

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
People, Inc. - Quail Creek Parkway
Adult Foster Care

**FINDINGS OF FACT,
CONCLUSIONS AND
RECOMMENDATION**

This matter came on for hearing before Administrative Law Judge Manuel J. Cervantes (ALJ) on September 20, 2012 at the Office of Administrative Hearings in St. Paul, Minnesota, pursuant to a prehearing order.

Max Kieley and Seth E. Dickey¹, Assistant Attorneys General, appeared on behalf of the Department of Human Services (Department). Gregory R. Merz, Attorney at Law, appeared on behalf of People, Incorporated (People). The record closed on December 28, 2012 upon the filing of the parties' post-hearing submissions.

STATEMENT OF THE ISSUES

1. Did the Department establish by a preponderance of the evidence that People, Inc. committed maltreatment by neglect under Minn. Stat. § 626.5572?
2. Did the Department properly impose a \$1,000 fine on People, Inc., pursuant to Minn. Stat. § 245A.07?

The ALJ finds that the Department established that on October 5, 2010, People committed maltreatment by neglect and that People was properly assessed a \$1,000 fine. The ALJ recommends that the Commissioner of the Department (Commissioner) AFFIRM the Department's Determination of Maltreatment and Order People to Forfeit a Fine.

Based upon the files, records, and the evidence adduced at the hearing, the Administrative Law Judge makes the following:

FINDINGS OF FACT

1. On October 27, 2008, AP (the vulnerable adult in this case) was struck by a motor vehicle while riding his bike.² He was 16 years old. This accident caused a

¹ Mr. Dickey became counsel for the Department on December 17, 2012.

² Ex. 26 at DHS 214-15.

severe traumatic brain injury which left him with numerous physical and mental impairments. These impairments included severe depression³ and severe ataxia which causes tremors, affecting his balance and his ability to use his hands.⁴

2. As a result of these impairments, AP has difficulty performing the physical and mental tasks required for daily living.⁵

3. On August 27, 2010, AP became a resident of the Quail Creek Parkway Adult Foster Care Residence (Quail Creek), managed by People.⁶

4. People has been in existence for 40 years, serving persons with serious and chronic mental illness.⁷ People provides a broad range of services, including residential services, in-patient treatment, outpatient outreach and in-home health care. People serves 5,000 – 6,000 persons with mental illness each year. People operates approximately 40 residential programs, including adult foster care programs licensed by the State of Minnesota.⁸

5. Quail Creek is an adult foster care home operated by People and licensed by the State of Minnesota.⁹ Quail Creek provides 24-hour staffing with overnight staff.¹⁰ Quail Creek is located in Anoka County and has a contract with Anoka County to provide adult foster care services.¹¹

6. Quail Creek is located in a split-level home located in a suburban residential neighborhood in Blaine.¹² The program serves four adults with a primary diagnosis of serious and persistent mental illness. Quail Creek's focus is to work with its residents on acquiring and improving skills in the areas of independent living skills, medication management, symptom management, and socialization, with an objective of moving residents into a less restrictive setting. Residents typically stay at Quail Creek for a year or two before moving into a residential placement where they have more independence.¹³

7. People normally provides extensive training to its employees regarding a wide variety of subjects, including training regarding compliance with the Vulnerable Adults Act.¹⁴ People also normally provides employees with specific training that covers the needs of the particular residents served by the program where they work as well as

³ Ex. 22 at DHS 154.

⁴ Ex. 25 at 194-201.

⁵ *Id.*

⁶ Ex. 25 at DHS 194.

⁷ Transcript (Tr.) at 204.

⁸ Tr. at 205.

⁹ Tr. at 94.

¹⁰ Tr. at 95.

¹¹ Tr. 94.

