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: 202308514

Date Issued: April 19, 2024

Name and Address of Facility Investigated:

Disposition: Inconclusive

Dungarvin Grimes
4033 Grimes Avenue North
Robbinsdale, MN 55422

Dungarvin Minnesota LLC
1440 Northland Drive Suite 100
Mendota Heights, MN 55120

License Number and Program Type:

1070833-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 a staff person (SP) hit, scratched, pushed, and stomped on a vulnerable adult (VA) causing the VA to have a black eye and other injuries.

Date of Incident(s): October 2, 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 (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 was obtained during a site visit conducted on November 3, 2023; from documentation at the facility and law enforcement records; and through six interviews conducted with the VA, two facility supervisory staff persons (P1 and P3), two staff persons (the SP and P2), and a facility client (C1). Attempts were made via phone and email to contact and interview the VA's mental health (MH1) case manager and the VA's mental health (MH2) therapist but the attempts were not successful. However, MH1 and MH2 provided documentation regarding the incident, including emails, and that information is below. The VA's family member (FM) and this investigator also communicated via email and that information is below.

The VA was diagnosed with major depressive disorder, anxiety disorder, post-traumatic stress disorder, attention deficit hyperactivity disorder, and fetal alcohol syndrome. The VA enjoyed spending time with his/her family members and friends. The VA was not subject to guardianship.

The VA's *Individual Abuse Prevention Plan* said that the VA had a history of physical and verbal aggression towards others. Staff persons were to "work" with the VA to "determine what made [the VA] aggressive" and find different ways to approach the VA and assist the VA in making positive choices. Staff persons were to offer the VA his/her as needed (PRN) medication when staff persons noticed a "change" in the VA's behaviors. The VA did not typically refuse his/her medications. The VA had a history of not accurately reporting "incidents" so staff persons were to document all "incidents" and report them to the facility supervisor.

The VA's *Coordinated Services and Supports Plan* said that the VA had "complex mental health" and also had limited cognitive abilities regarding processing consequences with actions. The VA could be "impulsive" and the VA's "reactions" could escalate to aggressive verbal and physical actions.

The VA's *Behavior Support Plan* said that the VA displayed behaviors including not following staff directions, verbal aggression, and physical aggression including hitting, punching, kicking, pinching, and scratching others. The VA also had a history of self-injurious behaviors including "inflicting injury" upon him/herself. Things that were "triggers" for the VA included saying "no" to a request or a change in routine. Staff persons were to be "calm," provide a time instead of saying "no," and allowing for a cool down period before attempting to "problem solve." Staff persons could also redirect the VA to relax in his/her room or go for a walk. If the VA injured him/herself, staff persons were to use "crisis management techniques" to keep the VA safe. If the VA displayed physical aggression, staff persons were to be aware of their environment and not have their back towards the VA. Staff persons were to use positive support training to remain clam and remove other housemates from the area. Staff persons were to use throw pillows to block hits, kicks, and scratches.

The facility was a one level home and had three clients including the VA, C1, and another client (C2).

According to MH1, on the date of the incident, the VA said that the SP "punched" him/her, stepped on his/her back, and "chased" the VA around a table. The VA said that s/he then went to his/her bedroom where the SP "came in and proceeded to provoke [the VA] until [the VA] struck [the SP]." The VA sustained a black eye and bruising on his/her leg from the incident. The VA also said that s/he did not feel "safe."

MH2 provided the following information:

- On October 4, 2023, around 3 p.m., MH2 met with the VA virtually. The VA told MH2 that on October 2, 2023, at 5 p.m., there was an "argument" between the VA and the SP about dinner. The VA then went to his/her room to "cool down" and at some point after, the SP came into the VA's room. The VA "did not remember" if the SP then pushed the VA or if the VA had "fallen to the [floor]." While the VA was on the floor, the SP "stomped" on the VA "several times." The VA then stood up and threatened to "hit" the SP and the SP then "scratched" the VA on his/her face and hit the VA in his/her eye. The VA told MH2 that someone then called 9-1-1 and that the VA went "into an ambulance."

- The VA told MH2 that s/he had back pain from the incident. MH2 also observed that the VA had a "bruised [left] eye." MH2 did not see additional injuries and said that s/he was "only able to see [the VA's face]" because they were on a virtual call. The VA told MH2 that following the incident, s/he was "safe" and staying in his/her bedroom.

