

**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:** 202408444

**Date Issued:** February 13, 2025

**Name and Address of Facility Investigated:**

Eagles Crest Foster Home  
519 24th Street Northwest  
Bemidji, MN 56601

Eagles Wing Foster Home, Inc.  
7326 Birchmont Court Northeast  
Bemidji, MN 56601

**Dispositions:**

**Allegation One:** Substantiated as to physical and emotional abuse of a vulnerable adult (VA) by a staff person (SP1).

**Allegations Two:** Substantiated as to physical and emotional abuse of the VA by a staff person (SP2).

**License Number and Program Type:**

1075947-H\_CRS (Home and Community-Based Services-Community Residential Setting)  
1069248-HCBS (Home and Community-Based Services)

**Allegation Three:** Inconclusive

**Investigator(s):**

Beth Virden  
Minnesota Department of Human Services  
Office of Inspector General  
Licensing Division  
PO Box 64242  
Saint Paul, Minnesota 55164-0242  
beth.virden@state.mn.us  
651-431-6572

**Suspected Maltreatment Reported:**

**Allegation One:** It was reported that a staff person (SP1) threw a vulnerable adult (VA) to the floor during an altercation. The incident was recorded (See Allegation Two) and SP1 posted and shared it to his/her social media account (Snapchat).

**Allegation Two:** It was reported that a staff person (SP2) recorded the altercation between SP1 and the VA in Allegation One and on another date "shoved" the VA and threw the VA to the ground.

Allegation Three: It was reported that a staff person (SP3) “shoved” or “pushed” the VA onto his/her bed more than once.

Allegation One Date of Incident: January 12, 2024

Allegation Two Date of Incident: September 2 and January 12, 2024

Allegation Three Dates of Incidents: Unknown, ongoing

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

Conduct which is not an accident or therapeutic conduct which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to:

- Hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult.
- The use of repeated or malicious oral, written or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

#### Summary of Findings:

Pertinent information was obtained during a site visit conducted on October 8, 2024; from documentation at the facility and law enforcement records; and through 11 interviews conducted with the VA, the VA’s guardian (G), the VA’s family member (FM), the VA’s case manager (CM), facility staff persons (SP1, SP2, P1, P5), supervisory staff persons (SP3 and P3), and an administrative staff person (P4). Attempts were made via telephone to contact and interview a staff person (P2); however, P2 did not respond to the attempts. Attempts were made via telephone and text message to contact and obtain follow up information from SP2; however, SP2 did not respond to the attempts. This investigation, including interviews, was completed jointly with a law enforcement officer (LEO).

The VA’s *Admission Form and Data Sheet* and *Individual Abuse Prevention Plan* provided the following information:

- In September 2023, the VA moved into the facility seeking support and services relating to his/her diagnoses, which included acquired brain injury, schizophrenia, and schizoaffective bipolar type.
- “[The VA] displays physical aggression through property destruction, throwing things at people, slamming doors, choking, pushing, and punching. This puts [him/her] at risk of retaliation from [his/her] peers.” If the VA showed signs of agitation or restlessness, or had disorganized speech or “unusual behavior,” the staff response should include giving the VA space, modeling desired behavior, remaining calm, shifting the focus, etc. All staff were mandated reporters and reported abuse or suspected abuse.

The facility was a single-family home where the VA lived with one other housemate (H). The facility provided at least one staff person 24 hours a day. In April 2024, the facility moved, changing addresses but maintaining the

same license number. It was reported that Allegation One occurred at the former house/address; Allegation Two occurred at the current house/address; and Allegation Three occurred at both locations.

The facility's *Professional Standards* policy stated that staff adhered to ethical and professional standards, which included treating clients with respect and dignity; and refraining from abusive, obscene, or profane language and behavior.

The facility's *Emergency Use of Manual Restraints* policy stated:

- Before a client's behavior posed an imminent risk of physical harm, staff were supposed to attempt de-escalation techniques, like a "calm" discussion or alternate activity.
- Staff were permitted to use physical contact for instructional techniques or intervention procedures when necessary, and if the contact was the least restrictive alternative possible to meet the client's needs, and if it was used to:
  - a) Calm or comfort the client by holding them with no resistance from that client.
  - b) Protect the client, who was at risk of injury due to frequent falls because of a medical condition.
  - c) Facilitate the client's completion of a task or response when the client does not resist, or the client's resistance is minimal in intensity or duration.
  - d) Block or redirect the client's limbs or body without holding or limiting their movement to interrupt behavior that might cause injury and with less than 60 seconds of physical contact by staff.
  - e) Redirect the client's behavior when the behavior does not pose a serious threat of harm and the behavior is effectively redirected with less than 60 seconds of physical contact by staff.
- If positive support strategies were ineffective at deescalating or eliminating a client's behavior, an emergency use of manual restraint (EUMR) might be necessary and used only when the following conditions were met:
  - a) Immediate intervention must be needed to protect the client or others from imminent risk of physical harm.
  - b) The type of manual restraint used must be the least restrictive intervention to eliminate the immediate risk of harm and effectively achieve safety.
  - c) The manual restraint must end when the threat of harm ends.
- The facility allowed the following types of EUMRs:
  - a) Physical escort/walking: Stages 1 and 2: Staff walked beside and slightly behind the person with one hand on the person's forearm, just below the elbow, applying firm, but gentle pressure. If this was ineffective, staff might use both hands with one on the small of the person's back and the other on the person's forearm applying firm, but gentle pressure.
  - b) Arm restraint/one staff person standing: 1 arm and 2 arm: Staff held the person's arm across the person's body, above the wrist, while also securing the person's other arm to their side.

- c) Arm restraint/one staff person sitting: 1 arm and 2 arm: Staff might need to transition from a standing to a sitting position. While restraining the person's arm(s), staff verbally notified the person of what they were doing and slowly backed up and lowered the person to the floor. Staff then sat or knelt behind the person. In the event the person attempted to hit staff with their head or aggressively rock back and forth, staff pulled slightly back while maintaining their restraint.
- Staff were prohibited from using the following actions:
  - a) Time out.
  - b) Aversive or deprivation procedures.
  - c) Punishment.
  - d) Prone restraints.
  - e) Language that ridicules, demeans, threatens, or is abusive.
  - f) Physical intimidation or a show of force.
  - g) Tripping or pushing.

