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: 202405861

Date Issued: January 29, 2025

Name and Address of Facility Investigated:

Disposition: Inconclusive

Living Well Disability Services
2666 Schletty Drive
Little Canada, MN 55117

Living Well Disability Services
1168 Northland Drive
Saint Paul, MN 55120

License Number and Program Type:

1070306-H_CRS (Home and Community-Based Services-Community Residential Setting)
1070299-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a vulnerable adult (VA) had a broken femur and unexplained bruising.

There were also concerns about multiple unexplained injuries to another vulnerable adult who lived at the same facility, during the same time period. Those allegations were investigated simultaneously and addressed in DHS report 202405726.

Date of Incident(s): June 7 to July 9, 2024

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (b), and Minnesota Statutes, section 626.5572, subdivision 15, and subdivision 2, paragraph (b), clause (1); and subdivision 17, paragraph (a):

Conduct which is not an accident or therapeutic conduct which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to: hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult.

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

Summary of Findings:

Pertinent information was obtained during site visits conducted on July 16 and 18, 2024; from documentation at the facility, law enforcement records, and medical records; and through eleven interviews conducted with two supervisory staff persons (P1 and P2), five facility staff persons (P3-P6 and P8), two registered nurses (RN1 and RN2) who worked at the facility, the VA's guardian (G), and the VA's case manager (CM). Attempts were made via telephone to contact and interview another staff person (P7), but the P7 did not respond to the requests. This investigator met the VA but the VA did not communicate due to his/her disability.

The VA was diagnosed with a profound intellectual disability, spastic quadriparesis, and a dislocated right hip.

According to the VA's *Individual Abuse Prevention Plan (IAPP)*:

- The VA was susceptible to physical abuse because s/he was not able to identify potentially dangerous situations; lacked community orientation skills; had "inappropriate" interactions with other persons; and was not able to defend him/herself from verbally and physically aggressive persons.

- The VA had a history of bruising and/or scratches caused by his/her uncontrolled spasticity.

- The VA was at risk of having an abusive incident go unnoticed because the VA was not able to verbally communicate and did not know how to report or identify potentially dangerous situations. Staff persons ensured the VA's safety with close physical, visual, and auditory proximity. If a potentially abusive situation came up, staff persons intervened by removing the VA from the situation, placing themselves between the VA and the aggressor, and assisting the VA to a safe location. Staff persons reported any suspected abuse according to facility policy.

- Due to his/her uncontrolled spasticity, the VA extended his/her legs and arms out and inadvertently scratched or kicked other persons, which put him/her at risk of aggression from other persons. Staff persons ensured the VA's ankle straps were securely fastened or positioned the VA in a location with ample room for leg and arm extension.

- Staff persons visually checked the VA's skin at bath time and during dressing and changing for any signs or

symptoms of injury. Any unusual scratches or bruises other than those mentioned above were reported "promptly."

According to the VA's *Coordinated Services and Support Plan (CSSP) Addendum*, the VA was "prone to bruising" because of "uncontrolled" spasticity. The VA was diagnosed with osteopenia (loss of bone density). Staff persons were trained on how to properly position and transfer the VA.

Facility documentation showed that staff persons were trained on the VA's support plans and the Reporting of Maltreatment of Vulnerable Adults Act prior to the incident.

The VA was hospitalized from June 7 to 10, and 13 to 17, 2024, for a urinary tract infection.

Regarding the VA's broken femur:

Medical records provided the following information:

- On June 20, 2024:
  - The VA was seen at an emergency room for swelling and redness of his/her right knee and staff persons were concerned because the VA's knee appeared "slightly more red and warm."
  - X-rays were taken and showed right femoral condyle fracture and diffuse bone demineralization. The doctor noted "multiple areas of bruising" including the VA's extremities and abdomen.
  - A long leg splint was placed on the VA's right leg. The VA was given morphine for pain management and prescribed hydrocondone 7.25 milligrams four times per day as needed for pain.
  - The VA was instructed to have a follow up visit with an orthopedic doctor "as soon as possible" or within a week.

- On June 24, 2024, the VA was seen by an orthopedic doctor and ordered to keep the splint on "at all times" and follow up in two weeks.

- On June 27, 2024, the VA was seen by an orthopedic doctor and had a repeat femur x-ray. The VA was approved to elevate his/her right leg for 15-20 minutes every hour. The VA was to limit time sitting up and required bed baths.

- On July 5, 2024, repeat x-rays showed that the fracture was "stable" compared to previous x-rays. The VA had a new long leg cast placed and ordered a follow up appointment.

