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Minn. Stat. § 480A.08, subd. 3 (2018).*

**STATE OF MINNESOTA
IN COURT OF APPEALS
A18-1926**

In the Matter of the Appeal by
Eriksmoen Cottages of St. Cloud, LLC
(License Nos. 1071214 and 1078291)
of the Determination of Maltreatment
and Order to Pay a Fine.

**Filed June 24, 2019
Affirmed
Halbrooks, Judge**

Minnesota Department of Human Services
File No. 34613

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relator Eriksmoen Cottages)

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Minnesota (for respondent Minnesota Department of Human Services)

Considered and decided by Johnson, Presiding Judge; Halbrooks, Judge; and
Peterson, Judge.*

UNPUBLISHED OPINION

HALBROOKS, Judge

Relator Eriksmoen Cottages of St. Cloud, LLC challenges the determination of the
Commissioner of the Minnesota Department of Human Services that respondent Minnesota

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

Department of Human Services (DHS) met its burden to establish by a preponderance of the evidence that Eriksmoen committed maltreatment by neglect of one of its residents. Because the record contains substantial evidence to support the commissioner's decision, we affirm.

FACTS

V.A.¹ has resided at one of Eriksmoen's facilities since December 2014. V.A. suffers from several medical conditions, including an ulcer, chronic pain, and depression. V.A. requires assistance with many activities of daily living due to paralysis on the left side of his body following a stroke.

In July 2017, following an investigation, DHS determined that Eriksmoen was responsible for maltreatment by neglect of V.A. because staff members repeatedly failed to follow V.A.'s care plan for minimizing his choking risk in two ways: (1) by allowing him to eat meals while he was lying down in his bed and (2) by not calling 911 immediately, or at all, when he choked on his food. This determination was based primarily on a choking incident that occurred at the residential home in May 2016. But during the course of the investigation, DHS learned that V.A. had also choked under similar circumstances on two prior occasions. Eriksmoen appealed the determination.

In October 2017, following a separate investigation, DHS issued a second determination of maltreatment by neglect of V.A. based on a finding that Eriksmoen staff

¹ DHS's brief and the commissioner's order both refer to the resident as V.A., i.e., vulnerable adult. The administrative-law judge (ALJ) in this case issued an order sealing the majority of the exhibits, reasoning that they contain confidential information of non-party vulnerable adults. Therefore, we will also refer to the resident as V.A.

members failed to follow V.A.'s care plan for minimizing his choking risk during an August 2017 incident by not staying in the room with V.A. while he ate after V.A. refused to sit up in his bed. Eriksmoen also appealed this determination.

DHS consolidated Eriksmoen's appeals, and a contested evidentiary hearing was held before an ALJ. Event reports from the choking incidents, V.A.'s file and care plans, Eriksmoen's internal reviews of the May 2016 and August 2017 incidents, training records of staff members, and notes from DHS investigators' interviews with Eriksmoen staff members and V.A. were admitted into evidence. DHS investigators Marie Tierney and Scott Broady testified on behalf of DHS. Eriksmoen did not call any witnesses.

The ALJ issued findings of fact, conclusions of law, and a recommendation. The ALJ determined that DHS failed to prove by a preponderance of the evidence that Eriksmoen was responsible for maltreatment by neglect of V.A. and recommended that the commissioner rescind the July 2017 and October 2017 determinations and orders to pay a fine. DHS filed exceptions to the ALJ's recommendation. Eriksmoen responded, requesting that the commissioner adopt the ALJ's recommendation.

In October 2018, the commissioner issued a final order. The commissioner departed from the ALJ's recommendation and affirmed both departmental determinations of maltreatment by neglect arising from the choking incidents.² Eriksmoen appeals.

² The commissioner also reversed a determination of maltreatment by emotional abuse of V.A. arising from an allegation that Eriksmoen staff refused to provide V.A. with a bedpan. Neither party appeals this portion of the commissioner's order.

DECISION

Eriksmoen argues that the commissioner's decision, with respect to both the July 2017 and October 2017 maltreatment determinations, is unsupported by the evidence.

