

**MALTREATMENT INVESTIGATION MEMORANDUM**  
**Office of Inspector General, Licensing Division**  
**Public Information**

*Minnesota Statutes, section 626.557, subdivision 1 states, "The legislature declares that the public policy of this state is to protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to maltreatment."*

**Report Number:** 202206650

**Date Issued:** February 15, 2023

**Name and Address of Facility Investigated:**

First Care Home Care LLC  
2526 Hennepin Avenue  
Minneapolis, MN 55405

**Disposition:** Substantiated as to neglect of a vulnerable adult by a staff person.

**License Number and Program Type:**

1106493-HCBS (Home and Community-Based Services)

**Investigator(s):**

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**Suspected Maltreatment Reported:**

It was reported that a staff person (SP) was driving a vulnerable adult (VA) when they were involved in a car accident. There were concerns that the SP failed to yield to another vehicle, who had the right of way. The VA sustained multiple injuries and was taken to the hospital.

**Date of Incident(s):** August 2, 2022

**Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (b), and Minnesota Statutes, section 626.5572, subdivision 15, and subdivision 17, paragraph (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 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 which is not the result of an accident or therapeutic conduct.

**Summary of Findings:**

Pertinent information for this investigation was obtained remotely, including documentation from the facility, law enforcement records, and medical records; and through three interviews conducted with a facility supervisory staff person (P1), a staff person (SP), and the VA. The VA's case manager (CM) and this investigator also communicated via email and that information is provided below.

The VA received individualized home support (IHS) "with training" services from the facility. These services included transportation. The hours and times per week that the VA received services varied depending on the VA's preferences.

The VA was diagnosed with a traumatic brain injury (TBI), depression, and schizophrenia. The VA was not subject to guardianship. The VA's *Coordinated Service and Support Plan Addendum Intensive Support Services* dated November 12, 2021, said that the VA was "alert and oriented." The VA wanted to "direct" his/her cares independently. The VA wanted his/her services to be "flexible" so that the services were "adaptable" to the VA's "changing needs and circumstances."

The CM provided the following information:

- At some point on August 2, 2022, the SP was driving the VA home after being at a casino when they were in a "severe car accident" and the VA was hospitalized. The CM did not know the exact time and location of the accident.
- On August 9, 2022, while the VA was hospitalized, the CM spoke to the VA about the accident. The VA told the CM that s/he was "bummed" about the accident and "in pain." The VA was not able to give the CM "too many details as to what happened." However, the VA said that the SP was "sober" at the time of the accident. Additionally, the VA was not able to "explain" his/her injuries to the CM but the CM said that it sounded like the VA had a "blockage" and "some surgery." The VA also told the CM that s/he received stitches on his/her buttocks and had "trouble" with his/her back.
- The CM then spoke to the facility, who said that they spoke to the SP, who said that all s/he could recall from the accident was being "hit" by the other vehicle and waking up in a hospital. The SP was also "injured pretty badly." When the CM spoke to the facility, s/he got the "impression" that the accident was the "other drivers fault." The facility felt "really bad" for both the VA and the SP regarding their injuries.
- On August 15 or 16, 2022, the CM spoke to the VA and again asked the VA what happened but the VA "did not remember." However, the VA said that it was the SP "who was at fault" but the VA was not able to provide additional information.
- On August 22, 2022, the CM called to check on the VA, who was still in the hospital, and the VA's "cognition was way off." The VA knew who the CM was but did not know where s/he was or why s/he was in the hospital. The CM then spoke to a social worker at the hospital who said that s/he had noticed that the VA seemed to be "more confused." Hospital staff persons were trying to figure out why the VA was having the "cognitive change."
- On September 3, 2022, the VA was discharged from the hospital and went to a transitional care unit. On September 7, 2022, the VA did not want to be at the transitional care unit so the VA left and returned

home.

- At some point, the CM saw the police report which showed that the accident occurred at a “T-intersection.” The CM “did not know” how the SP did not see the other vehicle when s/he “pulled out in front of [it].” The other vehicle then hit the side of the SP’s car.
- The VA was typically able to provide accurate information. However, since the accident, the VA’s “cognition seem[ed] to have declined” and the VA’s “recollection of the incident does not really exist.” The VA was not able to tell the CM “what” happened or where the incident occurred. However, at some point, the CM told the VA what was in the police report, so the VA knew a “bit more.”
- The VA’s favorite pastime was “gambling” and the VA had staff persons take him/her to local casinos. The SP was either driving the VA to the casino or returning home from the casino when the incident occurred.
- Prior, on June 28, 2022, the VA told the CM that his/her “worker” was a “terrible driver” and that the VA was going to “request” a different “worker.” However, the VA decided to continue with this staff person as they “got along well otherwise.” The CM did not know if the “worker” was the same staff person involved with the car accident but thought that it was (Note: The facility said that there was one prior staff person who worked with the VA, aside from the SP).
- The VA had received services from the facility for approximately one year. The CM did not have any concerns with the facility and said that they were “good” to work with, responsive, and “eager to help.”

