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: 202406062

Date Issued: January 8, 2025

Name and Address of Facility Investigated:

Disposition: Inconclusive

MSOCS Afton
14829 70th Street South
Hastings, MN 55033

Minnesota Community Based Services
3200 Labore Road, Suite 104
Vadnais Heights, MN 55110

License Number and Program Type:

1096994-H_CRS (Home and Community-Based Services-Community Residential Setting)
1070559-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a vulnerable adult (VA) left the facility without the knowledge or supervision of staff persons and that while unsupervised, the VA sustained burned feet and scraped knees, and a head laceration.

Date of Incident(s): July 11, 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 August 12, 2024; from documentation at the facility, law enforcement records, and medical records; and through interviews conducted with the VA's guardian (G), the VA's case manager (CM), facility staff persons (SP1, SP2, P1, P2, and P3), a facility nurse (P4), and a supervisory staff person (P5). Two attempts were made to interview the VA; however, each time, the VA was unavailable so not interviewed; however, s/he provided information to P1 and a healthcare professional (HCP), which was included in this report.

The VA's support plans provided the following information:

- The VA's *Identifying Information* stated that in February 2022, s/he moved into the facility seeking supports and services relating to his/her diagnoses, which included schizophrenia disorder.

- The VA's *Self-Management Assessment* stated that the facility provided the VA with 2:1 staffing between 7 a.m. and 3 p.m.; 3:1 staffing between 3 and 11 p.m.; and 1:1 staffing between 11 p.m. and 7 a.m. Staff attempted to build a "strong" relationship with the VA by using consistent communication, trust, and validation of the VA's feelings. In the event the VA's anxiety was "high," staff encouraged the VA to "relax" in a chair, listen to music, and/or use his/her "breathing techniques." The VA had a history of leaving the facility without the knowledge or supervision of a staff person and tended to leave and go into vehicle traffic "due to poor safety skills and anxiety." Staff intervened when necessary to ensure the VA's safety. "Staff will be aware of [the VA's] whereabouts by completing a personal check-in with [him/her] every 30-minutes."

- The *Coordinated Service and Support Plan Addendum* stated, "All staff conduct 15-minute verbal check-ins with [the VA]." "[The VA] cannot come and go from the [facility] at will without staff with [him/her]."

The facility was a single-family home set off a highway by a longer driveway. The highway was two-lanes with a 55 mile per hour (mph) speed limit. The surrounding area included large forests, country roads, farms, and crop land. The facility was about 0.5 miles from an entrance to Afton State Park, which was just past an intersection with another 55 mph highway.

The facility was a duplex. The VA was the sole occupant on the basement level ("downstairs") and another housemate (H) was the sole occupant on the main level ("upstairs"). Downstairs, there was a large living room centrally located. The VA's bedroom was off the southwest corner of the living room. A staff office was in the northeast corner and a bathroom was in the southeast corner. There was a kitchenette next to the bathroom. It was possible to see into the kitchenette from the office and see into the VA's bedroom from the living room. The VA's bedroom had two windows; one window was an egress, which slid open and was able to be exited in an

emergency. The VA's bedroom door was lockable with staff having a key. The facility provided separate staff for the VA and the H; however, the staff could assist one another if needed.

A law enforcement report and the VA's medical records included the following information:

- On July 11, 2024, at 2:12 p.m., 9-1-1 dispatch received a call requesting assistance to the facility to help search for the VA, who was missing. An unidentified staff person told the responding law enforcement officers (LEO) that the VA had been missing "up to 90 minutes."

- Nearing the facility, the LEOs saw the VA sitting down on a biking/walking paved trail adjacent to the highway just prior to the state park entrance. [Note: According to bing.com, this location was about 0.3 miles from the facility.]

- The VA had "a significant amount of blood" on his/her forehead and face.

- When the LEOs approached the VA, the VA attempted to hit an LEO and spat on another. The LEOs restrained the VA to the ground and the VA began hitting his/her head repeatedly against the pavement. The LEOs placed a soft object under his/her head and waited for an ambulance. Upon arrival, emergency medical services provided the VA with oxygen, and while being helped into the ambulance, the VA punched an LEO in the face.

- After the ambulance left, the LEOs cleared the scene with no further or follow-up actions taken against the VA. [Note: The law enforcement report did not state what time the LEOs found the VA alongside the highway and/or when the VA left by ambulance.]

- At 3:41 p.m., the VA arrived at the emergency room. A healthcare professional (HCP) administered a procedural sedation and an antipsychotic to the VA, and sodium chloride intravenously.

- The VA told the HCP that earlier that day, s/he heard voices telling him/her to hurt people, and so s/he went into his/her bedroom to avoid facility staff. The VA then left the facility through his/her bedroom window. The VA was supposed to always take his/her portable oxygen machine with him/her but did not. The VA was in the community for "about an hour" and then fell into a ditch hitting his/her head.

