

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE COMMISSIONER OF HUMAN SERVICES

In the Matter of the Maltreatment,
Disqualification, and Revocation
Determination of Patrick Lyons' Adult
Foster Care License

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

A hearing in this matter was conducted by Administrative Law Judge Steve M. Mihalchick on June 8, 2004, at the Rochester City Hall, Room 306, 201 Fourth Street SE, Rochester, MN 55904. The hearing record closed on the day of the hearing.

William L. French, Attorney at Law, P.O. Box 6323, 627 Woodhaven Court NE, Rochester, MN 55903, appeared for Patrick Lyons (Licensee). Michael E. Burns, Assistant Attorney General, Suite 900, 445 Minnesota Street, St. Paul, MN 55101-2127, appeared for Olmsted County Community Services (the County) and the Minnesota 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

1. Whether Licensee engaged in acts constituting maltreatment by neglect under Minn. Stat. §§ 626.557, subd. 9c(b) and 626.5572, subds. 15 and 17(a), when he failed to supervise a vulnerable adult in his foster care program on several occasions according to the designated supervision plan.

The Administrative Law Judge finds that Licensee repeatedly failed to supervise the vulnerable adult according to the supervision plan and concludes, therefore, that such acts did constitute recurring maltreatment by neglect.

2. Whether Licensee engaged in an act constituting maltreatment under Minn. Stat. §§ 626.557, subd. 9c(b) and 626.5572, subds. 15 and 17(a), when he failed to monitor the medication of one of the vulnerable adults in his foster care program over several months.

The Administrative Law Judge finds that Licensee failed to monitor the medication of the vulnerable adult and concludes, therefore, that such acts did constitute recurring maltreatment.

3. Whether Licensee 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) (2002).

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.

4. Whether, under Minn. Stat. § 245A.07, the Department correctly ordered the revocation of Licensee's adult foster care license based upon the finding that Licensee had committed recurring maltreatment.

The Administrative Law Judge concludes that the Department properly revoked Licensee's adult foster care license.

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

FINDINGS OF FACT

Licensee's Residential Adult Foster Care Program

1. Licensee began providing Residential Adult Foster Care at his home in Rochester, Minnesota, in approximately 1988, after retiring from the sheet metal industry. Licensee's ex-wife and their son also each run a residential adult foster care home in the Rochester area.

2. The adults in Licensee's program are semi-independent and need assistance with some daily living skills, ranging from hygiene to cooking to managing money. Licensee runs the program with government funds and with assistance from community day programs that supervise vulnerable adults in a work setting and aid them with various occupational skills. He completes his annual adult foster care training requirements of six hours per year in a timely manner, often attending more than the required number of hours.^[1]

Client C.M.

3. C.M. is a 55-year-old male with mild mental retardation.^[2] He came to live in Licensee's home as a client in 1996. C.M. is independent in that he drives his own truck, socializes with friends, makes his own lunches, and provides his own self-care.^[3] However, he does need supervision and reminders to wear clean clothing. He is able to hold regular employment, and has worked as a janitor at a local truck stop through Ability Building Center (ABC), a day work-assistance program.^[4] In his free time, C.M. enjoys watching stock car races, driving in his truck, and doing manual labor at his friend Klint's farm in Stewartville, MN. But C.M. is financially vulnerable and does not understand the consequences of the decisions he makes with money, so a conservator assists him with money matters.^[5] In addition, Olmsted County provides case management to C.M.^[6] Licensee and C.M. have a good working relationship and get along well together.

4. On or about July 6, 2000, Licensee hired Rebekah Bailey to cook and clean for the residents of the house.^[7] Licensee and Ms. Bailey drafted a written agreement, and she received room and board in exchange for her housekeeping services, as stated in their contract dated July 6, 2000.

5. On July 9, 2000, Rochester Police arrested C.M. in a local park after a seven-year-old boy reported to his mother that C.M. had touched his genitals and buttocks in the park's public restroom.^[8] Police charged C.M. with Criminal Sexual Conduct and C.M. spent six months in jail.

