The Behavior Management Policy states that if behavior occurs that is harmful to the client or to others and no provisions for the use of control procedures are included in the plan, staff must intervene at the least intrusive level of intervention that has the effect of stopping the challenging behaviors and maintaining safety. It states that the use of manual restraint or mechanical restraint may be authorized in an crisis and provides the form for reporting use of emergency restraint.<sup>[22]</sup>

12. VA1 has profound mental retardation and is unable to communicate with staff verbally or through sign language. VA1's behavioral issues include noncompliance, aggression, drinking out of the toilet, and urinating in inappropriate places.<sup>[23]</sup> Since moving to EGF-CSP, VA1's aggressive behaviors of biting and scratching that were common at FFRTC "have been remarkably controlled".<sup>[24]</sup>

13. The Individual Program Plan Training Record ("program plan") for VA1 addresses how staff members are to respond to VA1's aggression and noncompliance.<sup>[25]</sup> It requires that if VA1 demonstrates behavior issues such as aggression, staff members should attempt to "divert his attention to an appropriate activity such as walking, swinging, exercise bike or music." If VA1 continues to exhibit the behavior despite the attempt to redirect him, staff members are required to direct him to a quiet area to allow him to relax. The program plan provides that if VA1 struggles during this attempt to direct him, staff members are to discontinue their efforts and protect other clients by removing them from the area. Similarly, if VA1 refuses to comply with a task after he has been directed to perform the task two times, staff members should use "graduated physical prompts and verbal instructions to shape him through the sequence of events leading to the . . . [outcome]." If VA1 struggles during this process, staff members are required to terminate the process. VA1's program plan does not allow a staff member to use any controlled procedure to address VA1's aggression or noncompliance, and the use of a controlled procedure for that purpose would be inappropriate unless it was an emergency.<sup>[26]</sup>

14. VA2 has several diagnoses, including profound mental retardation, psychotic disorder NOS, obsessive compulsive behavior around the issue of eating, a seizure disorder, and others. His ability to communicate is limited to gestures and a few manual signs. He has several behavioral issues including noncompliance, pica, screaming, rocking, and aggression toward staff and peers.<sup>[27]</sup> VA2's behavioral issues have also improved greatly since he moved to EGF-CSP.<sup>[28]</sup>

15. VA2's program plan addresses how staff are to respond to his aggression, property destruction, inappropriate urination, and pica.<sup>[29]</sup> It states that staff are to use verbal redirection and graduated physical prompts in an attempt to halt inappropriate behavior. If VA2 resists the physical prompts, staff members are to discontinue such prompts. If redirection is unsuccessful and he continues to be aggressive, other clients should be removed from his proximity for their protection. As with VA1, VA2 does not have a Rule 40 program that would allow staff to use any controlled procedure in response to VA2's aggression, and the use of a controlled procedure would be inappropriate unless it was an emergency.<sup>[30]</sup>

## **Appellant**

16. Appellant started employment at EGF-CSP on January 30, 2001, as a Human Services Technician.<sup>[31]</sup> Previously, he had worked for a year in Michigan as a program counselor for people with developmental disabilities and for two years at Developmental Homes, Inc. (DHI), at one of its group homes in North Dakota. Appellant had also interacted with an uncle who is developmentally disabled and worked with his grandmother in foster care for three years. He apparently attended the University of North Dakota while working at DHI and EGF-CSP. He recently graduated from UND with a degree in Aviation Studies-Air Traffic Control.<sup>[32]</sup> He is now seeking employment with the FAA.<sup>[33]</sup>

17. Like all new hires, Appellant received an Orientation Training Form the day he started work that listed the orientation materials he was to read and understand.<sup>[34]</sup> Most of the materials are to be read alone and some are gone over with someone at the Facility.<sup>[35]</sup> Appellant read many of the materials that first day, January 30, 2001, and marked them completed. Among the materials he completed that day was a five page document entitled, "Therapeutic Intervention Orientation."<sup>[36]</sup> It stated that the purpose of therapeutic intervention (TI) treatment is to predict violence by observing clues from residents so that staff can intervene to prevent violent episodes. It listed a number of things to watch for, gave tips on preparing for crisis intervention, and recommended various forms of verbal intervention, to be followed by physical intervention if verbal persuasion failed. It stated that only approved TI methods should be used and that if staff have not completed the eight hour TI Techniques course, they should contact the course instructors.<sup>[37]</sup>

18. The TI methods or techniques are techniques that staff are allowed and trained to use to defend themselves or another client from attack or aggression by a client, and to contain the client, if necessary. They include blocks, releases from various holds, takedowns, and "escorts" and "come alongs."<sup>[38]</sup> By their titles, "escorts" and "come alongs" appear to be physical prompt and manual restraint techniques to move a client to another location.