The *Incident Dakota Sheriff* said that on August 2, 2022, around 3:30 p.m., the SP was transporting the VA in the SP’s vehicle in Hastings, Minnesota, when the SP “failed to yield” to another vehicle, who had the right of way, causing a car accident. Law enforcement issued a citation to the SP for “failing to yield [to] right of way.” The SP and the VA were then transported to the hospital via ambulance. The SP was driving a Honda CRV and the other driver was in a “FRHT [freight]” truck.

According to Google Maps, the intersection of the incident occurred at a “T” in the road. The road the SP was traveling had a stop sign at the intersection. The road the other driver was on (the top of the T) had a speed limit of 55 miles per hour to the east and 45 miles per hour to the west. The other driver did not have a stop sign or yield, meaning that if going the speed limit, the other driver would have hit the SP’s vehicle at 55 miles per hour.

The ambulance records showed that on August 2, 2022, the ambulance was “dispatched” for a traffic accident. Upon arrival, they found a vehicle off the roadway with “significant” left side damage. The VA was a passenger in the vehicle and it was unknown if the VA was wearing a seat belt (Note: The hospital records showed that the VA had a “seatbelt sign” on his/her lower abdomen.) A “cervical collar” was placed on the VA and the VA was “extricated” from the vehicle due to “altered mental status.” The VA was then placed in the ambulance and “immediately” transported to the hospital due to his/her “condition.” During transport, it was “revealed” that the VA had a “serious” laceration to his/her right forearm and bleeding was “controlled.” Blood was also coming out of the VA’s right ear and bleeding was “controlled.” The VA complained of left side abdominal and hip pain and it was noted that the VA had a “large contusion and abrasion on [his/her] left lower quadrant.” The VA’s vitals were monitored and the VA was hypotensive (low blood pressure). Pain meds were withheld due to hypotension and possible internal injuries. The VA’s mental status was noted as “confused.” Medical records from the hospital provided the following information:

- On August 2, 2022, at 4:14 p.m., the VA arrived to the emergency room due to a “trauma” after a “high speed” motor vehicle accident and the VA was the “restrained driver.” The VA was hypotensive and was found to have “active mesenteric hemorrhage” so the VA was taken to the emergency room. The VA also had abdominal pain and “other distracting injuries.” Additionally, “shock” was likely due to “acute blood loss anemia.”
- The VA was diagnosed with a left temporal (temple) bone fracture, comminuted left “lilac” bone fracture, a right arm laceration, active mesenteric (organ in the abdomen) hemorrhage, small abdominal wall hernia containing small bowel without obstruction, and left sixth through eleventh rib fractures. Additionally, the VA had “extensive purple bruising” on his/her left hip and lower abdomen.
- The VA had an exploratory laparotomy (general surgical operation where the abdomen was opened and the abdominal organs were examined for injury), small bowel resection, lysis of adhesions (minimally invasive spine surgery), proctoscopy (visual examination of the lower rectum and anal canal using a medical instrument called a proctoscope), and temporary abdominal closure with “wound vac placement.” The VA had pain management and “pulmonary toilet [used to clear mucus and secretions from the airways]” for the rib fractures. The VA also had a head computed tomography scan. Additionally, the VA had two lacerations on his/her left ear and had “laceration repair” via sutures. The VA was “critically ill” and required continued monitoring and cares.
- The VA was initially “confused and intermittently agitated.” The VA also had “delirium” which was likely attributed to sustaining a TBI. The VA said that s/he was in the hospital because s/he had “trouble breathing at home.” When asked about a car accident, the VA “adamantly denied” that s/he had been in one. The VA had short term memory loss and had “trouble with memory surrounding event.” On August 11, 2022, the VA said that his/her memory was “improving.”
- The VA was discharged from the hospital on September 2, 2022, and went to a transitional care facility.

