

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HUMAN SERVICES

In the Matter of the Determination
of Maltreatment and Order to Forfeit
a Fine for ACR Homes, Inc.,
License No. 20073639

**RECOMMENDED ORDER GRANTING
ACR'S SECOND MOTION FOR
SUMMARY DISPOSITION**

The above-entitled matter is pending before Administrative Law Judge Barbara L. Neilson. On June 23, 2010, the Administrative Law Judge issued an order granting in part and denying in part the initial motion filed by the Respondent, ACR Homes, Inc. (ACR) for summary disposition. On September 13, 2010, ACR filed a Second Motion for Summary Disposition. On October 13, 2010, the Department of Human Services (DHS or Department) filed a Response in Opposition to ACR's motion.

Samuel D. Orbovich, Attorney at Law, Fredrikson & Byron, P.A., appeared on behalf of ACR. Cara M. Hawkinson, Assistant Attorney General, appeared on behalf of the Department.

Based upon the files, record, and proceedings in this matter, and for the reasons set forth in the attached Memorandum,

IT IS HEREBY RECOMMENDED that ACR's Second Motion for Summary Disposition be GRANTED, and that the Department's request for summary disposition be DENIED.

Dated: November 9, 2010.

s/Barbara L. Neilson

BARBARA L. NEILSON
Administrative Law Judge

MEMORANDUM

In this contested case proceeding, Respondent ACR is challenging a maltreatment determination made by the Department on September 10, 2008, and the two \$500 fines levied as a result of that determination. The Department found that neglect had occurred in connection with an incident in which a vulnerable adult (VA) fell and sustained an injury requiring surgery during an attempt by one of ACR's employees to transfer the VA from her wheelchair to her bed. The Department further determined that the neglect was attributable to ACR's failure to train the employee on the proper transfer protocol.

The primary issue involved in this case is whether or not ACR and/or its staff neglected the VA within the meaning of the applicable statute, or whether a statutory exception applies. As noted in the June 23, 2010, ruling on ACR's first Motion for Summary Disposition, the Vulnerable Adults Act (VAA)¹ defines "neglect" to mean:

- (a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care, 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.²

The term "therapeutic conduct" is defined to mean "the provision of program services, health care, or other personal care services done in good faith in the interests of the vulnerable adult by: (1) an individual, facility or employee or person providing services in a facility under the rights, privileges and responsibilities conferred by state license, certification, or registration; or (2) a caregiver."³ Under the "therapeutic error with injury" exception added to the VAA in 2007,⁴ a vulnerable adult is not deemed to have been neglected for the sole reason that:

an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:

- (i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
- (ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
- (iii) the error is not part of a pattern of errors by the individual;
- (iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;

¹ Minn. Stat. §§ 626.557 – 626.5573.

² Minn. Stat. § 626.5572, subd. 17(a).

³ *Id.*, subd. 20.

⁴ 2007 Minn. Laws Ch. 112, Sec. 57, codified as Minn. Stat. § 626.5572, subd. 17(c)(5).

(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and

(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.⁵

First Motion for Summary Disposition

On March 17, 2010, ACR filed its first Motion for Summary Disposition. On March 31, 2010, the Department filed a Memorandum in Opposition to the motion in which it also requested that summary disposition be granted in the Department's favor. ACR filed a Reply Memorandum in April 2010 and oral argument on the motions was heard in May 2010.

On June 23, 2010, the Administrative Law Judge issued an order denying the Department's request for summary disposition and granting in part and denying in part ACR's motion for summary disposition. The undisputed facts involved in this matter were discussed at length in the June 23, 2010, ruling, and will not be repeated here. ACR's motion was granted with respect to:

1. its argument that the applicability of the "therapeutic error with injury" exception set forth in Minn. Stat. § 626.5572, subd. 17(c)(5), must be considered in this case before it can be concluded that maltreatment occurred or that the facility, the individual, or both should be deemed responsible for maltreatment under Minn. Stat. § 626.557, subd. 9c(c); and
2. its establishment of the factors set forth in Minn. Stat. § 626.5572, subd. 17(c)(5)(i)-(vi), of the "therapeutic error with injury" exception.

