

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

In the Matter of the Maltreatment
Determinations and Orders to Forfeit a Fine
for People, Inc. – Quail Creek Parkway
Adult Foster Care and People Inc. -
Colonial Adult Foster Care

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

This is a consolidated matter. The allegations regarding People Inc. Colonial Adult Foster Care came on for hearing before Administrative Law Judge Manuel J. Cervantes on July 10, 2012, at the Office of Administrative Hearings in St. Paul. On July 30, 2012, the parties submitted post-hearing briefs, and on August 13, 2012, the parties filed reply briefs. The allegations regarding Quail Creek Parkway Adult Foster Care came on for hearing on September 20, 2012. The record on the consolidated matter closed on December 17, 2012.

Max Kieley, Assistant Attorney General, appeared at the hearing on behalf of the Department of Human Services (“the Department” or “DHS”). Seth E. Dickey, Assistant Attorney General, was subsequently substituted as counsel for the Department.¹ Gregory R. Merz, Attorney at Law, Gray Plant Mooty law firm, appeared on behalf of People Incorporated – Colonial Adult Foster Care (Respondent).

STATEMENT OF ISSUES

1. Is People Incorporated – Colonial Adult Foster Care responsible for maltreatment of a vulnerable adult by failing to provide adequate supervision within the meaning of Minnesota Statutes §§ 626.557, subd. 9c(c) and 626.5572, subds. 15 and 17(a)?

2. If so, did the Department properly assess a \$1,000 fine against People Inc. – Colonial Adult Foster Care pursuant to Minnesota Statutes § 245A.07, subd. 3(c)(4)?

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

¹ See, Letter dated October 10, 2012.

FINDINGS OF FACT

1. People Incorporated is a Minnesota corporation that provides a wide range of services to people with mental illness, including adult foster care, case management, in-home nursing care, support services, programs for the homeless, and residential services. Through its various programs, People Inc. serves approximately 5,500 people each year.²

2. People Inc. operates four adult foster care homes, including Colonial Adult Foster Care (Colonial House). Colonial House provides residential services to four adults with serious and persistent mental illness in a “home-like,” non-institutional setting.³

3. Colonial House is a split-level home located in a residential neighborhood in Burnsville, near the intersection of County Road 5 and 136th Street. Inside the front door is an entryway with stairs leading up to the main level of the home and down to the lower level. Located on the upper (main) level are the kitchen, dining room, living room, two bedrooms, a bathroom, and a staff office. A living area, two bedrooms, and a laundry room are located on the lower level. The front door entryway also has a door that leads to the attached garage.⁴

4. Krystal Whisler is employed by People Inc. as a Mental Health Practitioner. She has been the “House Lead” at Colonial House since January of 2011. Her duties include interacting with the residents, participating in risk management meetings, engaging in crisis intervention, and passing medications.⁵

5. Rachel Silver is employed by People Inc. as the Administrative Program Manager for People Inc.’s four adult foster care houses, including Colonial House. Her job duties include conducting intake interviews, hiring and scheduling staff, and drafting and reviewing treatment plans and procedures.⁶

6. Scott Hinchee is employed by People Inc. as a Senior Program Manager. Mr. Hinchee oversees People Inc.’s adult foster care programs, including Colonial House.⁷

7. Colonial House has “24 hour awake staff,” which means that at least one staff person is awake and present in the house at all times when residents are present. Typically, two staff persons are on duty during the day, and one staff person is on duty at night.⁸

² Testimony of Timothy McGuire.

³ McGuire Test.

⁴ Whisler Test.; Ex. 3 at DHS 17.

⁵ Whisler Test.

⁶ Silver Test.

⁷ Testimony of Scott Hinchee.

⁸ Whisler Test.; Silver Test.