6. On January 12, 2001, C.M. was released from jail when a judge found him incompetent to stand trial.^[9] To protect the safety of both the public and C.M., the judge required that C.M.'s interdisciplinary team (IDT)^[10] create a supervision plan for C.M. to be in place at all times.^[11] The plan, dated January 18, 2001, allowed C.M. to work in-house at ABC and take the city bus to and from the job, with the agreement that C.M.'s ABC coordinator would call his foster care provider if C.M. did not arrive at work in a timely fashion, and C.M. would call the foster care provider if for some reason he left work early. Second, the plan prohibited C.M. from having any unsupervised time in the community, with the exception of his bus rides to and from ABC. C.M. was limited to two hours unsupervised time at home. The IDT intended to allow only Licensee, a staff person of Licensee, C.M.'s case manager, or an ABC staff person to supervise C.M.^[12] Third, the plan prohibited C.M. from driving, took his truck away, and allowed no contact with minors, at home or in the community.

7. The County approached Licensee about whether he would accept C.M. back into his adult foster care program. Licensee accepted C.M.'s return to his care, understanding the general nature of C.M.'s criminal offense and that he must be highly supervised. Licensee was obligated to inform the County immediately of any violations of the plan by C.M. Licensee requested respite money so that he could hire an individual to assist him and give him a break on weekends, if necessary.^[13] The County agreed to look in to Licensee's eligibility for respite funds.

8. On February 22, 2001, Olmsted County social worker Cindy Stenzel^[14] went to Licensee's home to pick up C.M. for a court hearing.^[15] Neither C.M. nor Licensee was at the home, and the unidentified man who answered the door told Ms. Stenzel to come back later in the day to talk to Rebekah Bailey, who was purportedly looking after the clients. Ms. Stenzel eventually found C.M. alone at the courthouse. After the hearing, C.M. refused her offer of a ride to work and did not return to work in a timely fashion.^[16] Ms. Stenzel reported to her supervisor(s) that C.M. was not following his supervision plan.^[17] Later that day, Ms. Stenzel called Rebekah Bailey who stated that she knew nothing about C.M.'s supervision plan. That night, Ms. Stenzel visited Ms. Bailey at Licensee's home and went over the details of the supervision plan. Ms. Bailey agreed to abide by the plan.

9. On June 6, 2001, Licensee met with Ms. Stenzel and other County Social Services employees dealing with C.M.'s case management. The group explained the criteria for respite funds and informed Licensee that he was not eligible for such funds for C.M.^[18] Licensee asserted that he needed respite funds because C.M.'s supervision plan was unreasonable and should be changed.

10. On August 6, 2001, the Department notified Keith Lewis, an Olmsted County Adult Foster Care Licensing Worker, that it had received a complaint through the Common Entry Point about the treatment of C.M.^[19] Mr. Lewis, Ellen Turner from the County, and Judy Betcher from the Department began an investigation into the allegation. They conducted interviews with Licensee and C.M. on September 20 and 27, 2001. C.M. told the investigators that since 2001, when he returned to Licensee's home under the supervision plan, he had been to stock car races, medical appointments, a friend's house, and in the community without supervision, as well as being alone in the house for more than two hours at a time.^[20] Licensee acknowledged that C.M. has gone alone to at least one car race.^[21] Additionally, both C.M. and an ABC staff worker stated that C.M. had gone to the doctor by himself on at least one occasion between July 30 and August 16, 2001.^[22] Licensee admitted that he did not always monitor C.M.'s compliance with the supervision plan because he did not believe that C.M. was dangerous. When asked how he monitored C.M.'s compliance with the plan, he stated, "I am not a corporate home, I don't or am unable to keep track of things."^[23] Licensee again suggested that the supervision plan should be reassessed.^[24] Licensee did not notify the County of any of C.M.'s violations of the supervision plan.

11. Licensee persisted in asking the County for respite funds and began to get frustrated that the County was ignoring his need for help. Licensee hired an attorney and asked him to be present at the house on August 9, 2001, for a meeting with some

County workers. Licensee also invited a mental health professional^[25] to attend the meeting and lend support to his need for respite funds.

12. In October, 2001, Licensee commenced a lawsuit against the County based upon his belief that a County worker had violated C.M.'s supervision plan and that he was being treated unfairly by County licensing workers.^[26] By this time, Licensee was convinced that the County had a vendetta against him and his family.