Facility documentation stated that SP1, SP2, SP3, P1, P2, and P3 received training on the VA's support plan and support plan addendum, including *Individual Abuse Prevention Plan*, the facility's policies and procedures, including the *Emergency Use of Manual Restraints*, and the Reporting of Maltreatment of Vulnerable Adults Act.

*Relevant Minnesota Statutes and Rules:*

Minnesota Statutes section 245D.04, subdivision 3, paragraph (a),

- clause (1) states that a person's protection-related rights include the right to have personal information kept private and be advised of disclosure of this information by the license holder.
- clause (6), states that a person's protection-related rights include the right to be treated with courtesy and respect.
- clause (16), states that a person's protection-related rights include the right to access the person's personal possessions at any time.

Minnesota Statutes, section 245D.06, subdivision 5, states the license holder is prohibited from using time out, seclusion, or any other aversive or deprivation procedure, as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience.

Minnesota Statutes, section 245D.06, subdivision 6, states in relevant part that the license holder must ensure that the emergency use of manual restraint complied with the requirements of this chapter, including the prohibition of prone restraints.

Minnesota Statutes, section 245D.061, subdivision 2, states that emergency use of manual restraint must meet the following conditions: (1) immediate intervention must be needed to protect the person or others from imminent risk of physical harm; and (2) the type of manual restraint used must be the least restrictive intervention to eliminate the immediate risk of harm and effectively achieve safety. The manual restraint must end when the threat of harm ends.

Minnesota Statutes, section 245D.061, subdivision 9, states in relevant part that the license holder must develop,

document, and implement a policy and procedures that promote service recipient rights and protect health and welfare during the emergency use of manual restraints. The policy and procedures must comply with the requirements of this section, including instructions for safe and correct implementation of the allowed manual restraint procedures.

Minnesota Statutes, section 245D.07, subdivision 1a, paragraph (a), 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.

Minnesota Rules, part 9544.0060, subpart 2, item (l), states that the license holder must ensure that prohibited actions are not used for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience.

*Allegation One: It was reported that SP1 threw the VA to the floor during an altercation. The incident was recorded (See Allegation Two) and SP1 posted and shared it to his/her social media account (Snapchat).*

The facility's *Confidential Nature of Company Affairs* and *Confidentiality* policies stated:

The operations of the facility ... should not be discussed with anyone outside the organization except when required in the normal course of business. Information concerning activities or operations of the facility, its staff and [clients], and the organization must be treated as confidential. Staff are encouraged to refrain from discussing the problems and concerns of the home outside of their regularly scheduled work hours. This includes social media posts ... Staff will not utilize social media while in the home or in the presence of a [client].

P5 stated that "a friend of a friend" told him/her that three or four videos involving a client, later identified as the VA, were posted to SP1's Snapchat (social media) private group chat. The Snapchat group included SP1, SP2, and two or three other unidentified people, not affiliated with the facility or the VA. P5 viewed a video that showed SP1 "slamming" the VA onto the ground. Then another, unidentified, person kicked the VA and SP1 laughed and said, "We're getting [the VA] good." The VA was bleeding in the video. P5 told this investigator, "I've done many holds (EUMRs with clients). That (conduct) was nothing similar to a hold." P5 did not have a copy of this video. [Note: The "friend of a friend" provided a video to law enforcement and law enforcement then provided it for this investigation. Based on P5's description of the Snapchat video s/he saw, the one provided to this investigator appeared to be a different video.]

The video provided for this investigation was posted on SP1's Snapchat private group chat on January 14, 2024, and included the following:

- The video started with an incident already underway and did not appear to be the start of the incident. The VA and SP1 were in a small hallway area at the bottom of a staircase. There was an office-type room in front of them.
- The VA and SP1 were standing side-by-side. The VA had his/her left arm around SP1's shoulders, and SP1 had his/her right arm around the VA's shoulders. They were struggling back and forth. SP1 and the VA each had one foot on the bottom stair with their other foot on the floor.
- SP1 stepped back and got behind the VA wrapping SP1's arms around the VA's torso. SP1 stepped back

further, which caused a shift in the VA's balance. SP1 continued stepping backwards and swung the VA's body to the floor landing inside the office. The VA landed on his/her right side and yelled something inaudibly as s/he went down. It appeared the VA struck his/her head on a vacuum cleaner, which rocked back and forth on the far side of the room.

- P1 was in the office and after the VA was on the floor, s/he stepped around the camera and out of the room. P1 did not say anything or make physical contact with the VA and/or SP1.
- Immediately upon the VA landing on the floor, SP1 knelt on either side of the VA's torso. SP1 said, while looking down at the VA, "What are you gonna do to me, huh? You ain't doing shit." SP1 stood, stepped over the VA's body, and said, "I'm done with your ass" before walking out of the room. There was a small amount of blood on the carpet next to the VA.
- The video was approximately 27 seconds.

The VA told this investigator and the LEO that s/he could not recall a specific incident involving SP1 but said there were "different times" when s/he ended up on the floor and that SP1 got "cheap thrills" or "jollies" over it. The VA said, "[SP1 has] either threatened to get on me (on the floor), or else getting on me (on the floor)." The VA could not recall a time when s/he was injured, involving the floor and/or SP1.

SP1 provided the following information:

- On January 12, 2024, SP1 was making dinner on the gas stove in the facility's kitchen. SP2, P1, and the VA were around or in the area.
- The VA began saying "violent things" to SP1, like how SP1 should "blow [SP1's] head off with a shotgun." SP1 was standing in front of the stove with his/her back to the burner, which was on. The VA approached and wrapped his/her arms around SP1's torso. "[The VA] put me on the stove with the open flame and there was a pan of oil on the stove ... My back almost touched the flame. The grease almost got knocked over on the stove. [The VA] pinned me against the stove ... [S/he is] punching me ... So, I was trying to get [the VA] to the ground and me and [him/her] were, like, going back and forth. I was like trying to get [him/her] on the ground." SP1 and the VA moved out of the kitchen and to the bottom of a staircase. "[The VA] had me in the headlock, and I took [him/her] to the floor, as I was trained to do." SP1 said, "If you can't get away, you take [the client] to the ground."
- After the VA was on the floor, SP1 walked outside. "I was really frustrated. So, I just went outside for a minute. I thought that was the best thing in that situation was to get away for a minute."
- The VA lay on the floor for about 30 minutes before getting up on his/her own. The VA had scraped his/her elbow on a wall during the incident but was otherwise uninjured.
- SP1 did not know the incident was recorded until a few days later when SP2 text a video of the incident to SP1. SP2 had recorded the incident using SP2's cellphone. SP1 then posted the video to his/her Snapchat private group chat because, "I was trying to show my [family member] and friends what I deal with at work, because they think it's easy work. I shouldn't have done that." SP1 also said that s/he previously posted other videos of the VA to his/her Snapchat group.

