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: 202404679

Date Issued: February 7, 2025

Name and Address of Facility Investigated:

Disposition: Inconclusive

SMC Care-Empowerment Healthcare
5200 63rd Ave. N.
Brooklyn Center, MN 55429

Empowerment Healthcare
7100 Northland Circle N.
Suite 207
Minneapolis, MN 55428

License Number and Program Type:

1079262-H_CRS (Home and Community-Based Services-Community Residential Setting)
1072822-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that two staff persons (SP1 and SP2) did not assist a vulnerable adult (VA) off the floor for four hours and that SP1 and SP2 "taunted" the VA telling the VA to "get up" by him/herself.

Date of Incident(s): May 23, 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 (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: 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 June 14, 2024, from documentation at the facility and law enforcement records; and through six interviews conducted with SP1, SP2, a facility client (C), a supervisory staff person (P1), and a facility staff person (P2). Although this investigator talked to the VA, the VA was unable to provide information in an interview due to his/her disability. The VA used a cane and a wheelchair for mobility and only had use of one side of his/her body due to a previous stroke.

The VA's *Individual Abuse Prevention Plan* stated that the VA had a history of falls and that "some falls are due to [the VA's] limitations while the majority are behavioral in nature." When the VA fell, two staff persons were to assist the VA and if they were "unable" or the VA "refuses," staff persons were to call 9-1-1.

The VA's *Care Plan* showed that some of the VA's diagnosis included, anxiety, depression, left side paralysis, and seizure disorder. If the VA fell, two staff persons were to help and if staff persons were unable to assist the VA, or the VA "refuses to allow staff assist," staff persons were to call 9-1-1.

The VA's *Fall Protocol* stated that the VA was sometimes able to assist with getting up, but that "this is not always the case for every incident," and that the "expectation is assistance will be provided immediately." After two "failed attempts" by staff persons to assist, 9-1-1 was to be called for assistance.

The facility's *Incident Report and Internal Review* provided the following information:

- Sometime after 10 a.m. on May 23, 3024, the VA "slid" out of his/her "wheelchair" onto the floor while in the living room.

- When SP1 was interviewed, s/he stated that at about 1 p.m., after lunch, the VA, who was sitting on a recliner in the living room at the time, "slid down the front of recliner and landed in front of the chair on the floor." During a 30 to 45-minute time span, SP1 and SP2 tried two times to assist the VA from the floor to his/her wheelchair, but SP1 and SP2 had "no success." As a result of that, 9-1-1 was called for a "lift assist." When SP1 was asked whether anyone was "upset" or whether there were "raised voices," SP1 said, "No," but that s/he was a "loud talker in general, but no [SP1] did not yell or demean any client."

- When SP2 was interviewed, s/he stated that between 10:30 and 11 a.m., SP2 was preparing lunch in the

kitchen and heard that the VA "slid down on the chair onto the floor in front of the recliner" in the living room. When that happened, SP2 moved the VA's wheelchair closer to the VA so the VA could use his/her "good arm" to pull him/herself up, but that did not work. SP2 stated that the VA was on the floor from about 10:30 a.m. until about 1 p.m. Shortly before 1 p.m., 9-1-1 was called. It took first responders about 20 minutes to arrive and assist the VA from the floor. Once the VA was back in his/her wheelchair at an unspecified time, the VA was brought to the table for lunch, but the VA did not want to eat lunch at that time. SP1 brought the VA back to the living room and about one hour later, SP2 reheated the VA's lunch because the VA was ready to eat. SP2 noted that while the VA on the floor, SP2 offered water to the VA. SP2 also stated that there was no yelling or raised voices during the incident.

- The C made one audio recording of SP1's and SP2's interactions with the VA while the VA was on the floor.

    - At 10:24 a.m. the C came out of his/her room and asked if s/he could help or call 9-1-1. The C was told, by an unspecified person, "You are not staff, go back to your room." SP1 then said, "I don't care even if [the C is] in there and can hear me, you're going to find your own way up." SP2 said, "Nobody put you there, you did. We don't take the resident and put them on the floor. I don't do that and [SP1] doesn't do that. [SP1] is telling you stop, stop, [the VA] but no, you decided to do it on your own, so you're going to be there till I'm ready to call 9-1-1 to pick you up."

    - At 10:37 a.m., an unknown staff person told the VA to get into his/her wheelchair.

    - At 10:44 a.m., the VA asked to sit in his/her wheelchair, which was "across the room." The VA then "scooted" across the floor and asked for a pillow. SP1 said, "You don't need no pillow," and that "if you get there, the pillow will be there." SP1 also said, "You did this to yourself."

    - At 10:46 a.m., SP1 said, "You only got one hand and that's the hand that is going to drag you up. So how are you going to get up?"

    - At 10:49 a.m., the VA was attempting to get to the "closest chair" and SP2 said that the chair belonged to a former client and that the VA should "go to your own chair," and "You're quick to argue, you love to argue. That's the same argument you were on when you threw yourself to the floor."

    - The VA was not heard to say anything on the audio recording.

A law enforcement report stated that the call for service came in at 1:42 p.m. on May 23, 2024, and that "no ambulance [was] needed" because first responders assisted the VA. The report did not provide information on the VA's condition at the time officers arrived at the facility.

The C provided information to this investigator that was similar to the information provided in the *Incident Report and Internal Review* but added that SP1 and SP2 were on their "phones" during much of the incident. The C described SP1's and SP2's tone as "yelling," such as SP1 saying that the VA should "drag" him/herself to the wheelchair and SP2 "agreeing" with SP1. The C did not see SP1 or SP2 make any attempts to help the VA, but the C also noted that s/he was not present during the entire incident. During the incident, the VA "didn't really say much."

