

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: 202403551

Date Issued: August 14, 2024

Name and Address of Facility Investigated:

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

NHS Northstar Specialized Services Phoenix
230 NW 1st Street
Chisholm, MN 55719

NHS Northstar Inc
227 West Lake Street
Chisholm, MN 55719

License Number and Program Type:

1069675-H_CRS (Home and Community-Based Services-Community Residential Setting)
1069654-HCBS (Home and Community-Based Services)

Investigator(s):

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Office of Inspector General
Licensing Division
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Suspected Maltreatment Reported:

It was reported that a staff person (SP) pushed a vulnerable adult (VA) off of a heater onto the floor and that the VA had bruising on his/her legs.

Date of Incident(s): April 22, 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 was obtained during a site visit conducted on May 15, 2024; from documentation at the facility and medical records; and through eight interviews conducted with five facility staff persons (P1, P2, P3, P4, and the SP), a facility supervisor (P5), a facility manager (P6), and the VA's guardian (G).

This investigation was done in conjunction with a law enforcement officer (LEO). Though this investigator met the VA, s/he was unable to provide information for this investigation.

According to the VA's plans, s/he was diagnosed with a severe intellectual disability, cerebral palsy, impulse control disorder, and a seizure disorder. The VA had a history of losing his/her balance and falling and wobbling back and forth when walking or standing. The VA had knee surgery in March of 2023 and was not able to walk on his/her own at the time of the incident and used a wheelchair for mobility most of the time. Sometimes the VA choose to crawl or pull him/herself up on things. The VA had a history of self-injurious behavior such as hitting him/herself in the jaw or head repeatedly for unknown reasons. The VA would bite herself or hit his/her head on the floor or a wall. In the past the VA rubbed his/her knuckles on hard surfaces and picked wounds down to the bone. If staff persons observed behaviors, they were to attempt to remove the VA from the situation or intervene and follow the VA's *Behavioral Support Plan* to address target behaviors such as giving the VA one on one attention, verbally or physically redirecting the VA to another location, repeat statements such as "calm" or "everything is okay," or whistle for the VA. The VA liked the color pink, was very sensory-oriented, liked eating candy, and liked when people whistled to him/her.

The facility was a two-level residence converted from a previous business with the main floor consisting of a porch, a dining room, a living room, a family room, a kitchen, an office, a staff person room, and an office. The VA's bedroom was on the main level. The second floor consisted of five bedrooms, a bathroom, and several closets. The basement of the facility contained the laundry room. When entering through the front door and through the porch, the VA's bedroom was on the immediate left. Further down that hallway and on the right, was an office space that had a full wall on the back and on one side, with a half wall on the other two sides. One wall was a counter area with a half-door that swung inward into the office area. When the office door was open, it rested against a wall heater. On the backside of the heater, was another wall of the office area, but it was an open wall with the stairway banister acting as a portion of the wall. The heater height was approximately three feet, four and a half inches and the height of the half-door was approximately three feet, eight inches. The depth of the heater was approximately one foot from the wall. The counter height was several inches taller than the door height. The VA lived at the facility with three other residents.

P6 provided the following information:

- On April 23, 2024, P6 received notification that the VA had bruising and swelling from something that had occurred on April 22, 2024. There were no cameras inside the facility, so no video recorded any possible incidents. The office of the facility had a half-door that was kept closed to secure the staff person office area. The VA had a history of crawling on the floor and was "really fast."