¹² *Id.*

¹³ *Id.*

¹⁴ Tr. at 134.

the Program Abuse Prevention Plan.¹⁵ People, however, provided minimal training to its Quail Creek employee, RKS.¹⁶

8. At Quail Creek, AP received care and treatment regarding a wide variety of vulnerabilities, including suicidal ideation.¹⁷ AP has stated that he is frustrated with his life and disabilities.¹⁸ This frustration is particularly acute during the month of October, because it is the month in which his injury occurred.¹⁹

9. On September 8, 2010, AP exhibited erratic behavior and made statements suggesting suicidal ideation after consuming caffeine and nicotine.²⁰ AP climbed onto a chair next to the edge of a second story deck, and began to mount the railing as if to jump off.²¹

10. A mental health practitioner, SD, held AP's arm and guided him down from the railing.²² This incident was logged by Quail Creek as an incident of psychiatric decompensation, which included suicidal ideation.²³

11. On September 10, 2010, Quail Creek conducted a Vulnerable Adult Risk Assessment. In collaboration with AP's mother (VW), AP's father and AP's county case manager, an Individual Abuse Prevention Plan (IAPP) was prepared for AP.²⁴ The IAPP recognized AP had a history of major depression and suicidal ideation. Number 12 of the IAPP, in relevant part, states,

Area of Vulnerability: Suicide Ideation/Suicide Attempts

Client has an (sic) hx of self-injurious thoughts or behaviors. Client has been hospitalized due to S/I in the past. Staff will monitor client if either of these are observed to ensure safety. Staff will assess client for S/I or H/I and ask client to sign a contract for safety. If client is unable to contract for safety than (sic) staff will seek further assistance through Riverwind Crisis center or 911. If client is exhibiting any of the above-mentioned behaviors then staff will monitor him continuously until resolved. All sharps and harmful substances will be kept in a lock cabinet to which only staff has a key.

¹⁵ Tr. at 115.

¹⁶ Ex. 8 at DHS 62. The ALJ notes that RKS's testimony at the hearing on September 20, 2012 differs from her report to the maltreatment investigator shortly after the October 5, 2010 attempted suicide. In light of its proximity to the incident, and to the extent that RKS's testimony differs materially from her report, the ALJ gives greater weight to RKS's report of October 26, 2010.

¹⁷ Ex. 25 at DHS 197.

¹⁸ Ex. 12 at DHS 100.

¹⁹ Ex. 7 at DHS 53.

²⁰ Ex. 13 at DHS 108.

²¹ *Id.*

²² *Id.*

²³ Ex. 13 at DHS 106.

²⁴ Ex. 36 at DHS 434, Tr. at 61 and 100.

12. On September 30, 2010, RKS began her employment at Quail Creek as a Mental Health Rehabilitation Worker.²⁵ RKS's position was temporary; used to supplement staff levels during an unexpected staff shortage due to illness.²⁶

13. RKS indicated that she was under qualified for the position for which she was hired, having less hours of experience than is typically required.²⁷ Due to the "fill in" nature of RKS' position, RKS received "quick training" which consisted of reading training materials in the presence of a supervisor.²⁸ Normally, a new employee shadows the supervisor for a full day and shadows a co-employee a second day before s/he starts a shift on their own. RKS did not receive this orientation.²⁹

14. RKS did not receive any specific training relative to responding to a resident who has displayed dangerous or risky behavior.³⁰ RKS was inexperienced and was not trained as thoroughly as she should have been.³¹

15. RKS indicated that the best way for me to learn was to sit with the clients and develop a relationship so I could further my work there. Quail Creek did not make RKS aware of the September 8, 2010 incident involving AP's suicidal attempt on the deck railing.³² RKS was aware however that as of October 2, 2010, AP's depression was worsening and he had requested that professional intervention occur to address his symptoms.³³

16. On October 5, 2010, AP was a passenger in his grandmother's car en route to a restaurant for dinner.³⁴ AP and his grandmother began to argue over AP's smoking in the car and his desire to stop to buy cigarettes.³⁵ AP became upset and threatened to jump out of the car. His grandmother pulled over along Minnesota Highway 65 to talk and AP exited the vehicle, making statements about jumping into traffic. He refused his grandmother's request that he get back into the car.³⁶

17. AP's grandmother called the police, who arrived shortly at their location.³⁷ AP got into the car with his grandmother immediately, without incident, and they proceeded to dinner.³⁸

²⁵ Ex. 8 at DHS 61-62. RKS did not work at Quail Creek after October 17, 2010.

²⁶ Ex. 9 at DHS 78.