8. People Inc. provides training to its employees on the Vulnerable Adults Act and its compliance requirements at the time of hire and on an annual basis thereafter.⁹ People Inc. also provides training to its employees on crisis intervention strategies and the privacy requirements mandated by the Health Insurance Portability and Accountability Act (HIPAA).¹⁰

9. Staff at Colonial House also receive training on how to identify symptoms of increased mental health distress and how to de-escalate or effectively intervene when a client exhibits such behaviors.¹¹

10. M.D. was a resident of Colonial House from 2009 - 2011. She began living at Colonial House in March of 2009, when she was approximately 18 years old.¹²

11. The other residents at Colonial House during the time that M.D. lived there, were three adult women with serious mental illness.¹³

12. M.D.'s legal guardian is her mother.¹⁴

13. M.D. has been diagnosed as bipolar and schizophrenic.¹⁵ M.D.'s symptoms include hallucinations, racing thoughts and hearing voices. When M.D. was experiencing worsening symptoms she would frequently pace, giggle or otherwise appear to respond to non-existent stimuli. When these symptoms were observed, staff at Colonial House would intervene by asking M.D. how she was doing and whether she was hearing voices. Staff would also try to distract her by engaging her in a game or taking her to the YMCA.¹⁶

14. All of the residents of Colonial House have written Risk Management Assessment Plans (RMAP). Colonial House staff members are responsible for reading and being familiar with each resident's RMAP.¹⁷ The purpose of the RMAP is to identify specific areas of risk for residents and to plan ways to reduce those risks. The RMAP addresses a variety of categories including physical disabilities, dietary needs, current medications, community survival skills, and risk of physical, sexual or emotional abuse.¹⁸

15. M.D.'s RMAP was developed in consultation with M.D.'s guardian, her case manager, and Colonial House staff.¹⁹

⁹ Ex. H; Ex. 11 at DHS 57; McGuire Test.

¹⁰ Whisler Test.; Hinchee Test.

¹¹ Silver Test.

¹² Whisler Test.

¹³ Whisler Test.

¹⁴ Whisler Test.

¹⁵ Ex 9 at DHS 42.

¹⁶ Whisler Test.

¹⁷ Exs. K and 15 at DHS 66; Whisler Test. and Silver Test.

¹⁸ Ex. 15.

¹⁹ Ex. 15 at DHS 84; Whisler Test.

16. M.D.'s RMAP identified her "eloping" or leaving Colonial House without informing staff as a risk. As of August 2010, M.D.'s RMAP provided that M.D. was prohibited from having any unsupervised time in the community. The restriction was put in place for M.D.'s own well-being and was due in part to instances where M.D. behaved "bizarrely," including disrobing in public settings, and a specific instance where it appeared that M.D. attempted to jump off a boat during an outing organized for the Colonial House residents.²⁰

17. Other residents of Colonial House were allowed to sign out and go into the community unsupervised.²¹

18. M.D.'s RMAP also identified particular symptoms she presented when she was feeling mentally unstable. These symptoms included pacing, racing thoughts, hearing voices, and responding to non-existent stimuli.²² M.D.'s RMAP provided that should M.D. exhibit these mental health symptoms, staff was expected to increase supervision of her.²³

19. Each resident also had a Client Emergency Plan that listed the resident's medications, identification information, and plans to follow in the event of particular crisis situations.²⁴

20. On four occasions between March and September of 2009, M.D. left Colonial House without notifying staff. Three of the occasions were relatively minor incidents where staff discovered M.D.'s absence almost immediately and returned her to the house. On those occasions, M.D. told staff that she had wanted to go for a walk and forgot to tell staff she was leaving. On the fourth occasion, in September 2009, M.D. left the house late in the evening and walked to a nearby Target store. M.D. remained at the store until it closed. Eventually, someone called the police and officers picked her up and returned her to Colonial House.²⁵

21. Following the September 2009 Target incident, staff at Colonial House decided to install an alarm system on each of the external doors of the house (front, patio, and garage door), and on M.D.'s bedroom window. The alarm would sound chimes whenever those doors or window were opened. A wireless speaker for the alarm system was located in the staff office on the upper main level of the house. People Inc. decided to install the door chimes to provide staff with an additional tool for monitoring when someone was entering or exiting the house. The speaker was located only in the staff office, instead of in another

²⁰ Ex. 3 at DHS 19; Ex. 15 at DHS 70-72; 80-81.

²¹ Whisler Test.; Ex. 15 DHS at 80-81.

²² McGuire Test; Ex. K and Ex. 15 at DHS 69--70.