19. Appellant didn't have the TI Techniques course until just over a year later, when it was presented at EGF-CSP on February 28, 2002. He, along with ten other EGF-CSP employees took the course that day from certified TI instructor Tim Olson.<sup>[39]</sup><sup>[40]</sup>

20. Appellant's Orientation Training Form indicates that on January 30, 2001, he also reviewed CSP-SOCS policy and procedure documents and five documents related to "ON-THE-JOB ORIENTATION" The Behavior Management Policy is one of the CSP-SOCS policies kept in the policy book and he would have reviewed it at the time.<sup>[41]</sup> One of the OJT Orientation documents was "Program Abuse Prevention Measures."<sup>[42]</sup> That is apparently a reference to a document entitled "General Measures for Abuse Prevention Program."<sup>[43]</sup> It is a policy written by CSP-SOCS for the EGF-CSP site. It states measures the Facility will use to prevent abuse—mainly, provide adequate staff trained in abuse prevention. It states that the Behavior Management Policy will be followed by all staff. Appellant would have reviewed that document on January 30, 2001.

21. In addition to reading documents, Appellant, like all new staff, would have been oriented by another staff member in the daily routing, the residents' program plans, ideas on methods that works with the clients, and how to redirect them.<sup>[44]</sup>

22. On April 28, 2001, Appellant completed the two-hour self-study course entitled, "Rule 40 / Non-aversive Approaches."<sup>[45]</sup> That course required him to view a 40 minute video on Rule 40,<sup>[46]</sup> "read/review" a copy of Rule 40,<sup>[47]</sup> review the FFRTC Behavior Management Policy,<sup>[48]</sup> and discuss any questions with his supervisor.<sup>[49]</sup> The video presentation explained the differences between prohibited, exempted, and

controlled procedures. It explained the main difference between physical prompting and manual restraint as whether the client was resisting the physical contact. It emphasized that the procedures are never to be used for punishment, but as ways to teach better behavior, and the need for the any procedure to be planned by the team and specified in the client's program plan.

23. On July 23, 2001, Appellant signed the Individual Program Plan Training Checklist forms for VA1 and VA2. By signing, he certified that he had read and understood all of the programs, methodologies, assessments, and data collection procedures listed for these clients in their current program plans.<sup>[50]</sup>

24. On November 15, 2001, Appellant again completed the two hour self-study course entitled, "Rule 40 / Non-aversive Approaches," because it was required to be completed by all staff by November 30, 2001.<sup>[51]</sup>

25. Appellant was regarded by his supervisors employees as a good employee who cared about the clients and gave no indication he would abuse any of them.<sup>[52]</sup>

Cheryl Kosmatka, another Human Services Technician, at EGF-CSP, thought that Appellant was a very nice person, but thought that Appellant was a bit too aggressive in his treatment of the clients and should have been more cordial with them.<sup>[53]</sup>

### **Appellant's Use of Shirtsleeves to Restrain Residents**

26. At meal time one day in late 2001 or early 2002, Appellant was working with Ms. Kosmatka at EGF-CSP. The four clients were sitting at the table waiting for their meal. VA1, who was wearing a sweat shirt or similar long-sleeved fleece shirt, pulled his left shirtsleeve over his hand and started twirling the end of the sleeve around, which the staff referred to as a "flicking" behavior for him. "Flicking" is a waving of the hands or a similar repetitive movement.<sup>[54]</sup> Appellant and Ms. Kosmatka were serving the clients their meals when Appellant, who was standing next to VA1, tied the loose end of VA1's left sleeve in a knot. He then said, "Cheryl, look at this."<sup>[55]</sup> Ms. Kosmatka approached Appellant and saw that VA1's left sleeve was pulled down over his hand and tied in a knot.<sup>[56]</sup> Ms. Kosmatka asked Appellant why he tied VA1's shirtsleeve and he said "so he doesn't flick" and something about eating.<sup>[57]</sup> Appellant untied VA1's sleeve after approximately three minutes.<sup>[58]</sup> VA1 had not been picking at an old sore on his side or exhibiting aggressive behaviors before Appellant tied his shirtsleeve. The only thing VA1 was doing was twirling his sleeve.<sup>[59]</sup>

27. Appellant could not have reasonably believed that his act of tying the sleeve of VA1 was the provision of program services, health care, or other personal care services done in the interests of VA1. His training and experience had taught him that such treatment of residents was inappropriate.

