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: 202403410

Date Issued: November 20, 2024

Name and Address of Facility Investigated:

Genesis Group Homes Brainerd Site
8998 County Road 45
Brainerd, MN 56401

Genesis Group Homes, Inc.
8245 93rd Avenue North
Minneapolis, MN 55445

Disposition: Substantiated as to physical and emotional abuse of a vulnerable adult by a staff person (SP1). Substantiated as to neglect by another staff person (SP2).

License Number and Program Type:

1105221-H_CRS (Home and Community-Based Services-Community Residential Setting)
1072844-HCBS (Home and Community-Based Services)

Investigator(s):

Lindsay Arth
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
lindsay.arth@state.mn.us
651-431-6537

Suspected Maltreatment Reported:

It was reported that a staff person (SP1) kicked a vulnerable adult (VA), put the VA in a "chokehold," and "slammed" the VA against a wall, resulting in bruises to the VA's arms and legs. SP1 also swore at the VA and called the VA a "retard" [referred to as the r-word throughout the remainder of the report]. Additionally, there were concerns that another staff person (SP2) observed the interactions and "did nothing."

Date of Incident(s): April 18 and 19, 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), clauses (1) and (2); 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 use of repeated or malicious oral, written or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

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 May 6, 2024; from documentation at the facility and law enforcement records; and through six interviews conducted with the VA, two facility clients (C1 and C2), a facility supervisory staff person (P1), a staff person (P2), and the VA's guardian (G) who was also the VA's family member. A community person (CP) from a mental health crisis line provided information via email and that information is below. Attempts were made via phone, text, email, and U.S. mail to contact and interview SP2, but the attempts were not successful. SP2 provided information to law enforcement and that information is below. Additionally, this investigator and SP1 communicated via text message about scheduling an interview. SP1 said that s/he "really wanted to talk" to this investigator because there was "way more to what happened then what was seen" but SP1 did not respond to subsequent attempts for an interview, including proposed dates/times suggested by this investigator.

The facility had two levels. The main level had an entryway, bedrooms, bathrooms, kitchen, and living room. The upstairs had bedrooms and a living room. There was a stairwell in the entryway that led upstairs.

The VA was diagnosed with mild intellectual disability, anxiety, depression, and attention deficit hyperactivity disorder. The VA enjoyed going for walks and shopping.

According to the VA's *Positive Behavior Support Plan*, the VA had a history of verbal and physical aggression towards others. The VA had difficulty respecting boundaries and communicating with others appropriately. The VA wanted to develop positive coping skills to improve self-control around handing situations that caused the VA to become "angry" including "tension reduction techniques" such as taking deep breaths, listening to music, or disengaging from staff to a quiet area. Staff persons were to keep their voice "calm and polite" and were to "validate" and listen to the VA. The VA's *Support Plan Addendum Intensive Services* said that the VA enjoyed others who were friendly, listened to him/her, encouraged him/her, and understood his/her diagnoses.

The VA's *Individual Abuse Prevention Plan* and *Self-Management Assessment* said that the VA could become aggressive towards others if "provoked" and may hit someone if the VA were hit first or if someone were

"upsetting" the VA. Staff persons were to intervene to keep the VA safe, including stepping between the VA and the other person and/or moving the VA to a safe environment. Additionally, staff persons were to report the abuse.

The facility scheduled showed that SP1 and SP2 worked with the VA, C1, and C2 during the overnight shift on April 18, 2024, from 9 p.m., until April 19, 2024, at 9 a.m.

An email from the CP to this investigator said that on April 19, 2024, the VA called a crisis line and spoke to the CP and told him/her that on the evening of April 18, 2024, SP1 "came out of nowhere" and "kicked" the VA's leg "seven times." SP1 then "stomped" on the VA and put his/her knees on the VA's head. The VA told the CP that s/he sustained bruising on his/her arms from the incident. The VA did not feel "safe" with SP1 and wanted to move out of the facility because of the incident.

The VA provided the following information:

- Prior to the incident, during the same evening, the VA had a "little behavior" including hitting C1 and C2. SP1 told the VA that s/he "shouldn't do that." SP1 and SP2 also "tried" to put the VA in a restraint because s/he was "hitting" C1 and C2 but SP1 and SP2 were not able to because the VA "kind of pulled" and "tried to get up."

