

MALTREATMENT INVESTIGATION MEMORANDUM
Office of Inspector General, Licensing Division
Public Information

Minnesota Statutes, section 260E.01, paragraph (a), "The legislature hereby declares that the public policy of this state is to protect children whose health or welfare may be jeopardized through maltreatment."

Report Number: 202403158

Date Issued: September 27, 2024

Name and Address of Facility Investigated:

Wings
1326 E Ripley
Litchfield, MN 55355

Disposition: Maltreatment determined as to neglect of three alleged victims by the staff person.

License Number and Program Type:

1047343-CRF (Children's Residential Facility)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a staff person (SP) had inappropriate verbal and physical interactions with three alleged victims (AV1-AV3) that included:

- The SP told AV1 one time, "You have a nice rack."
- AV2 was talking with another resident and said, "I like the way they spank me," and the SP winked at AV2 and said, "I'm a little gun-shy," and hit AV2's buttocks with a piece of paper.
- The SP rubbed AV3's back "intimately" and said to AV3, "You can rub your dirty hands all over me."

Date of Incident(s): Prior to April 17, 2024

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 260E.03, subdivision 15, paragraph (a), clauses (1) and (2):

Failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so.

Failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so.

Summary of Findings:

Pertinent information was obtained during a site visit conducted on April 26, 2024; from documentation at the facility; and through 14 interviews conducted with two supervisory staff persons (P1 and P2), four staff persons (P3-P6), AV1-AV3, the SP, AV2's family member (FM2), and AV3's family member (FM3). Another youth and their family member were interviewed, but did not provide information pertinent to the allegations. Attempts were made to via telephone, mail, and/or email contact and interview AV1's family member (FM1), another resident's (R), and two staff persons (P7 and P8), but the attempts were unsuccessful. Information from multiple staff persons was that P7 was a supervisory staff person, however, P7's personnel file documented s/he was a staff person.

The facility provided residential care for adolescents in need of out of home placement. The facility had separate gendered wings (G1 and G2) that had a common room in between. A staff bathroom and a laundry room were located next to the G1's wing in the common room. Past the common room was a dining room used for meals provided to the residents. The dining room had a counter that separated the dining room and the kitchen.

P1-P6 and the SP provided consistent information that residents were spoken to with respect and courtesy and that staff persons were not allowed to touch residents and that there should be "bubble" between staff persons and residents.

The facility's *Treatment Rules for Staff* stated that staff persons "are prohibited from touching clients in any way. Exceptions are only allowed in circumstances in which touch is necessary to preserves client's safety." The facility's *Ethics, Boundaries, and Professional* policy stated, "Staff should safeguard a client's physical, emotional, ... wellbeing. Behaviors that could damage a clients wellbeing include but are not limited to; verbally attacking clients ... and shaming or embarrassing clients."

The facility's personnel file showed that the P1-P8 and the SP were each trained on the facility's *Treatment Rules for Staff, Ethics, Boundaries, and Professional* policy, and the Reporting of Maltreatment of Minors Act prior to the incidents.

Regarding AV1:

AV1's *Client Face Sheet* stated AV1 was seventeen years old at the time of the incident and diagnosed with major depressive disorder, post-traumatic stress disorder, generalized anxiety disorder, cannabis use disorder, and alcohol use disorder. AV1's *Individual Treatment Plan* stated that staff persons were to help AV1 develop effective coping skills to manage his/her substance abuse and mental health concerns. AV resided in G2.

AV1 provide the following consistent information to this investigator and in the facility's internal review:

- AV1 moved into the facility on February 28, 2024. On an unknown date two to three weeks after, AV1 was in the dining room with the other residents for lunch. AV1 said that s/he was wearing a "tight but

not a tight, tight" shirt and walked up "alone" to the lunch counter to grab his/her lunch. When AV1 reached the counter, the SP was standing there but AV1 did not speak with the SP. AV1 said that the SP "mimicked me" and was "walking with [his/her] chest poked out," and said to AV1, "You have a big set there."

