

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: 202308445

Date Issued: December 29, 2023

Name and Address of Facility Investigated:

Disposition: Inconclusive

Dungarvin Vine
1001 E Vine St
Owatonna, MN 55060

Dungarvin Minnesota LLC
1440 Northland Dr Ste 100
Mendota Heights, MN 55120

License Number and Program Type:

1115203-H_CRS (Home and Community-Based Services-Community Residential Setting)
1070806-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that there was a lack of supervision at the facility leading to a vulnerable adult (VA) ingesting foreign objects on more than one occasion. There were also concerns about lack of supervision while the VA was at the hospital and that there were medication errors two times a week for the last two months.

Date of Incident(s): Prior to October 2023 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 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 October 19, 2023; from documentation at the facility; and through eight interviews conducted with five facility staff persons (P1, P2, P3, P4, P5), the VA's case manager (CM), the VA's guardian (G), and the VA.

The facility was a one level home. In the front of the home was a kitchen and dining area. In the back was a living area. To the left of the living room area was a hallway along which were the VA's bedroom, a bathroom, and the staff person office. The VA's bathroom had a clouded shower curtain hung with two plastic hooks. The toilet seat was attached to the toilet and was not able to be removed. All cupboards with supplies were locked. There were cameras in the home. The staff person office had a self-closing, automatic locking door. The VA's medications were stored in the office.

The VA was diagnosed with major depressive disorder, generalized anxiety disorder, borderline personality disorder and an eating disorder (pica-eating substances that provided no nutritive value). The VA enjoyed going to the craft store and the pet store.

The *Support Plan Addendum* stated that the VA had an extensive history of engaging in verbal and physical aggression, leaving without supervision, property damage, severe self-harm, suicidal ideation, suicide attempts, and medication overdosing. The VA had a two to one staffing ratio at all times. One to one supervision would be permitted only in extenuating circumstances and with supervisor approval. Due to the VA's vulnerabilities and as a safety precaution, staff persons completed periodic room checks for drugs, medications, and small objects that could be ingested for self-harm. The VA did not have privacy in the bathroom or his/her bedroom due to past behavior of stealing medications or harmful objects if swallowed. The VA allowed pocket searches when s/he arrived back to the facility from outings. Following an "incident" involving pills, batteries, or other items that caused self-harm, the VA was not transported to any locations with these items for two weeks to reduce the risk of self-harm.

The *Safe Plan Protocol* stated that if the VA self-harmed, staff called 9-1-1 as needed and informed the CM and G. If 9-1-1 was not needed, staff persons consulted with a medical professional as needed and followed any guidance. The incident was documented, and the Safe Plan Response was initiated. The Safe Plan Response indicated that the AV was not transported to any location that had medication/pills or batteries until discussed at a weekly team meeting for his/her safety and well-being and used that time to return to "baseline." Any necessary medical transportation continued as planned.

The *Vehicle Protocol* was a protocol that had staff persons perform a thorough check on the facility vehicle following a check list of items before taking the VA out into the community. Staff persons put any packages obtained in the trunk and the VA did not have access to the trunk.

The *Outings Protocol* contained steps for staff persons to take prior to an outing such as making sure the location was an approved location and was safe during the outing. Approved outing locations were listed.

The *Showering & Hygiene Protocol* stated that staff persons completed a bathroom check which contained a detailed list of things to check. After the check, the VA entered and used the bathroom with the door open. One staff person stood outside of the bathroom door while a second staff person entered and gave the VA 2 inches of shampoo, conditioner, body wash, mouthwash, and his/her toothbrush with toothpaste applied. After the VA used these items, staff persons took empty containers and toothbrush and locked them in the staff person office. Staff persons handed the VA his/her deodorant, waited until the VA used it, then locked it back in the staff person office. Once the VA exited the bathroom, staff persons disposed of any trash in the outside garbage bin.

