

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

In the Matter of the Indefinite
Suspension, Maltreatment,
Disqualification and Revocation
of the Adult Foster Care License of
Debbera Kline

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

This matter came on for hearing before Administrative Law Judge Barbara J. Runchey (the ALJ) on August 19, 2009, at Rochester City Hall, Rochester, Minnesota. The record closed with the submission of a letter brief and proposed Findings from Debbera Kline on September 16, 2009 (with a correction received on September 17, 2009) and proposed Findings from Olmsted County on September 17, 2009.

Geoffrey A. Hjerleid, Senior Assistant Olmsted County Attorney, appeared on behalf of the Olmsted County Community Services Department (the County) and the Minnesota Department of Human Services (DHS). William L. French, Esq. appeared on behalf of the Licensee, Debbera Kline.

STATEMENT OF ISSUES

1. Was the indefinite suspension of Licensee's adult foster care license appropriate under 245A.07, subd. 3?
2. Did the indefinite suspension of the Licensee's license violate her substantive or procedural due process rights?
3. Did Licensee commit acts of maltreatment of a vulnerable adult?
4. Were the acts of Licensee's alleged maltreatment serious and/or recurring?
5. Does Licensee's alleged serious or recurring maltreatment support a determination that Licensee posed an imminent risk of harm to persons served by the license?
6. Is Licensee disqualified under Minn. Stat. § 245C.15?

7. Is revocation of Licensee's adult foster care license an appropriate licensing sanction?

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

FINDINGS OF FACT

1. Licensee operated Home Sweet Home, an adult foster care home since 2003.¹ She testified that she has a ninth grade education and was employed as a Certified Nursing Assistant for approximately 20 years prior to becoming an adult foster care provider.²

2. In addition, as part of her foster home licensure, Licensee received vulnerable adult abuse training, CPR, and First Aid training.³

3. Licensee was licensed to provide adult foster care services for five persons, ages 55 years and older.⁴

4. Licensee undertook the care of MCO on or about June 5, 2008. MCO was a 94-year-old female, born on January 27, 1914. MCO had multiple medical conditions and mental health needs commensurate with her age and she was taking a number of medications and vitamin supplements.⁵ According to Licensee, MCO's condition required one-on-one assistance at all times.⁶

5. On June 5, 2008, MCO underwent a limited examination by Susanna M. Marjanovich, RN, CNP, at Mayo Clinic. MCO's diagnoses included chronic renal insufficiency, diabetes mellitus type 2, Hx [history] of respiratory infection, mild dementia with depression and anemia. Among other case notations, it was noted that MCO suffered from "chronic renal insufficiency, CR was 1.2 in January. She remains on low dose of Lasix. Hx [history] of fluid overload while at Maple Manor." The case notes also reflected that MCO "will be discharge[d] with prescriptions, 30 day supply." The report is unclear as to what precise prescriptions MCO received although her current medications were listed as

Aspirin 81 mg by mouth daily. (hold); Synthroid 100 mcg by mouth daily; Metoprolol 75 mg by mouth twice daily; Amaryl 1 mg by mouth daily; Seroquel 12.5 mg by mouth daily; Aricept 10 mg by mouth daily; Remeron 15 mg by mouth daily; Tylenol 1000 mg by mouth every 6 hours as needed for pain; Multivitamin one tablet by mouth daily; Calcium 600 mg

¹ Testimony of Debbera Kline

² *Id.*

³ Ex. 1

⁴ Ex. 2

⁵ Ex. 7-10

⁶ Test. of D. Kline

by mouth twice daily; Vitamin D 800 units by mouth once daily; Prilosec 20 mg by mouth daily; Lasix 20 mg every day; Calmoseptine to periaerea bid.⁷

6. MCO's prescriptions were filled at Kasson Pharmacy in Kasson, Minnesota. Records from Kasson Pharmacy indicate that on June 5, 2008, the day MCO left Maple Manor nursing home and entered foster care at Home Sweet Home, her prescription for Furosemide 20mg [generic version of Lasix] was filled for a 30-day supply. There were no further refills of this prescription noted in the Kasson Pharmacy records after this date.⁸

7. Licensee testified that she had always given MCO her Lasix despite the fact that Kasson Pharmacy records indicated that this prescription had not been refilled since June 5, 2008. She testified that she and/or a family member had also filled the prescription and also recalled that MCO came from Maple Manor with extra medication and that a family member had also provided Licensee with additional Lasix.⁹

8. Licensee also asserted and her Medication Administration Records reflected that MCO had been given this drug and others consistently since MCO was in her care.¹⁰

9. However, other Mayo Clinic medical records indicate that MCO's treating physician had received information that some time before MCO's doctor appointment on August 1, 2009, there was an issue about MCO receiving Lasix. In a Prescription Order from Mayo Clinic dated August 1, 2008, it is noted that MCO "needs to be on ES Tylenol 4 times per day to be given around [around] each meal and at bedtime. She also needs to be on Vicron C. daily and a multiple vitamin daily and back on her Lasix 20 mg daily."¹¹

10. On August 13, 2008, MCO underwent a limited examination by Dr. Jennifer J. Hartman at the Mayo Family Medicine-Kasson Clinic. MCO was brought in by her son, LO because of a question of a "persistent UTI" [urinary tract infection]. It was noted that MCO continued to have blood transfusions, the most recent which was on August 5, 2008. According to the listing of current medications, MCO's Lasix of 20 mg was "increased to 40 mg daily for next two days until follow up with primary physician" and under "DISCONTINUED MEDICATIONS" it was noted "Lasix 20 mg by mouth every day (7-11-07). Restarted 8/1/08."¹²

11. On August 15, 2008, MCO underwent a limited examination at Mayo Family Medicine-Kasson Clinic by Dr. Michael W. Justice. She was seen for a follow up of her UTI. Under HISTORY OF PRESENT ILLNESSES, it reflects:

⁷ Ex. 7

⁸ Ex. 3

⁹ Test. of D. Kline

¹⁰ Test. of D. Kline and Ex. 4

¹¹ Ex. 8

¹² Ex. 10

Also she evidently had stopped her Lasix for three weeks. She was on just 20 mg. She gained 12 pounds of weight which was probably weight [water]. She has had some ankle edema and a little bit of shortness of breath. When she saw Dr. Hartman two days ago she restarted her Lasix at a dose of 40 mg a day.