13. The County removed C.M. from Licensee's care on January 1, 2002, and placed him at the REM – River Bluffs facility.^[27]

14. In an investigative report dated June 4, 2002, Mr. Lewis and Ms. Betcher outlined their findings as well as the agreements signed by Licensee and C.M. to abide by the supervision plan, including the Individual Resident Placement Agreement (requiring Licensee to ensure that C.M. follows the plan and to call "crisis" as needed), the Adult Foster Care Worksheet (detailing the parameters as to who is an appropriate supervisor of C.M.), and the Abuse Prevention Plan Assessment (addressing C.M.'s inappropriate interactions with others and his lack of understanding of sexuality). Mr. Lewis and Ms. Betcher concluded 1) that maltreatment had occurred in that there was neglect by the failure or omission of Licensee to supply C.M. with supervision which was reasonable and necessary to maintain C.M.'s physical or mental health or safety; 2) that none of the mitigating factors of Minn. Stat. § 626.557, subd. 9c(c) applied to this situation; and 3) that the maltreatment was recurring under Minn. Stat. § 245A.04, subd. 3d (4).^[28]

15. By letter dated June 4, 2002, that same day, the Department notified Licensee of the maltreatment determination and the disqualification from direct contact with vulnerable adult receiving foster care services by Department-licensed programs. The letter outlined the process by which he could request reconsideration of both determinations.^[29] Licensee submitted timely appeals of both determinations.^[30]

16. On August 28, 2002, Mr. Lewis recommended to the Department that Licensee's adult foster care license be revoked based upon the Department's indication that it intended to uphold the maltreatment determination and not grant a set aside or variance to the disqualification.^[31]

17. The Department completed two Risk of Harm Assessments of Licensee dated September 4 and 20, 2002.^[32] Each assessment ranked Licensee as "high risk" in six or seven of eleven categories based upon the intentional nature of the violation, the vulnerability of the victim and the other adults in Licensee's care, the short length of time since the disqualifying event, Licensee's lack of training since the event, and Licensee's failure to accept responsibility for the event. Both of the assessments recommended that the disqualification not be set aside.

18. By letter dated September 23, 2002, the Department issued a Notice of Reconsideration of Maltreatment Determination and Notice of Reconsideration of Disqualification and Revocation.^[33] The Commissioner upheld the Department's determinations and relied upon the following statutory factors: the recurring nature of and consequences of the maltreatment, the recency of the maltreatment, the vulnerability of the victim, and the vulnerability of the people for whom Licensee provides direct contact services. Accordingly, the Commissioner upheld the revocation as directed by Minn. R. 9555.5105 to 9555.6265. The Notice informed Licensee of his right to a contested case hearing. Licensee submitted a timely appeal of the maltreatment determination, the disqualification, and the revocation.^[34]

Client D.B.

19. D.B. is a 53-year-old male with mental retardation and paranoid delusional disorder. Licensee took D.B. into his home as a client on July 15, 1997, after he was evicted from his apartment.^[35] D.B. takes medication for conditions including lateral epicondylitis (tennis elbow), hyperlipidemia (an increase of lipids in the bloodstream), Klinefelter's Syndrome (a congenital chromosomal abnormality affecting the endocrine system), right carotid bruit (a murmur caused by a clogged artery in the neck), microhematuria (red blood cells in the urine), cerebrovascular disease (a disease affecting the blood vessels in the brain), and high cholesterol.^[36] He receives Haldol shots twice per month to treat his paranoid delusional disorder.^[37] A public health nurse administers the Haldol shots and REM Semi-Independent Living Services (REM-SILS) drives D.B. to each of his appointments. The REM-SILS staff spent 3.5 hours per week with D.B. and was also responsible for explaining to D.B. the importance and proper use of his medications.^[38] Edward Jaakola is D.B.'s social worker from Jackson County, the county where D.B.'s foster care services originated. According to D.B.'s medication supervision plan, Licensee, as the foster parent, is responsible for storing, passing and monitoring each of D.B.'s medications.^[39] D.B. is his own guardian but needs verbal prompts to complete his daily hygiene and minimal supervision in reading and writing, and managing his money and time.^[40] D.B., like C.M., works through ABC's day-work assistance program.^[41]