- MH2 said that the VA had not said anything similar prior. MH2 did not have any reason not to believe the VA regarding the incident.

The VA provided the following information:

- On the date of the incident, the VA was "upset" because staff persons did not tell him/her that dinner was ready. The VA then went to his/her bedroom to calm. After a couple of minutes, the VA calmed and then went to eat dinner. The VA did not like the food served so wanted to make noodles for him/herself. C1 was cooking something on the stove and the SP told the VA that it was "too dangerous" to use the stove with C1 when the VA was "upset." The SP also said that the VA was a "danger" to him/herself and could not use a knife or the stove. The SP told the VA that s/he needed to "calm" and then stood between the VA and C1. The VA told the SP to "move out of [his/her] space" and the SP responded by stating, "I don't have to," and then asked, "What are you going to do about it?" The VA then "yelled" that s/he was "not going to do anything" but that s/he "really wanted to hit" the SP. The VA said that instead of hitting the SP, s/he threw his/her noodles across the floor and then went to his/her room to calm, where the VA "blasted" music from his/her TV but was not "bothering anyone."

- The VA said that the SP then came into the VA's bedroom without knocking and stated that the VA "needed to clean up [his/her] mess." The SP then began touching the VA's TV and asked the VA turn down the volume but the VA told the SP to "stop touching my shit." The SP said, "What are you going to do about it? Are you going to hit me?" The VA then hit and scratched the SP's face which the VA said was "on accident." The SP then "punched" the VA in his/her left eye and the VA fell or was "pushed" to the floor. The SP then told P2 to call 9-1-1. After P2 called 9-1-1, the SP and P2 attempted to put the VA in a restraint, with either the SP or P2 behind the VA and the other on the side of the VA. One of the VA's arms was restrained. P2 held the VA "down on the ground" while the SP "stomped" on the VA's back "several times" which "hurt." The VA said that s/he kicked the SP and P2 and that s/he kicked either the SP or P2 in the stomach. The VA "called for help" but neither C1 nor C2 helped the VA. The VA said that C1 and C2 would not provide accurate information regarding the incident. The VA said that no staff person offered the VA's PRN medication to him/her during the incident.

- After the restraint, the VA notified the FM and another family member, and was crying. The FM, law enforcement, and emergency medical technicians (EMT's) came to the facility "right after" the incident. The EMT's looked the VA over and there were "no marks" on the VA's back or "anywhere else" on his/her

body. However, the VA's arm "hurt the whole night" and the following day, the VA had bruising on his/her left arm and left eye. However, the VA did not know if staff persons saw the bruising.

- At some point following the incident, facility supervisory staff persons asked the VA to provide details about how the SP stepped on his/her back and the VA said that the "ambulance checked me out and there were no marks on me." When the VA was asked how s/he "ended up on the floor," the VA said that s/he was not "restrained" on the floor. The VA also said, "I do not know. I think when [the SP] punched me in the left eye is when I fell onto the floor."

The FM provide the following information:

- The FM said that on October 2, 2023, staff persons called him/her to the facility. When the FM arrived, a law enforcement officer told the FM that the VA "attacked" staff persons. The SP had two scratches on his/her face, between one and two inches long. The EMT's then "checked [the VA] out" and there were "no visible marks" on the VA. While talking to the EMT's, the VA said that the SP "threw [him/her] to the [floor] and stepped on [his/her] back" and that P2 "held" the VA down. The FM then took the VA to his/her home to "avoid an unnecessary hospital visit" and while at home, the VA told him/her that s/he was "punched" in the face. The VA also told the FM that the SP "chased" him/her around a table" and that s/he was "dragged off the bed and pushed to the [floor]." The VA told the FM that s/he scratched the SP's face because the SP was in the VA's face stating, "You aint gonna hit me."