- While being assessed in the emergency room, the VA punched the HCP's chest.

- The HCP checked the VA for broken bones and head injuries, which were negative, and the VA's blood laboratories were within normal limits. The VA was diagnosed with left knee pain after a fall, left foot pain and skin tear after a fall, and a large frontal hematoma after a trauma or a fall.

- Later that evening, the VA was discharged back to the facility and instructed to return if his/her symptoms worsened and/or to follow up with his/her primary care physician if needed. The VA was not prescribed new medications or referred for any specific follow-up care.

SP1 and SP2 provided the following information:

- On July 11, 2024, between 7 a.m. and 3 p.m., SP1 and SP2 were assigned to work downstairs with the VA;

and P2 and P3 were assigned to work upstairs with the H. The VA was sleeping in his/her bedroom when SP1 and SP2 arrived. [Note: Around 1:30 or 2 p.m., P4 arrived for unrelated reasons but was not scheduled to work, and P5 arrived at some point to work in his/her office, which was upstairs.]

- Around 9:30 a.m., SP1 administered the VA's medications. Around 10 a.m., the VA was up and watching Price is Right with SP2 in the living room. SP1 completed paperwork in the nearby staff office. At 10:58 a.m., the VA told SP1 that s/he had a headache. SP1 administered an over-the-counter pain reliever. Around 11 a.m., the VA ate breakfast and after breakfast, the VA went into his/her bedroom.

- According to SP1, this was a "typical" morning routine. "[The VA] was in a great mood that day."

- Around noon, the VA came out of his/her bedroom and ate lunch in the kitchenette. SP1 sat with the VA and SP2 was in the staff office.

- According to SP2, while watching them in the kitchenette, s/he saw the VA attempt to punch SP1; however, SP1 verbally redirected the VA without further incident. According to SP1, the VA did not have any maladaptive "behaviors" that day.

- SP1 and SP2 each said that after lunch, the VA went into his/her bedroom. Around 1:15 or 1:20 p.m., the VA came out and used the bathroom.

- According to SP2, when the VA was walking back to his/her bedroom, s/he attempted to "forcefully" enter the staff office. SP1 redirected the VA, who went back into his/her bedroom without further incident around 1:20 p.m.

- According to SP1, the VA "kicked" the office door, but it was not intentional. The VA "bumped" the door. SP1 did not believe the VA was trying to enter the office.

- Before entering his/her bedroom, the VA asked staff that his/her 2:30 p.m. medications be administered at 2 p.m. that day. SP1 called P4, who said that this was okay to do.

- At 1:40 p.m., SP1 and SP2 both went to the VA's bedroom door and knocked; however, the VA did not answer. SP1 and SP2 decided to check on the VA later and left without opening the door or hearing the VA in the room.

- At 1:55 or 1:57 p.m., SP1 and SP2 both returned to the VA's bedroom door with his/her medications and again, after knocking, the VA did not answer. SP2 unlocked the door using the staff key. SP2 said, "I saw [the VA] was not there so immediately I went upstairs and couldn't find [the VA]." SP1 said, "[The VA] wasn't there ... The (bedroom) window was open."

- SP2 told the staff upstairs (P2-P5) that the VA was missing. P2 remained inside with the H, while the rest searched the premises but did not find the VA. SP1, SP2, P4, and P5 used vehicles to search while P3 walked the area. SP1 believed the VA was "hiding" from them. SP1 and SP2 drove towards Afton State Park and saw the LEOs with the VA. SP2 said, "I saw [the VA] sitting on the ground" trying to hit the LEOs. The VA had cuts on his/her forehead and knees. The LEOs called for an ambulance. SP2 and P5 remained with the VA waiting for the ambulance while the other staff returned to the facility.

- SP1 and SP2 each believed they searched for the VA about 30 minutes before finding him/her with the LEOs. They did not know how much time passed between when the VA left through his/her window and when the search began.

- SP2 said that the weather that day was "very nice, warm ... maybe 70 (degrees) ... not cold."

- SP1 and SP2 each said that at the time of the incident, there was no protocol in place regarding what staff should do if the VA left the facility unsupervised or regarding how often staff should check on the VA when s/he was in his/her bedroom.

- SP1 said that when s/he was initially trained on the VA, s/he was told that if the VA was "showing aggression" or "hitting," staff should complete 15-minute checks on the VA. Regarding the day of the incident, SP1 said, "There weren't any signs ... no signs [the VA] was struggling at all." SP1 did not know why the VA left without staff on the day of the incident.

