

**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:** 202308012

**Date Issued:** June 7, 2024

**Name and Address of Facility Investigated:**

**Disposition:**

REM Ramsey, Inc - Suncrest  
1646 Suburban Avenue  
St. Paul, MN 55106

**Allegation One:** Inconclusive  
**Allegation Two:** Inconclusive

REM Ramsey Inc  
6600 France Avenue South Ste 500  
Edina, MN 55435

**License Number and Program Type:**

1071862-H\_CRS (Home and Community-Based Services-Community Residential Setting)  
1071829-HCBS (Home and Community-Based Services)

**Investigator(s):**

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**Suspected Maltreatment Reported:**

**Allegation One:** It was reported that a staff person (SP1) yelled at two vulnerable adults (VA1 and VA2) and squeezed VA1's hand, causing pain and resulting in a bruise.

**Allegation Two:** It was reported that another staff person (SP2) touched VA1's chest and stomach.

**Date of Incident(s):** Prior to September 19, 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), clauses (1) and (2); and subdivision 2, paragraph (c):**

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.
- 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.

Any sexual contact or penetration between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility. Sexual contact is defined by Minnesota Statutes, section 609.341, as the intentional touching of the intimate parts with sexual or aggressive intent. 'Intimate parts' includes the primary genital area, groin, inner thigh, buttocks, and breast.

#### Summary of Findings:

Pertinent information was obtained during a site visit conducted on September 22, 2023; from documentation at the facility; and through 12 interviews conducted with two facility managers (P1 and P2), four facility staff persons (SP1, SP2, P3, and P4), VA1's case manager (CM), VA1's family member (FM), VA2's guardian (G), a mental health professional (MHP, not affiliated with the facility), VA1, and VA2. VA1 and VA2 were the only clients living at the facility.

VA1's support plan stated that VA1 was diagnosed with schizoaffective disorder, seizure disorder, and "cognitive deficits." VA1 had a history of incontinence and regularly needed assistance with cleaning him/herself after. VA1 also had a history of refusing help with cleaning him/herself and at times, would refuse medications. Sometimes, VA1 was unsteady on his/her feet, refused to use a walker, and was prone to frequent falls. VA1 enjoyed working on latch hook projects, reading The Bible, and reading and writing poetry.

VA2's support plan stated that VA2 was diagnosed with spastic hemiplegia, cerebral palsy, intermittent explosive disorder, and generalized anxiety disorder. VA2 liked to go bowling, do art projects, do puzzles, and bake.

All staff persons interviewed for this investigation were trained on the Reporting of Maltreatment of Vulnerable Adults Act and VA1's and VA2's support plans.

*Allegation One: It was reported that SP1 yelled at VA1 and VA2 and squeezed VA1's hand, causing pain and resulting in a bruise.*

P1, P2, and P3 provided the following information:

- P1 stated that on the evening of September 16, 2023, P1 received a phone call from SP1 stating that VA1 had diarrhea throughout the "majority of the day," that there was fecal matter in VA1's bedroom, and that VA1 was not allowing SP1 to clean VA1 or his/her room.
- P1 and P2 both stated that they were at the facility giving a tour on September 18, 2023, when they were told that VA1 wanted to talk to them. VA1 told them that SP1 was upset with VA1 on Saturday (September 16, 2023) and "grabbed and squeezed" VA1's hand, which resulted in a bruise. As SP1 did

this, s/he told VA1 that s/he “stinks.” P1 added that VA1 told him/her that when SP1 squeezed the VA’s hand, s/he also said, “You talk too much,” and “You never take showers.” SP1 went on to tell VA1 that there was a previous client that lived at the house that “got away with things” with other staff persons “but not with [SP1].” P1 and P2 both stated when VA1 approached them that both P1 and P2 observed bruising on the top of VA1’s hand. P1 stated that the bruise was “purple-blue,” shaped in a circle and “looked like a thumbprint.” VA1 showed P2 that SP1 grabbed VA1’s hand “kind of like a handshake but pinched right here” and indicated the area between the forefinger and the thumb. (On September 18, 2023, at approximately 3:23 p.m., P1 took a photograph of the VA’s right hand, which showed bruising on the top side of VA1’s hand, located between the ring and little finger).

