

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: 202309298

Date Issued: May 17, 2024

Name and Address of Facility Investigated:

Disposition: Inconclusive

REM Arrowhead Inc 85th Avenue
322 N. 85th Ave. W.
Duluth, MN 55807

REM Arrowhead Inc.
6600 France Ave. S. Ste. 350
Minneapolis, MN 55435

License Number and Program Type:

1080933-H_CRS (Home and Community-Based Services-Community Residential Setting)
1071667-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported a staff person (SP) yelled at a vulnerable adult (VA), and talked about seeing the VA naked and the VA "putting on a show."

Date of Incident(s): On or around October 31, 2023

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (b), and Minnesota Statutes, section 626.5572, subdivision 15, and subdivision 2, paragraph (b), clause (2); and subdivision 17, paragraph (a):

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

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 December 13, 2023; from documentation at the facility; and through five interviews conducted with the VA, a facility staff person (P1), a facility supervisor (P2), a community person (CP), and the SP.

Facility documentation showed the VA enjoyed collecting plants, listening to music, shopping, and watching TV. The VA had a goal of being more "socially involved in the community." The VA was not subject to guardianship, and was diagnosed with an acquired brain injury, cognitive impairment, depression, seizure disorder, a history of substance use, and multiple physical health concerns. The VA was able to advocate for him/herself.

The facility was in a residential neighborhood, and the facility driveway was located near the VA's bedroom. A walkway ran from the driveway to the facility front entrance, and the walkway was next to the VA's bedroom/windows. The VA's bedroom faced a street, and during the site visit the VA's curtains were open. It appeared difficult to reach and adjust the curtains due to the VA's decorative plants.

The facility completed an *Internal Review (IR)* which provided the following information:

- The VA told a community person (CP) on or around October 31, 2023, the SP made comments about seeing the VA naked because his/her window blinds/curtains were open.
- The VA also told the CP the SP did not intervene when a housemate hit the VA.
- The SP told the CP that s/he and the VA had been "arguing, yelling, screaming, and eventually swearing at each other," during the morning (November 1, 2023) that the VA was meeting the CP.
- The VA's daily notes did not provide any information regarding the alleged maltreatment.
- In January 2023 and August 2023, the facility documented multiple discussions with the SP related to his/her work performance including sleeping while on shift, not following operational processes, not following medication administration records, and telling vulnerable adults that it was not staff persons' job to complete cleaning tasks.
- The facility found that other staff persons and vulnerable adults heard the SP raise his voice toward the vulnerable adults at the facility and the SP used an inappropriate word to describe the VA's chest.

The CP provided the following information:

- The VA informed the CP that the SP and the VA engaged in “screaming, swearing, and yelling at each other.” The VA had increased mental health symptoms that related to his/her diagnosis of “obsessive compulsive disorder, bingeing and purging, depression, and anxiety.”
- The VA also told the CP that “last week” while the VA was changing clothes in his/her bedroom the SP arrived at the facility. The SP was able to see the VA “naked from the waist up” through the VA’s bedroom window. The VA said after seeing the VA through the VA’s window, the SP walked into the facility and made multiple comments regarding the VA. The comments included that it was the “second time your goodies have been on display for me,” and the SP said s/he would “call the police if you keep running around naked.”
- The VA also told the CP that the SP said “several other things about [the VA’s] body and nudeness.” The statements from the SP were made in front of other vulnerable adults at the facility. The VA told the CP that s/he was “very humiliated and felt threatened” that the SP said that s/he would “call the police” because s/he was “unclothed” in his/her bedroom.

The VA provided the following information:

- The VA said s/he was changing clothes and the SP arrived at the facility. The VA saw the SP’s car lights and tried to move to his/her closet because his/her window curtains were open. The VA said the SP walked past the VA’s window and saw the VA without clothing. Once inside the facility the SP made multiple comments throughout the day to the VA regarding him/her seeing the VA without clothes, which the VA said was embarrassing. The VA denied being emotional but did not appreciate the SP continuing to make comments about the incident.
- The VA said the SP had previously made other sexual comments, not about the VA, but in general about the SP’s personal life. During the interview the VA imitated hand gestures/motions of sexual acts the SP made in the presence of the VA. The VA said s/he was not affected by those statements or actions but did not believe they were professional.

