DEPARTMENT OF HUMAN SERVICES

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: 202403675

Date Issued: February 21, 2025

Name and Address of Facility Investigated:

Disposition: Inconclusive

Symanitz Brittany Ann & Symanitz David Robert
212 E. Century St.
Belle Plaine, MN 56011

Symanitz Foster Care
212 E. Century St.
Belle Plaine, MN 56011

License Number and Program Type:

1103098-AFC (Adult Foster Care)
1104557-HCBS (Home and Community-Based Services)

Investigator(s):

Thomas Nixon
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
thomas.c.nixon@state.mn.us
651-431-2155

Suspected Maltreatment Reported:

It was reported that a staff person (SP) abused a vulnerable adult (VA), causing bruises on the VA's eye and knee.

Date of Incident(s): April 25, 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 a site visit conducted on May 16, 2024; from law enforcement (LE) records and documentation at the facility; and through 11 interviews conducted with the VA, two facility staff persons (the P and the SP, who were family members to one another), the VA's case manager (CM), two family members who were also the VA's guardians (G1 and G2), a resident of the facility (R1), an employment support staff (ES), and three community persons (CP2, CP3, and CP5.) A community person (CP4) did not respond to phone, text, and mailed interview requests.

The facility was a split-level home in a residential area. On the lower level was a family room with a couch and television, bathroom, and two bedrooms. On the upper level at the top of the stairs was a living room area and to the left was a hallway that led to bedrooms and a bathroom. To the right was a kitchen with an island in the center. Beyond the kitchen was a dining room space with sliding doors that led outside to an upper-level deck with stairs down to the fenced in backyard. There was a pond nearby.

The VA's diagnoses included moderate cognitive impairment and Down syndrome. The VA at times hit him/herself when upset. The VA enjoyed video games, sports, the Power Rangers, the Special Olympics, and spending time with family and a community person (CP1).

The VA's *Coordinated Services and Supports Plan* stated that when the VA was "really frustrated" the VA might hit or push at others. This typically happened when the VA was attempting to leave the facility without supervision, and staff persons were trying to get the VA to come back. The VA did not have approved community alone time and had left the facility unsupervised on four different occasions since moving into the facility. The VA often left via the backyard, so the facility built a fence around the backyard to help as a visual reminder to stay in the yard. The facility had alarms placed on the doors to alert staff persons if the VA were to leave unsupervised.

The VA's *Intensive Support Self-Management Assessment* stated the VA had a fear of deep water and was able to tell staff persons that s/he did not know how to swim.

The VA's *Positive Support Transition Plan* stated staff persons were to "block exits" so the VA could not leave without supervision. Whenever staff persons used physical redirection with the VA, an incident report was to be completed.

The VA's *Coordinated Service and Support Plan Addendum Intensive Support Services* stated that as a last resort to interrupt a behavior that may result in injury to the VA or others, staff persons could block or redirect the VA's limbs without folding or limiting their movement, with less than 60 seconds of physical contact by staff persons. Staff persons were to "always use verbals to assist with the behavior before ever having to go hands on."

The VA's *Progress Review Report* from August of 2023 stated the VA was working "saying *[sic]* where [s/he] is supposed to be and safe." The VA at "random times" left the facility unsupervised, and the police had to be involved.

The VA did not have any rights restrictions, including no restriction on the VA's right to engage in chosen activities, nor on the VA's freedom and support to access food at any time.

The VA's *Progress Note* from April 25, 2024, stated that the VA "was wanting more food and tried to make more after being told it was not a choice. [The VA] tried to run off and was stopped with physical redirection… After the incident, the VA took a shower and went to bed." It was not documented who wrote the *Progress Note*.

The VA provided the following consistent information to the DHS investigator, LE, and for the facility's internal review:

- The VA lived at the facility for "one year" and things there were "good." The VA liked to play games, ride bikes, spend time with family and friends, and spend time on TikTok. The P was "nice" to the VA and the SP was "cool" and "awesome."

