STATE OF MINNESOTA
IN COURT OF APPEALS
A16-1329

In the Matter of the Appeal by
Meridian Services, Inc. of the Determination
of Maltreatment and Order to Pay a Fine.

Filed April 17, 2017
Reversed
Kirk, Judge

Department of Human Services
File No. 65-1800-31921

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Considered and decided by Kirk, Presiding Judge; Peterson, Judge; and Kalitowski, Judge.*

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

KIRK, Judge

In this certiorari appeal, relator Meridian Services Inc. (Meridian) challenges a maltreatment determination by respondent department of human services (DHS), arguing that

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

DHS erred by ruling that (1) relator's use of a restraint chair on Jane Doe constituted abuse under the Minnesota Vulnerable Adults Act (MVAA); and (2) relator's administration of Benadryl to Jane Doe constituted neglect under the MVAA. Because DHS acted in an arbitrary and capricious manner in finding maltreatment by abuse, and because Meridian's administration of Benadryl to Jane Doe was de minimis conduct that did not meet the statutory definition of maltreatment by neglect, we reverse.

FACTS

Jane Doe is a developmentally disabled adult who suffers from various mental illnesses, including mood disorders with psychotic features, and borderline personality disorder. Doe lived at DHS-operated facilities from age 15 until she was transferred to Meridian's care in 2011. Due to severe childhood trauma, Doe engages in life-threatening behaviors, including violence toward herself and others. She has a history of ingesting harmful non-edible objects, and self-biting. She has unpredictable aggression and can be difficult to control and restrain. At one DHS facility, Doe was responsible for over 30 assaults on staff.

DHS employed numerous methods to treat and manage Doe's behavioral and mental health issues: medications, various types of therapy, electroconvulsive therapy, seclusion, and mechanical restraints. Use of a "mechanical restraint," as defined during the times relevant to this case, included the use of devices such as straps, restraint chairs, or restraint boards to limit a person's movement or hold a person immobile as an intervention precipitated by a person's behavior. Minn. R. 9525.2710, subp. 23 (2013). These measures never fully prevented Doe's behavioral outbursts, but they reduced the danger.

In 2004, Doe was transferred to the state security hospital in St. Peter, Minnesota, where she was first confined to a restraint chair. A restraint chair is an upright chair that confines an occupant using wrist, ankle, shoulder, and waist straps. A person confined to a restraint chair is unable to move her arms or legs without staff assistance.

Minnesota statutes and rules regulate the use of "aversive and deprivation procedures," which include the use of mechanical restraints, such as restraint chairs, in all facilities providing licensed services to persons with developmental disabilities. *See* Minn. Stat. § 245D.06, subd. 5 (2016); Minn. Stat. § 245.825, subd. 1 (2016) (allowing the DHS commissioner to promulgate rules governing use of aversive and deprivation procedures); Minn. R. 9525.2700-.2810 (2013) (establishing standards for the use of certain aversive and deprivation procedures, including mechanical restraints and restraint chairs). Prior to 2014, for a licensed facility to use a restraint chair on a person with developmental disabilities the facility was required to create a written plan detailing the use of the procedure. Minn. R. 9525.2750. These reports were commonly called "rule 40 plans." The rules mandated "regional review committees" composed of a licensed psychologist, facility representatives, guardians, and DHS to monitor the use of mechanical restraints. Minn. R. 9525.2790.

In 2011, due to a federal class-action lawsuit challenging DHS's use of seclusion and mechanical restraints on DHS facility residents with developmental disabilities, DHS agreed, as a part of a settlement, to discontinue the use of mechanical restraints on those residents. *See Jensen v. Minnesota Dep't of Human Servs.*, 138 F. Supp. 3d 1068, 1070 (D. Minn. 2015). DHS also agreed to pursue improvements in the care of persons with developmental disabilities. As a class member in the lawsuit, Doe was targeted for monitoring. A DHS

behavior analyst with DHS's community support services (CSS) division, a DHS psychiatrist, and a county social worker all monitored Doe's case.

