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: 202302732

Date Issued: July 7, 2023

Name and Address of Facility Investigated:

REM Heartland Hengen
1005 Hengen St.
Fairmont, MN 56031

Disposition: Inconclusive

License Number and Program Type:

1071465 License number-H_CRS (Home and Community-Based Services-Community Residential Setting)
1071456 License number-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a vulnerable adult (VA1) found a bottle of alcohol in the garage of the program that belonged to a supervisory staff person (SP). It was reported that the SP drank alcohol and then drove VA1 and another vulnerable adult (VA2).

Date of Incident(s): Ongoing prior to March 28, 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 a site visit conducted on April 19, 2023; from documentation at the facility; and through thirteen interviews conducted with VA1, VA2, three supervisory staff persons (P1-P3), VA1's guardian (G1) who was also VA1's family member, VA2's guardian (G2) who was also VA2's family member, five staff persons (P4-P8), and the SP.

VA1 enjoyed going out into the community, shopping, bowling, working, and spending time with G1. VA1's diagnoses included moderate intellectual disability, cerebral palsy, attention deficit disorder, anxiety, and depression.

According to VA1's plans, VA1 was allowed by G1 to have two alcoholic beverages a week due to a family history of alcoholism and concerns with how alcohol would interact with his/her medications. VA1 was monitored by staff persons while in the community because at times, VA1 attempted to purchase additional beer in bars and restaurants if s/he had money. VA1 was allowed to be gas stations alone to make purchases without staff supervision. After VA1 left the gas station s/he showed staff persons what was purchased and the receipt.

VA2 enjoyed collecting items, MN sports teams memorabilia, going out to eat, shopping, and spending time with his/her family. VA2's diagnoses included intermittent explosive disorder, moderate intellectual disability, obsessive compulsive disorder, anxiety disorder, attention deficit hyperactivity disorder, cerebral palsy spastic dysplasia, and cortical blindness.

VA1 provided the following information:

- G1 limited the amount of alcohol VA1 could consume per week and VA1 preferred to drink beer. VA1 bought beer with staff persons at a liquor store and stored in a locked area in the facility or purchased it while out in the community with staff to drink at bars or restaurants.

- On unknown dates, the SP took VA1 to a liquor store to get alcohol and the SP purchased his/her own bottle of Fireball and beer. The SP then put his/her alcohol in the car and took it home. VA1 did not see the SP bring alcohol into the facility.

- In July 2022, VA1 went on a two-night trip with the SP to the Mall of America. The SP was the only staff person with on the trip. (Note: Receipts showed the trip was from July 7 to 9, 2022.) While on the trip VA1 and the SP went to the liquor store. (Note: A liquor store receipt for VA1 was dated July 7, 2022.) VA1 said at the liquor store s/he purchased beer and the SP purchased beer and a "little" bottle of Fireball. At the hotel during both evenings VA1 and SP drank together.

- One evening the SP took a selfie photo of him/her and VA1 and both held a beer in their hands. VA1 and the SP held different types of beer cans. VA1 said this was the only time s/he drank with the SP and the SP did not drive anywhere after s/he drank the alcohol.

- VA1 said about three months later, s/he found "a little bottle of Fireball in the garbage" in the kitchen buried under a few items. VA1 did not tell anyone at that time. VA1 also smelled alcohol on the SP's breath in the past and did not tell anyone because the SP was the only staff on.

- On March 28, 2023, VA1 was in the facility garage to wait for his/her ride to work. P4 came into the garage and talked with him/her. VA1 saw a bottle of Fireball Cinnamon Whisky in the rear of a dresser that did not have drawers that was stored in the garage. VA1 was allowed to have a limited amount of alcohol at the direction of G1 and was concerned that staff persons would believe the bottle was his/hers. VA1 told P4 about the bottle. P4 talked with VA1 about the bottle not being his/hers and then VA1 was picked up for work.

- VA1 believed the Fireball belonged to the SP because it was the same brand s/he saw the SP purchase in the past. VA1 never had concerns about the SP's driving in the past and did not see the SP act differently on the job that would lead him/her believe the SP was intoxicated at work.

VA2 provided the following information:

- VA2 was not aware any situations where staff persons might be drunk while on the job. VA2 did not recall any instances where staff persons were acted unusual, talked differently, or smelled unusual.