- On April 22, 2024, the SP was scheduled to work from 6:30 a.m. until 2:00 p.m. and left around 1:30 p.m. when P2, his/her shift replacement, arrived at the facility. The SP was also working with P1 that day, who worked from 7:00 a.m. to 7:00 p.m.
- P3, who worked the overnight shift arrived to work on April 22, 2024, at around 8 to 9 p.m., and noticed that the VA had bruising on his/her shin, and his/her eye was "swollen shut." P3 had worked the overnight shift the night before and neither the bruising, nor the eye swelling was present on the April 21, 2024, overnight shift. When P3 arrived at the facility on April 21, 2024, the VA had an adhesive bandage on a wound area on his/her left eye, but it was not swollen. There had been bandages on the VA's face where s/he had been "hitting" him/herself prior to April 21, 2024.
- On April 22, 2024, P1 told P2 that s/he and the SP were working together and that P1 assisted the VA into bed to take a nap around noon and that P1 had not noticed bruising or the swollen eye when the VA began his/her nap. P2 began his/her shift at 1 p.m. When the VA woke from his/her nap at around 2:30 p.m., P2 assisted the VA with a change of clothing and at that point, noticed bruising on the VA's left leg and left foot, as well as the VA's left eye being swollen shut. P2 told P6 that during the approximate 30 minutes of overlap between the SP's and P2's shifts, that the SP told P2 that the VA was climbing on the heater next to the staff person office but that the SP had "pushed [the VA] off of it." P6 said that after the incident date, the facility attempted to contact the SP for further information, but the SP had not returned phone calls.
- P1 told P6 that earlier in the shift, P1 was doing laundry in the basement and heard the SP yell, "No," very "loud." P1 "never explored" why the SP yelled, "No."
- The following day, on April 23, 2024, the VA was taken to the emergency room at about 9:00 a.m. and the doctor determined that the eye injury/swelling was likely due to self-injurious behavior, and also due to an infected tooth. The VA sometimes "hit" or "poked" him/herself throughout the day, especially when s/he experienced pain in an area. There was no treatment directed for the leg bruising other than to "let them heal." No additional care was recommended for the bruising.

P1 provided the following information:

- On April 22, 2024, P1's shift began at 7 a.m. and the VA was in his/her bedroom when P1 arrived. When the VA got up, s/he was "hitting" him/herself and trying to "climb over the heater" to get into the office area. The SP was in the staff person office at the time. The VA currently could not walk due to his/her "leg" (the VA had recent knee surgery). Sometimes the VA would crawl on the floor on his/her hands and knees or sometimes come out of his/her room in a wheelchair. After the other three residents had left the facility for the day, P1 went downstairs to do laundry. While downstairs, P1 heard the SP say, "No," and then heard a "thud." The volume of the word no was "maybe a three or a four" on a scale of one to ten, ten being very loud and one being very quiet and the volume of the "thud" P1 heard was "probably a two." When P1 came back upstairs, the VA was "crawling around" on the floor. P1 asked the SP what happened, and the SP told P1 that the VA had "crawled" onto the heater. P1 did not observe any "new" injuries on the VA at this time but had not observed the VA's bare legs until after the VA awoke from his/her nap.

- If staff persons were in the office, the VA would “pull” him/herself up onto the heater from a seated position in the wheelchair or crawl onto the stairs, then onto the heater, then get onto the half door, and then onto the counter of the office area. This might happen several times a shift. P1 did not see the VA on the heater on April 22, 2024.
- The VA had “self-injurious behaviors” thus, would have “wounds and bruises all the time” from hurting him/herself. The VA wore a soft-style helmet. Typically, the VA would use the back of his/her wrist and palm or knuckles to “hit” his/her cheek. The VA had an injury on his/her head and on his/her cheek and had a bandage on the cheek where the eye was swollen. The VA liked having a bandage on his/her face. After lunch, P1 changed the VA’s adult absorbent undergarment, put on a fresh bandage on his/her face, and helped the VA into bed for a nap. P1 removed the VA’s pants to change the adult absorbent undergarment but did not see bruising on the VA’s legs then.
- P2 started his/her shift at 1 or 2 p.m. After the VA’s nap at around 2:30 p.m., the VA came out of his/her bedroom with no absorbent undergarment or pants on, which was “common.” P1 and P2 had the VA go back to his/her room. P1 and P2 were able to see the VA’s skin on his/her legs. P2 went into the VA’s bedroom first and mentioned to P1 that s/he noticed two bruises on the VA’s left foot and left leg. The bruises on the leg looked “fresh” and were purple and “new.” There was an older “yellow” one on the VA’s thigh. The new bruises were a little larger than the size of a quarter but were not “round.” The VA’s left foot had a swollen area. P1 took pictures and sent them to P5 and another supervisory staff person. The VA was not acting differently and seemed to be his/her “normal self.” P1’s shift ended at 7 p.m. P1 did not notice any changes in the VA’s injuries or behavior prior to leaving. Later, P1 thought P3 came in for the overnight shift, but was gone prior to P3’s arrival.
- April 22, 2024, was the SP’s last day working at the facility and s/he “didn’t do much” and “sat in the office” while others worked. P1 felt like the SP was maybe more “aggressive” with the VA than other staff persons.
- On April 23, 2024, P1 came into work at the request of the facility to answer questions and saw that the VA’s eye was more swollen than the day prior.
- P1 never witnessed the SP to be “aggressive” toward the residents, but staff persons would “gently” assist the VA off of the heater, which P1 showed this investigator, using P1’s “open palm” to the “top of the [VA’s] head.” P1 stated that that was how staff persons assisted the VA off the heater, but that they would “lower [the VA] to the floor” while the VA held onto the half door. Sometimes two staff persons would assist the VA off the heater, but often it was one staff person. If the VA had fallen off the heater, an incident report would be written. The VA had not fallen off the heater in the time that P1 could recall and was not sure if s/he had ever fallen off.

