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: 202300971

Date Issued: October 18, 2023

Name and Address of Facility Investigated:

Taylor SLS Inc (Basswood House)
1019 N Basswood Ave.
Duluth, MN 55811

Taylor SLS Inc.
2644 Hagberg St.
Duluth, MN 55811

Disposition: Allegation One: Inconclusive
Allegation Two: Inconclusive
Allegation Three: Inconclusive and False
Allegation Four: Inconclusive

License Number and Program Type:

1068042-H_CRS (Home and Community-Based Services-Community Residential Setting)
1068039-HCBS (Home and Community-Based Services)

Investigator:

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Suspected Maltreatment Reported:

Allegation One: It was reported that a staff person (SP1) was "rough" with two vulnerable adults (VA1 and VA2). It was also reported that VA2 had unexplained bruising.

Allegation Two: It was reported that SP1 yelled loudly at the clients. During the course of the investigation, it was reported that two staff persons (SP2 and SP3) told VA2 to, "Get the fuck out of the way."

Allegation Three: It was reported that VA1 and VA2's cares were neglected including VA1 and VA2's medications not being properly administered, VA1 and VA2 missing multiple medical appointments, SP1 refusing to help VA1 and VA2 with their personal cares, and VA1 and VA2 not being provided nutritious meals.

Allegation Four: It was reported that SP1 locked VA1 in his/her bedroom, and during the course of the investigation, it was reported that SP1 locked VA1 out of the facility.

Date of Incident(s): Ongoing prior to January 31, 2023

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (b); and Minnesota Statutes, section 626.5572, subdivision 15; subdivision 2, paragraph (b), clauses (1-4); and subdivision 17, paragraph (a):

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:

- Hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult.

- 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.

- Use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and

- Use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

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 February 9, 2023; from documentation at the facility; and through 12 interviews conducted with two supervisory staff persons (P1 and P6), seven facility staff persons (SP1, SP2, P2-P5, P7), a facility client (C), VA1's guardian (G1), and a facility administrator (P8).

This investigator reached out to SP3 by telephone and United States mail. SP3 did not respond.

The facility was a multi-level facility. The basement had a family room, a laundry room, and an office. The lower level had an office, VA1's bedroom, and a bathroom adjacent to VA1's bedroom and next to stairs leading up to the main level. The main level consisted of a kitchen, a dining room, a living room, and VA2's bedroom and bathroom. There was a full glass patio door between the dining room and living room that led to the backyard. The upper level had two bedrooms, one of which was the C's, and a bathroom.

VA1's diagnoses included "autism with multiple [disabilities]," and pica (an eating disorder where a person eats things that were not food and had no nutritional value). VA1 did not communicate using words but was incredibly

receptive to language and could understand what was being said to him/her and what was happening around him/her. VA1 liked to go to the zoo, go to the park, and go out to the backyard.

VA2's diagnoses included fetal alcohol syndrome (FAS) and failure to thrive. VA2 had severe vision loss, bilateral hearing loss in both ears, and was non-verbal. VA2 enjoyed listening to music, watching television, and going to the movies.

VA2's *Coordinated Services and Support Plan (CSSP)* stated that VA2 communicated through gestures and alternative verbal communications. In the past VA2 used a communication device but did not enjoy the device and appeared to be content with communicating via his/her own methods.

Facility records showed SP1-SP3 and P1-P7 were trained on the Reporting of Vulnerable Adults Act and the VAs' plans.

G1 stated that s/he had not heard of any concerns and was interested in the outcome of the investigation. G1 said VA1 was nonverbal and if a staff person was "mean" to him/her that VA1 "might shy away from [that staff person]" and that if VA1 was mad, s/he might "fight back," but mostly VA1 would want to leave the situation.

G2 was notified about the investigation however, s/he did not provide information to this investigator.

Allegation One: *It was reported that SP1 was "rough" with VA1 and VA2. It was also reported that VA2 had unexplained bruising.*

Regarding SP1 being "rough" with VA1 and VA2:

SP2 stated that SP1 grabbed VA1 by his/her shoulders and "aggressively" pushed VA1 to a seat. VA1 sat down and SP1 pushed VA1's shoulders down. VA1 got more and more "agitated." SP2 did not see any injury to VA1 at that time. SP2 stated that SP1 grabbed VA1 and VA2 and "forcefully" and pushed them. SP1 "aggressively" guided VA2 back to his/her bedroom and SP1 "often" did not allow VA2 to leave his/her bedroom. SP2 said that when s/he helped VA2 to a seat, SP2 placed one hand on VA2's shoulder to guide VA2 to a chair to sit down. SP2 denied pushing or shoving VA2.

P3 said that SP1 was "very" physically aggressive with VA1 and VA2. P3 said that SP1 "shoved" and "pushed" them while SP1 called them names and "cursed." SP1 pushed VA1 into his/her bed.

SP1 said that VA2 had a "good sense" of where s/he was going and that if VA2 was going to bump into something SP1 used verbal cues to redirect VA2. If SP1 needed to physically redirect VA2, SP1 put his/her hand between VA2 and the wall or put his/her hands gently on VA2's shoulders because VA2 bruised easily. SP1 denied being "rough" with clients.

P1, P2, P4, P7, and the C provided the following information:

- P4 saw SP3 push VA2 to his/her bedroom during a meeting. P4 said after the meeting s/he talked to SP3 about how staff persons cannot push clients. P4 said that VA2 only needed guidance with the stairs while

in the facility and that staff persons were to help by placing a hand over VA2's hand. P4 did not think VA2 was injured by SP3's actions.

- P2 saw SP2 and SP3 push VA2 towards his/her bedroom by pushing between VA2's shoulder blades with their hands. P2 did not see any injuries to VA2 as a result of this. P2 said VA2 walked faster when SP2 and SP3 did that and stumbled but did not fall. P2 said that if staff persons saw VA2 about to bump into something they were supposed to say something and if staff persons were close enough, they were supposed to grab VA2's shoulders and gently direct VA2 to where s/he was going.

- P1 was trained to verbally guide VA2 when s/he needed assistance walking and to physically assist VA2 by holding his/her hands. P1 witnessed SP2 and SP3 "firmly escorting" VA2 around. P1 stated that it was not shoving. P1 said s/he had not witnessed any other staff person be aggressive.