- The FM said that s/he did not initially notice the VA's "black eye" but on October 3, 2023, around 2 p.m., the FM "started to notice some bruising" including a "purple and green eye." The FM thought that s/he initially did not notice the bruising due to the VA's skin tone. The FM did not recall which eye had the bruise but the VA sent the FM photos of the bruises on October 4 and 5, 2023. On October 3, 2023, around 3:30 p.m., the FM brought the VA back to the facility. On October 4, 2023, the VA had a therapy appointment via video chat and the VA told his/her therapist about the incident, including that the SP went into his/her room to turn down the TV volume and the VA got upset. The FM had concerns that the incident was a "power struggle" between the VA and the SP. The FM said that the VA had a history of "attacking" staff persons prior, including the SP. The FM had concerns if staff persons had "proper training" to work with the VA. The FM was not aware of any other way that the VA could have sustained the bruising and thought that the SP "punched" the VA "intentionally" because the SP was not "able to detach from the situation."

P2 provided the following information:

- P2 said that on October 2, 2023, s/he and the SP were cooking dinner and that "everyone was in a good mood and having fun." The SP gave the VA his/her medications and the VA stated that s/he was going to wait until dinner to take them. The VA then asked if dinner was ready and P2 said that it was not. The VA was "upset" and asked why it was not done and P2 told the VA that the meat was not cooked all the way. The VA was holding his/her medications and then went to his/her bedroom and "slammed" the door. The VA then came out of his/her bedroom and was swearing and stated, "I am not waiting anymore." The VA had his/her own noodles and wanted to cook them. The VA then went to the stove where C1 was preparing food and C1 was "visibly nervous" due to the VA being "upset." P2 knew that the VA was upset due to the VA's "tone." The SP stood between the VA and C1 and told the VA that s/he needed to "calm down" before cooking food with hot water because it was not "safe." P2 said that the SP was attempting to calm the VA. The VA then threw the noodles and "swore and shouted" and then

went to his/her bedroom.

- P2 began cleaning up the "noodle mess" and a "short time later," P2 heard the SP calling for help. P2 "ran" into the VA's bedroom and saw the VA punching the SP and "beating on" the SP whose face was bleeding. P2 "did not know" if the VA had a weapon in his/her hand but in the past had "threatened" staff and clients with things including a screwdriver. P2 asked the VA to "stop" but the VA did not and was "very strong" so the SP and P2 attempted to restrain the VA. P2 went behind the VA and grabbed the VA's arms from behind, but during this, the VA kicked P2 in the stomach. P2 then let go of one of the VA's arms and the SP and P2 tried to lower the VA to the floor. The VA "kicked and fought" and then sat on the floor. The SP and P2 then let the VA "go" and the SP called 9-1-1. P2 said that the incident took "less than a minute." Law enforcement arrived and talked to "everyone in the house" and asked the VA if s/he was "okay." The FM also arrived at the facility and the VA left with the FM.

- P2 did not see the SP hit, punch, or step on the VA's back. P2 did not see the SP chase the VA around a table and the VA never told P2 that the SP did those things. P2 never saw any injuries to the VA, including on the date of the incident or after and said that the VA would have told him/her if s/he was injured, because the VA and P2 had a "good relationship." However, P2 heard that the VA had injuries after s/he returned from the FM's home but P2 did not see those injuries. P2 did not have any concerns with the SP's interactions and said that the SP did as s/he was trained to do.

C1 said that on the date of the incident, the VA began calling "everyone" names because the VA was "upset over food." The VA then hit the SP and the SP and P2 attempt to put the VA in a restraint so that the VA could not hurt others. The SP held the VA's arms and P2 held the VA's feet. C1 then saw the VA punch the SP in the face and the VA kick P2 in his/her stomach. The SP called 9-1-1 and C1 went downstairs because s/he was "afraid for [his/her] safety" because the VA "usually targets [C1]." C1 said that no staff person ever hit, stomped on, or punched the VA. The SP and P2 did not do anything "harmful" to the VA. The VA was C1's "best friend" but C1 said that s/he "had to say the truth" regarding the incident. The SP was the "only one that was hurt that night" as the SP and P2 tried to "calm" the VA. The VA had "redness" on his/her cheek but C1 did not know what caused that. C1 never saw the VA with a black eye. At some point, the VA said that the SP hit him/her, but C1 did not see that. The VA had a history of throwing "hot coffee" and his/her phone at others.

