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: 202304015

Date Issued: August 18, 2023

Name and Address of Facility Investigated:

Disposition: Inconclusive

MSOCS Arbor Way
900 Arbor Way
Sauk Rapids, MN 56379

Home and Community Based Services
3200 Labore Rd Ste 104
Vadnais Heights, MN 55110

License Number and Program Type:

1070577-H_CRS (Home and Community-Based Services-Community Residential Setting)
1070559-HCBS (Home and Community-Based Services)

Investigator(s):

Tessa Ripka
Minnesota Department of Human Services
Office of Inspector General1070577
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
tessa.ripka@state.mn.us
651-431-6612

Suspected Maltreatment Reported:

It was reported that when a staff person (SP) supervised a vulnerable adult (VA) at work, the SP was rude, demanding, and aggressive. The SP asked the work supervisor to write up the VA and deny the VA bathroom breaks. It was also reported that while at the facility, the SP snapped at the VA and talked down to the VA.

Date of Incident(s): May 11, 2023, prior and ongoing

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 was obtained during a site visit conducted on June 12, 2023; from documentation at the facility; and through eight interviews conducted with five facility staff persons (SP, P1, P2, P3, P4), the VA's case manager (CM), the VA's guardian (G), and the VA.

The VA was diagnosed with developmental disabilities, anxiety disorder, diabetes, and pica (eating disorder where a person swallowed things that were not food and did not have nutritive value). The VA enjoyed playing videos and going fishing.

The *Coordinated Services and Supports* Plan indicated that staff persons were with the VA at all times to monitor for swallowable objects (due to pica diagnosis) and to meet his/her health and safety needs.

The *Individual Abuse Prevention Plan* indicated that the VA made unhealthy meal choices. Staff persons prepared three healthy meals and two healthy snacks daily and encouraged the VA to follow a low carb diabetic diet. The VA was diagnosed with pica which resulted in him/her swallowing objects and frequent hospitalizations and procedures to remove the objects. The VA had one to one staffing during a majority of waking hours.

The *CBS-Self-Management Assessment* provided the following information:

- The VA was diagnosed with pica which had resulted in him/her swallowing glass, nails, thumb tacks, beads, razor cartridges, lighters, batteries, vent air fresheners, hand soap pumps, pen caps, and ear buds which resulted in multiple emergency room visits and hospitalizations. The VA had one to one staffing and staff persons observed for any change in mood.

- If the VA expressed that s/he was upset, anxious, or depressed and wanted to immediately use the bathroom or go to his/her bedroom, staff persons should ask how s/he was feeling and redirect to an activity until his/her anxiety level went down. Staff persons checked the VA's mouth and pockets before s/he used the bathroom or before going to an area that was not supervised. If the VA ingested an object, staff persons took the VA to a medical provider to get checked.

- The VA was diabetic and struggled with following a diabetic diet. Staff persons role modeled and encouraged the VA to eat a diabetic diet and reduce carbohydrate choices to maintain blood sugar levels.

The VA provided the following information:

- The VA did not get along with the SP. The SP was rude to the VA, was always on his/her phone, and "always" yelled at the VA telling the VA what to do.

- When the VA went to work, the SP followed the VA into the employee only area and told the VA where to go. The VA usually did what s/he was supposed to be doing.

- The SP told the VA to eat leftovers all the time and the VA did not enjoy always having leftovers. When the VA wanted a salad, the SP said "No, no no, no you can't have a salad." The SP wanted the VA to have leftovers. Another staff person got the VA a salad.

The *Incident Report Form*, and P1-P4 provided the following information:

- The VA had a job in the community where s/he worked evening hours. A staff person accompanied the VA to his/her job to support the VA in several ways. Staff persons made sure the VA stayed on task and verbally prompted him/her if needed. Staff persons also made sure the VA did not have access to any non-edible items that s/he might attempt to swallow.

- The VA's work supervisor (S) informed the facility that the SP showed "aggression" and "disrespect" to the VA at work. The SP typically took the VA to his/her job several times a week. The S said the SP tried to get the VA written up, yelled at the VA, made the VA feel bad, and did not give the VA "room" to do his/her job. The SP also wanted the S to cut the VA's regular breaks because the SP felt the VA was taking too many bathroom breaks. The VA expressed concern and anxiety that s/he did not want to work with the SP.

- P1 said at the facility, the SP at times ignored the individuals, was on his/her phone all the time, and did not interact with the individuals. The SP did not give a lot of choices for meals or snacks to the individuals, and refused to do walks or community activities with the VA. The SP was often short with the VA and did not seem to enjoy being around the VA.

- P2 said the SP was quick to be irritated with the VA and sounded annoyed with the VA but had no other concerns with the SP's interactions.