ACR's motion was denied as to its assertion that it was entitled to judgment as a matter of law that the staff person involved in the incident was providing personal care services "in good faith in the interests of the vulnerable adult" within the meaning of Minn. Stat. § 626.5572, subds. 17(c)(5) and 20. The Administrative Law Judge concluded that genuine issues of material fact remained for hearing regarding (a) whether the staff person involved in the incident was providing personal care services "in good faith in the interests of the vulnerable adult" within the meaning of Minn. Stat. § 626.5572, subds. 17(c)(5) and 20, at the time of the incident; and (b) if not, whether ACR, the staff person, or both were responsible under Minn. Stat. § 626.557, subd. 9c(c), for substantiated maltreatment.

⁵ *Id.*, subd. 17(c)(4) (emphasis added).

Second Motion for Summary Disposition

Following the issuance of the above ruling, ACR submitted a Second Motion for Summary Disposition. In the pending motion, ACR contended that the issues remaining in this matter may be resolved by applying the law to the facts contained in an affidavit submitted with the motion by T.L., the staff person involved in the incident. In her affidavit, T.L. described the training she received after beginning employment at ACR and what occurred on the day the VA was injured. T.L. indicated that her orientation at ACR included classroom training with ten to fifteen other new employees. Among the topics discussed was training on mechanical lifts. T.L. stated that she was required to pass (and did pass) quizzes on various topics, including mechanical lifts, before she was allowed to enter the second phase of training.⁶ During the second phase of training, T.L. shadowed ACR staff at the Magnolia Home (where the VA lived) as they performed their duties. Most of her time was spent observing, but sometimes the teaching staff directed her to assist with a specific task in their presence.⁷ She indicated that her main responsibility during the shadowing period was to learn by watching and follow directions that were given to her by the teaching staff. During the second phase of training, T.L. observed typical shifts, was oriented to the four residents who lived at the Magnolia Home, and learned “major fundamentals” of each resident. She took an open book quiz on each of the residents in the home regarding their conditions and needs, including transfer type. She also became oriented to the home itself and the staff’s duties at the home.⁸ A shadowing period of approximately three days was required as part of T.L.’s training before she could be assigned a shift at Magnolia.⁹

According to her affidavit, T.L. observed two different techniques to transfer residents from a wheelchair to a bed or a bath during her shadowing training: the mechanical Hoyer lift (which she had also learned about in her classroom training), and a technique she called a “pivot transfer.” She believes that the two staff members who she observed transferring the VA did not prefer to use the Hoyer, and the Hoyer was primarily used for the other residents who had substantial osteoporosis or paralysis in their legs. T.L. indicated that she saw two different staff members transfer the VA from her wheelchair to her bed using a pivot transfer, but stated that these staff members were taller and larger than she was. She emphasized that “each told me that I should use the Hoyer lift when transferring the VA and not do a pivot on my own.”¹⁰ When T.L. observed the two staff members doing pivot transfers with the VA, each staff would face the VA, hold her, help her lift from the chair, tell her to grab the bed rail, instruct her to pivot her weight on her good foot, turn her, and gently lower her to the bed, while talking her through each step of the process.¹¹

⁶ First Affidavit of [T.L.], ¶ 5.

⁷ *Id.* at ¶¶ 6-7.

⁸ *Id.* at ¶ 6.

⁹ *Id.* at ¶ 7.

¹⁰ *Id.* at ¶ 8.

¹¹ *Id.* at ¶ 10.

On the day of the incident involved in this case, T.L. stated in her affidavit that she was near the VA, who was sitting in the main room watching television, when she realized that the VA's briefs and undergarments needed to be changed. When she asked the VA whether she wanted to be changed, the VA nodded yes.¹² T.L. asked the other staff person in the vicinity if it would be alright if she left the room to change the VA, and the other staff person said it would.¹³ This was the first time that T.L. had performed a transfer of any resident by herself.¹⁴ T.L. then wheeled the VA to her room, positioned her wheelchair parallel to her bed, and went to the bathroom where the Hoyer lift was stored. As she was getting the Hoyer lift, T.L. decided not to use it. In her affidavit, T.L. explained:

I made the decision to not use it [the Hoyer lift] because I thought the pivot transfer would be better for the VA under the circumstances. She was incontinent, and likely uncomfortable. I believed I could accomplish the undergarment change faster with the pivot transfer and believed that I could safely duplicate the transfer that I had seen staff perform. I also knew that the VA could comprehend, and would follow, my oral instructions.¹⁵

T.L. further stated in her affidavit:

I did not skip the Hoyer lift out of any selfish motive. I was in no personal rush. My shift still had over an hour to complete and nothing was distracting my attention away from the VA's needs. I sincerely thought the pivot transfer would be the best and most efficient way to position the consumer to enable me to change her soiled briefs comfortably and quickly. I had recently seen the pivot transfer, and I knew the VA would follow my oral instructions.¹⁶

Thereafter, T.L. locked the wheelchair in place in position near the bed, propped both foot rests up to clear the way for the VA to rise with her assistance and told the VA to grab the bedrail, lean on her, and place her weight on her "good" leg and foot.¹⁷ Unfortunately, the VA's paralyzed foot got caught on the foot rest during the pivot even though T.L. had moved it out of the way and caused the VA (who T.L. acknowledged was "much taller" than T.L.) to fall diagonally to her left. T.L. lost her balance as a result.¹⁸ She held onto the VA during the fall and went down to the floor with her, hoping to slow down the momentum and minimize the impact. She protected the VA's

¹² *Id.* at ¶ 11.

¹³ *Id.* at ¶ 12.

¹⁴ *Id.* at ¶ 13.

¹⁵ *Id.* at ¶ 14.

¹⁶ *Id.* at ¶ 15.

¹⁷ *Id.* at ¶¶ 17-18.

¹⁸ *Id.* at ¶ 19.

head with one hand, and positioned the direction of the fall to avoid having the VA hit her head on the dresser.¹⁹

T.L. stated in her affidavit that she is sincerely remorseful for her mistake.²⁰ She reiterated:

Even though the training staff expressly told me to use the Hoyer mechanical lift when transferring the VA on my own, I decided to use the pivot transfer because I thought that would get the resident out of her soiled undergarments faster than using the Hoyer. I had only the best interests of the VA in mind when I made that decision. I did not reject the Hoyer out of any self-interest or selfish motivations. I was not sidetracked by any personal distraction, like taking a cell phone call, texting, watching the television or engaging in personal conversations with other staff. I wanted to change the undergarments as promptly as possible, but I was not hurrying for any personal reason. My mistaken decision to do a pivot rather than use the available mechanical lift was made in good faith. Her fall caused me to realize I should have followed my training staff's instructions to use the mechanical lift and that I erred by trying the pivot transfer.²¹

Based upon T.L.'s affidavit and its analysis of relevant case law, ACR argued that it is entitled to summary disposition in this matter. ACR contended that T.L.'s actions fall squarely within the statutory exception applicable to individuals who make an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm. ACR maintained that T.L. was engaged in therapeutic conduct at the time the VA's injury occurred because she was transferring the VA from her wheelchair to her bed in order to change the VA's soiled undergarments. ACR asserted that T.L. acted in good faith and in the VA's interests when she decided to use a pivot transfer rather than the Hoyer lift. As set forth in T.L.'s affidavit, she thought she could safely duplicate the pivot transfer she had observed others perform, and she believed she could change the VA more quickly and relieve the VA's likely discomfort faster if she used the pivot transfer. She was not acting in furtherance of any selfish motive. After the VA fell, T.L. realized that she made a mistake when she decided to attempt a pivot transfer and she should have followed her training staff's instructions to use the available Hoyer lift.

In its response in opposition to the Motion, the Department argued that ACR's motion should be denied because facts remain in dispute or, in the alternative, that summary disposition should be granted in favor of the DHS because the facts support a determination that T.L.'s actions were not conducted in good faith in the interests of the VA. The Department first asserted that genuine issues of material fact remain as to whether T.L.'s actions were taken in good faith in the interests of the VA. The Department emphasized that the VA's risk management plan indicated that either the

¹⁹ *Id.* at ¶ 20.

²⁰ *Id.* at ¶ 23.