- On an unknown date, the VA, R1, and the SP were downstairs at the facility where they watched the NFL Draft on television and ate food, including pasta and pizza that was delivered. The VA finished his/her pasta and asked the SP for some of the pizza. The SP told the VA s/he could not have the pizza as it was for another resident (R2). The VA "got frustrated" and went upstairs to the kitchen. The VA began to make him/herself more food and put ramen in the microwave. R1 and the SP went to the kitchen, and the SP told the VA to "stop" and that the VA "couldn't eat more." The SP grabbed the food out of the microwave and put it on the counter. The VA got "so frustrated," wanted to "escape," and wanted to see CP1, so the VA went to leave through the sliding door to the deck.

- The VA provided conflicting information to the DHS investigator, LE, and for the facility's internal review regarding the next events:

  - The VA told the DHS investigator s/he opened the patio door and the SP got between the VA and door and "blocked" the VA's way. The SP swung his/her right arm and hand at the VA. The SP's hand hit the VA on the head and the VA said, "Don't hit me." The SP said "mean words" to the VA, but the VA did not recall what they were. The SP went behind the VA and put his/her arms around the VA's "sides." The SP raised his/her arms up to "hold" the VA. The VA then slipped which caused him/her to fall to the floor. The SP told the VA that his/her nose was bleeding, but the VA did not know what caused the injury.

  - The VA told LE the VA was by the sliding door, the SP was behind him/her, and the SP hooked both arms under the VA's armpits to restrain him/her. The VA then got a bloody nose, slipped, and fell to the ground, and the SP hit the VA with an open hand. The VA also told LE that the SP sometimes spanked the VA.

- The VA provided information for the facility's internal review that the SP "pulled" the VA's wrist which hurt, and the VA "slipped on the floor." The VA then hit his/her own head, slapped his/her own face "a bunch," and "pound[ed]" his/her own chest. The VA denied being spanked by the SP.

- The SP said, "Don't get mad," that s/he "love[d]" the VA, and s/he "would not tell [the P]." The SP asked the VA, "Please don't do that again," and to go take a shower as they needed to leave to pick up R2. The VA took a shower and then s/he, the SP, and R1 went to get R2.

- The VA denied the SP ever shoved or pushed him/her during the April 25, 2024, incident, but said the SP "throwed" the VA on a different night. The VA did not recall when or why that happened, nor if anyone else was around.

CP2, CP3 and CP5 provided the following information:

- CP2 stated that on April 26, 2024, around noon, the VA was dropped off by the SP at his/her job at a store. CP2 saw that the VA was "upset" and "almost in tears." CP2 asked the VA what was wrong, and the VA answered, "Nothing, I do not want to talk about it." CP2 saw that the VA had a black eye on his/her left side, was bruised under his/her left eye to his/her nose, and there was a red area around the VA's left upper eye lid. CP2 asked the VA how the injury occurred. The VA "mumbled" something about that s/he was hungry and wanted more food. The VA said the SP told him/her s/he was not able to have more food, the VA hurt his/her wrist, and that s/he did not want to talk about it.

- CP3 stated that on April 26, 2024, CP3 asked the VA how his/her day was. The VA said his/her eye and wrist hurt. CP3 saw the VA's left eye looked swollen and red. The VA said that the SP "threw me," and made a motion of being "grab[bed] by the shirt and toss[ed] off to the side." The VA also said that the SP "spanks" the VA "really hard." The VA motioned that the SP slapped his/her face. CP3 told CP5 about the conversation.

- On April 26, 2024, CP5 noticed the VA appeared "distraught" and CP5 saw on the VA's left eye there was a "visible little bruise." However, CP5 did not talk with the VA about what happened.

CP4 told both the ES and CP5 that s/he did not normally work or interact with the VA, but on April 26, 2024, the VA approached him/her in the breakroom. The VA told CP4 s/he was "not having a good day" and the SP "beat [him/her] up a bit." The VA said his/her wrist, back, and neck hurt before CP4 changed the subject.

