

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HUMAN SERVICES

In the Matter of the of the Temporary
Immediate Suspension of the Family
Child Care License of Lena Christians,
now Lena Wheeler

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

This matter came on for Hearing before Administrative Law Judge Steve M. Mihalchick on September 3, 2003, at the Lyon County Government Center, Marshall, Minnesota. The hearing record closed on the date of the hearing.

Tricia Zimmer, Assistant Lyon County Attorney, 607 West Main St, Marshall, MN 56258, appeared for the Department of Human Services (the Department) and Lincoln, Lyon and Murray Human Services (LLMHS). Lena Wheeler, 1340 County Road 5, Balaton, MN 56115-3170, appeared on her own behalf.

NOTICE

This Report is a recommendation, **not** a final decision. The Commissioner of Human Services will make a final decision after reviewing the administrative record, and may adopt, reject or modify these 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 the 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 ascertain 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. 2. The record closes upon the filing of comments, or upon the 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.

STATEMENT OF ISSUE

Pursuant to Minn. Stat. § 245A.07, subd. 2a, the sole issues are whether the temporary immediate suspension should remain in effect and whether the Department has demonstrated that reasonable cause exists to believe that Licensee's failure to comply with applicable law or rule poses an imminent risk of harm to the health, safety, or rights of day care children served by her.

The Administrative Law Judge concludes such reasonable cause does exist and that the temporary immediate suspension should remain in effect.

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

FINDINGS OF FACT

1. Licensee has been licensed to provide family childcare in her home since October 2002. She very recently remarried and lives in Lyon County with her husband, mother, and 17-year-old son. Licensee had been a day care provider in Marshall, Minnesota, from about 1982 to 1992, then moved to Oregon where she also provided day care for about five years. She returned to Minnesota in 2000.^[1]

2. Licensee's mother is licensed as a caregiver under Licensee's "C. 3." license, which allows the two adults to care for up to 14 children. However, Licensee normally cares for about seven children because she is most comfortable with that many children in her care.^[2]

3. Licensee's home is on the west side of County Road 5, which comes north out of Balaton. The fairly long driveway from the road goes along the south side of the house and around to the back. There is an unfenced play area located beyond the driveway at the back of the south side. There is a patio door on the south side, slightly to the rear of the middle of the house. Its front edge is a "boundary" the children are not to cross. In other words, they are not to go down the driveway. The back of the yard is very large with a garden. It is possible to observe parts, but not all of the play yard from the patio door on the side and the kitchen window on the back of the house. There is a back door near the middle of the house with a small window.^[3]

4. Licensee provides care for the four and one-half year old daughter and two and one-half year old son of Sara Davis. In Ms. Davis' view, the boy is unusually active and fast, and Licensee was aware of that. One day in early June 2003, Ms. Davis dropped off her son for day care, but not her daughter as she usually did. As she drove off down the driveway and turned onto the road, Licensee was holding the boy in her arms.^[4]

5. Ms. Davis had arrived somewhat later than normal because she had dropped her daughter off at summer pre-school and Licensee was already outside with the other children who were playing there. Normally, the children are dropped off in the home and the parents leave. On this occasion, the boy was clinging to his mother. Licensee took him from his mother and brought him over to a push car to play with so Ms. Davis could leave for work. Licensee thought he would not feel so bad after he saw her leave.

6. After Ms. Davis left, Licensee went into the house to go to the bathroom. Her mother was feeding an infant, so nobody was watching the children outside for several minutes.^[5]

7. Soon after Licensee went inside, the boy pushed the push car down the driveway and turned down the road the direction he had seen his mother go. Mike Nelson, a local minister, saw the boy walking along the road with the push car about 60 to 70 yards from the driveway. He walked the boy back up the road and driveway to the house, which took three to five minutes. He knocked on the door and was met by

Licensee, who was immediately concerned and said, “Oh, my goodness! What happened?”^[6]

8. After Reverend Nelson had explained what had happened, Licensee went outside and talked to the boy. She had previously told him about the “boundaries” the children were required to stay within and restated those limits to him. She brought him in the house for a “time out” for violating the boundaries of the play area and called Ms. Davis at work to report what had happened.^[7]