- VA2 went on community outings to various locations with the SP, which included to the bowling alley. VA2 had no concerns with how the SP's drove on the outings.

G1 provided the following information:

- VA1 had a history of "poor judgement" and needed staff supervision and support in the home and community apart from being able to make small purchases on his/her own in a gas station.

- G1 did not have any concerns about staffing and services prior to the allegations. G1 was not told of any concerns VA1 had about the facility.

- G1 limited VA1's alcohol use of two drinks per week due to a family history of alcoholism and possible complications with medications VA1 was on. G1 said VA1 wanted to drink more and may lie about if s/he got more alcohol or coffee than s/he was limited to, which was why VA1 needed staff person supervision.

- VA1 was not to purchase alcohol without staff person supervision and could have alcohol in the home or in the community with staff supervision. The staff persons were to check VA1's purchases and receipt after s/he was in a gas station alone.

- G1 spoke with VA1 about the alcohol found in the garage and VA1 said s/he believed it belonged to the SP. VA1 said when s/he went to purchase his/her own alcohol that SP bought that brand for him/herself. VA1 smelled alcohol on the SP in the past and did not tell someone as s/he was not sure who to talk to.

- G1 did not believe the alcohol belonged to VA1 because VA1 preferred beer and did not care for wine and "would never drink hard liquor."

- G1 was concerned about the photo where VA1 and the SP held beers while on a trip because the SP was the only staff person with VA1 and solely responsible for his/her supervision. G1 spoke with VA1 about the trip and was told the SP drank beer and the same brand of hard alcohol found in the home while in the hotel. G1 was concerned the SP took the photo and sent it to others as it was a confidentiality issue.

- G1 was told by VA1 that the SP asked him/her, "Who's side are you going to take, mine or [G1]?" G1 was concerned the SP attempted to manipulate, "bully," and be "abusive verbal" towards VA1 and continued to work with VA1 without other staff present.

G2 provided the following information:

- VA2 was "usually happy" unless s/he was denied a request. This could lead to VA2 "outbursts." VA2 might not recall or comprehend items due to his/her mental functioning.

- G2 talked on the telephone with VA2 "every night" and s/he did not express any facility or staff person concerns to G2. G2 did not have any concerns about the facility or staff persons, apart from staff shortages, and felt the facility helped and advocated for VA2.

- VA2 did not drink alcohol and G2 was unsure if VA2 would recognize the signs or someone who drank alcohol.

P4 provided the following information:

- On March 28, 2023, P4 worked the morning shift and talked with VA1 while s/he waited in the garage for his/her ride to work. VA1 began to scream and grabbed a bottle of Fireball that was in the back of the dresser without drawers that was stored in the garage. VA1 was concerned that s/he would get blamed for the Fireball and get into trouble. P4 talked with VA1 that s/he knew the Fireball was not VA1's and that P4 would follow up on the situation. P4 did not believe the bottle belonged to VA1 because VA1 preferred beer and VA1 had not talked about "mixed drinks" in the past. VA1 was picked up by his/her ride and taken to work. P4 text messaged P3 a photo of the bottle and explained VA1 found it in garage. P3 texted P4 to dump the bottle out and to throw it away. P3 said the bottle was not dusty and did not appear to have been in the dresser very long.

- VA1 told P4 s/he believed the Fireball belonged to the SP because s/he saw the SP purchase Fireball in the past when with at the liquor store and VA1 found a small bottle of Fireball in the garbage can in the kitchen a while ago. P4 talked with other staff persons in the facility who were concerned that the SP drank on the job. P4 said s/he was told by community people s/he knew that SP1 smelled of alcohol while with VA1 at the bowling alley. P4 did not report this at the time because s/he was not there and did not have proof.

- P4 denied that the Fireball was his/hers and denied s/he ever drank at work.

P3 provided the following information:

- P3 received a text message on March 28, 2023, from P4 who asked to talk because VA1 found a bottle of Fireball in the garage. P3 believed it was a 1.75 bottle of alcohol that was "just about empty." P3 instructed P4 to dump the alcohol and throw the bottle away. P3 asked P4 who s/he thought the bottle belonged to and P4 said s/he thought it belonged to the SP because P5 previously expressed concerns that the SP drank at work.