20. Mr. Jaakola visits D.B. approximately once every three months. Each year Mr. Jaakola meets with D.B. and his current foster care provider to complete an annual review of D.B.'s employment status, medical health, functioning skills, and Individual Resident Placement Agreement and progress on goals from the past year. Mr. Jaakola met with D.B. and Licensee on December 12, 2000, and December 13, 2001. Jaakola wrote the information on a review form each time and all three individuals signed both agreements and received a copy.^[42] The completed form made multiple references to Licensee's responsibility to store, pass, and monitor D.B.'s medications; it also listed as a concern D.B.'s possible resistance to taking his medication.^[43]

21. During a relicensing visit on September 1, 2001, the County verified that Licensee's records on D.B., including a medication record, an Individual Abuse Prevention Plan, an Individual Service Plan, and initial and annual reviews of the Individual Resident Placement Agreement, were up to date.^[44]

22. In March, 2002, Mr. Jaakola visited D.B. and Licensee in Rochester, at which time they discussed D.B.'s medications and Licensee's responsibility to dispense them, as well as the desirability of D.B.'s continued placement with Licensee.^[45]

23. On May 23, 2002, the Department received a report through the Common Entry Point that Licensee had allegedly engaged in maltreatment against D.B. by failing to give D.B. his heart medication (Zocor) over an extended period of time.^[46] Five days later, REM-SILS Director Linda Chappuis called a meeting of D.B.'s Interdisciplinary Team to discuss D.B.'s progress and problems.^[47] In August, 2002, REM took

possession of D.B.'s medications from Licensee, and for about three weeks, the REM staff set up the medication in daily pill boxes and sent them home with D.B.

24. On August 27, 2002, D.B.'s physician doubled the daily dose of Zocor. That same day, one of the REM workers went to Licensee's home to inform him of the change in dosage and to return the medication, in its daily pill boxes, to Licensee.^[48] REM had decided that it was unable to effectively monitor the situation given the limited number of hours D.B. spent with REM each week. Licensee refused to double the dosage until he heard from D.B.'s physician. When the REM worker took D.B. to a medical appointment two days later, the worker checked D.B.'s pill box and saw that multiple medications had been administered incorrectly.^[49] By letter dated August 29, 2002, Ms. Chappuis informed Mr. Jaakola of REM's decision.^[50] REM did continue to transport D.B. to his medical and dental appointments, including his Haldol shots.

25. The County removed D.B. from Licensee's care on September 3, 2002.^[51]

26. Leah Olsson, an investigator with the Department, interviewed Licensee at his home on March 7, 2003. Licensee denied that he was ever in charge of or in possession of D.B.'s medications prior to the end of August, 2002.^[52] He expressed frustration with the frequent turnover and disorganization of the REM staff and claimed that the passing of D.B.'s medication was always solely REM's responsibility. Licensee stated to Ms. Olsson that he had no knowledge of D.B.'s Zocor prescription or any physical or age-related health problems other than D.B.'s need for glasses and his inability to walk a straight line.^[53] Licensee told Ms. Olsson that he was rarely invited to D.B.'s IDT meetings, and that when he did attend, the responsibility for D.B.'s medication was unclear and never clarified for him by the IDT.^[54] He denied ever receiving a copy of the 2000 and 2001 Annual Reviews of D.B. Ms. Olsson asked Licensee if D.B. had a problem with his heart, and Licensee responded, "I don't know."^[55]

27. In Ms. Olsson's Investigation Memorandum, dated September 5, 2003, she outlined her findings as to the allegations against Licensee.^[56] She found that the allegations of maltreatment against D.B. were on-going between January, 2001 and August, 2002. Between September 5, 2002, and July 7, 2003, Ms. Olsson interviewed D.B., Licensee, Mr. Jaakola, a County adult foster care licenser, two individuals from ABC, D.B.'s primary physician, and another of D.B.'s health care providers. She also collected and reviewed 27 different documents relating to the matter. Based on her interviews, Ms. Olsson concluded that Licensee's actions regarding D.B. constituted maltreatment, that Licensee was responsible for the maltreatment under Minn. Stat. § 626.557, subd. 9c(c), that the maltreatment was "recurring" under Minn. Stat. § 245C.02, subd. 16 (2003), that Licensee was disqualified, and that Licensee's adult foster care license should be revoked.^[57]

28. By written notice of September 5, 2003, the Department notified Licensee that it had substantiated Licensee's failure to monitor D.B.'s medication, as described in the Investigation Memorandum, which was attached.^[58] 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. The notice set forth Licensee’s rights to request reconsideration of the maltreatment and disqualification determinations.

