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: 202401274

Date Issued: May 9, 2024

Name and Address of Facility Investigated:

REM Ramsey Goodrich
917 Goodrich Ave
Saint Paul, MN 55105

REM Ramsey Inc
6600 France Ave S
STE 500
Edina, MN 55435

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

License Number and Program Type:

1108800-H_CRS (Home and Community-Based Services-Community Residential Setting)
1071829-HCBS (Home and Community-Based Services)

Investigator(s):

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Minnesota Department of Human Services
Office of Inspector General
Licensing Division
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Suspected Maltreatment Reported:

It was alleged that a staff person (SP) smoked marijuana while driving a vulnerable adult (VA) in the facility van.

Date of Incident(s): February 10, 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 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 March 20, 2024; from documentation at the facility; and through four interviews conducted with two facility supervisors (P1 and P2), and two facility staff persons (P4 and the SP). Attempts were made via telephone to contact and interview two staff persons (P3 and P5), but neither responded to the requests. However, P3 and P5 provided information for the facility's *Internal Review* and that information is included below. This investigator met the VA, but due to his/her diagnoses, s/he was unable to provide information for this investigation.

The facility was a multi-level home with four resident bedrooms, additional bedrooms used as sensory rooms and staff offices, multiple living room areas, a dining room, a kitchen, and a basement. Four residents, including the VA, lived at the facility and all had similar diagnoses.

The VA was diagnosed with moderate intellectual disabilities and autism spectrum disorder. According to the VA's *Individual Abuse Prevention Plan (IAPP)*, the VA required 24-hour awake supervision by one staff person. The VA's *IAPP* also stated that s/he "may not" be developmentally capable of developing the skills required to report abuse to the appropriate person and did not communicate verbally. The VA enjoyed dogs and spending time with his/her family.

Facility documentation showed that on February 10, 2024, the SP worked 7:41 a.m. to 8:00 p.m., P3 worked 7:58 a.m. to 10: 15 p.m., P4 worked 8:00 a.m. to 10: 14 p.m., and P5 worked 8:31 a.m. to 2:00 p.m.

P1 and text messages provided the following information:

- On February 10, 2024, between 3 and 4 p.m., P1 received a text message from P3 that stated the SP might be under the influence. At 5:30 p.m. P1 received a text message from P4 that stated the SP was under the influence. After P1 received the second text message, s/he called P2 to see what the next course of action should be. P2 told P1 to go to the facility and talk with P3, P4, and the SP.

- Between 7 and 7:30 p.m. P1 arrived to the facility. and the van, nor the SP and the VA, were at the facility so P1 called the SP. The SP told P1 s/he took the VA on a van ride and that they would be back in half an hour but they did not return until around 8:30 p.m. P1 stated that earlier in the day, s/he picked up a van from another program operated by the same license holder and at that time, it was "clean" and did not have a "smell." After the VA and the SP returned to the facility, P1 went outside to the van. P1 stated that inside the van smelled "the normal smell of [marijuana]" and that it was "mostly" on the driver's side of the van.

- P1 then went back inside and asked the SP if s/he was under the influence, and the SP was "laughing." The SP stated, "Nothing like that happened." P1 stated that the SP was "looking down" while talking and did not make eye contact when talking to P1. At that time, P1 told the SP to leave.

- P1 then checked on the VA and the VA did not show any signs of intoxication or smell like marijuana. The VA watched TV and played games.

- P1 stated that s/he previously told the SP not to take the clients on van rides after 7 p.m., because the SP had a history of being out for "a long time." The SP also had a history of smoking marijuana, because P1 smelled marijuana on the SP before. P1was not aware of any other times that the SP smoked marijuana around the clients.