- P3 called P5 and asked if s/he had concerns about any staff persons who drank. P5 said there were two occasions where s/he thought the SP may have drunk alcohol at work. P5 talked about one instance where the SP was "slurring [his/her] words" after s/he took VA1 to the bowling alley. P5 said there was another instance where s/he could "smell it on [the SP] and that [s/he] was kind of talking funny." P5 said s/he did not report it and was "wrestling" with reporting it did not want to say anything since s/he had no proof. P3 and P1 met with the SP who denied it was his/her bottle.

- On May 10, 2023, P6 sent P3 a photo of the SP and VA1 with alcohol beverages. P3 no longer worked at the facility and encouraged P6 to follow up with his/her supervisor about the photo.

- P3 denied that the Fireball was his/hers and denied s/he ever drank at work.

P5 provided the following information:

- P5 typically worked the evenings when VA1 and the SP went to the bowling alley. Prior to VA1 finding the bottle of Fireball in the garage, P5 worked an evening shift at the facility when the SP took VA1 and VA2 to the bowling alley where alcohol was available. Upon return their return, P5 smelled liquor, but was not certain if the smell was from VA1 or the SP. P5 said that VA2 does not drink alcohol. P5 said the SP was "very happy, sing song-y in [his/her] voice and I think I smelled it on [him/her]" and P5 thought s/he heard the SP have "slurred" speech. P5 did not report his/her suspicion because s/he thought s/he might be mistaken about what was smelled.

- About two weeks later during an evening shift, P5 took VA1 to the bowling alley and the SP worked with the other residents in the home. When P5 and VA1 returned to the facility P5 heard the SP slur a word and thought s/he might be drunk, but did not smell any alcohol on the SP. P5 said s/he did not report his/her suspicion because she "could not imagine anyone doing that."

- When P5 was told by P4 that VA1 found a bottle of Fireball in the garage s/he told P4 about his/her previous concerns that the SP might have drunk alcohol while working. P3 then called P5 and shared his/her concerns that the SP drank at work. P5 spoke with VA1 about the bottle of alcohol in the garage. VA1 told P5 s/he thought the bottle belonged to the SP because the SP purchased that type of alcohol when they went to the liquor store. P5 also said the SP gifted out small bottles of Fireball to other staff persons in the past.

- P5 was later told by P4 that P1 and P3 met with the SP in the facility office and the SP told P4 s/he "got [his/her] butt chewed" by them.

- P5 denied that the Fireball was his/hers and denied s/he drank at work.

P6 provided the following information:

- P6 said s/he was not aware of and did not have any concerns about any staff persons drinking alcohol while working. P6 heard the SP talk about how s/he drank Fireball outside of work, but did recall any instances when the SP had slurred speech or looked drunk while on the job.

- On May 10, 2023, P6 remembered s/he had received a photo from the SP of the SP and VA1 each holding a beer while on a July 2022 trip. P6 did not recall when s/he received the photo, but the screenshot was taken on October 7, 2022. P6 said s/he forgot about the photo until after VA1 found the Fireball bottle and s/he happened to have looked through his/her phone and saw the photo again. P6 could not recall if others were also sent the photo.

- P6 denied that the Fireball was his/hers and denied s/he drank at work.

P1 provided the following information:

- P1 was aware that VA1 found a bottle of alcohol in the garage, gave it to P4, and P4 was instructed by P3 to dump the alcohol and throw away the bottle. P3 was told by staff persons they believed the bottle belonged to the SP. Staff persons told P1 that the SP talked about how s/he enjoyed Fireball and the SP had smelled of alcohol at work.

- P1 and P3 met with the SP. The SP was showed the photo of the bottle and denied it belonged to him/her. The SP acknowledged that in the past s/he had come to work hungover and had "gone for lunch beers or two with friends" prior to his/her shift a few hours later, but denied being drunk or "tipsy" at work. P1 was unaware of the additional bottle of Fireball found in the garbage and confirmed that when the SP purchased his/her alcohol while with VA1 it was against facility policy because it was personal shopping while on the clock.

- P1 thought the bottle may have been from a former client in the home from a long time prior. (Note: P4 stated the client was gone for three to four years, the client drank wine, the dresser was placed in the garage maybe six to eight months ago, and there was no dust on the Fireball bottle.)

