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: 202304102

Date Issued: September 8, 2023

Name and Address of Facility Investigated:

REM Ramsey, Inc. - Brenner
2010 Brenner Ave
Roseville, MN 55113

REM Ramsey Inc
6600 France Ave S Suite 500
Edina, MN 55435-1878

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

License Number and Program Type:

1071840-H_CRS (Home and Community-Based Services-Community Residential Setting)
1071829-HCBS (Home and Community-Based Services)

Investigator(s):

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Office of Inspector General
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Suspected Maltreatment Reported:

It was reported that a staff person (SP) left four vulnerable adults (VA1 – VA4) unsupervised at the facility. As a result, VA1 left the facility and was found by law enforcement.

Date of Incident(s): May 12, 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 June 23, 2023; from documentation at the facility and law enforcement records; and through nine interviews conducted with two supervisory staff persons (P1 and P2), two staff persons (SP and P3), VA1's-VA4's guardians (G1-G4), and a law enforcement officer (LEO).

Due to their respective disabilities, VA1–VA4 were not interviewed. VA1-VA4 had no unsupervised time at the facility or in the community.

VA1's diagnoses included moderate intellectual disability, autism, attention-deficit hyperactivity disorder, and seizure disorder. VA1 liked going to Burger King, volunteering, spending time outside, and swimming.

VA2's diagnoses included autism and seizures and s/he was non-verbal. VA2 enjoyed puzzles, movies, his/her iPad, spending time with his/her family, and attending church.

VA3's diagnoses included autism, profound intellectual disability, anxiety, and major depressive disorder and s/he was non-verbal. VA3 enjoyed being with G3, snacks, playing piano, and his/her iPad.

VA4's diagnoses included autism, was non-verbal, and had episodes of anxiety, agitation, physical aggression, and self-injurious behaviors. VA4 enjoyed community activities, car rides, puzzles, listening to music, and spending time with G4.

The facility was a split-level home located on a residential area next to an intersection by office buildings where the cross-street speed limit was 40 miles per hour. Staff persons provided 24 hours care that included an awake overnight staff person. The main level of the of the home included a kitchen, living room, bathroom, three-season porch, and two bedrooms. The lower level of the home included a staff office and two bedrooms. There were chime alerts on all the exterior doors that sound when opened. The front entrance door had a doorknob with a lock and a reversed deadbolt to prevent the VAs from leaving unsupervised. The reversed deadbolt key slot was on the inside of the home and the latch to unlock it was on the outside of the home. Staff persons engaged the deadbolt with the key from inside the facility that prevented VA1-VA4 being able to open the door and leave without staff person knowledge. A combination realtor box was locked inside the door to allow staff access to the keys. The facility used a Rights Restriction to allow the door to be locked from the inside.

According to timeanddate.com the weather in Roseville, Minnesota, USA (), on May 12, 2023, between 6 p.m. and 12 a.m., was overcast and the temperature ranged between 64 and 70 degrees Fahrenheit with 19 to 11 miles per hour winds.

Law Enforcement Records provided the following information:

- On May 12, 2023, around 10:30 p.m. a neighbor phoned 9-1-1 and reported VA1 was outside on the street in his/her underwear. Law enforcement officers (LEO) arrived on the scene at 10:45 p.m. The LEO were at the intersection on the street west of the facility and did not locate VA1. (Note: The intersection

was approximately 500 feet from the facility.) The LEO then located VA1 near an intersection north of the initial intersection. (Note: This intersection was approximately 1,000 feet away from the initial intersection which showed VA1 traveled approximately 1,500 feet from the facility.)

- The LEO learned VA1 was autistic and non-verbal, and was unable to communicate through writing or texting. VA1 was placed in the back of the squad car and hospital and fire paramedics arrived. VA1 was recognized by fire paramedics and the LEO was told where VA1 lived. VA1 was assessed by paramedics and the LEO brought VA1 back to the facility. (Note: There was no information provided that VA1 sustained any injury.)

- At the facility, the LEO saw "the glass front door was closed, and the main front door was open." The LEO knocked on the door and announced their presence several times with no response. The LEO went inside, again announced their presence with no response, and discovered there was no staff person present. The LEO searched the home and found VA2 and VA4 asleep in their bedrooms. The LEO was not aware at that time that VA3 was also asleep in his/her bedroom.

- The LEO saw information for P1 posted, called P1, and told P1 the above information. (Note: An *Internal Report* written by P1 said s/he was called by the LEO at 11:20 p.m.) P1 told the LEO the SP was to be at the facility to supervise VA1-VA4 from 9:30 p.m. to 8:00 a.m. The LEO told P1 a car was not in the driveway of the facility and that the situation needed to be addressed immediately.

- The LEO waited at the facility until the SP arrived at the facility approximately one hour later. The SP said s/he had been hungry and went to McDonald's to get food. (Note: The McDonald's the SP told the LEO s/he went to was three-miles (seven-minutes by car) from the facility. The LEO discussed with the SP the risks of the vulnerable adults left alone and unsupervised and left the facility at 11:52 p.m.

