

**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: 202300125

Date Issued: April 5, 2023

Name and Address of Facility Investigated:

Munsinger Bridges MN
2056 47th St. SE
St. Cloud, MN 56304

Bridges MN
1932 University Ave. W.
St. Paul, MN 55104

Disposition: Substantiated as to neglect of a vulnerable adult by a staff person.
Inconclusive as to physical abuse.

License Number and Program Type:

1103760-H_CRS (Home and Community-Based Services-Community Residential Setting)
1079030-HCBS (Home and Community-Based Services)

Investigator(s):

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Office of Inspector General
Licensing Division
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Suspected Maltreatment Reported:

It was reported that a staff person (SP) got into a physical altercation with a vulnerable adult (VA).

Date of Incident(s): January 5, 2023

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 (1); and subdivision 17, paragraph (a):

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: hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult.

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 a site visit conducted on January 23, 2023, from documentation at the facility, law enforcement records, and through seven interviews conducted with the VA, the VA's guardian (G), four facility staff persons (P1-P4) and a facility management staff person (P5). Although this investigator contacted the SP to request an interview, the SP did not respond to the requests. However, the SP provided information to law enforcement so that information was included below.

The VA lived on the main level of the facility and had one awake staff person (determined to be P2 during the investigation) assigned to him/her during overnight hours. Another client, who slept during the incident, lived on the upper level of the facility and had two staff persons assigned to him/her, one of which was an awake staff (the SP) and the other (determined to be P1 during the investigation) was allowed to sleep when the client slept. P5 stated that the VA had access to all areas within the facility. The facility had a refrigerator on the upper level of the facility and the freezer section was on the bottom part of the refrigerator. The facility had video surveillance cameras with audio.

The VA's *Individual Abuse Prevention Plan* showed that the VA enjoyed working and earning a paycheck. The plan stated that the VA had a history of engaging in verbal aggression toward others. When that happened, staff persons were trained to provide verbal redirection to the VA and "verbal de-escalation."

A review of the VA's file did not identify a specific diagnosis for the VA or note that s/he had a history of engaging in physical aggression toward others but noted that the VA had an epileptic seizure disorder.

A law enforcement report provided the following information:

- At about 2:34 a.m. on January 5, 2023, a law enforcement officer (LEO) was dispatched to the facility due to an "assault call." When the LEO arrived, s/he talked to the VA, who was outside when the LEO arrived. The VA stated that s/he was trying to access the refrigerator that s/he was "allowed to use" when the SP and "other staff [persons] were trying to prevent" the VA from accessing the refrigerator. The SP then stepped toward the VA and got in the VA's "face." When that happened, the VA "backed off" and the SP "continued forward and grabbed [the VA] by the throat."
- The VA stated that the SP "grabbed" the VA's "throat four times in total before the two were separated."
- The report stated, "While speaking with other staff [persons] who witnessed the incident, it appears that [the VA] commonly makes up things to make [him/herself] look like the victim."

- When the LEO talked to the SP, the SP stated that s/he and “other staff [persons] were unsure” if the VA “was allowed to use that refrigerator or if it belongs to another client.” When the SP “asked” the VA to “go back downstairs,” the VA became “upset” and “there was a physical altercation between the two of them.” The SP stated that s/he “only used” his/her “hands to push [the VA] away” from the SP and that the VA was “attacking” the SP and “punching” the SP “several times in the leg.”
- The report did not document that the VA had any injuries, red marks, or bruising.

The VA provided the following additional information to this investigator:

- Prior to the incident, the VA asked P2 if s/he could go to the upper level to get ice (the VA did not have ice on the lower level) and P2 said, “Yes.” While the VA sat on the floor to get ice, some of the ice fell behind a basket that held the ice, so the VA took the basket out. When the VA took ice out and put it in a cup, the SP, who had been sitting on a couch, got up and walked toward the VA. The SP “stood over the top of me” and “told me flat out that I need to get the hell out of there,” and “That’s not your belongings.” The VA said, “I know what’s [the other client’s] and I know what’s mine, so you need to stay out of it.” The SP then “knocked” the cup of ice “out of my hand,” which caused the VA to become “upset.” Because the ice was “all over the floor,” the VA picked it up and when that was done, the VA again put ice in the cup and set it next to the VA.
- The VA put the basket back into the freezer and as s/he closed the door, the SP “knocked the cup out of my hand again,” which again caused the ice to spill onto the kitchen floor. Again, the VA picked up the ice and put it in the sink while the SP was “still following me around the kitchen” while P2 used the bathroom. The SP told the VA to “stop” doing what s/he was doing and “get downstairs” because the VA, who was now standing, “don’t belong upstairs.”
- The SP then used his/her hand to “grab” the VA’s “throat.” The VA “shoved” the SP away because the VA “couldn’t get a breath.” A few minutes later, the SP “did the same thing” again and the VA “pushed” the SP away. As that happened, P2 came out of the bathroom and told the VA to “go downstairs,” but the VA did not do that because the VA “wanted to beat the shit” out of the SP. As P2 tried to “hold” the VA “back” from the SP, the VA told P2, “No, you just stay away. I don’t want you to get hurt.”
- The VA then went to get ice again and the SP “attacked me again” and said, “I’m going to kill you.” The SP also told the VA that one of his/her family members was a “bitch.” The SP then “grabbed my throat” again (third time). When that happened, P2 stood between the SP and the VA and told the VA to “relax.” During the incidents, P1, who sat on the couch, “didn’t say anything or do anything.”
- The SP then “grabbed my throat” again (fourth time) and “grabbed me by my hair and threw me on the floor.” The VA then was “hitting [the SP’s] foot” so the SP would “let go.” The VA then got up and picked up a dining room chair and planned to throw it at the SP but threw it on the floor instead. The VA then said, “Don’t you dare grab my throat ever again.” After that, the VA went outside because s/he “knew they were going to call the police.”
- When the SP held the VA’s throat the first three times, the SP held it about two to three minutes, but when the SP held the VA’s throat the last time, the SP held it for four to five minutes.

- When the VA was asked about possible injuries s/he had related to the incident, the VA stated that s/he had a "bruise" on his/her right shoulder, a "big black and blue mark" on the VA's right arm, and that his/her right wrist was "all black and blue."

This investigator viewed camera video footage (57 minutes) of the incident on January 5, 2023, (the audio portion, except for the VA's voice, was very difficult to hear) and observed the following:

- While P1 and the SP sat on a couch in the living room, the VA entered the upper level, went to a freezer, and sat on the floor. About one minute later, the SP got up and talked to the VA, but the SP's words were not audible. The SP returned to the living room.
- While the SP sat on the couch, s/he said something to the VA, but it was not audible. The VA said, "Bullshit, I can be up here all I want," and the SP, who then got up and walked toward the VA, said, "No you cannot." The SP told the VA s/he "could be there in the morning" but that the other client was trying to sleep so the VA needed to "be respectful of that." The VA and the SP were standing face to face both using elevated, loud voices.
- The VA said, "Don't fucking grab my throat," but the SP was not touching the VA's throat. The SP pushed the VA's chest when the VA moved close to the SP and the VA again said, "Don't grab my fucking throat." P2 stood in between the VA and the SP but the VA moved around P2 to hit the SP.
- The SP and the VA continued to stand close to one another. The VA was verbally aggressive, and the SP was talking to the VA in an elevated tone, but it was inaudible on the video what the SP was saying. The VA continuously lunged toward the SP and the SP used his/her hands to prevent the VA from hitting the SP, but there were several occasions where the SP pushed the VA away when the VA got into the SP's personal space. The SP and the VA made contact with each other's arms several times including the SP briefly grabbing the VA's clothing when the VA swung his/her fist at the SP. The VA kicked the SP and was punching toward the SP. The VA then grabbed onto the SP and went to the ground still holding the SP. The SP said, "I'm not fighting you," and the VA punched the SP's leg so the SP moved around the VA. The VA held onto the SP's lower body and P2 told the VA to "let go" of the SP. The VA stood up and continued to attempt to get around P2 to the SP. The VA, P2, and the SP moved out of the camera view but could still be heard. The VA continued to be verbally aggressive. P2 and the SP were talking but that was inaudible on the video. Less than a minute later, the VA walked back into the camera view and grabbed something made of cloth from the floor and threw it. The VA continued to be verbally aggressive toward the SP and the SP walked away to the couch.
- Toward the end of the incident, the VA continued to be verbally aggressive and stood right next to the SP face to face. Then, the SP said, "I'm going to sue your ass," and "Get the fuck out." The SP pushed the VA away. The VA grabbed a chair and raised it up to throw it at the SP but then threw the chair onto the floor. The SP sat on the couch and the VA continued to be verbally aggressive telling the SP, "You do not grab my fucking throat ever," several times. The VA continued to walk around yelling names at the SP, including using racial slurs until the VA went outside when law enforcement arrived.

