DEPARTMENT OF HUMAN SERVICES

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: 202308981

Date Issued: March 27, 2024

Name and Address of Facility Investigated:

Divine House Crisis II
14050 40th Street NE
Raymond, MN 56282

Divine House Inc
328 5th St. SW STE 5
Willmar, MN 56201

Disposition: Substantiated as to neglect of a vulnerable adult by a staff person

License Number and Program Type:

1069241-H_CRS (Home and Community-Based Services-Community Residential Setting)
1069140-HCBS (Home and Community-Based Services)

Investigator(s):

Emily Kearns/Scott Brandt
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
651-431-6513

Suspected Maltreatment Reported:

It was reported that a staff person (SP) pushed down a vulnerable adult (VA), causing the VA to hit his/her head, knocking the VA "unconscious." The VA had a bruise on his/her arm and had a headache.

Date of Incident(s): October 22, 2023

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

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

Summary of Findings:

Pertinent information was obtained during a site visit conducted on November 2, 2023; from documentation at the facility, law enforcement records, a video surveillance file, an audio surveillance file, and medical records; and through seven interviews conducted with two facility staff persons (the P and the SP), the VA, a case manager (CM), the VA's guardian (G), a community health care professional (CHCP), and a facility health care professional (HCP).

The VA's *Individual Abuse Prevention Plan* (IAPP), stated that the VA's diagnoses included oppositional defiant disorder, bipolar disorder, attention-deficit/hyperactivity disorder, moderate intellectual disability, and autism. The VA enjoyed watching the Minnesota Twins, going camping, doing yarn crafts, and coloring. The VA's goals were to learn to read and to go on the "Family Feud" TV show.

The facility was a single-story residence with a basement. The main floor consisted of a combined dining/living room area with a kitchen, three bedrooms, two bathrooms, and a stairwell leading downstairs. The VA's bedroom was at the end of the hall on the main floor, sharing a wall with the kitchen. The basement had a stairwell coming into a living room area with an attached kitchen. Through the kitchen was a laundry room and through that, a storage/office space. On the other side of the stairway was a bedroom and bathroom.

The VA provided the following information:

- The day of the incident, the VA was away from the facility eating dinner with a family member. When the VA arrived back at the facility, the VA used "naughty words" like "dammit" and "fuck you" to the SP when asking for medication before the typical time that they were given, which was 7:00 p.m. The VA threw a fan at the SP. The SP "pushed" the VA down and held him/her on the floor causing the VA to hit his/her head. The VA's head had been hurting since the incident. The SP told the VA not to throw things. The VA stated that after the incident, the P came downstairs. The SP told the VA that s/he almost hit the SP in the head with the fan. Additionally, the VA stated that s/he was "unconscious the whole time" and did not "remember anything" while s/he was laying on the floor after this happened. The VA did not hit his/her head on the fireplace. Then the VA went to bed and slept.

- When the VA was upset, staff persons usually talked to the VA to get him/her to "calm down."

The SP provided the following information:

- The day of the incident, while the SP ate dinner on the lower level, the VA asked for his/her medications early. The evening medications were typically given at 7:00 p.m., sometimes as early as 6:45 p.m. so the SP asked the VA to wait a little bit longer. The VA became upset and threw the fan at the SP. When the VA threw the fan at the SP, the SP could have tried to verbally deescalate the VA, but the SP thought that the VA was going to next throw a chair at the SP. The SP stated that s/he had to physically intervene until the VA was calm due to "imminent risk to protect [the VA]" and the SP. The SP stated that the two "met

in the middle" and "came down" to the floor. The VA was not unconscious, and the SP checked to see if the VA was hurt and stated that the VA was "not at all" hurt. The SP stated that s/he tried to protect the VA's head and attempted to "guide [the VA] to the ground." The VA cried and the P came downstairs. The VA and the P eventually went for a walk.

- The SP was recently retrained on the use of restraints a month or so before the incident. The SP was "upset" that this happened because things had "never escalate[d] this quickly" before. The SP stated that this was not the first time that the SP had to "put [the VA] down." The SP had to "protect" the VA and his/herself. The SP did not like to "throw down anyone" but the VA was an imminent risk to the SP. The SP was "trying to put [the VA] down in a good way."