- The C had not seen any staff person be rough with VA1 or VA2. The C said if staff persons assisted VA2 they put their hands on VA2's shoulders or lightly around his/her wrists.

- P6 heard from the C that SP2 and SP3 "shoved" VA1 and VA2 around.

- P7 did not see staff persons "rough" with VA2.

Regarding VA2's unexplained bruising:

VA2's plans stated that VA2 "will scream, pinch, and bite [him/her] self."

SP2 stated that VA2 sometimes had five purple dots that looked like someone's fingerprints on him/her and one time s/he had a "big bruise" on his/her chest. SP2 said that VA2 would bite his/her own wrist when VA2 was upset.

P3 said that VA2 ran into things in the house "many times." P3 said that VA2 bruised easily. P3 did not remember the exact dates but saw fingerprint or knuckle sized bruises on VA2's arm, shoulder, and chest. P3 stated that s/he documented this and reported it to P6.

SP1 stated that VA2 bruised easily and that VA2 sometimes bit or pinched him/herself. VA2 also liked to go under his/her bed. SP1 said there was a bruise chart and usually the overnight staff person charted on unless staff persons saw something suspicious. SP1 had not seen any bruising on VA2 that looked "suspicious."
SP1 denied being "rough" with VA2.

P1, P2, and P4-P7 provided the following information:

- P1 said that VA2 pinched him/herself, bit him/herself, and slapped him/herself. P1 stated that the facility used a bruise/body log for VA2 and if there were any marks not made by self-injurious behavior, an incident report was filled out. P1 stated that due to VA2's vision, s/he sometimes bumped into things, especially when VA1 left a stool or chair out.

- P6 stated that VA2 had a history of running into things and the facility's practice was to conduct a body check in the morning and evening. P6 said that VA2 pinched him/herself on the thigh, belly, and face and that left pin dot sized red marks. P6 said on occasion VA2 crawled under his/her bed and one time from doing this ended up with a bigger bruise on his/her shoulder.

- P7 stated that VA2 ran into walls if s/he moved too fast. P7 said s/he did a body check every morning and documented any new bruising. Depending on the nature of the bruising P7 wrote an incident report. P7 said staff persons stopped writing incident reports when VA2 ran into the walls because there were days P7 had to write 15 incident reports.

- P5 said that VA2 felt his/her way around the house and staff persons guided VA2 only when s/he went downstairs, otherwise, VA2 was able to navigate on his/her own. P5 said that VA2 occasionally stumbled into things. P5 knew VA2 bruised easily and that VA2 liked to spend time under his/her bed listening to music.

- P4 said that VA2 banged his/her fist against his/her head, pinched him/herself, and bit him/herself. P4 said sometimes there were bruises and scratches as a result of this. P4 stated staff persons had a body log to document bruising on VA2.

- P2 said VA2 had bruises on his/her knees and elbows sometimes from bumping into things and that VA2 pinched him/herself "a lot."

The C, P1, P2, P4, P6, P7, and P8 did not have concerns with how SP1 treated the clients.

Conclusion for Allegation One:

Regarding SP1 being "rough" with VA1 and VA2:

SP2 stated that SP1 grabbed VA1 and VA2 "forcefully" and pushed them. SP2 saw SP1 "aggressively" push VA1 into a seat. SP2 did not see any injuries on VA1. P3 said that SP1 "shoved" and "pushed" VA1 and VA2 while SP1 called them names and "cursed." SP2 saw SP1 "aggressively" guide VA2 into his/her bedroom, and P3 saw SP1 push VA1 into his/her bed.

SP1 stated that if s/he needed to physically redirect VA2, SP1 put his/her hand between VA2 and the wall or put his/her hands gently on VA2's shoulders because VA2 bruised easily. SP1 denied being "rough" with clients.

P4 saw SP3 push VA2 to his/her bedroom during a meeting, so s/he talked to SP3 about his/her actions. P4 did not think VA2 sustained any injuries. P2 saw SP2 and SP3 push VA2 towards his/her bedroom by pushing between his/her shoulder blades with their hands. P2 did not see any injuries to VA2. P2 said VA2 walked faster when SP2 and SP3 did that and stumbled but did not fall. SP2 denied pushing or shoving VA2.

The C, P1, P2, P4, P6, P7, and P8 did not have concerns with how SP1 treated the clients.

Although SP2 and P3 stated that SP1 was "aggressive" and "shoved and pushed" the clients, given that the C, P1, P2, P4, P6, P7, and P8 did not have concerns with how SP1 treated clients, that SP1 and SP2 denied being "rough"

with clients, that VA2 sometimes needed staff persons to physically assist him/her with walking, and there was no other information to support or refute that SP1, SP2, or SP3 were "rough" with the clients, there was not a preponderance of the evidence whether any staff persons' actions were anything other than therapeutic conduct and could be reasonable expected to cause physical pain or injury.

It was not determined whether physical 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: Hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult).

Regarding VA2's unexplained bruising:

SP2 and P3 each stated that they saw bruises on VA2's body that looked like fingerprint marks. They also stated that VA2's had bruising on his/her chest area.

Consistent information was provided by P1-P3 and P5-P7 that VA2 sometimes ran into things around the house. P2 said this caused marks to VA2's elbows and knees. SP1, P5, and P6 also stated that VA2 liked to crawl under his/her bed. P6 said doing that caused VA2 to have a big bruise on his/her shoulder one time.

VA2's plans, SP1, SP2, P1, P2, P4, and P6 provided consistent information that VA2 exhibited self-injurious behavior, including biting, pinching, and hitting. P6 said that VA2 pinched him/herself on the thigh, belly, and face and that left pin dot sized red marks. P4 said sometimes there were bruises and scratches as a result of this.

SP1, P3 and P5 each said that VA2 bruised easily. P6 and P7 stated that staff persons performed a daily body check to see if VA2 had bruises. SP1, P1, P3, P4, P6, and P7 each stated that bruises were documented.

