

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: 202403489

Date Issued: January 10, 2025

Name and Address of Facility Investigated:

Disposition: Substantiated as to neglect of a vulnerable adult by the facility

REM Arrowhead, Inc. - Wallace
1224 Foster Avenue
Duluth, MN 55811

REM Arrowhead Inc.
6600 France Avenue South, Suite 350
Minneapolis, MN 55435

License Number and Program Type:

1071677-H_CRS (Home and Community-Based Services-Community Residential Setting)
1071667-HCBS (Home and Community-Based Services)

Investigator(s):

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Minnesota Department of Human Services
Office of Inspector General
Licensing Division
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Suspected Maltreatment Reported:

It was reported that a vulnerable (VA) passed away after choking on food that a staff person (SP) did not prepare in a manner consistent with the VA's support plan. During the course of the investigation, it was also reported that the SP did not call 9-1-1 in a timely manner after the VA began to choke.

Date of Incident(s): April 20, 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 May 1, 2024; from documentation at the facility; from records from a fire department, an ambulance service, and a medical examiner; and through interviews conducted with three facility staff persons (P1, P2, and the SP) and a family member/guardian (FM) of the VA.

The VA's diagnoses included autism and a seizure disorder. The VA communicated using vocalizations and limited speech. The VA was 44 years old at the time of his/her death.

The VA enjoyed going for car rides, walks, eating blizzards from Dairy Queen and cheeseburgers from McDonalds, shopping to pick out his/her own snacks, and Spiderman.

The VA's *Coordinated Services and Supports Plan* dated October 24, 2023, stated that the VA was at risk for choking. The VA enjoyed eating and was fairly independent with eating after his/her food was set up. The VA had a tendency to eat very fast, which could cause choking. Staff persons were to cut the VA's food into bite sized pieces to make it easier for him/her to chew. Staff persons were to provide the VA with reminders to slow down while s/he was eating.

The facility's support plans dated October 25, 2023, for the VA stated:

- The VA ate very quickly and did not cut up his/her food into bite sized pieces. The VA would also "chug" his/her liquids in one attempt. Staff persons were to cut up the VA's food into bite sized pieces no bigger than one inch in size. Staff persons were to remind the VA to eat slowly and put his/her utensils down between bites. The VA was to be given beverages in a slow sip cup.
- The VA ate rapidly, sought out food, and would stuff food in his/her mouth. Staff persons were to provide the VA with "direct supervision" when eating or drinking. The VA was to sit upright in a chair at a 90 degree angle while eating and for at least 30 minutes after a meal.
- The VA required at least one staff person to be on the premises at all times.

The VA's *Aspiration and Choking Avoidance Plan* dated November 22, 2022, stated:

- Staff persons did not need permission to call 9-1-1.
- Staff persons were to call 9-1-1 and start emergency procedures as trained if any of the following occurred; the VA appeared to be actively choking such as s/he could not speak; was turning blue or was blue; was having difficulty breathing or was not breathing; or appeared gravely ill.

- Symptoms that required immediate attention were if the VA was gagging, gurgling, or coughing during or after eating or drinking. If one of those signs was observed, staff persons were to not allow the VA to continue to eat or drink and immediately report to the designated contact person for the facility or to a medical professional.

P1, P2 (a supervisory staff person), an administrative staff person (P3), and the SP provided the following information regarding the VA during mealtimes:

- P1, P2, and the SP each stated that the VA's food did not need to be cut up before the VA ate and P2 said "everyone knew" that staff persons did not need to cut up or dice the VA's food. P3 stated that depending on the food, the VA's food was to be cut up in bite sized pieces.
- P1 stated that in the past, due to the VA's medications, the VA was on thickened liquids but not anymore. P1 stated that the VA had a choking protocol where staff persons were supposed to stay in the kitchen with the VA or sit at the table to make sure s/he was not "cramming" food into his/her mouth. If the VA was "shoveling" food into his/her mouth, staff persons could take his/her plate away, encourage the VA to chew and swallow, and/or take a drink. The VA liked sandwiches because s/he could "cram" them into his/her mouth. If the VA ate a sandwich, staff persons were to cut the sandwich in half. Prior to the incident, P1 was not aware of any time that the VA choked.
- P2 stated that the VA used to be on a medication that made him/her lethargic, so doctors ordered thickened liquids and soft foods for the VA. Since the VA was no longer on that medication, the VA was able to eat regular foods and liquids. The VA was at risk for choking so staff persons were to monitor the VA when the VA ate. It was "well known" that the VA could eat regular foods and liquids if the VA was supervised by staff persons while s/he ate. When the VA ate, staff persons did not have to sit at the table with the VA, but staff persons needed to be right by the VA watching the VA. The VA still would "cram" food in his/her mouth that s/he liked such as pizza or sandwiches. If P2 gave the VA peanut butter sandwiches s/he cut them in half. If the VA was in a "cramming food type of mood," P2 would cut sandwiches into quarters. The VA could be given a whole hamburger to eat and would take normal bites and not have any issues eating it. Prior to the incident, P2 was not aware of any time that the VA choked.
- P3 stated that the VA used to be on thickened liquids but not at the time of the incident. Staff persons were to remind the VA to slow down when eating and if the VA did not, staff persons could take his/her plate away or cover the plate with their hand so the VA did not continue to put food into his/her mouth.

An administrative staff person (P4) stated that at the time of the VA's death, s/he was unable to find any doctor's orders pertaining specifically to the VA's diet.

The main level of the facility included a living room and an eat in kitchen. The kitchen table was in the kitchen lengthwise against a wall with room for one chair at each end and two chairs on the side. In the kitchen, there was a LifeVac, a device to assist if someone was choking.

A LifeVac was a portable, non-invasive, single-use suction device designed to clear an airway in the event of choking on an object. The LifeVac included a mask that was attached to a handle, similar to a plunger. The mask was fitted over the mouth and nose and the plunger type handle was pressed to create a strong pull or suction to

dislodge the object out of the throat to create a vacuum seal, similar to a hard cough. The steps were to be repeated to create a strong pull or suction to dislodge the object until successful. Once the item was dislodged, the LifeVac was removed.

The SP documented the following:

On April 20, 2024, at 6:20 p.m., [the VA] was sitting at the dinner table eating a peanut butter sandwich, [s/he] had a mouthful and wanted to get up and sit in [his/her] chair but asked [the VA] to please stay seated at the table and finish eating and swallow [his/her] food so [s/he] wouldn't choke so [s/he] still got up and started to choke and started to walk from the kitchen to the back door in the living room choking and trying to throw the sandwich up. I proceeded to help [the VA] back to the table to clear the airway and [s/he] started to fall to the floor in the kitchen and I caught [him/her] and layed [him/her] on the floor on [his/her] right side and continued to clear the airway. I messaged [P1] asking [him/her] to come back [as soon as possible] to help me and then tried to call [P2] then [P1] called back and told [him/her] what was going on and [s/he] asked if I called 9-1-1 and told [him/her] not yet but I will so let [him/her] go and called 9-1-1 and told the dispatch what was going on that [the VA] was choking on a peanut butter sandwich and [s/he] was on the floor and I was clearing out [his/her] airway and they asked me if [s/he] was breathing and I told them barely and the paramedics showed up within minutes and took over.

The facility's internal review stated that the facility reviewed screenshots of the SP's, P1's, and P2's phones from the day of the incident. At 6:24 p.m., the SP called P2 and texted P1, at 6:26 p.m., P1 called the SP, and at 6:28 p.m., the SP called 9-1-1.

A fire department report stated that they received the call on April 20, 2024, at 6:29 p.m. and arrived at the facility at 6.32 p.m.

An ambulance report stated that they received a call on April 20, 2024, at 6:30 p.m. and arrived at the scene at 6:41 p.m. When paramedics arrived, fire department responders were working on suctioning the VA's airway and doing chest compressions. Fire department responders said that they had been on the scene for three to five minutes. When they arrived, the VA had a pulse but lost the pulse soon afterward. Their suction unit was full and clogged with what they were able to get out of the VA's airway. Paramedics saw "a lot of the sandwich and peanut butter" in the VA's airway and suctioned the airway. Paramedics attempted defibrillation and ventilation, and initiated chest compressions, but were not successful in reviving the VA.

A Final Autopsy Protocol stated that the VA's cause of death was "apparent choking." The VA's airway was clear at autopsy due to it being removed by emergency medical services. The VA had natural disease including focal severe atherosclerotic coronary artery disease (narrowing of an artery that supplies blood to the heart), cardiomegaly (an enlarged heart likely due to hypertension), and nephrosclerosis (scarring of the kidneys likely due to hypertension). The VA also had multiple rib fractures consistent with cardiopulmonary resuscitation. The VA's toxicology was negative for tested substances.