Also noted under "CURRENT MEDICATIONS" is "Lasix 40 mg by mouth daily." It is also noted under IMPRESSIONS/REPORT/PLAN: "will continue on Lasix 40 mg daily along with salt restrictions, elevation of her legs and TED stockings."¹³ There was no notation in this report of any injuries, bruises or lacerations on MCO's body.

12. It was Licensee's practice to leave Home Sweet Home from approximately 1:00 p.m., Friday, and to return at approximately 1:00 p.m., the following Monday. During the weekend, she employed assistant care providers. The assistants worked on a rotating shift every other weekend. Licensee left Home Sweet Home on August 15, 2009, at approximately 11:00 a.m., at which time, DB (weekend caregiver) took over weekend duties.¹⁴

13. During a telephone call to Home Sweet Home on Saturday August 16, 2008, DB indicated that MCO was not eating properly and that she had let her rest. Later on August 16, 2008, during another telephone call to Home Sweet Home, DB indicated to Licensee that MCO had fallen out of bed to the floor, and that because she was unable to lift her, she had called MCO's family for assistance. DB reported that MCO had fallen face down on her tummy with her undergarments partially pulled off. Licensee directed DB to lift MCO off the floor and according to Licensee, DB refused indicating that a family member was coming to assist lifting MCO off the floor.¹⁵

14. Upon arriving at Home Sweet Home, CO, who was MCO's nephew, found MCO laying face down on the floor with scrapes to her face and knees and with her undergarments pulled partially down. He assisted MCO up and indicated that MCO was alert. He left a short time later.¹⁶

15. Licensee returned to Home Sweet Home on Monday August 18, 2008, and observed bruises on MCO arms and scrapes to her knees¹⁷.

16. As part of the later maltreatment investigation, DHS investigator Dee McNama concluded that DB was responsible for the maltreatment of MCO in connection with her falling. Ms. McNama could not determine if such maltreatment was serious or recurring. The maltreatment of MCO for which DB was found to be

¹³ *Id.*

¹⁴ Test. of D. Kline

¹⁵ *Id.*

¹⁶ Exs. 18, 34, 40

¹⁷ Test. of D. Kline, Exs. 40, 41

responsible is not relevant to the incidents of maltreatment for which the Licensee was subsequently determined to be responsible.¹⁸

17. Early during the day on Sunday, August 18, 2009, Licensee observed that MCO was not herself, had no appetite and was lethargic. She assisted MCO to bed at approximately 8:30 p.m. Because she was concerned about MCO, she checked on her several times and noticed MCO was snoring loudly and was drooling/bubbling mucus and/or saliva/spit.¹⁹

18. On August 18, 2009, at approximately 10:45 p.m., Licensee telephoned MCO's son because she was concerned about MCO. Licensee was unable to reach MCO's son and spoke with his wife, KO. Licensee expressed her concerns to KO. According to Licensee, she told KO that MCO was not doing well and had a lot of fluid bubbling and saliva coming from her mouth. According to Licensee, KO indicated that this was normal and that no ambulance was necessary.²⁰

19. KO asserted that during the August 18, 2009, telephone conversation she had with Licensee that Licensee did not make it sound as if MCO was sick or that Licensee was concerned.²¹

20. Licensee checked on MCO repeatedly during the night. On August 19, 2009, at approximately 6:45 a.m., Licensee unsuccessfully attempted to wake or rouse MCO. MCO continued to have saliva coming from her mouth and had to use a towel to wipe it so that MCO did not get wet. MCO was not responsive. Licensee then repeatedly attempted to reach MCO's son, LO, who had Power of Attorney. Shortly before 9:00 a.m., Licensee was able to reach a family member. Thereafter, Licensee made a 911 call and requested an ambulance at approximately 9:09 a.m.²²

21. On August 19, 2008, MCO was transported by ambulance and was treated at St. Mary's Hospital. The hospital notes reported the following under IMPRESSION/REPORT/PLAN: "#1 unresponsiveness; #2 hypoglycemia, resolved; #3 worsening left pleural effusion and consolidation; #4 acute renal failure with azotemia; #5 elevated troponin with ST changes on ECG; #6 urinary tract infection with frank pyuria; #7 vulnerable adult, suspect abuse; #8 code status: DNR/DNI." The notes also reflect that there was a frank discussion with MCO's son regarding the serious nature of MCO's medical situation and that MCO had an advanced directive on file and that MCO was DNR/DNI.²³

22. MCO died a day later on August 20, 2008 at Mayo Hospital.²⁴

¹⁸ Ex. 36

¹⁹ Ex. 40, Test. of D. Kline

²⁰ Test. of D. Kline

²¹ Exs. 36, 40

²² Test. of D. Kline and Exs. 17, 18, 36 and 40

²³ Ex. 10

²⁴ Test. of D. Kline, Exs. 6 and 17

23. Licensee submitted an Incident Report for Foster Provider dated August 18, 2008. In this Report, she noted that MCO had fallen out of bed onto the floor, that she returned to the foster home on August 18, 2008, and noticed bruises on both arms and on back and scrapes on both knees.²⁵

24. On August 18, 2009, a Suspected Abuse and Neglect – Adult Report was submitted by Mayo Clinic. The concerns submitted by MCO’S son and daughter-in-law, LO and KO alleged neglect and the Brief Account of Concern reads as follows:

They were notified today at 9:30 this morning by caregiver at Home Sweet Home that [MCO] was ‘not able to be aroused. They had been trying since 5:00 to wake her up. I asked if they had checked her blood sugar and they told me no, what do you want us to do since our meter doesn’t have numbers on it? They didn’t even think to call an ambulance.’

Family also expressed concerns that on Sunday (08/17/08) around 16:30 they received a call from a caregiver named [DB] that patient had fallen on the floor, [DB] was unable to lift patient off of the floor and was calling family for assistance. A grand-son [CO], 951 – 5067) went to facility and found patient still lying face down on the floor. Family does not know how long patient was on the floor prior to them being called for assistance. They estimate it took family approximately 15 minutes to arrive at the home. [CO] told family he placed his arms under [MCO’s] arms to lift her from the floor. Today, family has noticed she appears to have ‘finger shaped bruises on her arms that were not there before. We also think she has rug burns on her knees.’