²³ Ex. 15 at DHS 70.

²⁴ Whisler Test.; Ex. L and 21.

²⁵ Silver Test.

or additional areas of the house, in order to keep Colonial House as “home-like” as possible. The door alarm/chime system was installed in March 2010.²⁶

22. At the direction of Colonial House’s County licenser, Ms. Silver drafted a written door alarm policy. The written policy required only that the alarm system be always on (24 hours a day) and that staff check the batteries weekly. It did not require staff to check the doors or windows whenever the chimes sounded, and it did not detail specific requirements or expectations regarding how staff should respond when the chimes sounded. The written door alarm policy also did not require that staff ensure that the front door remained closed.²⁷

23. People Inc. did not provide any training to staff as to what they were required or expected to do when the chimes sounded.²⁸

24. The door alarm policy was intended to reduce the risk of M.D. eloping from Colonial House.²⁹

25. M.D.’s RMAP was amended to reflect that the door alarm system was installed to reduce M.D.’s elopement risk. Under the heading “Plan to reduce risk” M.D.’s RMAP states: “People Incorporated has installed an alarm system for the doors and [M.D.’s] window, which notify staff when a door or window is opened.”³⁰

26. Ms. Whisler would check the front door when the chimes sounded about 80 percent of the time.³¹ Ms. Silver, on the other hand, almost always checked the doors when the chimes sounded. Usually, the chimes were activated when one of the residents stepped outside to smoke a cigarette.³²

27. Three of the four residents at Colonial House smoked. As a result, the door chimes would activate frequently as the residents stepped in and out of the house to smoke cigarettes throughout the day.³³

28. If a staff person was on the lower level of the house, they might not hear the sound of the chimes.³⁴ However, if a staff person was standing at the entry of the laundry room, she would be able to see the front door at the top of

²⁶ McGuire Test.; Silver Test.; Hinchee Testimony; Ex. 15 at DHS 68.

²⁷ McGuire Test.; Silver Test.; Ex. 3 at DHS 19; Ex. 10 at DHS 51; Ex. 11 at 56; Ex. 23 at DHS 115 and Ex. 25 at DHS 119.

²⁸ Silver Test.

²⁹ Ex. 15 at DHS 68.

³⁰ Ex. 15 at DHS 68; Whisler Test.

³¹ Exs. 3 at DHS 18 and 10 at DHS 51; Testimony of Stillday and Whisler.

³² Ex. 10; Testimony of Stillday.

³³ Ex. 10 at DHS 50.

³⁴ Ex. 10 at DHS 52; Whisler Test.

the stairs. The laundry room was approximately six to eight feet directly away from the stairs leading to the front entryway.³⁵

29. Colonial House did not install an alarm on the front storm door. Thus, if the main door was left open, chimes would not sound when the storm door was opened or closed.³⁶

30. After the last eloping incident in September 2009, M.D. did not leave Colonial House without informing staff again until more than a year later on February 17, 2011.

February 17, 2011, Incident

31. On the morning of February 17, 2011, Ms. Whisler arrived for work at Colonial House at about 8:00 a.m. Ms. Silver arrived for work at Colonial House at about 8:30 a.m. Ms. Whisler and Ms. Silver were the only two staff members on duty at Colonial House that morning. Another staff member was scheduled to come in at noon that day.³⁷

32. In addition to M.D., one other resident, J.E., was present at Colonial House on the morning of February 17, 2011.³⁸

33. At approximately 9:15 a.m. Ms. Whisler knocked on M.D.'s bedroom door to see if she was awake. At about 9:30 a.m., M.D. got up and went to the staff office to receive her medications. After receiving her medications from Ms. Whisler, M.D. took a shower, got dressed, did her chores, and then watched television on the lower level living area of the house.³⁹

34. At about 10:00 a.m., J.E.'s caseworker arrived at Colonial House and met with J.E. for about an hour. J.E.'s caseworker left Colonial House at approximately 11:00 a.m.⁴⁰

35. At about 10:45 a.m., M.D. went to the staff office and asked Ms. Whisler and Ms. Silver if someone could take her to the YMCA. Ms. Whisler told M.D. that no one was able to take her at that moment but that someone might be able to take her in the afternoon. M.D. went back downstairs and continued watching television.⁴¹

³⁵ Whisler Test.