- SP1 said that his/her statements to the VA, recorded in the video, were not consistent with his/her training but that the VA was the “most physical and violent client” SP1 had ever worked with. “[The VA] was always attacking me.”
- SP1 said that his/her physical conduct towards the VA, recorded in the video, was reasonable because, “[S/he] had me in a headlock and I almost got severely injured on the stove.”
- Regarding the facility’s training on EUMRs, SP1 said, “They never really showed us exactly. All I know is, all I truly know is that when we get them to the ground, [their] arms have to be on their sides ... on their stomachs ... Otherwise, they never really showed us how to do the restraints.” The client could get up from the floor once they “seem calm” or after spending no more than 15 to 30 minutes on the floor. SP1 was trained on EUMRs by SP3.
- The VA typically showed s/he was “calm” by apologizing and “not saying verbal threats.”

SP2 provided the following information:

- On an unknown date, SP1 was cooking, and the VA “clicked on” and tried to “set [SP1] on fire.” SP2 could not remember what happened next. “I can’t really give you a full story, because it happened almost a year ago.” [Note: The incident was approximately nine months prior to SP2’s interview date.]
- SP2 did not have concerns with how SP1 handled the situation. “You have to get physical with [the VA] because [s/he’s] just, we have to protect ourselves ... I’m not gonna let the old [wo/man] (referring to the VA) beat me up ... I’m not gonna beat [the VA] up or something like that. [SP1] did what [s/he] had to do. [SP1] did [his/her] job. [SP1] handled the situation.”
- SP2 said that staff were authorized to use EUMRs when a client was “very aggressive,” but it was different for every client. The EUMR was released when the client was “calm.” SP2 was trained on EUMRs by SP3.
- SP2 said that there were “multiple videos” posted to SP1’s Snapchat.

P1 stated that s/he did not recall specifics of what happened on January 12, 2024. “There was an endangerment to staff.” “In my opinion, [SP1’s conduct] was a safe use of guiding [the VA] to the floor ... There was an open flame and oil, and [SP1 was] keeping [the VA] away from us and causing further injury to us. I wouldn’t say it was a use of force, but what I was taught to do. I was taught that if it’s useful to keep safe, do it but don’t excessively do it.” P1 was trained on EUMRs by SP3. P1 did not know that anyone recorded the incident and said that staff sometimes recorded the VA’s behaviors to document what was happening. P1 said that the incident frightened him/her because s/he had not experienced anything similar.

SP3 provided the following information:

- SP3 was responsible for training staff, including on EUMRs.
- The VA was “stubborn” and had a history of being “very aggressive” and making “lots of threats.” When this occurred, SP3 told staff to tell the VA to take a break and ask the VA to go to his/her bedroom. Staff were supposed to verbally redirect the VA to his/her bedroom. If the VA refused, SP3 told staff to place a

hand on the VA's back to turn his/her body and guide him/her towards his/her bedroom. If the VA refused to walk, SP3 told staff to walk away and give the VA space to "reset and calm" him/herself. [Note: SP3 added that at some point after January 12, 2024, staff were instructed not to place a hand on the VA's back but rather verbally direct him/her to "take a break." It was determined that physical touch to redirect the VA did not calm him/her.]

- Regarding telling the VA to "take a break," this was not a "timeout." At the time of this incident, the VA was living at his/her former house/address. "At the old house, it was necessary for [him/her] to go to [his/her] room to take a break. We didn't tell [him/her] to go there but, in that house, there was no space. The only real place [s/he] could go to get away from everyone and reset was going to [his/her] room." "The only time we ask [him/her] to take a break was if [s/he] was being verbally aggressive or super manic." SP3 added that at the VA's current house/address, s/he might choose to take a break at the kitchen table or living room; however, the VA "normally" went to his/her bedroom.
- Staff were authorized to use one type (or one technique) of EUMR and SP3 trained staff to use this one technique. SP3 could not recall the name of the technique but described what it entailed. "It's where you redirect [the client] facedown. You put their arms at their sides, and you straddle their hips and their butt, and you hold them there. That was the hold I was taught when I first started. I don't think we were taught any other kinds. We were told never do it face-up. They can spit at you and head-butting and biting, and it's harder to control them. Facedown with arms at their sides." [Note: SP1 also said that s/he placed clients on their stomachs during EUMRs and that s/he was trained to do this by SP3. SP1's and SP3's use of prone restraints was a violation of Minnesota Statutes, section 245D.06, subdivision 6, which prohibited prone restraints; and a violation of Minnesota Statutes, section 245D.061, subdivision 9, which ensured instructions for safe and correct implementation of the allowed manual restraint procedures.]
- Regarding how to get the client facedown, "Normally it's a redirection by shoulder or hand and then just drag them down ... Use their momentum to get them down."
- Once the client was facedown and deescalated, staff slowly released their arms. For example, staff told the client, "I'm going to give you an arm back and see how you do and then give them another arm back." The speed in which this occurred depended on the client's "emotional level" and/or if they were "frustrated" or "tired." Once the person was fully released, staff might ask them to stay on the ground for a minute "just to cool off" before immediately standing up. The client might then choose to stay on the ground longer.
- Regarding SP1 posting the video of the VA on Snapchat, SP3 said that this conduct "goes against everything I've learned."
- SP3 was not aware of prior, similar concerns with SP1's conduct.