The ES provided the following information to the DHS investigator and LE:

- The ES stated on April 26, 2024, about 1:30 p.m., CP5 called the ES with the concerns about the VA and the ES arrived at the store to talk to the VA about 10 minutes later. The ES found the VA in the breakroom and sat down to talk with him/her. The ES saw that VA's eye had "some red bruising" on the "inside corner to mid eye."

- The VA told the ES that the previous night at the facility s/he was in the kitchen after s/he ate all the pasta. It was dark outside and s/he wanted to go outside on the deck to leave the house. The VA tried to get outside and the SP "grabbed" the VA. The VA motioned that the SP grabbed the VA under the armpit

and around the chest. The SP pulled the VA and "threw" the VA to the floor. The VA hit his/her left eye when s/he hit the floor. Due to the impact of the floor, the VA's nose started bleeding and his/her wrist and knee hurt.

- The VA showed the ES two small marks on his/her right knee that were red, but not bruised. The VA did not say how his/her knee got hurt. The ES asked the VA if s/he and the SP were "playing ball or anything" and the VA said they were not. (Note: According to the ES, CP2 told the ES "Something about how [the SP] threw a ball and it hit [the VA] in the eye." However, CP2 and the VA each denied to the DHS investigator there was any ball involved in the incident.) The VA changed the subject, and did not further explain what happened. The ES worked with the VA until the end of his/her shift. At 4 p.m. the VA was picked up by the SP. When the SP arrived, the VA referred to the SP as his/her "buddy" and did not seem "bothered" by the SP being there. There was no conversation between the ES and the SP at this time.

The P provided the following information:

- The VA was supported by staff persons on independence, safety out in the community, and understanding risks. While the VA's memory was "good overall," s/he might struggle with timelines if the VA was upset. The VA might "get things mixed up" and tell people that things s/he dreamt actually happened, including accusations that someone harmed him/her. The VA believed that people on television were his/her friends and his/her answers to a question might change throughout the day. The VA and SP got along "pretty well" as they watched television and worked on projects together. At times when the SP redirected the VA, the VA did not listen.

- The VA might mislead others to try to get what s/he wanted, to get away with something s/he should not have done, or to direct attention to someone else instead. If the VA was asked if s/he lied, s/he might admit to it.

- When the VA was upset and a staff person just touched the VA, the VA might respond, "Don't do that, it hurts." When the VA was hurt, s/he asked for Tylenol or to see a doctor.

- The VA historically struggled around limitations with food. The typical pattern was the VA ate dinner with the others, got a second serving, and then asked for more. Staff persons responded by encouraging the VA to slow down, asking the VA to wait for an hour until his/her stomach settled, and then offering options to the VA if s/he was still hungry.

- The VA did not have any right restrictions on food, was given "access to everything," and "grabb[ed] as [s/he] pleases." The VA was encouraged to pick healthy items that did not "make [the VA] sick" or to wait for an hour to eat something, which worked "90% of the time." The other 10% of the time when the VA insisted on eating, staff persons told the VA that was not a good idea and reminded the VA s/he might get sick. Once the VA got food, a staff person should not take the food away from the VA.

- After conversations about limitations with food, the VA might "tap" on his/her teeth. This was a sign that the VA's "wheels [were] turning" and that s/he might consider leaving the facility without supervision. When staff persons tried to talk with the VA to get him/her to not leave the facility, the VA might drop to the floor or "stand there." The VA might also grab his/her hair, slap his/her face, and "beat" his/her chest.

When the VA engaged in those behaviors, staff persons reminded the VA s/he might hurt him/herself. Staff persons typically waited for the VA to calm down as the hits were "typically not enough" force to need intervention.

- When the VA attempted to leave the facility without supervision, staff persons were to block the exit by standing in front of the door, putting their arms out, and physically redirecting the VA back to the room where they previously were. Usually this worked but sometimes the VA "swung" at the person, "drop[ped] to the ground," and/or "grab[bed] [his/her] face and [said], 'I am so frustrated,' or, 'I can't do this.'" The VA might also "yell, scream, roar, hit [his/her] head, pull [his/her] hair, and beat [his/her] chest like a gorilla."