28. Sometime between November 2001 and February 2002, Jane Breyer, another Human Services Technician at EGF-CSP, was working with Appellant. Appellant and VA2 were sitting next to each other on the couch and Ms. Breyer was sitting in an oversized chair approximately ten feet across the room from them.<sup>[60]</sup> VA2 was sitting on the couch socializing with Appellant and Ms. Breyer and not exhibiting any

aggressive behaviors. For no good reason, Appellant took both of VA2's shirtsleeves, pulled them out beyond VA2's hands, and tied them together in a knot.<sup>[61]</sup> Being so restrained caused VA2 great emotional distress—he made noises that showed his frustration and struggled to pull his sleeves apart. He tried to take the shirt off by working it up over his head, but Appellant pulled it down and told him that he had to keep it on. Appellant was laughing and appeared to Ms. Breyer to be “joking around.” Appellant stopped pulling the shirt down after a minute or two and then Ms. Breyer, who had herself become frustrated by the events, helped VA2 remove the shirt over his head. She then untied the knot, but had to use her teeth to do so because the knot was very tight.<sup>[62]</sup>

29. On another occasion during the same time frame, a similar incident occurred in Ms. Breyer's presence with Appellant tying VA2's sleeves, but the details are unknown. The only thing Ms. Breyer recalls is untying two different color shirts.<sup>[63]</sup>

30. Appellant could not have reasonably believed that his acts of tying the sleeves of VA2 together was the provision of program services, health care, or other personal care services done in the interests of VA2. His training and experience had taught him that such treatment of residents was inappropriate.

### **The Department's Investigations and Findings**

31. On April 17 and 18, 2002, the Department received complaints of possible maltreatment by Appellant of the four clients at EGF-CSP.<sup>[64]</sup> Two Department investigations were initiated—first, an internal investigation by CSP management and, later, a maltreatment and licensing investigation by the Department's Division of Licensing (“Licensing”). On April 18, 2002, Appellant was placed on paid administrative leave.<sup>[65]</sup> He has not worked at EGF-CSP since.

32. Investigator Cheryl Dietz began Licensing's investigation about May 15, 2002.<sup>[66]</sup> On May 29, 2002, she interviewed Ms. Kosmatka, Ms. Breyer, and Appellant. She also spoke with the CSP supervisor and the Behavior Analyst from Fergus Falls who is Therapeutic Intervention instructor at EGF-CSP. She reviewed employee files and spoke again with Appellant.<sup>[67]</sup>

33. Dietz investigated three allegations of suspected maltreatment. The first was that Appellant had driven a Facility van at 110 mph with the four residents on board. The second was that Appellant had tackled one of the residents causing him to fall to the floor. The third was that Appellant had once tied VA1's shirtsleeve in a knot and had tied VA2's shirtsleeves together on more than one occasion.

34. On January 1, 2003, Licensing issued an Investigative Memorandum (the Investigative Memorandum), written by Dietz and her supervisor, reporting the results of the investigation.<sup>[68]</sup> It noted a history of conflicts between Appellant and Ms. Kosmatka and Ms. Breyer and concluded that there was not a preponderance of evidence to substantiate the first and second allegations. Despite the conflicts and noting that Appellant admitted that he had tied the sleeves of VA1 and VA2, the Investigative Memorandum reported that a preponderance of evidence demonstrated that the tying of the sleeves was abuse by conduct that was not an accident or therapeutic.

35. By written notice of January 3, 2003, the Department notified Appellant that it had substantiated that Appellant had tied the shirtsleeves of two vulnerable adults restricting use of their hands and arms and causing or likely causing them emotional distress, as described in the Investigation Memorandum, which was attached. The notice stated that the conduct constituted maltreatment, and that because it occurred more than once, it was “recurring maltreatment” that “disqualified” him from any position allowing direct contact with persons served by programs licensed by the Department or similar programs. The notice also stated that it had also been determined that Appellant posed an imminent risk of harm to persons served by such programs and must be immediately removed from a position allowing direct contact. The notice set forth Appellant’s rights to request reconsideration of the maltreatment, disqualification, and risk of harm determinations.<sup>[69]</sup>

36. By request dated February 8, 2003,<sup>[70]</sup> Appellant requested reconsideration of the maltreatment, disqualification, and risk of harm determinations.<sup>[71]</sup>