- P3 stated that on September 18, 2023, VA1 told P3 that over the weekend, VA1 had an “accident” (bowel related) and SP1 got mad at VA1 for having the accident. SP1 “threatened” VA1 while grabbing VA1 by the hand and was “squeezing really hard,” causing a bruise. VA1 told P3 that when SP1 was squeezing VA1’s hand, SP1 was talking about a former staff person and said in an “angry voice” something along the lines of, “Y’all [might have] got rid of [him/her] but you can’t get rid of me.” VA1 seemed “upset,” was crying, and said s/he was “scared to tell [anyone]” about the bruise. At that time, P3 observed a bruise on the VA’s hand, which was not on the VA’s hand the last time P3 worked, which was September 14, 2023.

VA1 provided the following information:

- VA1 would “rather not say” due to “confidentiality” when asked how staff persons treated him/her. VA1 needed some assistance during showering but stated that s/he could use the bathroom on his/her own.
- VA1 remembered taking a pill for diarrhea over the weekend, possibly on Saturday night (September 16, 2023) while SP1 was working the overnight shift. VA1 was in his/her bedroom and SP1 came in to say goodnight and noticed that VA1 had “made a mess” and said, “Let’s go clean you up.” SP1 was mad at VA1 and brought up a past client to VA1 and said, “You might get away with this with other staff [persons], but you won’t get away with it with me.”
- VA1 showed this investigator bruising (on September 20, 2023) on his/her right hand where SP1 “pressed [his/her] thumb down” while VA1 was sitting on the toilet. VA1 told SP1 that it would leave a bruise, and SP1 replied, “No, it won’t.” When asked what else SP1 said to VA1, VA1 responded that s/he could not remember. On a pain scale of zero to ten, VA1 stated that it was “a three” when SP1 pushed on his/her hand.

In the internal review and in an interview, VA2 stated that SP1 treated VA1 “not good” and said, “Push thumb, [VA1’s] hand, black-blue, [his/her] hand.” VA2 did not see SP1 squeeze VA1’s hand but saw the bruise “yesterday.” (In the facility’s internal review, VA2 said s/he saw SP1 squeeze VA1’s hand.) When asked for an example of something that SP1 said to VA1, VA2 stated, “Not nice words,” such as “swear words,” “shit,” “bad word,” and “shut up.” VA2 said that SP1 needed “soap in [his/her] mouth” for swearing. VA2 held open five fingers on his/her hand, indicating “five times” when asked how often SP1 swore at VA1. VA2 stated that when SP1 would yell at VA1, VA1 would be “not good” afterwards.

SP1 provided the following information:

- On September 15, 2023, SP1 noticed that VA1 had a small bruise on his/her hand. When SP1 asked VA1 about its origin, VA1 did not know how it happened. SP1 denied causing the bruise. (There was nothing noted in the VA's case notes for September 15 or 16, 2023 regarding the bruise.)
- On September 16, 2023, SP1 took a 4 to 10 p.m. shift before his/her 10 p.m. to 8 a.m. overnight shift. When SP1 arrived at 4 p.m., VA1 was laying in his/her bed and SP1 did not "notice any concerns" regarding VA1. The previous staff person did not mention anything to SP1 about how VA1 was feeling. SP1 later went into VA1's bedroom and saw that the VA was lying in a "wet bed" from having a bowel movement. SP1 assisted VA1 with changing clothes. At about 5 p.m., VA1 came to the dining room table and ate dinner. VA1 ate like any other "normal" day and went back to his/her room. SP1 continued to check on VA1 every half hour. VA1 would tell SP1, "I can do things on my own," when SP1 would offer help. Between 5:30 and 6:30 p.m., SP1 went back to check on VA1 and a disposable brief with "poop" was on the floor of VA1's bedroom. SP1 cleaned up the room, disposed of the brief, and then went back to check on VA1. Sometime after 7:00 p.m., VA1 asked SP1 for anti-diarrheal medication because according to SP1, VA1 had a "runny stomach." SP1 called P1 to ask for permission because the facility nurse was on vacation. P1 approved this. VA1 took the medication and went into the kitchen. When VA1 left the table and walked toward his/her bedroom, SP1 noticed that VA1 was "leaking" another bowel movement. VA1 told SP1 that s/he wanted to go to his/her bedroom. SP1 called VA1 by name and said, "No, we can't go to your [bed]room. We are going to the bathroom. I have to change you. I have to clean you," and asked VA1 if SP1 could help with showering. SP1 assisted VA1 to the bathroom and encouraged VA1 to take a shower, but VA1 refused multiple times and said s/he wanted to go back to his/her bedroom. SP1 told VA1 that s/he could not leave him/her this way. After SP1 assisted VA1 to the bathroom and VA1 sat on the toilet, VA1 said that s/he wanted to stay seated on the toilet. So instead, for the next thirty minutes, SP1 assisted VA1 with removing VA1's disposable brief and used warm water and soap to clean VA1 while s/he sat on the toilet. SP1 gave the VA Imodium and checked on him/her throughout the night. SP1 did not provide details regarding the rest of the evening.
- SP1 noticed at about 6:00 a.m. in the morning that VA1's bedding was "soiled" and asked VA1 to get up so that s/he could launder his/her bedding. VA1 refused multiple times and refused to take his/her "normal medication" or get out of bed. SP1 added that at the end of his/her shift, s/he told the oncoming morning staff person about VA1's bowel movements the evening before, that VA1 was given anti-diarrheal, that VA1's room "was stinking" and that the trash "stunk." VA1 was in his/her bedroom and SP1 did not think that VA1 could hear him/her, but that it was possible.
- SP1 denied several times "having to grab" VA1's hand and stated that the bruises "have been there." SP1 stated that the way s/he was talking to this investigator, was the tone of voice s/he always used and that was "normal" to VA1 and added that s/he had "an accent." SP1 added that when s/he would speak in a "gentle" voice, combined with his/her accent, the clients could not understand what s/he was saying, and s/he typically talked "louder." SP1 stated that VA1 does not talk, so SP1 would not say, "You talk too much," to him/her. SP1 denied swearing at or using disrespectful language toward VA1 and VA2. SP1 stated that his/her tone of voice was sometimes "loud," and others might perceive that as yelling, but SP1 denied yelling at VA1 and VA2.

P1 – P4 provided the following information:

- P1 stated that VA1 was going through a “depression” lately and his/her personal hygiene would decline as a result. VA1 had fallen a lot lately, but there had not been reports of falls which indicated injuries to VA1’s hands.
- P2 stated that VA1 seemed to be in a “slow, steady decline” related to his/her mental health issues and accepting help, especially in relation to needing help with cleaning up after bowel movements.
- P3 stated that when VA1 refused cares, staff persons were to stay close and continue to offer to help clean VA1. Staff persons were also to watch VA1 to make sure that s/he would not fall.
- P4 stated that when VA1 refused help with showering, P4 would give him/her time as staff persons could not force him/her to take a shower.

VA2 provided the following information in the internal review and in an interview:

- VA2 liked living at the facility.
- SP1 “yelled at” VA2 and said that SP1 was “not nice,” was “mean,” and “hurt my feelings.” SP1 would swear at VA2 using phrases like “shut up,” “bitch,” and “fuck.” VA2 could not recall when this happened but said it happened one time. VA2 stated that s/he was telling the truth.