The *Bathroom Protocol* showed that staff persons performed a bathroom check according to a detailed checklist prior to the VA using the bathroom. The VA then entered the bathroom with the door open. One staff person stood outside the bathroom door. The second staff person stood inside the bathroom and faced the opposite direction of the VA while s/he used the bathroom. After the VA used the bathroom, staff persons gave the VA a dixie cup of liquid soap to wash his/her hands. The VA exited the bathroom with staff persons.

The *Awake Overnight/Daytime Bedroom Protocol* stated that an evening staff person performed a room check before the VA entered his/her bedroom to go to sleep. Staff persons did checks during the overnight to ensure that the VA was safe. If the VA woke in the middle of the night to use the bathroom, staff persons followed the *Bathroom Protocol*.

The *Medication Protocol* stated that all medications were prepared in the staff person office with the door closed. That staff person prepared the medications and administered the medications to the VA in the kitchen. Staff persons performed a visual mouth check to make sure the VA did not cheek the medication by asking the VA to open his/her mouth and lift his/her tongue.

The Department of Human Services (DHS) received information that on October 2, 2023, the VA was brought into the hospital. One staff person left, and the other staff person was typing reports on a laptop minimally paying attention to the VA.

The VA said s/he enjoyed living at the facility and thought it was a good place for him/her. The staff persons kept the VA safe. The VA was "irritated" at times with the restrictions and wished s/he had less restrictions. There was always two staff persons with the VA. When the VA was off his/her "safety plan," s/he had a little more freedom so s/he could be in his/her bedroom alone when sleeping and go to bathroom with the door propped. This was the only time staff persons did not have direct eyes on the VA, otherwise staff persons followed the VA wherever s/he went.

P1-P5 provided the following information:

- The facility had made changes to the physical plant to keep the VA safe including installing self-shutting and self-locking doors for the staff person offices, changing out the shower curtain from fabric to clear frosted plastic, installing a corded phone, and installing cameras in the facility.
- The VA had two to one staffing, but his/her annual plan stated that the facility could do a one-to-one ratio in emergency situations. P1 often filled in hours to make sure the VA had two to one staffing in cases when staff persons called in or did not show up for their scheduled shifts. When P1 started in May 2023,

the facility was frequently at a one-to-one staffing ratio. Since then, the facility and P1 advocated for the staff persons, and they were very rarely one to one staffing. The facility was pulling staff persons from different facilities within the company as needed to keep the facility fully staffed.

- P1 said that the VA had very limited privacy and the VA's interdisciplinary team was very involved and frustrated with the continuous attempts of self-harm by the VA and if it were up to them the VA would not have any privacy in his/her home. The facility wanted to make sure the VA had some privacy in any way that worked.
- P1-P5 each thought upper management was doing a good job of supporting staff persons and trying to keep the VA safe. The VA was smart and resourceful. P1 said that when the VA could not get one thing, s/he resorted to another thing.
- The VA went to the hospital often so a treatment plan was developed that the hospital made a decision within six hours of the VA being there and decided whether s/he would be admitted. If the VA was admitted staff persons left the VA with hospital staff persons. Until the VA was admitted staff persons stayed with the VA at the hospital.
- P1 said that on the last occasion that the VA went to the hospital, a staff person "hit the nurse button" and told the responding nurse that it had been 6 hours and asked if a decision was made on whether they were admitting the VA. The nurse said it looked like the VA was staying so staff persons left the hospital. Another nurse called and said that staff person refused to stay with the VA. P1 determined that the nurse that talked with the staff persons was not aware of the VA's treatment plan.
- P2 said s/he heard that one time one or both overnight staff persons left the hospital. P2 thought one staff person stayed and the other staff person came back later to do the shift change. P1 confirmed that both staff persons were to stay at the hospital with the VA until s/he was admitted.
- P5 said there was an occasion where a staff person left the hospital while the VA was there at 2:30 a.m. The staff person thought the VA had been admitted and the staff persons scheduled for the morning shift did not arrive. P1 called P5 to go into the hospital and be with the VA.
- The VA was supervised within eyesight at all times, except in the bathroom. Staff persons remained right outside the door with the door cracked. When the VA went to bed, one staff person sat in the bedroom until the VA fell asleep then staff persons could stay outside of the room with the door open and do 30 minutes checks. If the VA had an incident of unsafe behavior, his/her *Safe Plan Protocol* was initiated. This was a two-week period where s/he would have to have the door open when s/he was in the bathroom and have staff persons in his/her bedroom at night for the entire night. If the VA was on the safe plan, it was posted in the staff person office and communicated by supervisory staff persons.
- The VA's medications were locked up in the staff person office which was also locked. Staff persons prepared and administered all medications. Due to a prior incident of cheeking medications, the VA's medications were now crushed and administered with yogurt or applesauce.
- Staff persons completed bedroom, bathroom, and vehicle checks using a checklist at various times