P3 said that the area where the incident occurred was in the facility's kitchen, which was "quite small" with a gas stove. In the event staff were in danger, cornered, and/or unable to get away, they might use an EUMR. Staff were trained to release the EUMR when the risk of harm ended. P3 was not aware of an EUMR in which the client was directed onto the floor. P3 added that staff could not use social media when clients were present. P3 did not have and was not aware of prior concerns with SP1's conduct.

P4 said that regarding the use of an EUMR, staff were trained to "not fight the client's force with force." If the

client started to go down to the floor, staff used the client's momentum and "went with it." They were not supposed to try and make the client go a different way than momentum was taking them. Once on the floor, clients were "never" positioned in a "picture-perfect" way and instead, might end up on their stomach. Staff were trained to, as soon as possible and when safety able to do so, reposition the client so they were not lying on their stomachs. P4 added that SP3's description of how to do an EUMR (e.g. "facedown" on the floor with arms at side ... "Drag them down ... Use their momentum to get them down)," the wording "maybe looked a little aggressive" but during an EUMR "that is what happens."

The FM recalled the VA telling him/her about being "thrown to the floor inside the house," but the FM could not remember when or what this entailed or details of what the VA said.

### Conclusion for Allegation One:

#### A. Maltreatment:

Consistent information was provided that SP1 posted three or four videos involving the VA to a group chat in SP1's Snapchat. This was inconsistent with the facility's *Confidential Nature of Company Affairs* and *Confidentiality* policies and a violation of Minnesota Statutes section 245D.04, subdivision 3, paragraph (a), clause (1).

In one video provided for review, SP1 was observed struggling back and forth with the VA before wrapping his/her arms around the VA's torso and then swinging him/her to the floor. SP1 then knelt over the VA and said, "What are you gonna do to me, huh? You ain't doing shit." "I'm done with your ass." P5 viewed a video that showed SP1 "slamming" the VA onto the ground. Then another, unidentified, person kicked the VA and SP1 laughed and said, "We're getting [the VA] good." The VA was bleeding in the video. SP1's conduct was inconsistent with the facility's *Professional Standards* and *Emergency Use of Manual Restraints* policies and violations of Minnesota Statutes section 245D.04, subdivision 3, paragraph (a), clause (6); and section 245D.061, subdivision 2.

In regard to this video, SP1 said that his/her actions were in response to the VA's behavior. "[The VA] had me in a headlock and I almost got severely injured on the stove." "I took [the VA] to the floor, as I was trained to do. If you can't get away, you take [the client] to the ground."

#### Regarding physical abuse:

Although the VA's physical aggression towards SP1 near a lit stove with burning oil would require staff persons' intervention, and that SP2, SP3, and P1 did not have concerns with SP1's conduct, SP1's interactions seen on video were not therapeutic or accidental. At the time SP1 swung the VA to the floor, they were no longer near the stove, the VA did not have SP1 in a headlock, and the VA was not punching SP1, so there was not an imminent risk of physical harm, which required an immediate physical intervention. In addition, swinging the VA to the floor was not consistent with the facility's allowable emergency use of manual restraint techniques and likely not the least restrictive intervention to effectively achieve safety. P5 stated that in the video s/he watched, the VA was bleeding; the video provided for this investigation showed blood on the carpet next to the VA; and SP1 said that the VA sustained a scraped elbow as a result of the incident. Therefore, there was a preponderance of the evidence that SP1's physical interaction with the VA was not an accident or therapeutic conduct and could reasonably be expected to produce physical pain or injury.

It was determined that physical abuse occurred (conduct which is not an accident or therapeutic conduct which

produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to: hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult).

Regarding emotional abuse:

Although SP1's interaction with the VA during the incident included statements such as, "What are you gonna do to me, huh? You ain't doing shit," and "I'm done with your ass," SP3 and P3, who were supervisory staff persons were not aware of any other incidents or concerns regarding SP1's verbal interactions with the VA, and the VA also did not provide information about other times SP1's verbal interactions included similar statements. Therefore, it was not determined if SP1's verbal interactions with the VA at this time were repeated in nature or a single incident.

SP1 did not initially know the incident was recorded but when SP2 shared it with SP1 a few days later, SP1 posted the video on social media to show his/her family member and friends what s/he "dealt with at work." SP1 also stated that s/he previously posted other videos of the VA to his/her Snapchat group. SP1's interaction at the time of the incident and actions of sharing the videos were inconsistent with the standards of a professional caregiver in a facility licensed by the Department of Human Services and were not accidental or therapeutic conduct. Although it was not determined whether SP1 engaged in repeated oral language towards the VA, there was a preponderance of the evidence that SP1's actions of sharing videos of the VA involved in maladaptive and physical behaviors with persons who were SP1's family members and friends, likely unknown to the VA and were not a part of the VA's team, was treatment that could be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

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

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.

SP1 was responsible for the VA's care and supervision and was trained on the VA's support plan and support plan addendum, including *Individual Abuse Prevention Plan*; the facility's policies and procedures, including the *Emergency Use of Manual Restraints*; and the Reporting of Maltreatment of Vulnerable Adults Act.

SP1 was responsible for maltreatment of the VA.

#### C. Recurring and/or Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by an individual meets the statutory criteria to be determined as "recurring or serious." Individuals determined to be responsible for recurring or serious maltreatment are disqualified from providing direct contact services.

Minnesota Statutes, section 245C.02, subdivision 16, states:

"Recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that maltreatment occurred and that the subject was responsible for the maltreatment.

Minnesota Statutes, section 245C.02, subdivision 18, states:

"Serious maltreatment" means sexual abuse, maltreatment resulting in death, neglect resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought, or abuse resulting in serious injury. For purposes of this definition, "care of a physician" is treatment received or ordered by a physician, physician assistant, or nurse practitioner, but does not include diagnostic testing, assessment, or observation; the application of, recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment. For purposes of this definition, "abuse resulting in serious injury" means: bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke. Serious maltreatment includes neglect when it results in criminal sexual conduct against a child or vulnerable adult.

It was determined that the substantiated physical and emotional abuse for which SP1 was responsible was recurring because SP1 was responsible for two incidents of maltreatment. SP1's physical abuse of the VA was an incident of maltreatment and sharing videos of the VA on social media on more than one occasion was a single incident of maltreatment. In addition, SP1 was responsible for serious maltreatment because the VA sustained tissue damage including a scraped elbow and was seen bleeding on video.