²¹ *Id.* at ¶ 22.

Hoyer lift or a two-person transfer should be used for the VA, and argued that, “[w]hile [T.L.] may believe she was acting in good faith, she clearly was not acting in the best interests of the VA” since she “blatantly fail[ed] to follow the VA’s risk management plan.”²² Second, the Department contended that genuine issues of material fact remain concerning culpability for maltreatment, specifically whether ACR employees were properly trained. The Department pointed out that T.L. apparently made assertions regarding the VA’s transfer protocol during ACR’s internal investigation of the incident that conflicted with the statements she made in the affidavit filed with ACR’s Second Motion, and contended that it “has the right to cross examine [T.L.] and other ACR Homes’ witnesses” on these issues.²³ Finally, the Department argued in the alternative that it is entitled to summary disposition because ACR “cannot provide documented evidence that [T.L.] acted in the VA’s interest because [T.L.] clearly did not follow the VA’s well-documented risk management plan.”²⁴

Analysis

As noted in the June 23, 2010, ruling, summary disposition is the administrative equivalent of summary judgment.²⁵ Summary disposition is appropriate when there is no genuine dispute about the material facts, and one party must necessarily prevail when the law is applied to those undisputed facts.²⁶ When considering a motion for summary disposition the decision maker must view the facts in the light most favorable to the non-moving party.²⁷ The moving party carries the burden of proof and persuasion to establish that no genuine issues of material fact exist.²⁸ The non-moving party cannot rely upon general statements or allegations, but must show the existence of specific material facts which create a genuine issue.²⁹

In the ruling on the first Motion for Summary Disposition, it was determined that ACR is entitled to summary disposition as to the factors set forth in items (i) through (vi) of the “therapeutic error with injury” exception.³⁰ It is also clear that the further statutory requirement that the incident result in an injury to the VA that reasonably required the care of a physician has been satisfied. The remaining issue presented in this Second Motion for Summary Disposition is whether ACR is entitled to summary disposition that T.L. made an “error in the provision of therapeutic conduct to a vulnerable adult that result[ed] in injury or harm” and thereby engaged in conduct that expressly does not

²² DHS Memorandum in Opposition at 4-5.

²³ *Id.* at 7-8. Significantly, the statutory exception refers to the “interests” of the VA, and not the “best interests” of the VA.

²⁴ *Id.* at 8.

²⁵ *Pietsch v. Mn. Bd. of Chiropractic Examiners*, 683 N.W.2d 303, 306 (Minn. 2004).

²⁶ *Sauter v. Sauter*, 70 N.W. 2d 351, 353 (Minn. 1955).

²⁷ *Ostendorf v. Kenyon*, 347 N.W. 834 (Minn. Ct. App. 1984), *Carlisle v. City of Minneapolis*, 437 N.W. 2d 712, 715 (Minn. Ct. App. 1988).

²⁸ *Theile v. Stich*, 425 N.W. 2d 580, 583 (Minn. 1988).

²⁹ *Murphy v. Country House, Inc.*, 307 Minn. 344, 351-52, 240 N.W. 2d 507, 512 (Minn. 1976).

³⁰ Minn. Stat. § 626.5572, subd. 17(c)(5)(i) through (vi).

constitute “neglect” pursuant to the first portion of Minn. Stat. § 626.5572, subd. 17(c)(5).³¹

The parties have not cited, and the Administrative Law Judge has not found, any court or administrative decision involving an analogous situation in which the alleged error in therapeutic conduct stemmed from an employee’s failure to follow a resident’s risk management plan. The cases that do exist are very fact-specific and primarily involve mistakes or omissions in providing medical treatment rather than the type of mistake involved here. Several of these cases do, however, support the view that the exception should not be interpreted in an unduly restrictive manner, and also provide some guidance for how the exception should be applied. For example, in *D.R.W. v. Minnesota Department of Health*,³² the Court of Appeals reversed a neglect determination by the Commissioner of Health and held that the therapeutic conduct exception applied to the treatment provided to a nursing home resident by a licensed practical nurse who was under the mistaken impression that the resident was merely suffering from anxiety rather than a life-threatening illness. The Court rejected the Commissioner’s argument that certain omissions in D.R.W.’s treatment of the resident rendered her ineligible for protection under the therapeutic conduct exception:

The commissioner found that because D.R.W.’s treatment of [the resident] involved omissions that could not be in [the resident’s] interests, application of the therapeutic conduct exception “does not make sense under these facts.” Because this conclusion unduly narrows the statutory protection allowed for therapeutic conduct, we hold that the commissioner’s decision was affected by an error of law.³³

The Court of Appeals then applied the statute to the undisputed facts, noting that D.R.W. had taken prompt action to contact the resident’s physician and administer the medication he prescribed. Although D.R.W. did not take the resident’s vital signs and report them to the physician, the Court found that “this omission was part of a course of treatment, done in good faith and intended as assistance for [the resident],” citing *C.J.K. v. Minnesota Department of Health*.³⁴ The Court emphasized that D.R.W. “did not fail to attend to her patient” but rather called the resident’s physician, obtained advice, and took action consistent with that advice. Even though D.R.W. did not take the resident’s vital signs and did not report all of the resident’s symptoms to the physician, the Court determined that “the evidence does not show that D.R.W. failed to act in good faith or

³¹ If the exception applies, there can be no finding of maltreatment by neglect and there will be no need to consider who is responsible for the maltreatment.

³² No. C5-01-526, 2001 WL 1187092 (Minn. App. 2001) (unpublished). In that case, D.R.W. had contacted the resident’s doctor immediately after the resident requested she do so, called the physician again when she hadn’t heard back from him within 45 minutes, and told the physician when he called back that the resident was agitated and wanted to go home. The physician prescribed medication to relieve the resident’s anxiety, and D.R.W. administered the medication to the resident. Later that day, the resident’s condition deteriorated and she died. The cause of death was identified as congestive heart failure, myocardial infarction, and acute cerebrovascular accident.

³³ *Id.* at *2.

³⁴ No. C9-00-583, 2000 WL 1617815 (Minn. App. 2000) (unpublished) (attached to ACR’s Memorandum in Support of Second Motion).

failed to consider [the resident's] best interests." Accordingly, the Court concluded that D.R.W.'s treatment of the resident constituted therapeutic conduct under the statute, and thus was not neglect or maltreatment of a vulnerable adult.³⁵

In *C.J.K. v. Minnesota Department of Health*, the case upon which the D.R.W. decision relied, a nurse employed at a nursing home believed that a resident was suffering from constipation, a chronic problem noted in her care plan. The nurse assessed the resident, performed a digital rectal examination, and gave the resident a suppository. Unfortunately, the resident was actually experiencing cardiorespiratory arrest, and later died. The Court of Appeals reversed the determination of the Commissioner of Health that the nurse committed maltreatment of the resident by neglecting to provide required care, and instead determined that he was engaged in therapeutic conduct under the statute. The Court found that "a good-faith misinterpretation of symptoms does not preclude the possibility that C.J.K. was engaging in therapeutic conduct if he was giving health care in [the resident's] interests." The Court noted that C.J.K.'s conduct "was not medically inappropriate; it simply did not go far enough. But the conduct did satisfy the test of therapeutic conduct because it consisted of appropriate health care for a documented and objectively determined condition; it was done in good faith; and it was intended to relieve [the resident] of her constipation." Although the Court indicated that "there apparently was a broader assessment that would have been appropriate," the Court found that the evidence did not indicate that C.J.K. failed to act in the resident's interests. The Court further emphasized that, "although C.J.K.'s failure to follow the nursing home's physician-notification policy and the possibility that his conduct fell below standard nursing practice might be relevant for other purposes, they are not determinative of whether or not C.J.K.'s conduct constituted maltreatment of a vulnerable adult as defined by statute."