P1 provided the following information:

- P1 said s/he was not present for the above-mentioned interaction between the VA and the SP, but the VA told P1 about the interaction later on the day of the incident. P1 said the VA did not seem to be emotionally affected, nor did it seem the VA had an increase of mental health symptoms after the alleged incident occurred.
- P1 said the VA made a comment regarding the SP stating the VA could be “arrested” due to the incident.
- P1 said the information the VA shared about the SP making a comment about the VA being naked in front of a window was consistent, but P1 was not aware of any sexual gestures the SP made or information the SP shared about his/her personal life. P1 said the VA laughed off the comment and did not ask the SP to

“stop.” P1 said there were interactions that were not appropriate such as the SP using a raised voice with the VA, but P1 did not consider those interactions to be “maltreatment.”

P2 said s/he was not present for the alleged incident, and was not aware of the allegations prior to the interview, however shared multiple concerns related to how the SP spoke to the VA. P2 said the interactions included but not limited to unprofessional statements related to a doctor’s appointment where the SP should have been able to have “adult conversations,” rather than talk like a s/he was in “high school,” as well as the SP discussing his/her personal life.

The SP provided the following information:

- The SP said that on the day of the incident upon arriving at the facility s/he witnessed the VA standing in front of his/her bedroom window naked, and the SP “did not handle the situation properly.” The SP said s/he made a comment to the VA about the VA exposing his/her naked body to the SP. The SP said s/he spoke to the VA in a way s/he “should not have,” and made a statement that was “not appropriate.” The SP told the VA to “put [his/her body parts] away.” The SP said the VA did not seem to be affected by the interaction while the SP was at the facility.
- The SP denied making any other statements related to the VA putting on a show or using the term “goodies” to describe the VA being naked. The SP denied making any sexual gestures in front of the VA.
- The SP said s/he had a good working relationship with the VA, and said there were past incidents the SP and VA would get into verbal arguments including swearing and raising their voices. The SP denied s/he called the VA any names.

The P1, P2, and SP were trained on the VA’s client specific information, the facility’s policies and procedures, and the Reporting of Maltreatment of Vulnerable Adults Act.

Relevant Rules and/or Statutes:

Minnesota Statutes section 245D.04, subdivision 3, paragraph (a), clause (6) states that a person’s protection related rights include the right to be treated with courtesy and respect.

Conclusion:

It was reported that on or around October 29, 2023, the SP saw the VA without clothing and made comments about seeing the VA without clothing on. The VA said s/he was in his/her bedroom and the SP arrived at the facility and could see the VA naked through a window. The VA said the SP made multiple comments throughout the rest of the day, and the VA felt embarrassed by the statements, and did not believe it was professional for the SP to make the comments. The VA said there was no other staff persons present when the comments were made. P1 was not present for the alleged incident, but had previously heard the SP make inappropriate comments, and raise his/her voice at the VA. P1 said the VA spoke with him/her regarding the incident, but the VA did not appear to be emotional or have any increased mental health symptoms.

The SP said s/he did make comments that were not professional and were other incidents in which s/he raised

his/her voice and used swear words while interacting with the VA. The SP did not observe the VA to be emotional due to the interaction.

The SP's interactions with the VA were not respectful, and the SP's behavior was inconsistent with the standard of a professional caregiver in a facility licensed by the Department of Human Services and a violation of Minnesota Statutes section 245D.04, subdivision 3, paragraph (a), clause (6). However, given that there was no further details regarding other incidents and this was a single occurrence, and that information was that the VA stated s/he was not "emotional" and the VA did not have an increase in mental health symptoms, there was not a preponderance of the evidence whether the VA was subject to treatment that produced or could reasonably be expected to produce physical pain or emotional distress or whether the VA was denied care or services necessary to maintain his/her physical or mental health and safety.

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

Action Taken by Facility:

The facility completed an internal review and determined the facility's policies and procedures were adequate, but not followed. The incident was not similar to past events, and the facility provided re-training on all staff persons at the facility. The facility took corrective action, and the SP was no longer employed at the facility.

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

A Correction Order was not issued to the facility for the violation outlined in this report because the facility took corrective action.