RN1, RN2, and the VA's progress notes provided the following information:

- On June 17, 2024, (the day the VA returned from the hospital) P5 noticed bruises on the VA's body while giving the VA a shower. (Note: the progress note did not say where the bruises were on the VA's body.)

- On June 18, 2024, P7 saw a "discoloration bruise" on the VA's leg. (Note: the progress note did not say which leg.)

- On June 18, 2024, at 9:24 a.m., P1 texted RN1 a picture of bruising on the back of the VA's right leg. P1 wrote that the VA "came with this." RN1 told P1 that if the VA experienced any pain concerns or not able to move his/her leg, then it should be further evaluated.

- On June 18, 2024, at 10:41 a.m., P2 noticed bruising on the VA's leg. There was no sign of pain or discomfort. At 3:30 p.m., RN1 contacted the hospital and asked if they had any additional information about the bruise and/or possible cause. A nurse told RN1 that there was documentation that the VA had bruises on both of his/her shins on June 13, 2024, but no mention of the back of the leg.

- On June 20, 2024, at 6:05 a.m., while conducting the VA's skin check, P2 noticed the VA's right knee was "swollen and felt "warm" when touched. P2 called the on-call nurse, who said to call 9-1-1 for an ambulance, and not have staff persons transport the VA to the hospital. An ambulance came and took the VA to the emergency room where x-rays were done and showed a leg fracture. The doctor advised no movement of the VA and that s/he be seen at orthopedics "as soon as possible." The doctor also said that the VA's bones were "very tiny" and "fragile" and the fracture could have possibly happened during the VA's last hospital stay.

- RN1 stated that since the VA was "really small and fragile" and had bone demineralization, that the VA's bones had been thinning for some time and it was common for persons with thinning bones to sustain fractures. RN1 stated that the fracture could have happened when the VA was at the hospital or at the facility. RN1 did not have concerns with staff persons' interactions with the VA. There was no known incident that accounted for the fracture.

RN2 heard about the fracture after the VA was seen at the hospital. After the incident, the facility required two staff persons to assist the VA with transfers to help prevent injuries. RN2 stated that the VA was "definitely fragile" and RN2 did not have concerns with staff persons' interactions with the VA.

P2 provided the following information:

- After the VA's hospital stay that ended June 17, 2024, staff persons were required to do skin checks. P2 did not work on June 17, 2024, when the VA returned from the hospital. On June 18, 2024, P2 saw a bruise on the back of the VA's right knee and P2 reminded staff persons to make sure it was documented.

- The day after P2 saw the bruise, a staff person noticed that the VA's knee was swollen. P2 contacted P4 and it was determined that P2 would go with the VA to the hospital. (Note: although P2 said the VA's knee was swollen on June 19, 2024, based on progress notes entries, the date was likely June 20, 2024.) The doctor told P2 that the VA was "very fragile" and could have possibly broken his/her femur from transporting the VA from place to place. P2 called the G while at the hospital and the doctor told the G that the fracture could have possibly happened while the VA was previously at the hospital.

P3 stated that the VA was "so small and fragile" and that staff persons did "not pay attention" and were "too rough" with the VA when transferring him/her. P3 did not see any abusive behaviors with other staff persons and did not think staff persons intentionally injured the VA. P3 previously told P1 about his/her concerns.

P1 and P8 were not aware of the incident until after the VA went to the hospital on June 20, 2024. P1 spoke to

the doctor and the doctor did not have concerns of abuse and said it was possible that the fracture happened at the hospital. P1, P4, and P8 each did not have concerns with staff persons' interactions with the VA.

P5 was not aware of the VA's leg until after the incident when P5 went to the facility and saw a cast on the VA's leg. P5 did not know how the VA's femur was fractured and did not have concerns with other staff persons' interactions with the VA.

P6 did not work often with the VA. P6 was aware of the VA's broken femur but did not have concerns with staff persons' interactions with the VA.

Conclusion regarding the VA's broken femur:

According to the VA's support plans, the VA was diagnosed with osteopenia (loss of bone density.) X-rays taken on June 20, 2024, showed a femoral fracture.

Given that staff persons first noticed the injury to the VA's right knee and leg on June 18, 2024 (the day after s/he returned from a hospital stay); that it was not known when and where the injury occurred; and that RN1, RN2, P1, P2, and P4-P8 did not have concerns about staff persons' interactions with the VA, there was not a preponderance of the evidence as to the cause of the VA's broken femur.

It was not determined whether physical abuse or neglect occurred (Conduct which is not an accident or therapeutic conduct which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to: hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult or the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care, or supervision which is reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult and which is not the result of an accident or therapeutic conduct).