P2 provided the following information:

- On April 22, 2024, P2 arrived at the facility for a 1 to 9 p.m. shift and the SP was “passed out” asleep at the front office desk. P2 “slammed” a chair on the ground to wake the SP. The SP was scheduled until 1:30 p.m. and there were tasks that had not yet been completed, but the SP told P2 the VA had been an “asshole” and had climbed up on the heater and the SP “shoved” the VA to the ground. P2 asked the SP

what s/he meant and why s/he did that because staff persons were supposed to “lower” the VA down. The SP stated that s/he “pushed [the VA] off,” and that the VA was “getting on my nerves.” The SP then said, “F this. This is my last day. I’m walking out.” The SP left at about 1:04 p.m. The VA then came out of his/her bedroom without pants or an adult absorbent undergarment on. P2 observed two “big,” bruises on the VA’s legs, “fresh purple coloring,” larger than a “half-dollar,” one on his/her foot, and “puss” coming out of bruising on the VA’s face but said that the VA “hits” him/herself on a regular basis. P2 called out to P1 and P1 stated that the bruises were not there when P1 assisted the VA in his/her bedroom for a nap earlier that day. P2 then took pictures to send to P5 and another supervisor. P3 arrived for the start of his/her shift and stated that the foot bruising was new, but that there were bruises on the VA’s leg before April 22, 2024. The face bruise was also there before, but P2 felt like P1 and the SP did not cover up the VA’s facial injury with a bandage like they should have done. P1 “played stupid” about the VA’s injuries and P2 felt that there was “no way” that the bruises appeared within the prior hours’ time. (Investigator’s note: P2 stated that s/he thought the injuries were to the VA’s right leg/foot, but images provided from P2 showed that they were on the left leg/foot).

- P2 had last worked on April 20, 2024, and had not seen the bruises on the VA.
- P2 next saw the VA on April 23, 2024, and the VA was the “same old” person and seemed “fine.”
- The VA climbed onto the heater at least once per day. Staff persons were trained to hold the VA’s arms so s/he would not fall. P2 would instruct the VA to hold onto P2 so that s/he would not fall. The half-door was generally kept closed when staff persons were in the office, but another client would also “slam” it shut if it were open, so it was often closed. Staff persons were not allowed to close the VA’s door completely when s/he was inside of his/her bedroom. The VA did not always use “signs” to communicate, so it could be “stressful” to help the VA. If the VA did not like a staff person, s/he would “hit” him/herself. Staff persons were trained to attempt to stop the VA from hitting him/herself and would attempt to help calm the VA, by asking what his/her wants or needs were. P2 would “physically intervene” by placing his/her own hand in the way so that the VA would “hit” P2 instead of hitting him/herself.