³⁶ Whisler Test.

³⁷ Ex. 10 at DHS 48.; Whisler Test.; Silver Test.

³⁸ Whisler Test.

³⁹ Whisler Test.

⁴⁰ Whisler Test.

⁴¹ Whisler Test.; Silver Test.; Ex. 10 at DHS 48.

36. At approximately 11:05 a.m., Ms. Whisler went downstairs to put a load of towels into the washing machine. As Ms. Whisler entered and exited the laundry room, she observed M.D. sitting on the couch watching television.⁴²

37. After putting the towels in the washing machine, Ms. Whisler went back upstairs to the staff office. Within a few minutes, she received a telephone call from M.D.'s County caseworker. Her telephone conversation lasted about 20 minutes.⁴³ Both Ms. Whisler and Ms. Silver were in the staff office from approximately 11:15 a.m. until 11:45 a.m.⁴⁴

38. Neither Ms. Whisler nor Ms. Silver noticed anything unusual about M.D.'s behavior that morning. M.D. was not exhibiting symptoms of increased agitation or worsening mental health stability. M.D. also did not appear to be upset or depressed.⁴⁵

39. The door chimes rang a number of times on the morning of February 17, 2011. Each time she heard the chimes, Ms. Silver checked to see who was entering or leaving the house. On each occasion that she heard the chimes, Ms. Silver noted that J.E. was going out on to the patio to smoke a cigarette.⁴⁶

40. Sometime between approximately 11:05 a.m. and 11:45 a.m. M.D. left Colonial House without notifying staff. Staff was unaware during this time that M.D. was gone. Neither Ms. Whisler nor Ms. Silver remember hearing the door chimes during this time period.⁴⁷

41. At about 11:30 a.m. on February 17, 2011, the Burnsville Police Department received a call that a female was jumping into traffic at County Road 5 and 36th Street, about one mile from Colonial House. Police officers were dispatched to the scene where they saw M.D. running into traffic. Before they could reach her, the police officers saw M.D. jump in front of a car. The driver of the car slammed on the brakes, but the car struck M.D. She landed on the car's hood and rolled off. The police officers pulled their squad car over and M.D. stood up, apparently uninjured. The police officers placed M.D. in the back of their squad car. After asking her a few questions, M.D. indicated to the officers that she wanted to hurt herself. The officers asked M.D. who she was and where she lived. M.D. could not or would not identify herself, but did give the officers the address for Colonial House as her residence.⁴⁸

⁴² Ex. 10 at DHS 49; Whisler Test.

⁴³ Whisler Test.

⁴⁴ Whisler Test.

⁴⁵ Whisler Test.; Ex. 10 at DHS 51; Silver Test.

⁴⁶ Silver Test.

⁴⁷ Whisler Test. and Silver Test.

⁴⁸ Exs. 3 (DHS-18) and 18; Testimony of Stillday.

42. At about 11:45 a.m. Ms. Whisler and Ms. Silver were in the staff office when they heard a male voice at the front door call out "hello?" Ms. Whisler went to the front door and observed two Burnsville police officers standing in the entryway.⁴⁹ The police officers asked Ms. Whisler if M.D. lived at Colonial House. When Ms. Whisler confirmed that M.D. did live there, the officers told her that M.D. had been found approximately one mile from Colonial House running into traffic.⁵⁰

43. Ms. Whisler led the police officers upstairs to the staff office to Ms. Silver. The police officers asked Ms. Whisler and Ms. Silver if they had noticed any signs that morning that M.D. was depressed or may want to harm herself. Both Ms. Silver and Ms. Whisler indicated that they had not noticed any unusual behavior on the part of M.D. that morning.⁵¹

44. As Ms. Silver continued to talk with the police officers in the staff office, Ms. Whisler went out to the squad car and talked to M.D., who remained seated in the back of the squad car. Ms. Whisler asked M.D. if she was injured and she indicated that she was not physically hurt. Ms. Whisler also asked M.D. if she had been hearing voices, and M.D. indicated that that was not the case.⁵²

