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**STATE OF MINNESOTA
IN COURT OF APPEALS
A17-1425**

In the Matter of Julitta Adu-Gyamfi,
R.N., L.P.N., R.N. License No. 184096-8,
L.P.N. License No. 58788-2.

**Filed June 4, 2018
Affirmed
Klaphake, Judge***

Minnesota Board of Nursing
File No. OAH 68-0904-33654

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Considered and decided by Ross, Presiding Judge; Reilly, Judge; and Klaphake,
Judge.

UNPUBLISHED OPINION

KLAPHAKE, Judge

Relator Julitta Adu-Gyamfi challenges a decision by respondent Minnesota Board
of Nursing placing limitations and conditions on her nursing licenses based on the board's
findings that relator violated requirements of the Minnesota Nurse Practice Act, Minn. Stat.

* Retired judge of the Minnesota Court of Appeals, serving by appointment pursuant to
Minn. Const. art. VI, § 10.

§§ 148.171-.285 (2016). Relator asserts that (1) the board improperly initiated a disciplinary hearing against her without a verified written complaint; (2) the board's decision was unsupported by substantial evidence, arbitrary and capricious, and a violation of due process because it was based primarily on hearsay evidence and speculation; and (3) the board violated due process by considering the Administrative Law Judge's (ALJ) order and costs at the same hearing. Because the hearing process satisfied due-process requirements and the board's decision is supported by substantial evidence and not arbitrary or capricious, we affirm.

D E C I S I O N

“[D]ecisions of administrative agencies enjoy a presumption of correctness, and deference should be shown by courts to the agencies' expertise and their special knowledge in the field[s] of their technical training, education, and experience.” *Reserve Mining Co. v. Herbst*, 256 N.W.2d 808, 824 (Minn. 1977). But an appellate court reviewing an agency decision may reverse or modify “the decision if the substantial rights of the petitioners may have been prejudiced” because the administrative decision was (1) based on unlawful procedure, (2) affected by an error of law, (3) unsupported by substantial evidence in view of the entire record, or (4) arbitrary or capricious. Minn. Stat. § 14.69 (2016). “The relator has the burden of proof when challenging an agency decision” *Minn. Ctr. for Env'tl. Advocacy v. Minn. Pollution Control Agency*, 660 N.W.2d 427, 433 (Minn. 2003).

“In reviewing an agency's decision on a legal issue, this court is not bound by the agency's ruling.” *In re Revocation of the Family Child Care License of Burke*, 666 N.W.2d 724, 726 (Minn. App. 2003). “A reviewing court must defer to the agency's fact-finding

process and be careful not to substitute its findings for those of the agency.” *Id.* A reviewing court does not retry facts or make credibility determinations, but must defer to an agency’s credibility determinations. *In re Appeal of Rocheleau*, 686 N.W.2d 882, 891 (Minn. App. 2004), *review denied* (Minn. Dec. 22, 2004).

I.

Relator argues that the board’s order should be reversed because the panel failed to provide a verified complaint before initiating the contested case against relator. “Before scheduling a contested case hearing, the executive director or executive secretary [of a health-related licensing board] must have received a verified written complaint from the complaining party.” Minn. Stat. § 214.10, subd. 2 (2016).

In October 2015, the board received a written complaint against relator, who was employed by a home-care agency; the complaint was signed and submitted to the board by H.M., who was initially relator’s supervisor and became her clinical manager in 2015. In July 2016, the board began a contested case proceeding against relator. The notice of hearing that the board provided to relator spelled out the violations of the nursing practice act alleged against relator and the conduct underlying those allegations. It was also supplemented by documents in her employment file relating to her substandard nursing practice and unprofessional conduct. Because relator was provided adequate notice of the allegations against her, the lack of a verified complaint is not a ground for reversal. *See Midway Ctr. Assocs. v. Midway Ctr., Inc.*, 306 Minn. 352, 356, 237 N.W.2d 76, 78 (Minn. 1975) (stating that “error without prejudice is not ground for reversal”).

II.

Substantial evidence

A decision is supported by substantial evidence when it is supported by (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; or (5) the evidence considered in its entirety.

Minn. Ctr. for Env'tl. Advocacy v. Minn. Pollution Control Agency, 644 N.W.2d 457, 464 (Minn. 2002).

Relator argues that the evidence was hearsay and, therefore, does not meet the substantial-evidence standard. In an administrative hearing, the ALJ “may admit all evidence which possesses probative value, including hearsay, if it is the type of evidence on which reasonable, prudent persons are accustomed to rely in the conduct of their serious affairs.” Minn. R. 1400.7300, subp. 1 (2017). Hearsay evidence was admitted through relator’s supervisor, A.S., regarding complaints by coworkers about relator not keeping schedules up to date, improperly administering medication through an intravenous (IV) port, and failing to timely document patient statuses. Emails and testimony about emails by coworkers who did not testify at the hearing were also admitted. The emails included complaints about relator’s late documentation, charting deficiencies, failure to schedule a patient for a blood draw, failure to correct a “start of care” plan for a patient despite repeated requests to do so, and complaints received by coworkers from patients.