Patient’s family expressed additional concerns regarding medications. Patient is scheduled to receive medicine four times a day. Facility is aware of this but the family was told by [Licensee] ‘that’s too hard for us to do. We give them on our own schedule.’ At one time, [MCO] expressed that her knees hurt when the daughter-in-law was visiting. She opened the patient’s pill box and determined medication had not been given on the prescribed schedule. The family gave an example of concern for their mother’s dignity. They put her in doubled up diapers so they don’t have to get her up at night. Family states that she [MCO] recently told us I did a bad thing. She went to the bathroom in a popcorn bowl to get back at them. They (staff) made her pick it up and didn’t tell us anything about it. An additional concern is that Debbie Kline has told us things she shouldn’t have about other residents. She told us that she [Licensee] thought [JS] was trying to kill his mother when she had lived at the home. [JS] had moved his mother to Pine Island and we think she might be trying to get back at him.²⁶

²⁵ Ex. 9

²⁶ Ex. 10

25. On August 20, 2009, a Mayo Clinic Expiration Summary was completed by Dr. Steven C. Adamson. The SUMMARY DIAGNOSIS was “#1 Unresponsiveness; #2 Hypoglycemia, resolved; #3 Worsening left pleural effusion and consolidation; #4 Respiratory failure; #5 Acute renal failure with azotemia; #6 Elevated troponin with ST changes ECG; #7 Urinary tract infection with frank pyuria; #7 vulnerable adult, suspect abuse”.²⁷

26. A Vulnerable Adult Maltreatment Common Entry Point (CEP) Intake Form was received by Linda Howard from St. Mary’s Hospital Social Worker on August 19, 2008. The Description of the Incident related MCO’s fall, discussed medication concerns as follows:

The family also reported that [MCO] is supposed to be getting medication 4 times per day but they believe she was only receiving it twice per day. It is believed that this was pain medication for her knees. A family member had been to visit [MCO] and she complained of pain in her knees. They checked her med box and the box was only set up with two pills per day for the pain when the medication should be given four times per day.²⁸

27. Licensee fired/terminated DB on August 19, 2008.²⁹

28. A Mayo Clinic Final Autopsy Report was completed on MCO on August 20, 2008. The Immediate Cause of Death is noted as follows:

IMMEDIATE CAUSE OF DEATH

1. Multifactorial cardiorespiratory failure:
 - a. Ischemic heart disease:
 - i. Coronary atherosclerosis, with grade 4 (of 4) stenosis of RCA, grade 3 stenosis of LCX and grade 2 stenosis of MLA and LAD.
 - ii. Obstructive intramyocardial vascular amyloidosis.
 - iii. Patchy chronic myocardial ischemic changes and interstitial fibrosis, non-transmural, of left ventricle.
 - iv. No acute coagulative myocyte necrosis histologically.
 - b. Chronic renal insufficient (clinical):
 - i. Arterial/arteriolonephrosclerosis of both kidneys (history of hypertension, diabetes).
 - ii. Evidence of prior atheroembolism.
 - c. Bilateral pleural effusions: right, 400 ml, serous; left, 200 ml, serosanguineous.

²⁷ *Id.*

²⁸ Ex. 11.

²⁹ Test. of D. Kline, Ex. 12

d. Pulmonary congestion, mild.

CONTRIBUTING CONDITIONS AND OTHER MAJOR DISEASES

1. Alzheimer disease, clinical.
2. Severe acute and chronic (follicular) cystitis.
 - a. Purulent-appearing urine.
 - b. Diffuse mucosal hemorrhage, severe.
 - c. Hemorrhagic renal pelvis, mild.
3. Atrophy and fibrosis of thyroid gland (history of Grave's disease).³⁰

29. The matter was referred to the Olmsted County Sheriff's Office for investigation by Olmsted County Community Services. Detective L. Rossman investigated the event and filed a Case Synopsis more fully set forth in Hearing Exhibit 18.³¹

30. On August 20, 2009, Ellen Turner, Licensor of Olmstead County Community Services recommended that DHS temporarily immediately suspend the adult foster care license because of a "perception that imminent danger to adults did exist and may continue to exist." The letter notes the August 19, 2008 report involving [MCO] and that [MCO] died last night.³²

31. The Minnesota Department of Human Services issued an Order of Immediate Suspension on August 20, 2008. At the time of this Order, the "incident remained under investigation."³³

32. By letter dated August 22, 2009, Licensee indicated she desired to appeal the Temporary Immediate Suspension and forwarded a summary of her testimony of events in a document entitled "Defense of Actions." In the Defense of Actions, Licensee stated:

At 8:30 pm I helped [MCO] get ready for bed. About 10:45 pm, I called [LO] on his cell and his wife [KO] answered. I told her that [MCO] is not doing particularly well-I see a lot of fluid bubbling. [KO] said it was normal, and I insisted that I had not seen this level of congestion before and I wanted to send her to the hospital. [KO] insisted it was normal and to let it go. I kept checking on [MCO] and at 5:00 am, I checked on her and she appeared to be sleeping heavily. At 6:45 am I tried to wake up [MCO] who was unresponsive. I had tried to call [LO]. Because I couldn't reach the family I called St. Mary's emergency room and talked to Kristen Coyle and described what was happening. [KO] suggested I talk to Social Services. I tried to call [LO] repeatedly, and called [KO] at 8:30am and told her I

³⁰ Ex. 14

³¹ Ex. 18

³² Ex. 15

³³ Ex. 16

can't wake [MCO] up. [KO] tried to talk to [MCO] on the phone but [MCO] didn't respond. [KO] reached [LO] who okayed calling the ambulance. [MCO] was taken to St. Mary's emergency room at approximately 9 am.³⁴

33. On August 26, 2009, Officer Rossman interviewed LO and KO. LO and KO indicated their concern that Licensee failed to properly administer medications to MCO, particularly Lasix and her Tylenol for pain. They also related what information they had about MCO's fall on August 16, 2008. Finally they expressed concern about Licensee's failure to call an ambulance when MCO was unresponsive during the morning hours of August 19, 2008, before an ambulance was called.³⁵

34. On August 27, 2008, Officer Rossman interviewed Licensee. During this interview, Licensee provided a transcribed statement, a daily log and a list of the medications for MCO. Licensee indicated that she was responsible for setting up MCO's medications and that she or other care givers gave MCO her medications four times per day. Licensee indicated that a doctor had stopped MCO's Lasix and that at a later appointment MCO's Lasix medication was increased to 40 mg. She told Officer Rossman about her telephone contacts with DB during the weekend period (Friday afternoon until Monday morning) she was away from Home Sweet Home. Licensee also indicated that she put MCO to bed at approximately 8:30 p.m. on August 19, 2008, and that she had checked on MCO periodically. At approximately 10:45 p.m., she said that she had called LO, had talked with his wife and had told her how she had observed that MCO was sleeping soundly. She also told KO that MCO had a lot of mucus/salvia/spit/drool coming from her mouth/throat, so much so that it necessitated her taking a towel to wipe it off so she did not get all wet. According to Licensee, despite her sense that it was an emergency, she was discouraged by KO from calling an ambulance/or sending MCO to the hospital. Licensee said that she checked on MCO several times during the night.³⁶

