

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: 202210710

Date Issued: March 3, 2023

Name and Address of Facility Investigated:

Zumbro Christian Park
7038 Bloomington Ave. S.
Richfield, MN 55423

Zumbro House, Inc.
525 Commons Dr.
Woodbury, MN 55125

Disposition:

Allegation One: False and Error in the provision of therapeutic conduct

Allegation Two: Inconclusive

Allegation Three: Inconclusive

License Number and Program Type:

1070731-H_CRS (Home and Community-Based Services-Community Residential Setting)
1070720-HCBS (Home and Community-Based Services)

Investigator(s):

Scott Brandt
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
scott.j.brandt@state.mn.us
651-431-6556

Suspected Maltreatment Reported:

Allegation One: It was reported that when a vulnerable adult (VA) did not take his/her morning medications prior to going to day program, staff persons did not bring medications to the VA in a timely manner which resulted in the VA becoming upset and crying. In addition, it was reported that the VA did not receive his/her night time medications on December 27 and 28, 2022.

Allegation Two: It was reported that staff persons were not following the VA's low sodium diet and not providing nutritious food to the VA.

Allegation Three: It was reported that the VA wore soiled clothing and that his/her living conditions were

deteriorating.

Date of Incident(s):

Allegation One: December 27 and 28, 2022

Allegations Two and Three: Unspecified dates prior to December 30, 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 was obtained during two scheduled site visits conducted on January 10, and 26, 2023, from documentation at the facility, from the VA's medical records, and through nine interviews conducted with the VA, the VA's case manager (CM), the VA's guardian (G), a staff person (P1) from the VA's day training and habilitation program, a facility health care professional (HCP), and three facility staff persons (P2-P4). Although this investigator contacted another facility staff person (P5), P5 did not respond to requests to be interviewed. Although the VA was interviewed, the VA provided only limited information for the investigation.

The VA's *Self-Management Assessment* showed that s/he enjoyed cleaning and assisting staff persons with cleaning at the facility.

The facility's training records showed that all facility staff interviewed for this investigation were trained on the Reporting of Maltreatment of Vulnerable Adults Act and the VA's specific care plans prior to the site visits.

Allegation One: It was reported that when the VA did not take his/her morning medications prior to going to day program, staff persons did not bring medications to the VA in a timely manner which resulted in the VA becoming upset and crying. In addition, it was reported that the VA did not receive his/her night time medications on December 27 and 28, 2022.

Facility documentation showed that the VA was diagnosed with moderate intellectual disability, moderate impulse control disorder, and diabetes. The VA had a history of seizures, hypertension, and anxiety.

The VA did not recall a time that s/he missed any medications.

At the time of the incidents, the VA's medications were stored in a filing cabinet in a living room and there was a key to the cabinet hanging on a wall by the cabinet. The VA took several medications in the morning, at 4 p.m./evening, and before bedtime. All of the VA's medications, with the exception of ferrous sulfate, were packaged together in blister packages from a local pharmacy labeled with the date and time they were to be administered. The ferrous sulfate was packaged separately from the rest because it was given daily but the time given rotated between morning and nighttime. The HCP stated that s/he wrote the date and time, on the back of

the card, that the ferrous sulfate medication was to be administered to the VA.

The VA's *Medication Administration Record (MAR)* showed that the VA was prescribed the following medications:

- At 8 a.m.:
 - 1 milligrams (mg) benztropine (a medication used to treat Parkinson's disease).
 - 1 mg glimepiride (a medication used to treat diabetes).
 - 4 mg guanfacine (a medication used to treat high blood pressure).
 - 100 mg Januvia (a medication used to treat diabetes).
 - 10 mg lisinopril (a medication used to treat high blood pressure).
 - 1 mg lorazepam (a medication used to treat anxiety).
 - 40 mg omeprazole (a medication used to treat acid reflux).
 - 100 mg quetiapine (a medication used to treat depression).
 - 3 mg risperidone (a medication used to treat mental health concerns).
 - .1 mg clonidine (a medication used to treat attention deficit hyperactivity disorder).
 - 1000 mg divalproex (a medication used to treat seizures).
 - 100 mg docusate Sodium (a medication used to treat constipation).
 - 325 mg ferrous sulfate (a medication used to treat iron deficiencies) every other day.
 - 150 mg metoprolol (a medication used to treat high blood pressure).
 - 20 mg paroxetine (a medication used to treat depression).
 - 700 mg quetiapine (a medication used to treat depression).
 - 300 mg trazodone (a medication used to treat sleep disorders).
 - Vitamin D