P3 provided the following information:

- P3 said that s/he first heard about the VA's injuries on October 16, 2023, during the VA's meeting with the FM. On that date, the FM showed P3 photos that the VA sent him/her on October 4 and 5, 2023. The photos were of a bruised right eye. The FM also said the VA had a bruised right arm but P3 did not see a photo of it. The FM said that the injuries looked like the VA was "dragged" on carpet. However, P3 said that the facility did not have any carpet and only had wood flooring. P3 did not see the injuries on the VA including on October 3, 4, and 5, 2023, when P3 was at the facility. The VA never told P3 that a staff person punched him/her in the eye or "stomped" on his/her back. P3 thought s/he would have seen the black eye if the VA had one. P3 also thought that the FM would have sought medical attention for the VA if the VA was injured. Staff persons also documented in the facility progress notes if they saw any injuries and there was nothing noted. Additionally, at some point, P3 asked the VA about the incident and the VA said that s/he "could not remember." P3 did not think the injuries occurred at the facility, because law enforcement and EMS did not see any when they observed the VA immediately following the incident. The FM also told P3 that the VA had a history of providing inaccurate information. Due to his/her diagnoses, the VA could get his/her "stories mixed up". Additionally, following the

incident, the SP had "deep" scratches on his/her face and the SP went to the dermatologist for it. P3 was not aware of the SP chasing the VA around a table during the incident.

- P3 said that the VA had a history of harming him/herself and others. When the VA displayed maladaptive behaviors, staff persons should give the VA space. Prior to the incident, P3 had seen "power struggles" between the SP and the VA where the SP and the VA would "go back and forth." P3 had spoken to the SP prior about his/her "tone" and told the SP not to "engage" the VA when s/he displayed behaviors. The SP typically was "really good" when interacting with the clients and the SP and the VA typically got along "good."

The *Investigation Report and Summary* provided the following information:

- C2 said that on the date of the incident, the VA got "mad" at P2 and the SP "about something" and then went to his/her bedroom. During this time, C2 also went to his/her bedroom and did not see anything because his/her bedroom door was closed the "whole time." However, C2 heard the VA yelling at P2 and the SP to get out of his/her bedroom. C2 also heard a "loud thud" and the VA yelled, "No. Get off me. You are hurting me." The VA also said that s/he was trying to "calm" and s/he asked the SP and P2 to leave and said that they were not leaving. C2 never saw any staff person hit or display physical aggression towards any client.

- Two staff persons (P5 and P6) who frequently worked with the VA said that they never saw any bruising on the VA, including around the VA's eye. The VA did not tell them about the incident.

- A staff person (P7) said that s/he trained staff persons at the facility including on behavioral intervention and restraints and s/he also wrote a behavior plan for the VA. However, P7 did not recall which staff persons s/he trained on these things.

Photos from the VA's cell phone dated October 4, 2023, showed a picture of the VA's face and arm. There were "markings" around the VA's right eye that were "consistent with the appearance of a bruise." There were also "markings" on the VA's upper right arm that were "consistent with the appearance of a bruise." Additionally, on October 5, 2023, the VA took a photo of his/her right elbow and face. There were "markings" on the VA's elbow that were "consistent with a bruise." However, there was "no visible bruising" on the VA's right or left eye.

The *T-Log Search* dated October 2 to 10, 2023, did not show any injuries to the VA.

P1 provided the following information:

- On October 9, 2023, the FM told P1 that s/he had "concerns" regarding the VA and P1 said that s/he would schedule a team meeting to discuss the concerns.

- On October 16, 2023, P1, the VA, the FM, MH1, P3, the VA's case manager (CM), and a supervisory staff person (P4) had a virtual meeting so that everyone was on the "same page" to support the VA "better." During this meeting, the FM shared photos of bruising on the VA's arm and eye. The FM said that the VA told him/her that the bruising occurred during a restraint on October 2, 2023, in which the SP punched the VA in the eye and stepped on the VA's back.

- The VA said that on October 2, 2023, a staff person hit him/her in the face. The VA "then proceeded to

contradict [him/herself] about 22 times in the next 45 minutes." The VA gave "different versions of the story" including that s/he was "not hit" but was "restrained." The VA's team then talked about different ways to "prevent restraints." The VA did not name a specific staff person and was "vague" and the "details were not clear." None of the VA's team expressed concerns about the incident but felt there were "inconsistencies." P1 said that it was "possible" that the VA felt that s/he was "pushed" and "manhandled" during a restraint because restraints were not "comfortable." However, P1 did not think it was a "reliable report" because the VA "kept changing" what s/he said. The VA had a "significant history" of not "telling the truth." However, P1 did not know the VA "well enough" to provide examples of when the VA did not tell the truth.