- AV1 said that s/he "felt disgusted" by the SP's comment due to "past stuff in my life that I went through." The comment "was like a trigger ... because someone said that to me before." AV1 then walked back to a table but did not immediately tell anyone about the incident. Two days later, AV1 one spoke with P1 about the incident and a decision was made that AV1 would no longer have contact with the SP and that other staff persons would bring meals to AV1.
- AV1 said that at other times the SP would tell jokes that made him/her "uncomfortable" but AV1 would "ignore" the SP. AV1 was not able to recall what the jokes were. AV1 said that s/he had no concerns about other staff persons in the facility.

P3 said that on an unknown date during lunch time s/he was in the dining room with the SP. AV1 walked into the dining room and stood near a table. The SP looked at AV1, and then grabbed two pieces of fruit and held the fruit up to his/her chest and began to "prance" around the dining room looking directly at AV1. The SP did not make any comments to AV1 while doing this. AV1 told the SP that "it made [him/her] feel weird" but the SP ignored AV1 and continued to "prance" around the room. P3 said that AV1 was "so uncomfortable" that AV1 had staff persons get his/her food and would then ate facing away from the SP. P3 then told P7 about the SP's actions.

P5 said s/he was not present during the incident, but a couple of days after the incident, AV1 told P5 that the SP had made a comment about chest and made a gesture regarding AV1's chest which made AV1 "very upset." P5 said that that the SP was then not at the facility for about a week and on a day after the SP returned to work, AV1 had a "panic attack." AV1 was "screaming" and said, "Why is [the SP] even there?" AV1 told P5 s/he was "uncomfortable" so P5 took the AV to the front of the building to "get some air." P5 said that it took two hours for AV1 to calm.

P2 said that on March 13, 2024, AV1 told him/her that the SP had made a comment "insinuating" AV1 had a big chest. Then on March 15, 2024, AV1 said that the SP told him/her, "Snitches get stitches." P2 was not able to provide any more information about the incidents. P2 then told P1 about the incident. P2 did not speak with the SP but told P1 about the incident.

P1 provided consistent information to this investigator and in the facility's internal review.

- P1 said that on March 13, 2024, P2 and P1 his/her concerns regarding the SP. AV1 said that the SP made a "suggestive" comment about AV1's chest and "poked [his/her] chest out" at AV1 and said, "You have a big set."
- On March 14, 2024, P1 met with AV1 to talk about the concerns and on March 15, 2024, AV1 told P1 that the SP said "snitches get stitches" to AV1. P1 spoke with AV1 and AV1 said that s/he did not want to see the SP "face to face." P1 made a decision to allow staff persons to get AV1's meals and bring them to AV1.
- On March 15, 2024, P1 spoke with the SP who denied the making the comments and gesture to AV1. P1 the spoke with the SP about the importance of being thoughtful in how they interact with residents and

that it was not within the facility's policy to make any sort of comments about resident's looks or body. The SP then confirmed that s/he understood the facility's expectations.

The SP provided the following information:

- On an unknown date during lunch, AV1 was at the lunch counter with other residents and said that s/he did not like the lunch that was made and wanted something else. The SP said, "No, that's not part of our menu today." The SP then offered alternative choices such as peanut butter and jelly sandwiches or fruit. AV1 and the other residents were "angered" and began to use "vulgar language." The SP said that there were no other staff persons in the dining area at that time.
- The SP said that s/he was not aware of the allegation until P1 spoke with him/her. The SP "100%" denied saying to AV1, "You have a big set." The SP said that those words were not in "[his/her] vocabulary."
- The SP did say that "snitches get stitches" when s/he put chocolate chips in the pancakes for the residents in G1 and told them not to say anything to the residents in G2 because they did not get chocolate chips and as a "joke" said "snitches get stitches."

