

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE COMMISSIONER OF HUMAN SERVICES

In the Matter of the Temporary
Immediate Suspension of the Family
Child Care License of Dardell and
Janese Posey

**FINDINGS OF FACT, CONCLUSIONS
AND RECOMMENDATION**

The above-entitled matter came on for hearing before Administrative Law Judge Linda F. Close, on July 19, 2006, at the Dakota County Attorney's Office, 1560 Highway 55, Hastings, MN 55033. The record closed at the end of the hearing day.

Margaret M. Horsch, Assistant Dakota County Attorney, appeared on behalf of the Department of Human Services (the Department) and Dakota County Social Services (the County).

Dardell Posey (Licensee #1) and Janese Posey (Licensee #2) (collectively, the Licensees), 4115 Strawberry Lane, Eagan, MN 55123, appeared on their own behalves without counsel.

STATEMENT OF THE ISSUES

Should the temporary immediate suspension of the Licensees' family child care license remain in effect, pending a final order, based on the existence of reasonable cause to believe that the Licensees' actions or failure to comply with applicable law poses an imminent risk of harm to the health, safety, or rights of persons served by the program?

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

FINDINGS OF FACT

1. The Licensees are mother and daughter who have held a joint family child care license since March 2004. Prior to that time, Licensee #1, the mother, was the sole license holder. The Licensees hold a C3 license, which allows them to care for up to 14 children when both providers are present. If only one provider is present, only 12 children may be cared for.^[1]

2. On May 17, 2006, a nurse social worker, Judy Rasmussen, went to the Licensees' home around 9:00 and again between 2:00 and 3:00 p.m. Rasmussen works for an agency that provides services to dual Medicare and Medical Assistance recipients. The purpose of her visit was to obtain from one such recipient, KJ, a signature on a required form. KJ regularly came to the Licensees' home for personal care by Licensee #2. Licensee #2, in addition to holding a joint family child care license with Licensee #1, is a licensed personal care attendant. When Rasmussen first stopped at the Licensees' home, KJ had not yet arrived. Rasmussen left the form with Licensee #2, who said she would give it to KJ when he arrived, so that Rasmussen could pick it up later.^[2]

3. When Rasmussen returned to the home in the afternoon, she knocked for about five minutes, but no one answered the door. Sandra Sommers, a PCA home care nurse, joined Rasmussen, and the two continued to knock. After another five minutes, school age children let them into the home. When she entered the home, Rasmussen saw a man coming down the steps. She and Sommers went downstairs to the basement and saw several children, some of whom were sleeping. No adult appeared to be present.^[3]

4. Rasmussen knew where KJ stayed in a basement bedroom, and she knocked on the bedroom door for about 5 minutes, waiting for the door to be answered. Sommers called out. Eventually, Licensee #1 came to the door wearing a night gown, but she did not come out. Instead, she closed the door. At that point, Sommers pounded on the door. Licensee #1 then came out of the room. During this time, the children were running around or crying. Rasmussen picked up an infant who was in a swing and had been crying.^[4]

5. Licensee #1 told the two nurses that it was her day off. She said she had recently had bypass surgery and had taken a percocet because she was in pain. When Rasmussen returned upstairs to leave the home, she saw asleep on the couch the man she had earlier seen on the steps. At no time did Rasmussen see any adult caring for the children.^[5]

6. Nurses Sommers and Rasmussen reported to social worker Joan Visnovec what they had seen on May 17th. On May 25, 2006, Visnovec and Jennifer Larson, a child protection worker, made a drop-in visit to the Licensees' home. Licensee #2 was there, but Licensee #1 was out with KJ. Licensee #1 returned to the home while the workers were still there. Licensee #2 reported that, on the 17th, she had left the children in the care of Licensee #1 during the

afternoon. Licensee #1 denied having taken percocet on the 17th. Licensee #1 admitted having left the children alone on the 17th so that she could nap. Licensee #1 said that her 17-year old son was home on the 17th. According to Visnovec, the son is not a qualified substitute care provider because of his age.^[6]

7. Through investigation, Visnovec established that 13 children were in day care on the afternoon of May 17th, which would have required two providers to be in attendance. Visnovec also contacted Intrepid Health Care Services, which is the organization through which Licensee #2 was providing care for KJ. Visnovec did this because it is not allowed for a licensee to provide personal care services at the same time as child care. Visnovec also discovered that the man who had been sleeping on the couch on May 17th was Adnonis Eskew, the grandfather of some of the day care children. Eskew sometimes picked the children up from day care, but he also did yard work for the Licensees. Because Eskew worked in the home, a background study was required for him, but none had ever been done.^[7]

