11-1800-21767-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE COMMISSIONER OF HUMAN SERVICES

In the Matter of the Revocation of the Family Child Care License of LaRhae Galarneault	**FINDINGS OF FACT, CONCLUSIONS, AND RECOMMENDATION**

This matter came on for hearing before Administrative Law Judge Barbara L. Neilson on February 23, 2011, at the offices of Benton County Human Services, 531 Dewey Street, Foley, Minnesota. The OAH record remained open until March 21, 2011, for receipt of post-hearing reply briefs from the parties.

Michelle L. Meyer, Assistant Benton County Attorney, P.O. Box 189, Foley, Minnesota 56329, appeared for Benton County Human Services (the County) and the Department of Human Services (Department).

LaRhae Galarneault (Licensee) appeared on her own behalf without counsel.

STATEMENT OF ISSUES

1. Did the Licensee fail to comply with rules and laws governing the manner in which infants are permitted to sleep while in day care and the age distribution of children in her day care?

2. If so, should her license be revoked?

The Administrative Law Judge concludes the Licensee failed to comply with the rules and laws in question but that revocation is not the appropriate sanction under Minn. Stat. § 245A.07, subd. 1 (2010).[1] The imposition of licensing conditions is a sufficient disciplinary response to ensure the safety of children in her care.

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

FINDINGS OF FACT

1. LaRhae Galarneault has been a licensed daycare provider in Rice, Minnesota, for approximately 36 years. During those years, Benton County licensing

[1] All references to Minnesota Statutes are to the 2010 edition; all references to Minnesota Rules are to the 2009 edition.

workers have issued a few correction orders for minor rule violations, but Ms. Galarneault was a provider in good standing as of August 27, 2010.[2]

2. On August 27, 2010, a 13-month-old toddler (A.B.) died when she stopped breathing during a nap while in care at the Licensee's home. The Licensee had put the child down for a nap at about 10:00 a.m. and tried to wake her for lunch at about 11:30 a.m., but the child was nonresponsive. The Licensee called 911 and performed CPR until paramedics arrived. They brought the child to the hospital, where she was pronounced dead.[3]

3. The medical examiner later determined that the child had died of acute bronchopneumonia.[4] The parents had noticed that the child had developed a cough that morning, but did not notice anything else unusual.[5] No one contends that the Licensee's care contributed in any way to the child's death.[6]

Capacity Violations

4. During the last five years, the Licensee has had either a C-1 or C-2 license, for up to ten children under school age in care. A C-1 license permits three of those children to be under the age of two years, only two of whom may be infants (under 12 months); a C-2 license permits two children to be under the age of two years, and one of those two may be an infant.[7]

5. When A.B.'s mother was a child, the Licensee was her daycare provider. When their children were born, the parents relocated to the area so that the Licensee could provide care for them. The Licensee cared for A.B. and her three-year-old brother from November 2009 through March 2010, when the parents lost their jobs. In June and July 2009, the Licensee cared for A.B. and her brother occasionally when the mother was looking for work. The mother found employment in August 2010 and started a two-week trial period with her employer on August 17, 2010. At this time, the children returned to the Licensee's care.[8]

6. In August 2010, the Licensee had a C-2 license, but under licensing rules she was allowed to operate in compliance with C-1 age distribution restrictions.[9]

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[2] Testimony of Natalie Burwick; Ex. 29 (2004 correction order for missing policy); Ex. 32 (April 2006 correction order for water temperature, mount fire extinguisher, grievance policy not signed by all families, immunization records incomplete for three children); Ex. 33 (May 2008 correction order for cleaning supplies accessible under kitchen sink, provider contract required change of terms, immunization records incomplete, replace pack-and-play with hole in mesh siding); Ex. 35 (make changes to provider contract). No violations were found during drop-in visits in 2005, 2008, and 2010. *See* Exs. 30-31, 34, and 36.
[3] Ex. 12.
[4] Ex. 13.
[5] Ex. 12.
[6] Opening Statement of the County.
[7] Testimony of Natalie Burwick. *See also* Minn. R. 9502.0367 C (1); 9502.0367 C (2).
[8] Ex. 16 (Burwick case note 8/30/10 at page 2); Testimony of LaRhae Galarneault.
[9] Test. of N. Burwick; Ex. 8.