45. The police officers decided to call the paramedics to take M.D. to the hospital for observation.⁵³

46. M.D. remained in the hospital for approximately two weeks. While she was in the hospital, M.D.'s mother and guardian, and her county case manager advocated strongly for M.D. to be allowed to return to live at Colonial House.⁵⁴

47. After the police left, Ms. Silver reported the incident to her supervisor, Scott Hinchee. Mr. Hinchee went to Colonial House and talked to Ms. Whisler and Ms. Silver about what happened.⁵⁵

48. Mr. Hinchee and Ms. Silver completed and filed an Incident Report with the Common Entry Point detailing the events of February 17, 2011.⁵⁶ In response to a question on the Incident Report form asking whether any policy/procedures needed to be modified in light of the incident, Mr. Hinchee

⁴⁹ Neither Ms. Whisler nor Ms. Silver can remember whether the front door had been left open when the police officers arrived or whether the officers opened the front door and activated the chimes.

⁵⁰ Whisler Test.

⁵¹ Whisler Test.; Silver Test.

⁵² Whisler Test.; Silver Test.

⁵³ Whisler Test.

⁵⁴ Whisler Test.; Silver Test.

⁵⁵ Hinchee Test.

⁵⁶ Ex.17 and I; Whisler Test.

answered “yes.” Mr. Hinchee concluded that People Inc. should put in writing what staff was expected to do when the door alarm chimes sounded.⁵⁷

49. On a Maltreatment of Vulnerable Adults form that Mr. Hinchee completed on February 18, 2011, he stated that the current door alarm policy did not “adequately outline a plan of response for staff.” Mr. Hinchee stated further that a revised door alarm procedure would be put in place by March 8, 2011, and that staff would be “informed of procedure regarding door alarms.”⁵⁸

50. People Inc. did agree to allow M.D. to return to Colonial House, but only after discussions with M.D.’s mother and case worker regarding the limits to the amount of supervision People Inc. was able to provide M.D.⁵⁹

51. M.D. returned to Colonial House after being discharged from the hospital. However, it was determined in late May of 2011, based on M.D.’s increasingly aggressive behaviors in the community, that Colonial House was no longer an appropriate placement for her. This decision was made in consultation with M.D.’s mother and guardian and M.D.’s caseworker. M.D. left Colonial House at the end of May 2011.⁶⁰

52. People Inc. staff drafted a couple of versions of the door chime policy. A revised door chime policy that was implemented in March 2011, provided that staff at Colonial House was expected to determine the cause of any activation of the door chimes occurring between 10:00 p.m. and 8:00 a.m.⁶¹ Eventually, People Inc. discontinued the door chime policy.⁶²

Procedural Findings

53. The Department’s Division of Licensing initiated a maltreatment investigation based on the Incident Report, Vulnerable Adult Maltreatment Reporting Form, and Serious Injury Report filed by Colonial House staff regarding M.D.’s February 17, 2011 elopement.⁶³

54. Between February 23 and March 1, 2011, DHS investigator Toni Stillday interviewed People Inc. employees Krystal Whisler, Rachel Silver and Scott Hinchee, as well as the mother and legal guardian of M.D. and M.D. herself.⁶⁴ A site visit was conducted by Ms. Stillday on February 24, 2011. Ms. Stillday also reviewed People Inc.’s Incident Report, Maltreatment of Vulnerable Adult/Minor Review, Program Abuse Prevention Plan, Door Alarm Procedure,

⁵⁷ Hinchee Test.

⁵⁸ Ex. 23 at DHS 114; Hinchee Test.

⁵⁹ Hinchee Test.; Ex. 11 at DHS 57.

⁶⁰ Silver Test.

⁶¹ Ex. 22 at DHS 112.

⁶² Hinchee Test. and Silver Test.

⁶³ Exs. 3, 12 and 13; Silver Test.; Hinchee Test.