SP1 was disqualified from providing direct contact services.

Allegation Two: It was reported that SP2 recorded the altercation between SP1 and the VA in Allegation One, and on another date, "shoved" the VA and threw the VA to the ground.

Regarding SP2 recording the altercation between SP1 and the VA in Allegation One

SP2 said that s/he recorded the incident between the VA and SP1 on January 12, 2024, which was posted to SP1's Snapchat group on January 14, 2024.

In the video, after SP1 swung the VA to the ground, knelt over him/her and stated, "What are you gonna do to me, huh? You ain't doing shit ... I'm done with your ass," SP2 zoomed the camera in so that it was focused on the VA's face. The VA was lying on his/her right side looking downward toward the floor. There was a small amount of blood on the carpet next to the VA. SP2 then said to the VA, "Damn. You got your ass whooped" before quickly moving the camera away and the video ended.

SP3 said that it was not common practice for staff to take videos of the clients in the house. However, when the VA first moved in, it was suggested staff take some videos of the VA's behaviors to show his/her interdisciplinary team. "I would take my phone out and I would record 15-30 seconds, and I would pass it along to the office, but I would delete the videos afterward."

Regarding SP2 shoving the VA and throwing the VA to the ground

The VA's *Individual Abuse Prevention Plan* stated:

[The VA] is at an increased risk of retaliation from [wo/men] [s/he] approaches or persons around [the wo/men] who may see the need to physically intervene. [The VA] will have staff near [him/her] at all times while in the community to help ensure [s/he] does not exhibit behaviors that would put [him/her] at risk. If [the VA's] tendency to approach [wo/men] puts [him/her] at risk in the community, [s/he] may need help understanding that it is dangerous. If [the VA] is threatened verbally or physically, staff will intervene and remove [the VA] from the situation. [The VA] does not go in the community unsupervised at this time.

The facility was in a residential neighborhood near other homes, public businesses, vehicle traffic, and traffic lights. A Walgreens pharmacy was 0.1 miles (about two city blocks) east of the facility. A gas station was 0.1 miles west of the facility. Each location was around a corner and not visible from the facility's front yard. Each could be accessed from the facility using streets with residential speed limits and not crossing any major intersections.

The facility's *Responding to and Reporting Incidents* policy stated that if a client left without the knowledge or supervision of a staff person, staff called 9-1-1 immediately and then called a supervisory staff person. Staff searched locations where the client might have gone.

The VA provided the following information:

- One morning, around 6 a.m., the VA walked alone to the Walgreens. The store was closed, but there was a car idling in the parking lot with a single wo/man inside. The VA approached the car and tried starting a

conversation with the wo/man.

- “Then when I got to the street, [SP2] was there in the street there, right near Walgreens.” SP2 used his/her right hand to “push” and “shove” the VA’s back “the whole time” as they walked back to the house. The VA gestured what SP2 was doing by holding his/her right arm straight out at his/her side and flapping his/her right hand. The LEO asked if SP2 was shoving him/her or if SP2 was guiding him/her with his/her hand on the VA’s back. The VA said, “I guess it wouldn’t be exactly a real shove, you know, but enough of a shove, you know, with [SP2’s] hand and arm.” “I did not like it or appreciate that.” The VA could not recall if SP2 said anything during this time.
- Once they made it to the facility driveway, the VA was “a little bit angry” at SP2. SP2 was standing “real close to me ... [and] shoved me and I just landed on the driveway ground.” The VA could not recall what part of SP2’s body s/he used to shove the VA to the ground, what happened immediately before SP2 shoved him/her, or if SP2 said anything during this time.
- The VA got up and entered the house. “Then in my bedroom, it’s like [SP2] had me lay down on the floor for like 10 or 15 minutes or so on my stomach.” The VA said that s/he was lying on the floor because “[SP2] told me to.” SP2 then took some of the VA’s personal possessions out of his/her bedroom, including a picture drawn in brown chalk. “[SP2] threatened to keep them or something or throw them away. A whole bunch of my wonderful possessions.” [Note: It was unclear in the VA’s account when his/her possessions were returned; the VA’s possessions were returned at some point.]

The G said that the VA had no unsupervised time in the community and staff needed to be with the VA “at all times.” If the VA wanted to throw garbage away outside, the G expected staff would be watching through a window. The VA’s support plans did not include anything about asking the VA to lie on the floor. The VA had previously raised concerns about the facility, but this was the first time the VA said something about being pushed by staff or had concerns of a physical nature.

The FM said that the VA told him/her that on the way back from the Walgreens, SP2 “shoved [the VA] hard and pushed [him/her] down on the ground.” The FM told this investigator that the VA was “very accurate” when recalling events. “Take it for the truth.”

SP2 provided the following information:

- Between September 1 and 2, 2024, SP2 worked the overnight shift, which was single-staffed and an asleep position.
- Around 3 a.m., the VA woke SP2 up and asked to go outside to throw out the garbage. This was a common occurrence for the VA. “I didn’t think nothing of it. So, I told [him/her], ‘Yeah, go ahead.’” SP2 did not get up or walk outside with the VA and instead, went back to sleep. [Note: SP1’s *Program Note*, written shortly after the incident, stated that this occurred at 6:10 a.m.]
- SP2 heard the door alarm as the VA left through the door to go outside and then waited for the door alarm indicating the VA returned inside. Two minutes passed and SP2 did not hear the door alarm. Another five minutes passed and then SP2 got up and went outside but did not see the VA. SP2 walked towards the gas station but still did not see the VA. “Now, I’m panicking.” SP2 was about to call SP3 but

decided to check the Walgreens first. SP2 walked to the Walgreens and saw the VA at a minivan "pressed against this [wo/man's] window." Just then, another vehicle came "flying down the road" and into the

Walgreens parking lot. The driver was "yelling" at the VA. SP2 "tried to explain" but the driver and the wo/man in the minivan swore at the VA and SP2, and then drove away.

