

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: 202209418

Date Issued: February 22, 2023

Name and Address of Facility Investigated:

Disposition: Inconclusive

Dungarvin France
3819 France Place
Brooklyn Center, MN 55429

Dungarvin Minnesota, LLC
1444 Northland Drive, Suite 100
Mendota Heights, MN 55120

License Number and Program Type:

1070847-H_CRS (Home and Community-Based Services-Community Residential Setting)
1070806-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a staff person (SP) did not treat a vulnerable adult (VA) in a respectful manner.

Date of Incident(s): Ongoing, prior to November 15, 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 2, paragraph (b), clause (2):

Conduct which is not an accident or therapeutic conduct which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to: the 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.

Summary of Findings:

Pertinent information was obtained during a site visit conducted on December 27, 2022; from documentation at the facility; and through interviews conducted with three facility staff persons and the VA.

The facility was a single level with a finished basement. The VA's bedroom was downstairs as well as a common area and a bathroom.

The VA's support plans stated:

- The VA was an artist who enjoyed painting.
- The VA had diagnoses related to his/her mental health.
- The VA was not subject to guardianship.
- The VA was able to be without staff persons at home and in the community for several hours each day.

The facility became aware of the VA's concerns, some of which were written down in a journal, at an interdisciplinary team meeting in November 2022. (The VA lived at the facility for several years and the SP worked with the VA since the VA moved to the facility.)

The VA provided the following information in a written journal, in a facility internal review report, and in an interview with this investigator:

- The VA lived at the facility for five years and recently reported that s/he had issues with the SP the entire time. The VA did not initially report his/her concerns because s/he did not like to get persons in trouble.
- Sometimes the VA and the SP had a "good relationship," but if the SP was in a bad mood, the SP could be "passive-aggressive" and respond to the VA in "snippy sentences." If the SP was mad, there were times when the SP gave the VA the "cold shoulder" and refused to talk to him/her. Whenever the SP was "cranky," s/he took it out on the consumers. The VA said that s/he was usually the target of the VA's frustration and anger, but the SP was also "mean" to two facility consumers (C1 and C2). The VA thought the SP was mean to him/her and C1 because they were "tough" and could "handle it." When the SP was mean to C2, s/he became sad and cried.
- When the VA and the SP had conflicts with each other, the SP would often end the conversation "abruptly" with a "snarky remark" and then walk away without resolving the issue. Later, when the VA tried to bring up the issue again, the SP would say things like, "I've moved past it. You can't hold onto it." The SP often made

“snide” remarks to him/her if s/he was unable to do something or if something was “too hard.” The VA recalled an incident that happened when flower pots full of dirt got knocked over and the SP made comments to the VA, “Did you sweep up the dirt, or did you just walk right over it?” and “is the broom too heavy” for your “steel muscles?”

- The SP often said one thing but later retracted the statement. The SP would say, “I didn’t say that” and then blame the VA’s memory issues when the VA brought these situations to the SP’s attention. The VA did have memory issues, but the VA did not forget things altogether and did not “make things up.” The VA provided an example that s/he had a bathroom downstairs that the SP said was only for the VA to use and that the VA should not let anyone else use it. The SP told the VA that s/he should lock the door to deter other persons from using it then told the VA that s/he could not lock the door due to it being a safety issue.
- On Election Day (November 8, 2022), the VA planned to vote. Prior to that day, the VA discussed with the SP that s/he wanted to vote in person as opposed to completing a mail in ballot like the other consumers. When the VA arrived home from work that afternoon, the VA reminded the SP about taking him/her to vote, but the SP did not respond. Instead, the SP walked away and made a phone call and talked on the phone until dinner. During and after dinner, the SP watched the news on television. In the internal review, the VA said that s/he did not mention again to the SP that s/he wanted to vote because, “You don’t get in the middle of [the SP] and [his/her] news.” (The VA told this investigator that s/he asked the SP again and the SP said that there was not time to vote.) After watching the news, the SP went home. P1 was also working at the time, but P1 was not able to drive the facility vehicle.
- When the VA left belongings around the facility, the SP took them and put them in the garage or in piles downstairs. The SP also left notes on the VA’s belongings that said, “If you don’t move these by a certain day/time, I’m putting them in the garage.” Sometimes the SP put the VA’s belongings in the garage before the VA had a chance to move them. After the VA had a surgery, the VA used a walker to walk and the VA left it in the entryway area, and when the SP arrived, the SP asked, “What’s this shit doing here?” The SP then put the walker in the garage and piled garbage on top of it. The VA had some belongings that s/he wanted to try to sell, but the SP wrote “junk” and “donate” on the boxes and put them in the garage next to the other things they were planning on throwing away. The VA brought the boxes back inside.
- The VA had an aloe plant. The SP took leaves off the VA’s aloe plant to use when the SP burned him/herself from cooking without asking the VA. The VA’s aloe plant did not get adequate light in the winter and the SP did not want it blocking the patio door where there was sun. The SP suggested that the VA buy a grow light for the plant. The VA ordered a grow light and when it was delivered, the SP “mocked” the VA because the light was too small to be effective and told him/her about a different light s/he should have purchased instead.
- The VA was scheduled to have hip surgery and the SP made comments that the VA was trying to sabotage the surgery due to his/her weight and smoking. The SP told the VA that there was always one person to look at it bigger than you that made you feel better about yourself
- If a family member gave the VA a gift, the SP told the VA, “Is that something you got from the family member,” in a manner that the VA thought the SPs/he sounded like the VA was a baby getting a toy.

