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: 202401187

Date Issued: April 5, 2024

Name and Address of Facility Investigated:

Lone Eagle Foster Home
1208 Denton Ave NW
Bemidji, MN 56601

Eagles Wing Foster Home Inc
7326 Birchmont Ct NE
Bemidji, MN 56601

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

License Number and Program Type:

1069261-H_CRS (Home and Community-Based Services-Community Residential Setting)
1069248-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a staff person (SP) admitted causing bruising on a vulnerable adult's (VA's) abdomen. The SP said s/he was experiencing psychosis. The VA had extensive deep purple bruising from his/her pubic area to sternum.

Date of Incident(s): Prior to February 4, 2024

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 (1):

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.

Summary of Findings:

Pertinent information for this investigation was obtained remotely, including documentation from the facility; and through five interviews conducted with a law enforcement officer (LEO1), two facility staff persons (P1 and P2), the VA's guardian (G), and a case manager (CM). The VA was not able to provide information for this investigation due to his/her diagnoses. Attempts were made to contact the SP via telephone, email, text message, and both certified and non-certified mail; however, s/he did not respond to any requests for an interview.

The VA liked watching movies, listening to county music, and sitting outside on a swing where s/he watched birds and squirrels at the feeders. The VA's diagnoses included Angelman syndrome, a genetic disorder that caused developmental delays, problems with speech and balance, and intellectual disabilities.

The VA's *Individual Abuse Prevention Plan* stated that s/he was vulnerable to physical abuse. The VA had a history of grabbing, hitting, and punching, and staff persons were trained to redirect the VA when s/he displayed those behaviors.

P1, P2, and/or the G provided the following information:

- On the evening of February 3, 2024, P1 was assisting the VA when s/he observed what looked like a "red rash" on the VA's stomach. When the VA stood up, P1 saw "purplish" bruising "under" the VA's stomach. Over the next days, the bruising became darker and extended over the entire width and length of the VA's stomach area.

- On February 4, P1 called the G and told him/her about the bruises on the VA. The G then went to the facility and brought the VA to the G's home where s/he took pictures of the VA's abdomen. The G observed bruising on the VA's abdomen from his/her genital area up to his/her sternum and horizontally from one side to the other.

- On February 6, 2024, the VA was seen at a "walk-in" clinic and diagnosed with "superficial bruising," and it was recommended the VA be seen by his/her primary physician for follow-up.

- On February 8, 2024, the VA was seen by his/her primary physician and diagnosed with "low iron." However, the primary physician was not able to say that the bruising was related to that diagnosis.

- On February 12, 2024, the SP sent a text to P1 asking to meet the following day. While texting back and forth the SP mentioned s/he wanted to have his/her "last meal" with a family member before P1 had to take the SP to "jail or a hospital." P1 said that s/he did not know "what to think" and had a "weird feeling" so on February 13, 2024, when the SP got into P1's car, P1 audio recorded the conversation. The

SP showed P1 two prescription bottles that were empty and told P1 the medications "should have lasted a month." The SP told P1 that "while in psychosis," the SP "gave [the VA] those injuries." The SP did not provide additional information regarding when or how the injuries occurred. P1 transported the SP to a hospital.

- The VA was not able to provide any information regarding the incident.

On February 23, 2024, the Department of Human Services received information from a community person (CP) that the SP stated when s/he was "under the influence" s/he "snaps and hurts people." The SP said that s/he "beat up" the VA and that the VA's stomach was "purple like a basketball." The bruising on the VA was attributed to low iron; however, the SP "knew it was from the attack" on January 31, 2024.

LEO1 did not interview the SP because s/he "lawyered up" when meeting with another officer (LEO2). LEO1 said that based on P1's audio recording, a report was sent to the county attorney's office to determine criminal charges.

The CM said that s/he heard about the incident from the G. The CM had no additional information.

The facility schedule showed that the SP worked the overnight shifts on January 30, and February 1, 2, and 3, 2024.

Information showed that staff persons were trained regarding the facility's polices and procedures, the VA's program plans, and the Reporting of Maltreatment of Vulnerable Adults Act.

Conclusion:

A. Maltreatment:

Information was consistent from P1, P2, and the G that on February 4, vertical bruising was observed from the VA's genitals to his/her sternum as well horizontal bruises over the VA's abdomen area from one side to the other. Although the SP did not respond to any attempts to be interviewed by this investigator, and declined an interview with law enforcement, on February 13, 2024, the SP admitted to P1 that s/he caused the bruising on the VA. Several days later, the SP admitted this a second time to the CP stating that the SP "beat up" the VA.

Although there were no witnesses to the incident, given that the SP worked the overnight on January 30, 2024, and admitted s/he "beat up" the VA and caused the VA's bruises that appeared on the VA a few days later, there was a preponderance of the evidence that the SP engaged in conduct that was not accidental and could be reasonably expected to produce physical pain or injury to the VA.

It was determined that 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).

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 received training specific to the VA and on the Reporting of Maltreatment of Vulnerable Adults Act. The SP admitted that s/he caused the bruises on the VA so was therefore responsible for the maltreatment of the VA.

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 abuse for which the SP was responsible was not recurring since it was a single incident. However, consistent information showed that the VA sustained bruises during the incident with the SP, which met the definition of serious maltreatment.

The SP was disqualified from providing direct contact services.

Action Taken by Facility:

The facility completed an *Internal Review* and determined that policies and procedures were adequate but were not followed by the SP. The SP no longer worked at the facility.

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

The SP was disqualified from a position allowing direct contact with, or access to, persons receiving services from programs, organizations, and/or agencies that are required to have individuals complete a background study by the Department of Human Services as listed in Minnesota Statutes, section 245C.03. The determination that the SP was responsible for maltreatment and the disqualification of the SP are each subject to appeal.