Although SP2 and P3 each stated that they saw bruises that looked like fingerprint marks, given that P1-P3, and P5-P7 stated that VA2 ran into things around the house, that SP1, P5, and P6 each stated that VA2 liked to crawl under his/her bed which sometime caused bruises, that SP1, SP2, P1, P2, P4, and P6 each stated that VA2 was prone to self-injurious behavior including, hitting, pinching, and biting, and that there was no specific information that any incident occurred with any staff person to cause the bruises, there was not a preponderance of the evidence whether VA2's bruises were self-inflicted or caused by any means other than accidental.

It was not determined whether physical 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: Hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult).

Allegation Two: *It was reported that SP1 yelled loudly at the clients. During the course of the investigation, it was reported that SP2 and SP3 told VA2 to, "Get the fuck out of the way."*

SP2 stated that SP1 yelled loudly at the clients as s/he pushed them. SP2 stated that staff persons told the clients, "[VA1] sit down," and "[VA2] go to your room." SP2 denied telling clients to "sit the fuck down."

P3 said that SP1 yelled at VA2 when VA2 wanted his/her radio. P3 said that SP1 "shoved" and "pushed" them while SP1 called them names and "cursed."

SP1 stated that s/he heard from other staff persons that SP2 and SP3 yelled at VA2 to "get the fuck out of the way" so that they could watch television.

P1, P2, P4, P5, and the C provided the following information:

- P4 had concerns with how SP2 and SP3 raised their voices to the clients, telling them, "You're not getting your speaker right now," "Go away," and "You're blocking the T.V." SP2 screamed at upper management about a scheduling conflict in front of other staff persons, guardians, and clients.

- P2 heard SP2 and SP3 yell at VA1 and VA2 instead of redirecting them. SP2 and SP3 raised their voices and told clients, "Get out of the kitchen." SP3 yelled at VA2 to get out of the way of SP3 watching television.

- P1 stated that s/he heard SP2 and SP3 sat on the couch and when VA2 got in the way of the television, SP2 and SP3 told VA2 to "get the fuck out of the way" because they could not watch their show. P1 had no concerns with how SP1 cared for the clients. SP1 took care of the facility when P6 left and SP1 "Put [his/her] heart and soul here and ha[d] the best intentions for these [clients]."

- The C said staff persons were gentle with VA1 but SP2 and SP3 raised their voices and were firm with VA2. The C had not heard any staff persons yell at the clients.

- P5 was told by the C that SP2 and SP3 "screamed" at VA2 and told him/her to "Get the 'F' out of the way of the T.V." P5 had "never" heard SP1 scream at VA1 and VA2. P5 stated that the C was able to "accurately pass on information."

- P6 said the C sometimes complained about P7 stating that, "[P7] is yelling at me." P6 said that P7 was loud, and s/he raised his/her voice to be heard. P6 heard from the C that SP2 and SP3 yelled at VA2 for getting in their way.

The C, P1, P2, P4, P6, P7, and P8 did not have concerns with how SP1 treated the clients.

Conclusion for Allegation Two:

SP2 and P3 said that SP1 yelled at the clients when s/he pushed them and P3 stated that SP1 yelled at VA2 when VA2 wanted his/her radio.

SP1, P1, and P6 heard from other staff persons or the C that SP2 and SP3 yelled at VA2 for getting in their way. However, the C told this investigator that no staff persons yelled at VA1 or VA2. P2, P4, and the C heard SP2 and SP3 raise their voices at VA1 and VA2. P4 heard "You're not getting your speaker right now," "Go away," and "You're blocking the T.V." and P2 heard "Get out of the kitchen."

SP2 and P3 stated that they heard SP1 yell at clients, P2, P4, and the C heard SP2 and SP3 raise their voices at VA1 and VA2, and several staff persons heard from other staff persons or the C that SP2 and SP3 told VA2 to, "Get the fuck out of the way," all of which was behavior inconsistent with the standards of a professional caregiver in a facility licensed by the Department of Human Services. However, given that some information was inconsistent and did not have details regarding occurrences, that SP1, SP2, and SP3 each denied the allegations, and that there was no further information to confirm or dispute what occurred, there was not a preponderance of the evidence whether SP1's, SP2's, or SP3's conduct was repeated or could be reasonably expected to cause emotional distress.

It was not determined whether emotional abuse occurred (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).

Allegation Three: *It was reported that VA1 and VA2's cares were neglected including VA1 and VA2's medications not being properly administered, VA1 and VA2 missing multiple medical appointments, SP1 refusing to help VA1 and VA2 with their personal cares, and VA1 and VA2 not being provided nutritious meals.*

VA1's plans stated that staff persons "will schedule, transport, and attend all of [VA1]'s medical appointments with [him/her]." Staff persons "will help [VA1] complete [his/her] personal hygiene routines."

Regarding medications of VA1 and VA2:

SP2 said that VA2 had a "medicated cream" that was to be applied to VA2 but was not getting applied by SP1 so VA2 broke out in blisters on his/her face and thighs. SP2 said every time VA2 used the bathroom staff persons were supposed to put the cream between VA2's legs and butt cheeks, but SP2 had not seen anyone apply the cream and VA2 had "bad" rashes. SP2 said that when SP1 took VA2 to the bathroom there was not enough time for SP1 to apply the cream. SP2 stated it was "A & D ointment," not a prescription, but SP2 did not know if VA2's doctor prescribed VA2 to use the ointment. SP2 stated that VA1 was supposed to receive his/her "narcotic" medication twice a day, but SP1 administered the medication up to four times a day. SP2 said there was one time that s/he stuck a note to the wall to notify the next staff person working that the clients had not been given their medications instead of communicating with P6, and the clients did not receive their medications. SP2 was not medication certified so could not give medications to clients.

SP1 said VA1's medications changed recently, and that his/her doctor ordered VA1's lorazepam (used to treat anxiety and seizures) to be changed from four times a day to twice a day. SP1 said VA1's medications were scheduled doses and if a dose was missed staff persons called the pharmacy or doctor to see if there were any adverse effects to giving VA1 his/her medication at the non-prescribed time. SP1 said there was one incident where s/he was not at the facility during the scheduled medication pass and asked SP2 to tell P7 that s/he needed to give VA1 his/her medication when P7 arrived for his/her shift. SP2 did not pass on that information so VA1 did not receive his/her medication. There was no information that the VA had adverse effects.