- P1 denied that the Fireball was his/hers and denied s/he drank at work.

The SP provided the following information:

- The SP worked at the facility for several years and was familiar with VA1's behaviors, relationship with alcohol, and limits set by G1. The SP worked evening shifts with VA1 that included community outings where VA1 drank alcohol and purchased his/her beer for home.

- The SP said when s/he went with VA1 to the liquor store, s/he purchased his/her own alcohol and then kept it in his/her car. The SP did not recall if s/he purchased Fireball with VA1 because s/he had not "purchased fireball in a long time." The SP said s/he gifted a "fun little bottle" of Fireball to a coworker.

- After the bottle was found in the garage, the SP met with P1 and P3 who discussed with the SP the facility policies regarding staff person not bringing alcohol or drugs to the facility. The SP said there were occasions when s/he came into the facility hungover or after s/he had a drink with lunch "several hours

before I would come to the shift." The SP denied s/he drank alcohol on the job or that s/he came to work drunk, slurred his/her words, or smelled of alcohol at work, but was told other staff persons made comments about it.

- The SP was unsure if the bottle in the garage was his/her. The SP said "there is potential" the bottle was his/hers and it "could be possible" the SP put the bottle there and did not recall. The SP said s/he would have alcohol in his/her car at work and would occasionally use his/her car to drive the vulnerable adults. The SP said it was possible s/he had the bottle in his/her car at work and placed it in the garage when s/he drove with a vulnerable adult. The SP denied the smaller bottle of alcohol found in the garbage was his/hers. The SP denied driving clients after s/he had been drinking.

- At the time of the SP's initial interview, the photo with the SP and the VA holding beers was not yet known. Attempts were made via telephone, text, email, and mail to obtain additional information from the SP. However, the SP did not respond to the requests.

P2 said s/he was not supervising or involved with facility when the allegation occurred. P2 was updated by P1 about the situation when s/he started in the new role and did not have any additional information.

P7 and P8 each separately denied the bottle of alcohol found in the garage belonged to them. P7 and P8 each separately denied drinking on the job and did not have suspicions of other staff persons drinking on the job.

The facility *Drug and Alcohol-Free Workplace Policy* stated it "prohibits the unlawful manufacture, distribution, dispensation, possession, or use of alcohol, illegal narcotics, drugs, or controlled substance while you are on Company business, providing services to individuals, using Company vehicles, or on Company property... You are also prohibited from reporting to work while under the influence of alcohol, illegal narcotics, drugs, or other controlled substances, except if the controlled substance are taken pursuant to the instructions of a licensed health care provider."

Facility documentation showed that the staff persons interviewed for this investigation, including the SP, were trained on the VA's support plans and on the Reporting of Maltreatment of Vulnerable Adults Act. The SP was also trained on the *Drug and Alcohol-Free Workplace Policy*.

Conclusion:

There were concerns that the SP drank while s/he worked with VA1 and VA2, but the SP denied doing so. Given that there was a photo that showed the SP and VA1 drinking together it was determined that one at least one occasion the SP drank while s/he worked with VA1, which was inconsistent with the standards of a professional caregiver in a facility licensed by the Department of Human Services and a violation of the facilities *Drug and Alcohol-Free Workplace Policy*. However, given that there was no information that VA1 and/or VA2 were harmed at any point, and that VA1 was of legal drinking age, there was not a preponderance of the evidence whether there was failure to supply VA1 and/or VA2 with reasonable and necessary care.

There were also concerns that the SP drove VA1 and/or VA2 after s/he had been drinking. Neither VA1 nor VA2 had any concerned regarding the SP's driving, the SP denied doing so, and there is no additional information to support or refute whether the SP drove after drinking. Therefore, there was not a preponderance of evidence whether there was a failure to supply VA1 and/or 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).

Action Taken by Facility:

The facility completed an internal review and determined that their policies and procedures were adequate and were followed. The SP no longer worked at the facility.

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

Minnesota Statutes, section 626.557, subdivision 3, requires mandated reporters at a facility to immediately report suspected maltreatment. The investigation determined that two individuals failed to report suspected maltreatment as required. A letter from DHS was sent to the individuals regarding their failure to report the suspected maltreatment and potential consequences for future such failures.