The facility provided a log of concerns and conversations that P1 had with the SP that included on March 13, 2024, AV1 reported that the SP made a comment that insinuated s/he had big breasts. On March 15, 2024, the SP denied making any comments to AV1. The SP was placed on suspension until s/he accepted the condition of additional training for March 18, 2024. The SP declined the offer. On March 22, 2024, the SP called P1 and accepted the conditions of additional training and returned to work on March 23, 2024.

Regarding AV2:

AV2's *Client Face Sheet* stated that AV2 was fifteen years old at the time of the incident and was diagnosed with major depressive disorder, generalized anxiety disorder, posttraumatic stress disorder, nicotine use disorder, and cannabis use disorder. AV2's *Individual Treatment Plan* stated that staff persons were to help AV2 develop effective coping skills to manage his/her substance abuse and mental health concerns. AV2 resided in G1.

AV2 said that approximately two weeks prior to April 26, 2024, s/he was standing near the staff bathroom with other residents, P4, and the SP. AV2 asked the SP a questions about lunch and then turned to his/her peers and said "something stupid" s/he could not recall making the other residents laugh. The SP then "smacked [AV2's] ass" with a piece of paper. AV2 turned to the SP and said "jokingly," "Oh, [the SP's name], I like when you do that." AV2 then said, "I'm sorry." The SP replied back, "It's okay, I was just a little bit gun-shy," and winked at AV2, which made AV2 feel "uncomfortable." AV2 thought the SP meant "something sexually" by the comment. AV2 then walked away from the SP. P4, who was nearby, came over to AV2 and asked him/her what the SP said and AV2 told P4 what happened. AV2 did not tell P1 about the incident.

FM2 said that s/he was not aware of any "concerns" regarding AV2 and had no concerns about the facility.

P4 said that on an unknown date s/he was standing near the staff bathroom, next to AV2, other residents, and the SP. AV2 had made a comment s/he "was not supposed to make" to the other residents (P4 could not recall what the comment was). The SP looked at AV2 and "winked" and said, "I'm a little gun-shy" to AV2 and then "smacked" AV2 on the "butt" with a piece of paper. P4 then told the SP, "You can't do that" and then the SP "quickly ran" into the staff bathroom and locked the door. P4 said that AV2 started to "freak out" so P4 directed

AV2 into the G1 wing. When P4 and AV2 entered the G1 wing AV2 said, “[S/he] can’t be fucking touching me like that,” and “[P4] you need to get rid of [him/her].” P4 helped AV2 calm and reported the incident to P7.

P3 said that on an unknown date s/he saw AV2, P4, and the SP standing next to the laundry room in the commons area as s/he stood on the opposite side of the commons room. The SP had a piece of paper in his/her hand and “slapped” AV2 on his/her “butt” and then walked away from AV2. P3 did hear any conversation between AV2 and the SP, but AV2 “froze” and then walked back into the G1 wing. P3 went to AV2 and asked AV2 if s/he was “okay.” AV2 replied that s/he wanted to talk with P1 but P1 was not at the facility at that time. P3 did not know if P1 was aware of the incident. P3 said s/he did not tell anyone about the incident because P4 told P7 who told P2.

AV1 was in the G2 wing when s/he saw the SP, AV2, and other residents near the staff bathroom, when the SP “slapped [AV2] on the butt with a piece of paper.” AV1 was not able to hear any conversation between the SP and AV2 and did not see AV2’s reaction to the incident.

P2 said that on April 10, 2024, P4 and P8 told P2 that they had heard the SP say, “I’m a little gun-shy” to residents after the residents made “inappropriate” jokes to each other about spanking. P2 did not get the names of the clients.

P1 stated s/he was not aware of the incident between the SP and AV2 prior to this investigation. Afterwards, P1 spoke with AV2 and AV2 provided P1 with information that was consistent with the information AV2 provided during his/her interview.

The facility’s internal review provided the following information: AV2 stated that the SP “tapped” his buttocks over his pants with a packet of papers. AV2 said that this occurred in the dining room in the presence of peers. AV2 stated that this made him feel uncomfortable. AV2 stated that SP did not engage in any previous or subsequent incidences of inappropriate touch.