From October 2010 to June 2011, Doe was at DHS's Crestview facility. Crestview's rule 40 plan noted that Doe had "restraint dependency," indicating a reliance on mechanical restraints in response to or to manage behaviors and emotions. Crestview's rule 40 plan found that the use of the restraint chair was necessary to ensure safety for Doe and the community. Under DHS's care at Crestview, Doe was using the restraint chair almost daily in 2010. Crestview's rule 40 plan did not explicitly provide Doe breaks from the restraint chair for meals or bathroom use, did not restrict the number of hours Doe could be in the chair, and did not explain the exact criteria for Doe to be released from the chair. While at Crestview, a DHS psychiatrist prescribed Doe Benadryl for anxiety, insomnia, and medication side effects. Crestview staff could give Doe Benadryl while in the restraint chair because it was prescribed three times a day for anxiety.

After Doe assaulted a DHS employee at the Crestview facility, nearly severing his thumb, DHS transferred Doe in June 2011 to live in her own duplex operated by Meridian. Meridian is a privately run provider licensed by DHS, and it operates 30 residential group homes. Before Doe's transfer to Meridian's facility, DHS and CSS staff trained Meridian staff on caring for Doe. The training included the use of the restraint chair. Meridian was skeptical about using the restraint chair and asked a DHS psychiatrist whether Doe could stop using it. The DHS psychiatrist advised against a "cold turkey" removal of the restraint chair.

After Doe's transfer, Meridian adopted Crestview's rule 40 plan with only minor changes. Meridian's final rule 40 plan was approved by DHS, as required by law at the time.

The DHS/CSS behavior analyst reviewed Meridian's rule 40 plan. Doe's guardian, a county social worker, and Meridian's human rights committee and "qualified mental retardation professional" also reviewed the plan. Meridian proposed a one-hour cap on Doe's use of the restraint chair, but the DHS/CSS behavior analyst, the county social worker, and the DHS psychiatrist opposed including this limitation.

Meridian's rule 40 plan required staff to continually monitor Doe while in the chair and record Doe's condition in a log every 30 minutes. Like Crestview's plan, Meridian's rule 40 plan did not explicitly provide for meal or bathroom breaks, or limit the hours Doe could spend in the chair. Like at Crestview, staff caring for Doe determined when it was safe to release Doe. Staff attending to Doe were directed:

> When [Doe] reports that her behavior is safe and staff observes that [Doe's] overt behavior appears to match her reports, staff will begin to release [Doe] from the voluntary mechanical restraint . . . . Staff may release a restraint every 10 minutes as long as [Doe] continues to communicate that she is safe and ready to be released, and staff believe [Doe] to be safe for release as well.

In 2012, a DHS psychiatrist changed Doe's prescription for Benadryl reducing the dosage and changing its use to "as needed" for insomnia. These changes to Doe's Benadryl prescription were not included in Meridian's rule 40 plan, which authorized Benadryl administration for insomnia and for medication side effects.

In 2013, the Minnesota legislature revised the laws on the use of restraints at licensed facilities caring for persons with developmental disabilities. 2013 Minn. Laws, ch. 108, art. 8, § 27, at 1165 (codified at Minn. Stat. § 245D.06, subd. 5 (2014)). The new law, effective January 1, 2014, prohibited the use of chemical, mechanical, or manual restraints as a

substitute for adequate staffing, for behavioral or therapeutic programs to reduce or eliminate behavior, as punishment, or for staff convenience. *Id*. The law eliminated rule 40 plans and required a "positive support transition plan" (PSTP) to phase out the use of all such restraints by December 31, 2014. *Id*., § 27, at 1167 (codified at Minn. Stat. § 245D.06, subd. 8 (2014)).

From October 2013 to January 11, 2014, Meridian operated under a "behavioral management plan with controlled procedures" (BMPCP) policy. Doe's use of the restraint chair under the BMPCP policy was substantially similar to use under the prior rule 40 plan. The policy was approved by the same team that approved the rule 40 plan.