35. Licensee continued to check on MCO during the night. On August 20, 2009, at approximately 5:00 a.m., she said that she checked on MCO and observed MCO to continue to "sleep hard" and continue to have significant amounts of salvia come from her mouth which necessitate towel(s). At approximately 6:30 a.m., Licensee attempted unsuccessfully to reach family members. She also asserted she called St. Mary's Hospital and indicated that she wanted to call an ambulance and spoke to someone there about her concerns about making the family angry and not having permission to call an ambulance. While on the telephone to St. Mary's Hospital, KO returned her telephone call. Licensee told KO that she had been trying to reach family members for approximately four hours. After getting hold of LO, Licensee indicated that she got permission to call an ambulance. Licensee then called 911 and requested that an ambulance be sent. She indicated to the 911 operator that MCO had congestive heart failure, had a UTI, was a diabetic and was not responsive.³⁷

³⁴ Exs. 19 and 20

³⁵ Exs. 18, 40

³⁶ *Id.*

³⁷ *Id.*

36. During the August 24, 2008 interview, Licensee indicated that it was her procedure not to call an ambulance unless she first contacted the family to get permission “unless they fell and got hurt.” There was no formal written policy regarding calling an ambulance.³⁸

37. On August 26, 2009, Detective Rossman also interviewed MCO’s son (LO) and daughter-in-law (KO). According to LO and KO, Licensee had misrepresented that she was a registered nurse and had inappropriately disclosed client information. They also believe that Licensee failed to dispense to MCO proper medications, including iron, Tylenol and Lasix. They also indicated that Licensee had “run out” of medication(s) for MCO. KO and LO also stated that Licensee did not indicate to them that an emergency situation existed on the evening of August 18, 2009, when Licensee called them. Licensee only told KO that MCO was snoring and had spit coming from the side of her mouth. Licensee did not indicate MCO was sick or that something was wrong. The next morning at approximately 9:30 a.m., KO received a telephone call from Licensee, who indicated that MCO was sleeping and that she could not wake her up. She indicated MCO was snoring and unresponsive. KO listened to MCO by telephone. MCO sounded as she was “gasping for air” to KO. She instructed Licensee to call an ambulance.³⁹

38. On August 31, 2008, Licensee filed an Incident Report for Foster Provider dated August 31, 2008. In this Report, Licensee indicated: that on August 19, 2008 at 6:45 a.m. she tried to call [LO]; that on August 19, 2008 at 8:45 a.m., she called 911 for an ambulance; and that on August 20, 2008, MCO died of natural causes at St. Mary’s Hospital.⁴⁰

39. During the course of his investigation, Olmstead County Detective L. Rossman, also investigated the circumstances surrounding the alleged neglect and death of MCO. He filed an Event Report and a Supplemental Report which detailed his investigation and included interviews with the following witnesses: Licensee; LMO (MCO’s son); KAO (MCO’s daughter-in-law); CO (MCO’s grandson); NCP (employee of Licensee); GAO (MCO’s daughter); DRB (employee of Licensee); CC (Mayo Clinic social worker); and Dr. Pfeiffer, Olmstead County Coroner. In addition, he reviewed various records as identified in Hearing Exhibits 18 and 19, medical documents, photographs taken at St. Mary’s Hospital, Olmsted County Services Intake information and the 911 call.⁴¹

40. On or before September 4, 2008, Investigator, Dee McNama was assigned by the Department as the investigator and initiated an investigation into the facts and circumstances surrounding the death and possible maltreatment of MCO while she was a foster care resident. She submitted an Investigative Memorandum

³⁸ Ex. 40; Test. of D. Kline

³⁹ Exs.18, 40

⁴⁰ Ex. 17

⁴¹ Exs. 18 and 19

dated June 4, 2009, in which she outlined the nature of the alleged maltreatment and a summary of her Findings.⁴²

41. During the course of her investigation, Ms McNama reviewed: The Hospital Admission Note for MCO dated August 19, 2008; the hospital's Expiration Summary for MCO dated August 20, 2008; Law Enforcement's Report; the Licensee's Defense of Actions from August 15, 2008 to August 25, 2008; the newspaper's obituary for MCO; the facility's medication administration records for MCO from June, July, and August 2008, the facility's Client Log Sheets for MCO for July and August 2008; the doctor's note from MCO's doctor dated August 1, 2008; MCO's Clinical Document Copy of a limited exam completed by MCO's doctor on August 15, 2008; pharmacy records for January 2008 through August 2008; and a letter from MCO's doctor dated June 4, 2008, regarding MCO's blood sugars.⁴³

42. After his investigation was completed, Detective L. Rossman sent a Criminal Case Referral to the Olmsted County Attorney's Office for review of the following charges against Licensee: 1) Mistreatment of Persons Confined in Violation of Minn. Stat. § 609.23 and 2) Criminal Neglect, Neglect of Vulnerable Adult in Violation of Minn. Stat. § 609.233, subd. 1.⁴⁴ On May 6, 2009, Assistant County Attorney Hjerleid advised that the previously pending criminal investigation was completed and that, with the completion of the criminal investigation, that the maltreatment determination was likely to be issued in the near future. No criminal charges were ever filed against Licensee.