- The VA said that on an unknown date, around 10 or 10:30 p.m., the VA and SP1 were in the entryway near the "bottom" of the stairs when SP1 kicked the VA's shin and stomach, resulting in bruising on the VA's right leg. SP1 also "jumped" on the VA, pushed the VA "down to the ground," and put his/her knee against the VA's head and then choked the VA by putting his/her hand around the VA's neck. Additionally, SP1 sat on the VA's back for 10 minutes which put "pressure" on the VA's stomach. C1, C2, and SP2 were present and C1 took video during some of the incident.

- During the incident, SP1 told the VA that s/he "deserved this." SP1 also told the VA that s/he was a "fucking bitch" and "fucking [r-word]." SP1 said the r-word "quite a few times," which C1 and C2 hear but did not get on the video.

- After the incident on the stairs, SP1 took the VA to the bathroom and pushed the VA "into the shower." The VA turned on the shower and got wet. SP1 was trying to get the VA to turn off the shower and also got wet. After about 25 minutes, the VA "decided" to go to bed. The following morning, the VA was "scared" to come out of his/her bedroom because of SP1. However, SP1 was already gone when the VA came out because his/her shift had ended. SP1 "lost [his/her] cool" and the incidents were "scary" and "traumatic." There were no prior similar incidents with SP1.

- SP2 observed the incident in the entryway but did not do "anything to help" the VA and SP2 did not see the incident in the bathroom.

The *crow Wing County Sheriff's Office Incident Report*, photos of the VA's injuries, and video footage from the incident provided the following information:

- Video footage taken by C1 during the incident, which appeared to be taken from the top of the stairwell, showed the VA sitting on the floor in the stairway landing and SP1 standing near the VA. SP2 stood towards the bottom of the steps in the middle of the stairwell, partially blocking the view of SP1 and the

VA. The VA "reached up" towards SP1 and SP1 "responded" by "pushing" the VA to the floor. The VA then sat up and reached his/her arm towards SP1's leg and SP1 "responded again by pushing [the VA] to the ground." The VA again sat up and continued to try and reach out towards SP1's legs. SP1 said "stop" and kicked the VA "several times" which this investigator counted to be three times.

- Undated photos taken by staff persons of the VA's injuries showed that the VA had "visible bruises" on both of his/her legs and arms. The VA also had a red scratch on the left side of his/her face, from his/her hairline to the corner of his/her eye.

- Law enforcement spoke to SP2 who said that on the night of the incident, s/he worked with SP1. During the night, the VA was "trying to fight" with C1 and C2, including "jumping" on a table to try and "get" C1 and C2. SP1 and SP2 were able to "separate" the VA, C1, and C2 and the VA went outside. When the VA came back inside, s/he had a stick and "threatened to stab everyone." SP2 was able to get C1 and C2 upstairs but C1 and C2 were "upset" so SP2 stood at the bottom of the stairs so that they did not "attack" the VA. During this time, the VA "hit" SP2 because s/he was trying to get past SP2 to get to C1 and C2. SP1 then "got [the VA] to the ground" and pushed the VA down with his/her foot to keep the VA from getting up. SP2 did not recall the number of times that SP1 used his/her foot to keep the VA "down" but said that it was "at least a couple of times." SP1 also told the VA to "stop." SP2 said that the incident occurred "quickly" and felt "wrong." However, SP2 "froze up" because s/he had been in "domestic incidents" and the incident "triggered" him/her. SP2 said that s/he "should have done something but did not." SP2 described SP1's interactions as "a little excessive" and said that the incident "should have never happened."

- After about 20 minutes, SP1 was able to get the VA to "calm" and then SP1 and the VA went into the bathroom, where they shut the door. SP2 did not know what occurred while they were in the bathroom aside from the VA needing new clothing, which SP2 got for the VA, because the VA sat in the shower and "got wet."

- Law enforcement made several attempts to interview SP1 but was unsuccessful.

- The law enforcement investigation and possible charges were still pending at the time of this report.

C1 provided the following information:

- On an unknown date, around 3 or 4 a.m., C1 was asleep when s/he "awoke" to the VA "slamming doors" and saying it was his/her "goal" to "wake everyone up." Earlier that evening, the VA had been hitting and kicking SP1, SP2, C1, and C2 and climbing on tables trying to "get" others for "multiple hours." SP1 and SP2 had called supervisory staff persons "so many times that night" who said to give the VA space and for C1 and C2 to go in their rooms.