- After the walk, the SP asked the VA how s/he was feeling and gave him/her some ibuprofen (a medication used for pain relief). The next day, both the VA and the SP apologized to each other, and the SP asked the VA not to throw things at the SP.

- When the SP was interviewed for the facility's *Internal Review*, the SP said that s/he did not use "therapeutic language" or follow the emergency use of manual restraint policy, and that the situation could have been "handled differently." However, the incident happened in a "matter of seconds," and s/he felt as though the VA was going to throw additional items at the SP. The SP said that s/he "reacted in the moment" by "grabbing" the VA and then both of them "going to the floor."

- The SP worked at the facility for a long period of time. The VA got mad easily, tended to get aggressive toward both staff persons and peers, and liked to "throw objects," but tended to have a good relationship with the SP. The VA talked to the SP about his/her problems and the SP listened. The SP would sometimes give the VA a PRN (as needed medication) to help keep the VA calm and for "aggression."

A "fish-eye" type camera was mounted on the ceiling of the downstairs living room area, in the area of the couch and fireplace. Separate video and audio files of the incident on October 22, 2023, were sent to this investigator by the facility, but the time stamps between the two were approximately fifteen seconds apart, making them unable to be viewed/heard simultaneously.

This investigator viewed the video and listened to the audio which showed the following:

- Visible in the video was a corner fireplace, made of what appeared to be brick. Adjacent to that was a window, which appeared to be mostly covered with padding, like a gymnastics mat. There was a sofa across from the fireplace with a dining room-type chair next to the sofa. Directly across from the sofa was an oscillating-style floor fan plugged into the opposite wall, also adjacent to the fireplace. There were two doorways; one leading upstairs, and the other to the basement bathroom and bedroom. Next to the end of the sofa, and further down in the room, away from the fireplace was a love seat where the SP was seated. Another dining room type chair was near the legs of where the SP was seated.

- On October 22, 2023, at approximately 6:30 p.m., the VA went downstairs after returning from the weekend with his/her family and asked the SP for his/her medication early. (While some of the specific words that the SP used were unintelligible from the audio file, both the SP and the VA each stated that the VA swore and requested that the SP give him/her the medications early, and the SP asked the VA to

wait a few more minutes, until 6:45 p.m.) When the VA did not want to wait any longer, it was heard on the audio that s/he yelled, "No, I'm fucking tired," followed by, "No, I'll fucking hit you." At that time, the VA walked toward the fan and knocked it over toward the SP. The fan broke as it bounced off the floor and hit the SP's left leg as the SP attempted to redirect the fan with his/her hand.

- The video showed that the SP took three or four steps toward the VA and the VA began to step backwards, away from the SP taking about two steps. The VA was not in arm's reach of the dining room type chair. The SP made physical contact with the VA, then they both went to the floor near the wall next to the fireplace, under the window. The SP was on the top of the VA and the VA was under the SP with his/her back on the floor. The VA's head was near the wall, but it was unclear in the video if the VA's head hit the wall.

- After about ten seconds, the SP stood up and walked away while the VA laid on the floor, with his/her hands moving. The SP picked up the fan from the floor and the P entered the room through the stairwell. For the next approximately seven to eight minutes, the P stood near the VA and continued to ask if s/he was okay and if s/he wanted to talk. The VA could be heard crying, talking, and occasionally seen moving throughout the entirety of the video/audio. Several times throughout the video and audio, the SP approached and tried to talk to the VA and the P, but the VA got upset. Eventually, the P told the SP that s/he should leave the area for a little bit to give the VA a chance to "calm down." At the end of the video, the VA agreed to go on a walk with the P and the VA got off the floor, using the couch to help him/herself stand. Both the P and the VA left the camera view as the recording ended.

The video and audio showed information mostly consistent with what the SP and the VA stated. However, the VA did not appear to be unconscious for any amount of time after the physical contact was made as was evident by the VA continuously seen moving and heard talking. Additionally, the facility's *Internal Review* stated that the SP was heard swearing at the VA, and this investigator was unable to discern from the audio recording what the SP said to the VA or if the SP swore at the VA.