P2 provided information that was consistent with the information P1 provided and the following information:

- After the SP and VA returned to the facility, P1 called P2 and stated that the SP smelled like marijuana and "appeared intoxicated." P2 then called the SP and said, "You were with an individual in our van, and you smell like marijuana and seem intoxicated that's very worrisome," to which the SP responded, "Yep," and hung up the phone. P2 called the SP again and told him/her that s/he was going to be removed from the schedule pending an internal investigation. Then the SP left the facility around 8:40 p.m.

- P2 was not aware of any similar allegations or incidents with the SP.

P3 provided the following information in the *Internal Review*:

- On an unknown date (later determined to be February 10, 2024) the SP "appeared to be under the influence," "pretty significant[ly]," and smelled of marijuana. During the day, P3 and the SP took the VA and the other residents bowling. When they left the bowling alley, the SP smelled of marijuana and drove the company van back to the facility. After they arrived back to the facility, the SP "disappeared" and was later found sleeping and "could not be roused" by P3 and P4.

- After the SP woke up, s/he assisted a resident in the shower. Afterwards, the SP "took [the VA] away from [his/her] dinner" and left the facility to go on another van ride. The VA seemed to be his/her "typical self" after the SP and VA returned from the van ride.

P4 provided the following information:

- On February 10, 2024, the SP was "supposed to" take the VA for a van ride in the late afternoon, but decided to take the VA earlier in the day which was "okay" because staff persons had done so in the past. After the SP and the VA returned from the van ride, the SP slept at the facility "more than usual" during the shift.

- While P4 prepared dinner, the SP gave another resident a shower. Then at the start of the meal, the SP wanted to take another resident out for a van ride, but the resident did not want to go. The SP then "pulled" the VA out of his/her seat, while the VA was still eating, and took the VA on a van ride. The VA was a "slow eater" and had only eaten half of his/her food before the SP took him/her for a van ride.

- P3 and P4 then texted P1 about their concerns and P1 came to the facility and called the SP to tell him/her to return. P4 stated the SP and VA were gone "more than an hour for sure."

- After the SP and the VA returned from the van ride, P1 went out to the van. When P1 returned inside, P1 told P4 that the van smelled like "smoke." P1 then called the SP into his/her office and when the SP left P1's office, the SP left the facility.

- P4 said s/he did not go in the company van that day and did not go bowling with P3, the SP, the VA, and the other residents.

P5 provided the following in the *Internal Review:*

- P5 went bowling with the residents and staff persons and was a passenger in the van the SP was driving. As the SP drove back to the facility from the bowling alley, the drive was "not too smooth" and the SP was "distracted" by playing music on his/her phone and singing.

- When P5 was asked if s/he smelled marijuana at any point that day, P5 stated that s/he "could not smell well." P5 stated that s/he left the facility after returning from bowling and did not discuss the incident with anyone.

The SP provided the following information during his/her interview and in the *Internal Review*:

- On an unknown Saturday (later determined to be February 10, 2024) the SP worked "all day." In the morning, the SP took the VA on a van ride, in the afternoon the SP assisted another resident in the shower, and after dinner took the VA on another van ride. The SP did not provide information about bowling until prompted and then the SP stated that s/he was in the bowling alley with the residents "the whole time."

- The SP stated that s/he smoked marijuana "about five minutes" before his/her shift but did not smoke during his/her shift. Regarding being under the influence at work, the SP stated it was a "functional influence" and that being "high" on marijuana was not like drinking alcohol.

- The SP stated that s/he did not smoke marijuana during his/her shift or in the company van at any time. The SP stated that s/he did not smoke marijuana while on the outing to the bowling alley. The SP also stated that the van did not have smell like marijuana "at all" and s/he did not know why the van would smell like marijuana.

- Around 7 p.m. that night, the SP received a call from P2 instructing him/her to return to the facility and the SP and the VA did so. Shortly after, P2 told the SP to leave the facility because of a "suspected smell of marijuana."

- The SP did not remember if s/he received training related to the facility's *Drugs and Alcohol* policy.