- C1 went upstairs with C2, because this was a "safe" place for the clients when the VA displayed behaviors. SP2 was on the stairs "blocking" the VA so the VA could not get upstairs to "hurt" C1 or C2. During this, C1 decided to video the VA's behaviors because the VA was trying to "attack" C1 and C2. However, as C1 was filming, C1 observed SP1 hit and kick the VA as s/he told the VA, "Stop." SP1 also "grabbed" the VA's shirt and neck and "threw" the VA against the wall, causing the VA to hit his/her head on the wall. C1 stopped recording and around this time, SP1 and the VA went to the bathroom to "talk." While in the bathroom, C1 heard a "big thud on the wall." However, SP1 had closed the bathroom door so C1 was not

able to see what happened. The VA was "yelling" and crying while in the bathroom but C1 thought that the VA was crying because s/he "felt bad" about the incident. When the VA came out of the bathroom, s/he had to change his/her clothes because s/he was wet. SP1 and the VA then talked to each other, and the VA told "everyone" that s/he was "sorry." C1 did not observe any injuries on the VA following the incident.

- C1 did not have any concerns with SP2 during the incident and said that SP1 "told" SP2 what to do, including to stand on the stairs so the VA could not get to C1 or C2. However, SP2 did not "stop anything" regarding SP1's interactions.

- SP1 had not done anything similar prior. However, on the date of the incident, SP1 "lost [his/her] temper" because the VA had been trying to hit SP1 for approximately five hours that evening.

C2 provided the following information:

- On an unknown date, the VA made "threats" to hurt C1 and C2. At some point, C1 and C2 were sitting at the top of the stairs when SP1 "blocked" the VA from going upstairs and SP1 hit and kicked the VA's shins. SP1 also "knocked" the VA onto the floor, "pinned" the VA to the floor, "smacked" the VA, and told the VA to "knock that crap off" because staff persons were "injured" because of the VA. SP1 also "swore" at the VA, including calling the VA a "bitch" and the r-word. SP2 was present and "let it all happen" and did not say anything.

- SP1 and the VA then went into a nearby bathroom so C2 went downstairs to see what was "happening" and saw the bathroom door open. SP1 was holding the VA in the shower and not letting the VA out. SP1 had also turned on the shower and the VA was "soaked."

- The incident "ended" when SP1 and SP2 told the VA that if s/he did not "knock it off," that they were going to take the VA's belonging out of his/her room. The VA "did not want that" so the VA, SP1, and SP2 "hugged" and apologized. C2 said that it was "really traumatizing" to watch a staff person "kick the crap out of someone."

- The following morning, the VA lifted his/her right pant leg and C2 saw that "everything" below the VA's knee had "black and blue spots everywhere." The VA also had a scratch above his/her left eye and a "big bruise" on his/her left shoulder.

- SP1 was typically "really nice." Following the incident, SP1 apologized and said that s/he was "seeing red the whole time" and did not "remember anything." SP1 also said that s/he had "pot brownies" in the car so C2 thought that SP1 was "under the influence of drugs."

P2 and the *General Event Reports* written by P2 provided the following information:

- On April 19, 2024, between 2 and 6 p.m., P2 was in the living room with the VA, C2, and a staff person (P4) when C2 told P2 and P4 that the VA "got whacked around like a pinball." P2 and P4 asked C2 what s/he meant and C2 said that SP1 "smacked" the VA against a wall and kicked the VA "multiple times." The VA then told P2 and P4 that s/he was "afraid" it was going to happen again. P2 assessed the VA and saw "some" bruises on the VA's left arm and leg near the VA's thigh and took photos. The VA also had an injury on his/her face which the VA said SP1 caused. However, P2 thought the injury on the VA's face may

have been due to the VA getting a "bunch of scrapes" due to running in the woods during a recent behavior that occurred on an unknown date prior to the incident. P2 and P4 then notified P1 and another supervisory staff person (P3).

- C1 had video of the incident which P2 watched. The video showed C1 at the top of the stairs and the VA sitting at the bottom. The VA was trying to hit SP1 and SP1 "kicked" the VA's leg and "pushed" the VA. P2 described it as "excessive force" by SP1. SP2 was standing on the stairway not doing or saying anything to "stop the abuse."

- The VA, C1, and C2 did not say anything about any incident in the bathroom with SP1.