43. ALJ Sangeeta Jain conducted a contested case hearing in the matter of the Temporary Immediate Suspension on September 24, 2008, and issued a recommendation more fully set forth in OAH Order No. 44-1800-10887-2 dated October 24, 2008.⁴⁵

44. Licensee's counsel took exception to portions of the ALJ's Jain's Recommendation, specifics which are more fully described in a letter dated November 5, 2008.⁴⁶

45. On November 12, 2008, the Commissioner issued a final agency decision in the contested Temporary Immediate Suspension matter involving Debbera Kline, the terms of which are more fully described in the Order dated November 12, 2008.⁴⁷

46. Licensee sought reconsideration of the Commissioner's Final Order. By Order dated November 24, 2008, the Commissioner affirmed the Temporary Immediate Suspension Order.⁴⁸

⁴² Ex. 36

⁴³ *Id.*

⁴⁴ Ex. 18

⁴⁵ Ex. 25

⁴⁶ Ex. 26

⁴⁷ Ex.27

⁴⁸ Ex. 29

47. On February 3, 2009, Ellen Turner of Olmsted County Community Services requested that the DHS indefinitely suspend the adult foster care license of Licensee because of a “perception that imminent danger to adults did exist and may continue to exist.” In addition, Ms. Turner indicated that “the report is still being investigated, and no conclusion has been made at this time.”⁴⁹

48. By letter dated February 10, 2009, Licensee was notified by the DHS of the Indefinite Suspension of her license to provide adult foster care. The letter addressed the background of action taken against her and indicated that “because the report remains under investigation, it is confidential data under the Minnesota Government Data Practices Act, and cannot be released in this letter.”⁵⁰

49. By letter dated February 18, 2009, Licensee appealed the Order of Indefinite Suspension and indicated that her attorney was “out of the country . . . from 20 February 2009 to 5 March 2009.”⁵¹ Licensee’s counsel was also advised by letter dated February 24, 2009, to complete and fax the paper necessary to initiate the appeal process to Ellen Turner at Olmstead County Community Services.⁵²

50. During the course of her investigation, Dee McNama reviewed copies of medication logs provided to her by Licensee at the time of her interview with Licensee. Dee McNama did not see Licensee make copies, rather they were provided to her by Licensee. At a later time during the investigation process, Dee McNama determined that four of the medication logs were missing, including the medication log for Lasix. On or about February 20, 2009, Dee McNama contacted Licensee and requested photocopies of the four log sheets. The medication log sheets were received by Dee McNama on February 20, 2009. Upon reviewing the logs, Dee McNama observed that aside from the name, dosage, physical description and frequency of the medication, the actual documentation in the photocopies was exactly the same.⁵³

51. At the contested hearing Licensee submitted what were purported to be “original” medication logs.⁵⁴ A review of the logs indicates that the medication logs for vitamin D, Furosemide, omeprazole, and seroquel are all the same photocopy of another log except for the top line (written in blue ink).⁵⁵ Specifically, the medication log for Furosemide indicates MCO was given 40mg since her admission to Home Sweet Home on June 5, 2008, but the dosage for this drug was not changed from 20 mg to 40 mg until MCO’s doctor’s appointment on August 13, 2009. Unlike the other medication logs for MCO, these four medication logs are clearly not “original” medication logs.

⁴⁹ Ex. 30

⁵⁰ Ex. 31

⁵¹ Ex. 32

⁵² Ex. 33

⁵³ Test. of D. McNama

⁵⁴ Ex. 42

⁵⁵ Ex. 42

52. At the hearing Licensee gave conflicting reasons regarding her assertion that Lasix had been given to MCO at all times. She asserted that Lasix was stopped at the July 11, 2008 doctor appointment, and that because KO did not believe this was appropriate that KO gave her a bottle of Lasix from KO's home and therefore Licensee had always given MCO the Lasix and that MCO was never off Lasix; that MCO may have had some Lasix left over from Maple Manor; that MCO's family had re-ordered the Lasix and/or Licensee gave Dee McNama all of her medication logs and that Licensee did not know if she got her originals back.⁵⁶

53. The appeal by Licensee was initially scheduled for May 6, 2009. On this date the parties agreed to continue the matter until June 17, 2009, as the previously pending criminal investigation involving Licensee would soon be completed.

54. On May 13, 2009, Licensee moved to dismiss the proceedings on various grounds more fully set forth in the Motion dated May 13, 2009. Specifically, Licensee requested dismissal based upon: the (1) department failed to make a determination regarding a final licensing sanction within ninety days from 12 November 2008, the date the final agency decision was made; or, in the alternative; (2) the Order of Indefinite Suspension of 10 February 2009 exceeded the scope of Minn. Stat. Sec. 245A.07 because the suspension was indefinite, or, in the alternative; (3) any suspension issued before a determination on final licensing sanction has been made can be no longer than ninety days from the date of the final agency decision; or, in the alternative, (4) the department, by failing to follow Minnesota law and by ordering an indefinite suspension, without establishing any conditions for its termination, has violated the Licensee's substantive and procedural due process rights under the fifth and fourteenth amendments to the United States Constitution.⁵⁷

55. A telephone prehearing was conducted on June 9, 2009.

56. By letter dated June 11, 2009, Assistant County Attorney Hjerleid submitted a written response to Licensee's motion and indicated that the maltreatment investigation involving Licensee had been commenced, and that Licensee has indicated she would request an administrative appeal of any negative licensing action.

57. On June 4, 2009, Dee McNama submitted an Investigative Memorandum which concluded, among other unrelated conclusions regarding responsibility for bedsores and MCO's fall out bed, that Licensee was responsible for Maltreatment of MCO's delay in obtaining medical care for MCO when MCO was unresponsive and concerning the administration of MCO's medications and as such, the maltreatment by Licensee was reoccurring which caused serious maltreatment.⁵⁸ Dee McNama also concluded that Licensees act(s) of maltreatment were recurring and serious.⁵⁹

⁵⁶ Test. of D. Kline

⁵⁷ Licensee's Motion dated May 13, 2009.

⁵⁸ Ex. 36

⁵⁹ *Id.*

58. On June 4, 2009, DHS notified Licensee that it investigated and made a determination of maltreatment, disqualification from direct contact and order of license revocation. The basis for the action was the alleged neglect of a vulnerable adult under Minn. Stat. § 626.5572, subds. 15 and 17(a). The basis of the maltreatment determination was that Licensee failed to call an ambulance or other medical care for MCO on August 18 and 19, 2009, when MCO appeared to be unresponsive and in need of emergency care.⁶⁰

59. On June 15, 2009, the date scheduled for the hearing on the Order for Indefinite Suspension, both parties agreed that the issues of the indefinite suspension, the maltreatment determinations, disqualification and any negative licensing action would be consolidated for one contested administrative appeal. On June 17, 2009, a Recommendation was issued consistent with the parties agreements.⁶¹

60. By letter dated June 19, 2009 to the Commissioner of Human Services, Licensee “appealed” the maltreatment determination, disqualification, and license revocation and requested a contested case hearing under Minn. Stat. ch. 14 and Minn. R. 1400.8505 to 1400.8612.⁶²

61. By Amended Notice of and Order for Hearing dated July 15, 2009, a consolidated hearing on the issues of Indefinite Suspension, Maltreatment, Disqualification and Revocation of the Adult Foster Care License of Licensee and August 19, 2009 hearing date was set.