- P1 did not see any injuries, including scratches or a black eye, to the VA during the meeting. If the VA sustained any injuries, it was to be documented in the health progress notes. P1 was not aware of any medical attention for the VA from a restraint or around October 2, 2023.

- P1 said that during the incident, the SP followed the VA's plans by offering the VA his/her PRN medication and ensuring the VA was "okay." However, that "approach" may have also made the VA feel "cornered." P1 did not have any concerns with the SP and was not aware of anyone having concerns. P1 also spoke to C1 who also did not have any concerns. C1 would "one hundred percent" say if s/he had concerns. Additionally, P1 was not aware of P2 having any concerns and said that P2 likely observed or "assisted" during the restraint.

The SP provided the following consistent information in his/her interview and the *Investigation Report and Summary* dated October 2, 2023:

- The SP said that on October 2, 2023, the VA was having a "good day," including watching TV with his/her housemates. The VA had 5 p.m. medications and at some point between 5 and 6 p.m., the SP gave the VA his/her medications which s/he typically took during dinner. P2 was making dinner and the SP and the VA "assumed" that dinner was ready. However, P2 then checked the food and realized it needed to "cook a little while longer." The VA became "upset" and went to his/her room. The VA had a history of getting "upset" if food was not ready on time or if the VA did not like the food. However, at times, the VA also got a snack to take with his/her medications if dinner was not ready.

- The VA then came out of his/her bedroom holding noodles that s/he wanted to make and during this time, C1 was also making dinner on the stove for him/herself. C1 began "shaking" because the VA was "upset." The SP got in between the VA and C1 and told the VA that you are "angry right now" and that the SP "could not allow [the VA] to cook" due to "safety." On prior occasions, the SP had seen the VA "that upset" and "attacked" his/her housemates, including throwing hot coffee at C1. The VA then became "more upset," threw the noodles on the floor, and "stormed" back to his/her bedroom.

- Approximately 10 to 15 minutes later, the SP went to the VA's bedroom to ask the VA if s/he took his/her medications and to give the VA his/her PRN medication. The VA's music was "very loud" and the VA told the SP, "Get the fuck out of my room." The SP again asked the VA if s/he took his/her medications and the VA stood up from his/her bed and "clawed" the SP's face. The SP's "response" was to "push" the VA's arms up and out of the way from the SP. The SP then attempted to leave the VA's bedroom but the SP was "cornered" and the VA "kept on attacking" the SP. The SP put his/her arms up to block the VA's "attacks" and was "screaming" for P2.
- P2 came into the VA's room, "grabbed" the VA's arm and pulled it behind the VA. The SP said that s/he

"immediately" felt that his/her face was bleeding and P2 told the SP that his/her face was bleeding. The SP thought that the VA used a weapon to "slice" the SP's face because in the past the VA had used weapons, including screwdrivers, during instances of physical aggression. The VA continued to be aggressive so the SP grabbed the VA's arm and then the VA "went down to the [floor]." The SP then released the VA and left the room to call 9-1-1 and the FM. The SP could hear P2 trying to calm the VA.

- The SP was not aware that s/he touched the VA's face during the incident but said that it was "possible due to the nature of the attack." However, the SP never "intentionally punched or intended to harm" the VA. The SP also said that s/he never "intentionally" pushed, punched, hit, or stepped on the VA and the SP did not see P2 do so. The SP said that would "absolutely" not be appropriate to do. The EMT's did not observe any marks or bruises on the VA and the SP said that s/he was the "only one treated" from the incident. After the incident, the FM took the VA to his/her home.

- On October 3, 2023, around 1 p.m., the VA returned to the facility. The VA was still "visibly upset" and "kept to" him/herself most of the day. The SP did not see any injuries to the VA on that date or after, including a black eye, scratches, or bruises. The VA typically indicated if s/he was in pain by asking for Tylenol or a bandaid, but the VA did not do so. Staff persons typically documented in a clients progress notes if there were any injuries on a client. The SP did not became aware of the injuries until the FM showed photos during a meeting approximately two weeks after the incident.

- The SP denied chasing the VA around a table.