7. The Licensee knew that if she were to provide full-time care to both A.B. and her brother, the Licensee would be over her licensed capacity for children under the age of two years. She decided to wait to apply for a variance until the mother's two-week trial period ended, so that she would have a better idea of how long she would be caring for the children.[10]

8. On August 27, 2010, the Licensee provided care for nine children. Two were school-age children; four were preschool age (between the ages of two and five); two were toddlers; and two were infants.[11] The Licensee was over capacity that day because she had four children under the age of two years. Although one of the infants did not normally receive care at the Licensee's home on Fridays, the Licensee had agreed to provide care that day so that his mother could run some errands. The infant was at the day care home from about 9:30 a.m. to about noon.[12]

9. Licensing workers conducted relicensing and drop-in visits at the Licensee's home each year between 2004 and 2010. The Licensee was never found to be in violation of capacity or age distribution requirements during those visits.[13]

10. On September 1, 2010, before receipt of the medical examiner's report, the Department issued an order of temporary immediate suspension when it learned that the Licensee was operating in violation of age distribution requirements on August 27, 2010.[14] The Licensee did not appeal the order of temporary immediate suspension.[15]

Infant Sleeping Practices

11. To reduce the risk of sudden infant death syndrome (SIDS), state law provides that license holders must place infants in a crib directly on a firm mattress with a fitted crib sheet that fits tightly on the mattress and cannot be dislodged by pulling on the corner of the sheet. Licensee holders must not place pillows, quilts, comforters, sheepskin, stuffed toys, or other soft products in a crib with an infant.[16] In addition, license holders must provide a crib, portable crib, or playpen for each infant or newborn in care. The equipment must be of safe and sturdy construction and conform to 16 C.F.R. 1508 to 1508.7 and 1509.9, or have a bar or rail pattern such that a 2 3/8-inch sphere cannot pass through. Infants and newborns may not sleep in a playpen with mesh sidings.[17] A mesh-sided playpen or crib may be used if the provider has

[10] Test. of L. Galarneault; Ex. 16 (Burwick case note 8/30/10 at page 2).
[11] Ex. 14.
[12] Test. of L. Galarneault; Testimony of Sarah Soltis (infant's mother); Ex. 16 (Burwick case note 8/30/10 at page 2).
[13] Exs. 29-36.
[14] Ex. 6.
[15] Test. of L. Galarneault.
[16] Minn. Stat. § 245A.1435.
[17] Minn. R. 9502.0425, subp. 9.

documentation that the crib is not listed as unsafe on the website maintained by the U.S. Consumer Product Safety Commission.[18]

12. In addition, license holders must maintain documentation that every crib (whether or not used for infants) that is used for or accessible to a child in care has been checked against the U.S. Consumer Product Safety Commission web site to determine whether the crib is listed as unsafe or has been recalled.[19]

13. The Licensee attended the Department's mandatory SIDS training in 2006, which is required every five years.[20]

14. On August 27, 2010, A.B. was sleeping in a mesh-sided pack-and-play (portable crib/playpen). Inside the pack-and-play was a pillow, a stuffed animal, and a blanket, and another blanket was draped on the corner of the crib.[21]

15. A.B. was 13 months old and was not considered an infant for purposes of the daycare statutes and rules.[22] The Licensee's use of a mesh-sided crib, a pillow, a stuffed animal, and a blanket in caring for A.B. did not violate any statute or rule.

16. The Licensee had two other pack-and-play cribs in her home, which the police photographed after paramedics took A.B. to the hospital. These cribs also contained pillows and blankets.[23] A licensing worker involved in the investigation asked the Licensee where the two infants in care that day slept; the Licensee stated that only one of the infants took a nap that morning (Baby A), and that she slept in her car seat, swing, bouncy seat, or on the floor. The Licensee stated that Baby A slept best in one of these items and that the mother also used these devices for naps. The Licensee also said Baby A sometimes slept on a blanket on the floor.[24] The Licensee also stated that she never allowed blankets, toys, or soft products in cribs with infants.[25]

17. The licensing worker informed the Licensee that infants can sleep only in cribs or pack-and-plays with a firm mattress and that permitting an infant to sleep elsewhere was high-risk SIDS behavior.[26]