- As part of the facility's *Internal Review*, the SP stated that s/he did not take a nap during his/her shift. The SP also stated that "everybody there" took naps and "every day" one of the staff persons was napping.

The company's *Drugs and Alcohol* policy stated in part, "The goal of the Company is to maintain a workplace free from the effects of drugs," and "All employees must be free from [...] being in any manner under the influence of a chemical that impairs their ability to provide services or care and must not result in effects that pose a direct threat to the safety of the employee or others."

According to online sources, there was differing information regarding how long a cannabis/marijuana high lasted. According to www.healthline.com, a cannabis high lasted anywhere from "2 to 10 hours" depending on the amount ingested, how it was consumed, the THC content, a person's body weight and metabolism, whether a person had eaten, and the person's tolerance level. When smoking or vaping marijuana, a person felt the effects within "2 to 10 minutes." "Dabs" which are a "highly concentrated" form of marijuana and smoked through a "special pipe," have a higher THC content than other forms of cannabis, so the "high kicks in almost instantly."

Facility documentation showed that the SP and P1-P4 received training on the facility's *Drugs and Alcohol* policy, the Reporting of Maltreatment of Vulnerable Adults Act, and the VA's plans.

Related Rules and Statutes

Minnesota Statute 196.20, subdivision 1, clause (8) states in part, it is a crime for any person to drive, operate, or be in physical control of any motor vehicle, within this state when the person is under the influence of cannabis.

Conclusion:

P1, P2, P4, and P3 (via the *Internal Review*) provided consistent information that on February 10, 2024, the SP appeared to be under the influence of and smelled like marijuana at various times during his/her shift. P2 also stated that the company van smelled like marijuana after the SP used the van. P5 provided information via the *Internal Review* that when the SP drove the van back to the facility, the drive was "not too smooth" and the SP was "distracted" by playing music on his/her phone and singing. When P5 was asked if s/he smelled marijuana at any point that day, P5 stated that s/he "could not smell well."

The SP acknowledged that s/he smoked marijuana "about five minutes" prior to starting his/her shift in the morning, but denied smoking during his/her shift, in the company van, or at the bowling alley. The SP stated s/he took the VA for a van ride in the morning and later in the day.

Given that P3 and P4 observed the SP acting in a manner consistent with being under the influence of marijuana, that the SP acknowledged smoking marijuana "about five minutes" prior to his/her shift, that P1 smelled marijuana in the company van in the evening after the SP used the van to drive the VA, that the SP drove the VA on a van ride both in the morning and in the evening, it was most likely that the SP was under the influence of marijuana while driving the VA during his/her shift. Although the SP also drove the other consumers to/from the bowling alley, it was unknown what time that was and P3 and P5, who drove with the SP, did not provide information for this report, so it was not determined whether the SP was under the influence of marijuana while driving to/from the bowling alley.

The SP's actions of smoking marijuana and driving any resident in a vehicle was not accidental or therapeutic, was illegal, and placed the resident at risk. Therefore, there was a preponderance of the evidence that there was a failure to supply the VA with care or services that were reasonable and necessary.

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:
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> (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;
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> (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.

Facility documentation showed that the SP was trained on the VA's plans, the facility's *Drugs and Alcohol* policy, and the Reporting of Maltreatment of Vulnerable Adults.

The SP was responsible for 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 neglect for which the SP was responsible was determined to be recurring. The SP drove the VA twice, approximately ten hours apart. The SP acknowledged that s/he smoked "about five minutes" before work and drove the VA in the morning. Then when the SP drove the VA in the evening, when they returned, P2 smelled marijuana in the van. It was therefore determined that the SP was under the influence each time. However, it was not serious because it did not result in an injury to the VA that required the care of a physician.

Action Taken by Facility:

The facility completed an internal review that stated that policies and procedures were adequate but not followed. There was not a need for additional staff training because the SP no longer worked at the facility. However, staff persons received additional training on interventions to be implemented if a coworker appears under the influence and plans on driving.

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.