The VA provided the following information:

- The VA did not recall the staff person’s name but said that at some point on August 2, 2022, the staff person (later determined to be the SP) had driven the VA to a nearby casino.
- At some point, the VA and the SP left the casino to drive back to the VA’s home, in Saint Paul, Minnesota. The SP was driving and the VA was in the passenger seat. They had just left the casino when the SP “turned a corner” to go back in the direction of the casino (the SP was in the correct lane) and the SP “damn near killed” the VA because a truck or SUV hit the SP’s car. The VA “did not remember” anything “after getting hit” but at some point, the VA was in the hospital.
- After the VA was discharged from the hospital, s/he had back surgery because his/her back was “totally messed up” following the incident. The VA “never” had issues with his/her back prior to the incident. The VA also had hearing loss after the incident. The VA had “perfect hearing” prior to the incident.
- The VA was not aware of the SP being distracted while driving, including on the phone, at the time of the incident. The SP was driving the speed limit. The VA did not recall who had the right of way.
- The SP typically worked with the VA “at least twice a week” but the hours varied. The SP had driven the VA to the casino on prior occasions. Prior to the incident, the VA had concerns that the SP was “not a

very good driver” and because of that, the VA had thought about finding a new staff person. This included that the SP drove “too slow” on the freeway, including driving 40 miles per hour. The SP would also “turn back around,” similar to what s/he did at the time of the incident. However, the VA did not know why the SP did so.

P1 and the *First Care Home Care LLC Incident Report and Internal Review* written by a supervisory staff person (P2) provided the following information:

- On August 5, 2022, one of the SP’s family members notified P2 of the incident. The family member told P2 that the SP got in a “car accident” while working with the VA and that the SP was in the hospital. P2 was not aware of the incident prior. P2 asked for “specific details” about the accident but the family member was not able to provide additional information other than the SP was in the hospital.
- P2 then called the SP and the VA but could not reach either. At some point, the facility was able to reach one of the VA’s family members who “confirmed” that the VA was in an “accident” and in the hospital. The facility was “never” able to speak to the VA about the incident, as the VA did not return their phone calls.
- At some point, the SP was discharged from the hospital and the SP spoke to P2 about the incident. The SP said that on August 2, 2022, the SP drove the VA in the community in the SP’s car. Around 1 p.m., the SP was driving the VA in Hastings, Minnesota, when the SP’s vehicle was hit on the driver’s side by a “semi-truck.” The SP said that the only thing s/he recalled was getting hit by the “18-wheeler truck.” The SP said that s/he awoke at a local hospital following the incident. The SP did not recall how s/he got to the hospital and was in the hospital for a “few days.”
- At some point after the facility spoke to the SP, the facility received a copy of police report and said that the SP was “not being honest” with the information s/he told the facility. This included that the police report said that the truck had the “right of way.”
- Staff persons were “encouraged” to use public transportation, such as a bus or train, to take the clients to activities. However, staff persons were also able to use their personal vehicles.
- There were no prior concerns with the SP, including with the SP’s driving. At some point prior to the incident, the VA told the facility that the SP was a “very good staff” and that they worked “well together.” The SP had provided his/her insurance information and driver’s license to the facility and there was “no inclination” that the SP was a “reckless driver.”
- The SP only worked with the VA and did not work with any other clients. The VA “directed” his/her own care regarding when the SP worked. However, the SP typically worked with the VA between two and four days a week and the VA could use his/her “hours” the way the VA chose. The SP’s responsibilities included taking the VA into the community and doing “activities” to keep the VA “engaged.”

The SP provided the following information:

- The SP said that on August 2, 2022, between 3 and 4 p.m., s/he was driving the VA to an “appointment” in Hastings, Minnesota. They were on a “highway” near a stop light when “all of a sudden,” the SP saw a “truck” coming towards him/her. The SP turned his/her steering wheel to “one side” and “put more gas on the gas pedal to escape from the huge accident about to happen.” The truck then hit the passenger side and back of the SP’s car. The SP said that s/he got into a “major” car accident and s/he sustained multiple injuries and was taken to the hospital. The VA was also taken to the hospital via ambulance but the SP did not know the extent of the VA’s injuries.
- The SP said that at some point after the incident, s/he received the police report which showed that the SP made a “mistake” while driving and that the other car had the “right way.” The SP said that the police report showed that s/he made a “mistake” at the “red light” and “entered” the intersection. The SP said that the incident was “just an accident.”
- The SP denied speeding or any distractions at the time of the incident, including cell phone use. When the SP drove, including drove others, s/he was “even more cautious.” The SP had a valid driver’s license and there were no prior concerns with his/her driving.

The *Safety Compliance Transportation Policy* said that while transporting clients, staff persons were to obey all the traffic safety regulations. This included driving the speed limit, following the traffic signs, ensuring the staff and client were wearing their seatbelts, and following other “regulations” by the State of Minnesota. Staff persons were not to use cell phones while driving.