Agency decisions “enjoy a presumption of correctness” and “deference should be shown by courts to the agencies’ expertise and their special knowledge in the field of their technical training, education, and experience.” *In re Excess Surplus Status of Blue Cross & Blue Shield of Minn.*, 624 N.W.2d 264, 278 (Minn. 2001) (quotation omitted). Agency decisions “may be reversed only when they are arbitrary and capricious, exceed the agency’s jurisdiction or statutory authority, are made upon unlawful procedure, reflect an error of law, or are unsupported by substantial evidence in view of the entire record.” *In re Revocation of Family Child Care License of Burke*, 666 N.W.2d 724, 726 (Minn. App. 2003); *see also* Minn. Stat. § 14.69 (2018). We will affirm an agency’s decision if the commissioner engaged in “reasoned decisionmaking,” even if this court would have reached a different conclusion. *Cable Commc’ns Bd. v. Nor-West Cable Commc’ns P’ship*, 356 N.W.2d 658, 669 (Minn. 1984). We defer to the agency’s factual findings, but review *de novo* the interpretation and application of statutes to the undisputed facts. *Mattice v. Minn. Prop. Ins. Placement*, 655 N.W.2d 336, 340 (Minn. App. 2002), *review denied* (Minn. Mar. 18, 2003).

The commissioner is not required to give deference to an ALJ’s recommendation, so long as the commissioner’s decision is explained and supported by substantial evidence. *See Excess Surplus*, 624 N.W.2d at 267, 274, 279; *see also* Minn. Stat. § 245A.08, subd. 5 (2018). Substantial evidence has been defined as ““(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.” *Dourney v. CMAK Corp.*, 796 N.W.2d 537, 539 (Minn. App. 2011) (quoting *Minn. Ctr. for Env’tl. Advocacy v. Minn. Pollution Control Agency*, 644 N.W.2d 457, 466 (Minn. 2002)). Our standard of review “is not heightened when the final decision of the agency decision-maker differs from the recommendation of the ALJ.” *In re Excelsior Energy Inc.*, 782 N.W.2d 282, 289 (Minn. App. 2010).

V.A. is protected by the Minnesota Vulnerable Adults Act. Minn. Stat. § 626.5572, subd. 21(a)(1) (2018); *see generally* Minn. Stat. §§ 626.557-.5572 (2018). The act defines maltreatment by neglect of a vulnerable adult as:

- (a) [t]he 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.

Minn. Stat. § 626.5572, subd. 17(a). Therapeutic conduct “means the provision of program services, health care, or other personal care services done in good faith in the interests of the vulnerable adult.” *Id.*, subd. 20. “[A] vulnerable adult is not neglected for the sole reason that: (1) the vulnerable adult . . . refuses consent or withdraws consent, . . . within the boundary of reasonable medical practice, to any therapeutic conduct.” *Id.*, subd. 17(c)(1).

A. July 2017 Determination of Maltreatment

Eriksmoen contends that the commissioner's decision affirming the July 2017 maltreatment determination is erroneous because the record does not demonstrate that Eriksmoen staff members failed to follow V.A.'s care plan by serving him food and allowing him to eat while he was lying down in bed. Eriksmoen also contends that the allegations of maltreatment at issue in the contested hearing did not include whether 911 was called promptly or at all, and that, even if they did, the record does not contain any evidence of "repeated incidents when staff members of [Eriksmoen] failed to call 911 when [V.A.] choked."

We acknowledge that this is a close case. But we defer to an agency's expertise, and there is "relevant evidence as a reasonable mind might accept as adequate" to support the commissioner's decision. At the hearing before the ALJ, Tierney testified that, in the course of her investigation, she found "a pattern of multiple incidents of staff members giving [V.A.] a meal when he was in his bed and not necessarily in an upright position." She also testified that, "even after those incidents, when I interviewed staff members about what the current practice was of how meals were given to [V.A.], some of the staff members I talked to stated that they continued to serve meals to him when he was lying down in bed." The event report from the May 2016 incident states that staff members "served the supper to [V.A.] while he was in his room." Additionally, Eriksmoen's internal review of the May 2016 incident states that staff members erred because V.A. "should be sitting up while eating," which supports an inference that staff members served him food when he was not sitting up.

Eriksmoen’s assertion that the allegations of maltreatment at issue did not include whether staff members appropriately called 911 is refuted by DHS’s initial determination, which stated that Eriksmoen committed a violation when staff members “failed to follow the facility’s incident response policies and procedures when they did not call 9-1-1 after [V.A.] choked while eating” in April 2015 and January 2016. The record contains evidence that staff members did not call 911, promptly or at all, on more than one occasion when V.A. choked. Eriksmoen’s written policies and procedures on responding to and reporting incidents state that staff members should call 911 if a person is experiencing a medical emergency. Yet the event reports in the record indicate that 911 was not called during the April 2015 incident or the January 2016 incident and that only “nonemergency” medical assistance was called on the latter occasion. V.A.’s care plan, developed in January 2016, provided that staff members should “immediately dial 911” if V.A. were to choke, but the event report from the May 2016 incident states that staff members waited 30 minutes to call 911. Therefore, on this record, we must conclude that the commissioner’s decision is based on “reasoned decisionmaking” and is supported by substantial evidence.