- P2 had not worked a shift with SP1 and only saw SP1 in "passing." P2 did not have any concerns with SP1 during those interactions. SP2 was a "new" staff person and P2 thought that the incident occurred during one of SP2's first shifts. P2 described SP2 as "nice."

- When the VA displayed behaviors, staff persons were trained to redirect the VA, including to journal or go on a walk, which "worked well." Staff persons could also switch with another staff person so that the VA had a "fresh face."

P1, an undated text message from SP1 to P1, and an undated text message from SP1 to C1 provided the following information:

- On the overnight of April 18 and 19, 2024, P1 received a "couple" text messages from SP1 stating that the VA was "starting to escalate a little bit." P1 told SP1 to keep him/her "updated." Around 2 a.m., when P1 was asleep, s/he received a "few" text messages from SP1 stating that the VA was "starting to act up" and that the VA had "never done that before" but P1 did not see the text messages until the following morning and never got any phone calls. SP2 was also working but P1 did not get any texts or call from SP2. The following morning when P1 went to the facility for his/her scheduled shift, the VA's behaviors were "resolved."

- Later that day, P2 told P1 that s/he was "concerned" about how SP1 and SP2 responded to the VA's behaviors the prior evening because C1 or C2 told P2 that SP1 put the VA in a "chokehold." P1 then watched C1's video from the incident which showed that SP1 kicked the VA a "few times." Additionally, SP1 put his/her hand near the VA's shoulder or head and "shoved" the VA "over to the side." P1 did not see the VA in a chokehold. P1 said his/her "stomach dropped right away" when s/he watched the video.

- The video footage had sound and during the footage, the VA "slowly" reached towards SP1 and SP1 "kept saying stop." Additionally, SP1 said "rude" things to the VA including that SP1 would make it "really fucking hard" for the VA. P1 did not hear SP1 call the VA the r-word and was not told that SP1 did so.

- During the incident, SP2 was "just standing on the stairs" and did not do anything. The incident occurred during SP2's second shift at the facility.

- P1 was not aware of any other concerns, including any incident in the bathroom.

- P1 saw photos of bruises on the VA's leg, near the VA's shins, which were in the same area that P1 saw SP1 kick the VA in the video. The VA told P1 that s/he was "okay" and the VA did not require any medical attention.

- The VA displayed behaviors such as slamming doors, turning on the porch faucet, sitting in the middle of the road, and attempting to hit staff persons or clients. The VA could be a "little challenging" when s/he displayed behaviors but was "easily redirected." Staff persons were trained to give the VA "space" if the VA was not harming him/herself or others. Staff persons could also use a "firmer tone" or give the VA a hug. If the VA was harming other clients or staff persons, staff persons could implement a manual restraint. During the incident, SP1 should have "backed away" from the VA if SP1 was "too overwhelmed" and had SP2 assist. Additionally, SP1 and SP2 should have called P1 for help instead of texting because P1 "could not hear" the text message. The VA had a history of displaying behaviors at night and when staff persons called P1, P1 could typically "bring [the VA] back down to a level" where the VA could go back to sleep and be at "baseline."

- SP1 had never done anything similar prior and was "always person centered" and "friendly."

- Following the incident, SP1 messaged C1 on social media. In the message, SP1 asked C1 "how long" s/he recorded him/her. SP1 also said s/he was "sorry" for the incident" and said that s/he had "blacked out." SP1 told C1 that s/he got "defensive" when the VA "threatened to go after" C1 and C2 and that s/he "should not have overstepped [his/her] role" but that s/he wanted to "protect" C1 and C2 from the VA.

- SP1 also sent P1 a text message after the incident stating that s/he wanted to "explain" the incident to P1. SP1 told P1 that the video footage did not show the VA "stalking" SP1, including into the bathroom. SP1 told P1 that the VA "pounded" on a window and tried to see SP1 while SP1 was using the toilet. SP1 also told P1 that the VA hit SP1 "five times" in SP1's genital area and a "couple" times on his/her head. SP1 also said that did not give SP1 any "reason for what [s/he] did" and SP1 was "disappointed" in him/herself. SP1 also told P1 that "lack of sleep" and not having his/her "medications" for two weeks "did not help any of it either." P1 did not respond to SP1's text.

The G said that the facility notified him/her of the incident. The VA did not say anything to the G about the incident but typically, the VA told the G when s/he had concerns. The G did not see the VA following the incident so did not see any injuries. The VA did not receive any medical attention. The incident "caught [the G] by surprise" because s/he had a "really good experience" with the facility.

