

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: 202405709

Date Issued: September 20, 2024

Name and Address of Facility Investigated:

Disposition: Inconclusive

Winter Family Care LLC Nygaard House
4953 Nygaard Rd
Brookston, MN 55711

Winter Family Care, LLC
4982 Paupores Rd
Brookston, MN 55711

License Number and Program Type:

1098135-H_CRS (Home and Community-Based Services-Community Residential Setting)
1088139-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that two staff persons (SP1 and SP2) pushed a vulnerable adult (VA) into a facility car and closed the car door on VA's foot when the VA became upset at a public library. The VA had bruising to his/her thumb and swelling to his/her arm.

Date of Incident(s): July 1, 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); 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: hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult.

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 an unannounced site visit conducted on July 18, 2024; from documentation at the facility and law enforcement records; and through interviews conducted with facility staff persons (P1, P2, SP1, and SP2), the VA, the VA's guardian (G), and an employee (E) from the public library.

Facility documentation showed that the VA was diagnosed with an intellectual disability, an impulse disorder, and an unspecified psychosis. The VA was subject to guardianship and had a 24-hour plan of care that included two to one staffing. The VA had a history of providing inaccurate information according to his/her *Individual Abuse Prevention Plan/Self-Management Assessment* and might "play one person off of another." When the VA was upset, s/he might have physically or verbally aggressive behaviors toward others without warning, including hitting others with his/her fists or household items, spitting, slapping, stabbing others with items, pulling others' hair, pushing others, or throwing items (food, rocks, bricks, or excrement) at others. The VA might use anything within his/her reach as a weapon to harm anyone who was near him/her when s/he was upset. If staff persons observed the VA becoming upset, they were to verbally redirect him/her, help the VA find a quiet place to calm, then talk with the VA about his/her actions.

In the community, the VA was to be supervised by "veteran" staff persons, and staff persons were to provide continuous supervision to the VA in the facility and in the community. The VA might become aggressive when s/he was told no, or when s/he felt overwhelmed, overstimulated, bored, or anxious. Watching television, changing the subject, coloring, or spending time alone often helped the VA to calm. The VA's team included a behavioral consultant who worked to find ways to decrease or eliminate the VA's aggressive behaviors toward staff and community persons. The VA might "push limits and boundaries" to find weaknesses in staff persons and might call the G immediately after returning from a community outing to say that staff persons do not take him/her anywhere or say that s/he wanted to take a nap, then call the G and say that no one will do anything with him/her, which might upset the G. After talking with the G, the VA might say, "My [G] says that I don't have to listen to you," or "My [G] says I don't have to do that."

The VA's *Community Support Plan (CSP)* stated that the VA might be transported in a vehicle with a plexiglass shield between the front and back seats, and the facility used an SUV with a plexiglass shield between the front and back seats to transport the VA. The VA was to sit in the back seat of the SUV and if s/he became upset in the SUV, s/he might throw his/her shoes at staff persons in the front seat, or hit or kick the shield, or the SUV's windows and doors. If the VA became upset when the SUV was in motion, staff persons were to pull over to the side of the road until the VA calmed, and call for support from a law enforcement agency if necessary. A very structured environment was important for the VA, and s/he enjoyed going bowling and liked to read books.

Interviews with this investigator, records from a law enforcement agency, facility documentation, and the facility's *Internal Review*, provided the following:

- The G said that a staff person whose identity s/he did not recall discussed the incident with the G shortly after it occurred and sent photographs of the VA's hand and foot to him/her. The VA's foot was beginning to bruise and there was a bruise on the VA's thumb. When the VA and G talked, the VA told the G that SP1 and SP2 pushed him/her into the back seat of the SUV at the library, then closed the door. The VA's foot was caught in the door and his/her thumb was injured during the incident. The G thought that the SPs might have been in a hurry at the library which would have irritated the VA, who preferred stability and consistency. However, some staff persons who worked with the VA were new, and other staff persons rotated between the VA's residence and other facility programs. The G thought that some staff persons at the facility spoke with the VA in a condescending manner and labeled the VA a "liar" which upset the VA. The VA needed more activities to keep him/her busy and staff persons needed better training to work with the VA.
- A photograph obtained by this investigator showed that on the evening of July 1, 2024, the VA had a small purple bruise slightly larger than a pencil eraser on the side of his/her left thumb. The VA's lower left arm was also visible in the photograph and did not appear to be injured. In addition, there were concerns that the VA had injuries/marks/bruises on his/her left foot, but a photograph of the foot taken on the evening of the incident showed no readily observable marks or injuries and no swelling.
- SP1 and SP2 each stated that on July 1, 2024, they took the VA on a community outing to the library that went well until it was time for the VA to leave. SP1 said that the VA wanted to take ten books from the library, but s/he told the VA that s/he could take three books. The VA agreed, and chose three books, then SP1, SP2, and the VA walked to the library exit. While exiting the library, the VA saw a flyer about a community bingo game and wanted to go. The game was a community event occurring at a future date and was not being held at the library. The VA became upset when s/he was unable to attend the event right away, then said that s/he wanted more books. There were free items (books, stickers, and pamphlets) at the exit of the library. The VA attempted to take multiple free books, all the stickers, and all the pamphlets, but eventually agreed to take one of each, then began walking toward the facility SUV.
- On the way to the SUV, the VA obtained tree bark, threw it at the SPs, and attempted to cough up phlegm to spit at the SPs. SP1 redirected the VA, who then tried to grab SP1's watch and take it from his/her wrist. SP1 redirected the VA into the SUV by placing the VA's books inside and asking the VA to get into the SUV. When the VA entered the SUV, s/he hit the doors, windows, and seats of the SUV with force with his/her fists and arms, kicked the passenger seat, swore, and spat at staff persons. The VA said that his/her foot was stuck in the door but was simultaneously kicking the back of the passenger seat while saying that his/her foot was stuck. When SP1 opened the door to check on the VA's foot, the VA "lunged" at SP1, threw books at him/her, called the SPs "bitches," and said that s/he was going to call the G when they returned to the facility. SP1 and SP2 checked the VA's foot, determined that it was not stuck, quickly closed the door, and began to drive to the facility.
- At the facility, the VA threw rocks at the SPs, including a baseball sized rock that SP1 deflected away from his/her head with his/her hand, which was bruised by the rock. Inside the facility, the VA threw water and silverware at the SPs and P1, a supervisory staff person, who was at the facility when the SPs and the VA

arrived. The SPs and P1 backed away from the VA to give him/her space, then exited the facility and watched the VA through a window near the main door. The VA calmed and staff persons ate dinner with the VA at about 6 p.m. Staff persons called the G to update him/her regarding the incident. The VA told the G that s/he bruises on his/her foot and thumb and that his/her arm was swollen. Staff persons sent photographs of the VA's foot, thumb, and arm to the G. The VA did not mention pain or injury to his/her hands or feet at the facility, and SP1 and SP2 played a card game with the VA but did not see injuries to the VA's hands. The *Internal Review* documented that after the incident, the VA had marks that were consistent with the VA hitting the inside of the SUV, determined that the VA did not sustain bruises from the incident, and had no marks at 12 p.m. the day after the incident.

- SP2 said that the VA became especially upset when s/he learned that the bingo game was for "older people," and s/he provided an account of the incident that was consistent with SP1's. About ten minutes passed from the time the SPs and the VA exited the library, until the VA entered the SUV. On the approximately 25-minute drive back to the facility, the VA spat at the SPs, hit and kicked the SUV's seats with his/her hands/fists/arms and feet, the library books, his/her shoes, and any other items s/he could find in the SUV. SP2 and SP1 worked to remain calm to redirect the VA. The VA to reached under the shield and grabbed SP2's seatbelt and clothing, and said, "Ha, ha, ha, I got you." SP2 did not observe injuries to the VA, but the VA told him/her later that his/her hand hurt.
- P1 and P2, an administrative staff person, provided consistent information that the VA might become upset easily. The VA did not think about his/her actions when s/he was upset, and might hit, punch, or kick staff persons, or throw any available item within his/her reach, at them. If the VA was upset and behaved aggressively, staff persons were to avoid being cornered by the VA, make sure that the VA was in a safe environment, then disengage from him/her, while supervising him/her from a safe distance out of his/her reach, but close enough to intervene if necessary. When the VA's behaviors were escalated, staff persons were to keep talking to a minimum. It would have been okay to supervise the VA visually from the deck through a window, but it would have been better to supervise the VA while in the room with him/her.
- After the incident, P1 observed a small bruise on the VA's thumb, and the VA said that his/her ankle hurt, but there were no visible injuries to the ankle. P1 thought that the VA sustained the injuries from hitting and kicking the car doors, windows, and the shield inside the SUV and had no concerns regarding the SPs' actions during the incident. The VA's injuries did not require evaluation or medical care from a health care professional.
- On July 18, 2024, this investigator viewed and photographed the interior and exterior of the SUV that the VA rode in to and from the library on the date of the incident. The inside panels of the passenger side door had dirty dusty smears that might have been from someone kicking the inside of the door, but it was not clear. The backs of the driver and passenger seats were cloth and were generally clean, but there were a few dirty smears on the lower part of the driver's seat. The interior of the SUV was in good repair and no damage to the interior was noted. This investigator stood on the deck and photographed the interior of the living area from the deck to determine whether anyone in the living area of the facility was visible through the window near the door. The photographs showed that most of the living area was visible from the window near the main door.