The SP said that on an unknown date s/he was walking out of the staff bathroom with paper in his/her hand. As s/he was coming out a group of residents walked by and as the SP was trying to lock the bathroom door the paper in his/her hand “brushed” a client’s shoulder. The SP did not recall who the client was, and that s/he had not engaged on any conversation with them. The SP denied saying “I’m a little gun-shy,” and did not know what that statement meant. (Note: According to the Merriam-Webster dictionary the definition of “gun-shy” was “markedly distrustful, afraid, or cautious.”)

Regarding AV3:

AV3’s *Client Face Sheet* stated that AV3 was seventeen years old at the time of the incident and was diagnosed with major depressive disorder, general anxiety disorder, cannabis use disorder, opioid use disorder, and nicotine use disorder. AV3’s *Individual Treatment Plan* stated that staff persons were to help AV3 develop effective coping skills to manage his/her substance abuse and mental health concerns.

AV3 provided the following consistent information during his/her interview and in the facility’s internal review:

- AV3 said that on an unknown date near the end of March 2024, s/he was standing in the dining room with the R during lunch. The SP came up behind AV3, “rubbed [his/her] hand down [AV3’s] back” and then walked into the kitchen and stood by the counter. AV3 felt “really uncomfortable” and “awkward because it was unnecessary.” AV3 said that “[the SP] should not be touching me.” AV3 then walked to the

counter to talk with the SP. AV3 said to the SP, "How would you like it if I did it to you?" The SP replied back, "You could rub your hands all over me." AV3 said that s/he felt "disgusted" after the SP's comment. AV3 said that s/he told P6 about the incident but did "not believe" P6 did "anything about." AV3 later told P3 who notified P1 of the incident.

- AV3 said that the SP had made other comments that made AV3 "uncomfortable." The SP had previously told AV3 that "[AV3] had beautiful eyes" and that "[AV3] should be a model."
- AV3 said that the SP was not to "touch" the residents and only certain staff persons were allowed to "touch" residents but was unfamiliar with what "touches were allowed other than fist bumps."

FM3 said that s/he had no prior concerns about the facility.

P3 said that on an unknown date, AV3 told P3 that the SP had "rubbed" his/her hands up and down AV3's arm and back which made AV3 feel "uncomfortable." AV3 said that s/he did not address the incident at the time because s/he was "too scared" but AV3 also told P7 about the incident. The next day P3 heard the SP say "[AV3] beautiful eyes come here" when it was time to grab lunch from the counter. P3 said s/he did not report the incident to his/her supervisor because AV3 told P7 and that AV3 did not mention the incident again to him/her.

P6 said that on an unknown date, AV3 told P6 that the SP had touched his/her "shoulder," and was "hitting on [AV3]," which made AV3 "uncomfortable." P6 did not know when the incidents occurred but directed AV3 to tell P1 if s/he wanted to and showed AV3 the "paperwork" to fill out if AV3 wanted to file a complaint P1. P6 was "unsure" if AV3 reported the incident to P1. P6 said s/he did not tell P1 or P2 about what AV3 said.

P2 said that on April 6, 2024, P7 told P2 that AV3 said that the SP was "rubbing [AV3's] back" and said to AV3, "You could run your hands all over my body." The SP also told AV3 "[s/he] had beautiful eyes" and that "[the SP] could stare into them all day long." P2 reported the incident P1.

P1 said that on April 11, 2024, P2 told him/her what AV3 told P7. AV3 had not said anything about the SP prior to this. P1 did not talk to the SP because his/her employment was ending. P1 spoke with AV3 after the SP no longer worked at the facility and AV3 provided information to P1 that was consistent with the information AV3 provided during his/her interview.

