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: 202210695

Date Issued: June 23, 2023

Name and Address of Facility Investigated:

SAFE Harbor Homes Inc
13308 W 3rd St
Duluth, MN 55808

SAFE Harbor Homes Inc
8226 Vinland St
Duluth, MN 55810

Disposition:
Allegation One: Inconclusive
Allegation Two: Inconclusive
Allegation Three: Inconclusive

License Number and Program Type:

1097826-H_CRS (Home and Community-Based Services-Community Residential Setting)
1066938-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

Allegation One: It was alleged that a vulnerable adult (VA1) sat on a couch soaked in urine for an unknown amount of time and was not moved by staff persons.

Allegation Two: It was alleged that staff persons failed to manage a vulnerable adult's (VA2) diabetes which resulted in a VA2 needing to have his/her leg partially amputated.

Allegation Three: It was alleged that after VA2 was administered his/her medications, VA2 gave one of the medications to another vulnerable adult (VA3).

Date of Incident(s):

Allegation One: December 28 to 29, 2022

Allegation Two: Ongoing prior to December 29, 2022

Allegation Three: January 28 and February 1, 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 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 an unannounced site visit conducted on January 19, 2023; from documentation at the facility, law enforcement records, medical records, and fire department records; and through ten interviews conducted with a firefighter (F), VA1's guardian (G), VA2 and VA3, two supervisory staff persons (P1 and P2), staff persons (P3-P5), and the SP. The SP provided limited information and attempts by this investigator to further interview the SP has been unsuccessful.

On the site visit this investigator noticed a strong odor of urine inside the facility. VA1 was sitting on a couch in the living room and there were numerous stains on the couch and on the carpet near the couch. VA1, VA2, and VA3 had bedrooms on the main floor. On the second floor, there was VA4's bedroom and a staff office that had a small fridge where VA2's insulin was stored. There were several additional concerns including black mold, suspected urine-soaked clothing sitting on the floor and in the hallway of the main floor, and a large amount of ice and snow on the exterior of the facility sidewalks. These concerns were referred to the county licensor.

The facility had *Daily Progress Notes* for all clients. However, the *Daily Progress Notes* were not consistently logged by staff persons and the facility was unable to locate some of them. This was a violation of Minnesota Statutes, 245D.095, subdivision 3, paragraph (b) clause (11), which states the license holder must maintain for each person copies of written reports regarding the person's status when requested according to section 245D.07, subdivision 3, progress review reports as required under section 245D.071, subdivision 5, progress or daily log notes that are recorded by the program, and reports received from other agencies involved in providing services or care to the person.

Staff persons worked seven days on and seven days off, 12 hours per shift. The shifts were from 8 a.m. to 8 p.m. and 8 p.m. to 8 a.m. When a staff person could not make it into a shift, other staff persons covered the shift, sometimes working more than 24 hours consecutively. Staff persons consistently stated that P1 and P2 assisted in covering shifts when there was no staff person available to work.

Staff persons stated they were trained on Maltreatment of Vulnerable Adults Act, but the facility was unable to provide the last known date of training on the Maltreatment of Vulnerable Adults Act. This was a violation of Minnesota Statutes, section 245D.095, subdivision 5, paragraph (a), clause (2), which states the license holder

must maintain documentation of staff training including the dates in which the training occurred, the number of hours per training, and the name of the trainer or instructor.

All staff persons, except for P3, stated they were trained on VA2's and VA3's plans. However, the facility had no documentation of when staff persons were trained which was also a violation of Minnesota Statutes, section 245D.095, subdivision 5, paragraph (a), clause (2), which states the license holder must maintain documentation of staff training including the dates in which the training occurred, the number of hours per training, and the name of the trainer or instructor.

P3 stated that s/he was told about VA1's plans but never reviewed VA1's file and did not receive training for VA2's or VA3's plans. This was a violation of Minnesota Statutes, section 245D.09, subdivision 4a, which states that staff persons, before providing unsupervised contact with a person served by the program, must review and receive instruction on the person's served support plan and review and receive instruction on the safe and correct operation of medical equipment used by the person to monitor a medical condition that could become life threatening.