37. Stella French of the Department’s Division of Licensing reviewed information in the Investigation Memorandum and the request for reconsideration submitted by Appellant. She did a risk of harm assessment using a Department worksheet. She rated seven of the eleven listed factors as “high risk,” and three as “medium risk.” She did not rate the length of employment factor because she had no information on it. She concluded that Appellant posed an imminent risk of harm and recommended that the disqualification not be set aside.<sup>[72]</sup>

38. Division of Licensing Supervisor Laura Plummer Zrust also reviewed the information in the Investigation Memorandum and the request for reconsideration submitted by Appellant. She independently completed a risk of harm worksheet and rated nine of the factors the same as French had.<sup>[73]</sup>

39. On March 25, 2003, the Department issued a Notice of Reconsideration of Maltreatment Determination and Notice of Reconsideration of Disqualification to Appellant. It stated that the Commissioner of Human Services had determined that the maltreatment determination was appropriate. The Commissioner also determined that the information used to disqualify Appellant was correct and that the maltreatment was recurring, which is a disqualifying characteristic under Minn. Stat. § 245A.04, subd. 3d. Finally, the Commissioner determined that Appellant had failed to demonstrate that he did not pose a risk of harm to persons served by covered programs and denied Appellant’s request to set aside the disqualification.<sup>[74]</sup> The notice informed Appellant of his right to request a contested case hearing.

40. Appellant filed a request for a contested case hearing by letter of May 6, 2003.<sup>[75]</sup> The Department issued a Notice of and Order for Hearing and Pre-hearing Conference on July 15, 2003. During the prehearing conference of August 19, 2003, the hearing was scheduled for December 11 and 12, 2003. The Department issued an Amended Notice of and Order for Hearing and Pre-hearing Conference on October 20, 2003. The Amended Notice incorporated the Investigation Memorandum.

## CONCLUSIONS OF LAW

1. The Administrative Law Judge and the Minnesota Department of Human Services have authority to consider and rule on the issues in this contested case hearing pursuant to Minn. Stat. §§ 14.50 and 245A.08.

2. The Department gave proper notice of the hearing, and all relevant substantive and procedural requirements of law or rule have been fulfilled.

3. Under Minn. Stat. § 626.5572, subd. 15, "maltreatment" means "abuse," "neglect," or "financial exploitation." Minn. Stat. § 626.5572, subd. 2(b), defines abuse, in relevant part, as:

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

(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

4. "Therapeutic conduct" means the provision of program services, health care, or other personal care services done in good faith in the interests of a vulnerable adult by an individual or employee of a facility.<sup>[76]</sup>

5. Appellant's acts of tying the shirt sleeves of VA1 and VA2 each constituted maltreatment in the form of abuse because each was the use of a mechanical restraint and, therefore the use of an aversive or deprivation procedure, for a person with developmental disabilities. The acts were not authorized under Rule 40 and, therefore, not authorized under Minn. Stat. § 245.825, and were not accidental or therapeutic conduct.

6. Any individual who has engaged in serious or recurring maltreatment of a vulnerable adult must be disqualified from direct contact with or access to persons receiving services from the facility.<sup>[77]</sup> "Recurring maltreatment" means more than one incident of maltreatment.<sup>[78]</sup>

7. Appellant has engaged in recurring maltreatment of vulnerable adults and must be disqualified.

8. The Commissioner may set aside a disqualification if the Commissioner finds that the individual does not pose a risk of harm to any person served by the facility.<sup>[79]</sup> In determining that an individual does not pose a risk of harm, the commissioner shall consider the nature, severity, and consequences of the event or events leading to the disqualification, whether there is more than one disqualifying event, the age and vulnerability of the victim at the time of the event, the harm suffered by the victim, the similarity between the victim and persons served by the program, the

time elapsed without a repeat of the same or similar event, documentation of successful completion by the individual of training and rehabilitation, and any other relevant information. In reviewing a disqualification, the Commissioner shall give "preeminent weight" to the safety of each person to be served by the facility.

9. At the time of the events near the start of 2002, Appellant posed a risk of harm to the residents of EGF-CSP. The nature of the events was violations of Rule 40 that Appellant had been trained in many times over the year he worked there. The violations were serious as directly contrary to the very purpose of the existence of the Facility. The consequences were the emotional distress caused the residents. There were three such events and the victims were very vulnerable in there inability to comprehend the actions. At the present time, Appellant is not proposing to work at a similar licensed program, but if he were, there would still be concern about him repeating his lapse of judgment and lack of concern for well-being of vulnerable adults. Appellant still poses a risk of harm to vulnerable adults in a group home facility.