The SP provided the following information about the incident in the internal review and in an interview with this investigator:

- On April 20, 2024, the SP arrived at the facility around 11 a.m. It was a normal work day with the consumers. P1 was also working. At about 6 p.m., after the VA took a nap, the SP prepared dinner for the VA. The SP made two peanut butter and jelly sandwiches for the VA and also gave the VA some juice to drink. The SP did not cut the sandwich into smaller pieces. The VA sat in a chair at the end of the table and the SP sat in a chair to the right of the VA. The SP was within arm's reach so s/he could grab the VA's plate which was what the SP typically did at mealtime with the VA because the VA overstuffing his/her mouth every day. The SP watched what the VA ate and everything was going fine. At some point, the VA "overstuffed" his/her mouth (the SP called it "chipmunk cheeks"). The VA then said that s/he was done eating and started to get up from the table. The SP asked the VA to stay seated, to finish chewing his/her food, and to swallow his/her food. The VA finished the first sandwich and reached for the second sandwich. The VA got more than halfway done with the second sandwich and had "chipmunk cheeks" again so the SP told the VA to finish what was in his/her mouth. The SP then went and got the VA more juice. The VA again got up and the SP asked the VA to sit down and chew his/her food. It took the VA about five minutes to eat the two sandwiches. Once the VA began eating, the SP watched the VA the whole time. Even when the SP got up to get the VA more juice, the SP continued to look at the VA.
- At that point, the VA walked toward the living room and started to choke. The VA first appeared like s/he was gagging and about to vomit. The VA walked to the back of the living room so the SP told the VA to come back to the kitchen and vomit in the trashcan. The VA started to walk toward the kitchen and the SP reached out for his/her hand to guide him/her so the VA would not go anywhere else. The VA pulled his/her hand away. The SP put his/her hand on the VA's back and patted the VA's back to clear anything. At some point, the SP started to panic. The VA leaned over the trashcan for a minute or two and nothing came out. The VA then stood back up and looked at the SP, the SP asked the VA if s/he was going to vomit. The SP asked the VA to go sit at the table, but the VA walked toward the living room. At that time, another consumer (C) saw that the SP was trying to get the VA to sit down so the C tried to grab the VA's hand, but the VA pulled his/her hand away. After that, the SP was able to get the VA to sit down at the kitchen table. During that time, the SP tried to clear the VA airway with his/her fingers, but at one point the VA bit the SP's hand.
- When the VA sat down, the VA leaned to his/her left side against the wall and then leaned back and the chair began to tip backward. The SP caught the chair and lowered the VA to the floor. At that point, the VA was gagging and gasping for air and the SP was using his/her fingers to try and clear as much as s/he could from the VA's mouth. The SP said that from the time the VA stood up from the table until the time the VA was on the floor about six minutes elapsed.
- After the VA was on the floor, the SP remembered the LifeVac that was on the kitchen counter and the SP used it on the VA. It seemed to be working as the VA moved as though s/he was going to throw up. The SP used the LifeVac four times and after each time using it, the VA gagged like s/he going to throw up and the SP was able to clear more food out of the VA's mouth.
- Prior to using the LifeVac, the SP called P2 but got P2's voicemail. The SP then sent a text message to P1. After sending P1 a text message, the SP started using the LifeVac. P1 then called the SP back. The SP asked P1 where s/he was and told P1 that the VA was on his/her right side on the floor choking and the SP needed help. P1 told the SP that s/he was almost back and to hang up and call 9-1-1. The SP then called 9-1-1. From the time the VA was on the floor until 9-1-1 was called, it was about four minutes. At that point, the VA was on the floor on his/her right side. 9-1-1 asked the SP if the VA's airway was clear and the SP said that s/he

was working on clearing the airway. At that point, the VA's airway was clear as far back as the SP could put his/her finger. The VA also had brown fluid coming out of his/her mouth. 9-1-1 asked if the VA was breathing and the SP said that s/he felt a faint breath and the VA still had color. The SP went back to using the LifeVac then the fire department came and took over caring for the VA.