Meridian, in consultation with DHS, completed a PSTP, which went into effect on January 30, 2014. The PSTP targeted Doe's restraints for elimination by December 31, 2014. Like the previous plans, the PSTP did not specify any limits on Doe's use of the restraint chair, or provide breaks for meals and bathroom access. Meridian staff continued to use the procedures set forth in the rule 40 plan along with internal protocols prepared by Meridian to guide staff. In accordance with state-law changes, Meridian began to eliminate Doe's dependence on the chair so that its use could end by December 31, 2014.

In June 2014, a DHS investigator was assigned to investigate an incident where Doe ingested and almost choked on a peach pit. In the process, the investigator learned about Doe's restraint-chair use and DHS initiated a new investigation on Meridian's use of the chair. The investigator learned that Doe's time in the restraint chair at Meridian ranged from a few hours to up to 11 hours a day; Meridian did not allow Doe to eat meals or snacks while restrained; and Meridian did not release Doe for bathroom breaks unless staff believed she was ready to be released. As a result, the investigator found that Doe frequently urinated in

the chair and would sometimes sit in her own urine for up to one hour before staff could clean Doe and the chair.

The investigator learned of Meridian's internal policies outside of the rule 40 plan and PSTP. Under Meridian's "Restraint Chair Reminders" protocol, staff were instructed: (1) not to touch or speak to Doe outside the 15 minute check-ins; (2) not to give Doe food or flavored drinks; (3) to prohibit Doe from using an iPad or watching television; (4) not to provide Doe with blankets or pillows for comfort; and (5) to wake Doe up if she fell asleep. The purpose was to disincentivize the use of the chair to lessen Doe's "restraint dependency." Meridian's internal protocols also advised staff to offer "as needed" medications if Doe became agitated. At the time Benadryl was only prescribed "as needed" for insomnia.

Meridian's rule 40 logs from January 1 to July 31, 2014, reveal that Doe spent much of her waking hours, sometimes as much as 10 hours a day, confined in the restraint chair. The logs show that Meridian staff refused to release Doe if she showed any sign of agitation, including: expressed frustration, clenched fists, racing thoughts, fluttering eyes, blank stares, or "talking outside of a check time." Meridian staff failed to release Doe for exercise every 60 minutes or lessen or discontinue restraints every 15 minutes. Doe often would have to ask multiple times before staff allowed her release. When Doe was confined in the chair, Meridian would often deny her one meal, and sometimes two consecutive meals. Doe missed scheduled meals on 53 occasions and urinated 26 times while in the chair. Meridian administered Benadryl to Doe six times when she was confined to the chair during this period. The parties dispute whether DHS knew of the manner in which Meridian was using the chair.

After DHS began its investigation, Meridian issued a new policy in July 2014 allowing Doe to leave the restraint chair at her own request. Doe's use and time in the chair substantially decreased until its use ceased later that year.

On September 9, 2014, DHS determined that Meridian committed maltreatment by abuse as defined under the MVAA at Minn. Stat. § 626.5572, subd. 2 (2016), based on Meridian's use of the restraint chair in caring for Doe. DHS also determined Meridian committed maltreatment by neglect under the MVAA by administering Benadryl to Doe outside of the prescribed use for insomnia. DHS fined Meridian $1,000 for each determination.

On December 5, 2014, the federal district court judge who oversaw the class-action lawsuit ordered DHS to immediately discontinue the use of restraints on Doe. Meridian, which had never been informed of Jane Doe's status as a class member in the lawsuit, complied with the order, and ended its use of the restraint chair for Doe's confinement.

Meridian challenged DHS's maltreatment determination and a hearing was held before an administrative law judge (ALJ) in April and June of 2015. On November 2, 2015, the ALJ recommended that the DHS commissioner affirm both the maltreatment determinations and the fines. On June 20, 2016, the commissioner, despite amending the findings in ways that were mostly favorable to Meridian, issued a final order affirming the maltreatment determinations and the fines. This appeal follows.