The C stated that the VA was on the floor from about 10 a.m. until the 9-1-1 call was made at about 2 p.m. The C also stated that the VA did not eat lunch until about 3 p.m. The C decided to record the incident when s/he saw the VA "dragging" him/herself "across the floor."

P1 provided the following information:

- P1 did not remember the date but stated that s/he received a text message from the C at an unspecified time. The C told P1 that the VA was on the floor and that SP1 and SP2 were not assisting the VA. P1 told the C that s/he was at an appointment with a family member and that if there was an "emergency," that staff persons would "handle it."

- The day after, P1 tried to talk to the VA about the incident, but the VA did not remember the incident.

- P1 had not observed any previous interactions from SP1 or SP2 with the VA that were concerning.

- When the VA fell, or placed his/her body on the floor, staff persons were trained to assist the VA and if they were unable to do so, they were trained to call 9-1-1.

P2, who was not present during the incident, provided the following information:

- Prior to the incident, the VA placed him/herself on the floor several times and sometimes, the VA was "strong enough" to get up from the floor without staff person assistance. When the VA could not get off the floor independently, staff persons were expected to assist the VA and if staff persons were unable to assist the VA with getting up, they were supposed to call 9-1-1.

- Although P2 did not remember the date, s/he went to work at the facility at about 3 p.m. on the day of the incident and when s/he arrived, the VA was eating lunch at the table.

SP1 provided the following information in an interview with this investigator:

- At an unspecified time "after lunch" on the day of the incident, SP1 assisted the VA from his/her wheelchair to the recliner. About 30-45 minutes later, the VA was attempting to get out of the recliner. When that happened, SP1 told the VA to stay in the recliner because SP1 and SP2 "cannot pick up" the VA and "they are not going to help pay my bills if I put my back out," but the VA got out of the recliner and laid on the living room floor.

- When the VA was on the floor, SP1 and SP2 told the VA that they were unable to assist the VA from the floor and that "you can pull yourself up in your wheelchair." Later, SP1 and SP2 tried to assist the VA from the floor a couple times with a gait belt, but they were not successful.

- SP1 said that after the VA had been on the floor for about 30-45 minutes, and several verbal attempts were unsuccessful to assist the VA, SP2 called 9-1-1. SP1 denied that the VA was on the floor for about five hours. SP1 also said that although his/her voice was "strict," SP1 did not "verbally abuse" the VA. SP1 described his/her tone of voice as being a "strong voice," but denied yelling at the VA.

SP2 provided information to this investigator that was mostly similar to the information provided in the *Incident Report and Internal Review* but added that the total time the VA was on the floor was about two hours and during that time, the VA was "relaxed." While the VA was on the floor, both SP1 and SP2 verbally prompted the VA to get off the floor on more than one occasion. SP2 also stated that there were times that the VA could get up on his/her own, but that the VA was not able to do that on the day of the incident. SP2 also said that s/he was trained to call a facility health care professional or 9-1-1 if staff persons could not assist the VA off the floor.

Job descriptions for SP1 and SP2 showed that one of their job duties included assisting clients with "transfers."

The facility's training records showed that all staff persons interviewed as part of this investigation were trained on the Reporting of Maltreatment of Vulnerable Adults Act and the VA's specific care plans prior to May 23, 2024.

Relevant Rule and/or Statute:

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

Conclusion:

Information showed that on sometime after 10 a.m. on May 23, 2024, the VA went from his/her wheelchair or recliner to the floor in the living room. The C said that the VA was on the floor for about four hours, even though SP1 said that the VA was on the floor for 30-45 minutes and SP2 said that the VA was on the floor for about two hours. SP1 and SP2 each provided information that they tried to assist the VA off the floor, but the C, who was not always present when the VA was on the floor, stated that s/he did not see SP1 or SP2 assist the VA.

SP1 and SP2 made comments to the VA, such as SP1 saying, "You're going to find your own way up," and SP2 saying, "Nobody put you there, you did," and "You're going to be there till I'm ready to call 9-1-1 to pick you up. SP1's and SP2's behavior was inconsistent with the standard of a professional caregiver in a facility licensed by the Department of Human Services and a violation of Minnesota Statutes, section 245D.04, subdivision 3, paragraph (a), clause (6).

Although information was inconsistent regarding how long the VA was on the floor and that SP1 and SP2 did not call 9-1-1 sooner to assist the VA up, given that SP1 and SP2 each said that they prompted the VA to get up which the VA would sometimes be capable of doing independently, that SP1 and SP2 stated they attempted to assist the VA from the floor but were unsuccessful, that SP1 and SP2 each denied yelling at or being demeaning to the VA, and that there was no information that the VA was harmed as a result of the incident, there was not a preponderance of the evidence whether there was a failure to provide the VA with reasonable and necessary care and services or whether SP1's and or SP2's conduct rose to the level of emotional abuse.

It was not determined whether neglect or emotional abuse 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 and 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, harassing, or threatening).

Action Taken by Facility:

The facility's *Incident Report and Internal Review* determined that although policies and procedures were adequate, they were not followed and that SP1's and SP2's actions showed "negligence." In addition, the facility provided additional training to all staff persons and SP1 and SP2 were no longer employed by the facility.

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

The facility was not issued a correction order for the violation outlined in this report because they took corrective action.