

**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:** 202210500

**Date Issued:** March 8, 2023

**Name and Address of Facility Investigated:**

**Disposition:** Inconclusive

Unlimited Possibilities W 97 1/2  
8425 W 97th Street  
Minneapolis, MN 55438

Unlimited Possibilities DBA Supported Living Solutions  
1504 E 122nd Street  
Burnsville, MN 55337

**License Number and Program Type:**

1107971-CRS (Community Residential Setting)  
1079470-HCBS (Home and Community-Based Services)

**Investigator(s):**

Deb Neubauer-Hoffman/Christine Henne  
Minnesota Department of Human Services  
Office of Inspector General  
Licensing Division  
PO Box 64242  
Saint Paul, Minnesota 55164-0242  
Deb.Neubauer-Hoffman@state.mn.us  
651-431-6567

**Suspected Maltreatment Reported:**

It was alleged that staff persons yelled at and argued with a vulnerable adult (VA) and called the VA names.

**Date of Incident(s):** Ongoing prior to December 19, 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 for this investigation was obtained remotely, including documentation from the facility; and through eight interviews conducted with two facility staff persons (P3 and P4), two supervisory staff persons (P1 and P2), a community person who worked with the VA outside of the facility (CP), the VA's case manager (CM), the VA's guardian (G), and the VA.

The VA told this investigator that s/he enjoyed shopping at stores like Walmart, Target, and the Dollar store. The VA's *Coordinated Services and Supports Plan (CSSP)* stated that the VA enjoyed his/her community involvement and had dreams to visit Disneyland. The VA was diagnosed with an intellectual disability, major depressive disorder, and anxiety disorder. The CSSP listed the following "barriers": difficulty communicating his/her feelings to staff "during conflict," history of physical and verbal aggression, and threats of self-harm and leaving the facility. The VA also engaged in "interfering" behaviors, made false statements/allegations, and was confrontational "at times." The VA did not "always" understand what was happening and needed time to process. The VA was vulnerable to "all forms" of abuse. The facility provided 24-hour awake supervision and two staff persons for the VA to "best support" him/her.

The VA told this investigator that staff persons at the facility "scream[ed]" at him/her, called him/her names like "big," and talked behind his/her back in a language other than English. The VA also did not "appreciate" being filmed on a phone by staff persons.

The CP said that on December 19, 2022, around 3:30 p.m., while on the phone with the VA, s/he overheard some "arguing" between unknown staff persons and the VA. The staff persons' voices sounded "angry" and "upset" and the CP felt "uncomfortable" with what s/he heard. When the VA tried to tell the CP that staff persons called the VA "names," filmed the VA without consent, and withheld the VA's birth control medication (that day and the day before the phone call), the staff persons interrupted the VA. The VA told the CP that staff persons were eating his/her food; however, the CP heard an unidentified staff person in the background say, "No, we're not doing that." The CP was not familiar with the VA's diagnoses, but was aware the VA had multiple prior complaints about staff persons.

P1 and the facility's staff schedule provided the following information:

- The facility's staff schedule showed that P1 worked on December 19, 2022, from 8 a.m. to 4 p.m. P1 told this investigator that s/he did not "argue" with the VA, but rather tried to "redirect" the VA. P1 said that due to the VA's depression, the VA's emotions "go by the second" and that his/her "actions" are "controlled" by his/her "emotions." P1 gave the example, that one time the VA had a doctor appointment and said that s/he had just gotten out of the shower, but when P1 checked the shower, it was dry. The VA then "scream[ed]," "yell[ed]," and called P1 "all kinds of names." P1 said that s/he

“disengage[d]” with the VA, but “the next thing [s/he] knew,” the VA was on his/her phone and told the G that P1 called him/her a “funky bitch,” which P1 denied. P1 said that when the VA got “into a mood” and “scream[ed]” and “yell[ed],” staff persons first tried to “redirect” the VA by asking the VA questions, but the more questions staff persons asked, the “angrier” the VA became. When these instances happened, P1 told the VA, “Please don’t disrespect me,” but did not “argue” with the VA.

- P1 did not know of any times where staff persons called the VA names or yelled at the VA.
- P1 acknowledged recording the VA on a cell phone and it was for the purposes of showing the VA’s behavioral situation to his/her supervisor.

The facility’s staff schedule showed that on December 19, 2022, P3 worked 9:06 a.m. to 9:09 p.m. P3 said that the VA was unable to report accurate information and had a “rollercoaster” of behaviors. “One minute [the VA’s] happy, one minute [the VA’s] sad, one minute [the VA’s] cussing me off, one minute [the VA’s] crying” . . . “It’s all over the place, one minute [the VA’s] hugging and saying sorry.” P3 denied yelling at the VA and said s/he was trained to “be kind” and “listen” to the VA and give the VA “space” when needed. P3 knew that the VA did not like it when staff persons spoke to each other in any language other than English so P3 would try to go to the office or another location if doing so.

P2 said that the VA had a two to one staff person ratio due to the VA’s history of making false allegations against staff persons. If that VA saw staff persons talking to one another, the VA believed that the staff persons were talking about him/her. P2 stated that the VA “verbally abuses” staff persons multiple times daily including “cussing [staff persons] out” and saying that staff persons were “sexually inappropriate” with him/her when there was no evidence of it.

P4 said that the VA “lov[ed] to chat” with staff persons, but often said one thing one day and a couple days later said “something different” so was not an accurate reporter of information. P4 worked the night shift and had never heard staff persons call the VA names.

The CM said that the VA’s ability to accurately report information was “not good” and that the VA “always says staff yell at [him/her].” Because of the VA’s false claims against staff persons, a two staff person ratio was provided for the VA.

The G said that the VA was unable to accurately report any information and “it was a roller coaster” with the VA.

The facility’s *Internal Review* said that P1 and P3 each denied yelling at the VA.

All staff persons interviewed were trained on the Reporting of Maltreatment of Vulnerable Adults Act and the VA’s plans prior to the incident.

### **Conclusion:**

The VA stated that s/he did not “appreciate” being filmed on a phone. P1 acknowledged having done so, but said it was to show his/her supervisor the VA’s behavioral situations.

Although the CP said that on December 19, 2022, s/he overheard some “arguing” between unidentified staff persons and the VA, P1 and P2, who worked at that time, each denied arguing with the VA.

The VA said that staff persons at the facility "scream[ed]" at him/her, called him/her names like "big," and talked behind his/her back in a language other than English. P1, P3, and P4 denied these allegations. P1, P2, P4, and the G each stated that the VA was not able to always provide accurate information and P2 said that the VA had a history of making false allegations against staff persons. Given the conflicting information regarding staff persons interactions with the VA and the VA's history of providing inaccurate information, there was not a preponderance of the evidence whether staff persons actions could reasonably be expected to produce 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 and followed and no additional staff training was needed.

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

No further action taken.