- When the VA displayed behaviors, staff persons were to redirect the VA. Staff persons also notified the FM because s/he was a "great support" for the VA, which the SP did during the incident. Staff persons also offered the VA his/her PRN medication, which the SP did on the date of the incident. However, the VA did not take it and instead "attacked" the SP.

- The SP said that s/he and the VA typically got along "good" but that the SP was a "rule person" which the VA did not like. The SP was not aware of any prior concerns regarding his/her interactions with clients, including the VA.

- Following the incident, the FM and the VA put a sign on the VA's bedroom door for the VA's "mood" regarding if the VA wanted staff persons to enter or not.

- The VA had a history of providing inaccurate information involving taking food and a staff person sleeping.

The *Robbinsdale Police Department* report was not detailed but noted that they were called for an "assault" because a "client attacked staff." There were no injuries noted to any person, including the VA.

The *Reporting and Investigating Adult Maltreatment* said that staff persons were not to slap, kick, pinch, or use corporal punishment towards a vulnerable adult.

The *Policy and Procedure on Positive Supports and the Emergency Use of Manual Restraints* said that an emergency use of manual restraint meant using a manual restraint when a person posed an immiment risk of physical harm to themselves or others and was the least restricie intervention that would achieve safety.

Facility documentation showed that P1, P2, P3, and the SP each received training on the Reporting of Vulnerable

Adults Act and on the facilities policies and procedures including client rights and positive supports training. P2, P3, and the SP were also trained on the VA's plans.

Relevant Rules and Statutes:

Minnesota Statutes, section 245D.061, subdivision 2, states that an emergency use of manual restraint 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 must be the least restrictive intervention needed to eliminate the immediate risk of harm and effectively achieve safety.

Conclusion:

On October 16, 2023, the FM shared photos that were taken on October 4 and 5, 2023, of bruising on the VA's arm and eye with the VA's team and said that the VA told him/her that the bruises occurred during a restraint on October 2, 2023, in which the SP punched the VA in the eye and stepped on his/her back. The VA also told MH2 that the SP "stomped" on the VA several times, scratched the VA on the face, and hit the VA in the eye. The VA told MH2 that s/he "did not remember" if the SP pushed him/her. The VA told MH2 that s/he had back pain from the incident and on October 4, 2023, MH2 observed that the VA had a bruised left eye. The VA told MH1 that the SP punched him/her, stepped on his/her back, and chased the VA around a table. The VA told MH1 that s/he had a black eye and bruising on his/her leg.

P2 and the SP each said that on October 2, 2023, the VA punched or scratched the SP when the SP went into the VA's bedroom to see if the VA took his/her medication. When there was an imminent risk of harm to the SP, the use of manual restraint became appropriate. Prior to implementing the restraint, the SP said that s/he attempted to leave the VA's bedroom but was "cornered." The SP then put his/her arms up to block the "attacks" and then called P2 for help. P2 came into the VA's bedroom and asked the VA to "stop" but the VA did not and was "very strong" so the SP and P2 attempted to restrain the VA. The VA "kicked and fought" during this and then sat on the floor. The SP and P2 then let go of the VA. P2 said that the incident took "less than a minute." The description of the incident provided by the SP and P2 was in compliance with Minnesota Statutes, section 245D.061, subdivision 2. Additionally, while the FM had concerns that the incident was a "power struggle" between the VA and the SP, which P3 said the SP had a history of doing, the SP and P2 appeared to be following the VA's plans, including that P2 and C1 each said that the SP was attempting to "calm" the VA and that the SP allowed the VA time in his/her bedroom before engaging with the VA. P2 also said that s/he did not have any concerns with the SP's interactions during the incident. P1 also spoke to C1 who also did not have any concerns but said that C1 would "one hundred percent" say if s/he had concerns.

Although the VA had bruising at some point following the incident, C1, C2, and P2 were each at the facility with the VA and the SP at the time of the incident; C1 and P2 observed portions of the incident and each said that no staff person, including the SP, hit, stomped on, or punched the VA and the SP denied doing those things. Based on the information obtained, there was not a preponderance of the evidence whether all of the SP's actions were therapeutic conduct or whether the VA sustained the injuries 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).

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were adequate but not followed. This included that the SP did not follow the positive supports policy as the SP went into the VA's bedroom during his/her "cool down period." Staff persons were retrained on positive support techniques.

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

No further action taken.