- The video showed that the SP was not in the kitchen and did not push the cup of ice from the VA's hand like the VA stated. Also, there was no time that the SP grabbed the VA's hair and threw the VA to the floor and the SP did not grab the VA's throat.
- Throughout the incident, P2 was heard providing verbal redirection to the VA, but it was not evident that P1 provided any verbal redirection to the VA.
- Throughout the incident, the SP did not speak to the VA in a calm manner and there was no information that the SP attempted to verbally redirect the VA or stop engaging with the VA, even when the VA began to leave the room at one point.

P2 provided the following information to this investigator:

- While P2 used the bathroom, s/he heard "an argument" between the SP and the VA. P2 heard the SP say that it was "too late" for the VA to get ice, which was something that the VA was able to do, and that the VA should "go downstairs."
- As the incident between the VA and the SP escalated, P2 got in between them and told the SP to "go somewhere else," but the SP did not do that.
- P2 did not see the SP grab the VA's neck.
- When P2 was asked how staff persons were trained to deal with the VA when s/he became upset, P2 stated that staff persons were trained to "listen" to what the VA said and give him/her "space" to calm down.
- P2 did not see any ice on the kitchen floor and did not hear the SP say derogatory comments related to the VA's family members. P2 did not see any injuries on the VA when the incident was over.

P1 provided the following information to this investigator:

- When the VA accessed the refrigerator, the SP told the VA that it belonged to the other client and that the client would "get mad." The VA then said, "No, I can do whatever I want." As the SP and the VA began to verbally escalate with one another, P1 told the VA to get what s/he wanted from the refrigerator and then leave. P1 also told the SP that the VA was allowed to access the refrigerator, but the SP "didn't listen."
- When the VA was physically aggressive toward the SP, the SP used his/her hands to "block" the VA. In addition, the SP tried to verbally redirect the VA to calm down.
- P1 did not see the SP push the VA or grab his/her neck. P1 saw the VA grab the SP's leg and when that happened, the VA went on the floor.
- P1 did not hear the SP say any negative comments to the VA about his/her family and heard the VA say that s/he was going to "sue" the SP, but P1 did not hear the SP say that to the VA.

- P1 did not see any injuries on the VA that night or in subsequent days following the incident. P1 also stated that s/he provided verbal redirection to the VA throughout the incident and told him/her to calm down and return to the lower level.

P3, who was not working at the time of the incident, stated that when s/he talked to the VA about the incident, the VA did not say much, but stated that s/he hit the SP and that the SP “grabbed” the VA’s neck. P3 did not notice any injuries on the VA when s/he saw the VA that day but noticed a “small bruise” on the VA’s right arm about two to three days later. P3 stated that the VA tended to “downplay” his/her role in events.

P4, who was not working at the time of the incident, stated that s/he worked with the VA later that day and that the VA, who was allowed to access the refrigerator on the upper level, stated that s/he and the SP got into a verbal and physical altercation, but the VA did not name the SP. The VA also told P4 that P2 tried to “mediate” the incident and provided verbal redirection to the VA. P4 did not see any injuries on the VA that day or on subsequent days following the incident. P4 also stated that staff persons were trained to deescalate clients by remaining “calm” and to “not escalate anything.”

A review of the VA’s case notes between January 5 and 10, 2023, showed no documentation that the VA had injuries, red marks, or bruising from the January 5, 2023, incident.

The G stated that when s/he saw the VA on January 13, 2023, the VA stated that when s/he put his/her finger near the staff person’s (the VA did not name the SP) face, the staff person “pushed” the VA’s finger, which caused the VA to go “down to the floor.” The VA told the G that when the LEO responded, the VA told the LEO that s/he did not need medical attention. Although the G noted bruising near the VA’s left eye, the VA told the G that the bruising was the result of the VA “rubbing” his/her eyes and that it was not related to the incident. In addition, the G stated that the VA “would be able to report the incident with a good degree of accuracy.”

The facility’s *Internal Review* provided the following additional information:

- The SP and the VA “pushed” each other and the SP “attempted to intervene” and “encourage” the VA to calm down, but P1 “had not made attempts to intervene and remained on the couch.” P2 “attempted to intervene during the physical altercation” between the SP and the VA, “but was unsuccessful.”
- The VA had a “small scratch” on the side of his/her face that “did not break the skin.” The report also indicated that the VA “did not request further medical attention regarding this.”

The facility’s training records showed that all staff persons, including the SP, interviewed for this investigation were trained on the Reporting of Maltreatment of Vulnerable Adults Act and the VA’s care plans prior to January 5, 2023. In addition, documentation showed that the SP was trained on “Positive Supports Rule Core Training” on September 18, 2022.