10. The attached Memorandum is incorporated by reference.

Based upon the foregoing Conclusions, the Administrative Law Judge makes the following:

### **RECOMMENDATION**

IT IS HEREBY RESPECTFULLY RECOMMENDED: that the Commissioner **AFFIRM** the determination of repeated maltreatment, the determination of disqualification of Frank Jackson IV, and the determination that the disqualification not be set aside.

Dated: June 4, 2004

s/Steve M. Mihalchick  
STEVE M. MIHALCHICK  
Administrative Law Judge

Reported: Tape recorded. Transcript prepared by:  
Brennan & Associates  
3052 Woodlark Ln  
Eagan, MN 55121-1915

### **MEMORANDUM**

As the parties have stated, this case comes down to a matter of assessing the credibility of Appellant, Ms. Kosmatka, and Ms. Breyer. Ms. Kosmatka's description of the tying of VA1's sleeve is the more believable than Appellant's. Her testimony about

the sore not bleeding is consistent with the testimony of other witnesses. There is some doubt about her veracity. By her own admission she was afraid that Appellant was out to get her fired. Therefore, she had some reason to make false statements about him. However, Appellant admits that he did tie the sleeve, so her basic allegation not disputed. Her testimony that what was happening at the time was that VA1 was twirling his sleeve is more believable than Appellant's testimony that VA1 had opened the old sore on this side and was flinging blood around.

There are several problems affecting the credibility of Ms. Breyer. She and Appellant seem to have had a fairly strange relationship and some of her views of relationships, organizations, and religion, seemed disjointed and unusual. Nonetheless, her testimony that Appellant tied the sleeves of VA2 together and then would not allow him to remove the shirt is believable. Again, Appellant admits the basic facts, but offers explanations of his actions and subsequent actions that are contradicted by Ms. Breyer and less believable.

There are reasons to believe much of what Appellant says. He admitted that he tied the sleeves rather than denying it. He seems to have a more precise recollection of specific facts and is able to relate them to other facts ways that makes sense. However, it appears that the several of his explanations are after-the-fact creations tailored to fit legal arguments or with the testimony that was given before he testified. For example, Appellant maintained in prior statements and in some of his testimony that VA1's sore was bleeding profusely and VA1 was "flicking" the blood around. At the hearing, he testified that he came up to VA1 and noticed a red spot of blood on his shirt.<sup>[80]</sup> That was after Ms. Tokar had testified that that was the greatest extent of bleeding she had ever noticed from VA1's sore.<sup>[81]</sup>

Moreover, some of Appellant's explanations seem counter to common sense. If he was trying to prevent VA1 from picking at the old sore, why didn't he just move his hand away with a physical prompt, or give him food to redirect his attention? Tying the sleeve would not have been the easiest and most effective way to stop the picking. If he was trying to stop VA2 from attacking Ms. Breyer, why didn't he do that by momentarily holding VA2's his hands, then physically prompting him to his room, rather than leading VA2 by his sleeves to the room as he claims to have done? It would have been easier. Leading someone by their sleeves would have been difficult and probably would have allowed VA2 to easily escape by slipping out of the shirt. It is unlikely that it happened that way.

S.M.M.

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<sup>[1]</sup> The Community Services Program – State Operated Community Services (CSP-SOCS) is now referred to as Minnesota State Operated Community Services (MSOCS). Transcript (T.) 184-85 and 320.

<sup>[2]</sup> T. 391, 394-396.

<sup>[3]</sup> Ex. 2.

<sup>[4]</sup> Ex. 29.

<sup>[5]</sup> “Aversive procedure” is defined as “the planned application of an aversive stimulus 1) contingent upon the occurrence of a behavior identified in the individual program plan for reduction or elimination; or 2) in an emergency situation governed by part 9525.2770.” Minn. R. 9525.2710, subp. 4. “Aversive stimulus” means “an object, event, or situation that is presented immediately following a target behavior in an attempt to suppress that behavior. Typically, an aversive stimulus is unpleasant and penalizes or confines.” *Id.* at subp. 5.

<sup>[6]</sup> “Deprivation procedure” is defined as “the removal of a positive reinforcer following a response resulting in, or intended to result in, a decrease in the frequency, duration, or intensity of that response. Often times the positive reinforcer available is goods, services, or activities to which the person is normally entitled. The removal is often in the form of a delay or postponement of the positive reinforcer.” *Id.* at subp. 12.