29. The Department received a timely appeal of both determinations from Licensee’s counsel dated October 17, 2003, in which he informed the Department that Licensee no longer lives in Minnesota and was no longer providing adult foster care services.^[59]

30. Laura Plummer Zrust of the Department’s Division of Licensing reviewed information in the Investigation Memorandum and the request for reconsideration submitted by Licensee. She completed a Risk of Harm Assessment worksheet on November 24, 2003.^[60] She rated seven of the eleven listed factors as “high risk,” and three as “medium risk.” She ranked Licensee as “high risk” based upon the vulnerability of the victim and the other vulnerable adults in Licensee’s care, the short length of time since the disqualifying event, Licensee’s lack of training since the event, and Licensee’s failure to accept responsibility for the event. Ms. Plummer Zrust concluded that Licensee posed an imminent risk of harm and recommended that the disqualification not be set aside.

31.

On November 25, 2003, the Department issued a Notice of Reconsideration of Maltreatment Determination and Notice of Reconsideration of Disqualification to Licensee.^[61] It stated that the Commissioner of Human Services had determined that the maltreatment determination was appropriate. The Commissioner upheld the Department’s determinations and relied upon the following statutory factors: the recurring nature of and consequences of the maltreatment, the recency of the maltreatment, the vulnerability of the victim, and the vulnerability of the people for whom Licensee provides direct contact services. The Commissioner thus determined that the information used to disqualify Licensee was correct and that the maltreatment was recurring, which is a disqualifying characteristic under Minn. Stat. § 245A.04, subd. 3d. The notice informed Licensee of his right to request a contested case hearing.

32. Licensee filed a request for a contested case hearing by letter dated December 27, 2003.^[62] The Department served a Notice of and Order for Telephone Prehearing Conference on March 12, 2004. The Department re-issued the Notice of and Order for Telephone Prehearing Conference on March 27, 2004, which incorporated the Investigative Memorandum. During the prehearing conference of April 6, 2004, the hearing was scheduled for June 8-11, 2004.

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." Subdivision 17 (a) of the same statute defines neglect as "a failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to supervision which is reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult"

4. "Recurring maltreatment" means more than one incident of maltreatment.^[63]

5. Licensee's conduct toward C.M. constitutes maltreatment by neglect because Licensee failed to give C.M. the care or services necessary to maintain C.M.'s health and safety. C.M.'s supervision plan was created both for the safety of minors in the community as well as for the safety of C.M., should there be any retaliatory actions against him. The judge presiding over C.M.'s criminal sexual conduct matter thought it appropriate to have C.M. committed. When this was not a possibility, the judge made C.M.'s release contingent upon a strict supervision plan. When Licensee consented to have C.M. back into his home for adult foster care services, the County was clear that C.M. must be highly supervised and Licensee agreed. Yet, during the County's investigation, Licensee admitted that he did not think C.M. was dangerous, and he felt that the supervision plan was too restrictive and even unnecessary. His testimony during the investigation was that he, as a small private home adult foster care provider, did not have the time or resources to maintain such a supervision plan for C.M. Licensee then proceeded to argue that if C.M. was such a danger to the community, Licensee should have had additional training as to how to deal with the client. Licensee's conduct toward C.M. constitutes recurring maltreatment because the neglect occurred on several occasions when C.M. attended at least one stock car race and up to three medical appointments on his own, as well as taking at least one unsupervised trip to his friend Klint's house.

6. Licensee's conduct toward D.B. constitutes maltreatment by neglect because Licensee failed to give D.B. the care or services necessary to maintain D.B.'s health and safety. D.B. had multiple serious health conditions that required medication. His case worker, Ed Jaakola, visited D.B. and Licensee, kept Licensee informed of changes in D.B.'s medical condition, and performed annual reviews for the care of D.B. On multiple occasions Mr. Jaakola and Licensee conferred about D.B.'s medications and Licensee's responsibility for them. Even if Mr. Jaakola never went over the annual reviews with Licensee in a face-to-face setting, the fact is that the County saw at least one annual review in D.B.'s file at Licensee's house, and Licensee should have read the review and been aware of his assigned responsibilities and Mr. Jaakola's areas of concern for D.B. While the communication between REM and Licensee may have been poor, it is simply not credible that Licensee was either 1) completely unaware of any of D.B.'s medication needs or 2) completely unaware of his involvement in the passing of medication. Licensee's conduct toward D.B. constitutes recurring maltreatment

because the neglect occurred over several months during which Licensee did not administer the necessary medication to D.B.

