STATE OF MINNESOTA
IN COURT OF APPEALS
A17-0310

In the Matter of the Appeal by Angela Khanai of the Maltreatment Determinations, Orders of Disqualification, Order to Pay a Fine, and Orders of Revocation.

Filed December 26, 2017
Affirmed
Reilly, Judge

Minnesota Department of Human Services
OAH Docket No. 14-1800-32758

Mary E. Cincotta, Throndset Michenfelder, LLC, St. Michael, Minnesota (for relator Angela Khanai)

Lori Swanson, Attorney General, Kathleen M. Ghreichi, Assistant Attorney General, St. Paul, Minnesota (for respondent Commissioner of Human Services)

Considered and decided by Worke, Presiding Judge; Rodenberg, Judge; and Reilly, Judge.

U N P U B L I S H E D O P I N I O N

REILLY, Judge

Relator challenges the commissioner of human services' decision affirming three maltreatment determinations, disqualifying relator from administering department of human services' (DHS) programs, and revoking relator's licenses to operate a foster-care home. Because the decision was based on substantial evidence in the record, we affirm.

FACTS

In 2015, relator Angela Khanai operated a foster-care home for two vulnerable adults (VAs, singularly VA1 and VA2) at her residence. That summer, DHS received three reports of maltreatment at relator's facility. DHS investigated the reports and found substantiated maltreatment for all three incidents. First, DHS determined relator secured her front door shut with a bungee cord and periodically locked the door to the VAs' living area in the lower level, which limited their free access to all the living areas in the residence. Second, DHS determined relator failed to keep adequate records of the VAs' medications, and DHS could not verify that the VAs had received their proper medications for a period of three months. Third, DHS determined relator failed to assist a VA after a nighttime bout with diarrhea.

DHS found that the maltreatment was recurring and disqualified relator from any position allowing direct contact with or access to persons receiving services from DHS-licensed programs. The commissioner also revoked relator's license to provide adult foster care and home- and community-based services.

On review, the administrative-law judge (ALJ) concluded that DHS proved each incident of relator's maltreatment of the VAs by a preponderance of the evidence. The ALJ found the maltreatment to be recurring and found that DHS properly disqualified relator from direct contact with persons receiving DHS services. The ALJ concluded that relator failed to prove by a preponderance of the evidence that she was in full compliance with the law during the incidents of maltreatment. The ALJ also determined that relator did not comply with the applicable laws or rules and that relator's license revocation was

justified. Relator did not testify at the ALJ hearing and offered only one exhibit, which was included to impeach VA1's testimony.

The commissioner adopted the ALJ's findings of fact and conclusions of law and issued her decision. The commissioner affirmed the maltreatment determinations, relator's disqualification, and the license revocations. The commissioner also denied relator's request for reconsideration. This appeal follows.

D E C I S I O N

Relator challenges the commissioner's findings as lacking the support of substantial evidence in the record. On review of an agency decision in a contested case, this court may reverse or remand if the decision is unsupported by substantial evidence in view of the entire record as submitted. Minn. Stat. § 14.69(e) (2016). A contested case is any proceeding before an agency in which the "legal rights, duties, or privileges of specific parties are required by law . . . to be determined after an agency hearing." Minn. Stat. § 14.02, subd. 3 (2016). Maltreatment determinations and disqualifications for recurring maltreatment are contested cases, because they are entitled to an agency hearing for review. Minn. Stat. § 256.045, subds. 3(4), 3(10) (2016).

This court will reverse a commissioner's decision if it is unsupported by substantial evidence in the record. *Sweet v. Comm'r of Human Servs.*, 702 N.W.2d 314, 318 (Minn. App. 2005), *review denied* (Minn. Nov. 15, 2005). Substantial evidence is: "(1) such relevant evidence as a reasonable mind might accept as adequate to support a conclusion; (2) more than a scintilla of evidence; (3) more than some evidence; (4) more than any evidence; and (5) evidence considered in its entirety." *Dourney v. CMAK Corp.*, 796

N.W.2d 537, 539 (Minn. App. 2011) (quotation omitted). An administrative agency's decision enjoys a presumption of correctness, and the appellate court defers to the agency's expertise and special knowledge in its field. *In re Cities of Annandale & Maple Lake*, 731 N.W.2d 502, 513-14 (Minn. 2007).

I.

A Minnesota Statute defines maltreatment as including "abuse" and "neglect." Minn. Stat. § 626.5572, subd. 15 (2016). "Abuse" is "[c]onduct which is not an accident or therapeutic conduct . . . which produces or could reasonably be expected to produce physical pain or injury or emotional distress." *Id.*, subd. 2(b) (2016). Such conduct could include "use of repeated or malicious . . . language . . . considered . . . to be disparaging, derogatory, humiliating, harassing, or threatening" and "use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion . . . ." *Id.*, subds. 2(b)(2)-(3). "Neglect" is "[t]he failure or omission of a caregiver to supply a vulnerable adult with care or services, including . . . health care[] or supervision which is . . . reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety. . . ." *Id.*, subd. 17(a)(1) (2016). Additionally, under licensing standards, residential-care residents must have "use of and free access to common areas in the residence." Minn. Stat. § 245D.04, subd. 3(b)(3) (2016).