An electronic communication record between P1 and VA1's health care provider provided the following information:

- On January 30, 2023, P1 messaged VA1's doctor to verify whether VA1's Olanzapine 7.5milligram (mg) prescription was to be taken one or two times daily. A nurse replied that VA1 was ordered to take it twice

daily. P1 responded and said that the old program director (P6) had VA1 taking it once a day in the evening. P1 asked if VA1 could continue it once per day and had no side effects from taking it once daily. The nurse replied and said that if there were not any side effects or increased behaviors from only taking once daily, then it was okay to continue once per day.

- On February 8, 2023, P1 stated that VA1 was "exhibiting more signs of aggression," self-injurious behavior, and agitation and that P1 thought it might be VA1's best interest to go back to two times a day, adding the morning dose.

P1, and P4-P7 provided the following information:

- P6 said VA2 had an eczema injection every two weeks. At the time only P6 was able to administer this injection. SP1 and P7 had an appointment with VA2's dermatologist to learn how to administer this medication but due to bad weather this appointment was missed and VA2 was not given his/her injection. VA2's doctor said there were no ill effects of VA2 missing this dose. P6 was aware of one to two medication errors that occurred in December of 2022 or early January 2023 where there was a miscommunication where SP1 told SP2 and SP3 to tell P7 to pass medication since SP2 and SP3 were not trained on that yet.

- P7 stated that on two occasions s/he missed giving VA1 his/her medication because SP2 and SP3 did not tell P7 that the previous staff person did not pass the medications. SP2 and SP3 were not trained in dispensing medications but had been told to pass on information to P7 from SP1 and one other staff person that VA1 still needed his/her medication.

- P1 said that prior to him/her starting there was a medication error due to miscommunication between staff persons, but then P1 retraining staff persons and created a staff person communication book.

- There was an eczema medication that P5 did not know VA2 was supposed to be getting. P5 stated that SP1 expressed frustration that P6 had not trained him/her on things before s/he left. P5 said SP1 had a lot of things "dumped" on him/her.

- P4 said medications were documented on the *Medication Administration Records* and that another staff person was recently trained on passing medications.

The facility's *Progress Notes* for VA1, VA2, and the C from October to December 2022, showed entries written by SP1, SP2, SP3, P3, P6, and P7 noting how the clients (VA1, VA2, and the C) day was, if cares were completed or refused, and if medications were administered.

The *Medication Administration Records* (MAR) for VA1 and VA2 from October through December 2022 showed medications were signed off on, as well as morning and evening care routines every day.

Facility documentation from December 2022, for "med[ication] error plan of action to prevent similar errors," stated the following:

> "In order to prevent this from happening again in the future we have taken the following steps: 1) All staff [persons] have been instructed to begin communicating with one another in a staff [person] log rather than relying on verbal communication being passed from one staff person to another. This will not only eliminate the opportunities for individuals to forget to pass a message, but it will also provide a written paper trail as evidence of messages being passed and received. 2) All current med[ication] certified staff [persons] are being retrained on proper med[ication] passing procedures and documentation. All non-med[ication] certified staff [persons] have been enrolled in a med[ication] class in order to eliminate times of day when a med[ication] passer is not available. The documentation of and reporting procedures for medication administration errors will be reviewed by all staff [persons] to prevent delays in taking appropriate action and notifying the proper individuals. 3) If or when a med[ication] error / missed med[ication] occurs staff [persons] need to call [the pharmacy] and talk with the pharmacist or call the consumer's [doctor's] office for instructions."

Facility records showed email communication between P1 and VA1's health care professional from January 2023, regarding VA1's change in medications and the side effects VA1 was experiencing.

Regarding VA1 and VA2's missed medical appointments:

SP2 stated that VA1 and VA2 missed medical appointments routinely since 2018. P1 was recently hired and had "done nothing" to get VA2 back on track with his/her health care needs. SP2 said that the medical appointments got "pushed back" a lot of times but SP1, P6, and P1 were responsible for setting them up.

P3 said that SP1 and P6 were responsible for talking clients to their appointments and over the last seven years, they had missed dental checkups and annual physicals.

SP1 stated that in the past it was P6 who set up and took VA1 and VA2 to medical appointments. There were times s/he called SP1 to have him/her cancel or reschedule the appointments. SP1 knew one time was due to bad weather, but other times P6 was supposed to take the clients to appointment but did not show up to take them. SP1 said now it was SP1, P1, and P4 who set up the appointments and took the clients to them.

P1, P6, and P7 provided the following information:

- P1 said that s/he heard that VA1 and VA2 were not taken to medical appointments when P6 was the supervisor. P1 said that s/he was not able to tell if the appointments were missed or just that they were not scheduled in a timely manner due to COVID-19.

- P7 asked SP1 to reschedule an appointment for VA2 once because there was bad weather. P7 was not sure if SP1 rescheduled or cancelled it. P7 thought P6 handled the appointments.

- P6 said that if the clients missed an appointment due to the facility being short staffed it was rescheduled.

VA1's *Medical Records* showed appointments from June 2019 through February 2023. These included office visits and telehealth appointments. These appointments were for family medicine, neurology, emergency department, laboratory, behavioral health, and gastroenterology appointments.

VA2's *Medical Records* showed appointments from December 2019 through February 2023. These included office visits and telehealth appointments. These appointments were for ophthalmology, dermatology, family medicine, radiology, endocrinology, orthopedics, rheumatology, emergency/urgent care, and laboratory appointments.

Regarding SP1 refusing to help VA1 and VA2 with cares:

SP2 stated that VA2 had a nightly care routine in which staff persons were supposed to help VA2 brush his/her teeth, get VA2 changed, and wash VA2's face. SP2 said that SP1 "seldom" did those things for VA2. SP2 said prior to January 2023, there was no way of knowing if VA2's teeth were brushed at night.

P3 said it was November or December 2022, that SP1 "did not help" VA2 with toileting or showering. P3 did not provide further details.