CONCLUSIONS OF LAW

1. Minnesota law gives the Administrative Law Judge and the Commissioner of Human Services authority to conduct this contested case proceeding and to make findings, conclusions, and recommendations or a final order, as the case may be.⁶³

2. The Department gave proper and timely notice of the hearing and fulfilled all substantive and procedural requirements of law, and rule so that the matters are properly before the Administrative Law Judge.

3. As it relates to the issuance of the indefinite suspension, the Commissioner must make a determination regarding whether a final licensing sanction must be issued under subdivision 3.⁶⁴

⁶⁰ Ex. 37

⁶¹ Ex.38

⁶² Correspondence dated June 19, 2009

⁶³ Minn. Stat. §§ 14.50 and 245A.08

⁶⁴ Minn. Stat. § 245.07, subd. 2a(b)

4. Pursuant to Statute, the Department issued an indefinite suspension of Licensee's foster care license on February 10, 2009 and as such, is a final licensing action.⁶⁵

5. Licensee's assertions that an indefinite suspension is not a "final licensing" action is without merit or support.

6. There was no evidence to support Licensee's assertion that actions of Olmsted County Community Services or the Minnesota Department of Human Services violated Licensee's substantive or procedural rights.

7. Maltreatment means "abuse," "neglect" or "financial exploitation"⁶⁶. Neglect is defined, in relevant part as:

The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited food, clothing, shelter, healthcare, or supervision which is: (1) 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; and (2) which is not the result of an accident or therapeutic conduct.⁶⁷

8. The Department met its burden of proof by a preponderance of evidence that Licensee was responsible for incidents of maltreatment of a vulnerable adult by failing to provide health care which was reasonable and necessary to maintain MCO's physical or mental health and safety by her delay in contacting emergency services for MCO while in her care and failing to properly administer to MCO her medications.⁶⁸

9. Licensee failed to establish by a preponderance of the evidence that she was in compliance with applicable rule or law with her delay in contacting emergency medical care.

10. Licensee failed to establish by a preponderance of the evidence that she was in compliance with applicable rule or law with her failure to properly administer to MCO her medications.

11. Licensee has engaged in recurring maltreatment of vulnerable adults and as a consequence should be disqualified.

12. Pursuant to Minn. Stat. § 245C.22, subd. 4(a) the Commissioner may set aside a disqualification if he finds that the individual has submitted sufficient information to demonstrate that the individual does not pose a risk of harm to persons served by the

⁶⁵ Minn. Stat. § 245.07, subd. 3

⁶⁶ Minn. Stat. § 626.5572, subd. 15

⁶⁷ Minn. Stat. § 626.5572, subd. 17

⁶⁸ Minn. Stat. §§ 626.557, subd. 9c(b); 626.5572, subds. 15 and 17(a)

license holder. In determining whether an individual has met the burden of proof, the following factors must be considered: (1) the nature, severity, and consequences of the event or events that led to the disqualification; (2) whether there is more than one disqualifying event; (3) the age and vulnerability of the victim at the time of the event; (4) the harm suffered by the victim; (5) vulnerability of persons served by the program; (6) the similarity between the victim and persons served by the program; (7) the time elapsed without a repeat of the same or similar event; (8) documentation of successful completion by the individual studied of training or rehabilitation pertinent to the event; and (9) any other information relevant to reconsideration.

13. When reviewing a disqualification, the Commissioner must give “preeminent weight” to the safety of each person served by the facility.⁶⁹

14. Licensee did not submit sufficient information to demonstrate that she does not pose a risk of harm by persons served and therefore, the Department has established that revocation of license is the appropriate negative licensing sanction.

15. Licensee poses a risk of harm to the vulnerable adults she serves. The neglect was inflicted upon MCO in Licensee’s private home. MCO was particularly vulnerable due to her medical/psychological condition. Other foster care residents would be similarly vulnerable.

16. The Commissioner must not issue a license if the applicant, license holder, or controlling individual has been disqualified and the disqualification was not set aside.⁷⁰

17. Licensee is disqualified and therefore, revocation of her license is required.

18. The Memorandum that follows explains the reasons for these Conclusions, and the Administrative Law Judge therefore incorporates the Memorandum into these conclusions.

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

RECOMMENDATION

The Administrative Law Judge recommends that the Commissioner of Human Services:

1. **AFFIRM** the determination of recurring maltreatment;
2. **AFFIRM** the Disqualification determination;

⁶⁹ Minn. Stat. § 245C.22, subd. 3

⁷⁰ Minn. Stat. § 245A.04, subd.7(e)

3. **AFFIRM** revocation of Debbera Kline's License to Provide Adult Foster Care;
4. **DISMISS** the Order of indefinite Suspension of Debbera Kline's License to Provide Adult Foster Care be rescinded

Dated: October 13, 2009

s/Barbara J. Runchey _____

Barbara J. Runchey
Administrative Law Judge

Reported: Digitally recorded (no transcript prepared)

NOTICES

This report is a recommendation, not a final decision. The Commissioner of Human Services (Commissioner) will make the final decision after a review of the record and may adopt, reject or modify these Findings of Fact, Conclusions, and Recommendation. Under Minn. Stat. §§ 14.61 and 245A.07, subd. 2a(b), the parties adversely affected have ten (10) calendar days to submit exceptions to this Report and request to present argument to the Commissioner. The record shall close at the end of the ten-day period for submission of exceptions. The Commissioner then has ten (10) working days from the close of the record to issue his final decision. Parties should contact Cal Ludeman, 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

I. **Dismissal of Administrative Action for the Indefinite Suspension of Licensee's Foster Care License.**

At the outset of the hearing, the ALJ denied Licensee's motion to dismiss the indefinite suspension matter. Licensee set out several bases in her motion dated May 13, 2009.

An "Indefinite Suspension" is a final licensing action under Minn. Stat. § 245A.07, subd. 3. The issuance of the Indefinite Suspension occurred within 90 days of the affirmation of the Temporary Immediate Suspension. Furthermore, Minn. Stat. § 245A.07 authorizes a license suspension. Minn. Stat. § 245.A.07 does not mandate or limit in any way how long a license suspension may last. A suspension is a bar from a privilege for a period of time. The length of a suspension is determined from the nature, severity and chronocity of the violation(s).