Relevant Statute:

Minnesota Statutes, section 245D.04, subdivision 3, paragraph (a), clause (6) states that a person’s protection-related rights include being treated with courtesy and respect.

Conclusion:

A. Maltreatment:

During the early morning hours of January 5, 2023, the VA went to the upper level of the facility to get ice. The camera footage showed that as the VA was getting the ice, the SP said something to the VA that was inaudible and the VA said, "Bullshit, I can be up here all I want." The SP, who then got up and walked toward the VA, said, "No you cannot," and then a verbal altercation occurred between the SP and the VA. The altercation escalated into a physical altercation. Camera footage showed the VA becoming physically aggressive toward the SP punching and lunging at the SP and showed the SP pushing the VA when the VA lunged at the SP and briefly grabbing the VA's clothing when the VA punched at the SP. The SP and the VA made contact with each other's arms several times while facing each other. The SP was heard on the camera footage making comments to the VA, such as, "I'm going to sue your ass," and "Get the fuck out." The VA was heard yelling names and racial slurs at the SP. Although the VA told the LEO and this investigator that the SP grabbed the VA's throat four times and the VA told this investigator that the SP pulled the VA's hair and threw the VA's cup of ice twice, camera footage showed that none of those things occurred.

Regarding physical abuse:

The VA stated that s/he had bruising from the SP's actions. P1 and P2, who were present during the incident, and P4, who saw the VA after the incident, did not see any bruising or injuries and there was no information documented in the VA's case notes or the law enforcement report regarding an injury or bruise. However, the *Internal Review* documented that the VA had a "small scratch" on the side of his/her face that did not break the skin. Therefore, it was not determined how or when the VA sustained the scratch or whether the VA sustained the scratch as a result of the SP's actions or by any means other than accidental.

The VA was physically aggressive toward the SP so the SP pushed the VA and grabbed the VA's clothing, which was inconsistent with the standards of a professional caregiver in a facility licensed by the Department of Human Services and a violation of Minnesota Statutes, section 245D.04, subdivision 3, paragraph (a), clause (6). However, there was no information that the SP pushing the VA or grabbing the VA's clothes could reasonably be expected to produce pain and other than a scratch on the VA's face which the cause of was not determined, the VA did not have any injuries. Therefore, there was not a preponderance of the evidence whether the SP's actions could be reasonable expected to produce pain or injury.

It was not determined whether physical 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: hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult).

Regarding neglect:

The *Individual Abuse Prevention Plan* showed that the VA had a history of engaging in verbal aggression toward others and when that happened, staff persons were trained to provide verbal redirection and "verbal de-escalation" to the VA.

The VA was getting ice when the SP said something to the VA that resulted in the verbal and physical altercation between the two. The SP was heard saying, "I'm going to sue your ass," and "Get the fuck out." In addition, the SP had an elevated tone of voice and throughout the incident, the SP did not speak to the VA in a calm manner. There was no information that the SP attempted to verbally redirect the VA or stop engaging with the VA, even when the VA began to leave the room at one point. The VA was solely upstairs at that point to get ice, and the SP's actions likely instigated the incident and caused the VA to continue to escalate which was inconsistent with the standards of a professional caregiver in a Department of Human Services licensed facility and a violation of Minnesota Statutes, section 245D.04, subdivision 3, paragraph (a), clause (6).

Given that the SP's actions instigated the incident, heightened the VA's aggression, and escalated the incident, there was a preponderance of the evidence that the SP failed to provide the VA with reasonable and necessary care and services.

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.

The SP was trained on the Reporting of Maltreatment of Vulnerable Adults Act and on the VA's plans. The SP was responsible for the care of the VA at the time of the incident. Therefore, the SP was responsible for neglect 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 neglect for which the SP was responsible did not meet statutory criteria to be determined as recurring or serious because it was a single event of neglect and there was no information that the VA was harmed as a result of the neglect.

Action Taken by Facility:

The facility completed an *Internal Review* and determined that although policies and procedures were adequate, the SP engaged in "non-therapeutic contact" with the VA. The SP was no longer at the facility and P1 and P2 received additional training.

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

The SP was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, the SP was notified by the Office of Inspector General that any further substantiated act of maltreatment, whether or not the act meets the criteria for "serious," will automatically meet the criteria for "recurring" and will result in the disqualification of the SP. The determination that the SP was responsible for maltreatment is subject to appeal.

A correction order was not issued for the violation outlined in this report because the facility took immediate corrective action.