- When emergency medical personnel arrived, the SP told them what was going on with the VA. Emergency medical personnel went through five suction machines, said that the VA had a lot of bread down his/her throat, and worked on the VA for 45 minutes without success.
- The SP gave the VA the sandwiches about 6 p.m. and that it was about 10 minutes from the first time the VA stood up at the table before s/he contacted P1 and P2. The SP did not think s/he should have waited that long to call, but s/he was focused on calming the VA down and trying to see what the SP could do to help him/her as the VA was pacing and panicking. The SP wanted to see if s/he could get the VA's airway clear. The SP was also trying to keep the VA from going downstairs or somewhere else in the facility. The SP called P2 and texted P1 before calling 9-1-1 because the SP was "panicked" and "freaking out" as it did not "register" with the SP what was happening.

In the internal review, the C stated that s/he was sitting on the living room couch when the VA was eating. While the VA ate, the SP sat next to the VA at the table, but the C did not hear the SP tell the VA to slow down or chew his/her food. The C did not hear the SP say anything to the VA. The SP generally worked on his/her own art projects at the table and wore headphones at work, but the C was not sure if the SP was wearing them at the time the VA choked. The C did not know what the SP was doing when the VA started to choke. The C realized that the VA was choking when the SP started to follow the VA around trying to get food out of the VA's mouth. The C asked the SP if there was anything s/he could do to help, and the SP did not respond. At the point where the VA was on the floor and appeared unconscious, the C asked the SP if s/he called 9-1-1, and the SP responded that s/he was trying to get a hold of P1. The C did not know when the VA started to eat or started to choke, but "it felt like a long time," maybe 10 or 15 minutes from when s/he first noticed the VA choking to when the SP called 9-1-1.

P1 provided the following information in the internal review and in an interview with this investigator:

- On April 20, 2024, P1 arrived at work between 1 and 2 p.m. For lunch, the VA had a hot dog and chewed and swallowed it fine. At about 5:30 p.m., P1 asked the SP if s/he could "clock out" to go and give a friend a ride. At 6:24 p.m., as P1 was driving back to the facility, s/he received a text message from the SP saying that the SP needed P1 to come back "quick." At 6:26 p.m., P1 called the SP and the SP told P1 that the VA was on the floor choking. P1 asked the SP if s/he called 9-1-1 and the SP said "no," but said that s/he called P2 and sent a text message to P1 and then P1 called him/her back. P1 told the SP to hang up and call 9-1-1.
- At about 6:36 p.m., P1 arrived at the facility. At that time, the fire department and paramedics were there, and the paramedics were bringing equipment into the facility. When P1 went inside, the fire department was doing cardiopulmonary resuscitation and suctioning bread out of the VA's mouth. At 7:19 p.m., paramedics pronounced the VA deceased. Paramedics said that the VA went too long without air and his/her heart could not keep up.

- When P1 arrived, the SP was handing the LifeVac to paramedics or the fire department. It did not look as though it was used, it was not dirty at all, and the VA had peanut butter all over his/her face.
- P1 received training on the VA's support plans and on the VA's risk of choking.

P2 and P3 provided the following additional information in the internal review and in an interview with this investigator:

- P2 stated that s/he believed that if the VA was able to stand up and pace before the SP realized that the VA was choking, that the SP was not paying attention to the VA. P2 recently had concerns with the SP as P2 would tell the SP something and the SP did not hear P2 so P2 believed that the SP had earphones in. Staff persons received training on the VA's support plans and were recently trained on how to use the LifeVac for choking.
- P3 stated that all staff persons were "well equipped" to assist the VA while the VA ate and that P2 and P3 had reiterated the protocol several times to all staff persons. P3 said that the SP was not "blind" to anything regarding how to support the VA. When the SP worked, the SP often sat in a corner and worked on his/her own art projects and personal tasks, and only got the bare minimum of work done during his/her shift.