The hearsay evidence was corroborated by nonhearsay evidence. On January 15, 2013, A.S., relator’s clinical manager through 2014, wrote a supervisor/manager

documentation note stating that she had called relator repeatedly to chart lab test results for a patient's potassium level. A.S. explained that potassium levels are important because abnormal levels can indicate cardiac problems. On January 16, A.S. called relator about missing documentation in patient charts for January.

In March 2013, A.S. drafted a corrective-action plan for relator due to her failure to complete documentation on time. A.S. gave relator a verbal warning, removed relator from her case manager position, and demoted her to a visiting nurse position. A.S. directed relator to complete patient charting within 24 hours and to timely complete patient admission documentation. A.S. explained that untimely and incorrect documentation impacts patient care because other staff cannot complete their documentation, see doctors' orders, or know when to see a patient.

T.V., relator's supervisor who testified at the hearing, emailed A.S. in August 2014 about relator's failure to timely complete and close a patient's chart, which resulted in another nurse being unable to determine whether another blood draw had been ordered for the patient, who was on a blood thinner.

On August 18, 2015, A.S. drafted a second corrective-action plan for relator. The plan stated that relator failed to communicate with case managers and patients in a timely manner, that case managers had complained that relator's patient reports were untimely, her documentation was incomplete, and she was not following up after patient visits. A.S. gave relator a written warning, stating that failure to meet the performance-improvement goals could result in further corrective action, including termination.

On October 2, 2014, A.S. drafted a third corrective-action plan for relator. The plan stated that patients had reported that they did not want relator for their nurse because relator was rude and unpleasant, was late for home visits, and did not call when she was going to be late.

On November 17, 2014, A.S. drafted a fourth corrective-action plan due to discrepancies on relator's timecard. Relator's timecard had discrepancies when compared to completed documentation in medical records, and she over-reported the number of patient visits she had completed.

On May 21, 2015, H.M., relator's clinical manager, met with relator to discuss her continuing documentation deficiencies. H.M. testified that relator's failure to complete documentation in a timely manner prevented the home-care agency from knowing when later visits should be scheduled and which providers to send to a patient's home for follow-up visits. H.M. explained that the lack of documentation prevented other nurses from preparing for their visits because there was no guidance on physician's follow-up orders. On May 29, 2015, H.M. again met with relator about her documentation deficiencies.

There was testimony about the transfer of relator's case manager load to M.M. M.M. testified that relator's charting for some patients was incomplete, including discharge summaries for three patients. H.M. testified that relator's transition of patient care was dangerous and that in one case, relator's failure to enter wound-care orders or information about a blood draw could have led to a patient's death.

After relator resigned, H.M. went through relator's supplies and found contaminated bloody syringes and needles in a plastic bag. The home-care agency's disposal policy

required that leftover blood in a syringe be deposited into a contained waste tube and that the waste tube, syringes, and needles be disposed of properly.

Relator cites *Pietsch v. Minn. Bd. of Chiropractic Exam'rs*, 683 N.W.2d 303, 309 (Minn. 2004) (reversing summary disposition that appellant engaged in unprofessional conduct when there was no evidence beyond mere assertions to support a conclusion that his solicitation methods were “unethical, deceptive and harmful to the public”); *In re Wang*, 441 N.W.2d 488, 494-95 (Minn. 1989) (reversing a violation finding when the only evidence linking the appellant to prescription refills was an unsubstantiated notation on a pharmacy record and the investigator’s testimony that appellant admitted authorizing the refills); and *In re Expulsion of E.J.W.*, 632 N.W.2d 775, 782 (Minn. App. 2001) (reversing expulsion when the only evidence connecting the appellant to the bomb threat was the officers’ testimony about what they were told by students).

In the cases relied on by relator, there was minimal or no evidence corroborating the hearsay evidence. Here, although the evidence about relator’s violations was to some extent hearsay, the hearsay evidence was corroborated by A.S.’s testimony about the corrective-action plans; the testimony of H.M., M.M., and T.V.; documents produced by relator’s supervisors that were discussed with and signed by relator; patient medical records; and the evidence about the contaminated items found in relator’s supplies.