SP1 said staff persons helped VA1 and VA2 with brushing their teeth and that if VA2 was not receptive s/he pushed staff persons hands away, and then staff persons documented that. SP1 said VA1 was more receptive to brushing his/her teeth and it was more of a hand over hand assist so that VA1 got both sides of his/her mouth. SP1 stated that the C sometimes refused his/her cares. SP1 denied skipping VA1 and VA2 cares.

P6 and P7 provided the following information:

- P7 stated that whoever was responsible for assisting VA1 and VA2 to get ready for bed was responsible for brushing their teeth. P7 stated that s/he noticed when VA1's and VA2's toothbrushes had not been moved from when P7 put them away in the morning. P7 stated that this happened every time SP2 and SP3 worked. P7 stated teeth brushing was on the *Medication Administration Record* so it should have been done and signed off on.

- P6 found it hard to believe that cares were not being done and when s/he worked with other staff persons the clients' cares were done "every" time.

The C, P1, P2, P4, P6, P7, and P8 did not have concerns with how SP1 treated the clients.

The facility's *Progress Notes* for VA1, VA2, and the C from October through December 2022, showed entries written by SP1, SP2, SP3, P3, P6, and P7 noting how their day was, if cares were completed or refused, and if medications were administered.

The MARs for VA1 and VA2 from October through December 2022, showed medications were signed off on, as well as morning and evening care routines.

Regarding VA1 and VA2 not being provided nutritious meals:

SP2 stated that there was supposed to be a specific meal plan, but the clients were mostly given chicken nuggets, potato chips, and "T.V." dinners. SP2 asked SP1 to provide some fruit and other items to eat, but SP1 "refused."

P3 stated that the facility bought "freezer food" and staff persons allowed VA2 to eat just chips.

P6 heard that SP1 bought processed foods for the clients to eat and that staff persons got into a bad habit of giving VA2 a bowl of chips for morning snack. P6 said that SP2 and SP3 complained about having frozen chicken breast and canned peaches instead of fresh.

SP1 said there was a meal planner where staff persons wrote out a week of meals to make. Lunches consisted of sandwiches, canned ravioli or soup, and leftovers. Breakfast was at the discretion of the overnight staff person but there were eggs and sausage, and skillet scrambles. Dinners consisted of chicken patty and French fries, homemade pulled pork, tacos, salads, or fish. SP1 said it depended on who made the menu and that staff persons tried to use what was in the facility first before going grocery shopping.

P1, P4, P7, and the C provided the following information:

- P1 said VA1 loved meals like lasagna, salads, sandwiches, homemade tater tot hotdish, and taco night. P1 said VA1 was not a picky eater, but there were some fruits s/he did not like.

- P4 said that VA1 and VA2 liked to eat anything. P4 said some of the meals VA1 and VA2 had eaten were ground beef, chicken, hot dogs, sandwiches, salad, fresh fruit and vegetables, frozen pizza, and lasagna.

- The C said the food was "excellent" and s/he had no complaints. The C said s/he ate pizza, tacos, steak, and burgers.

- P7 said staff persons tried to vary the clients' diet. P7 was not aware of who picked lunches and dinners, but the overnight staff persons were responsible for breakfast. P7 stated that s/he made egg scrambles.

Conclusion for Allegation Three:

Regarding medications of VA1 and VA2:

SP2 stated that VA2 did not receive his/her medicated ointment from SP1 and that SP1 administered VA1's "narcotic" medication four times a day when it was only supposed to be administered twice a day.

SP1 stated that VA1's lorazepam medication was recently changed from four times a day to twice a day. SP1 stated that if a dosage was missed staff persons called the pharmacy or doctor to see if there were any adverse effects to giving VA1 his/her medication at the non-prescribed time.

SP1, SP2, and P7 all stated that there was an incident where SP1 told SP2 to tell P7 to administer medications in the evening as SP1 left for the day and SP2 was not medication trained. P7 did not receive this information and medications were missed that night.

VA1's and VA2's MARs from October through December 2022 were documented, as well as *Progress Notes* from that time frame with entries stating medications were administered.

Although SP2 stated that VA2 did not receive his/her medicated ointment, and that SP1 administered VA1's "narcotic" medication four times a day when it was only supposed to be administered twice a day, given that there were recent changes in VA1's lorazepam, and that facility records showed medications were administered

to VA1 and VA2 from October through December 2022, there was not a preponderance of the evidence whether there was a failure to provide reasonable and necessary care and services.

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).

Regarding VA1 and VA2's missed medical appointments:

SP2 and P3 stated that VA1 and VA2 routinely missed appointments from 2018 through 2022. SP2 said that the medical appointments got "pushed back" a lot of times but SP1, P6, and P1 were responsible for setting them up.

SP1 stated that in the past it was P6 who set up and took VA1 and VA2 to medical appointments. There were times s/he called SP1 to have him/her cancel or reschedule the appointments.

P6 and P7 stated that there were occasions when appointments were rescheduled due to weather, or the facility being understaffed. P1 heard that the clients were not taken to appointments, but s/he was not sure if they were missed or just off track from COVID-19.

VA1's *Medical Records* showed appointments from June 2019 through February 2023. These included office visits and telehealth appointments. These appointments were for family medicine, neurology, emergency department, laboratory, behavioral health, and gastroenterology appointments.

VA2's *Medical Records* showed appointments from December 2019 through February 2023. These included office visits and telehealth appointments. These appointments were for ophthalmology, dermatology, family medicine, radiology, endocrinology, orthopedics, rheumatology, emergency/urgent care, and laboratory appointments.

Although SP2 and P3 stated that VA1 and VA2 routinely missed appointments from 2018 through 2022, given that P6 and P7 stated that appointments were rescheduled due to weather or the facility being understaffed, that P1 was not sure if the clients appointments were missed or just off track from COVID-19, and VA1's and VA2's *Medical Records* showed they attended appointments to a variety of doctors either in person or via telehealth from 2019 through 2023, there was a preponderance of the evidence that there was not a failure to provide VA1 and VA2 with reasonable and necessary care and services.

It was determined that neglect did not occur (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).