- On June 15, 2023, the LEO met with the SP to discuss the incident. The SP told the LEO that on May 12, 2023, s/he had not eaten all day prior to the start of his/her shift and so s/he "stepped out to get food." The SP left the facility and "just closed the door and did not lock it." The SP went to a McDonalds and got food and believed s/he returned to the facility in less than 30 minutes. The SP said no one called him/her about the situation and s/he was not aware VA1 left the facility until s/he returned to the facility and the LEO was inside with VA1. The SP told the LEO that this was the first time in three years of employment at the facility that s/he left VA1-VA4 alone. The SP said s/he was trained to not leave the home while on shift until another staff person arrived. The SP was not charged with any crimes and the case was closed.

P1 provided the following information:

- VA1 lived at the facility for several years. VA1 used gestures and a Picture Exchange Communication System (PECS) to communicate with staff by pointing at items within a set of images. Prior to VA1 moving into the facility, s/he had a history of leaving unsupervised seeking out gasoline to smell. When VA1 moved in, staff persons were trained on VA1's elopement protocol. VA1 left unsupervised from the facility only one time prior to the May 13, 2023, incident. VA1 was unable to relay his/her address to others and did not wear any sort of identification. P1 was unsure if VA1 could recognize the facility independently.

- VA1 had a one-to-one staff person during the day until 10:00 p.m. and required an awake overnight staff person due to occasionally being awake during the overnight, his/her history of leaving unsupervised, and needing to be redirected back to bed. VA1 typically slept well and often slept through the night without issue.

- The SP worked at the facility for several years and primarily worked the awake overnight shifts. The SP had no previous corrective action.

- P1 provided information regarding his/her conversation with the LEO that was consistent with the information provided in the Law Enforcement Records.

- P1 called the SP when s/he got off the phone with the LEO and the SP told P1 s/he went to get food because s/he was hungry, did not bring food to the facility, and left ten minutes ago. P1 told the SP that s/he was not allowed to leave the facility or leave VA1-VA4 unsupervised and needed to get back to the facility immediately. P1 believed the SP was back to the facility within 15 to 20 minutes of getting off the phone. (Note: The *Internal Report* written by P1 stated SP1 returned to the facility at 11:40 p.m.) The LE talked with the SP about situation once s/he arrived back to the facility and then left.

- Immediately after P1 talked with the SP, s/he called his/her supervisor about the situation and discussed how neither of them were able to go to the facility. P1 was told to call other possible staff persons to finish the shift and if s/he was unsuccessful to have the SP work until the morning and they would deal with the situation in the morning. P1 called possible staff persons and P3 was able to come in for the remainder of the shift. P1 called the SP and told him/her a replacement staff person was on the way called P3 to confirm s/he was able to get into the house and that the SP went home. P1 calculated based on the phone call with P3 and his/her timesheet that P3 arrived at the facility 30 to 45 minutes after the SP got back to the facility.

- On May 15, 2023, P1 emailed G1-G4 separately about the incident. P1 informed G1 of VA1 leaving unsupervised and G2-G4 that VA2-VA4 were unsupervised for approximately 20-30 minutes. P1 could not recall exactly when, but saw VA1 either three or four days after the incident and s/he appeared his/her normal self and unimpacted by what occurred. P1 was not aware of any information that VA1 accessed any gasoline or was harmed while leaving unsupervised.

- Staff persons are trained that they cannot leave VA1-VA4 alone unsupervised, were to bring food in prior to the shift or eat the food at facility, and if a situation came up on the overnight, they were to call the on-call staff person.

P3 provided the following information:

- On May 13, 2023, sometime before midnight, P3 received a call from P1 who asked if s/he was available to work at the facility right away as a replacement staff person. P1 said there was a situation where the LEO were involved, but did not share any more information.

- P3 arrived at the facility about midnight and called the SP to have him/her unlock the door. P3 noted that the door alarm did not go off when the door was opened. P3 did not get a chance to talk with the SP because the SP left immediately after P3 arrived. P3 walked through the facility, checked on VA1-VA4, and they were each asleep in their beds.

- The remainder of the shift, VA1-VA4 slept and around 3:30 to 4 a.m. VA2, VA3, and VA4, started to wake. VA1 stayed in his/her room until about 7:30 to 8 a.m. when the morning staff came in. P3 did not see anything unusual about VA1-VA4 that showed they were impacted by the prior night.

P2 provided the following information:

- VA1 had a one-to-one staff person due to his/her maladaptive behaviors and his/her history of leaving unsupervised. VA1 had an upstairs bedroom to attempt to prevent him/her from leaving out the window. Staff persons were to actively engage with VA1 when s/he was awake to reduce the chances of VA1 leaving unsupervised. VA1 typically slept well, but might wake to get food from the kitchen. Staff persons were trained to give VA1 a light snack and direct him/her back to bed.

- VA2 was normally slept well and did not wake on the overnight shifts. VA2 could possibly have a seizure on the overnight and staff persons were to check on him/her.

- VA3 was normally slept well, but could be incontinent during the night and needed to be checked on every two hours and possibly changed.