- On one occasion, the SP was upset and talked about C1 plugging in his/her cell phone and made a comment why were "retards" able to have cell phones. The SP made the comment in the year 2020. On one or two occasions that the VA could recall, C1 did something "silly" and the SP called C1 a "bad word. "
- The VA did not have concerns about other staff persons.

P1 provided the following information in the facility internal review report and in an interview with this investigator:

- When P1 worked with the SP, the SP was "condescending" and it was "my way or the highway." If the SP was upset, the SP's mood would affect staff persons and consumers at the facility. The SP did not realize what tone of voice s/he used when talking to persons. The SP usually only showed his/her "temper" with C1 or the VA.
- On Election Day, the VA arrived home from work and asked the SP about taking him/her to vote. The SP did not respond and then was on the phone until dinner. The SP ate dinner, watched the news, and left about 6:30 p.m. P1 was not able to drive the company vehicle and could not take the VA to vote.
- The VA often left belongings upstairs and P1 would remind the VA to take them downstairs. The SP told staff persons that they should bring his/her belongings downstairs as the VA will not do it. If the VA did not, P1 would take them downstairs "gradually." The SP either hid the VA's belongings in the garage or threw them downstairs.
- The SP persuaded C1 and C2 to do things the way the SP wanted things done, but made C1 and C2 think it was their idea. The SP made comments about C1's boy/girlfriend such as s/he did not deserve C1.
- P1 never heard the SP use "bad names" that caused him/her concern. The SP might tell C2 "come on slow poke" because C2 moved slowly. Sometimes the SP called the VA "packrat."

A supervisory staff person (P2) provided the following information in the facility internal review report and in an interview with this investigator:

- P2 worked at the facility since October 2022. Prior to the recent concerns, P2 heard concerns about the SP's interactions with staff persons, but never heard any concerns about how the SP interacted with consumers. P2 was not aware of the issue with voting until after reading the journal entries that the VA showed with his/her interdisciplinary team. P2 said that staff persons could have called P2 if there was an issue with the VA voting.
- P2 said that the VA had belongings in the garage that the SP wanted to get rid of. The SP contacted P2 about getting the garage cleaned up and things hauled away, so there was room to park a vehicle. The VA's belongings were put to the side of the garage so they would not be disposed of with other items. P2 told the VA that his/her belongings would not be thrown away without his/her knowledge or approval and told the VA to go through his/her belongings in the garage in case there was anything s/he wanted to bring back inside. P2 believed that the VA was an accurate reporter of events. Prior to the allegations, P2 did not have concerns about the SP.

The facility internal review report included the following information from six additional staff persons (P3-P8):

- P3 stated that s/he did not often work with the SP. P3 had concerns about how the SP treated P3, but P3 was not aware of any concerns about how the SP interacted with the consumers.
- P4 stated that s/he did not have any concerns about the SP's interactions or with any of the consumers. The SP was "respectful" and "fair" with his/her interactions with staff persons and the consumers. P4 never witnessed the SP use derogatory or insulting language toward the consumers.
- P5 stated that s/he occasionally worked with the SP. P5 said that the SP was not "mean," but could be "very blunt." Prior to the investigation there were some conflicts between the SP and another staff person.
- P6 stated that s/he worked with the SP several days each week. The SP's job responsibilities included delegating work to the other staff persons. The SP had a good relationship with the consumers. P6 never heard the SP use derogatory or insulting language toward the consumers.
- P7 stated that s/he occasionally worked at the facility. P7's interactions with the SP were positive and the "environment" at the facility was "very peaceful." P7 never heard the SP use derogatory or insulting language toward the consumers.
- P8 stated that the SP made "snide" remarks and gave persons the "cold shoulder," but did not know if the SP realized what s/he was doing. P8 stated that s/he had several concerns about how the SP treated the consumers. The SP ran "the house" like it was his/her own and talked to the consumers like they were his/her children. P8 stated that SP had been overheard saying things to a consumer who was diabetic like, "You're going to end up like your [brother/sister]," who died due to being overweight and diabetic. The SP also made comments like "you stink" to a consumer who smoked. The SP also decided whether or not C1 was allowed to visit his/her boy/girlfriend.
- P8 stated that if the VA did not agree with the SP, the SP would not discuss it with the VA which led to power struggles between the SP and the VA. If the VA left belongings out on the table, the SP would place notes on them that said "trash" or moved them before the VA had a chance to move them him/herself.