⁶⁴ Ex. 3; Stillday Test.

and M.D.'s Risk Management Assessment and Plan, Emergency Plan and Progress Notes.⁶⁵

55. Based on Ms. Stillday's investigation, the Department determined that People Inc. (Colonial House) was responsible for maltreatment of M.D. in the form of neglect/inadequate supervision under Minn. Stat. §§ 626.557, subd. 9c(c), and 626.5572, subds. 15 and 17(a). The Department concluded that because M.D. left Colonial House without the knowledge of the staff and was unsupervised in the community, the facility was responsible for maltreatment.⁶⁶

56. In its investigation report, the Department determined that People Incorporated – Colonial House was responsible for maltreatment by reason of neglect and concluded the following:

There was a preponderance of the evidence that the VA [vulnerable adult] had a history of leaving the facility without staff persons' knowledge and his/her RMAP included door alarms to reduce this risk; however, the VA was able to leave the facility without SP1's and SP2's⁶⁷ knowledge and was unsupervised in the community. While unsupervised, the VA attempted self-harm by jumping in front of motor vehicles.⁶⁸

57. On June 30, 2011, the Department issued a Determination of Maltreatment and ordered People Inc, to forfeit a fine in the amount of \$1,000 under Minn. Stat. § 245A.07, subd. 3(c)(4), due to substantiated maltreatment by the license holder. The Order informed People Inc. of its right to request reconsideration of the maltreatment determination and its right to request a contested case hearing.⁶⁹

58. By letter dated July 1, 2011, People Inc. timely requested a contested case proceeding.⁷⁰

59. On February 15, 2012, the Commissioner served a Notice and Order for Prehearing Conference and Hearing. The prehearing conference was held on April 3, 2012, and the hearing was held as scheduled on July 10, 2012.

60. A Protective Order was entered in this matter on March 19, 2012.

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

⁶⁵ Ex. 3 at DHS-17.

⁶⁶ Exs. 2 and 3 at DHS-20.

⁶⁷ Staff person 1 and Staff person 2 (Whisler and Silver).

⁶⁸ Ex. 3 at DHS-19.

⁶⁹ Ex. 2.

⁷⁰ Ex. 1.

CONCLUSIONS

1. The Administrative Law Judge and Commissioner of Human Services have jurisdiction in 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 procedural requirements of law and rule.

4. Pursuant to Minn. Stat. §§ 626.557, subd. 9d(f), and 245A.08, this is a consolidated contested case hearing on the maltreatment determination and the imposition of a fine.

5. Minn. Stat. § 245A.07, subd. 3(c)(4) authorizes the forfeiture of a fine when a maltreatment finding of a vulnerable adult is made under Minn. Stat. § 626.557. Appeal of a maltreatment finding and forfeiture are consolidated pursuant to Minn. Stat. § 245A.085.

6. The Department bears the burden of proving by a preponderance of the evidence that the Respondent maltreated a vulnerable adult by neglect.⁷¹

7. As a person receiving services in a licensed care adult foster care home, M.D. is a “vulnerable adult” for purposes of the Vulnerable Adults Act.⁷²

8. Neglect of a vulnerable adult constitutes maltreatment.⁷³ Neglect is defined to mean 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.⁷⁴

9. The rules governing adult foster care services and licensed adult foster care homes defines “supervision” to mean:

⁷¹ Minn. Rules 1400.7300, subp. 5.

⁷² Minn. Stat. § 626.5572, subd. 21.

⁷³ Minn. Stat. § 626.5572, subd. 15.

⁷⁴ Minn. Stat. § 626.5572, subd. 17(a).

- A. oversight by a caregiver as specified in the individual resident placement agreement and daily awareness of a resident's needs and activities; and
- B. in the presence of a caregiver in the residence during normal sleeping hours.⁷⁵

10. In determining whether the facility or an individual is the responsible party for substantiated maltreatment, Minn. Stat. § 626.557, subd. 9c(c) states that the following mitigating factors must be considered:

- (1) whether the actions of the facility or the individual caregivers were in accordance with, and followed the terms of, an erroneous physician order, prescription, resident care plan, or directive . . . ;
- (2) the comparative responsibility between the facility, other caregivers, and requirements placed upon the employee, including but not limited to, the facility's compliance with related regulatory standards and factors such as the adequacy of facility policies and procedures, the adequacy of facility training, the adequacy of an individual's participation in the training, the adequacy of caregiver supervision, the adequacy of facility staffing levels, and a consideration of the scope of the individual employee's authority; and
- (3) whether the facility or individual followed professional standards in exercising professional judgment.