The board determined that:

[B]y failing to timely and adequately document her nursing care, including lab test results and doctors’ orders, and by improperly disposing of used syringes, [relator] failed to perform nursing with reasonable skill and safety in violation of Minn. Stat. § 148.261, subd. 1(5); by failing to timely and

adequately document her nursing care and by improperly disposing of used syringes, [relator] engaged in unprofessional conduct that failed to conform to minimal standards of acceptable and prevailing nursing practice and created a danger to patients' health and safety in violation of Minn. Stat. § 148.261, subd. 1(6); by failing to timely and adequately document her nursing care, [relator] improperly managed patient records in violation of Minn. Stat. § 148.261, subd. 1(16); by engaging in unprofessional conduct, [relator] violated a state law relating to the practice of nursing in relator's licenses violation of Minn. Stat. § 148.261, subd. 1(18).

Viewing the record in its entirety, substantial evidence supports the board's findings, and those findings support its conclusions on relator's violations of the nursing practice act.

Arbitrary and capricious

[A]n agency ruling is arbitrary and capricious if the agency (a) relied on factors not intended by the legislature; (b) entirely failed to consider an important aspect of the problem; (c) offered an explanation that runs counter to the evidence; or (d) the decision is so implausible that it could not be explained as a difference in view or the result of the agency's expertise.

Citizens Advocating Responsible Dev. v. Kandiyohi Cty. Bd. of Comm'rs, 713 N.W.2d 817, 832 (Minn. 2006). An agency decision is arbitrary or capricious if the decision is based on whim or is devoid of articulated reasons. *CUP Foods, Inc. v. City of Minneapolis*, 633 N.W.2d 557, 565 (Minn. App. 2001), *review denied* (Minn. Nov. 13, 2001).

Relator argues that less stringent conditions should have been imposed on her licenses. When a licensed professional breaches professional standards, "the nature and duration of the discipline is best determined by his or her fellow professionals, who are in a superior position to evaluate the breaches of trust and unprofessional conduct."

Padilla v. Minn. State Bd. Of Med. Exam'rs, 382 N.W.2d 876, 886-87, review denied (Minn. Apr. 24, 1986). The legislature has conferred on the board, not the ALJ, the discretion to determine the type of discipline to impose. *Id.*

The board placed the following conditions on relator's licenses (1) prohibiting her from working in home care, group homes, assisted-living facilities, schools, or through temporary placement agencies; (2) requiring that she attend seven hours of continuing education with a nurse consultant to address time management, documentation standards, infection control, and therapeutic communications; (3) requiring that she follow the consultant's recommendations; (4) requiring relator to provide the board with a report on what she learned through the instruction; and (5) requiring quarterly reports from relator's nursing supervisor. Because all of these conditions are either related to the deficiencies in her performance of nursing or means of monitoring her performance to guard against future deficiencies, the conditions are not arbitrary or capricious.

Due process

Due-process protections include reasonable notice, a timely opportunity for a hearing, the right to be represented by counsel, an opportunity to present evidence and argument, the right to an impartial decision-maker, and the right to a reasonable decision based solely on the record. Full due-process requirements, however, do not attach to a general fact-finding investigation conducted by an agency.

Humenansky v. Minn. Bd. of Med. Exam'rs, 525 N.W.2d 559, 565 (Minn. App. 1994).

We have already addressed relator's argument that the board's order was based on unreliable hearsay. A three-day hearing was conducted at the Office of Administrative Hearings (OAH), and relator had the opportunity to present evidence and confront and

cross-examine witnesses. After the ALJ issued the recommended order, the relator was afforded the opportunity to submit exceptions and present written and oral arguments to the board. The board's hearing process satisfied due-process requirements.

III.

Minn. Stat. § 148.262, subdivision 4, states:

Any person whose license or registration has been revoked, suspended, or limited may have the license reinstated and a new registration issued when, in the discretion of the board, the action is warranted, provided that the person shall be required by the board to pay the costs of the proceedings resulting in the revocation, suspension, or limitation of the license or registration certificate and reinstatement of the license or registration certificate, and to pay the fee for the current registration period.

Relator contends that she was denied due process because the board considered the ALJ's order and costs at the same hearing.¹ Relator was provided with a copy of the panel's statement of costs which included itemized invoices, and relator had the opportunity to object to, and did object to, the statement of costs. See *Proetz v. Minn. Bd. of Chiropractic Exam'rs*, 382 N.W.2d 527, 533 (Minn. App. 1986) (affirming imposition of costs for ALJ's services and court reporter without a hearing when relator had the opportunity to object to

¹ Relator mischaracterizes the order for costs as a "civil penalty" under Minn. Stat. § 148.262, subd. 1(6), which states that the board may:

[I]mpose a civil penalty not exceeding \$10,000 for each separate violation, the amount of the civil penalty to be fixed as to deprive the nurse of any economic advantage gained by reason of the violation charged, to reimburse the board for the cost of counsel, investigation, and proceeding, and to discourage repeated violations.

imposition of costs but failed to do so). Here, the board had a proper basis for assessing the costs, and the relator had the opportunity to be heard on the issue. The board's consideration of the ALJ's order and costs at the same hearing satisfied due-process requirements.

Affirmed.