Facility documentation showed that the SP and P1 received training on the Reporting of Maltreatment of Vulnerable Adults Act prior to the incident. The SP also received training on the VA’s plans and “safe transportation.” The SP had a valid driver’s license.

### Conclusion:

#### A. Maltreatment:

Although the VA did not recall specific details of the incident due to his/her injuries, the SP and the *Incident Dakota Sheriff* said that on August 2, 2022, around 3:30 p.m., the SP was transporting the VA in the SP’s vehicle in Hastings, Minnesota, when the SP failed to yield to another vehicle, who had the right of way, causing a car crash. The VA sustained multiple injuries and was taken to the hospital and required surgery. This included a left temporal bone fracture, a comminuted left “lilac” bone fracture, a right arm laceration, active mesenteric (organ in the abdomen) hemorrhage, small abdominal wall hernia containing small bowel without obstruction, and left sixth through eleventh rib fractures. Additionally, the VA had “extensive purple bruising” on his/her left hip and lower abdomen.

Given that the SP failed to follow traffic laws and yield to the right of way to another car when required, resulting in the car crash injuring the VA, and that failing to follow traffic laws was not therapeutic or accidental, there was a preponderance of the evidence that the SP failed to supply the VA with care or services which are reasonable and necessary to maintain the VA’s physical or mental health or safety.

It was determined that neglect occurred (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

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

B. Responsibility pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (c):

When determining whether the facility or individual is the responsible party for substantiated maltreatment or whether both the facility and the individual are responsible for substantiated maltreatment, the lead agency shall consider at least the following mitigating factors:

- (1) whether the actions of the facility or the individual caregivers were in accordance with, and followed the terms of, an erroneous physician order, prescription, resident care plan, or directive. This is not a mitigating factor when the facility or caregiver is responsible for the issuance of the erroneous order, prescription, plan, or directive or knows or should have known of the errors and took no reasonable measures to correct the defect before administering care;
- (2) the comparative responsibility between the facility, other caregivers, and requirements placed upon the employee, including but not limited to, the facility's compliance with related regulatory standards and factors such as the adequacy of facility policies and procedures, the adequacy of facility training, the adequacy of an individual's participation in the training, the adequacy of caregiver supervision, the adequacy of facility staffing levels, and a consideration of the scope of the individual employee's authority; and
- (3) whether the facility or individual followed professional standards in exercising professional judgment.

Prior to the incident, the SP was trained on Reporting of Maltreatment of Vulnerable Adults Act and on the facility's safe transportation policy which stated that staff persons were to obey all traffic regulations. The SP was responsible for maltreatment of the VA.

C. Recurring and/or Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by an individual meets the statutory criteria to be determined as "recurring or serious." Individuals determined to be responsible for recurring or serious maltreatment are disqualified from providing direct contact services. Minnesota Statutes, section 245C.02, subdivision 16, states:

"Recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that maltreatment occurred and that the subject was responsible for the maltreatment.

Minnesota Statutes, section 245C.02, subdivision 18, states:

"Serious maltreatment" means sexual abuse, maltreatment resulting in death, neglect resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought, or abuse resulting in serious injury. For purposes of this definition, "care of

a physician" is treatment received or ordered by a physician, physician assistant, or nurse practitioner, but does not include diagnostic testing, assessment, or observation; the application of, recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment. For purposes of this definition, "abuse resulting in serious injury" means: bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke. Serious maltreatment includes neglect when it results in criminal sexual conduct against a child or vulnerable adult.

It was determined that the substantiated maltreatment for which the SP was responsible was not recurring because it was a single incident but was serious maltreatment because the VA sustained serious injuries which reasonably required the care of a physician including surgery. The SP was disqualified from providing direct contact services.

**Action Taken by Facility:**

The facility completed an internal review and determined that policies and procedures were adequate and followed. The facility updated their policies and procedures to include that staff persons were to notify the facility if they took a client outside of the "larger metro area." Additionally, if a staff person was involved in an accident with a client, they were to notify the facility. The incident was not similar to prior incidents.

**Action Taken by Department of Human Services, Office of Inspector General:**

The SP was disqualified from a position allowing direct contact with, or access to, persons receiving services from programs, organizations, and/or agencies that are required to have individuals complete a background study by the Department of Human Services as listed in Minnesota Statutes, section 245C.03. The determination that the SP was responsible for maltreatment and the disqualification of the SP are each subject to appeal.