The SP denied that s/he touched any resident on the back. The SP said that s/he was trained not to "touch" the residents and it was "just ridiculous" that s/he would ever say "rub your hands all over me." (Note: The SP ended the interview prior to its completion) but provided information for the facility's internal review. The SP denied the majority of the reports alleged by staff and residents but acknowledged the need to improve his/her boundaries with residents and limit his/her workplace actions to those listed on his/her job description.

P1 and P2 had prior concerns regarding the SP's verbal interaction with residents. The SP was retrained on how to properly interact with residents and that the SP was to solely focus on his/her specific job duties which did not include being a direct supervisor of residents.

- The facility provided a log of concerns and conversations that P1 had with the SP that included on April 6, 2024, P7 reported that a resident from G1 told him/her that the SP said s/he had "beautiful eyes" and that "[s/he] could stare into them all day." P7 also reported that the SP told the G1 resident that "s/he] could rub his dirty hands all over me" and that the G1 resident said that the SP was "rubbing [his/her]

back." P7 also reported that the SP entered the G1 wing, sat down, and interacted with the residents. (Note: P1 did not talk to the SP about this incident.)

Conclusion:

A. Maltreatment:

Regarding AV1:

AV1 said that on an unknown date prior to March 15, 2024, s/he was alone by the kitchen counter and when the SP "mimicked" him/her and was "walking with [his/her] chest poked out" and then told AV1 "You have a big set there." The AV said that s/he "felt disgusted" due to "past stuff in my life that I went through" after the SP made his/her comment. P3 stated that on one occasion s/he was in the dining room with the SP when AV1 entered the dining room, the SP placed two pieces of fruit at his/her chest and "pranced" around dining room while looking at AV1.

P1 spoke with the SP and the SP denied that the incident happened. The SP acknowledged that s/he said "snitches get stitches" but that it was said as a "joke" referring to an incident where G2 residents received chocolate chips and the G1 residents did not.

Although the SP denied the allegations to P1 and during his/her interview, given that P3's account of what s/he saw the SP do was similar to AV1's account, and that the SP had reason to minimize his/her actions for fear of repercussions, there was a preponderance of the evidence that the SP engaged in the interaction with AV1 as described by P3 and AV1.

Regarding AV2:

AV2 said that on an unknown date two weeks prior to April 26, 2024, s/he was standing near the G1 with other residents, P4, and the SP. AV2 said "something stupid" to make his/her peers "laugh." The SP then "smacked [AV2's] ass" with a piece of paper. AV2 then turned to the SP and said in a "joking" way, "Oh, [SP], I like when you do that." AV2 then said, "I'm sorry," to the SP. The SP replied back, "It's okay, I was just a little bit gun-shy," and then winked at AV which made AV2 feel "uncomfortable." P4 was near AV2 and heard the conversation between the SP and AV2. P4 told the SP, "You can't do that," and then the SP ran into the bathroom. P3 and AV1 saw the SP "slap" AV2 on his/her "butt" but neither heard the conversation. P3 said that AV2 then "froze" and then entered the G1 wing.

The SP denied saying, "I'm a little gun-shy," but said that on an unknown date s/he was walking out of the staff bathroom with paper in his/her hand. As s/he was coming out a group of residents walked by and as the SP was trying to lock the bathroom door the paper in his/her hand "brushed" a client's shoulder. The SP did not recall who the client was, and that s/he had not engaged on any conversation with them.

Although the SP denied the allegations during his/her interview, given that P4's account of what s/he saw the SP do was consistent with AV2's account, that AV1 and P3 also saw the SP "slap" AV2 on the buttocks, and that the SP had reason to minimize his/her actions for fear of repercussions, there as a preponderance of the evidence that the SP engaged in the interaction with AV2 as described by AV2, P4, P3, and AV1.

Regarding AV3:

AV3 said that on an unknown date near the end of March 2024, the SP came up behind AV3 and “rubbed [his/her] hand down [AV3’s] back” and then walked into the kitchen and stood by the counter. AV3 felt “really uncomfortable” with the interaction. AV3 then walked to the counter to talk with the SP and said to the SP, “How would you like it if I did it to you?” The SP replied back, “You could rub your hands all over me.” AV3 later told P3 and P6 consistent information about the incident. The day after that, P3 heard the SP say “[AV3] beautiful eyes come here” when it was time for lunch.