- At 4 p.m.:
 - 1 mg benztropine
 - 500 mg metformin (a medication for diabetes)
 - 100 mg quetiapine
 - 2 mg risperidone

- At bedtime:
 - 40 mg atorvastatin (a medication used to lower cholesterol).
 - 1 mg benztropine
 - .1 mg clonidine
 - 1000 mg divalproex
 - 100 mg docusate sodium
 - 325 mg ferrous sulfate every other day
 - 150 mg metoprolol
 - 20 mg paroxetine
 - 700 mg quetiapine
 - 300 mg trazodone

P1 provided the following information:

- At about 8:30 a.m. on December 29, 2022, the VA, who normally did not take medications at the day program, got to the day program and told P1 that s/he "didn't want to die." The VA told P1 that s/he had not received his/her medications that morning at the facility.
- P1 took the VA into a "sensory room" to help him/her calm down. The VA was not acting "normal" and was "looking at walls" and "spacing out."
- At about 9 a.m., P1 called the facility, but did not remember who s/he talked to (during the investigation it was determined that P1 talked to P2). When P1 told P2 that the VA had not received his/her morning medications that morning at the facility, P2 told P1 that s/he would be there "within" an hour. When P2 got to the day program at 10:37 a.m., P2 brought the VA's lunch to him/her, but did not have the VA's medications and said that the key to the medication cabinet was missing, but that s/he would bring the medications to the VA as soon as possible.
- When the VA ate lunch at about 11 a.m., P1 sat with the VA, but the VA did not eat and was "distracted." About 15 minutes later, the VA went to the bathroom and after s/he was done using the bathroom, the VA asked to eat again, but did not eat and was "shaking," "staring into space" and saying that s/he "doesn't want to die."
- At about 1 p.m., P2 came back to the facility and the VA "bolted" to P2's car. P1 was not certain whether the VA took the medications because the VA left with P2 (an incident report, written by P1, stated that "house staff [persons] arrived" at 11:54 a.m.).

P2, P3, and the HCP provided the following information to this investigator:

- When P2 got to the facility on the morning of December 29, 2022, the VA had already left for the day to go to the day program and P2 learned from the morning staff person that the VA "refused" to take his/her morning medications and refused to take his/her lunch to the day program, which was not unusual.
- P2 did not remember who called to say that the VA had not taken his/her morning medications at the day program, but P2 took the medications and lunch to the VA at about 10 a.m. When P2 got to the day program, the VA came outside and "didn't want to stay there" so P2 brought the VA back to the facility and the VA took his/her morning medications. When the VA stated that s/he had a headache, P2 gave the VA pain medication. Later, the VA seemed to be doing well and said that his/her headache was better.
- Later that afternoon, after P2 had left for the day, P3 was working his/her shift at the facility. P3 called P2 because the VA was feeling "shaky." As a result, P2 returned to the facility to assess the VA. The VA told P2 that s/he thought that s/he was having a seizure, but P2 did not see signs that the VA had a seizure. P2 stated that the VA was "pacing," but P2 had seen the VA do that previously. P2 tried to assist the VA with checking his/her blood sugar (the VA typically did this independently), but the VA refused. P2 also encouraged the VA to seek medical care that afternoon, but the VA "refused." When P2 left, s/he told P3

to call if the VA's condition changed and P2 called the HCP and told him/her. The HCP stated that s/he would see the VA the following day. P2 did not hear anything more from P3 that night. At some point, P3 assisted the VA with checking his/her blood sugar but P3 did not recall what the level was and stated it was "normal." P3 did not recall what the VA ate that night, but remembered that the VA was "awake a lot," which was not unusual.