²⁷ Ex. 8 at DHS 62. The ALJ notes that RKS's testimony at the hearing on September 20, 2012 differs from her report to the maltreatment investigator shortly after the October 5, 2010 attempted suicide. In light of its proximity to the incident, and to the extent that RKS's testimony differs materially from her report, the ALJ gives greater weight to RKS's report of October 26, 2010.

²⁸ Ex. 9 at DHS 78.

²⁹ *Id.*

³⁰ Ex. 8 at DHS 69.

³¹ *Id.* at 79.

³² Ex. 8 at DHS 68-69, Ex. 9 at DHS 79.

³³ Ex. 18 at DHS 127, Tr. at 169.

³⁴ Ex. 7 at DHS 52-53.

³⁵ *Id.*, Ex. 8 at DHS 64, Tr. 154.

³⁶ Ex. 7 at DHS 52-53.

³⁷ Ex. 7 at DHS 52-53.

18. After dinner, AP was dropped off at the facility by his grandmother.³⁹ At AP's request, his grandmother did not accompany him into the facility.⁴⁰ Upon entering the facility, AP indicated to staff and other residents that he had enjoyed the outing with his grandmother.⁴¹

19. AP's grandmother proceeded directly to VW's home and related the incident that occurred along the highway. At approximately 7:00 p.m. the same evening, VW called the facility and spoke to RKS.⁴²

20. VW described to RKS the incident that occurred along the highway, indicating that it was very risky behavior and could be considered a suicide attempt. VW also related that October is a difficult time for AP every year because October is the month when he was injured in the bike accident.⁴³ VW requested that the facility staff keep "an extra eye" on AP. RKS responded that he is already kept within an "arm's length." The telephone conversation lasted approximately one-half hour.⁴⁴

21. Following the telephone conversation, RKS was responsible for the supervision of AP while SD distributed medication to the other residents on the lower level.⁴⁵ At that time, AP was on the deck smoking with other residents.⁴⁶ The other residents left the deck to take their medications, leaving AP alone.⁴⁷

22. RKS completed her evening chores. AP was not visible to RKS for a 5-10 second period that it took RKS to return the vacuum cleaner to a closet and walk across the kitchen towards the deck door.⁴⁸ It was at this point that AP jumped over the railing; to a fall of approximately 15 feet.⁴⁹

23. RKS did not see AP walk to the railing, climb the chair, or jump over the railing, but as she entered the deck, heard the sound of AP's impact with the ground below.⁵⁰ RKS ran to look over the railing, heard AP moaning, then ran downstairs and outside to find him lying on his back. AP was conscious.⁵¹ The Blaine police were called at 8:17 p.m. and arrived in less than ten minutes.⁵²

³⁸ Ex. 7 at DHS 53.

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ Ex. 14 at DHS 113.

⁴² Ex. 7 at DHS 53, Ex. 8 at 64, Tr. at 174.

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ Ex. 14 at DHS 113.

⁴⁶ *Id.*

⁴⁷ Ex. 8 at DHS 63.

⁴⁸ Tr. at 178.

⁴⁹ Ex. 8 at DHS 65, Ex. 28 at DHS 228.

⁵⁰ *Id.*

⁵¹ Ex. 8 at DHS 65-66.

⁵² Ex. 28 at DHS 228.

24. Although RKS had approximately 47 minutes from the end of the phone conversation until AP jumped, RKS did not relate any information gained in the telephone conversation to SD that evening until AP was lying on the ground after his jump.

25. When the Blaine police saw AP on the ground, the officer said, “oh, it’s you again,” recognizing AP from the earlier Highway 65 incident. It was at this point that RKS was reminded that she intended to tell SD, who was also present near AP, that AP had the earlier episode.⁵³

26. While lying on the ground, AP stated that he had been depressed lately and he tried to kill himself.⁵⁴

27. As a result of the suicide attempt, AP suffered a fracture of the right humerus, and was transferred to the hospital for inpatient psychiatric and neurological care. AP did not return to Quail Creek.⁵⁵

28. SD, an experienced mental health practitioner of five years, indicated that if RKS had told her of the earlier Highway 65 incident, “we would have been on him constantly, no time alone, that is what we usually do when we have clients in crisis. I could have skipped 1:1 [one on one with another client] to help him [AP] or [RKS].....⁵⁶

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

CONCLUSIONS

1. The Commissioner of Human Services and the Administrative Law Judge have jurisdiction to consider this matter pursuant to Minn. Stat. §§ 14.50 and 245A.07.