P3 provided the following information:

- P3 arrived to work around 8 to 9 p.m. on April 22, 2024, for an awake overnight shift and saw P2. The evening staff person usually filled in P3 on what kind of day the clients were having. P2 told P3 about the VA’s bruising and facial injuries, the latter from the VA “hitting” him/herself with the palm of his/her hand. P3 stated that the injuries were not there when P3 ended the previous overnight shift, which ended around 6:30 or 7 a.m. on April 22, 2024.
- P3 observed a previous “faded” and “barely there” bruise, but “bigger” and “fresh,” “purple, black, and blue,” bruising, with smaller bruises around the larger one. They were not “faded, yellow, or green” which were “healing” bruises on the VA’s shin. The bruise looked like a “handprint or finger” grabbing the VA’s leg. The VA’s eye was “swollen” and red, and unable to be opened at all, There was also a small “scrape” on the VA’s cheek where the VA “hit” his/her face.
- The VA “hit” or “threw” him/herself in and out of bed or wheelchair and would “push off” the side of the

bed to move him/herself, which caused bruising. Staff persons were allowed to “step in” if the VA was “hitting” him/herself. The “concern” for P3, was that staff persons, including P1 and the SP were not “stepping in” to stop the VA from “hitting” him/herself. P3 said that the SP and P1 had to have been allowing the VA to “hit” him/herself “for hours” with the palm of his/her hand on the face. P3 stated that the SP told P2 that the SP “pushed” the VA off the heater instead of “gently bringing [the VA] down.” P3 took pictures of the injuries and called multiple supervisory staff persons to let them know, sending the pictures as well. In the morning, the VA’s face was “more swollen” and P3 knew that the VA could hit him/herself “pretty hard.” P3 was not as concerned about another bruise on the side of the VA’s ankle because of the VA “throwing” him/herself. P3 filled out an incident report.

- The VA slept through the night for P3 when s/he worked overnights. Staff persons were to keep the VA’s door closed, but not completely shut because it was hard for the VA to open the door while in his/her wheelchair. Also, if the VA fell out of bed, staff persons could easily see and assist the VA. The VA was normally awake at 5 to 5:45 a.m., but during the past week, the VA had been up every hour “hitting” him/herself. P3 and other staff persons were trained to put their hand between the VA’s hand and face, or “hold” the VA’s hand or wrist slightly to “stop the motion” of hitting. P3 also spoke to him/her in a calm voice. The VA would stop and would sign to P3 so they could resolve what the VA wanted or needed. The VA never climbed the half door or heater when P3 worked, but P3 would sit and talk to the VA.
- P3 never worked a shift with the SP but had had a little bit of shift overlap in the mornings and had heard that the SP slept while working. When P3 came in after the SP was working, the facility would be a “complete disaster.” The SP did not often volunteer to help P3 with morning tasks.

P4 provided the following information:

- P4 was not working the day of the incident but saw the SP after the incident outside of the facility. The SP asked P4 to “vouch” for the SP. The SP told P4 that s/he “pushed” the VA off the heater, but not in a way that would “hurt” the VA, however, s/he asked P4 not to tell this investigator or the facility that the SP said s/he “pushed” the VA off the heater. P4 told the SP, “I wasn’t there,” and saying that would be “lying.”
- P4 worked a day or two after the incident and said that the VA was doing “pretty good.”

P5, a supervisory staff person, provided the following information:

- P5 could not recall the date but the Monday after the incident learned about it. P4 and P2 both told P5 that the SP stated that s/he “straight up pushed” the VA off the heater.
- P5 was not working the day of the incident and received text messages from P2 including images of the VA’s injuries and a brief description. P3 also emailed P5. Neither P2 nor P3 knew where the bruising came from. P5 thought that the SP’s shift was 8 a.m. until sometime in the afternoon. P5 thought that the SP worked his/her entire shift and s/he did not get a call or text from the SP that day asking if s/he could leave early and that date was the SP’s final shift at the facility. The SP did not usually leave early from his/her shifts but if s/he did, the SP would contact P5 to inform him/her. The SP did not inform P5 of

the "incident" with the VA.

- According to P2, P1 said that the bruises were not there "a couple hours ago," that day. The images of the bruises looked dark, not yellow. They were "fresh" and were a "purply, blue brown" with not too much brown. There were a few more injuries noted, but it was "not unusual" for the VA to "throw" him/herself around "quite often" causing bruises.
- P5 had no concerns about anything s/he "witnessed" with staff persons' treatment of the clients at the facility, including the VA.