Allegation One: *It was alleged that VA1 sat on a couch soaked in urine for an unknown amount of time and was not moved by staff persons.*

VA1 enjoyed watching television. VA1 was diagnosed with depression, anxiety, and hallucinations. Due to his/her diagnoses, VA1 was not interviewed for this investigation.

VA1's *Coordinated Service and Support Plan (CSSP)* and *Individual Abuse Prevention Plan (IAPP)* stated VA1 had incontinence and required reminders from staff persons to utilize the bathroom and change his/her soiled clothing. VA1's *CSSP* stated s/he suffered from frequent urinary tract infections (UTI).

Interviews with P1-P5 provided the following information:

- Information was consistent that VA1 had incontinence and at times refused to wear disposable adult undergarment, but s/he would wear underwear. Staff persons asked VA1 if s/he needed to use the bathroom and checked his/her disposable adult undergarment throughout the day. P3-P5 provided consistent information that if VA1 refused to wear a disposable adult undergarment, staff persons checked VA1 approximately every 30 minutes to see if VA1 was wet. P1 stated there was not a "standard" on how staff persons were trained to physically check VA1 for urine but stated staff persons were trained to change VA1's disposable adult undergarment every one to two hours.

- P3-P5 provided consistent information that VA1 was checked during the night for wetness and/or the odor of urine roughly every half hour to hour. VA1's urine had a "very strong" odor and staff persons used this as an indicator in determining if s/he had urinated throughout the day and night. During the day, VA1 used a soil pad while sitting on the couch to reduce the chance of urine soaking into the couch. When VA1's urine soaked through his/her disposable adult undergarment/underwear and the soil pad, staff persons cleaned the couch with sanitizer and VA1 sat on a separate couch or chair in the living room until the couch was dry.

- P5 stated that on December 29, 2022, at approximately 8 a.m., when s/he arrived at the facility, the SP was working alone from the prior shift. The SP told P5 that VA1 fell onto his/her back at approximately "mid-day" the previous day while outside smoking a cigarette at the facility but was unable to provide an

exact time. The SP told P5 that VA1 "just laughed it off and was fine." P5 did not ask the SP what s/he did to assist VA1 after the fall.

- When P5 went into the living room, VA1 was lying on the couch soaked in urine. The SP told P5 that at approximately 6:15 a.m., s/he tried to get VA1 changed but was unable to move VA1 due to VA1 being in pain. The SP told P5 s/he thought about calling 9-1-1 because s/he was not able to move VA1, but did not do so and did not provide P5 with a reason. P5 asked VA1 about the pain and immediately called 9-1-1 when VA1 indicated that s/he could not move due to the pain. P5 stated VA1 was sitting in urine for "awhile" prior his/her arrival but did not know how long.

The G stated s/he did not have any concerns about the allegations or facility.

The F was dispatched to the facility on December 29, 2022, at 8:14 a.m., because VA1 had fallen at an unknown time on the previous day and wanted to go to the hospital. When the F arrived, VA1 was sitting on a couch that was "completely soaked in urine." VA1 was wearing a disposable adult undergarment that was soaked with urine and VA1 had urine running down his/her leg.

According to the fire department's *Patient Care Report,* VA1 was transported to the hospital via ambulance due to his/her fall. The *Patient Care Report* stated VA1 was sitting on the couch and soaked with urine.

VA1's *Medical Records* stated that on December 29, 2022, s/he was admitted to the hospital for physical therapy due to his/her fall and was discharged on January 10, 2023. VA1 did not have any soft tissue damage or injuries that were not associated with his/her fall but received physical therapy while at the hospital. VA1 was also diagnosed with a UTI while at the hospital. There was no documentation regarding VA1 being soaked in urine or related effects.

Daily Progress Notes for VA1 for December 28 to December 29, 2022, were requested but they were not provided by the facility. This was a violation as stated above.

The SP said that s/he checked VA1 for incontinence every 30 minutes. When VA1's urine soaked through onto the couch, the SP changed VA1 and cleaned the couch. The SP then ended the phone interview and subsequent phone calls to, and messages left for the SP were not returned.