The SP provided the following additional information:

- On April 20, 2024, the SP worked on his/her own artwork at the table earlier during his/her shift, but set it aside when making dinner. The SP was not wearing headphones when the VA was eating. The SP did have a computer out at the table as s/he was checking to make sure that medications that s/he administered to the VA (at 4 p.m.) and to the C (at 5 p.m.) were signed off as given. In the internal review, the SP was told that s/he did not pass any medications that day and then "expressed confusion" and said that s/he did pass the C's medications that day.
- When the SP began working with the VA (in July 2021), the SP read the VA's support plans. The SP was aware that there was a LifeVac in the kitchen if staff persons needed to use it. The SP was not sure if there was anything specific written about the VA and choking. The SP was trained on the VA's *Aspiration and Choking Plan* in 2021 but did not remember what the plan said. Since the SP began working with the VA, some sandwiches needed to be cut up and some did not. If the VA was given a sandwich, staff persons could cut it in half, but the SP never cut up the VA's food, and never cut up a sandwich before the VA ate it. When asked if giving the VA a full sandwich and watching the VA eat was consistent with the VA's support plans, the SP said that could not "honestly" remember, but also said that his/her actions that day were consistent with what s/he was supposed to do. The SP stated that s/he did not receive training on basic first aid or choking, but did receive training on the Reporting of Maltreatment of Vulnerable Adults Act.

The FM stated that the VA would stuff his/her mouth full of food if staff persons were not watching him/her while s/he was eating. Staff persons were to be sitting with the VA to make sure that after the VA took a bite or two of food, the VA swallowed it before putting more food in his/her mouth. The FM believed that staff persons cut up the VA's food. Prior to the VA's death, the FM said that staff persons were good to the VA, but maybe some staff persons could have had better training to work with the VA.

The facility's *Triage General First Aid* policy stated that if a person was choking, staff persons were to take the following steps. If the person could speak or cough, do not touch the person and encourage them to cough. If the person was unable to speak or cough, follow training guidelines for either back blows or abdominal thrusts until the object was forced out, the person could cough forcibly, breathed or became unconscious. If the person became unconscious, call 9-1-1.

Facility documentation showed that prior to the incident the SP, P1, and P2 each received training on the Reporting of Maltreatment of Vulnerable Adults Act, the facility's *Triage General First Aid* policy, and on use of the LifeVac. P1 and P2 each received training on the VA's *Aspiration and Choking Avoidance Plan*. P2 received training on the VA's other support plans. There was no documentation that either P1 or the SP received training on the VA's support plans and no documentation that the SP received training on the VA's *Aspiration and Choking Avoidance Plan*.

Relevant Statutes

Minnesota Statutes, section 245D.07, subdivision 1a states that the license holder must provide services in response to the person's identified needs, interests, preferences, and desired outcomes as specified in the support plan and the support plan addendum, and in compliance with the requirements of this chapter.

Minnesota Statutes, section 245D.095, subdivision 5 states that the license holder must maintain a personnel record of each employee to document and verify staff qualifications, orientation, and training.

Conclusion:

A. Maltreatment:

On April 20, 2024, at about 6 p.m. the SP served two peanut butter and jelly sandwiches to the VA. The SP did not cut up the sandwiches prior to giving them to the VA, but said that s/he watched the VA the entire time that the VA was eating. While eating the sandwiches the VA began to choke. The SP said that as soon as the VA began to choke, s/he intervened to address the VA's choking and at 6:28 p.m., the SP called 9-1-1 and initiated cardiopulmonary resuscitation. Emergency medical personnel responded and shortly thereafter, the VA's pulse stopped. Emergency medical personnel tried but were not able to revive the VA. A *Final Autopsy Protocol* stated that the VA's cause of death was "apparent choking."

Regarding serving food to the VA that was not cut up:

The VA's support plans identified that the VA was at risk for choking because s/he ate rapidly, sought out food, and stuffed food in his/her mouth. The support plans stated that staff persons were to cut up the VA's food into bite sized pieces no bigger than one inch in size. In addition, staff persons were to provide the VA with "direct supervision" when eating or drinking and remind the VA to eat slowly.

Information from staff persons showed that the common practice at the facility was inconsistent with the VA's support plans. Although P3 stated that depending on the food, the VA's food was to be cut up in bite sized pieces, P1, P2, and the SP each stated that the VA's food did not need to be cut up before the VA ate. Although there was

no information that the VA had choked in the past, it was both reasonable and necessary for staff persons to follow the VA's support plans which was a violation of Minnesota Statutes, section 245D.07, subdivision 1a.