18. On September 2, 2010, when licensing workers served the Licensee with a temporary immediate suspension order, they asked to see the other pack-and-plays in which infants slept. The Licensee said that she did not allow infants to sleep in pack-and-plays, but used a playpen or sometimes allowed them to sleep on the floor on a blanket. The licensing workers asked to see the playpen, and the Licensee showed

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[18] Minn. Stat. § 245A.146, subd. 3(d).
[19] Minn. Stat. § 245A.146, subds. 2 & 3.
[20] Ex. 9.
[21] Ex. 12.
[22] *See* Minn. R. 9502.0315, subp. 16 (infant means a child who is at least six weeks old but less than 12 months old).
[23] Ex. 15.
[24] Ex. 16 (Burwick case note 8/30/10 at page 3).
[25] Ex. 16 (Burwick case note 8/30/10 at page 2).
[26] *Id*.

them an older-model portable playpen she said she had been using since a parent gave it to her in the middle of July. The playpen had a sheet that was not tight-fitting. The Licensee did not have the crib safety documentation for the playpen, because she had been unable to find a model number on it.[27] The Licensee also explained that she did not place infants to sleep in car seats, but she allowed them to continue to sleep in car seats if they arrived at daycare asleep in them.[28]

19. On September 8, 2010, licensing workers interviewed the Licensee again about her infant sleeping practices. The Licensee said she allowed one eleven-month-old infant, G.S., to use a blanket or stuffed animal when he slept, because his mother had instructed her to do so. She also said she allowed infants to sleep on the couch or the floor after feeding them, because she wanted to keep them near her. She said she would allow infants to sleep in a bouncy chair so that she could bring the chair with her as she moved around the house. If they fell asleep in a swing, she would allow them to remain there. If they arrived at daycare asleep in a car seat, she would allow them to remain there.[29]

20. The mother of G.S. confirmed that she had instructed the Licensee to allow her son to sleep with his blanket or stuffed animal.[30]

21. On October 5, 2010, the Licensee completed additional SIDS training conducted by Benton County Human Services. She also completed an online training and assessment on SIDS conducted by Educarer, Inc.[31]

22. On October 6, 2010, the medical examiner's report was issued, which attributed the child's death to infection. County licensing workers then forwarded the report to the Department with a recommendation that the suspension be lifted. The County also recommended that the license be placed on conditional status for one year, based on the Licensee's failure to comply with statutes and rules with regard to sleeping infants.[32] The County attached a "sleep plan" signed by the Licensee, which stated that she would require infants to sleep in approved pack-and-plays that would be inspected and checked monthly against the CPSC website. The sleep plan also provides that she would place infants on their backs and allow no blankets or soft products in the crib. In addition, the Licensee certified that she had destroyed the older-model playpen.[33]

23. On November 5, 2010, at the direction of the Department, the County issued a Correction Order to the Licensee documenting violations of Minn. Stat. § 245A.1435(a) & (b), for allowing infants to sleep in chairs or swings as opposed to cribs, and for permitting an infant to use blankets or stuffed toys; Minn. Stat. § 245A.146, subd. 2, for failing to maintain crib safety documentation for the older-model playpen;

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[27] Ex. 16 (Lorsung and Shoberg case notes). The Licensee did have crib safety documentation for the pack-and-plays used in her daycare. *See* Ex. 18.
[28] Ex. 16 (Shoberg case note).
[29] Ex. 16 (Zuwalski case note).
[30] *Id*.
[31] Ex. 4.
[32] Exs. 3 & 4.
[33] Ex. 4.

and Minn. R. 9502.0367 C(1), for being over capacity from August 17, 2010, to August 27, 2010. The Licensee was told to complete the form with information as to when and how she had corrected these violations and to return it to her licensing worker by November 24, 2010.[34] The Licensee completed the form and mailed it back on or about November 18, 2010.

24. On November 17, 2010, the Department advised County licensing workers that it intended to revoke the Licensee's child care license.[35]

25. On November 19, 2010, the Department issued an order revoking the Licensee's license.[36]

26. The Licensee filed a timely appeal.[37] The Department issued a Notice and Order for Hearing on January 5, 2011.

27. The Licensee's daycare families, including the parents of A.B., strongly support the Licensee and urge that she be allowed to provide care for their children. They view the revocation of her license as a "huge mistake;" a failure of the system; and an unnecessary cause of additional emotional distress and trauma for the Licensee and their families, on top of the tragic loss of the child.[38]

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

CONCLUSIONS OF LAW

1. The Administrative Law Judge and the Commissioner of Human Services have jurisdiction over this matter pursuant to Minn. Stat. §§ 14.50 and 245A.08.