- SP2 then verbally redirected the VA back to the facility "as quick as possible" before the VA engaged in a maladaptive behavior. SP2 said, "I was agitated, irritated" at that time. SP2 put his/her hand on the VA's back. "I'm pushing [him/her] back to the house. And it's a fast push. So, I'm trying to hurry up, like trying to push [him/her] back. I'm not pushing [him/her] back, but I'm like, I got my hand on [his/her] back, like, redirect [him/her] but the fast way, so I'm walking fast behind." The VA yelled at SP2, "Hey. Stop. Take your hands off me."
- When they arrived at the facility driveway, the VA punched SP2's chin. SP2 pushed the VA and the VA fell to the ground. SP2 helped the VA up and they walked inside.
- The VA went to his/her bedroom, but three or four times opened his/her bedroom door, yelled, and slammed the door. Because the H had a history of getting "agitated" when woken up, SP2 told the VA that if s/he "didn't stop, I'm gonna start taking your things." The VA continued to "yell" so SP2 "started grabbing [the VA's] writing utensils" and putting them in the living room hoping the VA would go to sleep. SP2 told the VA that s/he would get his/her belongings back when s/he stopped yelling and slamming his/her door. However, the VA immediately opened the door and yelled again. SP2 told the VA, "Lay next to the bed, and don't get up until [SP3] gets here."
- SP2 explained, "We're not supposed to put [the VA] in a hold. So, my best, my best situation was, 'You're gonna lay down on the floor.'" The VA was lying face up. "That's all. I was telling [him/her], 'Stop. Shut up.'"
- The VA then lay on the floor until SP3 arrived, which was around 7 or 8 a.m. SP2 moved a chair outside the VA's bedroom door. SP2 said, "Just so [the VA] don't get up. I sat there at [his/her] front door and I told [him/her] [s/he] will sit there. Just don't say nothing until [SP3] gets here."

The facility's *Program Notes*, completed by SP2, stated for September 2, 2024, "At 6:10 [a.m.,] [the VA] told staff [s/he] was going to throw away trash outside. [The VA] actually went to Walgreens[.] Staff went to get [him/her] on the way [s/he] punch staff called staff the N word, staff redirect [the VA] to [his/her] room."

SP3 provided the following information:

- The morning of September 2, 2024, "maybe 9 a.m.," SP3 arrived at the facility and did not see the VA lying on the floor. Instead, the VA was sitting at his/her desk writing.
- SP2 told SP3 that the VA took the garbage outside and walked away from the house. SP2 said s/he saw the VA leave and was immediately following him/her. SP2 caught up to the VA in the Walgreens parking lot and "redirected" him/her back to the facility. When they were on the edge of the driveway, the VA "tried to swing on [SP2] and fell." The VA did not sustain injuries. SP2 did not say anything to SP3 about the VA lying on his/her bedroom floor.

- SP3 said that the VA was allowed to go outside to throw the garbage away without SP2 being directly with him/her. SP2 was supposed to “just pay attention” to when the VA left and returned.
- In the event the VA declined to walk back to the house from the Walgreens, SP2 was to verbally redirect the VA back to the house. If the VA sat down and started screaming, SP2 “would probably call me” and “I’d say walk away and see if [the VA] follows or I’d come in and see if I can redirect [the VA].”
- Staff were not trained to ask the VA to lie on the floor, but the VA had a history of choosing to sit on the floor. SP3 wondered if the VA sat on the floor in the past with SP2 and it worked to deescalate and so SP2 suggested it this time too. “I’m not sure how that turned into [the VA] on the floor.”
- Staff should not take the VA’s property unless the VA was using the item as a weapon.
- SP3 believed SP2 was “just trying to do the right thing and it might [have gotten] a little out of hand.” SP3 did not have and was not aware of prior concerns with SP2’s conduct.
- SP3 believed the VA would “generally provide pretty accurate information” if asked about the incident.

P3 provided the following information:

- P3 heard from SP3 that the VA took the garbage out and that SP2 “had eyes on [him/her]” and redirected the VA back to the house but that the VA walked to the Walgreens with SP2 following. P3 did not know if SP2 used verbal redirection and/or part of his/her body to redirect the VA back to the house. Staff were not trained to push a client.
- P3 was not aware of the VA’s sustaining injuries consistent with being pushed to the ground in the driveway. If the VA punched SP2, SP2 could use physical blocks, which might be “hard to determine exactly if it’s a block or a push.”
- P3 was not aware of the VA lying on his/her bedroom floor. Staff were not trained to ask the VA to lie on the floor. Because it was early in the morning, P3 believed it was acceptable to ask the VA to lie in bed, but staff could not force the VA to do so.
- P3 did not have and was not aware of prior concerns with SP2’s conduct.

### **Conclusion for Allegation Two:**

#### **A. Maltreatment:**

On January 12, 2024, SP2 recorded a video in which s/he was heard saying to the VA, who had just been swung to the floor by SP1 and was bleeding, “Damn. You got your ass whooped.” SP2’s statement was a violation of Minnesota Statutes section 245D.04, subdivision 3, paragraph (a), clause (6).

SP3 said that it was not common practice for staff to take videos of the clients in the house. However, when the VA first moved in, it was suggested staff take some videos of the VA’s behaviors to show his/her interdisciplinary team. “I would take my phone out and I would record 15-30 seconds, and I would pass it along to the office, but I would delete the videos afterward.”

The VA and SP2 provided consistent information that on September 2, 2024, the VA left the facility without supervision, which was inconsistent with the VA's *Individual Abuse Prevention Plan* and a violation of Minnesota Statutes section 245D.07, subdivision 1a, paragraph (a). The VA approached an unknown wo/man in the community, just prior to SP2's arrival. When SP2 found the VA, s/he pushed or shoved him/her back to the house, which was inconsistent with the facility's *Emergency Use of Manual Restraints* policy and in violation of Minnesota Rules, part 9544.0060, subpart 2, item (l). Upon going inside, SP2 removed some of the VA's property from his/her bedroom and made the VA lay on the floor until SP3 arrived, which were violations of Minnesota Statutes section 245D.04, subdivision 3, paragraph (a), clauses (6) and (16); and Minnesota Statutes section 245D.06, subdivision 5.

Regarding physical abuse:

The VA said that SP2 shoved him/her to the ground in the driveway. SP2 said that the VA tried to punch him/her and while pushing the VA away, the VA fell to the ground. SP2 also stated that s/he pushed the VA "fast" for over one city block back to the house despite the VA's statements for him/her to stop and when the VA punched SP2 in the driveway, SP2 pushed the VA again.