- SP2 said that on the day of the incident, s/he saw the VA attempt to punch SP1 in the kitchenette and attempt to "forcefully" enter the office. However, that said, when SP2 was initially trained on the VA, s/he was told to give the VA space if s/he was "exhibiting behaviors." "The best way to deal with [him/her] anytime [s/he] is exhibiting behaviors is to give [him/her] space."

- SP1 could not recall the last time the VA left without supervision prior to the incident and said that it did not happen very often. SP1 was not aware of previous times the VA left unsupervised through his/her bedroom window.

- SP2 was aware the VA had a history of leaving without supervision but that this incident was the sole time it happened when SP2 was working.

- SP1 and SP2 each said that the VA's window had an alarm, which "beeped" when the window was opened; however, at the time of the incident, the installation of the alarm was such that it only beeped in the upstairs staff office. The alarm was not audible downstairs. The upstairs staff were responsible for alerting the downstairs staff if an alarm occurred. SP1 and SP2 were not informed of any alarm by P2 and P3, and P2 and P3 each told them they did not hear any alarms that day.

The facility's *Internal Review* and P1-P5 provided the following information:

- Around 2 p.m., SP2 ran upstairs and told P2-P5 that the VA was "gone," and that the VA's bedroom window was open. P2 and P3 each said that the VA's window alarm did not beep in the upstairs staff office as it was supposed to. P5 wondered if the window was already open from the night prior for fresh air purposes, and so therefore, was not alarmed at the time. The alarm system was such that it only beeped when the window was first opened but would not continue beeping if it remained open.

- P2 stayed inside with the H while SP1, SP2, and P3-P5 searched the yard and could not find the VA. P5 then drove his/her vehicle on the highway searching while SP1, SP2, and P4 were in another vehicle and P3 walked the area. At 2:06 p.m., P5 called 9-1-1. SP1, SP2, and P3-P5 provided consistent information that about 2:30 p.m., law enforcement found the VA at the entrance to Afton State Park, "a half mile up the street." The VA had "bruises" and/or "was bleeding" from his/her forehead and an ambulance took

him/her to the emergency room.

- P1 said that on July 12, 2024, the VA told him/her that at the time of the incident, s/he was "upset" and went into his/her bedroom. The VA lay down for about five minutes before getting up and leaving through his/her bedroom window. The VA went through the backyard gate, down the driveway, and onto the highway. The VA walked in the middle of the highway and at least one passerby stopped their vehicle to check on the VA and told him/her to get out to the street. The VA continued walking for "a long time," and felt "really hot" and exhausted." The VA fell and rolled into a ditch with rocks. The VA stayed there until the LEOs found him/her.

- Following the incident, P5 reviewed daily notes and interviewed staff persons and had concerns with the information provided. Staff did not document what times the VA went into his/her bedroom or what happened between 10:58 a.m. and 1:40 p.m. At 1:40 p.m., SP1 and SP2 knocked on the VA's door and the VA did not answer so the staff left. "They decided to give [the VA] space without ensuring [s/he] was in the room." "My concerns were that [the VA] has no alone time." At least one staff should have remained within "earshot" of the VA's bedroom. That said, P5 also said that there was not a written protocol in place for how often staff should check on the VA when in his/her bedroom. "Which is something that is kind of strange if you have [a person who leaves without supervision (e.g. the VA)]. I am sure there are plans somewhere but not sure if they were kept." [Note: In June 2024, P5 took over his/her position at the home from a previous supervisor, who created the VA's support plans. P5 was told that the former supervisor proposed implementing five-minute checks on the VA when in his/her bedroom; however, P5 could not find any documentation that this was implemented or that staff received training on this change.] Following the incident, P5 created an *Elopement Protocol*, and a protocol that staff must remain within auditory range of the VA and check on the VA every 15 minutes when in his/her bedroom.

- P5 also said that at the time of the incident, the window alarm system only beeped in the upstairs staff office. Again, the previous supervisor had the alarm system installed this way and P5 was told this was due to an unidentified person's "noise sensitivity issues." The facility leased the home and so needed the landlord's approval to make changes. P5 was also told that the alarm system was "old" and could not be changed without installing an entirely new system. Following the incident, that same day, P5 reached out to the landlord and ordered the installation of new window sensors and an alarm receiver for the downstairs staff office.

- P1-P4 provided information that at the time of the incident, "There was never really a protocol in place." Some staff checked on the VA "periodically" when in his/her bedroom or gave the VA "space" when his/her "anxiety (was) low," and some only checked on him/her if s/he was experiencing "aggression." P1 said that s/he got "that jive something isn't right," s/he "occasionally" knocked on, or listened through, the VA's bedroom door, which according to P1, should occur at least every 30 minutes. Following the incident, P1-P4 were instructed to check on the VA every 15 minutes by knocking on the door and/or by sitting outside the door listening for noises.