The P provided the following information which was consistent with what could be seen/heard on video/audio:

- On October 22, 2023, at about 6:15-6:20 p.m., the P was in the main floor kitchen and heard a "bang" coming from downstairs. The P knew that the VA and the SP were downstairs. The bang sounded like "something hit" something and the P did not know what the sound was until the P was given more information from the SP and was able to put it into context. The VA was "crying really loud" so the P went downstairs right away and saw the VA on the floor against the wall and the SP sitting on the loveseat. The SP appeared "upset" and described that the P had not seen the SP "upset" before and the P "can tell when someone's upset." The P repeatedly asked what had happened. The VA stated that the SP "hit" him/her. When the P asked the SP what happened, the SP stated that the VA tried to throw the fan at the SP and the VA said that s/he bumped his/her head. The P offered to help the VA get up several times and the VA did not want to get up. At one point, the SP approached the VA and the P to see if the VA was okay. The VA seemed to get more agitated, so the P asked the SP to go upstairs so that the VA could "calm down" and the SP did so.

- The VA laid on the floor for "maybe five minutes" while the P continued to talk to the VA and ask

questions. The P offered to take the VA on a walk. At that point the VA said that the SP pushed him/her, s/he bumped his/her head against the wall, and s/he was "feeling dizzy." The VA told the P that s/he hit his/her head where s/he had previous "brain damage." The P stated that the VA was conscious the entire time.

- Then, the P and the VA went on a walk and when they returned, the VA showed the P a bruise that was approximately three inches in size and was "long and skinny," located near the bicep on the inner area of the VA's left arm that was purple and green. When the VA and the P got back from the walk, the VA went to bed and said that his/her head hurt. The P thought that the SP gave the VA medication for pain management and then the P told another unnamed staff person to let the HCP know about the incident.

- The P had not worked at the facility very long, but was told to "stay away" from the VA when s/he was mad because s/he tended to spit on people and on one occasion, the VA threw a cane at the P. The P felt like s/he had a good rapport with the VA and knew how to get the VA to "deescalate." Staff persons were to try to deescalate residents by communicating with them before utilizing an emergency "hold." The goal was to get the client to calm down so that an emergency hold was not needed. There were mats in the facility that they could utilize when using a "hold" but "there was no mat" in this situation. (Note: There was a mat hanging over the window above where the incident occurred, but it is unknown if the P or the SP saw it there.) The P said that s/he was not downstairs when the incident occurred and did not hear anything before the "bang," so s/he was unsure if the SP followed procedure.

- The P's statement in the facility's *Internal Review* showed that the P did not report the incident as maltreatment as s/he believed that the SP used a "hold," and that the SP would be following up with filling out "paperwork."

The facility's *Emergency Use of Manual Restraint (EUMR) Policy* stated that in order to use an EUMR, the emergency must meet the following conditions:

- Immediate intervention must be needed to protect the person or others from imminent risk of physical harm; and

- The type of manual restraint used must be the least restrictive intervention to eliminate the immediate risk of harm and effectively achieve safety. The manual restraint must end when the threat of harm ends.

- There were four approved EUMRs, three of which could be performed with only one staff person present. It was required that the EUMR last no longer than 60 seconds. Following the use of an EUMR, the staff person was to report the use of the EUMR by filling out an EUMR report and an incident report.

The HCP provided the following information:

- The VA enjoyed talking to and telling stories to the HCP but stated that follow-up questions were required to find out if the events the VA was talking about had recently happened or if they had happened a while back. Generally, the VA would show the HCP various injuries on his/her body and tell the HCP about areas

  that were "hurting." The VA frequently complained about staff persons who caused "pain or injury,"

wanting the HCP to check the injuries out.

- On Monday, October 23, 2023, the VA told the HCP that s/he was downstairs and got put into a "hold" and bumped his/her head "right here" and pointed to a spot on his/her head. The HCP examined the VA's head, both in the area where there was pain, and in general, looking under the hairline, looking for redness, bumps, bruising, and scrapes. The HCP compared both sides of the head and did not see "any evidence of any injury of any kind." The HCP also examined the VA's eyes, which s/he complained about "frequently," due to side effects of a medication the VA was on. The VA's eyes were "normal and equal."