The VA's *Individual Abuse Prevention Plan* stated that the staff response should include giving the VA space, modeling desired behavior, remaining calm, shifting the focus, etc. Although the VA's physical aggression towards SP2 would require some intervention, they were outside when it occurred and there was not an imminent risk of harm to SP2, so it was likely that physical intervention was not immediately needed or to the degree implemented by SP2. In addition, given that repeatedly pushing someone "fast" for more than one city block and then pushing them away and them falling could reasonably be expected to produce pain and/or injury for the person, there was a preponderance of the evidence that SP2's conduct, was not accidental or therapeutic, and could reasonably be expected to produce physical pain or injury to the VA.

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

Regarding emotional abuse:

Although there was no information to show why SP2 recorded the video of the VA, which was later posted to SP1's Snapchat group, SP2 said that staff had previously recorded some behaviors to share with the VA's interdisciplinary team. Although SP2 did not share the video with the VA's interdisciplinary team and instead sent it to SP1, SP1 was also responsible for the VA's care, and it was unknown if SP2 was aware SP1 planned to post the video on Snapchat. Therefore, it was not determined if SP2's actions regarding the recording of the video were therapeutic conduct.

SP2's conduct on September 2, 2024, included repeatedly pushing the VA down the street for more than one city block despite the VA's statements to "stop," and once inside, telling the VA and requiring him/her to lay on the floor in his/her bedroom and told the VA, "Shut up." In addition, on January 12, 2024, SP2 focused a camera on the VA's face, after the VA was thrown to the ground by SP1, and stated to the VA, "Damn, you just got your ass whooped." SP2's conduct on both dates was inconsistent with the standards of a professional caregiver in a facility licensed by the Department of Human Services.

Given that SP2's non-therapeutic verbal interactions occurred on more than one date and were not accidental, there was a preponderance of the evidence that SP2's conduct, was repeated oral language that would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

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

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:

- (2) 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;
- (3) 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
- (4) whether the facility or individual followed professional standards in exercising professional judgment.

SP2 was responsible for the VA's care and supervision and received training on the VA's support plan and support plan addendum, including *Individual Abuse Prevention Plan*; the facility's policies and procedures, including the *Emergency Use of Manual Restraints*; and the Reporting of Maltreatment of Vulnerable Adults Act.

SP2 was responsible for maltreatment of the VA.

C. Recurring and/or Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by an individual meets the statutory criteria to be determined as "recurring or serious." Individuals determined to be responsible for recurring or serious maltreatment are disqualified from providing direct contact services.

Minnesota Statutes, section 245C.02, subdivision 16, states:

“Recurring maltreatment” means more than one incident of maltreatment for which there is a preponderance of evidence that maltreatment occurred and that the subject was responsible for the maltreatment.

Minnesota Statutes, section 245C.02, subdivision 18, states:

"Serious maltreatment" means sexual abuse, maltreatment resulting in death, neglect resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought, or abuse resulting in serious injury. For purposes of this definition, "care of a physician" is treatment received or ordered by a physician, physician assistant, or nurse practitioner, but does not include diagnostic testing, assessment, or observation; the application of, recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment. For purposes of this definition, "abuse resulting in serious injury" means: bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke. Serious maltreatment includes neglect when it results in criminal sexual conduct against a child or vulnerable adult.

It was determined that the substantiated physical and emotional abuse for which SP2 was responsible was recurring maltreatment because SP2 was responsible for two incidents of maltreatment. SP2's physical abuse of the VA was an incident of maltreatment and SP2's verbal interactions with the VA on more than one occasion was a single incident. However, it was not serious because there was no information provided that the VA sustained an injury.

SP2 was disqualified from providing direct contact services.

*Allegation Three: It was reported that SP3 "shoved" or "pushed" the VA onto his/her bed more than once.*

The VA provided the following information:

- “[SP3 has] been physically, and I would say even, like mentally too, kind of abusive to me.”
- “[SP3] shouts and yells [his/her] head off at me.” SP3 said things like, “You’re a [age] year old [wo/man]. Act your age,” and “Sniff (or smell) my ass.” The VA said that statements like these happened “many times.”
- More than once, SP3 told the VA, “Go to your room.” The VA added, “As if I’m a child or something.” The VA could not recall what would be happening immediately before SP3 told him/her to go to his/her room. The VA said that most of the time, s/he went to his/her bedroom when SP3 told him/her to. At least once, SP3 grabbed the VA’s paperwork, which the VA had been working on at the dining table and threw it on the VA’s bedroom floor.
- At least once, the VA ran into his/her bedroom with SP3 “chasing me.” More than once, SP3 “threw” or

“shoved” the VA onto the VA’s bed. One time, the VA hit his/her head on a wall by the bed.

- The VA did not provide additional details regarding the incidents such as dates, times, and/or witnesses to any incident.

The FM provided the following information:

- SP3 “had no patience” with the VA and rolled his/her eyes at the VA. The FM said, “It was like [SP3] didn’t keep it from me that [s/he] didn’t like [the VA].”
- The VA told the FM that SP3 “shoved” the VA onto his/her bed and “pushed” the VA to the ground. When the FM brought these concerns to SP3, SP3 told the FM, “[The VA] has delusions ... [The VA] is schizo.”
- The VA also told the FM how SP3 frequently said things to the VA such as, “Smell my ass.” The FM said that s/he did not hear any interactions as such when s/he observed SP3 interacting with the VA.
- When the VA moved out of the facility in October 2024, a staff person (P2) told the FM that s/he saw SP3 throw the VA onto his/her bed and the ground. P2 did not provide additional details to the FM or dates or timeframes this occurred. One time, when P2 was documenting something that the VA said happened, SP3 said, “Who are they going to believe? You? Or a paranoid schizophrenic?”, referring to the VA.