- The E said that the library reviewed its video recordings from the time and date of the incident, but the recordings did not show the incident with the VA and the SPs.
- Records from a law enforcement agency showed that the agency investigated the allegations in this report, referred the matter to the Department of Human Services, and took no further action.

There were also concerns that the facility and its grounds were unkempt and poorly maintained. On the date of the site visit, the facility was neat and clean. However, the grass surrounding the facility was long, about knee high in some places, and the linoleum in the kitchen was torn, but had been trimmed to prevent anyone from tripping on it. P1 said that facility maintenance persons mowed the yard at the facility, and it was difficult to cut parts of the yard because they were fenced. The linoleum tore when kitchen chairs were repeatedly pushed away from the kitchen table over the linoleum. The facility was planning to repair or replace the linoleum. Concerns regarding the facility cleanliness and upkeep were referred to the county licensor for any necessary action.

The facility's *Safe Transportation Policy* showed that staff persons were to follow procedures to ensure safe transportation and assist individuals with seatbelts and other equipment to ensure their safety in facility vehicles.

The facility's personnel and training records showed that staff persons who provided information for this report were trained on the Reporting of Maltreatment of Vulnerable Adults Act and the facility's policies and procedures prior to the incident.

Conclusion:

Information was consistent that on July 1, 2024, there was an incident at the library during which the VA became upset and sustained a bruise to his/her thumb.

The G learned of the incident, and the VA told him/her that SP1 and SP2 pushed the VA inside the facility SUV then closed the door on the VA's foot, which caused injuries to the VA's hand, arm, and foot.

Photographs of the VA's hand, arm, and foot showed that the VA had a small purple bruise on his/her thumb, but no other injuries/swelling were clearly visible in the photographs.

SP1 and SP2 were with the VA at the library when the VA wanted to take multiple books, stickers, and pamphlets from the library, but the SPs redirected the VA to take three books, one free book, one sticker, and one pamphlet. SP2 thought that it also upset the VA when s/he wanted to participate in a bingo game, but was told the game was for older people, was set for a future date, and was not at the library.

The VA declined to get into the SUV, threw multiple items at the SPs, spat on, or attempted to spit on the SPs, and grabbed SP1's watch. After the VA got into the back seat of the SUV, s/he hit the SUV's windows, doors, seats, and the shield between the front and back seats. The VA said that his/her foot was stuck in the door, but SP1 and SP2 each stated that the foot was checked, and it was not stuck in the door. The SPs drove back to the facility with the VA, but at the facility, the VA threw rocks, silverware, and water at the SPs and P1, who all backed away from the VA and exited the facility to give the VA time to calm. The VA was supervised through the window near the door and when s/he calmed, staff persons re-entered the facility and the rest of the day passed without incident.

The E said there was no video of the incident and records from the law enforcement agency showed that the agency investigated the incident but took no further action.

The VA had a bruise on his/her thumb and said that his/her ankle hurt, and the VA might have had a swollen arm or bruised foot. However, given that information was consistent that the VA hit and kicked inside the SUV, that no information showed that SP1 or SP2 had physical contact with the VA, or closed the SUV door on him/her, that the law enforcement agency investigated the incident, but took no further action, and that the VA's injuries were assessed but did not require medical care, there was not a preponderance of the evidence whether SP1 or SP2 engaged in non-therapeutic conduct which could reasonably be expected to produce pain, injury or emotional distress, or whether there was a failure to provide the VA with health care or supervision which was reasonable and necessary to obtain or maintain the VA's health or safety.

It was not determined whether physical 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: hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult; 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* which determined that their policies and procedures were adequate and were followed. The facility planned to discuss the incident at the VA's team at the VA's next team meeting, then make any changes necessary to the VA's plans. Staff persons were retrained on the supervision expectations for the VA.

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

No further action taken.