- VA4 occasionally woke during the night and needed redirection from staff persons to go back to his/her room. VA4 might also go to the fridge to get food or play on his/her iPad. VA4 might also injure him/herself by hitting his/her head and needed staff support during the overnight.

- The SP was trained by P1 for the overnight position. The SP was trained that if there was a situation during the overnight shift s/he was to call P2 and then P1 if need be. The SP was to bring in personal food and items to the shift and s/he was not allowed to leave VA1-VA4 unsupervised or alone at the facility.

- On May 13, 2023, P2 worked until 5 or 5:30 p.m. and went home. That night, P1 called P2 and told him/her about the situation. P2 was not able to go to the facility to replace the SP.

- The next morning, May 14, 2023, P2 went to the facility and saw nothing unusual about VA1 that showed s/he accessed gasoline or was injured when s/he left unsupervised. P2 said VA1 appeared "normal" as if s/he did not know what occurred.

- P2 had no prior concerns about the SP and considered him/her to be a "top notch" staff person and good at his/her job.

G1-G4 were informed by P1 of the incident that occurred. G1 said VA1 services were "fine." G2 said s/he was concerned about the turnover rate with the staff. G3 and G4 thought there could be more communication from the facility and G3 said staff persons could do more to engage with VA3.

The SP provided the following information:

- The SP worked the overnight shift for VA1-VA4 for four years and his/her responsibilities included cleaning the kitchen and bathroom, and completing the laundry. VA1-VA4 mostly slept through the night but occasionally woke to get water or use the bathroom. Afterwards, the SP directed them back to bed.

- On May 13, 2023, the SP worked the overnight shift and when s/he arrived VA1 was awake and in the living room with a staff person. The staff person left the facility and the SP put a load laundry in. Around 10:15 to 10:30 p.m. VA1 went to bed and was asleep. The SP checked on VA1-VA4 and saw they were all sleep.

- Around 10:45 to 10:50 p.m. the SP left the home to get something to eat. (Note: The LEO report stated they were assigned to the incident at 10:43 p.m. and arrived at 10:45 p.m., prior or at the same time the SP said s/he left the facility.) The SP said s/he closed the door and used the deadbolt latch outside the door to secure it shut. The SP believed the alarm to the door was turned off prior to his/her shift, but was unsure why the previous staff person turned it off. The SP drove to a McDonald's on Snelling Ave in Roseville, 10 to 15 minutes away from the facility, got food, and drove back. The SP believed s/he was gone no longer than 30 to 45 minutes.

- The SP arrived back to the facility the LEO were inside the home. VA1 was awake and did not appear to be injured or impacted by the situation. The SP could not be certain, but believed the LEO said they were called by a neighbor and the VA1 was found on the street outside the facility. The LEO left and the SP directed VA1 to his/her bedroom.

- P1 called the SP and told him/her that another staff person would be coming to work the remainder of the shift. The SP denied that s/he talked with P1 prior to returning to the facility. The SP saw that VA2-VA4 were asleep in their beds and did not see VA1-VA4 the remainder of the time until P3 arrived less than 30 minutes later.

- The SP said s/he made a "mistake" that was in "poor judgement" when s/he left the facility and left VA1-VA4 unsupervised. The SP was trained to not leave during the overnight shift and if there was an issue or complication s/he was to contact a supervisor for guidance. The SP said this incident was the only time s/he left VA1-VA4 unsupervised.

Facility documentation showed that the SP was trained on the Reporting of Maltreatment of Vulnerable Adults Act, the facility *Employee Handbook*, and on the VA's plans.

Conclusion:

A. Maltreatment:

Information from all sources was consistent that on May 12, 2023, while on an awake overnight shift, the SP left the facility and drove to a nearby McDonald's for food leaving VA1-VA4 unsupervised. While unsupervised, VA1 left the facility unclothed, was seen by a neighbor, and the neighbor called 9-1-1. The LEO located VA1, and brought him/her back to the facility. About one hour after the LEO found VA1, the SP arrived back to the facility where the LEO remained. There were no injuries to VA1-VA4.

Given VA1's-VA4's diagnoses and risks, each had no unsupervised time at home or in the community and required a staff person to remain present and awake at the facility during the nighttime. Therefore, there was a preponderance of the evidence that the SP leaving the facility for between 30 to 60 minutes, leaving VA1-VA4 without staff persons supervision, during which time VA1 left unclothed, was not accidental or therapeutic conduct, placed each at risk of harm, and was a failure to supply each with care or services that were reasonable and necessary to maintain their physical or mental health or safety.

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;
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> (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 responsible for the care and supervision of VA1-VA4 at the time of the incident. Facility documentation showed that the SP was trained on the Reporting of Maltreatment of Vulnerable Adults Act, the facility Employee Handbook, and on VA1's-VA4's plans.

The SP was responsible for maltreatment of VA1-VA4.

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. While the SP left four vulnerable adults unsupervised on his/her overnight shift, it was a single incident for which VA1-VA4 did not sustain any serious injury which reasonably required care of a physician.

Action Taken by Facility:

The facility completed an internal review, and determined that policies and procedures were adequate, but not followed. The SP no longer worked at the facility.

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.