throughout the day. Rooms and areas were thoroughly checked for any potentially dangerous items.

- The VA used a CPAP (positive airway pressure machine-used to treat sleep-related breathing conditions) that was kept on his/her nightstand right next to his/her bed. The head strap on the CPAP machine had magnets on each side that kept it in place.

The G said that the facility continued to make changes when incidents occurred but that there was “always going to be something,” and the VA would “find something.” The G felt that staff persons should be in the bathroom and bedroom with the VA at all times not just have the door cracked but the facility said that the VA had to have some privacy.

P2, P3, and A *General Events Report* dated August 25, 2023, provided the following consistent information:

- At approximately 8 p.m., the VA asked to use the tool kit to clean the bottom of the vacuum. Since there was no current protocol that said the VA was not allowed to do that, P3 got out the toolbox and sat on the floor supervising the VA while P2 watched from the couch. The VA worked on the vacuum for a while getting dust out. At some point, the VA asked P3 for a Lysol wipe to clean the vacuum. The wipes were locked so P3 got up and told P2 that P3 was going to grab a wipe. P3 came back and put away the tools and vacuum in the staff person office.
- Later, the VA went to the bathroom. The VA asked to weigh him/herself in the bathroom with his/her scale. Staff persons had previously done a sweep of the bathroom and so P3 handed the VA the scale and the VA went into the bathroom to weigh him/herself. The current protocol allowed staff persons to stand near the bathroom door with the door cracked.
- The VA also asked to use his/her electric razor, so P3 gave the VA his/her razor as well which was kept in the staff person office. P3 heard shaving noises and nothing of suspicion. The VA then came out of the bathroom.
- At approximately 8:30 p.m., the VA changed his/her clothes, paced around, and said, “I hate myself.” The VA then handed P3 a mini screwdriver that the VA snuck and said s/he swallowed a battery. The VA said s/he put the screwdriver up his/her sleeve while s/he was cleaning the vacuum. P3 went and unscrewed the scale and saw that one battery was missing. The VA was taken to the hospital.
- P3 and another staff person did the overnight shift with the VA at the hospital and left when the morning shift arrived to relieve them. P3 said that staff persons were with the VA the whole time during the overnights and sat in the same room. When the overnight shift was over, one staff person drove the facility vehicle back and picked up the morning shift staff persons and drove them back. Then one morning staff person drove the overnight staff persons to the facility and then returned to the hospital.
- Staff persons no longer let the VA use tools and used them for the VA if needed.

P4, P5, and A *General Events Report* dated October 2, 2023, provided the following information:

- The VA asked for his/her electric safety razor so s/he could shave and bathe. P5 asked the VA to get

his/her clothes and P5 would get the razor. P4 followed the VA as s/he got clothing and then went to the bathroom. While standing by the bathroom P5 grabbed the razor from the staff person office and handed it to the VA.