P1-P4 provided the follow information regarding SP1 yelling at VA1 and VA2:

- P1 stated that VA2 made complaints about SP1 but P1 thought they were “untruthful” because VA2 had a history of providing unreliable information. On a previous occasion, VA2 reported that SP1 pushed him/her down the stairs but those statements were deemed untruthful because VA2 later “admitted to lying about it.”
- P2 stated that VA1 was not reliable in reporting information and it seemed like a “fake cry” without tears when s/he was describing what SP1 did to his/her hand. VA1 did not cry and the next sentence that VA1 spoke after explaining the hand squeezing incident, s/he sounded “just fine,” so it was hard for P2 to judge VA1’s reliability.
- P2 stated that no additional concerns about SP1’s interactions with clients had been brought to his/her attention, with exception to VA2, who had talked about SP1 “yelling at” VA2. VA2 was not reliable at reporting information and would sometimes admit to “lying.” For example, when VA2 was asked if s/he was telling the truth, VA2 would say, “That didn’t happen,” and then VA2 “gets upset and sad and cries.” SP1’s normal talking voice was “very loud” and might have come across as “yelling.” P2 did not know if VA1 and VA2 would understand that the SP was not yelling at them.
- P3 stated s/he never worked with SP1 more than just “in passing.” VA2 told P3 that SP1 would tell VA2 to “get out of [his/her] face” or to “leave me alone.” P3 directed VA2 to tell a facility supervisor about that.

P3 said that VA2 “fibs a lot.” One example provided was when VA2 said s/he did not know where an item was located, but when asked several minutes later, s/he admitting to knowing where it was.

- P4 stated that VA1 or VA2 had brought concerns forth regarding a staff person that yelled or swore at them. P4 stated that they did not like the way they were spoken to. VA1 made a complaint to P4 on September 17, 2023. VA1 told P4 that the reason s/he refused the morning medications was because of how SP1 was talking to VA1 over the weekend.

The MHP stated that VA1 did not bring up anything about SP1 or other staff persons swearing at him/her or treating him/her disrespectfully.

The CM said that s/he did not have concerns about the care that the VA received at the facility and VA1 never brought concerns about staff persons to the CM. Due to VA1's mental health diagnoses, "especially in times of psychosis," VA1 might not be an accurate reporter of events.

The FM stated that VA1 had never mentioned anything related to staff persons yelling or swearing and had not said anything bad about the staff persons to the FM. The FM said that VA1 was "pretty good" at providing reliable information and "does not lie."

The G said that VA2 had never expressed any concerns about staff persons and that when the G would visit the facility, VA2 was always interacting with staff persons in a positive way. Additionally, VA2 could provide information but was not a reliable reporter of information in that s/he would likely not be able to comprehend what was happening.

#### **Conclusion for Allegation One:**

##### *Regarding the bruise on VA1's hand:*

Although VA1 had a bruise on his/her hand and was consistent with what s/he told P1, P2, P3, and P4, stating that SP1 squeezed VA1's hand, given that SP1 denied causing a bruise on VA1's hand and that SP1 stated that VA1 had a bruise on his/her hand the day before, that VA1 stated it was like a "handshake," and that there was varying information regarding VA1's ability to provide reliable information, there was not a preponderance of evidence whether the bruise on VA1's hand was caused by means other than accidental or caused by the SP, or whether SP1 squeezing VA1's hand could be reasonably expected to produce pain or injury.

It was not 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).

##### *Regarding SP1 yelling at VA1 and VA2:*

While VA2 said that SP1 yelled at and swore at VA2, and treated VA1 "not good," there was varying information regarding VA2's ability to provide reliable information. SP1 stated that s/he had a loud voice but would never yell or swear at clients. VA1 had never complained about staff persons to the FM or the CM. P2 said that SP1 had a "loud voice" which might have been interpreted by the clients to be "yelling" but that SP1 was not actually upset with the clients when SP1 spoke.

