DEPARTMENT OF HUMAN SERVICES

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: 202406179

Date Issued: August 28, 2024

Name and Address of Facility Investigated:

AME Community Services
151 15th St. NE
Suite 104
Buffalo, MN 55313

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

License Number and Program Type:

1068370-HCBS (Home and Community-Based Services)

Investigator(s):

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Licensing Division
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Suspected Maltreatment Reported:

It was reported that a staff person (SP) provided transportation services to a vulnerable adult (VA) while under the influence of alcohol and that the SP was arrested.

Date of Incident(s): July 16, 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 July 25, 2024, from documentation at the facility, from law enforcement records, and through six interviews conducted with the SP, two facility management staff persons (P1 and P2), the VA's legal representatives (G1 and G2), and a law enforcement officer (LEO). Although this investigator met the VA, the VA was unable to provide information in an interview due to his/her disability.

At the time of the investigation, the facility provided in-home support services to the VA, who resided with G1 and G2, while the VA prepared to move into a facility operated community residential setting (CRS). Staff persons provided community integration activities and transportation to and from the activities. The VA used a wheelchair for mobility.

The VA's support plan showed that s/he enjoyed listening to music, going to movies, and playing bingo. The plan further stated that some of the VA's diagnoses included epilepsy and "adjustment disorder with anxiety."

P1 provided the following information:

- On the day of the incident, July 16, 2024, the SP worked at one of the facility CRS locations in from 9 a.m. until 3 p.m. A staff person brought the VA to the CRS arriving around 9 a.m. During the day, P1 was working but was "in and out" of the CRS and had a "nice conversation" with the SP at some point. Throughout the day, the SP drove the VA into the community.

- Between 2:45 and 2:50 p.m., the SP, who was driving his/her personal vehicle, and the VA, who was seated in the front passenger seat, returned to the CRS and the SP parked his/her vehicle on the street in front of the facility. P1 looked outside and saw that the passenger door was open, and the SP was laying on the grass. When P1 went outside to check on the SP and ask if s/he was okay, the SP said that s/he was fine. P1 asked the SP if s/he needed assistance with transferring the VA from the SP's vehicle to the VA's wheelchair.

- When the SP said that s/he did not need assistance with transferring the VA, P1 went back inside the facility. Before the SP was able to transfer the VA from the SP's vehicle to the VA's wheelchair, the SP decided that s/he did not have time to bring the VA inside the CRS because the SP needed to transport the VA to another facility CRS location. During P1's interactions with the SP, P1 did not smell alcohol and noted no concerns that the SP might be under the influence of alcohol.

P2 provided the following information:

- At about 3:45 p.m. on July 16, 2024, the SP and the VA arrived at a second facility CRS location where P2 was working. The SP parked his/her vehicle in the garage, which was a "small space" and because the VA needed space to get out of vehicles and make transfers to his/her wheelchair, P2 thought it was "weird" that the SP parked in the garage.

- P2 went out to the garage to see if the SP needed assistance transferring the VA from the SP's vehicle to the VA's wheelchair. After the SP and P2 transferred the VA, all three went inside.

- Shortly after everyone was inside, the SP repeatedly asked P2 who was bringing the VA back home. P2 told the SP several times that P2 would be providing that transportation later. P2 noticed that the SP was "holding" onto the counter in the kitchen and that his/her eyes were "squinting." P2 also thought that the SP was having a hard time "processing" information. P2 did not smell alcohol on the SP, but stated that s/he did not get close to the SP.

- When the SP left at about 4 p.m., P2 heard a "crash" in the garage. When P2 went to the garage, P2 noted that when the SP backed his/her vehicle out of the garage, the SP "busted" the rearview mirror. After that happened, the SP picked up three or four pieces of the mirror and said, "Oh well."

P1 also said that after s/he and P2 had a meeting the following day, July 17, 2024, they discussed the SP and what they both saw the day before. Because the SP did not show up for work on July 17, 2024, and because the SP did not respond to text messages, P1 had a "random thought" to check a county website and saw that the SP had been arrested the previous day, July 16, 2024, for driving under the influence and that the SP was currently in jail.

The facility's *Internal Review* provided information that was consistent with the information provided by P1 and P2 but added that the SP "did not write progress notes and did not clock out of [his/her] shift on [July 16, 2024]," and, "There was a McDonald's cup in [the SP's] car, so it is assumed [s/he] went to McDonald's for lunch."

According to www.mapquest.com, the driving distance between the two CRS locations (the route the SP drove with the VA on the day of the incident) was about 12 miles.

The SP provided the following information:

- On the morning of July 16, 2024, another staff person transported the VA to the CRS the SP was at. The SP began working with the VA at about 9 a.m. that day.

- At about 11:30 a.m., the SP used his/her personal vehicle to take the VA to lunch at McDonald's, and then to a community center.

- At about 2 p.m., the SP and the VA returned to the CRS. The VA, who had difficulties with transitions, did not want to get out of the front passenger seat. The SP opened the door and then "sat" on the grass, but later said that s/he "probably was laying on the grass" because the VA was not willing to get out of the SP's vehicle and because the SP was not feeling well. The SP had a "headache and body aches." After waiting about 20-25 minutes, the SP decided that s/he and the VA needed to leave to go to the second CRS because the VA was going to participate in an activity at that location that began at 3 p.m. When the SP was asked to describe his/her driving patterns between the two locations, the SP said that his/her driving was "fine."

- When the SP got to the second CRS, s/he parked his/her car in the facility's garage and with assistance from P2, the SP and P2 assisted the VA into the facility.