Regarding the VA's unexplained bruising:

The CM stated that s/he knew the VA since September 2023, and things were "fine." Starting on June 23, 2024, the facility notified the CM of bruises on the VA's body "almost every two to three days" (Note: the CM did not specify where on the VA the bruises were located.) The CM requested additional information from the facility and was not given explanations for how the bruises happened. The CM read in the VA's progress notes that the bruises appeared after a "rough night."

The VA's progress notes showed the following:

- On June 20, 2024, RN1 saw and took pictures of bruises on the VA's abdomen, right hand/wrist, right leg where the splint was, right foot, left hand/wrist, and left posterior forearm. The bruises were consistent with "various inpatient procedures" the VA had when s/he was in the hospital, such as IV sites, lab draws, and insulin injections.

- On June 23, 2024, the "on call" registered nurse (no name was provided) documented a "mark" on the inside of the VA's lower lip.

- On June 27, 2024, P8 did a skin check and documented a "scratch" on the VA's right hand. At 6 a.m., P2 checked the scratch, cleaned the area, and the mark came off because it was chocolate milk.
- On July 1, 2024, P8 saw "small redness" on the VA's nose. P8 notified P2 and RN1. On July 3, 2024, RN1 documented a "skin check" for the VA and saw "redness" on the VA's nose.

- On July 9, 2024, there were multiple notes from staff persons and RN1 about a "pink area" on the VA's right elbow that appeared "old." The VA did not have signs of pain or discomfort. Staff persons continued to monitor the area. There was no documented cause of the injury.

- On July 9, 2024, P2 looked at the VA's right elbow and saw a yellow bruise that had a "small scratch" on the bruise. P2 also saw a yellow bruise on the VA's right eyebrow. The VA did not indicate pain or discomfort. P2 notified RN1 who recommended a neuro check and staff persons monitored the VA for any signs of pain or change. There was no documented cause of the injury.

- On July 9, 2024, RN1 and P2 discussed possible contributing factors to the increase in bruises including the "increased handling" of the VA because of regular skin checks; the VA slept with his/her hands near his/her face; and slept with a hard item next to his/her face. RN1 noted that recent labs did not indicate any contributing factors.

P2 stated on July 9, 2024, the VA had a bruise on his/her right eyebrow. At first when P2 saw the VA in his/her bedroom s/he did not see the bruise because of the lighting. But shortly after, the VA was brought to the dining area to eat breakfast and P2 saw a yellow bruise. P1 came to the facility and P2 told P1 about the bruise who then informed RN1. On an unknown date, after approximately one week off work, P2 saw a faint yellow bruise near the VA's eye and nose that was "fading." There was no known incident that caused the VA's injuries.

RN1, P1, and P2 knew about a bruise on the VA's face on July 9, 2024, and thought it was from a hard plastic toy that the VA kept with him/her while in bed. RN1 instructed staff persons to use "soft" toys with the VA in bed. It was also common for the VA to lay his/her face against his/her hands while sleeping. P4 stated that when the VA was "irritable" and holding the toy, s/he previously "flail[ed]" and "flung" the toy near his/her face.

P6 stated there was one previous occasion when the VA had a "little" bruise near his/her jaw. P6 also saw the VA's hands near his/her face often which could have resulted in bruising, so did not have concerns about the bruises.

P5, P8, and RN2 were not aware of bruises on the VA's face.

RN1, P1, P2, P4, P5, and P6 did not have concerns with staff persons' interactions with the VA.

The G became aware of the bruises on the VA's face from a community person. The G called the facility and asked about the bruises and they confirmed there were bruises but they were not documented. Staff persons told the G that the VA had bruises because s/he was "old." The G had concerns with P5, P6, and P8 because they "lack[ed] compassion" and "lacked caring" but the G did not think they would intentionally hurt the VA.

Conclusion regarding the VA's unexplained bruising:

According to the VA's plans, the VA had a history of bruising and/or scratches of unknown origin because of uncontrolled spasticity. It was concerning that the VA had various small injuries to his/her face from June 23 through July 9, 2024. However, given that RN1, P1, P2, and P6 each provided information that the VA had his/her hands or a plastic toy near his/her face; and that RN1, P1, P2, P4-P6 each stated they did not have concerns with staff persons' interactions with the VA; there was not a preponderance of the evidence as to the cause of the bruises on the VA's face.

It was not determined whether physical abuse or neglect occurred (Conduct which is not an accident or therapeutic conduct which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to: hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult or the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care, or supervision which is reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult and which is not the result of an accident or therapeutic conduct).

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were adequate and followed. Staff persons were reminded of the importance of documenting the VA's skin checks.

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

No further action taken at this time.