- The HCP was familiar with "holds" that staff persons used but had not seen one implemented for many years and knew that training was provided for certain kinds of "holds" that were the "least restrictive." One example that the HCP gave was how staff persons were supposed to use a mat to take a client to the floor safely. The HCP also stated that when "holds" were used, an EUMR form was to be filled out, along with notifying the guardian and the case manager. It was not a requirement to inform the HCP of the use of "holds," but some staff persons let the HCP know, regardless, and if the resident got injured. In this instance, the HCP did not recall getting called about the "hold" during the incident or possible injuries to the VA.

- When the VA told the HCP about the "hold" and hitting his/her head, the HCP was not sure if this was a recent incident that the VA was talking about. After the VA told the HCP about his/her head, s/he next showed the HCP "two small bruises" on his/her inner right arm which the HCP thought looked like they "had happened the week before at some point." The HCP did not say which arm was bruised.

- The HCP did not see any evidence of injury from the use of the "hold," and documented his/her observations in the VA's file. The HCP's statement in the facility's *Internal Review* showed that the HCP believed that the VA was "inconsistent with [his/her] symptoms" when reporting symptoms.

The CHCP stated that on Monday, October 23, 2023, the VA had an appointment at a clinic where the CHCP worked and the VA told the CHCP that a "new staff [person]" pushed him/her down, s/he hit his/her head, and was "knocked unconscious." The VA told the CHCP that s/he was "scared" of the SP and that she was pushed. The staff person who brought the VA to the clinic was unaware of this incident. The CHCP could not understand the name of the staff person that the VA provided other than saying it was a "new staff person." The VA showed the CHCP a purple bruise, roughly "the size of a quarter" located on the underside of the VA's arm, between the armpit and elbow. No images were taken of the bruise by the CHCP. The CHCP did not examine the VA's head or document any notes about this incident.

The G stated that s/he received a phone call from the SP on October 24, 2023, two days after the physical contact that the VA was "put in a hold, like a restraint" and that s/he was sorry for the late notice. According to the G, the VA was capable of recalling information and was "truthful" when recalling information. The G stated that the VA had a history of self-injurious behavior such as hitting his/her head into a wall and up until this point, had been doing well at this facility, since arriving in May of 2023. The reason that the VA was placed at this facility was due to his/her history of being physical with other residents and staff persons at previous facilities.

The CM provided the following information:

- The SP called the CM the day after the incident, October 23, 2023, and left a voicemail stating that a "hold" had occurred, but the SP did not provide any other details at that time. At a monthly meeting, the following Friday, October 27, 2023, the VA told the CM in a video chat session that s/he hit his/her head, that the HCP checked his/her head, and that s/he no longer had pain.

- When the CM was asked to provide information related to the VA's reliability, the CM stated that the VA was "not always" reliable. One example given was that the VA would say "everything's great" during check-ins but would get off the call and have behaviors such as purposely plugging the toilet, flooding the basement as a result, later saying s/he was mad and that things were not okay.

- Transition periods were tough for the VA, such as on the day of the incident, when s/he came back to the facility after being with family over the weekend, or vice versa. The VA moved to this facility because of behaviors that the VA was having and that the VA's team was working on getting him/her another place to live where the VA was the only resident.

All staff persons interviewed for this report were trained on the Reporting of Maltreatment of Vulnerable Adults Act, *Emergency Use of Manual Restraint on an Emergency Basis*, and the VA's care plans.

Conclusion:

A. Maltreatment:

Information showed that on October 22, 2023, the VA arrived back to the facility after being with family and wanted to get his/her medication about 30 minutes earlier than normal. The SP asked the VA to wait a little longer and then the VA got upset, made verbal and physical threats, before knocking over a fan which hit the SP's leg. The SP redirected the fan with his/her hands and then took three or four steps toward the VA who started backing away. The SP made physical contact with the VA as s/he took a step backwards and they fell to the floor with the SP on top of the VA. The SP got up after about ten seconds. The P immediately came downstairs to see what was going on and observed the VA on the floor. The P continued to talk to the VA until the VA got up and agreed to go on a walk with the P.