The SP provided the following information:

- The VA had recent surgery and could not stand upright "fully" so s/he would stand like a "flamingo." The VA "had this thing" where s/he would climb on the half-door to the office and onto the heater several times per day, using the stairs or standing and pulling him/herself up on the heater. The facility did not train staff persons on how to get the VA off the heater. The SP said that one way was to get as close to the VA as possible, and "hook" his/her own arms under the VA's underarms with open palms, or have hands on the VA's shoulders to "ease" and assist the VA off the heater into the wheelchair or onto the floor. The SP said that P5 said s/he could use that method to help the VA down. At times, the VA would "drop" his/her weight and fall to the floor or "fall backwards." The VA sometimes ended up with bruises as a result of this. The SP stated that on his/her last day, when the VA was on the heater, the SP got his/her hands under the VA's arms to assist the VA off, and the VA dropped his/her weight, landing on his/her knees on the floor instead of on his/her bottom in the wheelchair. The VA did not land "hard." The SP could "see" how "bruises could come in" because the VA landed on his/her legs and knees, but the SP would "never intentionally hurt" any of the clients. The SP could not "completely control" how the VA landed.
- The VA just stared at the SP afterwards and did not react at all. The VA would "stare" at clients and staff persons. The VA would "cry" if s/he was hurt and did not. Afterward, the VA climbed up into his/her wheelchair.
- The SP denied pushing the VA off the heater and "would never put hands" on a client. The SP denied telling anyone that s/he "pushed" the VA off the heater. The SP may have said, "I pulled [the VA] off," or "pulled [the VA] back." The SP "would lay down" his/her life for his/her clients. The SP "loved" his/her clients and "advocate[d]" for them. The SP had a "speech impediment," "spoke fast," and there may have been a "miscommunication."
- P1 was working with the SP that day, and would "hide" from the VA, around the corner or on another level of the facility so that the VA could not find him/her or ask P1 for help.
- The office door was closed when the VA would climb on it. If the door was open, s/he might wheel him/herself into the office.
- At the beginning of the SP's last shift at the facility, which began at 6:30 a.m., the VA had some scratches, rugburn on his/her tailbone from "dragging" him/herself on the carpet, and some markings on the eye from "hitting" him/herself "for hours." The VA also had leg bruising. The VA bruised "easily." The VA had

a “huge” habit of “hitting and harming” him/herself and was “non-verbal.” The VA would at times, continue to hit him/herself, typically above the left eye until a staff person would ask the “right questions.” Staff persons were trained to wrap their arms around the VA’s arms to stop him/her from hurting him/herself. The injury on the VA’s face “never healed” in the time that the SP worked at the facility, which was approximately a month.

- The facility had “bright lights” that gave the SP “migraines.” The SP would sometimes turn the lights off but other clients in the facility would turn them on so sometimes the SP would put his/her “head on [the] desk.”
- The SP denied saying, “I don’t give a fuck and I’m leaving early,” on his/her final shift at the facility and said that s/he asked P5 if s/he could leave early that day. The SP was scheduled to work until 1:30 p.m., and the SP stated that s/he left at 1 p.m. The SP stated that P5 was working that day. The SP also stated that P5 was at the facility when this happened or that s/he told P5 about the VA “dropping” onto the floor. (Investigator’s note: no one else interviewed for this investigation, including P5, stated that P5 was working on the day of the incident).

The G stated that the VA had knee surgery over the last year and the recovery had been “long” and “drawn out.” The VA was very “sensory-oriented” and did not enjoy leaving the facility unless it was going out to eat or to buy candy. The VA used a few words but was mostly “non-verbal.”

During a tour at a facility, P4 showed this investigator and the LEO one way that the VA would climb up on the heater or half-door area. The VA had “very strong” arm strength and was able to pull him/herself up on to it while sitting in his/her wheelchair. The VA only climbed up on it when the office half-door was closed. If the half-door was open, the VA would just “wheel” him/herself into the office. The VA would only do this if a staff person was in the office.

