

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: 202303376

Date Issued: July 21, 2023

Name and Address of Facility Investigated:

Brothers & Sisters of Compassion Care, LLC
2355 Highway 36 West, Suite 400
Roseville, MN 55113

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

License Number and Program Type:

1107264-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a staff person (SP) smoked marijuana and drank alcohol with a vulnerable adult (VA). It was also reported that the SP drove the VA to meet with persons of the opposite gender.

Date of Incident(s): Unknown dates prior to April 20, 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 May 23, 2023; from documentation at the facility; and through three interviews conducted with a facility supervisory person (P1), a facility staff person (SP), and the VA's case manager (CM). Several attempts were made via telephone and US mail to contact and interview the VA, but the VA did not respond to the requests.

According to the VA's plan, the VA enjoyed visiting family, walking, listening to music and going to movies. The VA worked toward securing his/her own housing and becoming employed. The VA was of legal drinking age and was not subject to guardianship. The VA was diagnosed with a cognitive processing disorder, depression, anxiety and post-traumatic stress disorder. Documentation from the facility showed the VA received eight hours of in-person in home services and one hour of remote services. The SP assisted the VA in life-skill training, problem solving, managing paperwork and community participation and mobility.

The following consistent information was provided from facility documentation and P1:

- The SP provided nine hours of support to the VA per week. Eight hours of support were in person and one hour was remote. The VA and the SP decided the time of the hours of support provided. The SP assisted the VA with running errands, managing appointments, and shopping. The SP also provided transportation for the VA to attend medical and therapeutic appointments.
- On March 15, 2023, a family member (FM) of the VA called P1 and stated the VA was upset because s/he found out the SP provided support services to other members of the VA's family. The FM also told P1 that the SP smoked marijuana and drank alcohol with the VA, and when the VA was with the SP and returned home, the VA looked like a "zombie."
- On a date after March 15, 2023, P1 asked the VA if the SP smoked marijuana and drank alcohol with the VA, and the VA said that it was "not true," and his/her medication made him/her act like a "zombie."
- On a date after March 15, 2023, P1 asked the SP if s/he smoked marijuana and drank alcohol with the VA and the SP acknowledged that s/he had but that it after working hours. The SP also told P1 that s/he and the VA developed a friendship.

The CM provided the following information:

- On April 20, 2023, during a meeting regarding the VA, the CM was shown a video of the VA from the FM, that showed the SP and the VA drinking alcohol together. The FM also told the CM that the SP and the VA smoked marijuana together and that the SP took the VA to meet persons of the opposite gender.
- The CM stated the VA self-medicated with marijuana before working with the SP, and showed "significant" improvement in mental health and reached goals after working with the SP. The VA became more motivated to secure housing and gain employment while working with the SP. The CM believed smoking marijuana and drinking alcohol did not interfere with the work between the VA and the SP.
- The VA had a history of sexual abuse and went to meet persons on his/her own, and the SP may have accompanied the VA for his/her safety.

- The relationship between the SP and the VA became more like a friendship than a “staff and client” relationship. After the SP no longer provided services to the VA, the VA told the CM that s/he wanted to work with the SP again and wanted to be friends with the SP.

The SP provided the following information:

- The SP provided services to the VA from November 2021 to March 2023. The SP drove the VA to the gym, to therapy appointments, and to the library. The SP also assisted the VA with budgeting and applying for jobs and housing. In March 2023, after the FM showed the CM a video, the SP told P1 that s/he could no longer work with the VA because the VA used the SP as a “cover up” with the FM. The SP no longer saw the VA or answered telephone calls from the VA.
- “Months” after s/he started working with the VA, the SP started smoking marijuana with the VA after working hours. The SP smoked marijuana with the VA less than 20 times and never drove the VA after smoking marijuana. The SP and the VA smoked marijuana at a park near the VA’s home and then the VA walked home and the SP went home. Sometimes the SP provided the marijuana and sometimes the VA provided the marijuana.
- Sometime in the winter of 2022, the SP drank alcohol with the VA because the VA asked the SP to drink with him/her. The VA and the SP each drank a double shot of tequila. This drinking incident occurred after working hours at the SP’s home.
- The SP drove the VA to visit with a person who the VA identified as his/her boy/girlfriend.
- On three to five occasions, the SP brought the VA to his/her house to “hang out” and watch movies. Two family members of the SP who were the opposite gender of the VA, also lived in the SP’s home. On one occasion the SP drove the VA to a friend of the SP’s house. This friend was the opposite gender of the VA. They were there for approximately an hour and “hung out,” and then the SP drove the VA home.
- The SP said that the FM did not want the VA to take anxiety medications so the VA smoked marijuana with the SP to lessen the VA’s anxiety. The SP said s/he was trained that the facility prohibited marijuana and alcohol by the SP while providing support services to the VA.

The facility’s *Drug and Alcohol Prohibition Policy* stated that consumption of alcohol and being under the influence of a controlled substance was prohibited while providing services.

P1 and the SP were trained on the facility’s *Drug and Alcohol Prohibition Policy*, the VA’s plans, and the Reporting of Maltreatment of Vulnerable Adults Act.

Conclusion:

A. Maltreatment:

Although the VA did not provide information for this investigation, information from the CM, P1, and the SP was consistent that on multiple dates prior to April 20, 2023, the SP smoked marijuana with the VA, drank alcohol with the VA, and drove the VA to meet persons of the opposite gender. Although it was inconsistent with the

standards of a professional caregiver to drink with a person served, the VA was of legal drinking age and there was no information in the VA's plan to show that the VA needed to abstain from drinking alcohol. In addition, the VA's plan showed the VA had a history of sexual abuse, however, there were no rights restrictions provided that the VA was not able to engage in relationships with persons of his/her choosing.

Given that at the time of the incidents marijuana was not legal, the SP was a staff person and the SP's action of smoking marijuana with the VA encouraged the VA to engage in activities that were illegal and likely hindered the VA's ability to have a consistent understanding of the parameters of a therapeutic relationship which could interfere with other individuals' attempts to provide him/her with therapeutic services both now and in the future. Therefore, there was a preponderance of the evidence that the SP failed to supply 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 had received training on the facility's *Drug and Alcohol Prohibition Policy*, the VA's plans, and the Reporting of Maltreatment of Vulnerable Adults Act.

The SP was responsible for maltreatment 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 was recurring because the SP stated s/he smoked with the VA more than one time and less than twenty, but it was not serious because the VA did not require the care of a physician.

The SP was disqualified from providing direct contact services.

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were adequate and followed. The SP received retraining on professionalism and boundaries.

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

The SP was disqualified from a position allowing direct contact with, or access to, persons receiving services from programs, organizations, and/or agencies that are required to have individuals complete a background study by the Department of Human Services as listed in Minnesota Statutes, section 245C.03. The determination that the SP was responsible for maltreatment and the disqualification of the SP are each subject to appeal.