11. The Department properly considered these factors in determining People Incorporated – Colonial House was responsible for maltreatment.

12. The Department has proven by a preponderance of the evidence that People Incorporated-Colonial House was responsible for maltreatment of M.D. by neglect by failing to supply supervision that was reasonable and necessary to maintain M.D.'s health or safety.⁷⁶ People Incorporated – Colonial House failed to properly implement M.D.'s RMAP and guard against her elopement risk by supplying adequate oversight to ensure that she did not leave the facility unsupervised, either through effective implementation of the door alarm system or through some other approach involving increased monitoring.

13. People Incorporated-Colonial House's failure to train staff members to either respond to the door alarm chimes or to ensure that the front door was closed, supports a determination of maltreatment by neglect (inadequate

⁷⁵ Minn. Rules 9555.5105, subp. 37.

⁷⁶ Minn. Stat. §§ 626.557, subd. 9(c)(c) and 626.5572, subds. 15 and 17(a).

supervision) within the meaning of Minn. Stat. §§ 626.557, subd. 9(c)(c) and 626.5572 subds. 15 and 17(a).

14. Under Minn. Stat. § 245A.07, subd. 3 (c)(4), the Department must assess a fine of \$1,000 for each determination of maltreatment of a vulnerable adult under Minn. Stat. § 626.557.

15. These Conclusions are reached for the reasons set forth in the Memorandum below, which is hereby incorporated by reference into these Conclusions.

Based upon the foregoing Conclusions, and for the reasons stated in the Memorandum attached hereto, the Administrative Law Judge makes the following:

RECOMMENDATION

IT IS HEREBY RECOMMENDED that the Commissioner of Human Services:

- (1) AFFIRM the maltreatment determination against People Incorporated – Colonial House; and
- (2) AFFIRM the order to forfeit a fine.

The Protective Order entered on March 19, 2012, shall remain in effect.

Dated: January 16, 2013

/s/ Manuel J. Cervantes
MANUEL J. CERVANTES
Administrative Law Judge

Reported: Digitally recorded; no transcript prepared.

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, 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 the Appeals and Regulations Division, Department of Human Services, P.O. Box 64941, St. Paul, Minnesota 55164-0941, to learn the procedure for filing exceptions or presenting argument.

If the Commissioner fails to issue a final decision within 90 days of the close of the record, this report will constitute the final agency decision under Minn. Stat. § 14.62, subd. 2a. The record closes upon the filing of exceptions to the report and the presentation of argument to the Commissioner, or upon 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

M.D. was residing at People Incorporated's Colonial House, a licensed adult foster care home, from approximately March 2009 until May 2011. M.D. has a serious and persistent mental illness and is a "vulnerable adult" for purposes of the Vulnerable Adults Act. M.D.'s symptoms included pacing, racing thoughts, hearing voices, and responding to non-existent stimuli. M.D.'s RMAP provided that should M.D. exhibit these mental health symptoms, staff was expected to increase supervision of her. While she resided at Colonial House, and particularly on February 17, 2011, People Incorporated – Colonial House was responsible for her care and was required to provide her with reasonable and necessary supervision to maintain her health and safety.

M.D.'s RMAP identified "elopement" as a risk and, as of August 2010, her RMAP was amended to provide that she was prohibited from going into the community unsupervised. M.D.'s RMAP also stated that the door alarm system was installed after M.D.'s September 2009 elopement to reduce the risk of M.D. eloping from the facility in the future.⁷⁷

The written door alarm policy, however, did not identify what was expected or required of staff when the door chimes sounded. Instead, the policy stated only that the alarm system was to remain on 24 hours a day and the batteries checked weekly. The policy did not require staff to check the doors or windows when the chimes sounded, and it did not require staff to ensure that the front door remained closed. In addition, People Inc. did not provide any training to staff members as to what was required or expected of them when the chimes sounded.