- The VA went into the bathroom while P4 sat outside the bathroom door with the door cracked open. After approximately 10 minutes the VA asked for a yogurt. P5 asked if the VA was really going to eat a yogurt in the bathtub and the VA replied that s/he wanted a snack while s/he soaked his/her back. P4 went to grab a yogurt while P5 remained by the door. When P4 returned P5 was having some abdominal pain and need to use the bathroom. P4 switched and sat at the bathroom door while P5 used the bathroom.
- The VA was in the bathroom for approximately five more minutes and then went to his/her bedroom. P4 took the electric razor and returned it to the staff person office. It did not appear to have been tampered with.
- The VA told P4 that the VA wanted some private space in his/her bedroom, so P4 sat at the end of the couch in visual view of the VA while s/he got dressed. P4 saw the VA going back and forth across his/her bedroom.
- The VA then came out of his/her bedroom and went to the cabinet and ripped down the two-week safe plan sign stating that s/he was no longer on the safe plan because s/he had swallowed a razor blade from his/her razor and a magnet from his/her CPAP machine. The VA was taken to the hospital.
- At the hospital the VA was put into a room around 9:30 p.m. At shift change at 10 p.m., P4 took the facility vehicle and went back to the facility while P5 remained with the VA. P4 picked up the overnight staff persons and brought them to the hospital. One overnight staff person then drove P4 and P5 back to the facility and then went back to the hospital.
- At the hospital, X-rays were taken, and the razor blade and magnet were visible. The VA remained in the hospital for observation until s/he passed the items.
- The facility got a new CPAP mask for the VA that had a Velcro fastener and did not contain a magnet. The VA now only used his/her electric razor in staff persons' presence.

Hospital paperwork showed the VA was seen on October 2, 2023, for swallowing a foreign object. Abdomen x-rays were completed five times.

General Event Reports showed on June 30, 2023, the VA declined to take evening medications. On July 19, 2023, a medication error was noted when the medication was not packed prior to a doctor's appointment. On July 25, 2023, a medication error showed that a medication was not on hand at the facility but was ordered from the pharmacy at that time. On August 7, 2023, a medication was missed at 12 p.m., but a pharmacist approved for it to be taken later in the day. On August 12, 2023, there was a dosage change in medication and the wrong dosage was administered for August 12-13, 2023. The pharmacy was contacted to get labeling to correct the error on the bubble packs. On August 25, 2023, the VA declined to take his/her medications. On September 1, 2023, a medication error was documented when a community outing lasted past the medication time. The medication

was given later with pharmacist approval.

Facility documentation stated that all staff persons interviewed received training on the VA's *Support Plan Addendum*, the facility's policies and procedures, and the Reporting of Maltreatment of Vulnerable Adults Act.

Conclusion:

Regarding supervision at the facility:

The VA said s/he always had two staff persons. When the VA was off his/her "safety plan," s/he could be in his/her bedroom without supervision when sleeping and go to bathroom with the door propped. This was the only time staff persons did not have direct eyes on the VA.

The VA's *Support Plan Addendum* stated that the VA had a two to one staffing ratio at all times. One to one supervision would be permitted only in extenuating circumstances and with supervisor approval.

P1 said prior to May 2023, the facility often was at a one-to-one staffing ratio, but P1 advocated for the VA and since then it was two to one staffing ratio. P1 often filled in any hours that the facility was not able to staff, or the facility pulled staff persons from other facilities within the company.

Information was consistent that on August 25, 2023, while using tools to clean the facility vacuum, the VA pocketed a screwdriver. Later the VA asked to weigh him/herself in the bathroom and use his/her electric razor. Staff person gave the VA the scale and razor and waited outside the bathroom door with the door propped open which was the protocol when the VA was not on his/her safe plan. After the VA was done using the items, the staff persons returned the items. Later the VA said s/he used the screwdriver to unscrew the battery compartment on the bathroom scale and swallow a battery. The VA was taken to the hospital to be monitored. Staff persons now used all tools for the VA as needed.