The *Rights of Persons Served* said that a person's service-related rights included the right to be free from maltreatment, including "fear of abuse" and to be treated with courtesy and respect.

The *Policy and Procedure on Reporting and Review of Maltreatment of Vulnerable Adults* said that all staff persons at the facility who encountered maltreatment of a vulnerable adult were "to take immediate action to ensure the safety of the person(s) served," including reporting within 24 hours. This included physical abuse.

Facility documentation showed that SP1, SP2, P1, and P2 were trained on the VA's plans and on the facility policy and procedures, including client rights and the Reporting of Maltreatment of Vulnerable Adults Act, prior to the incident.

Relevant Rules and/or Statutes:

Minnesota Statutes section 245D.04, subdivision 3, paragraph (a), clause (6) states that a person's protection related rights include the right to be treated with courtesy and respect.

Conclusion:

A. Maltreatment:

The VA's *Positive Behavior Support Plan* stated that the VA had a history of verbal and physical aggression towards others. The VA had difficulty respecting boundaries and communicating with others appropriately. The VA wanted to develop positive coping skills to improve self-control around handing situations that caused the VA to become "angry" including "tension reduction techniques" such as taking deep breaths, listening to music, or disengaging from staff to a quiet area. Staff persons were to keep their voice "calm and polite" and were to "validate" and listen to the VA.

The VA's *Individual Abuse Prevention Plan* and *Self-Management Assessment* said that the VA could become aggressive towards others if "provoked" and may hit someone if the VA were hit first or if someone were "upsetting" the VA. Staff persons were to intervene to keep the VA safe, including stepping between the VA and the other person and/or moving the VA to a safe environment.

Regarding physical abuse:

Information from all sources was consistent that on April 18 and 19, 2024, SP1 and SP2 worked at the facility for the overnight shift. During the night, the VA displayed aggressive behaviors towards SP1, SP2, C1, and C2. At some point, C1 and C2 were upstairs while SP1, SP2, and the VA were at the bottom of the stairs. Information was consistent from video footage, the VA, C1, and C2 that SP1 kicked the VA and pushed the VA. Although it was not observed on the video footage, the VA also said that SP1 put his/her knee against the VA's head and then choked the VA by putting his/her hand around the VA's neck. C2 also said that SP1 "pinned" the VA to the floor and "smacked" the VA. Additionally, C1 said that SP1 threw the VA against the wall, causing the VA to hit his/her head.

Although SP2 did not respond to this investigator's attempts for an interview, SP2 told law enforcement that SP1's interactions were "a little excessive." SP2 also told law enforcement that SP1 pushed the VA down with his/her foot to keep the VA from getting up. SP2 did not recall the number of times that SP1 used his/her foot to keep the VA "down" but said that it was "at least a couple of times."

Following the incident, the VA had bruises on both his/her legs and arm. P1 said that the bruises on the VA's legs were in the same area where SP1 kicked the VA in the video. In addition, the VA had a red scratch on the left side of his/her face, from his/her hairline to the corner of his/her eye. While P2 thought the injury on the VA's face may have been due to the VA getting a "bunch of scrapes" due to running in the woods during a recent behavior that occurred on an unknown date prior to the incident, there was no other information provided that the VA had a scratch on his/her face prior to the incident.

SP1's actions as described by C1, C2, the VA, and SP2 were not accidental or therapeutic conduct; were inconsistent with the VA's *Positive Behavior Support Plan* and *Individual Abuse Prevention Plan* and *Self-Management Assessment*; and were a violation of Minnesota Statutes section 245D.04, subdivision 3, paragraph

(a), clause (6). Given the aforementioned consistent information from multiple persons and video footage, there was a preponderance of the evidence that SP1 kicked and pushed the VA, put his/her knee against the VA's head, pinned the VA to the floor, smacked the VA, and threw the VA against a wall, causing the VA to hit his/her head and sustain bruises on his/her arms and legs and a scratch on his/her face, which produced injury and could reasonably be expected to produce physical pain to the VA.

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).