The facility internal review report included the following information from C1, C2, and another consumer (C3):

- C1 stated that s/he liked all the staff persons who worked at the facility. All the consumers liked the SP because the SP took them on activities. C1 stated that none of the staff persons, including the SP, were ever mean to him/her and s/he never heard anyone use the word "retard." C1 was able to make arrangements and visit his/her boy/girlfriend whenever s/he wanted to go, with or without staff persons taking him/her. There were no restrictions on when or how often s/he could visit him/her.
- C2 was not able to be interviewed.
- C3 stated that s/he "loved" all the staff persons including the SP. C3 was not able to provide any additional information.

The SP provided the following information in the facility internal review report and in an interview with this investigator:

- The consumers complained to the SP about problems they had with staff persons, but no one brought complaints about him/her. Over the last few years, the VA had been making significant progress in improving how s/he handled his/her frustrations. The SP noticed that around September 2022, the VA had been getting sad more often and was getting angry or frustrated much more quickly than before. The VA also had some medication changes in October 2022.
- The SP said that the bathroom in the basement was "technically" in the VA's space, it was not the VA's private bathroom and could be used by anyone who needed to use it. The VA locked the door and when another consumer tried to use it they had an accident. The SP never told the VA that s/he was allowed to lock the bathroom.
- On Election Day it was the VA's decision to not vote. Prior to Election Day, the VA talked to the SP about wanting to vote in person. The SP twice offered to get the VA an absentee ballot, but the VA wanted the experience to go vote in person. On Election Day, the VA came home from work, but never mentioned anything to the SP about wanting to go vote. The SP did recall making a phone call on Election Day and denied that the VA asked him/her for a ride to vote. The SP said that s/he "firmly" believed that the consumers should have the right to vote and would have taken the VA if the VA asked the SP to take him/her. After the election, the VA never brought up to the SP about being unable to participate. The SP requested mail in ballots for the other consumers to vote because they did not want to wait in line to vote.
- The SP stated that the VA was "messy" and left his/her belongings all over the facility. The other consumers complained because they were expected to keep their belongings picked up and put away. If the VA left belongings around, the SP left post-it notes as reminders for the VA to put them away. If the VA did not pick up his/her belongings, the SP brought them downstairs.
- The garage at the facility was full of "junk" such as furniture and bags of clothes to donate. There was no room to park a vehicle. On November 10, 2022, the SP and P2 talked about contacting a company to haul away the stuff they did not want anymore. The SP was supposed to mark things in the garage to distinguish it between "junk" and "keep." The VA previously put three totes of his/her belongings that s/he was trying to sell in the garage for storage. The SP marked them as "save." The VA also had a large desk in the garage that s/he had previously purchased for his/her room (it cost \$15) but could not get it down the stairs. The VA then tried to sell the desk but was not able to so it just sat in the garage. The VA bought another desk which was currently being used downstairs. The SP did not want to make the VA pay money to get rid of the old desk and thought s/he was doing him/her a favor including it in the junk the facility was getting rid of. On the evening of Thursday, November 10, after the SP labeled all the items in the garage, the VA came home from work and had an "outburst" about his/her stuff being put in the junk pile. Besides the desk, none of the VA's stuff was considered junk, so s/he was not sure why the VA was upset. The SP did not remember if s/he ever labeled a box of the VA's belongings as donations without asking the VA. The VA usually determined what s/he was going to donate him/herself.
- The VA used to keep his/her aloe plant in the kitchen window but recently needed to find a new place for it. Due to the lack of window space, the SP told the VA that s/he saw a commercial for a grow light and

suggested the VA purchase one as a substitute for the sunlight. The VA did his/her own research and purchased one on his/her own. When the grow light arrived, the SP asked the VA if it was big enough, the VA showed him/her the different light settings and determined the light was a sufficient source of light for the plant. On one occasion, the SP took a piece off the bottom of the plant that had a "dead end." The SP thanked the VA, but the VA got really mad at the SP. The VA becoming mad was "not like" the VA and in the past the VA would have handed the SP a piece of the plant.