8. On June 5, 2006, Licensee #1 self-reported to Dakota County Social Services a car accident that had occurred on May 30th. Licensee #1 said that her car had jumped a curb and hit a building and another car. Licensee #1 reported that she had had two energy drinks before the incident. Licensing worker Laurie Haenke followed up on the self-report and discovered that Licensee #1 had driven her car into a building occupied by a liquor store. When Licensee #1 backed up, she struck a parked vehicle, causing it to hit its owner, who was standing next to the vehicle. Haenke learned that Licensee #1 had left the scene of the accident and had gone home. A police officer came to the Licensees' home, saw Licensee #1 inspecting her car, and then witnessed her go into her home.^[8]

9. The police officer knocked on the door, which Licensee #2 answered. Licensee #2 told the officer that Licensee #1 had been on the wagon for one year. The officer then interviewed Licensee #1 and administered a preliminary breath test, which registered .261 blood alcohol. The officer arrested Licensee #1 and took her to the liquor store, where a witness identified Licensee #1 as the driver of the car that had hit the building. An officer examined the building and found that the impact of Licensee #1's car had moved the wall it struck and caused product to fall from the shelves inside the store. Licensee #1 was charged with leaving the scene of a personal injury accident; leaving the scene of a property damage accident; driving while under the influence of alcohol; and reckless driving.^[9] Licensee #1 provided a urine sample after her arrest. The toxicology report indicated a blood alcohol concentration of .19.^[10]

10. On June 5, 2006, based on the May 17th and May 30th events, the County recommended to the Department a temporary immediate suspension of the Licensees' family child care license.^[11] On June 6, 2006, the Department

issued an Order of Temporary Immediate Suspension.^[12] The Licensee appealed the suspension, resulting in the instant hearing.

11. On July 13, 2006, Visnovec wrote to Licensee #1, notifying her of several violations in connection with care provided on the 17th. Specifically, Visnovec found lack of supervision; incapacity of the provider due to drug use; provision of false or misleading information during the investigation; and failure to provide for a background study of a person working in the licensed home.^[13] Since the temporary immediate suspension was already in effect, no licensing action was provided in the July 13th letter.

12. The Licensees both testified about their deep feelings for the children in their care. They submitted letters from four parents of day care children and a letter from a minister who has known Licensee #1 for ten years. All speak positively to the Licensees' care for children.^[14] The Licensees also submitted the County's 2005 parent evaluation summary, which uses a 1-4 rating scale, with 4 being the highest. The Licensees achieved scores of 4.0 in 13 of 14 categories, with the 14th category being a 3.5.^[15]

13. The Licensees did not know that Licensee #1's son could not be considered a qualified substitute provider.^[16] Licensee #2 did not know that she could not provide personal care services to KJ at the same time she was providing child care.^[17]

Based on these Findings of Fact, the Administrative Law Judge makes the following:

CONCLUSIONS

1. The Commissioner and the Administrative Law Judge have jurisdiction in this matter under Minnesota law.

2. The Department gave proper and timely notice of the hearing and has fulfilled all procedural requirements of law and rule.

3. The hearing on a temporary immediate suspension is limited to a consideration of whether the temporary suspension should remain in effect pending the Commissioner's final decision.^[18]

4. At hearing, the burden of proof is on the Department to show that reasonable cause exists to believe that the license holder's action or failure to comply with applicable law or rule poses an imminent risk of harm to the health, safety, or rights of persons served by the program.^[19]

5. The Department has demonstrated reasonable cause to believe that violations of the family child care licensing laws and rules have occurred.

6. The Department has demonstrated reasonable cause to believe that there is a risk of imminent harm to the health or safety of children served by the Licensee.

7. The Memorandum that follows explains the reasons for these Conclusions.

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

RECOMMENDATION

Based upon these Conclusions, the Administrative Law Judge recommends that: the Order of Temporary Immediate Suspension suspending the family child care license of Dardell and Janese Posey be AFFIRMED.