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

3. Minn. Stat. § 626.5572, subdivision 17, in relevant part, defines maltreatment by neglect as:

(1) 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:

⁵³ Ex. 8 at DHS 66.

⁵⁴ *Id.*

⁵⁵ Ex. 30 at Q-DHS 268

⁵⁶ Ex. 10 at DHS 91.

(2) 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

(3) which is not the result of an accident or therapeutic conduct.

4. Quail Creek failed to provide AP with reasonable and necessary supervision to maintain his health and safety, considering his mental capacity, particularly, his suicidal ideation and multiple attempts to injure himself. The ALJ declines to accept People's position that the suicidal attempt on October 5, 2010 was unexpected or an unforeseeable accident.

5. Quail Creek was aware of AP's history of self-injurious thoughts and behaviors. It incorporated this fact in AP's IAPP because, among other reasons, of his previous suicidal ideation on September 5, 2010. Quail Creek did not relay the September 5, 2010 incident to RKS. This information should have been conveyed to her by Quail Creek during training.

6. RKS learned of the September 5, 2010 incident from VW during their telephone conversation prior to AP's attempted suicide on October 5, 2010. RKS also knew that the month of October was a difficult time for AP because it was the anniversary month of his accident and resulting injury. RKS was also aware as of October 2, 2010, that AP was feeling depressed and requested professional intervention.

7. Because of her lack of experience and lack of appropriate training, RKS failed to recognize the critical significance of this information, failed to notify her more experienced coworker of VW's phone call, and failed to provide the appropriate and reasonable supervision that AP and the circumstances required.

8. Quail Creek was on notice that AP had exhibited dangerous and potentially suicidal behavior prior to dinner with his grandmother when VW called the facility and informed RKS of these facts. Quail Creek failed to respond to VW's report and failed to implement the procedure in AP's IAPP. The staff did not assess AP's suicidal ideation and determine whether a safety contract was necessary or implement the continuous monitoring as contemplated by his IAPP.

9. RKS's coworker, SD, articulated Quail Creek's customary action under these circumstances. She said, "[had we known] we would have been on him constantly, no time alone, that is what we usually do when we have clients in crisis. I could have skipped 1:1 [one on one with another client] to help him [AP] or [RKS]...."

10. The telephone conversation between VW and RKS occurred roughly between 7:00 p.m. and 7:30 p.m. The police were called at 8:17 p.m. RKS had approximately 47 minutes to inform SD of VW's concerns. Even assuming *arguendo* that RKS did not have enough time to relate this information to SD, Quail Creek still had

an obligation to provide AP with appropriate and reasonable supervision under the existing circumstances.

11. The Department has established by a preponderance of the evidence that People committed, and is responsible for, maltreatment by neglect of AP on October 5, 2010.

12. Minn. Stat. § 245A.07, subdivision 3(c), in relevant part, states:

(4) Fines shall be assessed as follows: the license holder shall forfeit \$1,000 for each determination of maltreatment of a child under section 626.556 or the maltreatment of a vulnerable adult under section 626.557 for which the license holder is determined responsible for the maltreatment under section 626.556, subdivision 10e, paragraph (i), or 626.557, subdivision 9c, paragraph (c)....

13. Given the finding of maltreatment by neglect, People is subject to a fine of \$1,000 under Minn. Stat. § 245A.07, subdivision 3(c)(4).

RECOMMENDATION

IT IS RECOMMENDED that the Commissioner AFFIRM the Department's Determination of Maltreatment and Order to Forfeit a Fine.

Dated: February 21, 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

This matter involves a finding by the Department of maltreatment of AP, an 18-year-old vulnerable adult by Quail Creek on October 5, 2010. AP suffers from severe depression and ataxia. The ataxia makes AP unstable, susceptible to falling, and he is unable to complete the grooming tasks of daily living because of hand tremors.