No evidence was presented that Licensee failed to receive adequate or proper notice of her rights, procedures involved or of any hearings. Licensee did not submit any evidence of substantive due process violation other than that her livelihood had been affected by the negative licensing action. There was no evidence to suggest any party purposely delayed any proceedings.

The hearing for indefinite suspension was initially scheduled for May 6, 2009 and was continued. At the time of the initially scheduled date, the maltreatment investigation was not completed. The facts and circumstances surrounding the events were complex and lengthy. At the telephone pretrial conference on June 9, 2009, Licensee was aware that the maltreatment investigation had been completed and that additional licensing action(s) had been commenced. Prior to the scheduled June 15, 2009 hearing date for Indefinite Suspension, the parties agreed that all matters would be consolidated as Licensee was aware of the conclusions and recommendations of the maltreatment investigation and requested that the matters be consolidated to avoid multiple hearings which would result in significant expense to her.

Licensee consented to a continuation of the Temporary Immediate Suspension pending the consolidation of the various issues.

The matter came on for a consolidated hearing on August 19, 2009, approximately one year after the allegations surfaced. Here, the Department investigated the allegations, made a maltreatment determination and disqualified Licensee as required by statute.

Notwithstanding the foregoing, it is not appropriate to have duplicative orders. To this end, because the ALJ is recommending that Licensee's foster care license be revoked due to Licensee's disqualification, the ALJ also recommends that the indefinite suspension action be dismissed. While there is no prohibition under Minn. Stat. ch. 245A for dual actions by the Commissioner, there is no further necessity for the indefinite suspension of Licensee's license under the facts presented where DHS has commenced the additional licensing actions. The ALJ believes having two licensing sanctions for the same alleged maltreatment is not appropriate under the facts presented.

II. Maltreatment

Under Minn. Stat. § 626.5572, subd. 15, maltreatment includes neglect. Under Minn. Stat. § 626.17 neglect is defined as (a) the failure or omission but a caregiver to supply a vulnerable adult with care or services, including by not limited to, food, clothing, shelter or supervision which is (1) 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; and (2) which is not the result of an accident or therapeutic conduct.

Licensee engaged in two separate acts of maltreatment. First, she failed to call emergency assistance for MCO and second, she failed to properly administer medications to MCO.

The record does support any credible defense to Licensee's incidents of maltreatment. The circumstances surrounding Licensee's behavior and her contradictory and expressed explanations compel a conclusion that Licensee cannot be trusted to meet the needs of particularly vulnerable adults.

A. Failure to call for emergency assistance

The public policy for reporting maltreatment of vulnerable adults under Minn. Stat. § 626.557, is to protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to maltreatment.

Licensee, as an adult foster care provider, received specific Vulnerable Adult training as well as training in first aid and CPR. Moreover, Licensee has worked as a certified nurse assistant for at least 20 years and should have known that in a life-threatening situation, medical assistance should be called immediately upon recognizing symptoms of MCO's distress.

Licensee was aware that MCO was in distress as early as Monday evening August 18, 2008, when she noticed that something was wrong with MCO as MCO did not eat well during the day, was lethargic and had fluid bubbling or saliva coming from her mouth which she had not seen in the past. In fact, Licensee was so concerned about MCO's condition that she attempted to reach MCO's son at 10:45 p.m. Regardless of the discrepancies between what conversations had occurred at 10:45 p.m., and even assuming a family member of MCO may have indicated that nothing should be done, (or in Licensee's words "denied her" permission to call an ambulance). Licensee had a duty to request medical attention for MCO. Family members were not present on August 18, 2008, and could not personally observe MCO's condition nor assess whether it was an emergency which required medical attention. Moreover, even after continuing to check on MCO throughout the evening and into the next morning, Licensee waited from 5:00 a.m. (when she again observed excessive drooling and could not rouse MCO), until she was able to reach a family member at approximately 10:45 a.m. before calling for emergency assistance.

Based on her training and experience, Licensee was aware or should have been aware of her responsibility to ensure the safety of her residents. Her responsibility was not contingent on third parties. MCO was 94 years old and in frail health. It was Licensee's obligation to promptly and timely seek medical attention for MCO in light of the facts and circumstances presented.

The fact MCO had a DNR/DNI, or that Licensee was under a belief that she could not call an ambulance without the permission of family members does not lessen the responsibility of Licensee to obtain prompt medical assistance for MCO particularly

as in this case where MCO was not able to call for emergency care due to her condition and vulnerability (including dementia, lack of mobility and inability to be roused). Having a DNR/DNI does not mean medical attention is withheld. Rather, comfort care, in lieu of extraordinary and invasive life saving measures could have been used had medical treatment been sought. Licensee's conduct resulted in MCO not being administered any treatment, including palliative care. A preponderance of the evidence established that Licensee's failure to call medical assistance is maltreatment. MCO was not provided with care or services reasonable and necessary to obtain and maintain MCO's physical or mental health.

B. Failure to properly administer medications

MCO was prescribed 13 medications. Medications were given at four different time periods during the day. According to Licensee, she kept current medication logs. Licensee failed to properly administer medications to MCO. Family members observed and reported that Licensee failed to properly administer to MCO her medication(s). Evidence established that all medications were ordered and filled through Kasson Drug by Licensee. The pharmacy records indicate that in July and August, 2008 vitamin D, Seroquel and furosemide (Lasix) were not refilled after June 5, 2008 up to the time of her death.

Medical records also indicate that Lasix should be "re-started." While Licensee asserted that all medications were properly administered and that her medication sheets constituted verification of this fact, it appears that Licensee fabricated four medication logs. They are photocopies and not original records. The medication logs are not a reliable indication as to whether medication was properly administered. Licensee's explanation regarding why medication logs were not original documents was contradictory and not credible. It does not appear that Licensee understands the importance of keeping current medication logs and why accuracy is necessary.

In addition, Licensee's testimony that she had obtained Lasix from MCO's daughter-in-law after MCO's discharge from Maple Manor Nursing Home was not credible.

Given that Licensee provided falsified medication logs; that MCO's medical records documented that Lasix had been stopped; that MCO had gained 12 pounds of water weight when the doctor saw MCO on August 15, 2008 and increased her Lasix medication from 20 mg to 40mg; and that pharmacy records showed that Lasix was not refilled in July and August, 2008, a preponderance of the evidence demonstrates MCO was not administered her medications properly by Licensee.