According to medical records, the VA was taken to the emergency room on April 23, 2024, to be treated for injuries to the face resulting from “self-harm behaviors” and the need for a dental procedure. The doctor recommended that the VA had a follow up with a dentist. There was no documentation for any assessment of bruising to the VA’s lower body.

All facility staff persons interviewed for this investigation were trained on the VA’s plans and the Reporting of Maltreatment of Vulnerable Adults Act.

Conclusion:

A. Maltreatment:

Information showed that on April 22, 2024, the VA climbed up onto the heater while the SP and P1 were working the morning shift and while P1 was downstairs, s/he heard, “No,” followed by a “thud.” When P1 came back upstairs, the SP told P1 that the VA had been on the heater. P1 did not observe any injuries to the VA at that time. The SP told P2 and P4 that s/he “pushed” the VA off the heater, telling P2 it was because the VA was an “asshole,” and was “getting on my nerves.” The SP told P4 that s/he did not intend to hurt the VA and hoped that P4 could “vouch” for the SP. The SP asked P4 not to tell this investigator that s/he said s/he “pushed” the VA off the heater.

P1, P2, P4, and the SP stated that the VA climbed on the heater regularly, sometimes more than once per day. P2 stated that staff persons were trained to hold the VA's arms so that s/he would not fall when they were assisting the VA off the heater. According to P1, staff persons would "gently" assist the VA off the heater, using P1's "open palm" to the "top of the [VA's] head." P1 stated that that was how they would get the VA off the heater, but that they would lower him/her to the floor while the VA held onto the half door. Sometimes two staff persons would assist the VA off the heater, but often there was one staff person working. P3 worked overnights and the VA did not climb on the heater when P3 worked.

According to the SP, the facility did not train staff persons on how to get the VA off the heater, but the SP said that one way was to get as close to the VA as possible, and "hook" his/her own arms under the VA's underarms with open palms, or have hands on the VA's shoulders to "ease" and assist the VA off the heater onto the wheelchair or onto the floor. On April 22, 2024, the VA "drop[ped]" his/her weight while the SP was assisting the VA to the wheelchair and the VA landed on his/her knees on the floor.

The SP denied pushing the VA off the heater and "would never put hands" on a client. The SP denied telling anyone that s/he "pushed" the VA off the heater. The SP may have said, "I pulled [the VA] off," or "pulled [the VA] back." The SP "would lay down" his/her life for his/her clients. The SP "loved" his/her clients and "advocate[d]" for them. The SP had a "speech impediment," "spoke fast," and there may have been a "miscommunication."

It was not determined if the bruising on the VA's legs were a result of the VA being pushed off the heater and no additional care for the leg bruising was required after the VA was seen by a doctor for facial injuries, which were believed to have been cause by the VA.

The SP failed to respond to requests by the facility to be interviewed for their *Internal Review*.

Although the SP denied pushing the VA off the heater, given that P1 heard, "No," followed by a "thud," that P2 and P4 provided consistent information that the SP told them that s/he "pushed" the VA off the heater and asked P4 to "vouch" for the SP even though P4 was not there during the incident, and that the SP had reason to minimize his/her actions for fear of consequences, there was a preponderance of the evidence that the SP engaged in conduct that was not accidental and could reasonably be expected to produce pain or injury.

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 was trained on the Reporting of Maltreatment of Vulnerable Adults Act and on the VA's plans. 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 did not meet statutory criteria to be determined as recurring or serious because the maltreatment was a single incident and the cause of the VA's injuries were not determined and did not require the care of a physician.

Action Taken by Facility:

The facility's *Internal Review* showed that the policies and procedures were not followed but were adequate. According to the *Internal Review*, P1 and P2 were retrained to report injuries the VA had to a facility health care professional immediately. There was no need for corrective action since the SP no longer worked at the facility.

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

The SP was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, the SP was notified by the Office of Inspector General that any further substantiated act of maltreatment, whether or not the act meets the criteria for "serious," will automatically meet the criteria for "recurring" and will result in the disqualification of the SP. The determination that the SP was responsible for maltreatment is subject to appeal.