Regarding emotional abuse:

The VA said that during the incident, SP1 told the VA that s/he was a "fucking bitch" and "fucking [r-word]," and that SP1 said the r-word "quite a few times." Although there was no video footage of SP1 saying these things, C2 provided information that was consistent with the information provided by the VA that SP1 called the VA a "bitch" and the r-word. SP1's swearing at the VA and calling the VA the r-word was and a violation of Minnesota Statutes section 245D.04, subdivision 3, paragraph (a), clause (6).

Although there was no information provided that SP1 had used repeated or malicious language in the past towards any client, given that the use of the r-word as an insult is generally considered to be derogatory when used towards any person and was particularly egregious especially towards a person who lived in a residential setting and was diagnosed with mild intellectual disability, there was a preponderance of the evidence that SP1's use of calling the VA the r-word during the incident would be considered by a reasonable person to be disparaging, derogatory, humiliating, or harassing, or threatening and could produce or reasonably be expected to produce emotional distress.

It was determined that emotional abuse occurred (conduct which is not an accident or therapeutic conduct which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to: the use of repeated or malicious oral, written or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, or harassing, or threatening).

Regarding neglect:

Video footage and information from the VA, SP2, C1, and C2 was consistent that SP2 witnessed SP1's interactions with the VA that included kicking and pushing the VA, putting his/her knee against the VA's head and then choked the VA by putting his/her hand around the VA's neck, "pinning" the VA to the floor and "smacking" the VA, throwing the VA against the wall, causing the VA to hit his/her head, and swearing at and calling the VA derogatory names including the r-word. However, SP2 did not intervene to protect the safety of the VA or take any additional action to notify any supervisory staff persons or any other persons or entities about the incident. Therefore, there was a preponderance of the evidence that there was a failure to supply the VA with care or services which were reasonable and necessary to maintain the VA's health or safety.

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;
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> (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.

On April 18 and 19, 2024, SP1 and SP2 were responsible for providing care and supervision to the VA. SP1 and SP2 were trained on facility policies and procedures including *Rights of Persons Served* which stated that a person's service-related rights included the right to be free from maltreatment, including "fear of abuse" and to be treated with courtesy and respect and *Policy and Procedure on Reporting and Review of Maltreatment of Vulnerable* which stated that staff persons were to take "immediate action" to ensure the safety of persons served in the event of maltreatment. SP1 and SP2 were also trained on the VA's plans, and the reporting of Maltreatment of Vulnerable Adults Act.

However, despite this on April 19, 2024, SP1 kicked and pushed the VA, put his/her knee against the VA's head, pinned the VA to the floor, smacked the VA, and threw the VA against a wall, causing the VA to hit his/her head. In addition, SP2 failed to intervene with SP1's abusive behavior, failed to seek help in order to protect the VA from harm, failed to notify any supervisory staff persons or any other persons or entities about the incident and told law enforcement that s/he "should have done something but did not."

Therefore, SP1 and SP2 were each 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 physical and emotional abuse for which SP1 was responsible was not "recurring" maltreatment because it was a single incident but was "serious" maltreatment because it resulted in bruises on the VA's legs and arms.

It was determined that the substantiated neglect for which SP2 was responsible was not recurring or serious maltreatment because it was a single incident and SP2's actions did not cause the serious injury to the VA. However, Minnesota Statutes, section 245C.15, subdivision 4, paragraph (b), clause (1) states in part that an individual is disqualified under section 245C.14 when an individual failed to make required reports under section 626.557 for incidents in which (i) the final disposition under section 626.557 was substantiated maltreatment, and (ii) the maltreatment was serious or recurring. Therefore, SP2 was disqualified from providing direct contact services.

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were adequate but not followed. This included the rights of persons served, including the right to live without "fear" of abuse and mandated reporting. SP1 and SP2 no longer worked at the facility.

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

SP1 was notified that s/he was responsible for recurring and serious maltreatment and that any future background studies for facilities, programs, organizations, and/or agencies that are required to have individuals complete a background study by the Department of Human Services as listed in Minnesota Statutes, section

245C.03, will result in his/her disqualification. The determination that SP1 was responsible for maltreatment is subject to appeal.

SP2 was disqualified from a position allowing direct contact with, or access to, persons receiving services from programs, organizations, and/or agencies that are required to have individuals complete a background study by the Department of Human Services as listed in Minnesota Statutes, section 245C.03. The determination that SP2 was responsible for maltreatment and the disqualification of SP2 are each subject to appeal.

Given that the facility took immediate corrective action, a Correction Order was not issued for the violations outlined in this report.