Although SP1 likely used an elevated voice when talking to VA1 and VA2 and had reason to minimize his/her actions, given that SP1 stated that when s/he spoke in a "gentle voice," and combined with his/her "accent," the clients could not understand SP1, SP1 stated s/he would speak louder to clients, and that although VA2 stated the SP used phrases like "bitch," "shut up" and "fuck," VA2 stated this happened once and there was no information that this was toward VA1 or VA2, there was not a preponderance of the evidence whether SP1 repeatedly used malicious oral language that could reasonably cause emotional distress.

It was not determined whether emotional 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, 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).

Allegation Two: *It was reported that SP2 touched VA1's chest and stomach.*

The MHP provided the following information:

- On September 21, 2023, the MHP met with VA1 for the first time. That day, VA1, VA2, and the MHP were sitting at the kitchen table at the facility and VA1 left for his/her bedroom, but then asked the MHP to come into his/her bedroom for a private conversation. Then, VA1 told the MHP that SP2 "violated my personal space" by touching VA1's stomach and chest. VA1 then started to cry. VA1 stated that s/he did not want to get "anybody in trouble" and was "scared" so s/he pretended to be sleeping during the alleged incident.
- VA1 told the MHP that it was the first time that s/he was telling anyone about this and was "scared for [VA2]." VA1 said that it occurred "the day before" September 21, 2023, but the MHP could not tell if that meant Tuesday night (September 19, 2023) or Wednesday night (September 20, 2023).

VA1 provided the following information to this investigator:

- VA1 was asked how s/he was treated by staff persons, and replied, "I guess okay," but then said s/he was at the point where s/he no longer trusted them. When asked why, VA1 stated that on Sunday or Monday (September 17 or 18, 2023), SP2 came into his/her bedroom, and put his/her hand over VA1's chest and stomach, then touched "right above the private area."
- Later in the interview, VA1 stated that the incident happened Monday or Tuesday (September 18 or 19, 2023), and that it happened in the middle of the night. VA1 added, "I can't remember that much." VA1 said that s/he was wearing jeans and a striped top at the time as s/he did not wear pajamas in bed.

SP2 provided the following information:

- SP2 worked overnight shifts on September 18 and 19, 2023. The shifts were from approximately 10 p.m.

until 8 a.m. SP2 was informed several days later that VA1 claimed that s/he was “touched inappropriately” by SP2. The overnight position required that SP2 was awake during the overnight shift.

- Both nights, VA1 and VA2 each slept through the night. Both mornings, SP2 knocked on VA1’s and VA2’s doors and waited for them to get up. During the overnights, SP2 denied going into VA1’s and VA2’s bedrooms. When they came to the kitchen, SP2 gave them their medications and breakfast “and nothing else.”
- The first morning, September 19, 2023, SP2 woke both VA1 and VA2 later than usual because s/he did not know how to access the medication key and had to wait for P4 to show him/her. On that morning, SP2 left later than 8 a.m. because s/he helped with medications before leaving, once the medication cabinet was unlocked. On the second morning, September 20, 2023, SP2 gave the VA1 and VA2 their medications, took VA1’s blood pressure, gave them breakfast, and left.
- SP2 stated that s/he did not have sexual contact with VA1.

The FM stated that prior to the allegations, VA1 had not brought complaints about staff persons to the FM, but the FM said that when VA1 called to talk to the FM about the alleged sexual abuse, that VA1 told the FM that s/he was “groggy” and “when I woke up [SP2’s] hands were down my shirt and everything.” VA1 told the FM that at the time s/he could not “process it” and seemed “pretty upset.” The FM said that s/he had spoken to VA1 on Thursday night (September 21, 2023), and that VA1 said that it happened one of the two prior nights. VA1 told the FM that s/he told the CM about the incident.