Eriksmoen further contends that V.A. had the right to refuse to sit up to eat and the right to have services provided in a way that supported his preferences and that the commissioner’s order does not refer to the service-related rights of V.A., his refusal to consent to therapeutic conduct, or Eriksmoen’s obligation to provide “person-centered” therapeutic conduct. DHS responds that Eriksmoen’s failure to act does not constitute therapeutic conduct and that, even if V.A. preferred to eat in bed, the neglect was not solely the result of V.A.’s refusal to consent to therapeutic conduct.

We agree with DHS that the therapeutic-conduct exception is inapplicable here. Therapeutic conduct is defined as the “*provision* of program services, health care, or other personal care services done in good faith in the interests of the vulnerable adult.” Minn. Stat. § 626.5572, subd. 20 (emphasis added). Failure to provide services—in this case, failure to comply with V.A.’s care plan and Eriksmoen’s policies and procedures—does not satisfy the therapeutic-conduct exception to neglect. *See J.R.B. v. Dep’t of Human Servs.*, 633 N.W.2d 33, 38 (Minn. App. 2001), *review denied* (Minn. Oct. 24, 2001) (concluding that failure to check a patient’s vital signs cannot be considered therapeutic conduct).

We also agree that V.A.’s right to refuse therapeutic conduct is inapplicable. *See* Minn. Stat. § 245D.04, subd. 2(3) (2018) (providing a person’s service-related rights to include refusing services). The record with respect to the July 2017 determination is silent as to whether V.A. refused to sit up to be served meals. But even assuming that V.A. had refused to receive his food while sitting up, such refusal would not negate Eriksmoen’s neglect by failing to call 911 when appropriate.

B. October 2017 Determination of Maltreatment by Neglect

Eriksmoen contends that the commissioner’s decision affirming the October 2017 maltreatment determination is erroneous because the record demonstrates that Eriksmoen staff members acted in accordance with V.A.’s care plan during the August 2017 choking incident. Eriksmoen states that the sole dispute with respect to this determination is whether V.A. refused to sit up, which would have, under V.A.’s care plan, required a staff member to remain in the room with V.A. while he ate. Eriksmoen asserts that there is no

documentation in the record that V.A. refused to eat sitting upright and, therefore, a staff member was not required to remain with V.A.

While this, too, is a close case, there is adequate evidence in the record to support the commissioner's conclusions. Although staff members did not document that V.A. refused to sit up on the day of the August 2017 incident, the event report states that V.A. was eating in bed "with the head of his bed raised as much as [V.A.] would allow." V.A. told Broady, the DHS investigator, that he eats in bed "quite a bit" and, prior to the August 2017 incident, regularly ate lying down. V.A. also stated that he was lying in his bed "kind of halfway on my side" when he choked in August 2017. The staff member who served V.A. dinner that day told Broady that, when she left V.A. with the food, his bed was up but he was lying on his side. The staff member indicated that, even if the head of the bed is raised, V.A. positions himself lower in the bed and that he eats dinner in his bed every day. Based on this evidence, the commissioner could reasonably determine that V.A. refused to sit up and that a staff member was therefore required to remain in the room while V.A. ate. Consequently, we conclude that there is substantial evidence in the record to support the commissioner's decision.

Eriksmoen also advances the same arguments made in the context of the July 2017 determination with respect to Eriksmoen's obligation to respect V.A.'s preferences and V.A.'s right to refuse therapeutic conduct. DHS counters that staff members' failure to remain in the room with V.A. does not constitute therapeutic conduct and that there is no evidence in the record that V.A. refused to allow a staff member to remain with him while he ate.

The commissioner specifically concluded that “while the record is clear that [V.A.] refused to adhere to requests or direction to sit upright in bed, there is no evidence that [V.A.]’s refusal to sit up in bed to eat rose to the level of refusing the services of staff as contemplated by Minnesota Statutes.” We agree. The record is also silent as to whether V.A. refused to allow Eriksmoen staff members to remain in his room while he ate. Accordingly, the failure of staff members to follow V.A.’s care plan and remain in his room cannot be justified by any action taken by V.A. or by the therapeutic-conduct exception for the reasons previously discussed.

We conclude that the commissioner did not err by affirming the July 2017 and October 2017 determinations of maltreatment by neglect issued by DHS against Eriksmoen.

Affirmed.