

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: 202308854

Date Issued: March 6, 2024

Name and Address of Facility Investigated:

Disposition: Inconclusive

Believe Again Home Care
2499 Rice Street Ste 135
Roseville, MN 55113

License Number and Program Type:

1102796-HCBS (Home and Community-Based Services)

Investigator(s):

Carla Harvieux
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
651-431-6616
carla.harvieux@state.mn.us

Suspected Maltreatment Reported:

It was reported that a staff person (SP) yelled at a vulnerable adult (VA) on several occasions and called him/her a "gross fat rude fucking bitch," and indicated that no one would believe the VA because s/he could not prove the SP's statements.

Date of Incident(s): Prior to October 18, 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 2, paragraph (b), clause (2):

Conduct which is not an accident or therapeutic conduct which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to: the use of repeated or malicious oral, written or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or

threatening.

Summary of Findings:

The apartment where the VA lived and received services was an unlicensed residential setting where the VA received services that were administered under the parent company's home and community-based services license. The VA's apartment will be referred to in this report as "the facility."

Pertinent information for this investigation was obtained remotely, including documentation from the facility; and through interviews conducted with facility staff persons (the P and the SP), and the VA's case manager (CM). The VA agreed to an interview with this investigator, but on the date of the interview, this investigator received a message from the VA cancelling the interview. Subsequent interview opportunities were offered to the VA, but s/he did not complete an interview with this investigator. However, the VA provided information to the CM and the P, that was included below.

The VA received ten hours of Individualized Home Supports each week from the program at the facility. Services provided to the VA included assistance with filling out paperwork, going on community outings/errands, organizing his/her belongings, preparing meals, and completing other related tasks as needed. The SP was to work with the VA to achieve his/her goals and scheduled and coordinated services with him/her.

Facility documentation showed that the VA was not subject to guardianship and was diagnosed with bipolar II, borderline personality disorder, and post-traumatic stress disorder. The VA did not have a history of providing inaccurate information and sometimes worked in the community. According to the VA's *Coordinated Services and Supports Plan*, the VA enjoyed spending time with the SP and thought that the SP calmed him/her. It was a bad day for the VA when s/he felt anxious, when there was bad weather, or when s/he felt stressed at work. The VA wanted to improve his/her health by losing some weight and eating healthier food, and these were goals in the VA's plans. It was important for the VA to participate in activities in the community when s/he could, and s/he enjoyed coloring and painting.

Interviews with this investigator, facility documentation, and the facility's *Internal Review*, provided the following:

- The VA did not complete an interview with this investigator, but according to the CM, the VA told him/her that the SP yelled at the VA on several occasions and called the VA a "gross fat rude fucking bitch," but the VA could not recall the dates of the incidents. In addition, the SP intimidated the VA by saying, "What can you prove?" The VA thought that no one would believe him/her about the SP's statements and seemed "genuinely scared" about the incidents.
- The CM said that the VA did not have a history of providing inaccurate information and his/her statements were generally on-target. The CM had no firsthand information regarding the allegations but took the concerns seriously.
- The P, who was a supervisory staff person, said that s/he was aware of the allegations in this report and added that when s/he asked the VA about his/her concerns regarding the SP, the VA "got offended" and said that s/he no longer wanted to work with the SP for the sake of his/her mental health. The P told the VA that they did not have another staff person available to immediately start working with the VA, and the P was unsure how quickly another staff person for the VA could be located and trained on the VA's plans. Losing weight was one of the VA's goals, and it was reasonable that a staff person would support

the VA's goals, but it was inappropriate for staff persons to describe anyone as "fat." Prior to the P becoming aware of the concerns, the SP and VA had worked well together, and there were no previous issues with the SP's work.

- The SP said that s/he previously worked with many individuals who received services from the program and had no issues with any of them. The VA had a history of paranoia, often thought that others called him/her names, and could successfully get along with co-workers for about three months, then started thinking that others called him/her names like "loser and idiot" behind his/her back, were upset with or did not like him/her or said that s/he was not good at his/her job. The VA would then quit his/her present job and look for a different one when there had been "zero conflict" with co-workers. When the VA made mistakes, s/he was very hard on him/herself and referred to him/herself as an "idiot," but the SP reassured the VA that it was okay and told him/her that everyone made mistakes.
- Near the end of the time that the SP worked with the VA, s/he assisted the VA to clean and re-organize his/her closet. The SP found some tablets of a medication prescribed for the VA that s/he should have taken in the closet and the VA became upset then told the SP that s/he did not want to take the medication because it made him/her gain weight.
- The SP denied that s/he yelled at the VA, denied that s/he raised his/her voice to the VA, and denied that s/he called the VA a "gross fat rude fucking bitch," or asked the VA, "What can you prove?" There was nothing to gain by raising the voice or yelling at anyone according to the SP. However, when the VA was upset with him/herself, s/he might describe him/herself as a "fucking stupid human being," but the SP reassured the VA that s/he was not, that everything was okay, and offered to help the VA.

The facility's personnel and training records showed that staff persons mentioned in this report were trained on the Reporting of Maltreatment of Vulnerable Adults Act prior to October 18, 2023.

Conclusion:

The VA did not complete an interview with this investigator, but information s/he provided to the CM showed that the VA told the CM that the SP yelled at the VA on several occasions, called him/her a "gross fat rude fucking bitch," and told the VA that s/he could not prove that the SP made the statements attributed to him/her. The VA seemed scared and did not have a history of providing inaccurate information.

The P said that s/he asked the VA about the allegations in this report, but the VA was offended and declined to work with the SP in the future. The VA and the SP previously worked well together, and the P was aware of no prior issues between them.

The SP denied that s/he yelled at the VA or raised his/her voice to him/her and denied that s/he called the VA a "gross fat rude fucking bitch" or implied that no one would believe the VA because s/he could not "prove" his/her concerns. The VA recently became upset with the SP when the SP saw some of the VA's prescribed medications that s/he should have taken in the VA's closet. The VA had a history of paranoia and the SP thought that the VA made self-disparaging statements that were similar to the ones the VA ascribed to the SP in this report when the VA became upset with him/herself.

Although the VA said that the SP called him/her a gross fat fucking bitch and had no history of providing inaccurate information, given that there were no witnesses to the incident, that there were no details regarding

how many occurrences or when the incidents occurred, that there were no previous concerns regarding the SP's work, and that the SP denied that s/he made the statements investigated in this report, there was not a preponderance of the evidence whether the SP engaged in conduct that caused or could reasonably be expected to cause emotional distress to the VA.

It was not determined whether emotional abuse occurred (conduct which is not an accident or therapeutic conduct which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to: the use of repeated or malicious oral, written or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening).

Action Taken by Facility:

The facility completed an *Internal Review* which stated that their policies and procedures were adequate and were followed.

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

No further action taken.