Regarding the SP's response once the VA began to choke:

The SP stated that s/he gave the VA the sandwiches at 6 p.m. and it took about five minutes for the VA to eat the sandwiches. The SP said that from the time the VA first stood up from the table until the time the VA was on the floor, about six minutes elapsed. The SP said the VA was gagging and gasping for air as the SP lowered the VA to the floor. From the time the VA was on the floor, it was about four more minutes before 9-1-1 was called. Documentation from the P1's, P2's, and the SP's phone showed that at 6:24 p.m., the SP called P2 and texted P1, at 6:26 p.m., P1 called the SP, and at 6:28 p.m., the SP called 9-1-1. Given the situation, it was reasonable for the SP to not recall the exact time of each phase of the incident, but the SP's descriptions of his/her actions were not inconsistent with the time frame that the VA started eating about 6 p.m., that the SP made his/her first call at 6:24 p.m., and that the SP called 9-1-1 at 6:28 p.m.

The VA's *Aspiration and Choking Avoidance Plan* stated that if the VA could not speak or was having difficulty breathing, staff persons were to call 9-1-1 and "start emergency procedures." The SP acted to address the VA's choking him/herself during the approximately ten minutes from when the VA first began to choke and stood up from the table until the SP called 9-1-1. However, after the VA was on the floor, the SP called P2 and texted P1 four minutes before calling 9-1-1, and therefore the SP reasonably could have called 9-1-1 at least four minutes earlier that s/he did. Given the inherent risk involved with choking on food, it was both reasonable and necessary for the SP to call 9-1-1 sooner, as indicated in the VA's *Aspiration and Choking Avoidance Plan*.

Because at the time of the VA's death, the VA's support plans were not followed in both failing to cut up the VA's food and failure to call 9-1-1 in a timely manner, there was a preponderance of the evidence that there was a failure to provide the VA with care which was reasonable and necessary to maintain his/her physical health and safety.

Although the failure to follow the VA's support plans was likely a factor in the VA's death, it was not determined whether the maltreatment caused the VA's death.

It was determined that neglect occurred (the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care, or supervision which is reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult and which is not the result of an accident or therapeutic conduct).

B. Responsibility pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (c):

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

- (1) whether the actions of the facility or the individual caregivers were in accordance with, and followed the terms of, an erroneous physician order, prescription, resident care plan, or

directive. This is not a mitigating factor when the facility or caregiver is responsible for the issuance of the erroneous order, prescription, plan, or directive or knows or should have known of the errors and took no reasonable measures to correct the defect before administering care;

- (2) the comparative responsibility between the facility, other caregivers, and requirements placed upon the employee, including but not limited to, the facility's compliance with related regulatory standards and factors such as the adequacy of facility policies and procedures, the adequacy of facility training, the adequacy of an individual's participation in the training, the adequacy of caregiver supervision, the adequacy of facility staffing levels, and a consideration of the scope of the individual employee's authority; and
- (3) whether the facility or individual followed professional standards in exercising professional judgment.

Information was consistent that prior to the incident the SP received training on the Reporting of Maltreatment of Vulnerable Adults Act and on use of the LifeVac. Although the SP stated that s/he read the VA's support plans and was trained on the VA's *Aspiration and Choking Avoidance Plan* when s/he began working at the facility in 2021, the facility was unable to provide documentation that the SP received training on the VA's current support plans, which was a violation of Minnesota Statutes, section 245D.095, subdivision 5. The SP also stated that s/he did not receive training on basic first aid or choking, but facility documentation showed that the SP received training on facility's *Triage General First Aid* policy. However, that policy addressed choking in general and not specific to the VA.

Because facility practice was not consistent with the VA's support plans which stated that the VA's food needed to be cut up, and because the facility did not ensure that the SP was trained on the VA's support plans that were current at the time of the VA's death, it was determined that the facility was responsible for the maltreatment of the VA.

C. Recurring and/or Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by a facility meets the statutory criteria to be determined as "serious."

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 facility was responsible did not meet statutory criteria to be determined as serious because it was not determined whether the maltreatment caused the VA's death.

Action Taken by Facility:

The facility completed an internal review and determined that their policies and procedures were adequate, but not followed in that the VA's support plans were not followed. P2 received corrective action for failure to ensure that staff persons training was up to date, P3 received corrective action for failure to ensure that the VA's support plans were coordinated, and all staff persons were to have training on all the individuals' support plans and medical protocols. The SP no longer worked at the facility.

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

On January 10, 2025, the license holder was ordered to forfeit a fine of \$1000 as a result of the substantiated maltreatment for which facility was responsible. The maltreatment determination and the Order to Forfeit a Fine are each subject to appeal.