AP is understandably frustrated because of a 2008 accident and his resulting disability. He has a history of self-injury requiring hospitalization and suicidal ideation before being admitted to Quail Creek in August 2010. On September 8, 2010, after a trip to Target with Quail Creek staff, and having consumed coffee and smoked cigarettes, AP was somewhat agitated upon his return to the facility. AP indicated that he wanted to go outside for fresh air, and staff suggested that he go onto the second floor deck because it was late and would make monitoring him easier.

AP proceeded onto the deck and was followed by SD. AP stood up onto a chair that was next to the railing as if attempting to jump over. Staff took AP by the hand and directed him down and back into the facility. AP went to bed shortly thereafter. The staff prepared an Incident Report indicating that AP experienced psychiatric decompensation, including suicidal ideation.

Two days later, on September 10, 2010, Quail Creek, along with AP's parents and his county case manager, conducted and developed a Vulnerable Adult Risk Assessment and Individual Abuse Prevention Plan (IAPP). Procedures were developed

to address AP's suicide ideation and/or suicide attempts. These procedures included an immediate suicide assessment, an offer of a safety contract, and close monitoring.

RKS began her employment as a Mental Health Rehabilitation Worker at Quail Creek on September 30, 2010. People normally provides extensive training for its employees regarding a wide variety of subjects, including training regarding compliance with the Vulnerable Adults Act. People also normally provides employees with specific training that covers the needs of the particular residents including their Individual Abuse Prevention Plan.

The record indicates that People provided eight hours of training to RKS before she started at Quail Creek, including a section on the general requirements of the Vulnerable Adults Act. However, because she was considered a temporary employee and staffing at Quail Creek was short-handed, minimal training was provided to her while she was there.

RKS indicated that she worked three four-hour shifts, or twelve hours, with the residents of Quail Creek before AP's suicide attempt on October 5, 2010. RKS indicated that she received "quick training" which consisted of reading training materials in the presence of a supervisor and on her own. RKS estimated that she used about a third of her time on duty to reading training materials. The rest of her training was on-the-job. She did not receive training relative to responding to a resident that is exhibiting dangerous or risky behavior and there is nothing in the record that she was provided AP's IAPP or that of any of the other residents at Quail Creek. Quail Creek did not advise her of the September 8, 2010 suicide attempt.

Her supervisor, MD, indicated that a new employee typically shadows the supervisor for a shift and shadows a co-employee a second shift before s/he starts a shift on their own. RKS did not receive this supervised training. RKS further indicated that she felt she was under qualified because she had less hours of experience than is typically required for her position. There is ample support in the record for the conclusion that RKS was not trained as thoroughly as she should have been considering the needs of the residents and her lack of experience.

On October 2, 2010, RKS became aware that AP's depression was worsening and of his request that he be provided professional intervention. The record is not clear whether Quail Creek acted on this request. On October 5, 2010, RKS, in her phone conversation with VW, became aware of the September 8, 2010 episode on the deck railing and that AP had caused a dangerous situation on Highway 65 requiring the police; which VW described to her as a suicide attempt.

RKS took no specific action to inform the more experienced staff of the call or provide AP with the required close monitoring much less the "arm's length" supervision which she indicated to VW she would provide. RKS was not aware of AP's IAPP so she could not have specifically complied with it.

RKS's more experienced coworker, SD, suggested reasonable supervision under the circumstances in this matter. She said that if RKS had informed her of VW's conversation, "we would have been on him constantly, no time alone, that is what we usually do when we have clients in crisis. I could have skipped 1:1 [one on one with another client] to help him [AP] or [RKS]...." The ALJ adopts this as a reasonable standard. The ALJ concludes that the Department has met its burden of proof by a preponderance of the evidence in establishing maltreatment by neglect because Quail Creek failed to meet its supervising responsibility to AP.

The ALJ rejects People's suggestion that because AP returned from dinner on the evening of October 5 appearing to be in a good mood and evincing no erratic behavior that this absolves them from their responsibility to properly supervise AP. In effect, this argument begs that the information RKS received that evening to be ignored.

Apparently, RKS did not understand the significance of the telephone call or simply forgot to tell SD about it in favor of pursuing her routine duties of vacuuming and other chores. In either case, Quail Creek failed to provide AP with the reasonable supervision he was entitled to under the circumstances and its failure constitutes maltreatment by neglect.

M. J. C.