Conclusion for Allegation One:

Information was consistent from facility documentation and interviews with staff persons that VA1 had incontinence. While at times VA1 used disposable adult undergarments, there were times VA1 refused and wore underwear. P1 and P2 stated staff persons were trained to change VA1's disposable adult undergarments or if VA1 refused to wear a disposable adult undergarment, staff persons checked on VA1 at least every 30 minutes.

At an unknown time on December 28, 2022, while the SP was working, VA1 fell outside of the facility. On December 29, 2022, at 8 a.m., P5 came to work at the facility and the SP told him/her that VA1 had fallen the prior day but did not provide a time. The SP said that after the fall, VA1 "just laughed it off and was fine." P5 then saw VA1 lying on the couch, soaked in urine. The SP told P5 that s/he tried to change VA1 at 6:15 a.m. but did not due to VA1 being in pain. VA1 sat in urine until P5 arrived and called 9-1-1 at 8 a.m., which was inconsistent with the standards of a professional caregiver in a facility licensed by the Minnesota Department of Human Services.

Although VA1 sat on a couch soaked in urine, given that it was not able to be determined how long VA1 sat in urine, that there was no information provided by staff persons or VA1's medical records that VA1 sustained any injury from being urine soaked, that VA1 had a history of not wanting to wear disposable adult undergarments, and that when P5 arrived at the facility s/he took immediate action and called 9-1-1, there was not a preponderance of the evidence whether there was a failure to supply VA1 with reasonable and necessary care.

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 Two: *It was alleged that staff persons failed to manage VA2 diabetes which resulted in a VA2 needing to have his/her leg partially amputated.*

VA2 was diagnosed with diabetes, borderline personality disorder, and bi-polar mood disorder. VA2 previously had a partial leg amputation due to diabetes. VA2 enjoyed writing and coloring and was not subject to guardianship.

The F had concerns that VA2's diabetes was "properly managed" by the facility because VA2 had to have a partial leg amputation. On December 29, 2022, while the fire department was at the facility for VA1, VA2 stated s/he wanted to be transported to the hospital for an "infected sore" on his/her leg. The fire department's *Patient Care Report* stated VA2's blood sugar was 515 milligrams/deciliter (mg/dl). VA2 was transported to the hospital via ambulance per VA2's request.

VA2's *Medical Records* stated VA2 was brought to the hospital on December 29, 2022, for a "medical screening exam" and appeared "well on examination." The *Medical Records* stated VA2's partially amputated leg was "doing well" and VA2 had a superficial skin wound that was treated with an antibiotic ointment.

According to mayoclinic.com, a safe blood sugar level is 140 mg/dl.

VA2's *CSSP* stated that VA2 understood his/her diabetes and dietary needs. Staff persons administered VA2 his/her medications and "oversaw" VA2's independent insulin administration and blood sugar checks throughout the day. On an unknown date prior to December 29, 2022, VA2 had a partial leg amputation due to complications from diabetes. VA2 was on a low-sodium diet and staff persons were to provide encouragement to VA2 to follow his/her diet plan. VA2 was supposed to change his/her own bandages when needed. Staff persons were required to assist VA2 making and attending all appointments as needed, desired, and/or required. VA2's file did not provide an exact date of his/her partial leg amputation.

VA2 stated s/he had diabetes that insulin dependent. VA2 checked her blood sugar five or six times daily and administered his/her own insulin based on the test results. VA2 stated P3 and P4 did not "know their job that well."

P1-P5 and facility documentation provided the following consistent information:

- VA2's insulin was stored in a small refrigerator in the staff office on the second floor of the facility. Staff persons brought VA2's insulin to VA2 when it was time for VA2 to test his/her blood sugar level and administer insulin.

- VA2 was responsible for monitoring his/her blood sugar and staff persons only assisted at VA2's request. VA2 had a notebook where s/he tracked his/her blood sugar readings, and s/he administered his/her insulin accordingly. (Note: Because VA2 administered his/her own insulin, staff persons did not track the insulin administration on a *Medication Administration Record*.)

- Staff persons encouraged VA2 to "eat healthier" and follow a low-sodium diet. P1 stated s/he purchased a sugar substitute for VA2 to use in his/her coffee. P2 stated VA2's partial leg was amputation was "two years ago" but did not provide an exact date.