P4 providing the following information:

- On Tuesday, September 19, 2023, P4 started his/her shift at 8 a.m., relieving SP2, who worked the overnight. When P4 arrived, VA1 and VA2 were both sitting at the kitchen table and they both seemed very happy. P4 did not have any concerns about VA1 and VA2.
- The following morning, Wednesday, September 20, 2023, P4 again relieved SP2 in the morning and worked from approximately 8 a.m. to 1 p.m. Upon arriving, VA2 was in the bathroom and VA1 was in his/her bedroom, asleep. When P4 went into VA1’s bedroom, VA1 did not express concerns about the overnight shift to P4.

P1 and P2 each stated that SP2 had worked as a fill-in staff person for about ten years and that they had no concerns about SP2 “sexually abusing” clients. They also stated that VA1 slept in jeans or clothing and not in pajamas.

The CM provided the following information:

- The facility told the CM that there had been an allegation made by VA1 regarding sexual contact with a staff person, but VA1 never told the CM about the allegation. The CM stated that s/he felt that VA1 would tell the CM if any type of abuse were happening to him/her. The CM felt that VA1 knew s/he could call the CM and that the CM would listen to his/her concern. The CM stated that VA1 recently had a “psychotic episode,” which was likely affecting his/her decision-making and that VA1 was not accepting

help with walking and was falling frequently.

- VA1 was not a “reliable reporter.”

#### **Conclusion for Allegation Two:**

On September 21, 2023, VA1 told the MHP that SP2 “violated my personal space” by touching VA1’s stomach and chest and started to cry. After telling the MHP, VA1 called the FM and told him/her about the incident. VA1 was unclear what overnight shift it occurred other than recently, prior to September 21, 2023, but information showed that SP2 worked the overnights on September 18 and 19, 2023.

Although VA1 told the MHP and the FM about SP2 touching VA1’s chest and stomach while s/he was sleeping, s/he did not tell any staff persons or the CM. Additionally, VA1 told the FM that s/he was groggy while SP2’s hand was on him/her but told the MHP that s/he was pretending to be asleep during this time. VA1 told the FM that s/he told the CM but the CM stated VA1 did not.

P4 relieved SP2 both mornings after SP2 worked the overnight shifts and on the first morning, VA1 and VA2 were both in the kitchen and appeared to be happy with no concerns. On the second morning, VA1 also did not express any concerns about SP2.

The MHP had not known VA1 very long but believed that VA1’s allegations about SP2 were valid. The FM also said that VA1 would not lie. However, the CM, P1, and P2 all stated that VA1 was not a reliable reporter, especially due to his/her mental health symptoms. P1 and P2 said that SP2 had worked with the company for almost ten years and during that time there had been no concerns regarding SP2’s treatment of clients.

SP2 denied touching VA1 while VA1 was sleeping or entering VA1’s bedroom at any point during both overnights. Although VA1 told the MHP and the FM that SP2 touched VA1’s stomach and chest, given that there was inconsistent information regarding VA1’s ability to reliably provide information, that SP2 denied the allegations, and that there was no further information to confirm or dispute either account, therefore there was not a preponderance of the evidence of whether SP2 had sexual contact with VA1.

It was not determined whether sexual abuse occurred (any sexual contact or penetration between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility. Sexual contact is defined by Minnesota Statutes, section 609.341, as the intentional touching of the intimate parts with sexual or aggressive intent. ‘Intimate parts’ includes the primary genital area, groin, inner thigh, buttocks, and breast).

#### **Action Taken by Facility:**

The facility completed an internal review and determined that their policies and procedures were adequate, but undetermined if they were followed. SP1 was to receive additional training and to discuss therapeutic vs. non-therapeutic interactions with individuals served. In addition, SP1 was to receive retraining on the Reporting of Maltreatment of Vulnerable Adults Act. VA1’s plans would be revised and VA2 would have a *Behavior Support*

*Plan* implemented. SP2 was retrained on the Reporting of Maltreatment of Vulnerable Adults Act. SP2 no longer worked at this facility.

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

No further action was taken.