Regarding SP1 refused to help VA1 and VA2 with cares:

SP2 stated that VA2 had a nightly care routine in which staff persons were supposed to help VA2 brush his/her

teeth, get VA2 changed, and wash VA2's face. SP2 said that SP1 "seldom" did those things for VA2. SP2 said prior to January 2023, there was no way of knowing if VA2's teeth were brushed at night.

P3 said it was November or December 2022 that SP1 did not help VA2 with toileting or showering.

SP1 denied skipping cares for VA1 and VA2. SP1 stated that the C sometimes refused to do his/her cares.

The MARs for VA1 and VA2 from October through December 2022, showed morning and evening care routines signed off on, including brushing teeth, flossing, and using mouthwash. *Progress Notes* from that time frame also had entries by several staff persons that these care were performed.

Although SP2 stated that VA2 had a nightly routine including brushing VA2's teeth which was "seldom" done by SP1 and prior to January 2023, there was no way of knowing if VA2's teeth were brushed at night, and that in November or December of 2022, P3 said that SP1 did not help VA2 with toileting or showering, given that facility documentation from October through December 2022, documented morning and evening care being performed by a variety of staff persons including SP1, and SP1 denied skipped cares for VA1 and VA2, there was a preponderance of the evidence that there was not a failure to provide VA1 and VA2 with reasonable and necessary care and services.

It was determined that neglect did not occur (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).

Regarding VA1 and VA2 not provided nutritious meals:

SP2 and P3 stated there was a lot of frozen foods and clients were not provided with health snacks. P6 heard that SP1 started buying more "processed" foods.

SP1 stated that there was a menu, but that staff persons tried to use what food was at the facility first before going to the grocery store.

P1, P4, P7, and the C stated that there was a variety of foods including homemade items. The C said the food was "excellent" and s/he had no complaints.

Although SP2, P3, and P6 stated that the clients were being served more frozen or "processed" foods, given that P1, P4, P7, and the C stated that there was a variety of foods including homemade items, the C stated the food was "excellent", and that SP1 stated that staff persons tried to use what food was at the first facility before going to the grocery store, there was a preponderance of the evidence that there was not a failure to provide VA1 and VA2 with reasonable and necessary care and services..

It was determined that neglect did not occur (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 Four: *It was reported that SP1 locked VA1 in his/her bedroom, and during the course of the investigation, it was reported that SP1 locked VA1 out of the facility.*

Due to VA1's food and beverage seeking behavior, s/he had *Rights Restriction* in place that stated that "all cupboards, cabinets, closets, and storage areas will be locked" and "due to a doctor ordered fluid restriction of no more than 1500 milliliters per day, the refrigerator will be locked to prevent [VA1] from obsessively helping [him/herself] to excessive beverages."

Regarding SP1 locking VA1 in his/her bedroom:

P3 said SP1 locked VA1 both in his/her bedroom and out of his/her bedroom. P3 gave an example of times when VA1 had incontinence inside his/her room and staff persons had to lock VA1 out of his/her room. P3 said that SP1 locked VA1 outside of his/her room so s/he could clean up VA1's room and another time SP1 was on the inside of VA1's room with VA1 to "try to put [VA1] to sleep."

SP2 stated that VA1 liked to run to the downstairs bathroom, flush the toilet, just stand there, and then go back upstairs. SP2 said that SP1 trained SP2 to lock the bathroom door. SP2 did not realize that s/he was not supposed to restrict the clients from things in their home by locking doors. SP2 denied using anything to lock VA1 in his/her bedroom. (Note: There were three bathrooms in the facility.)

SP1 said s/he heard from the C that SP2 and SP3 used a phone charger cord to lock VA1 in his/her bedroom and out of the bathroom, but SP1 did not see that. SP1 told P6 about what the C said and P6 said s/he would look into it. P6 stated that s/he talked with the C and there "wasn't anything there." SP1 said, "We don't lock [him/her] out or in anywhere."

P1, P2, P4-P7, and the C provided the following information:

- The C found a charging cord tied to the handrail at the bottom of the steps just outside of the lower-level bathroom. SP2 and SP3 "claimed they locked the bathroom with the charging cord." The C thought SP2 and SP3 locked VA1 in his/her bedroom with the cord because the C heard VA1 bang on his/her door, but the C did not see the cord tied to VA1's bedroom handle. The C said the only door locked was the door to the basement and that was because of VA2's vision.

- P1 said s/he had "never" seen VA1's bedroom door locked. P1 said s/he had a conversation with SP2 and SP3 during one of their shifts because they had locked the downstairs bathroom door because VA1 kept running down to flush the toilet. P1 told them that it cannot be locked, and their job was to redirect VA1 when s/he had that behavior.

- P4 said VA1's bedroom door was "never" locked. P4 said there was an incident in which P1 noticed that VA1's bathroom door was locked, so P1 followed up with all staff persons to make sure they were aware that the bathroom door cannot be locked. P4 was not aware of who locked the bathroom door.

- P2 said that when s/he started s/he noticed that the downstairs bathroom door was locked and thought it was normal until s/he realized it was only locked when s/he worked with SP2 and SP3. P2 said SP2 and SP3 did not like VA1 going into the bathroom and flushing the toilet. P2 brought it up to P1 who made sure all staff persons knew the door was not supposed to be locked.

- P7 stated that s/he was not trained to lock the bathroom door, but a former staff person had done it when s/he was frustrated with VA1 playing the "door game." P7 said that when s/he relieved SP2 and SP3 from their shift, the bathroom door was locked. P7 asked SP2 and SP3 why the bathroom door was locked, and they said because of the "game." P7 told them they were not allowed to do that. P7 did not know anything about locking VA1's or VA2's bedrooms doors and did not see a reason to try to lock VA1 in his/her bedroom because VA1 was able to unlock the door.

- P5 did not witness but heard from the C that SP2 and SP3 used a phone cord and locked VA1 in his/her bedroom by tying the other end to another door so VA1 was not able to get out. P5 said staff persons were not allowed to lock doors.

- P6 said that VA1 played the "door game" when s/he opened and slammed both the bedroom and bathroom doors. P6 said VA1 opened the door a crack, tapped on the door, and then slammed it shut. P6 said VA1's bedroom door could be opened from the inside. There was a staff person who was no longer with the facility that locked the bathroom door so that VA1 was not able to slam the door. P6 did not remember SP1 locking doors but heard from the C that SP2 and SP3 locked the doors. P6 also stated that P7 "commonly locked doors."