- P2, P3, and P5 were not aware of previous times the VA left unsupervised through his/her bedroom window. P5 said that historically the VA left by going up the stairs and out the garage door.

- P4 said that the VA left without supervision one other time when s/he was working but otherwise, the incidents were "kind of spaced (out)."

- The facility's *Internal Review* stated that most recent time of the VA leaving without supervision prior to the incident was September 29, 2022.

The G said that the VA had a history of running outside and into the street; however, staff had been good about keeping the VA within sight and intervening. The G was not aware of a specific time-requirement when staff should be checking on the VA when in his/her bedroom. The VA did not have known triggers and might be calm one minute and then "freaking out" the next. "This is the first time with [the VA] climbing out the window." The G believed that the facility overall did a "great job." Since the incident, the facility installed additional alarms and increased checks, which the G believed was "sufficient" for preventing a similar situation in the future.

The CM did not have prior concerns with the facility's overall care and supervision of the VA.

The facility's *Program Abuse Prevention Plan* stated that staff were to always be on the premises when the individuals were home and remain within "auditory or visual distance" of the individuals. Individuals had privacy in their bedroom and in the bathroom, "which are areas in which individuals are not supervised."

The facility's *Incident Response Policy* stated that in the event an individual was missing, staff called 9-1-1 and followed instructions given by emergency personnel.

Facility documentation and information obtained during interviews stated that SP1, SP2, and P1-P5 were trained on the VA's *Identifying Information, Self-Management Assessment* which stated, "Staff will be aware of [the VA's] whereabouts by completing a personal check-in with [him/her] every 30-minutes," and *Coordinated Service and Support Plan Addendum* which stated, "All staff conduct 15-minute verbal check-ins with [the VA];" the facility's *Program Abuse Prevention Plan* and *Incident Response Policy*; and the Reporting of Maltreatment of Vulnerable Adults Act.

Relevant Minnesota Statutes and Rules:

Minnesota Statutes, Section 245D.07, subdivision 1a, paragraph (a), states the license holder must provide services in response to the person's identified needs, interests, preferences, and desired outcomes as specified in the coordinated service and support plan and the coordinated service and support plan addendum, and in compliance with the requirements of this chapter. License holders providing intensive support services must also provide outcome-based services according to the requirements in section 245D.071.

Minnesota Statutes, Section 245D.09, subdivision 3, paragraph (a), states in part that the license holder must ensure that staff providing direct support are competent to meet the person's needs and requirements as written in the support plan and support plan addendum.

Conclusion:

Information was provided that on July 11, 2024, at some point between 1:20 and 1:57 p.m., the VA left the facility through his/her bedroom window without SP1 and SP2 knowing. At 1:55 or 1:57 p.m., SP1 and SP2 discovered the VA was missing, alerted P2-P5, and they searched the surrounding area. Around 2:30 p.m., law enforcement officers found the VA about 0.3 miles from the facility. The VA had fallen and sustained injuries to his/her forehead, knees, and feet. The VA was taken to an emergency room where s/he received intravenous fluids. The

VA was discharged later that evening with no new medications or referrals for follow-up care.

The VA's *Self-Management Assessment* and *Coordinated Service and Support Plan Addendum* provided different information regarding how often staff persons were to check on the VA. The *Self-Management Assessment* stated, "Staff will be aware of [the VA's] whereabouts by completing a personal check-in with [him/her] every 30-minutes," and the *Coordinated Service and Support Plan Addendum*, which stated, "All staff conduct 15-minute verbal check-ins with [the VA]." The different information in the VA's plans and staff persons failure to check on the VA between 1:20 and 1:57 p.m. were violations of Minnesota Statutes, Section 245D.07, subdivision 1a, paragraph (a).

In addition, SP1, SP2, P1, P2, P3, and P4 each provided consistent information that there was no plan/protocol in place for checking on the VA. Given that 15- and 30-minute checks were outlined in the VA's plans and that information showed that SP1, SP2, P1, P2, P3, and P4 were trained on the VA's plans yet none were able to articulate what information the plans provided regarding the VA's checks, this was a violation of Minnesota Statutes, Section 245D.09, subdivision 3, paragraph (a).

However, it was unknown when the VA left through the window and even had staff persons completed either 15- or 30-minutes checks, the VA still could have left the facility without staff knowing. Therefore, there was not a preponderance of the evidence whether there was a failure to supply the VA with care or services, which was reasonable and necessary for the VA's health and safety.

It was not determined whether 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).

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were adequate. The VA's support plans were not followed in that staff did not provide "adequate supervision" of the VA. The facility retrained staff on the VA's support plans, created an *Elopement Protocol*, and purchased motion sensors which alerted into the downstairs staff office.

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

On January 8, 2025, the facility was issued a Correction Order for the violations outlined in this report.