Information was consistent that on October 2, 2023, the VA asked to shave and shower. Staff persons retrieved the electric razor from the staff person office and gave it the VA. Staff persons remained outside the bathroom door with the door propped open. After 10 minutes, the VA asked for a yogurt as she/he wanted to have a snack while s/he soaked his/her back. One staff person went to get a yogurt and gave it to the VA. After 5 minutes, the VA got out of the tub and went to get dressed. One staff person locked the razor up. It did not appear to have been tampered with. The VA wanted to privacy in his/her bedroom, so staff persons waited outside the VA's bedroom but within visual site while the VA got dressed. The VA came out and said that s/he swallowed a blade from his/her razor and a magnet from his/her CPAP machine that was in his/her bedroom. The VA was taken to the hospital to be monitored. The facility purchased a different CPAP mask for the VA that did not contain a magnet and changed the VA's protocol to have a staff person present when the VA used his/her razor.

Although the VA was able to access and swallow potentially unsafe items on August 25, and October 2, 2023, given that staff persons followed facility protocols and plans agreed upon by the VA's team, that the VA said s/he had two staff persons with him/her during each shift, that after each incident changes were made to the VA's plan as needed, and that the VA was not injured, there was not a preponderance of the evidence that there was a failure to provide the VA with supervision which was reasonable and necessary to maintain the VA's physical health and safety.

Regarding supervision at the hospital:

DHS received information that on October 2, 2023, the VA was brought into the hospital. One staff person left, and the other staff person was typing reports on a laptop minimally paying attention to the VA.

Information was consistent from staff persons that if the VA was in the hospital two staff persons remained with the VA until the VA was admitted to the hospital. If the VA was in the hospital during a shift change, one staff person drove the facility vehicle back to the facility and picked up the two new staff persons and then drove them to the hospital. One of the new staff persons stayed at the hospital while the other new staff person drove the two previous staff persons back to the facility and then came back to the hospital. Because of the VA's frequent hospital visits a plan was developed with the hospital that the hospital made a decision within six hours whether they were going to admit the VA. Once the VA was admitted staff persons left the hospital and the hospital was responsible for the VA. The VA had a two to one staffing ratio at all times. One to one supervision would be permitted only in extenuating circumstances and with supervisor approval.

There was information that on at least one occasion there may have been miscommunication about whether the VA had been admitted and staff persons left the hospital before the VA was admitted. Once P1 received communication from the hospital about what had happened, s/he sent staff persons back to the hospital.

Although there was an occasion where staff persons left the hospital before the VA was admitted, and brief times where there was only one staff person at the hospital with the VA while staff persons completed shift changes, given that the facility was allowed to staff one to one in extenuating circumstances, that the facility and the hospital agreed upon a plan to give staff persons clear parameters on when they were able to leave the hospital, and that the VA was not harmed on these occasions, there was not a preponderance of the evidence whether there was a failure to provide the VA with supervision which was reasonable and necessary to maintain the VA's physical health and safety.

Regarding the medication errors:

General Event Reports showed that from June 2023-September 2023, on two occasions the VA declined to take his/her medications, on two occasions a medication was missed but was given later in the day with pharmacist approval, and on three occasions a true medication error occurred.

Although there were three separate medication errors in the last four months, that were not able to be fixed or were because of the VA declining, given that staff persons corrected any errors that they were able to, took action to reorder or correct errors once they were discovered, and that the VA was not harmed as a result, there was not a preponderance of the evidence whether there was a failure to provide the VA with care or services that were reasonable and necessary to maintain the VA's physical or mental health or safety.

It was not determined whether neglect occurred (the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care, or supervision which is reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult and which is not the result of an accident or therapeutic conduct).

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were adequate and followed. The VA's plan was updated after the incident on August 25, 2023, and after the incident on October 2, 2023, the VA's plan was again updated at the VA's team meeting so that the bathroom door remained open not cracked regardless of whether the VA was on his/her safe plan or not.

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

No further action taken.