- When P2 got to the facility the following morning, December 30, 2022, the VA slept until about noon, which was not unusual. When the VA woke up, the VA was "Okay," but P2 continued to ask the VA to go seek medical care because the VA stated, the night before, that s/he thought s/he was having a seizure. The VA agreed to seek medical care.
- On December 30, 2022, the HCP was at the facility. Although the VA was "fine" and "happy," the HCP noticed that the VA's bedtime doses of medications had not been administered to the VA on December 27 and 28, 2022. When the HCP asked P2 why the medications were not given to the VA, P2 told the HCP that the HCP told P2 "not to give" the VA his/her medications.
- P2 stated that on December 27, 2022, s/he had communication with the HCP because P2 had some questions related to the VA's ferrous sulfate medication. From that communication, P2 interpreted that all of the VA's medications in the blister pack were to be discontinued and the VA was to only receive the ferrous sulfate medication. After that conversation, P2 "verbally" told other staff persons.
- The HCP said that there was "miscommunication" between him/her and P2 and that the HCP meant that all bedtime medications were to be given to the VA and the ferrous sulfate was to be given from a specific card, but that P2 misinterpreted that and gave instructions to staff person to not administer the bedtime medications in the blister pack, but to only give the ferrous sulfate to the VA.
- Because the VA missed two doses of evening medications and had not slept well, the HCP thought it was best to have the VA evaluated in the hospital. While the VA was hospitalized, it was determined that the VA did not have a seizure.

The MAR stated that on December 27, and 28, 2022, the VA received his/her prescribed morning and 4 p.m. medications and the bedtime medications were held with a note written that "[P2] said to hold." On December 29, 2022, the VA received his/her prescribed morning medications (P5 signed off on the MAR as having administered these medications, but this was the dose that the VA initially refused prior to leaving for day program so P2 later administered these medications to the VA). The VA received his/her prescribed 4 p.m. and bedtime medications.

The G stated that s/he talked to the VA every Friday and the G did not notice any specific changes when the VA missed the two bedtime doses.

A review of the VA's case notes did not show any entries between December 14 and 30, 2022. An entry by the HCP on December 30, 2022, provided information that was consistent with the information s/he provided to this investigator, but the HCP added that the VA displayed some incidents of property destruction the night before.

The VA's medical records showed that the VA was seen in the emergency room (ER) on December 30, 2022, that the VA had one seizure "yesterday." No treatment was provided and the VA was discharged the same day. On January 3, 2023, the VA was seen by his/her primary care physician who documented that in his/her "professional opinion," that the VA did not have a seizure on December 29, 2022.

Conclusion for Allegation One:

Regarding the missed bedtime medications on December 27 and 28, 2022:

The VA received several medications in the morning, at 4 p.m./evening, and at bedtime. The medications came to the facility from the pharmacy packaged together in a blister pack labeled with the date and time they were to be administered with the exception of ferrous sulfate which was packaged separately (the time of the dose varied every other day).

On December 27, 2022, P2 and the HCP discussed the VA's bedtime medications and P2 mistakenly interpreted what the HCP said to mean that all of the VA's bedtime medications should be discontinued and that the VA was to only receive the ferrous sulfate. On December 29, 2022, P1 stated that the VA was not acting "normal" during the day, P2 stated the VA felt "shaky" that afternoon into evening. The VA did not have worsening or additional symptoms that evening but had some sleeplessness overnight, which however was not that unusual.

On December 30, 2022, the HCP was at the facility and stated the VA was "fine" and "happy." Then the HCP discovered that the ferrous sulfate was the only medication given to the VA at bedtime on December 27 and 28, 2022. Because of that, the HCP thought that the VA should be medically evaluated. The VA was seen in the ER on December 30, 2022, and discharged the same day with no treatment provided.

Although the VA did not receive his/her prescribed bedtime medication on two occasions because of a miscommunication between P2 and the HCP and that the VA had some symptoms that were possibly effects from not receiving the bedtime medications as prescribed, given that as soon as this was discovered, the VA was evaluated by a medical professional and no treatment was provided/needed, and that the VA's physician determined that the VA did not have a seizure.