<sup>[7]</sup> Minn. R. 9525.2700, subp. 1.

<sup>[8]</sup> Minn. Stat. § 626.557.

<sup>[9]</sup> Minn. R. 9525.2730.

<sup>[10]</sup> Minn. R. 9525.2720 C.

<sup>[11]</sup> Other types of exempted procedures include corrective feedback, relaxation techniques, positive reinforcement, temporary withdrawal of goods and services, temporary interruptions in instruction, and token fines. Minn. R. 9525.2720.

<sup>[12]</sup> Minn. R. 9525.2740, subp. 1.

<sup>[13]</sup>

Minn. R. 9525.2750, subp. 1

<sup>[14]</sup> T. 414-17.

<sup>[15]</sup> Minn. R. 9525.2710, subp. 22.

<sup>[16]</sup>

Minn. R. 9525.2750, subp. 1 H.

<sup>[17]</sup> Minn. R. 9525.2710, subp. 23.

<sup>[18]</sup>

Minn. R. 9525.2750, subp. 1 I.

<sup>[19]</sup>

Minn. R. 9525.2770, subp. 2.

<sup>[20]</sup>

Minn. R. 9525.2770, subp. 6.

<sup>[21]</sup> Ex. 30. Fergus Falls Regional Treatment Center has the same policy. Ex. 31.

<sup>[22]</sup> Ex. 30.

<sup>[23]</sup>

T. 238-39.

<sup>[24]</sup>

T. 427-28.

<sup>[25]</sup>

Ex. 18.

<sup>[26]</sup>

T. 234.

<sup>[27]</sup> Ex. 21.

<sup>[28]</sup>

T. 428.

<sup>[29]</sup>

Ex. 22.

<sup>[30]</sup>

T. 234.

<sup>[31]</sup> Ex. 30.

<sup>[32]</sup> Ex. 5, at 00047.

<sup>[33]</sup> T. 568-69.

<sup>[34]</sup> Ex. 26.

[35] T. 193-98.

[36] Ex. 27.

[37] Ex. 27, at 251h. This page of the document ends mid-sentence.

[38] T. 399-400; Ex. 7, at 00059-60.

[39] Ex. 34.

[40] Contrary to the Investigative Memorandum's finding, Facility records do not show that Appellant received a "TI update" on February 28, 2001. Ex. 2, at 0006.

[41] T. 219.

[42] Ex. 26.

[43] Ex. 36.

[44] T. 222-23.

[45] Exs. 26 and 32.

[46] Ex. 1.

[47] Ex. 29.

[48] Exs. 30 and 31

[49] Ex. 28.

[50] Exs. 19 and 23.

[51] Exs. 25 and 33.

[52] T. 266, 464-65, 478-80; Ex. P-10.

[53] T. 172-73.

[54]

T. 161-72; Ex. 3, at 00039.

[55] T.

165.

[56] T.

168.

[57] T. 168

;Ex. 3, at 00039.

[58]

Ex. 3, at 00039.

[59]

T. 169-70.

[60]

T. 324, 327-28.

[61]

T. 324-29.

[62]

T. 332-34.

[63]

T. 323, 341.

[64] Ex. 8, at 00065.

[65] T. 562.

[66]

Ex. 2, at 0001.

[67] T. 36-37; Exs. 2-7.

[68] Ex. 2.

[69] Ex. 41.

[70] The request for reconsideration was received by the Department on February 9, 2003, and considered timely by the Department. Ex. 45 at 291.

[71] Ex. 42.

[72] T. 680-87; Ex. 43.

[73] T. 756; Ex. 44.

[74] Ex. 45.

[75] Ex. 46. The Department did not contest the timeliness of the request.

[\[76\]](#) Minn. Stat. § 626.5572, subd. 20 (2003).

[\[77\]](#) Minn. Stat. § 245C.14, subs. 1 and 2, and § 245C.15, subd. 4(b)(2) (2003)(formerly found in Minn. Stat. § 245A.04, subd. 3d(a)(4)).

[\[78\]](#) Minn. Stat. § 245C.02, subd. 16 (2003)(formerly found in Minn. Stat. § 245A.04, subd. 3d(a)(4).

[\[79\]](#) Minn. Stat. § 245C.22, subd. 4 (2003)(formerly Minn. Stat. § 245A.04, subd 3b(b)).

[\[80\]](#) T. 512.

[\[81\]](#) T. 241-44.