- P8 heard that SP2 and SP3 locked VA1's bathroom door so they did not have to "deal with the annoyance of [VA1]."

The C, P1, P2, P4, P6, P7, and P8 did not have concerns with how SP1 treated the clients.

Regarding SP1 locking VA1 out of the facility:

On October 15, 2022, SP2 observed VA1 bang on the cabinets looking for food and SP1 was "fed up" so s/he "dragged" VA1 outside and slammed the door. VA1 screamed and tried to open the door. SP2 stated that this happened repeatedly over four to five minutes and SP1 smiled during this incident, s/he thought it was "funny" to "slam" the door in VA1's face when VA1 tried to enter the facility.

SP2 stated that P6, SP3, and P3 also had information about SP1 locking VA1 out of the facility and that the information was being "swept under the rug."

P3 said there was a video that showed VA1 locked outside of the patio door. P3 said that SP1 was not visible in the video, but that s/he locked VA1 outside for almost 30 minutes. P3 also told this investigator that P3, him/herself, was not a "very credible" person or a "pillar of honesty."

SP1 said P7 documented how many times VA1 played the "door game" during the overnight. SP1 explained that the "door game" was VA1 opening and shutting a door or sometimes VA1 walked in and out of the door and shut it repeatedly. In the warmer months VA1 used the door from the dining room to go outside. SP1 said sometimes

s/he and VA1 played the game together and they both opened and shut the doors. SP1 said, "We don't lock [him/her] out or in anywhere." SP1 denied locking VA1 outside.

P1, P2, P4-P7 provided the following information:

- P5 said that when VA1 got excited s/he waved his/her hands by his/her face and made a verbal "groaning" noise. VA1 smiled and moved his/her hands around. When VA1 was upset, s/he bit his/her hand. P5 witnessed SP1 play a game with VA1 where VA1 was outside. P5 was not sure of the date, but stated it was warm outside. P5 said s/he did not know if SP1 locked the door or if VA1 locked the door going outside. P5 said there was both a dead bolt and a push lock on the handle and P5 had locked him/herself out before by accidentally locking the push lock. P5 did not see SP1 lock the door, but VA1 was outside and s/he and SP1 communicated through the glass. P5 said that VA1 was smiling, waving his/her hands, and rocking back and forth on his/her feet.

- P6 stated that VA1 used "butterfly fingers" in front of his/her face as a way to calm him/herself when overstimulated. P6 heard there was a video that showed VA1 locked outside. VA1 was trying to take VA2's lunch and SP1 locked VA1 outside to stop him/her from doing so. P6 did not see this video.

- P8 said that P3 expressed concerns about SP1 locking VA1 outside when SP1 was "annoyed" by VA1. P8 spoke with other staff persons who said SP1 played the "door game" with VA1. P8 stated there was a video that showed VA1 outside and VA1 seemed to be waving his/her hands. P8 stated the video was "grainy" and s/he was not able to tell if the door was locked. P8 stated that SP1 was not in the video.

- P1 stated that VA1 would open and shut doors in an obsessive type of way. P1 said VA1 "played peek a boo" with his/her bedroom door and liked to open it to see what was going on and then slammed it shut and did that repeatedly. P1 stated that staff persons would "play along" with VA1 when s/he did this. P1 said that when VA1 was happy s/he laughed and sometimes s/he lifted his/her hands in the air and shook his/her hands. P1 said that VA1 had different pitches in his/her voice and made a distinct sound when excited. P1 said when VA1 was frustrated, s/he bit his/her hand. P1 said there was an incident prior to him/her working at the facility where SP1 was playing with the doors with VA1, but SP1 told P1 that it was in a "fun" manner and SP1 did not lock VA1 out.

- P4 said VA1 loved the "door game" and s/he opened and shut doors to see what was around. P4 said different staff persons played the game with VA1. P4 stated that VA1 expressed happiness by having his/her palms facing outwards and wiggling his/her fingers. When VA1 was frustrated s/he slammed doors, hit walls, paced around the house, made a really loud noise similar to yelling, and sometimes bit his/her own hand.

- P2 stated that when VA1 was happy s/he laughed and put his/her hands up to his/her face and wiggled them. When VA1 was upset s/he banged on things and sometimes s/he bit his/her hand. P2 said VA1's favorite thing to do was to go into the bathroom and flush the toilet. VA1 also liked to shut the bedroom and bathroom doors if they were open.

- P7 said normally VA1 was asleep when P7 worked. P7 said the "door game" was when VA1 popped open his/her bedroom door and banged it shut.

The C, P1, P2, P4, P6, P7, and P8 did not have concerns with how SP1 treated the clients.

The *Incident Report* for the incident on November 6, 2022, at 12:40 p.m., written by P6 stated that "what was indeed shown in the video was that [VA1] was outside in the backyard and the deadbolt of the patio door was in the locked position." "The video did not show [SP1] at any time, it did not show [VA1] being shoved outside, it did not show how the door became locked, it did not show [VA1] in any distress or attempting to come inside, rather only pacing to and from the door, nor did it show the length of time [VA1] was locked outside."

According to www.wunderground.com, the high temperature on October 15, 2022, was 43 degrees Fahrenheit (F°) and had periods of cloudy sky and light snow.

According to www.wunderground.com, the temperature on November 6, 2022, at 12:40 p.m. was 45 degrees Fahrenheit (F°) and was mostly cloudy.

This investigator reviewed two videos:

The first video from October 15, 2022, was 14 seconds in length and showed SP1 standing inside the facility and VA1 outside. VA1 opened the door and SP1 closed the door two times that were visible in the video. VA1 waved his/her hands and vocalized. SP1 had a smile on his/her face. SP1 and VA1 were both in t-shirts and it was light outside.

The second video from November 6, 2022, was 16 seconds in length and grainy in quality. It showed VA1 outside the door leading from the dining room to outside. It was sunny outside and VA1 was in a t-shirt. VA1 moved his/her head back and forth and had his/her hand up on the glass and was moving it. SP1 was not in the video and due to the graininess, this investigator was unable to determine if the door was locked.