Minnesota Statutes, section 626.5572, subdivision 17, paragraph (c), clause (4), states, "A vulnerable adult is not neglected for the sole reason that an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care."

P2's failure to accurately ensure that HCP's orders were accurately implemented and communicated to other staff constituted an error in the provision of therapeutic conduct. This error in the provision of therapeutic conduct to the VA by P2 was not maltreatment.

It was determined that neglect did not occur (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).

Regarding the VA's morning medications not being administered to the VA in a timely manner on the morning of

December 29, 2022:

Information from the investigation showed that although P5 signed off that s/he administered morning medications to the VA on December 29, 2022, the VA did not receive those medications at 8 a.m. as outlined in the MAR because the VA refused and went to day program. Information from P1, who worked at the VA's day program, showed that when the VA arrived at day program that morning, the VA was not acting normally and stated that s/he had not had his/her morning medications.

Conflicting information was provided regarding when the VA eventually received the morning medications. P1 stated that P2 did not bring the VA's morning medications to the VA until about 1 p.m. but P2 stated that s/he administered the medications to the VA at about 10 a.m. Although the VA was "not acting normally," and received the medications later than prescribed, it was not determined if the VA's change in behavior was because the VA received the medications late on December 29, 2022, because the VA missed most evening medications on December 27 and 28, 2022, or a combination of both. However, given that the VA refused his/her morning medications when P5 offered and that the VA eventually received his/her morning medications, there was a preponderance of the evidence that there was not a failure to provide the VA with reasonable and necessary care and services.

It was determined that neglect did not occur (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).

Allegation Two: *It was reported that staff persons were not following the VA's low sodium diet and not providing nutritious food to the VA.*

The VA's *Self-Management Assessment* showed that s/he enjoyed assisting with meal preparation and was "open to suggestions for a varied and healthy meal and understands that [his/her] housemates also have a choice in items on the menu."

The VA's *Individual Abuse Prevention Plan* showed that s/he had a moderate developmental disability and "does not make healthy food choices and prefers junk food and fast food over nutritional value." As a result, "staff [persons] will continue to keep healthy food in the kitchen refrigerator" and store extra food in other areas of the facility.

A doctor's order, provided to the investigator by the CM, was dated November 15, 2022, and stated "diabetic diet," "low sodium," and "lower carb," but specific parameters were not identified.

The VA was not aware of any dietary requirements s/he had, but stated that s/he enjoyed eating "fried chicken."

P1 stated that for approximately three months, the VA had been coming to the day program with an excessive amount of sodium in his/her lunches. P1 gave an example in which the VA had two packages of "ramen noodles" which were about 1800 mg of sodium and "Hormel meals" which were 1600-1900 mg of sodium. The G stated that in mid-December 2022, the facility began preparing specific meals for the VA that were specific to his/her dietary guidelines, but that the VA felt that other clients "get the better food."

P2-P4 provided information that the facility attempted to follow the VA's dietary guidelines, but there were times that the VA refused to follow those guidelines and times that the VA took food as a result. When that happened, staff persons attempted to redirect the VA to eat healthier options, and although the VA would sometimes comply, there were times the VA refused.

A picture, taken by this investigator on January 10, 2023, showed a menu posted in the kitchen. The picture did not show that separate meals were prepared for the VA. The menu showed what was to be prepared for breakfast, lunch, dinner, and a snack. Information showed that a variety of fruits and vegetables were offered, as well as "chips," "yogurt," and salads.

Notes provided by the CM stated that on October 6, 2022, that menus were not available and "one staff [person] needed an explanation of what a menu is." On October 18, 2022, the CM documented that staff persons "were going to get menus." On November 18, 2022, the CM sent a fax to the facility regarding the dietary guidelines for the VA and told staff persons to "plan for this diet" and "ask clinic for assistance."

The facility had a "Healthy Living Policy," which stated that it was "committed to providing healthful, nutritious meals and snacks, as well as a daily exercise."