2. The Department of Human Services gave proper and timely notice of the hearing in this matter.

3. The Department has complied with all relevant procedural requirements of statute and rule.

4. The Commissioner may make a license conditional, suspend or revoke a license, or impose a fine if a license holder fails to comply with applicable law or rule. In applying these sanctions, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program.[39]

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[34] Ex. 5.
[35] Ex. 16 (Burwick case note 11/17/10).
[36] Ex. 2.
[37] Ex. 1.
[38] Testimony of Jill Skaja; Testimony of Sarah Soltis; Testimony of Jenny Benoit; Ex. 37.
[39] Minn. Stat. § 245A.07, subd. 1(a).

5. At a hearing regarding a licensing sanction, the Commissioner may demonstrate reasonable cause for action taken by submitting statements, reports, or affidavits to substantiate the allegations that the license holder failed to comply fully with applicable law or rule. If the Commissioner demonstrates that reasonable cause existed, the burden of proof shifts to the license holder to demonstrate by a preponderance of the evidence that the license holder was in compliance.[40]

6. When a license holder is placing an infant to sleep, the license holder must place the infant in a crib directly on a firm mattress with a fitted crib sheet that fits tightly on the mattress and overlaps the mattress so it cannot be dislodged by pulling the corner of the sheet. The license holder must not place pillows, quilts, comforters, sheepskin, pillow-like stuffed toys, or other soft products in the crib with the infant. These requirements apply to infants up to and including 12 months of age.[41]

7. There must be a safe, comfortable sleeping space for each infant and newborn. A crib, portable crib, or playpen with waterproof mattress or pad must be provided for each infant or newborn in care.[42]

8. The Licensee violated Minn. Stat. § 245A.1435 and Minn. R. 9502.0425 by failing to ensure that infants slept only in a crib on a firm mattress and by allowing an infant to use a blanket or other soft product.

9. Effective January 1, 2006, all licensed child care providers must maintain the following documentation for every crib used by or that is accessible to any child in care: (1) the crib's brand name; and (2) the crib's model number. Any crib for which the license holder does not have the required documentation must not be used by or be accessible to children in care.[43]

10. The Licensee violated Minn. R. 9502.0425, subp. 9, by using or having accessible to children in care an older model playpen that lacked a model number.

11. Providers shall be licensed for the total number of children, ten years of age or younger, who are present in the residence at any one time. Within the licensed capacity, the provider must comply with age distribution restrictions specifying the maximum number of children under school age, infants, and toddlers who are in care at any one time.44 A group family day care license with one adult caregiver permits no more than three children under the age of two years at any one time.[45]

12. The Licensee failed to comply with the age distribution requirements of her license between August 17, 2010, and August 27, 2010, when she had four children under the age of two years in care.

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[40] Minn. Stat. § 245A.08, subd. 3.
[41] Minn. Stat. § 245A.1435(b).
[42] Minn. R. 9502.0425, subp. 9.
[43] Minn. Stat. § 245A.146, subd. 2.
[44] Minn. R. 9502.0365, subp. 1.
[45] Minn. R. 9502.0367 C.

13. The violations regarding infant sleeping practices were chronic and severe, but they had no impact on the health, safety, or rights of children in care. The violation regarding noncompliance with age distribution requirements was isolated and minor, and it also had no impact on the health, safety, or rights of children in care. The Administrative Law Judge concludes that, based on the record as a whole, a conditional license is adequate to address these violations and that revocation of the license is not warranted.

14. These Conclusions are reached for the reasons set forth in the attached Memorandum, which is incorporated herein by reference.

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

RECOMMENDATION

IT IS HEREBY RECOMMENDED: That the Commissioner rescind the revocation of LaRhae Galarneault's license but instead impose appropriate conditions on her license.