7. 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 a Department-licensed program.^[64] Licensee has engaged in recurring maltreatment of vulnerable adults for the above-cited reasons and therefore, 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.^[65] 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. As demonstrated by Licensee’s utter disregard for the needs of C.M. and D.B., Licensee poses a risk of harm to the vulnerable adults that he serves. Therefore, the disqualification should not be set aside.

10. Minn. R. 9555.6125, subp. 4.D. states that adult foster care program operators “must not have a disqualification” under Minn. Stat. § 245A.04, subd. 3d. Licensee has been disqualified and therefore, revocation of his license is required under the rule. Even a consideration of the nature, chronicity, or severity, under Minn. Stat. § 245A.07, subd. 1, of Licensee’s violations does not allow for the overturning of the revocation of his license.

11. 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 recurring maltreatment, the determination of disqualification of Patrick Lyons and the determination that the disqualification not be set aside, and the revocation of Patrick Lyons’ license to provide adult foster care.

Dated: July 9, 2004

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

Reported: Tape recorded (four tapes).

MEMORANDUM

At the hearing, Licensee argued that the case against him as to C.M. should be dismissed for failure to pursue in a timely manner, citing Minn. R. 9543.0120. The rule states that, within 30 days of the receipt of an appeal packet from the Department, the County shall arrange with the Office of Administrative Hearings “a timely date and location for the hearing.” Licensee’s interpreted the rule to mean that the hearing must be held within 30 days of receipt of the appeal. This is a clear misinterpretation of the rule, which allows the County 30 days to arrange for the hearing. Licensee further asserted that, even without his misinterpretation of Minn. R. 9543.0120, the matter still took far too long to come to hearing. The facts show that issues regarding C.M.’s supervision plan surfaced in February, 2001. The County did not act on this information against Licensee until August, 2001, when the Department received a complaint through the Common Entry Point. The matter did not come to hearing until June, 2004. But the delay resulted in part from the allegations that surfaced in May, 2002, involving D.B. and the need to consolidate the two allegations into one hearing. The fact remains that the County and the Department did investigate the allegations about Licensee’s supervision of C.M., made the maltreatment determination, disqualified Licensee as required by statute, and removed C.M. from Licensee’s care. The lack of timeliness and efficiency of this investigation reflects poorly upon the County and Department, but the fact remains that Licensee failed to supervise C.M. according to the supervision plan and provide D.B. with his medication.

Second, Licensee argued that the County inappropriately counted, as one of his supervision violations of C.M., the July, 2000, incident with the young boy in the park. Leah Olsson of the Department, made this incorrect statement in her investigation memorandum dated September 5, 2003.^[66] The allegation was repeated as an issue in the Notice and Order for Telephone Prehearing Conference issued by the Commissioner of the Department. At the hearing, Ms. Olsson’s supervisor, James Janezek, testified that Ms. Olsson’s statement was an error that he did not see until the night before the hearing. Ms. Olsson was not the Department staff person assigned to investigate the allegations regarding C.M. It appears that Ms. Olsson misunderstood the details of July Betcher’s investigation. The testimony of Keith Lewis also clarified any confusion as to Ms. Olsson’s statement. The County knew that any allegations against Licensee as to C.M. were from violations of the supervision plan, which was a result of the July, 2000, park incident.

Third, Licensee claims that the whole matter is the result of a vendetta the County has against him and his family. According to Licensee, the County resumed

investigation into the allegations regarding C.M. and began removing clients from his care after he pressed the issue of respite funds, obtained an attorney in August, 2001, and commenced a lawsuit against the County. The County did not act alone and does not have final authority over the status of Licensee's adult foster care license. The County made recommendations to the Department, who reviewed each decision and applied the statutory factors to reach the decision they did. No witness for the Department claimed to harbor any animosity toward Licensee.