The facility's *Internal Review of an Alleged Maltreatment Report* showed that the VA had a "history of making unhealthy food choices and prefers junk food and fast food" and "has taken food from housemates as well as continued to eat until there was no food in the home." The review also stated that the VA "eats [his/her] lunch on the van ride to work, in hopes that staff [persons] there will purchase fast food for lunch." As a result, "residential staff [persons] have requested [the VA's] day program communicate if [the VA] arrives to work with a minimal lunch so follow up can be implemented." Also, the review stated that staff persons will "encourage residents to follow dietary requirements made my health care providers."

Conclusion for Allegation Two:

Although the VA was on a low sodium diet and concerns were raised that the facility did not comply with the VA's dietary requirements, information from facility documentation and P2-P4 showed that staff persons attempted to provide nutritionally balanced food and comply with the VA's dietary requirements, however there were times that the VA refused to comply. Given that, there was not a preponderance of the evidence whether there was a failure to provide the VA with reasonable and necessary care and services.

It was not determined whether 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).

Allegation Three: *It was reported that the VA wore soiled clothing and that his/her living conditions were deteriorating.*

The VA's *Self-Management Assessment* showed that the VA was "receptive to [staff persons'] prompts and instructions to complete [his/her] laundry. However, [s/he] is more successful at maintaining [his/her] laundry with staff [person] assistance."

Notes by the CM provided the following information:

- On September 23, 2022, the VA's clothing, sheets, and towels were lying on the bathroom floor and there was "urine smell, mold on clothes."
- On October 6, 2022, there was a box of clothing in the lower level that contained the VA's "moldy/urine soaked clothing."
- On October 11, 2022, the VA's bedroom "smelled good," but his/her closet was "not organized."

P1 stated that the cleanliness of the VA's clothing had been an ongoing issue for some time, but that it had worsened since early December 2022. P1 also stated that the VA's clothing was stained at times, and that there were times that the VA wore the same outfit every day for five days in a row. Also, P1 felt that the VA's mental "state of mind" had deteriorated within the last month due to staff persons not following dietary guidelines (see allegation two) and the cleanliness of the VA's clothing.

The VA denied wearing soiled clothing.

During this investigator's scheduled site visits on January 10 and 26, 2023, the VA was observed and his/her clothing appeared to be clean. In addition, the facility appeared to be clean and there was no apparent odors.

P2-P4 provided mostly similar information that staff persons laundered the VA's clothing as often as possible and that staff persons provided verbal redirection to the VA if the VA wore soiled clothing, but that there were times that the VA refused to comply with requests from staff persons.

The G stated that sometimes the VA complied with requests to change soiled clothing, but that there were also times the VA would refuse to do so.

The facility's *Internal Review of an Alleged Maltreatment Report* showed that in "October 2022, a site visit took place at [the VA's] home. [The VA's] bedroom and laundry were found to be in disorder. Upon discovering this, all staff [persons] working with [the VA] were retrained on the *Facility Sanitation Policy*. Since then, there have been no additional reports of concern made."

Conclusion for Allegation Three:

Concerns were brought forward that the VA wore soiled clothing and the investigation showed that although there were times that the VA wore soiled clothing and that soiled clothing was evident at the facility, the facility recently developed a plan for washing the VA's soiled clothing regularly and appeared to address concerns related to urine soaked clothing. In addition, information also showed that staff persons were working with the VA to resolve issues of him/her wearing soiled clothing, but that there were times that the VA refused to comply. Given that, there was not a preponderance of the evidence whether there was a failure to provide the VA with reasonable and necessary care and services.

It was not determined whether 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).

Action Taken by Facility:

The facility completed an internal review and determined that although policies and procedures were adequate, they were not followed. Although the review did not identify who did not follow the policies and procedures, additional training was provided to P2. The review also stated, "On an ongoing basis, the Program Coordinator and the Program Director will complete routine check-ins through the week to address nutritional options on site, residential laundry, site cleanliness and overall/general site conditions. The Program Director will complete on-site visits at a minimum of once weekly to ensure Zumbro House Policies are implemented."

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

No further action taken at this time.