- P3 said that last June (2022), the VA told P3 that the SP was "very short" with the VA, did not want to do anything with the VA and was rude to the VA. P3 had seen the SP ignore the VA while the SP was on his/her phone and get short with the VA especially if the VA interrupted the SP. P3 had never seen the SP confront or yell at the VA. The VA did not seem comfortable asking the SP for what the VA needed or asking to go on an outing.

- The VA was diabetic and if his/her blood sugar was too high staff persons might try to talk the VA out of certain food items and suggest healthier items.

The SP provided the following information:

- The VA had a job in the community that staff persons accompanied him/her to. Staff persons kept an eye on the VA during his/her work shift and made sure s/he did not eat anything that was not food. This included going into the employee break room with the VA and standing outside the bathroom door when the VA was in the bathroom.
- At the VA's job, staff persons typically sat in a chair near the VA while s/he worked. When the VA was on

his/her break, the SP sat with the VA in the breakroom. The VA usually talked to other employees if anyone else was on break.

- Due to the VA's history of swallowing objects, staff persons sometimes monitored the bathroom by standing just inside the door outside of the stall. The VA had a catheter with a bag, so s/he typically did not need to use the restroom often while s/he was at work.

- On one occasion, during a shift at work, the VA was going into the bathroom every 15 minutes. The S approached the SP and wanted the SP to do something about it because the VA was taking too many breaks. The SP told the S that staff persons were just there to keep the VA safe. If the VA was not doing his/her job correctly, the S needed to address it with the VA.

- The SP said that s/he could tell the VA something but the VA most likely would not listen and it should come from his/her supervisor. The VA continued to use the bathroom, so the SP said s/he was going to come inside and stand just inside the door to make sure the VA was okay.

- The SP did not feel s/he was rude, aggressive, or yelled at the VA. At times staff persons got frustrated and the VA might be able to hear that in the staff persons' voice. The VA asked the same questions repeatedly. The SP tried to be honest with the VA if the SP's patience level was low.

- The meals at the facility were preplanned and prepared by staff persons. Individuals were encouraged to help plan the menu but usually did not show much interest. The VA was offered an afternoon snack of his/her choice. The evening snack was supposed to be a "healthy snack" due to the VA's high blood sugar. There was a snack drawer where the VA could choose his/her snack.

- Since the VA worked evening hours at his/her job, s/he was not at the facility for dinner time. Previously the VA loved leftovers and took leftovers from the day before for his/her meal at work. Lately the VA had been refusing leftovers. Since the evening meal was not ready before the VA left for work, staff persons offered leftovers or a sandwich for the VA's dinner.

- The SP felt s/he had a good relationship with the VA. There were times the VA was frustrated with the SP typically when SP was asked to complete hygiene tasks. The SP did not feel s/he was rude or aggressive with the SP and had never yelled at the VA.

During the course of the investigation, additional concerns were voiced that other staff persons did not always take the VA out on preferred activities and gave the VA "consequences" or yelled at the VA when s/he had urinary incontinence. Information was not provided regarding details of occurrences or if staff persons were involved who the staff persons were so these concerns were not investigated further and the focus of the investigation was the aforementioned allegations.

Conclusion:

The VA said s/he did not get along with the SP. The SP was rude to the VA, always on the phone, and yelled at the VA. The SP followed the VA into work areas that the SP should not go into.

At the VA's community job it was reported that the SP was disrespectful and aggressive to the VA. The SP asked the S to write up the VA or cut the VA's normal breaks because the VA took too many bathroom breaks. P1, P2, and P3 each had concerns about the SP refusing to take the VA on outings, and sounding annoyed or short with the VA.

Due to the VA's pica diagnosis, s/he had one to one staffing. Staff persons checked the VA's mouth and pockets before s/he used the bathroom or before going to an area that was not supervised.

The SP said s/he sat near the VA at work and while s/he was in the employee break room. On one occasion, the VA was going to the bathroom every 15 minutes. The S approached the SP and wanted the SP to do something. The SP said that if the VA was not doing his/her job, the S needed to address it with the VA. The SP did not feel s/he was rude or aggressive with the SP and had never yelled at the VA.

While it was possible that not all of the SP's interactions with the VA were entirely therapeutic and each P1-P3 said that at times the VA sounded short or annoyed with the VA, given the VA required supervision while at work, that the SP said s/he told the S to address any problems directly with the VA, and that the SP denied yelling or being rude or aggressive to the VA , there was not a preponderance of the evidence whether any of the SP's language or actions could be reasonably 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 policies and procedures were adequate but not followed when the VA was not treated with courtesy, dignity, and respect. Staff persons reviewed the *Conduct Between Staff and Individuals* policy and the *Employee Code of Conduct.*

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

No further action taken.