9. Licensee and Ms. Davis met the next day to discuss the incident. Ms. Davis found the incident scary and Licensee’s supervision unacceptable and a concern to her. They discussed changes that would be made. Licensee would continue to be the one to supervise the children when they were outside and promised that she would do so more closely. Whenever Licensee had to step away, she would be sure that her mother or son, a helper, would be informed and would supervise the children until she returned. Licensee would remind the children regularly of the boundaries of the outside play area. Ms. Davis would always bring the boy into the house so that he wouldn’t watch her drive off. With these changes in place, Ms. Davis continued to take her children to Licensee for day care. She felt that Licensee thereafter did provide closer supervision and observed that Licensee’s mother was often by the kitchen window observing the play area. However, there were times that she arrived at the house to find children outside without Licensee or her mother nearby.^[8]

10. On July 23, 2003, Rebecca Sik, the LLMHS Licensing Worker, received a telephone complaint about Licensee’s day care. The anonymous caller reported that the children are often outside without supervision, that a man had found a two-year-old pushing a child’s car along the side of Highway 5 and walked him back to the house, that children run up to vehicles arriving at the house, that there was a lack of supervision even though two adults were licensed, that there was no fence around the play area, that Licensee “has taken a little more precautions” since the incident with the two-year-old, and that Licensee and her mother smoke in the home during day care hours. The next day the person called again to report that Licensee would not be doing day care for a while because of a leg ulcer. The Licensing Worker referred the complaint to Shannon Brewers, the LLMHS Child Protection Worker, and awaited the results of the Child Protection investigation.^[9]

11. The Child Protection Worker met with Licensee on July 31, 2003. She also spoke by phone that day with Reverend Nelson whose name had been given her by Licensee. She was not able to speak to the Complainant because that person’s identify was not known.^[10]

12. Upon the conclusion of an investigation, a Child Protection Worker must determine whether “maltreatment” has occurred and whether child protective services are needed. “Maltreatment” means “physical abuse”, “neglect”, “sexual abuse”, “mental injury” or “maltreatment in a facility” such as a day care facility. A determination that child protective services are needed must be based upon conditions sufficient to cause a Child Protection Worker,

to conclude that a child is at significant risk of maltreatment if protective intervention is not provided and that the

individuals responsible for the child's care have not taken or are not likely to take actions to protect the child from maltreatment or risk of maltreatment.^[11]

13. On August 4, 2003, the Child Protection Worker spoke with her supervisor, Paul Horn, to discuss the investigation. They concluded that the Child Protection Worker would issue a determination that maltreatment in the form of neglect had occurred, but that child protective services were not needed at this time. That determination was based upon an assessment of the safety of the child in the day care home, which determined that the risk level was low.^[12]

14. On August 4, 2003, the Child Protection Worker met with the Licensing Worker to discuss the Child Protection determination. The Child Protection Worker also called Ms. Davis, the boy's mother, and left a message to have her call. On August 5, 2003, the Child Protection Worker issued the determination that neglect had occurred, but that child protection services were not needed. Later that day, Ms. Davis called the Child Protection Worker.^[13] Licensee did not request a reconsideration of the Child Protection determination.^[14]

15. The Licensing Worker provided the Child Protection determination to the Department and had discussions with the Department regarding the appropriate procedure.^[15] On the afternoon of August 6, 2003, the Department issued the Order of Temporary Immediate Suspension to Licensee and faxed it to the Licensing Worker to be served personally upon Licensee.^[16] On August 7, 2003, the Licensing Worker, along with Case Aide Marilyn Opdahl, drove to Licensee's home to serve the Order of Temporary Immediate Suspension.^[17]

16. The Order of Temporary Immediate Suspension cited the July 23, 2003, report alleging maltreatment in the day care home as the basis for the immediate suspension. It further stated that due to the serious nature of the violation under investigation, the County could not ensure the safety of persons served by the program and, therefore, that the Department found that the health, safety, and rights of children in Licensee's care were in imminent danger.^[18]

17. When the Licensing Worker and Case Aide arrived to serve the Order of Temporary Immediate Suspension, they found three children playing outside alone and unsupervised. The children were two day care children ages six and one-half and two and one-half and Licensee's grandson, who was three years old at the time. The Case Aide observed Licensee's mother look out the window in the kitchen door when she heard them drive up. Licensee's mother went to get Licensee who was inside the house. Licensee opened the door to let the Licensing Worker and case aide in. When they entered they found the kitchen very heavy with cigarette smoke in the air and observed two cigarette packs lying on the kitchen counter along with an empty ashtray.^[19]

18. Licensee testified that just prior to the Licensing Worker and Case Aide arriving, she had gone into the house to sit down and rest her leg. She also testified that it was her mother or her son who had been smoking in the home at the time the workers arrived.