SP3 provided the following information:

- SP3 said that there were times when s/he redirected the VA to his/her bedroom and the VA ran into his/her room and jumped on his/her bed. “Then [the VA would] scream, ‘Don’t beat on me. Don’t assault me. Keep your damn hands off me.’ This happened “multiple times.” SP3 said that s/he did not beat or assault or throw or shove the VA onto his/her bed.
- One time, the VA threw baseballs at SP3. SP3 redirected the VA to his/her bedroom by physically turning the VA towards his/her bedroom and in response, the VA ran into the room and jumped onto his/her bed. SP3 did not push the VA onto his/her bed.
- Another time, the VA was in the kitchen getting “really ornery and was yelling and screaming.” SP3 asked the VA to go to his/her bedroom and the VA declined. In response, SP3 grabbed the VA’s books, writing utensils, and paperwork and carried it to the VA’s bedroom. The VA followed and when they made it to the VA’s bedroom door, the VA punched SP3’s chin. SP3 physically turned the VA away from him/her and the VA then jumped onto his/her bed. “I don’t know if [s/he] thought I pushed [him/her]. I definitely didn’t.”
- SP3 added, “[The VA] hates me, like with a passion, since [s/he] moved in. I’ve been the only person [s/he] has any experience with that stops [him/her] from being with the [ladies/gentlemen] so [s/he] hates me.”

P3 provided the following information:

- In November 2023, the VA said that SP3 was pushing him/her onto his/her bed. At that time, P3 “thoroughly discussed” these concerns with the VA’s interdisciplinary team and with SP3. The VA was becoming “very mentally unstable” during that time. “We felt strongly that it was false accusations based on just our discussions with [SP3] and [the VA’s] mental status and disdain for [SP3].” The VA’s interdisciplinary team requested the facility install cameras in the facility, which was pending.
- P3 was not aware of the VA sustaining injuries consistent with being thrown or shoved onto a bed.
- P3 did not have concerns with SP3’s conduct.

### **Conclusion for Allegation Three:**

The VA provided information to this investigator, the FM, and P3 that more than once SP3 pushed or shoved him/her onto his/her bed, made comments like, “Sniff (or smell) my ass,” and told the VA to go to his/her bedroom when s/he was demonstrating maladaptive behaviors; “As if I’m a child or something.” The VA stated that on one occasion SP3’s actions caused the VA to hit his/her head on a wall. The FM saw SP3 rolling his/her eyes at the VA and said that P2 told him/her that s/he saw SP3 push the VA onto his/her bedroom. However, P2 did not respond to requests for an interview.

Had SP3’s engaged in statements to the VA like “sniff (or smell) my ass” and “go to your room,” it would be inconsistent with the standards 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). However, given the VA’s “distain” for SP3, and the lack of details and witnesses regarding dates, frequency, and/or context, there was not a preponderance of the evidence whether SP3 made these nontherapeutic comments to the VA or engaged in physical interactions with the VA.

It was not determined whether physical or emotional abuse occurred (conduct which is not an accident or therapeutic conduct which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult; and/or 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 completed internal reviews and determined the following:

Allegation One: Policies and procedures were adequate but not followed as it related to the Snapchat video. Additional training was provided on privacy guidelines. There was not a need for additional corrective action, and the allegation was not similar to past concerns with SP1 and/or the VA.

Allegation Two: Policies and procedures were adequate and followed. There was not a need for additional training or corrective action, and the allegation was not similar to past concerns with SP2 and/or the VA.

Allegation Three: Policies and procedures were adequate and followed. There was not a need for additional training or corrective action, and the allegation was not similar to past concerns with SP3 and/or the VA.

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

SP1 and SP2 were each disqualified from a position allowing direct contact with, or access to, persons receiving services from programs, organizations, and/or agencies that are required to have individuals complete a background study by the Department of Human Services as listed in Minnesota Statutes, section 245C.03. The determination that SP1 and SP2 were responsible for maltreatment and the disqualification of SP1 and SP2 are each subject to appeal.

On February 13, 2025, the facility was issued a Correction Order for the violations outlined in this report. In addition, the Department of Human Services determined that given the violations outline in this report, the license holder failed to ensure the designated coordinator provided supervision, support, and evaluation of activities that include: oversight of the license holder's responsibilities assigned in the persons support plan addendum; and instruction and assistance to direct support staff implementing the coordinated services and support plan and the service outcomes, including direct observation of service delivery sufficient to assess staff competency, which was a violation of Minnesota Statutes, section 245D.081, which states that the license holder must meet the requirements of program coordination, evaluation, and oversight.

Allegation Three: It was reported that a staff person (SP3) “shoved” or “pushed” the VA onto his/her bed more than once.

Allegation One Date of Incident: January 12, 2024

Allegation Two Date of Incident: September 2 and January 12, 2024

Allegation Three Dates of Incidents: Unknown, ongoing

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

Conduct which is not an accident or therapeutic conduct which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to:

- Hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult.
- The use of repeated or malicious oral, written or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

### Summary of Findings:

Pertinent information was obtained during a site visit conducted on October 8, 2024; from documentation at the facility and law enforcement records; and through 11 interviews conducted with the VA, the VA’s guardian (G), the VA’s family member (FM), the VA’s case manager (CM), facility staff persons (SP1, SP2, P1, P5), supervisory staff persons (SP3 and P3), and an administrative staff person (P4). Attempts were made via telephone to contact and interview a staff person (P2); however, P2 did not respond to the attempts. Attempts were made via telephone and text message to contact and obtain follow up information from SP2; however, SP2 did not respond to the attempts. This investigation, including interviews, was completed jointly with a law enforcement officer (LEO).

The VA’s *Admission Form and Data Sheet* and *Individual Abuse Prevention Plan* provided the following information:

- In September 2023, the VA moved into the facility seeking support and services relating to his/her diagnoses, which included acquired brain injury, schizophrenia, and schizoaffective bipolar type.
- “[The VA] displays physical aggression through property destruction, throwing things at people, slamming doors, choking, pushing, and punching. This puts [him/her] at risk of retaliation from [his/her] peers.” If the VA showed signs of agitation or restlessness, or had disorganized speech or “unusual behavior,” the staff response should include giving the VA space, modeling desired behavior, remaining calm, shifting the focus, etc. All staff were mandated reporters and reported abuse or suspected abuse.

The facility was a single-family home where the VA lived with one other housemate (H). The facility provided at least one staff person 24 hours a day. In April 2024, the facility moved, changing addresses but maintaining the