- The SP left shortly after 3 p.m. and while leaving, the SP's mirror was damaged. The SP stopped at Walgreens to get some "cold and flu medication." The SP did not remember what time s/he got home, but when the SP got home, the LEO "pulled" into the SP's driveway at his/her home because there was a

concern that the SP "drove over the line" on the highway. When the SP was asked if that happened, the SP said, "I may have." The SP refused to provide further information but denied that s/he used alcohol that day and denied that alcohol was in his/her personal vehicle.

A *Minnesota State Patrol DWI (driving while intoxicated) Report* and an interview with the LEO provided the following information:

- At 4:27 p.m. on July 16, 2024, the SP was pulled over due to his/her "driving conduct" and because the SP was "all over the road." As the LEO approached the driver's side, the LEO "immediately smelled a strong odor of a consumed alcoholic beverage emitting from the driver."

- The LEO noted that the SP's "eyes were watery/glassy and [his/her] speech was slurred." The LEO asked the SP if the SP had a particular medical condition and the SP said, "No." The LEO also noted that the SP was "swaying from side to side, front to back, and still had a strong odor of alcohol." The LEO asked the SP when the last time was that s/he consumed alcohol and the SP stated that it was "last night."

- The LEO documented, " I believe that [the SP] was under the influence of alcohol and was unsafe to be driving." The SP's preliminary breath test (PBT) was .190 (the legal limit in the state of Minnesota was .08). Based on that test, the LEO stated that the SP was "probably impaired" when the SP provided transportation to the VA and that the PBT test was "the most accurate measurement." When the LEO was asked whether the SP could attain a PBT level of 1.90 in about one and a half hours (the amount of time between when the SP left the second CRS and his/her shift and the time s/he got home), the LEO stated that, "I would say that [the SP] was probably drinking before 3 p.m., well before 3 p.m."

- The SP was "handcuffed" and "under arrest for DWI." The SP was transported to jail and charged with fourth degree DWI and "open bottle."

- When the LEO performed an "inventory search" of the SP's vehicle, the LEO discovered two containers, one in the center console and one on the passenger seat both containing "alcohol substance."

There was no information provided in the investigation that the VA was harmed or injured because of the incident.

The SP's *Employee Time Sheet* showed that the SP worked with the VA from 9 a.m. until 4 p.m. on July 16, 2024.

G2 stated that in previous interactions with the SP, G2 had no reason to believe that the SP used alcohol while providing services to the VA.

The facility had a policy which stated that the use of alcohol or drugs while providing services to clients was prohibited. The facility's training records showed that the SP was trained on this policy on May 28, 2024. In addition, the facility's training records showed that all staff persons interviewed for this investigation were trained on the VA's specific care plans and the Reporting of Maltreatment of Vulnerable Adults Act prior to July 16, 2024.

Conclusion:

A. Maltreatment:

On July 16, 2024, the SP worked with the VA at the CRS starting at 9 a.m. The SP drove the VA into the community. Between 2:45 and 2:50 p.m., the SP and the VA returned to the CRS and the SP parked his/her vehicle on the street in front it. When P1 noticed that the passenger door was open and the SP was laying on the grass, P1 went outside to check on the SP. When the SP told P1 that s/he was fine, the SP decided s/he did not have time to take the VA into the CRS because the SP needed to drive the VA to the second CRS for an activity so they left. P1 did not smell alcohol and noted no concerns that the SP might be under the influence of alcohol.

At about 3:45 p.m. on July 16, 2024, the SP and the VA arrived at the second CRS according to P2, who was working at that location. The SP parked his/her vehicle in the garage. After the SP and P2 transferred the VA, the three went inside. P2 noticed that the SP was "holding" onto the counter in the kitchen and that his/her eyes were "squinting." P2 also thought that the SP was having a hard time "processing" information. The SP repeatedly asked who was bringing the VA home. P2 did not smell alcohol on the SP, but stated that s/he did not get close to the SP. When the SP left at about 4 p.m. (3 p.m. according to the SP, but 4 p.m. according to the SP's *Employee Time Sheet*), P2 heard a "crash" in the garage and noted that when the SP backed his/her vehicle out of the garage, the SP "busted" the rearview mirror and said, "Oh well."

At 4:27 p.m., the SP was stopped due to his/her "driving conduct" and arrested for driving while intoxicated when his/her PBT was .190, which was more than twice the legal limit in Minnesota. The LEO's report documented that alcohol was found in two containers within the SP's personal vehicle, that the SP had a "strong odor" of alcohol, and that the SP was "unsafe to be driving." The LEO stated that to obtain a PBT of .190, the SP was likely drinking alcohol before 3 p.m. that day.

The SP acknowledged that s/he "may have" driven over the line on the highway after leaving the second CRS, but denied drinking alcohol that day and the SP denied that alcohol was in the SP's vehicle.

Although the VA was not harmed because of the incident and the SP denied drinking while driving, given that the SP had reason to minimize his/her actions for fear of consequences, that P2 and the Employee Time Sheet stated the SP left at 4 p.m. which was 27 minutes prior to having a PBT of .190 and being arrested for a DWI so it was more likely than not that the VA was under the influence of alcohol while driving the VA, and that the LEO stated the VA was impaired which poses a significant risk to the VA's safety, there was a preponderance of the evidence that the SP failed to provide the VA with reasonable and necessary care and services.

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:

(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.

Given that the SP was trained on the Reporting of Maltreatment of Vulnerable Adults Act and was responsible for the VA's care and supervision, the SP was responsible for the neglect 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 not recurring or serious because it was a single incident and the VA was not injured.

Action Taken by Facility:

The facility's *Internal Review* stated that although policies and procedures were adequate, they were not followed by the SP. The SP was no longer employed by 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.