Dated: July 31, 2006

s/Linda F. Close

Linda F. Close
Administrative Law Judge

Reported: Taped, 3 tape(s)
No transcript prepared

NOTICE

This report is a recommendation, not a final decision. The Commissioner of Human Services (the Commissioner) 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. The parties have 10 calendar days after receiving this report to file Exceptions to the report. At the end of the exceptions period, the record will close. The Commissioner then has 10 working days to issue his final decision. Parties should contact Cal Ludeman, acting Commissioner of Human Services, Box 64998, St. Paul MN 55155, (651) 431-2907 to learn the procedure for filing exceptions or presenting argument.

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

MEMORANDUM

The Department has the burden of demonstrating that reasonable cause exists for the temporary immediate suspension of the Licensee's family child care license. The Department may demonstrate reasonable cause for the suspension by submitting statements, reports, or affidavits to substantiate the allegation that the Licensee violated the rules and statutes governing the license.^[20] Here, the Department submitted the testimony of two licensing workers and a witness to the May 17th conduct. The Department also submitted copies of the police and toxicology reports regarding the May 30th incident.

The reasonable cause standard is slight, presumably to assure that vulnerable children are protected pending a full hearing and final decision on the matter. The ALJ finds reasonable cause to believe that the Licensees pose an imminent risk of harm to the health, safety, or rights of persons served by the program.

On May 17th, Licensee #2 left the children in the care of Licensee #1 at a time when Licensee #1 was ill and taking drugs that prevented her from caring for the children. Licensee #1 was bedridden that day. She did not hear the outside door when the nurses knocked and it took her 10 minutes after they knocked at her bedroom door to collect herself. Thus, the 13 children present had no provider at all, at a time when two providers had to be caring for them. Licensee #1's teenage son was too young to be a qualified substitute and, in any event, neither Rasmussen nor Sommers saw him in the home on the afternoon of May 17th. Mr. Eskew was not qualified either; indeed, he should not have been present in the home, because he worked for the Licensees and had never undergone a background study.

It is of further concern that Licensee #1 drove under the influence of alcohol during day care hours and entered the licensed home while under the influence. At the time Licensee #1 came home, her blood alcohol content was more than twice the legal limit according to the preliminary breath test and was just under that according to the toxicology report. Although Licensee #1 denied she entered the home after the accident, the police report is more credible than Licensee #1's testimony on this point. In addition, it should be noted that Licensee #2 was in the home when Licensee #1 returned. It was Licensee #2 who let the officer into the home to interview Licensee #1 about the accident.

Licensee #1 self-reported the incident to a social services worker, but when she did so, she lied in important respects. She told the worker she had consumed "energy drinks," not alcohol. And she said that she had followed up with the store and car owners about damaging their property. This was false, as Licensee #1 had left the scene of the accident without speaking to either.

It was apparent at hearing that both Licensees care greatly about the children they care for. They have achieved high marks from the parents of the

day care children. In addition, they have apparently conducted the day care without problems until May of 2006. While these may be reasons for a different outcome at a full hearing on the merits, as of this time, the Department has clearly made a case for a continued temporary immediate suspension of the license.

L. F. C.

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- [\[1\]](#) Testimony of Joan Visnovec, MSW (Visnovec Testimony).
 - [\[2\]](#) Testimony of Judy Rasmussen, RN (Rasmussen Testimony).
 - [\[3\]](#) Rasmussen Testimony.
 - [\[4\]](#) Rasmussen Testimony.
 - [\[5\]](#) Rasmussen Testimony.
 - [\[6\]](#) Visnovec Testimony.
 - [\[7\]](#) Visnovec Testimony.
 - [\[8\]](#) Testimony of Laurie Haenke (Haenke Testimony)
 - [\[9\]](#) Ex. B.
 - [\[10\]](#) Ex. C.
 - [\[11\]](#) Ex. E.
 - [\[12\]](#) Ex. F.
 - [\[13\]](#) Visnovec Testimony; Ex. D.
 - [\[14\]](#) Respondents' Ex. 1
 - [\[15\]](#) Respondents' Ex. 2.
 - [\[16\]](#) Testimony of Licensee #1 and Licensee #2.
 - [\[17\]](#) Testimony of Licensee #2.
 - [\[18\]](#) Minn. Stat. § 245A.07, subd. 2a (a).
 - [\[19\]](#) Minn. Stat. § 245A.07, subd. 2a (a).
 - [\[20\]](#) Minn. Stat. § 245A.08, subd. 3.