S.M.M.

[\[1\]](#) Testimony of Licensee.

[\[2\]](#) Testimony of Joleen Predmore. His I.Q. is approximately 63.

[\[3\]](#) DHS 126.

[\[4\]](#) DHS 90.

[\[5\]](#) DHS 126.

[\[6\]](#) DHS 127.

[\[7\]](#) DHS 42.

[\[8\]](#) DHS 2, 85-91.

[\[9\]](#) DHS 53.

[\[10\]](#) The IDT consisted of C.M., Licensee, Joleen Predmore, a county licenser, and C.M.'s conservator. DHS 2.

[\[11\]](#) DHS 230.

[\[12\]](#) DHS 3.

[\[13\]](#) Licensee testified that the County promised him respite money.

[\[14\]](#) Cindy Stenzel was standing in for Joleen Predmore, who was on maternity leave during this time.

[\[15\]](#) DHS 52. The hearing involved the dismissal of the Judge's petition for commitment

[\[16\]](#) DHS 52.

[\[17\]](#) DHS 61.

[\[18\]](#) DHS 68.

[\[19\]](#) Testimony of Keith Lewis. The Common Entry Point at the Department is the place through which complaints regarding the treatment of vulnerable adults are received. The Department then notifies the appropriate County social service agency.

[\[20\]](#) DHS 3-5.

[\[21\]](#) DHS 31.

[\[22\]](#) DHS 4-5.

[\[23\]](#) DHS 31.

[\[24\]](#) DHS 3.

[\[25\]](#) The record is unclear as to whether this individual is a psychiatrist or a psychologist.

[\[26\]](#) DHS 639-650. The record is not clear as to the outcome of the lawsuit.

[\[27\]](#) Testimony of Joleen Predmore.

[\[28\]](#) DHS 6-7 and testimony of Keith Lewis.

[\[29\]](#) DHS 238-39.

[\[30\]](#) DHS 265-70.

[\[31\]](#) DHS 282.

[\[32\]](#) DHS 271-72.

[\[33\]](#) DHS 243-47.

[\[34\]](#) DHS 248.

[\[35\]](#) Testimony of Edward Jaakola.

[\[36\]](#) DHS 314-15.

[\[37\]](#) DHS 417, 576-77.

[\[38\]](#) DHS 443.

[\[39\]](#) DHS 439, 443, 446, 450 and testimony of Edward Jaakola.

- [40] DHS 440. REM also assists with some of these independent living skills and maintains D.B.'s checkbook.
- [41] DHS 438, 449.
- [42] DHS 436-46 and 447-57.
- [43] DHS 443, 446.
- [44] DHS 320.
- [45] Testimony of Edward Jaakola.
- [46] DHS 351-53. The complaint also alleged that Licensee allowed people who were unfamiliar to the clients to stay at the house when Licensee was away.
- [47] DHS 569. The team is made up of D.B., Licensee, an ABC representative, and a REM-SILS representative. The team meets two to four times per year.
- [48] Licensee testified that the REM worker told him to double D.B.'s dose of a certain drug. He could not recall which drug. Licensee spoke to Ed Jaakola about this deviation from the prescription, and Mr. Jaakola advised Licensee to abide by the doctor's prescription. DHS 381-82.
- [49] DHS 316.
- [50] DHS 480.
- [51] Testimony of Edward Jaakola.
- [52] DHS 381-87.
- [53] DHS 384.
- [54] DHS 385.
- [55] DHS 386.
- [56] DHS 313-24.
- [57] DHS 321-24.
- [58] DHS 614-15.
- [59] DHS 637-38.
- [60] DHS 653.
- [61] DHS 654-57.
- [62] DHS 660-61.
- [63] Minn. Stat. § 245C.02, subd. 16 (2003)(formerly found in Minn. Stat. § 245A.04, subd. 3d(a)(4)).
- [64] Minn. Stat. § 245C.14, subds. 1 and 2, and § 245C.15, subd. 4(b)(2) (2003)(formerly found in Minn. Stat. § 245A.04, subd. 3d(a)(4)).
- [65] Minn. Stat. § 245C.22, subd. 4 (2003)(formerly Minn. Stat. § 245A.04, subd 3b(b)).
- [66] DHS 324.