Dated: April 15, 2011.

s/Barbara L. Neilson
BARBARA L. NEILSON
Administrative Law Judge

NOTICE

This report is a recommendation, not a final decision. The Commissioner of Human Services will make the final decision after a review of the record and may adopt, reject or modify these Findings of Fact, Conclusions, and Recommendation. Under Minn. Stat. § 14.61 (20010), the Commissioner shall not make a final decision until this Report has been made available to the parties for at least ten days. The parties may file exceptions to this Report and the Commissioner must consider the exceptions in making a final decision. Parties should contact Lucinda Jesson, Commissioner, Department of Human Services, P.O. Box 64998, St. Paul, MN 55164-0998, (651) 431-2907, to learn the procedure for filing exceptions or presenting argument.

If the Commissioner fails to issue a final decision within 90 days of the close of the record, this report will constitute the final agency decision under Minn. Stat. § 14.62, subd. 2a (2008). In order to comply with this statute, the Commissioner must then return the record to the Administrative Law Judge within 10 working days to allow the Judge to determine the discipline to be imposed. The record closes upon the filing of exceptions to the report and the presentation of argument to the Commissioner, or upon the expiration of the deadline for doing so. The Commissioner must notify the parties and the Administrative Law Judge of the date on which the record closes.

MEMORANDUM

The County argues that the Licensee has "chosen to not follow the law regarding safe sleeping practices for infants since the law came into effect in 2002." It also argues that she has risked the safety of children in her care "by picking and choosing to follow rules and regulations based on their 'reasonableness.'" The County contends the Licensee has chronically violated the law and significantly and unnecessarily increased the chances of an infant dying from SIDS in her care. Based on the chronicity of the safe sleeping practices violations and the severity of the potential consequences, the County argues the Department had reasonable cause to revoke her license.

The record reflects that the Licensee did not disagree with the rules and statutes, but rather, that she was not aware of them. She acknowledged receipt of newsletters and mailings from the County on these topics and said that it "must have gone over her head" and acknowledged that she had no good reason for being unaware of the rules. There is no evidence that she was selectively picking and choosing which rules to apply based on her own belief as to what was reasonable. She is charged with knowing the statutes and rules applicable to providers but, in assessing the nature of the violation, lack of knowledge is a different matter than deliberate refusal to comply.

The County attached significance to the Licensee's statement that she "allows kids to sleep with their blankies and security items," and the Department relied on this statement, along with photographs showing "mesh-sided cribs with loose fitting sheets and child size quilts hanging over the sides of the cribs" to conclude the Licensee has allowed infants to sleep with blankets and soft products in their cribs. The Licensee consistently stated that she did not allow infants to sleep in cribs with blankets or stuffed animals, only children older than one year. The record reflects that the only infant she allowed to use a blanket was the 11-month-old who slept in his car seat and whose mother directed her to let him use the blanket during naps. The fact that the mother directed this approach does not mean it was not a violation of daycare rules; but again, it does provide context and insight into the nature of the violation and demonstrates that the Licensee did not deliberately ignore a law intended to ensure the safety of children.

The County also suggested that the Licensee was less than truthful in suggesting that Baby A's mother had directed her to allow the baby to sleep in a car seat or bouncy seat. What the Licensee said, as reflected in the licensing worker's notes, is that Baby A "always sleeps best in one of these items and that is how the mother does it also."[46] The Licensee did not say that Baby A's mother had directed her to use the same methods, and Baby A's mother confirmed that she had not given the Licensee any such direction.

The Licensee did fail to ensure that infants slept in a crib, and this was a chronic violation. But she did it because she wanted to be able to see the infants as they slept. She did allow one infant to use a blanket while napping, and she did this based on the mother's direction. She apparently did use, for a short period of time, one older-model

[46] Ex. 16 (Burwick case note 8/30/10 at page 3).

playpen that lacked the required safety documentation; the remaining cribs had the safety documentation required by rule. The Licensee also failed to comply with the age distribution requirements of her license between August 17, 2010, and August 27, 2010, when she had four children under the age of two years in care.

The Licensee developed a sleep plan as well as a plan for managing capacity and age distribution issues, and she committed to following all rules and statutes. She testified that she would follow all applicable laws and rules if her license were reinstated. The Licensee has had a long and relatively violation-free career as a provider, and she was not responsible in any way for the death of the child in her care. Based on the record as a whole, the Administrative Law Judge concludes that children in her care are not at imminent risk of harm and that monitoring and licensing conditions are sufficient to address the violations that did occur.

B. L. N.