After considering these cases and the plain language of the VAA, the Administrative Law Judge is not persuaded by the Department's argument that the "therapeutic error with injury" exception cannot apply as a matter of law under the circumstances of the current case. In essence, the Department contends that T.L. clearly could not have been acting in the "best interests" of the VA because she used a transfer method that was not consistent with the resident's risk management plan, and that T.L. thus is not entitled to coverage under the exception. As noted above, the statutory exception requires only that the person making the error be providing services in good faith and "in the interests" of the VA, and does not incorporate the heightened "best interests" analysis urged by the Department. In addition, the language of the therapeutic conduct exception is unambiguous and does not suggest that a mistake

³⁵ *Id.* at *3. In a separate case decided approximately seven weeks earlier, the Court of Appeals upheld the Commissioner's maltreatment determination involving the registered nurse who worked with the same resident during the shift prior to D.R.W.'s shift. *J.R.B. v. Department of Human Services*, 633 N.W.2d 33 (Minn. App. 2001) (decision attached to ACR's Memorandum in Support of Second Motion) (holding that the record contained substantial evidence supporting the Commissioner of Health's decision that J.R.B. failed to provide the care that was reasonable and necessary to maintain the resident's condition, emphasizing that the nurse did not obtain a blood pressure reading or alert the resident's doctor to the significant change in the resident's condition).

involving a failure to follow a risk management plan is to be treated differently than other types of errors that may occur.³⁶ In the view of the Administrative Law Judge, the Department's interpretation is contrary to the plain meaning of the statute and would unduly restrict the circumstances under which the exception could apply.

In the first Motion for Summary Disposition, the Administrative Law Judge found that genuine issues of material fact remained regarding whether T.L. was providing personal care services "in good faith in the interests of the vulnerable adult" within the meaning of Minn. Stat. § 626.5572, subds. 17(c)(5) and 20, at the time of the incident. More specifically, the ALJ noted that questions remained concerning what T.L. was told by other staff members about the transfer approach she should use, as well as her motivation and intent when she chose to use the "pivot" transfer approach on the date of the incident. T.L.'s affidavit filed in connection with the Second Motion addressed both of these matters. Consistent with prior statements she had made to the DHS investigator,³⁷ T.L. confirmed in her affidavit that both of the staff members who she shadowed told her that she should use the Hoyer lift when she transferred the VA. T.L. also provided information in the affidavit regarding her intent on the day of the incident. She explained that she started to retrieve the Hoyer lift but then changed her mind and decided to use a "pivot" transfer because she believed that she could perform the transfer safely and thought that it would be a faster way to relieve the discomfort the VA was likely experiencing due to her soiled undergarments. T.L. also indicated that she was not rushing for personal reasons but was only considering the VA's needs and interests.

The undisputed facts in this case show that T.L. was providing personal care services to the VA at the time of the incident. "Therapeutic conduct" is expressly defined in the statute to include the provision of personal care services.³⁸ As part of the process of changing the VA's incontinence briefs, T.L. erroneously used a transfer method that she had been told not to use with the VA. Although T.L. made an error in choosing that method, she believed that she could accomplish the transfer properly and simply sought to use an approach that would relieve the VA more quickly of the discomfort she was likely experiencing. As such, T.L. acted in good faith and in the interests of the VA. The Department did not provide any affidavits with its response in opposition to ACR's motion that cast doubt on the veracity of the statements made by T.L. in her affidavit, nor has it otherwise shown that a genuine issue of material fact remains for hearing with respect to the applicability of the therapeutic error with injury exception. As determined in the Order regarding ACR's First Motion for Summary Disposition, the other factors set forth in Minn. Stat. § 626.5572, subd. 17(c)(5)(i)-(vi), have all been established.

The Administrative Law Judge concludes that this situation falls squarely within the statutory exception for "therapeutic error with injury" and does not constitute

³⁶ Pursuant to the canons of construction set forth in Minn. Stat. § 645.16, "When the words of a law in their application to an existing situation are clear and free from all ambiguity, the letter of the law shall not be disregarded under the pretext of pursuing the spirit."

³⁷ See First Orbovich Aff. attached to First Motion for Summary Disposition, Ex. C, at DHS 3, 4.

³⁸ Minn. Stat. § 626.5572, subd. 20.

“neglect” within the meaning of the VAA’s definition of “neglect.” Accordingly, the Administrative Law Judge recommends that ACR’s Second Motion for Summary Disposition be granted, and that the Department’s Maltreatment Determination and Order to Forfeit a Fine be rescinded.

B. L. N.