The SP denied that s/he touched any resident on the back and said that s/he was trained not to “touch” residents and that it was “ridiculous” that s/he would ever say “rub your hands all over me.”

Although the SP denied the allegations during his/her interview, the SP had reason to minimize his/her actions for fear of repercussions. In addition, AV3 provided similar information during his/her interview and to P3 and P6 regarding the SP’s interactions and the interaction was similar in nature to those described by AV1 and AV2. Therefore, it was more likely that the SP engaged in the interaction as described by AV3.

AV1, AV2, and AV3 were each at the facility for support regarding their substance abuse and mental health disorders. AV1’s, AV2’s, and AV3’s *Individual Treatment Plans* stated that staff persons were to help each develop effective coping skills to manage his/her substance abuse and mental health concerns, so it was reasonable that each would likely continue to need supports to develop and maintain the necessary life and social skills to maintain and build healthy relationships. The SP’s interactions with AV1, AV2, and AV3, who were 17, 15, and 17 years old (respectively), likely hindered their ability to have a consistent understanding of the parameters of a therapeutic relationship which could interfere with other individuals’ attempts to provide therapeutic services to each both now and in the future.

Therefore, there was a preponderance of the evidence that the SP failed to maintain professional boundaries and that the SP’s interactions with AV1, AV2, and AV3 were detrimental to their ongoing mental health, were a failure to supply necessary care, and a failure to protect them from conditions or actions that seriously endangered their mental health.

It was determined that neglect occurred (a failure by a person responsible for a child’s care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child’s physical or mental health when reasonably able to do so. Failure to protect a child from conditions or actions that seriously endanger the child’s physical or mental health when reasonably able to do so).

B. Responsibility pursuant to Minnesota Statutes, section 260E.30, subdivision 4, paragraph (a), clauses (1) and (2):

When determining whether the facility or individual is the responsible party, or whether both the facility and the individual are responsible for determined maltreatment in a facility, the investigating agency shall consider at least the following mitigating factors:

- (1) whether the actions of the facility or the individual caregivers were according to, and followed the terms of, an erroneous physician order, prescription, individual care plan, or directive; however, this is not a mitigating factor when the facility or caregiver was responsible for the issuance of the erroneous order,

prescription, individual care plan, or directive or knew or should have known of the errors and took no reasonable measures to correct the defect before administering care;

- (2) comparative responsibility between the facility, other caregivers, and requirements placed upon an employee, including the facility's compliance with related regulatory standards and the adequacy of facility policies and procedures, facility training, an individual's participation in the training, the caregiver's supervision, and facility staffing levels and the scope of the individual employee's authority and discretion; and
- (3) whether the facility or individual followed professional standards in exercising professional judgment.

The SP was trained on the Reporting of Maltreatment of Minors Act and the facility's *Treatment Rules for Staff, Ethics, Boundaries, and Professional policy*. The SP was responsible for maltreatment of AV1-AV3.

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" maltreatment. The SP's interactions with AV2 and AV3 were single incidents so it was determined that the SP's overall interactions with AV1, AV2, and AV3 represented a pattern of behavior and therefore a single incident, and AV1-AV3 did not require the care of a physician.

Pursuant to Minnesota Statutes, section 260E.35, subdivision 6, paragraph (c) all investigative data maintained in this report will be kept by the Department of Human Services for at least ten years after the date of the final entry in the report.

Action Taken by Facility:

The facility completed an internal review and determined that their policies and procedures were adequate but was not adequately followed by the SP. 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.

Certification:

The information collection procedures followed in this investigation were pursuant to Minnesota Statutes, section 260E.30, subdivision 6, paragraph (c). All individuals that are subjects of data in this investigation have the right to obtain private data on themselves which was collected, created, or maintained by the Department of Human Services.