When the SP was interviewed for the facility's *Internal Review*, the SP said that s/he did not use "therapeutic language" or follow the emergency use of manual restraint policy, and that the situation could have been "handled differently." The incident happened in a "matter of seconds," and s/he felt as though the VA was going to throw additional items at the SP. The SP said that s/he "reacted in the moment" by "grabbing" the VA and then both of them "going to the floor."

The VA stated that s/he was "dizzy" and complained of injuries to his/her head and arm. The P stated that the bruises on the VA's arm were "green," but the HCP stated that the bruises were from the week before. Additionally, the HCP did not find any evidence of injury on the VA's head or while checking the VA's eyes. The VA stated that s/he was "unconscious" the whole time, but the P, the SP, and the video and audio showed that s/he was not unconscious at any point during or after the incident. While the internal review stated that the SP swore at the VA, this investigator could not discern what the SP said to the VA.
Although the SP stated s/he restrained the VA because there was an imminent risk of harm, given that the VA was backing away from the SP when the SP moved toward the VA and "grabbed" the VA, that the SP could have

moved away from the VA rather than physically engage, and that the chair the SP thought the VA was going to throw at the SP next was not within the VA's reach, there was a preponderance of the evidence that the SP failed to provide the VA with reasonable and necessary care and services.

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

B. Responsibility pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (c):

> When determining whether the facility or individual is the responsible party for substantiated maltreatment or whether both the facility and the individual are responsible for substantiated maltreatment, the lead agency shall consider at least the following mitigating factors:
>
> (1) whether the actions of the facility or the individual caregivers were in accordance with, and followed the terms of, an erroneous physician order, prescription, resident care plan, or directive. This is not a mitigating factor when the facility or caregiver is responsible for the issuance of the erroneous order, prescription, plan, or directive or knows or should have known of the errors and took no reasonable measures to correct the defect before administering care;
>
> (2) the comparative responsibility between the facility, other caregivers, and requirements placed upon the employee, including but not limited to, the facility's compliance with related regulatory standards and factors such as the adequacy of facility policies and procedures, the adequacy of facility training, the adequacy of an individual's participation in the training, the adequacy of caregiver supervision, the adequacy of facility staffing levels, and a consideration of the scope of the individual employee's authority; and
>
> (3) whether the facility or individual followed professional standards in exercising professional judgment.

The SP was trained on the VA's plans and on the Reporting of Maltreatment of Vulnerable Adults Act. Therefore, the SP was responsible for the maltreatment.

C. Recurring and/or Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by an individual meets the statutory criteria to be determined as "recurring or serious." Individuals determined to be responsible for recurring or serious maltreatment are disqualified from providing direct contact services.

Minnesota Statutes, section 245C.02, subdivision 16, states:

> "Recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that maltreatment occurred and that the subject was responsible for the maltreatment.

Minnesota Statutes, section 245C.02, subdivision 18, states:

> "Serious maltreatment" means sexual abuse, maltreatment resulting in death, neglect resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought, or abuse resulting in serious injury. For purposes of this definition, "care of a physician" is treatment received or ordered by a physician, physician assistant, or nurse practitioner, but does not include diagnostic testing, assessment, or observation; the application of, recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment. For purposes of this definition, "abuse resulting in serious injury" means: bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke. Serious maltreatment includes neglect when it results in criminal sexual conduct against a child or vulnerable adult.

It was determined that the substantiated neglect for which the SP was responsible did not meet statutory criteria to be determined as recurring maltreatment because it was a single incident or as serious maltreatment because it was not determined if the bruise the VA had was sustained during the incident and the VA did not require the care of a physician.

<u>Action Taken by Facility</u>:

The facility's *Internal Review* showed that although policies and procedures were adequate, they were not followed by the SP. Some of the policies and procedures that were not followed by the SP included the facility's employee conduct and discipline policy and the maltreatment of Vulnerable Adults Reporting Policy and Procedure. The facility provided additional training to the SP as well as other staff persons.

<u>Action Taken by Department of Human Services, Office of Inspector General</u>:

The SP was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, the SP was notified by the Office of Inspector General that any further substantiated act of maltreatment, whether or not the act meets the criteria for "serious," will automatically meet the criteria for "recurring" and will result in the disqualification of the SP. The determination that the SP was responsible for maltreatment is subject to appeal.