D E C I S I O N

I. Maltreatment-by-Abuse Determination

Meridian argues that the commissioner's decision was arbitrary and capricious because she concluded that Meridian's conduct was abuse after DHS abruptly and without notice changed its interpretation of the law regarding restraint-chair use. Meridian also argues that the commissioner erred as a matter of law because Meridian's treatment of Doe did not fit the definitions of abuse under Minn. Stat. § 626.5572, subd. 2; was exempted because it was therapeutic; and should have been evaluated under the special provision authorizing aversive and deprivation procedures.

When reviewing an agency decision this court may reverse the decision if the substantial rights of the relator may have been prejudiced because the administrative finding, inferences, conclusion, or decisions are in excess of the statutory authority or jurisdiction of the agency, affected by other errors of law, or arbitrary or capricious. Minn. Stat. § 14.69 (2016). The party challenging an agency decision bears the burden of proving that the decision violated provisions of the Minnesota Administrative Procedures Act. *In re Review of 2005 Annual Automatic Adjustment of Charges*, 768 N.W.2d 112, 118 (Minn. 2009). An administrative agency's decision enjoys a presumption of correctness and appellate courts defer to the agency's expertise and special knowledge in its field. *In re Cities of Annandale & Maple Lake NPDES/SDS Permit Issuance*, 731 N.W.2d 502, 514 (Minn. 2007). Although this court defers to an agency's findings of fact if they are reasonably supported by the evidence in the record, the interpretation of statutes and their application to undisputed facts

present questions of law that this court reviews de novo. *Mattice v. Minn. Prop. Ins. Placement*, 655 N.W.2d 336, 340 (Minn. App. 2002).

"Abuse" under the relevant portion of the MVAA is defined as:

> (b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
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> . . . .
>
> (2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;
>
> . . . .
>
> (4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

Minn. Stat. § 626.5572, subd. 2. The commissioner concluded that Meridian committed abuse as defined under both subsections (b)(2) and (b)(4) of Minn. Stat. § 626.5572, subd. 2.

Meridian argues that DHS acted in an arbitrary and capricious manner when it took two diametrically opposed interpretations of Minn. Stat. § 626.5572, subd. 2. Meridian contends that, from June 15, 2011, through December 31, 2013, DHS did not find Meridian was abusing Doe through the manner it was using the restraint chair. Then, under DHS's second interpretation of the law after January 1, 2014, it found abuse.

"An agency's decision is arbitrary or capricious if it represents the agency's will and not its judgment." *In re Review of 2005 Annual Automatic Adjustment of Charges*, 768 N.W.2d at 118. A ruling is arbitrary and capricious if an 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.

Id. (citation omitted).

Here, DHS's maltreatment-by-abuse decision "entirely failed to consider an important aspect of the problem," because it did not recognize DHS's role in approving not only Meridian's use of the restraint chair but the manner of the chair's use. For example, Meridian obtained DHS's approval of its rule 40 plan, BMPCP policy, and PSTP, all regulating the use of the chair. The rule 40 plan and BMPCP policy stated that Meridian's staff was to release Doe "[w]hen [she] reports that her behavior is safe and staff observes that [her] overt behavior appears to match her reports." The plans do not mention an exception for bathroom breaks or meals, which is a reasonable approach given the significant danger Doe could pose to herself or staff if released prematurely.

DHS argues that Meridian exceeded the scope of the rule 40 plan by depriving Doe of food and bathroom access while in the chair.[1] But, given that the restraint chair was used to prevent Doe's self-injurious and assaultive behaviors, and the plan allowed release when staff determined it was safe for Doe, it was reasonable for Meridian to interpret these plans and

[1] The commissioner's final decision faulted Meridian for continuing to follow the rule 40 plan, noting that the PSTP was supposed to replace it. However, the commissioner's final decision also noted that Meridian "had until December 31, 2014 to phase out the rule 40 plan." Under Minn. Stat. § 245D.06 (2014), the commissioner's latter interpretation was correct. Thus, the commissioner's contention that only the PSTP and Meridian's internal policies were in effect after the PSTP was developed is incorrect.

issue internal policies disallowing breaks for meals or bathroom access, especially given Doe's history of injuring herself and assaulting others.