The Department argues that People Incorporated - Colonial House committed maltreatment by neglect of M.D. by failing to ensure that she did not leave the house unsupervised. The Department asserts that People

⁷⁷ Ex. 15.

Incorporated was on notice that M.D. was at risk for eloping, and it installed an alarm system to reduce that risk. The Department contends, however, that the door alarm system was inadequate because there was no written policy requiring staff to respond when the chimes were activated and to ensure that the front main door remained closed so that the chimes would sound when the door was opened. According to the Department, by enacting an inadequate door alarm policy, People Incorporated failed to provide M.D. with the supervision necessary to maintain her health and safety.

People Incorporated-Colonial House asserts that there was nothing about M.D.'s behavior on the morning of February 17, 2011, that should have put Colonial House staff on notice that she would elope from the facility and attempt to harm herself. It notes that M.D. did not exhibit any of the symptoms she typically exhibited when feeling less mentally stable, such as pacing or reacting to non-existent stimuli. Instead, she took her medications in the morning, showered, interacted appropriately with staff, and asked to go to the YMCA about 30 minutes before she eloped from the house. Had M.D. been exhibiting signs of increased mental health stability, the Respondent asserts that staff would have increased supervision and interaction pursuant to her RMAP.⁷⁸ In addition, People Incorporated points out that more than one year had passed since M.D. last eloped from Colonial House.

The Administrative Law Judge finds that M.D.'s demeanor the morning she eloped is relevant to the issue of whether People Incorporated provided her with appropriate supervision, but that it is not determinative. As a vulnerable adult with a serious mental illness, the behaviors M.D. typically exhibits when experiencing worsening symptoms are useful indicators for staff, but unfortunately they are not guarantees of future conduct. Despite her seemingly stable behavior on the morning of February 17, 2011, M.D. eloped unnoticed from Colonial House and, after walking about one mile, very nearly killed herself by running in front of traffic and being struck by a car.

Given that in the late morning of February 17, 2011, both Ms. Whisler and Ms. Silver were in the staff office where the alarm's speaker was located, it is likely that the front door was left open by someone and that M.D. was able to leave without activating the chimes. Although M.D.'s RMAP did not require that staff supervise her on a 1:1 basis or keep her constantly within sight or sound, Colonial House was required to provide her reasonable supervision necessary to maintain her health or safety in consideration of her mental capacity or dysfunction. In order to properly implement M.D.'s RMAP, People Incorporated – Colonial House was required to supply adequate oversight of M.D. to ensure she did not leave the facility unsupervised. People Inc. could have done this through effective implementation of the door alarm system or through some other approach that involved increased monitoring. People Incorporated chose to

⁷⁸ See, Ex. 15 at DHS 70.

implement a door alarm system, and its failure to effectively implement that door alarm system resulted in inadequate supervision of M.D.

After careful consideration of the entire record, the Administrative Law Judge concludes that the Department has shown by a preponderance of the evidence that Colonial House failed to provide M.D. with supervision that was reasonable and necessary to maintain her health and safety. The record established that People Incorporated failed to implement an adequate door alarm policy that identified what was expected or required of staff members when the door chimes activated. People Incorporated also failed to train staff on these expectations and failed to make an effort to ensure the front main door remained closed. Something as simple as posting a sign by the door directing people to make certain to close the door when entering or exiting the house, would have reflected at least a minimal effort to ensure the alarm system would operate as intended.

Given M.D.'s history of elopement and self-injurious behavior when out in the community, People Incorporated was obliged to come up with a protocol it would have staff follow to ensure the door alarm system was adequate to reasonably address M.D.'s elopement risk. By failing to do so, People Incorporated failed to provide M.D. with reasonable supervision. In addition, it is appropriate to find that the facility, rather than individual staff members, is the responsible party for the maltreatment due to the inadequacy of its policies, procedures and training.

Based upon the record as a whole, the Administrative Law Judge finds that People Incorporated is responsible for maltreatment of M.D. by failing to provide adequate supervision. The ALJ recommends that the Commissioner affirm the Department's maltreatment determination and order to forfeit fine levied against People Incorporated – Colonial House.

M.J.C.