- The VA had an upcoming surgery and the SP asked the VA about being scared of the surgery and would s/he continue to be able to smoke. The SP was "joking around" with the VA and made a comment about being the biggest person in a family, but the SP was talking about someone other than the VA.
- The SP never made fun of the VA's relationship with a family member. The VA never gave the VA the "silent treatment," but at times told the VA that s/he was busy and had to finish something. If the VA wanted something, the VA wanted attention "right away."
- C1 has been with his/her boy/girlfriend for 20 years and C1 liked to see him/her as often as s/he could. C1 had unsupervised time and could visit him/her independently and even spend the night at his/her house. There were no restrictions on when or how often C1 could go unless his/her boy/girlfriend was busy. Staff persons typically assisted C1 to set up rides on Metro Mobility, otherwise C1 could go by him/herself. At one point, C1 and his/her boy/girlfriend had an argument and C1 talked about ending their relationship. The SP admitted making comments towards C1 such as, "You have to be careful" and s/he might find someone else if "you don't treat [him/her] right." The SP denied calling C1 a "retard" or using any other derogatory language towards him/her or about him/her. The SP stated that s/he never used the word "retard" at the facility. The SP admitted that sometimes s/he got frustrated with C1, but s/he was never mean to him/her and always apologized afterward.
- The SP and other staff persons had talked to C2 regarding concerns about his/her health. C2 was diagnosed with diabetes and was making poor health choices included sneaking or hiding food. The SP said that comments s/he made to C2 about "ending up like [his/her] brother" were made out of concern and not meant to criticize C2.
- The SP stated that s/he received training on consumer rights, training specific to the VA, and training on the Reporting of Maltreatment of Vulnerable Adults Act.

The SP documented the following in the VA's progress notes on November 11, 2022:

Writer received a call from one of the evening staff [persons] from last evening, alerting the writer to a behavior outburst [the VA] had last evening. [The VA] was irate that the garage had been cleaned up yesterday, and all of the broken furniture and other junk had been marked as such so that when the removal team comes, everything would be ready to go. The toilet seat [the VA] and [his/her brother/sister] have been working on refurbishing for over a month was placed on a shelf so it wouldn't be removed. The writer had asked the evening staff [person] to show [the VA] the totes and bags of things that appeared to belong to [him/her] and ask [him/her] what [s/he] wanted to do with them. This pile was marked "save" until [the VA] could look them over and decide what to save, where to put it, and what to donate or dispose of. The old desk

[the VA] hauled here last summer and dumped in the garage was marked junk because [the VA] doesn't want it and, in fact, bought a different one, and [s/he's] tried to give it away, but no one else wants it either. Having the program pay to haul it away will save [the VA] from having to pay for that [him/herself] or to arrange a storage unit to house it. France needs to be able to park a car in the garage during sour weather, unload groceries, etc., and the desk is in the way. Meanwhile, the writer will try to nail down a day the junkers are coming so [the VA] knows how much time [s/he] has to dispose of the desk [him/herself] if that's [his/her] plan. [The VA] did take the totes and boxes to [his/her] area of the basement and also [his/her] walker. The walker wasn't marked in any way yesterday because the plan is to put it in the back of the garage as soon as room opens up back there.

The facility's *Service Recipient Rights* policy stated that consumers had the right to be treated with courtesy and respect.

Facility documentation showed that the SP received training specific to the VA, training on the Reporting of Maltreatment of Vulnerable Adults Act, and training on consumer rights prior to the allegations.

Relevant Statute:

Minnesota Statutes, section 245D.04, subdivision 3, paragraph (a), clause (6) states that consumers have the right to be treated with courtesy and respect.

Conclusion:

In November 2022, the VA brought several concerns regarding the SP's interactions with the VA surrounding issues that included voting, handling of the VA's possessions, and statements made to the VA about personal issues. The SP provided information showing that events described by the VA took place, but the SP provided detailed information that differed from the VA's detailed description of events. There was also some concerns the VA brought forward regarding the SP and other consumers, mainly C1, but C1's statement did not support what the VA said and C1 did not have concerns with the SP.

The SP had reason to minimize his/her actions and it was possible that the VA perceived the SP's actions different than what the SP intended. Regardless, it was likely that there were occasions that the SP engaged in interactions with the VA that were not therapeutic in nature. Those actions were a violation of Minnesota Statutes section 245D.04, subdivision 3 and a violation of facility policy which both stated that the VA had the right to be treated with courtesy and respect. However, there was not a preponderance of the evidence whether the SP engaged in non-therapeutic conduct that would reasonably be expected to cause the VA emotional distress.

It was not determined whether emotional abuse occurred (conduct which is not an accident or therapeutic conduct which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to: the 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).

Action Taken by Facility:

The facility completed an internal review and determined that their policies and procedures were adequate, but not followed in that the SP violated facility policy as s/he did not interact with the VA in a professional and competent manner. The facility took correction action with the SP and planned to retrain the SP on the Reporting of Maltreatment of Vulnerable Adults Act and consumer rights. The SP no longer worked with the VA.

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

Because the facility had a *Service Recipient Rights* policy which the SP was trained on and the facility took immediate action with the SP regarding the SP violating facility policy, a Correction Order was not issued for the violation outlined in this report.