There is substantial evidence in the record to support each of the commissioner's three maltreatment determinations.

First, DHS documentation, DHS investigator testimony, and VA1's testimony support the commissioner's maltreatment determination that relator limited the VAs' free

access to the living areas in the residence. According to the evidence, relator routinely locked the door from the basement to the upstairs living area, denying the VAs "free access to common areas in the residence." *Id.* The use of a chair and an alarm system to block access to the kitchen and the main floor during the night also limited "free access." *Id.* The front door tethered with a bungee cord prevented "free access" to and from the front entrance of the house. *Id.* Further, relator told VA1 that she should not use the bathroom upstairs because she was dirty and smelly. VA2 reported not feeling accepted while living there. Confining the VAs to the bottom floor of a residence is not acceptable conduct for a foster-care provider under Minnesota law. Substantial evidence in the record supports this maltreatment determination.

Second, DHS documentation, DHS investigator testimony, pharmacy records, and relator's own documentation of the VAs' medical care support the commissioner's maltreatment determination that relator failed to administer necessary health care to the VAs. Under Minnesota law, a residential-care license-holder must record a VA's medication on their medication administration record (MAR) for each medication administered. Minn. Stat. § 245D.05, subd. 2(c)(1-5) (2016). The VAs in this case were prescribed antipsychotics, antidepressants, and antianxiety medications, among others. There is evidence in the record that relator did not administer the correct medications to the VAs. Relator completed MARs for March and some of April, but not May, June, or July. Even where relator completed an MAR, numerous medications were missing from the record, and the commissioner fairly inferred that the medications were not administered. Relator failed to keep adequate records or provide the VAs the correct

medications, which provides substantial evidence of "neglect," or, the "absence of care . . . essential to obtain or maintain the vulnerable adult's health . . . ." Minn. Stat. § 626.5572, subd. 17(b) (2016). Substantial evidence in the record supports this maltreatment determination.

Finally, DHS documentation, DHS investigator testimony, and VA1's testimony supports the commissioner's maltreatment determination that relator failed to assist VA1 after a nighttime bout of diarrhea. "Neglect" is "[t]he failure or omission by a caregiver to supply a vulnerable adult with care or services, including . . . health care[] or supervision which is . . . reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety . . . ." *Id.*, subd. 17(a)(1). The evidence establishes that relator did not assist VA1 after she woke up in the middle of the night covered in diarrhea. Relator told VA1 to take a shower and to leave her bedding in the bathtub. VA1's care plan described how she would need assistance while bathing, which is such "supervision which is . . . reasonable and necessary to . . . maintain the [VA's] physical or mental health or safety . . . ." *Id.*; *see also* Minn. Stat. § 626.557, subd. 14 (2016) (requiring a caregiver to provide care outlined in a resident's care plan). VA1 reported being in the shower for 45 minutes, because it took a long time to wipe and clean all of the diarrhea from her body. Relator did not assist VA1 with bathing or changing her bed linens. Substantial evidence in the record supports this maltreatment determination.

Relator did not testify or present meaningful evidence at the ALJ hearing. As a result, DHS presented most of the evidence. Viewing the record as a whole, there is no

evidence controverting the commissioner's findings, and we conclude that there is substantial evidence in the record to support the decision.

II.

Relator challenges the commissioner's failure to provide a conditional license or other equitable relief. Under Minn. Stat. § 245A.07, subd. 1 (2016), the commissioner may revoke a license when the license-holder does not comply with the applicable law. When deciding whether to invoke sanctions, the commissioner must consider the "nature, chronicity, or severity" of the violations and the effect on the persons served by the license-holder. *Id.*; *see also* Minn. Stat. § 245C.02, subd. 16 (2016) (defining "recurring maltreatment" as more than one incident of maltreatment for which the person is responsible); Minn. Stat. § 245C.15, subd. 4(b)(2) (2016) (disqualifying an individual from working with DHS clients for seven years after substantiated recurring maltreatment). We presume the agency's decision is correct and show deference to an agency's conclusion in an area of its expertise. *W. McDonald Lake Assoc. v. Minn. Dep't of Nat. Res.*, 899 N.W.2d 832, 837 (Minn. App. 2017) (quotation omitted). We will reverse a commissioner's decision if it is not supported by substantial evidence in the record. *Sweet*, 702 N.W.2d at 318.

Relator offers no factual or legal support for her argument that the commissioner erred by failing to grant a conditional license or other equitable relief. Relator simply lists the alternative penalties available to the commissioner without providing any reasons why they should have been imposed. *See* Minn. Stat. § 245A.06, subd. 1 (2016) (describing correction orders and conditional licenses as alternative penalties for failing to comply with

the applicable law). Relator makes no arguments about the "nature, chronicity, or severity" of the maltreatment episodes. Minn. Stat. § 245A.07, subd. 1. The commissioner did not err by revoking relator's licenses to operate a residential-care home, and we affirm the decision.

Affirmed.