19. The Licensing Worker served the Order of Temporary Immediate Suspension upon Licensee and explained it to her.^[20] By letter dated August 6, 2003, Licensee appealed the temporary immediate suspension which was received by the Department on August 12, 2003.^[21] The Notice of and Order for Hearing in this matter was issued by the Department on August 13, 2003. The Notice of Hearing was served by LLMHS upon Licensee on August 19, 2003.^[22]

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.07, subd. 2a.

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. R. 9502.0365, subp. 5, “[a] licensed provider must be the primary provider of care in the residence. Children in care must be supervised by a caregiver.”

4. Supervision of an infant, toddler, or preschooler means that the caregiver is within sight or hearing at all times and is capable of intervening and protecting the health and safety of the child. Supervision of a school age child requires that the caregiver be available to protect the health and safety of the child.^[23]

5. Licensee failure to be present or to have her mother present outside with toddlers and preschoolers in the play area is a violation of Minn. R. 9502.0365, subp. 5, requiring children in care to be supervised by a caregiver. Observing toddlers and preschoolers through a window can be adequate supervision when the window provides a view of the entire play area and of all the children, particularly if the window is open to allow the children to be heard. However, the window in Licensee’s home did not allow such a view. Thus, the supervision provided by Licensee and her mother failed to meet the requirements of the rules.

6. Reasonable cause exists to believe that Licensee’s violations of the supervision rules pose an immediate risk of harm to the health, safety, and rights of the children served by her day care. The fact that Licensee and her mother did not know that the young boy who walked down the driveway and down the road and was gone for at least six minutes demonstrates that a risk of serious harm existed at that time. Two-year-olds, particularly fast ones, can disappear in a minute and she left the children unsupervised for several minutes. Moreover, despite her claims, Licensee has actually done nothing to change that style of supervision. Toddlers and preschoolers are left alone outside while Licensee and her mother are inside only occasionally checking on the children through windows and doors that provide inadequate ability to observe the children. The fact that Licensee allows smoking in the home during day care hours by her mother and son, and probably herself, is not directly related to supervision, but demonstrates a lack of respect for the rules and lack of concern for the health of the children in care.

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

RECOMMENDATION

IT IS HEREBY RECOMMENDED that the Order of Temporary Immediate Suspension be **AFFIRMED**.

Dated: September 18, 2003.

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

NOTICE

Pursuant to Minn. Stat. § 14.62, subd. 1, the Minnesota Department of Human Services is required to serve its final decision upon each party and the Administrative Law Judge by first class mail.

Reported: Tape recorded (2 tapes). No transcript prepared.

^[1] Testimony of Lena Wheeler.

^[2] Testimony of Lena Wheeler and Rebecca Sik.

^[3] Testimony of Rebecca Sik, Marilyn Opdahl, Denise Crumrine, Lena Wheeler; Exs. 8 and 9.

^[4] Testimony of Sara Davis.

^[5] Testimony of Lena Wheeler; Ex. 4 (Appeal letter).

^[6] Ex. 7 (Note of CP Worker discussion with Reverend Nelson).

^[7] Testimony of Lena Wheeler; Ex. 4 (Appeal letter).

^[8] Testimony of Sara Davis and Lena Wheeler.

^[9] Ex. 1 (Complaint Form); Testimony of Rebecca Sik.

^[10] Testimony of Paul Horn; Ex. 7 (CP Assessment case notes).

^[11] Minn. Stat. § 626.556, subd. 10e.

^[12] Testimony of Paul Horn; Ex. 7 (CP Assessment case notes).

^[13] Ex. 6 (Child Protection Determination); Ex. 7 (CP Assessment case notes).

^[14] Testimony of Paul Horn.

^[15] Ex. 3 (case notes).

^[16] Ex. 2.

^[17] Testimony of Rebecca Sik and Marilyn Opdahl; Ex. 2 (Order of Temporary Immediate Suspension); Ex. 3 (case notes); and Ex. 5 (Opdahl dictation notes). The testimony at hearing was that the Order was delivered August 6, which is also what the case notes state. However, the case notes state that the delivery was completed at 11:47 a.m. and the fax was not sent by the Department until 3:43 p.m. Opdahl's dictation notes indicate that the delivery was made on August 7, 2003. That appears more likely to be the correct date.

^[18] Ex. 2.

^[19] Testimony of Rebecca Sik, Marilyn Opdahl, and Lena Wheeler; Ex. 5 (Opdahl dictation notes).

[\[20\]](#) Testimony of Rebecca Sik.

[\[21\]](#) Ex. 4.

[\[22\]](#) Notice of and Order for Hearing and Ex. 5 (Opdahl dictation notes).

[\[23\]](#) Minn. R. 9502.0315, subp. 29a.