DHS concedes that to reduce Doe's dependence on the restraint chair, the goal was to disincentivize her preference to use the chair. The commissioner's order found that the purpose of depriving Doe of "social contact, activities, *food, comfort*, and media," while in the chair was to make the chair unappealing and disincentivize its use as a coping mechanism. (Emphasis added.) These disincentives matched both Meridian and DHS's goal of eliminating Doe's use of the chair by December 31, 2014, as mandated by the law. The commissioner noted that the DHS/CSS behavior analyst and the DHS psychiatrist endorsed this approach, and the Crestview facility took a similar approach. Meridian cannot be faulted for continuing this approach, especially during the phase-out period in 2014.

DHS's decision was also arbitrary and capricious because the commissioner's order offered explanations that ran counter to the evidence. DHS's contention that it never approved the manner in which the restraint chair was used and that the record is "inconclusive" as to whether DHS knew of the specific manner in which Meridian used the chair is not supported by the record. For example, the DHS/CSS behavior analyst and the DHS psychiatrist advised against a one-hour cap on the time Doe could be in the chair. The DHS/CSS behavior analyst testified that he viewed the "Restraint Chair Reminders" policy while visiting Doe, a document which specifically stated Doe is not to receive bathroom breaks and meals while in the chair. The DHS/CSS behavior analyst also became aware that Doe had urinated in the

chair, but did not believe this showed abuse had occurred.[2] The commissioner's findings note that the purpose of depriving Doe of both food and comfort was to disincentivize the chair, an approach endorsed by DHS staff. Furthermore, Meridian provided DHS with information regarding the frequency and duration of Doe's use of the chair, which DHS reviewed monthly or quarterly.

We agree with Meridian that DHS took two diametrically opposed interpretations of Minn. Stat. § 626.5572, subd. 2, and that DHS's shift in interpretation was capricious. Before DHS's investigation of Meridian in June 2014, depriving Doe of food or comfort in the restraint chair was an approved method to lessen her dependency on the chair pursuant to the new law. After the investigation, the manner in which Meridian used the chair constituted abuse according to DHS. When an agency intends to substantially change its interpretation of a rule that a party has relied upon, it must outline those changes in clear terms in promulgated rules. *St. Otto's Home v. Minnesota Dep't of Human Servs.*, 437 N.W.2d 35, 45 (Minn. 1989). The supreme court reasoned in *St. Otto* that to hold otherwise would allow DHS to "have the rug quickly pulled from under" the party relying on the interpretation. *Id*. Because DHS approved the plans Meridian adopted, used the same plans in prior DHS facilities, rejected Meridian's request to cap Doe's hours in the chair, and previously endorsed the approach of depriving Doe food and comfort while in the chair, DHS's sudden and

[2] As mandatory reporters pursuant to Minn. Stat. § 626.5572, subd. 16 (2016), the DHS/CSS behavior analyst, the DHS psychiatrists, Meridian's staff members, and the county social worker, who were caring for Doe, all had a duty to report abuse or neglect of a vulnerable adult. Minn. Stat. § 626.557 (2016). Yet, none of the multiple mandatory reporters caring for Doe felt a need to report the manner of Meridian's use of the restraint chair.

unexpected about-face quickly pulled the rug from under Meridian when DHS found Meridian's restraint-chair use constituted abuse.