Conclusion for Allegation Four:

Regarding SP1 locking VA1 in his/her bedroom:

SP2 stated that VA1 liked to run up and down the stairs to go to the lower-level bathroom and flush the toilet. SP2 stated that s/he was trained by SP1 to lock the bathroom door. P3 said SP1 locked VA1 both in his/her bedroom and out of his/her bedroom. P3 stated that when staff persons needed to clean VA1's bedroom when VA1 was incontinent, staff persons locked VA1's bedroom door. P3 also stated that SP1 locked VA1's bedroom door when SP1 was in VA1's bedroom with VA1 when VA1 was going to sleep. P6 said a previous staff person used to lock the bathroom door so VA1 was not able to slam the door. P7 said there were times when s/he relieved SP2 and SP3 that the bathroom door was locked. P4 said there was an incident when VA1's bathroom door was locked, so P1 followed up with all staff persons letting them know that the door was not supposed to be locked. P1 stated that s/he had a conversation with SP2 and SP3 about not locking the bathroom door.

SP1, P1, P4, P5, P6, and P7 provided information that VA1's bedroom door was not locked. P1 and P4 stated that it was "never" locked, SP1 stated staff persons did not lock VA1 in or out of anywhere, P5 said it was not allowed, and P6 and P7 stated VA1's bedroom door could be opened from the inside. P8 heard that SP2 and SP3 locked the bathroom door when they were "annoyed" with VA1.

The C found a charging cord tied to the handrail at the bottom of the steps just outside of the lower-level bathroom. SP2 and SP3 "claimed they locked the bathroom door with the charging cord." The C thought SP2 and SP3 locked VA1 in his/her bedroom with the cord because the C heard VA1 bang on his/her door, but the C did not see the cord tied to VA1's bedroom door handle. SP1, P5, and P6 heard from the C that SP2 and SP3 used a cord to lock VA1 in his/her bedroom, none of them witnessed this. SP2 denied using anything to lock VA1 in his/her bedroom.

Although several staff persons stated that the lower-level bathroom door was locked, that SP2 said s/he was trained by SP1 to do so, and that the C found a phone charging cord tied to the bottom of the handrail, given that SP2 and SP3 stated previous staff persons trained them to lock the bathroom door and did not lock the bathroom door while VA1 was in the bathroom, that when P1 was made aware of the situation, s/he trained staff persons not to lock doors, that no one witnessed the phone charging cord tied to either VA1's bathroom or bedroom, that VA1's bedroom door could be unlocked from the inside and VA1 was capable of doing so, and that there were two other bathrooms in the facility that could be used by VA1, there was not a preponderance of the evidence whether any staff person unreasonable confined VA1 or forced separation.

It was not determined whether aversive deprivation procedures occurred (use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825).

Regarding SP1 locking VA1 out of the house:

On October 15, 2022, SP2 observed VA1 bang on the cabinets looking for food and SP1 was "fed up" so s/he "dragged" VA1 outside and slammed the door. VA1 screamed and tried to open the door. SP2 stated that this happened repeatedly over four to five minutes and SP1 smiled during this incident, s/he thought it was "funny" to slam the door in VA1's face when VA1 tried to enter the facility.

P3 said there was a video that showed VA1 locked outside of the patio door. P3 said that SP1 was not visible in the video, but that s/he locked VA1 outside for almost 30 minutes.

P1, P2, P4, P7, and SP1 all stated that VA1 liked to open and shut doors. SP1 said sometimes, s/he played the door game with VA1. P1, P2, P4, and P5 stated that VA1 wiggled his/her fingers by his/her face when VA1 was happy, and P6 said it was a way that VA1 calmed him/herself when overstimulated. P1 and P5 stated that VA1 vocalized when s/he was happy. P1, P2, P4, and P5 stated that VA1 sometimes bit him/herself or banged on walls when frustrated.

On one occasion P5 witnessed SP1 play a game with VA1 where VA1 was outside. P5 did not see SP1 lock the door, but VA1 was outside and s/he and SP1 communicated through the glass. P5 said that VA1 was smiling, waving his/her hands, and rocking back and forth on his/her feet.

P8 stated there was a video that showed VA1 outside and VA1 seemed to be waving his/her hands. P8 stated the video was "grainy" and s/he was not able to tell if the door was locked. P8 stated that SP1 was not in the video.

The *Incident Report* for the incident on November 6, 2022, at 12:40 p.m., written by P6 stated that "what was indeed shown in the video was that [VA1] was outside in the backyard and the deadbolt of the patio door was in the locked position." "The video did not show [SP1] at any time, it did not show [VA1] being shoved outside, it did not show how the door became locked, it did not show [VA1] in any distress or attempting to come inside, rather only pacing to and from the door, nor did it show the length of time [VA1] was locked outside."

This investigator reviewed two videos, the first one SP1 was inside the facility and VA1 was outside. VA1 opened the patio door and SP1 closed it. VA1 waved his/her hands by his/her face and vocalized. SP1 was smiling. The second video only showed VA1 outside the patio door and moving his/her hands. SP1 was not in the video and due to the quality of the video this investigator was unable to determine if the door was locked.

The C, P1, P2, P4, P6, P7, and P8 did not have concerns with how SP1 treated the clients. SP1 denied locking VA1 outside.

Although SP1 is shown in one video to be closing the door on VA1 while VA1 was outside, and that SP2 stated that SP1 "dragged" VA1 outside because SP1 was "fed up" with VA1's food seeking behavior, given what this investigator observed in the video was consistent with P1's, P2's, P4's, and P5's description of how VA1 behaved by wiggling his/her fingers and vocalizing when s/he was happy, that it was not determined if the door was locked either occasion, and that SP1 denied locking VA1 outside, there was not a preponderance of the evidence whether SP1 unreasonably confined VA1 or forced separation.

It was not determined whether aversive deprivation procedures occurred (use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825).

Action Taken by Facility:

The facility completed an *Internal Review* and found their policies adequate but not followed by SP2 and SP3. P6, SP2, and SP3 no longer worked at the facility.

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

No further action taken.