III. Disqualification

Under Minn. Stat. § 245A.04, subd.7(e), the Commissioner must not issue a license if the applicant, license holder, or controlling individual has been disqualified and the disqualification has not been set aside.

Under Minn. Stat. § 245C.14, subd. 1(a), the Commissioner must disqualify an individual who is the subject of a background study from any position allowing direct contact with persons receiving services from the license holder or entity identified in section 245C.03, upon receipt of information showing an investigation results in an administrative determination listed under section 245C.15, subdivision 4(b).

Under Minn. Stat. § 245C.15, subd.4(b)(2), an individual is disqualified under section 245C.14 if less than seven years has passed since a determination or disposition of the individual's substantiated serious or recurring maltreatment of a vulnerable adult under section 626.557.

A. Recurring maltreatment is defined by Minn. Stat. § 245C.02, subd. 16, as “more than one incident of maltreatment for which there is a preponderance of evidence that the maltreatment occurred and that the subject was responsible for the maltreatment.” Licensee engaged in more than one incident of maltreatment. Licensee was responsible for both the delay in seeking emergency medical assistance for MCO on August 18, and 19, 2008, as well as failing to give MCO appropriate medications, particularly Lasix. Even though the alleged incidents were inflicted on the same vulnerable adult, the conduct is distinct and separate and did not occur at substantially the same time and place or out of a continuous and uninterrupted course of conduct. As such, there is a pattern of maltreatment.

B. Serious Maltreatment is defined by Minn. Stat. § 245C.02, in pertinent part, as “maltreatment resulting in death, maltreatment resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought, or abuse resulting in serious injury.” This statute goes on to define “abuse resulting in serious injury” as

bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth, injuries to the eyes, ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke.

DHS concluded that Licensee's conduct in not giving MCO her prescribed medications was “serious” based on the coroner's opinion that pulmonary congestion was a contributing cause of MCO's death and that Lasix would have cleared that up. However, there was insufficient evidence produced to show a causal connection between the failure to provide the Lasix and MCO's death. Therefore, a preponderance of the evidence does not substantiate “serious” maltreatment.

C. Risk of Harm Analysis. Under Minn. Stat. § 245C.16, if the Commissioner determines that an individual studied has a disqualifying characteristic, the Commissioner shall review the information immediately available and make a determination as to the subject's risk of harm.

The Commissioner has the burden of proving by a preponderance of the evidence that Licensee poses a risk of harm to any person served by the program and that her disqualification should not be set aside because she does pose such a risk. Under Minn. Stat. § 245C.16, subd. 1, the Commissioner must examine all relevant information available to determine if Licensee poses an imminent risk of harm to persons receiving services from her adult foster care home, including the following factors: (1) the recency of the disqualifying characteristics, (2) the recency of discharge from probation for the crimes; (3) the number of disqualifying characteristics; (4) the intrusiveness or violence of the disqualifying characteristic; (5) the vulnerability of the victim involved in the disqualifying characteristic; (6) the similarity of the victim to the persons served by the program where the individual studied will have direct contact; (7) whether the individual has a disqualification from a previous background study that has not been set aside; and (8) if the individual has a disqualification which may not be set aside because it is a permanent bar under section 245C.24, subdivision 1, the Commissioner may order the immediate removal of the individual from any position allowing direct contact with, or access to, persons receiving services from the program. In reviewing a disqualification, the Commissioner must give "preeminent weight" to the safety of each person to be served by the facility. Licensee's apparent disregard and failure to accept any responsibility for her actions poses a risk of harm to vulnerable adults that she serves.

Under the facts of this case, the two acts of maltreatment occurred within a short period time and to the same vulnerable adult. The acts of maltreatment occurred within the past 12 months and as such are very recent. MCO was a vulnerable adult who lacked the physical and mental ability to intercede on her own behalf. MCO was totally and completely dependent upon Licensee to assist with all her needs including food, shelter, walking, bathing, toileting, medicine and even for the very act of picking up a telephone to call emergency personnel for assistance. She was unable to perform any of the tasks without the assistance of Licensee. As such she was particularly vulnerable and reliant upon Licensee to assist her. The public policy behind maltreatment reporting requirements is to protect adults, who because of physical or mental disability or dependency on institutional services are particularly vulnerable to maltreatment. Licensee's actions in failing to properly administer medications and call for emergency assistance is particularly egregious due to MCO complete dependence upon her. Under the law, Licensee bears the burden at the hearing of establishing by a preponderance of the evidence that she does not pose a risk of harm to any person served by the program. In this case the ALJ has concluded that the evidence falls short of meeting this burden.

D. Disqualification Set Aside. Under Minn. Stat. § 245C.14, subd. 1(b)(2), no individual who is disqualified following a background study under section 245C.13,

subdivisions 1 and 2, may be retained in a position involving direct contact with persons served by a program or entity identified in section 245C.03 unless the Commissioner has provided written notice stating that the Commissioner has set aside the individual's disqualification for that program or entity identified in section 245C.03, as provided in section 245C.22, subdivision 4.

Based upon the record, it appears that Licensee properly and timely appealed the maltreatment, disqualification and license revocation with her letter to the Commissioner dated July 6, 2009. A disqualified individual may also request reconsideration of a disqualification. Based upon the record it is unclear whether Licensee requested reconsideration of disqualification. It is also unclear whether the Commissioner responded to Licensee's reconsideration request pursuant to Minn. Stat. § 245C.22, subd. 1, and if so, what action if any, was taken. Therefore, because this information is not in the record, the ALJ has not made any recommendations on whether Licensee's disqualification should be set aside under Minn. Stat. § 245C.16.

IV. License revocation

Revocation of Debbera Kline's adult foster care license is appropriate. Because Licensee, as the controlling individual and license holder and has been found to be responsible for recurring maltreatment, which is a disqualification under Minn. Stat. § 245C.14, revocation of Licensee's foster care license is the appropriate action.

Under Minn. Stat. § 245A.04, subd.7(e)(1), the Commissioner must not issue a license if the applicant, license holder, or controlling individual has been disqualified and the disqualification was not set aside.

Under Minn. Stat. § 245A.07, subd. 3(a), the Commissioner may suspend or revoke a license, or impose a fine if a license holder fails to comply fully with applicable laws or rules, if a license holder, or a controlling individual has a disqualification which has not been set aside under section 245C.22. Because Licensee has failed to fully comply with applicable laws or rules and has a disqualification which has not been set aside, revocation of Licensee's foster care license is an appropriate licensing action.

B. J. R.