Finally, the commissioner erred as a matter of law in finding abuse under subsections (b)(2) and (b)(4) of Minn. Stat. § 626.5572, subd. 2. Given Doe's dangerous, self-injurious, and assaultive behavior, Meridian's treatment of Doe was designed to prevent Doe from harming herself or others, and therefore could not be seen by a reasonable person to be "disparaging, derogatory, humiliating, harassing, or threatening." Further, under Minn. Stat. § 626.5572, subd. 2(b)(4), the "use of any aversive or deprivation procedures for persons with developmental disabilities" authorized under Minn. Stat. § 245.825 is not abuse. Section 245.825, subd. 1, in turn, prohibits

> (1) the application of certain aversive and deprivation procedures in facilities except as authorized and monitored by the commissioner; [and] (2) the use of aversive and deprivation procedures that restrict the consumers' normal access to nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, and necessary clothing.

Here, Meridian's rule 40 plan, BMPCP policy, and PSTP all were authorized and monitored by DHS employees. DHS argues that under subsection (2) Doe was deprived of normal access to a nutritious diet and ordinary use of hygiene facilities while in the restraint chair. But, because Meridian confined Doe to the chair because she was a danger to herself and others, and DHS staff wanted to disincentivize the chair by not offering meals and comfort, Meridian's conduct was reasonable. There was no evidence that Doe was deprived of normal access to a nutritious diet or ordinary hygiene facilities when Doe was not in the restraint chair during a crisis.

We conclude that the substantial rights of Meridian were prejudiced because the administrative findings and decision in this case were arbitrary and capricious, and were affected by other errors of law. Doe's self-injurious and assaultive behavior, Meridian's reasonable reliance on DHS approved plans, DHS's knowledge of Meridian's manner of use of the restraint chair, and DHS's abrupt shift in its interpretation of the MVAA, support our conclusion. Because we reverse the abuse determination on these grounds, we do not address Meridian's other arguments.

II. Maltreatment-by-Neglect Determination

Meridian next argues that the commissioner acted in an arbitrary and capricious manner in finding abuse through neglect. Meridian argues that the doses of Benadryl, an over-the-counter medication, were insufficient to create harm, and that the administration of six low doses of Benadryl on different days is not a failure in care sufficient to jeopardize Doe's physical or mental health.

"Neglect" means:

> (a) 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.

Minn. Stat. § 626.5572, subd. 17(a) (2016).

The commissioner affirmed the ALJ's conclusion that Meridian committed maltreatment by neglect when Meridian's staff administered six doses of Benadryl in May

and June 2014 while Doe was in the restraint chair. The ALJ reasoned that, because Meridian used the Benadryl as a "chemical restraint" and for staff convenience, "Meridian failed to supply [Doe] with the care and services reasonably necessary to maintain [Doe's] physical or mental health or safety."

We fail to see, as a matter of law, how Meridian's administration of low doses of Benadryl to Doe on six different occasions constituted neglect. While we agree with DHS that actual harm is not an element of neglect, Meridian's conduct was de minimis. Meridian's use of Benadryl was pursuant to its internal policies on how to handle Doe while she was in a crisis. Doe's PSTP allowed for "as needed" medication "in the hope they would provide additional support during times that Doe struggled to control herself." Even though Meridian's use of the Benadryl was outside of its prescribed use for insomnia, Meridian used the medication to provide additional support to Doe while in a crisis. Therefore, its use was not a "failure or omission" by Meridian to provide necessary care.

The commissioner determined that Meridian's use of Benadryl was an impermissible use of a "chemical restraint," and that under Minn. Stat. § 245D.06, subd. 5 (2014), Meridian was prohibited from using chemical or mechanical restraints to reduce or eliminate behavior, as punishment or for staff convenience. But, even if Meridian's use of Benadryl could be considered a chemical restraint under the law, just like mechanical restraints, Meridian had until December 31, 2014 to phase out such interventions. Minn. Stat. § 245D.06, subd. 8(a)(1) (2014). Further, the PSTP was made in consultation with DHS and allowed for "as needed" medications to support Doe in times of crisis.

Because Meridian's use of Benadryl was de minimis conduct, and because the commissioner's determination that its use constituted neglect because it was an impermissible chemical restraint was in error, Meridian's substantial rights were prejudiced by an error of law.

Reversed.