The SP ended the phone interview prior to this investigator's questions about VA2 and subsequent phone calls to, and messages left for the SP were not returned.

According to the facility's *Safe Medication Assistance and Administration Policy*, staff persons administered medications in accordance with a client's plans and after the staff person successfully completed medication administration training.

Conclusion for Allegation Two:

Although the F had concerns with staff persons not managing VA2's diabetes; given that VA2, his/her plans, and P1-P5 all provided consistent information that VA2 was responsible for testing his/her blood sugar level and administering his/her insulin; that VA2 was not subject to guardianship; that staff persons encouraged VA2 to "eat healthier" and follow a low-sodium diet plan; and that VA2 was responsible to change his/her own bandages when needed, there was not a preponderance of the evidence whether there was a failure to supply VA2 with reasonable and necessary care.

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 alleged that after VA2 was administered his/her medications, VA2 gave one of the medications to VA3.*

VA3 was diagnosed with anxiety, depression, borderline personality disorder, and had a history of substance abuse. VA3 liked to go for walks, color, and write. VA3 was not subject to guardianship.
According to VA2's *Medication Administration Record (MAR)*, VA2 was prescribed multiple medications including 15 milligram (mg) buspirone hcl/BuSpar (antianxiety), taken three times per day.

According to VA3's *MAR*, VA3 was prescribed multiple medications including a 15 mg tablet of BuSpar, taken once per day. According to VA3's *CSSP,* staff persons were responsible for administering his/her medications.

According to Drugs.com, BuSpar is an anti-anxiety medication. Taking too much BuSpar can lead to nausea, sleepiness, and drowsiness.

P1-P5 and facility documentation provided the following information:

- VA2 and VA3 were administered their medications as prescribed and then it was documented on the respective *MAR*.

- P2 stated s/he was not certain how VA2 and VA3 shared medications, but s/he believed VA2 "cheeked" the medications (temporarily storing the medication inside his/her mouth) and then gave it to VA3 when staff persons were not looking. These incidents were documented in incident reports and *Daily Progress Notes*.

- According to an *Incident/Significant Event Report*, on January 28, 2023, P5 saw VA2 hand VA3, VA2's BuSpar and VA3 put it in his/her sweatshirt pocket. P5 asked VA2 and VA3 about the BuSpar and they each denied what P5 saw. VA3 did not give P5 the BuSpar and P5 did not search VA3. P5 was instructed by P2 to only document the incident.

- According to an *Incident/Significant Event Report*, on February 1, 2023, P4 saw VA2 "attempt to pass" his/her BuSpar to VA3 while they were in the kitchen. P4 then told VA2 to take his/her BuSpar and s/he did without further incident.

- P2 stated after finding out VA2 gave VA3 BuSpar, staff persons received training on additional measures to reduce the likelihood of future incidents, including requiring VA2 to drink all the water given with his/her medications and having VA2 show staff persons the inside of his/her mouth and cheeks to ensure the medications were swallowed. Staff persons were instructed to give VA2 his/her medications in common areas of the facility such as the kitchen and living room and ensure VA2 and VA3 were physically separated when medications were administered to reduce the likelihood of VA2 and VA3 sharing BuSpar. If staff persons suspected VA2 giving his/her BuSpar to VA3, they were to contact the pharmacy and document the incident in an incident report.

- P1 contacted the pharmacy after both incidents. The pharmacy told P1 to notify them if it occurred again. There was no information provided that either VA2 or VA3 were harmed as a result of sharing medications.

Conclusion for Allegation Three:

Consistent information was provided that VA2 and VA3 were each prescribed 15 mg of BuSpar, taken once and three times per day respectively.

Although it was concerning that VA2 and VA3 shared BuSpar on two dates, given that once it was realized that it occurred more than one time, additional steps were implemented to minimize their ability to do so, and there was no information provided that there was any impact to VA2 or VA3, there was not a preponderance of the evidence whether there was a failure to supply VA2 and/or VA3 with reasonable and necessary care.

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 policies and procedures were adequate and followed. The facility internal review found there was a need for and completed additional staff training for checking VA1's incontinence and additional training on medication administration.

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

On June 23, 2023, the facility was issued an Order of License Revocation which included the violations outlined in this report.