- When the VA left the facility without supervision, staff persons were to follow on foot or in a vehicle to try to catch up and talk with the VA. If there was only one staff person at the facility then R1 came with to find the VA. The VA might take a different route each time s/he left, go through neighbors' yards, or sit someplace for a while. When the VA was located staff persons attempted to process with the VA about his/her choices and the risks of his/her actions. If the VA was not found "within so many minutes," LE was sometimes involved to help find the VA. The facility was near water and VA was not able to swim. There was a concern the VA might not think of this when s/he was upset and go into the water.

- On April 25, 2024, the P was not at the facility and on April 26, 2024, the P called the SP and the VA when they were on their way to the VA's workplace. The VA "sounded great." Later that day, the P got an email from the ES about the alleged incident between the VA and the SP.

- The P called the SP to discuss what happened on the night of April 25, 2024, and forwarded the ES's email to the SP. The SP said the email was not true and they "had a great night." The SP told the P that the VA wanted ramen and the SP said no. The VA tried to leave out the back door, and the SP grabbed the VA's wrist and walked him/her back into the facility. When the VA came back in, the SP shut the door, and the VA dropped to the ground. When the VA "fell" s/he gave him/herself a bloody nose. The SP offered to help the VA with the bloody nose, but the VA declined. The SP cleaned the blood around the VA and helped the VA to calm.

- When the P talked with the VA and the SP individually later on, neither said there was any injury to the VA during the incident. The P saw the VA had a "small bruise" near his/her eye that was "not a black eye." When the P asked the VA about the incident the VA did not mention that the SP slapped, spanked, or threw him/her.

R1 provided consistent information to the DHS investigator, LE, and for the facility's internal review, that s/he watched the NFL Draft on the downstairs television with the VA and the SP. The SP ordered food for everyone to eat. The VA went upstairs, and R1 and the SP followed him/her to the kitchen. The VA yelled, "I want more food," and the SP told the VA no. The VA opened the door and acted like s/he planned to leave to see CP1. The SP grabbed the VA's wrist, "pulled" the VA away from the door, and the VA fell on the floor. The VA then "hit [him/herself]" in the "eye" and "face." The VA caused him/herself to get a "bloody nose." R1 denied seeing the SP hit the VA. The SP tried to get the VA cleaned up, but the VA said s/he was fine. R1 declined to provide additional information.

The SP provided the following information to the DHS investigator and LE:

- The SP and the P knew the VA for many years. The VA needed reminders and guidance for steps on hygiene tasks, to put items away, and to clean up after him/herself, especially when s/he was excited about an upcoming event.

- Historically, the VA had been dishonest and tried to hide things from staff persons. When the VA forgot or did not do what was asked, the VA struggled to take accountability. The VA might attempt to get someone else in trouble to cover up or to distract the staff person from what happened.

- The VA fixated on eating food and being out in the community, and pursued each without discussing it with others or disregarding others' feedback. If the VA was not able to do these activities, s/he got "upset" and might leave the facility without supervision which could lead to the VA putting him/herself in dangerous situations.

- When this occurred, staff were to follow the VA by foot or vehicle. If the VA left and was not found, 9-1-1 was to be called. If the VA left the facility without supervision and only one staff person was there with R1 and/or R2, then R1 and/or R2 went with the staff person to locate the VA. When staff person caught up with the VA, they attempted to talk with the VA about the situation and the risks involved. The staff person stayed with the VA until s/he was calm and ready to return.

- On April 25, 2024, during the day the VA and the SP worked on projects at the facility and things were "great." About 6 p.m., the SP, the VA, and R1 watched the NFL Draft in the lower living room. The VA was excited and dressed up for the event. The SP ordered delivery food for dinner. The VA had his/her own pasta dish and the others shared pizza.

- Around 8:30 to 8:45 p.m., after the VA finished his/her food and ate some breadsticks, s/he wanted the last few slices of the pizza. The SP said the VA had just finished his/her food and the pizza was being saved for R2. The SP suggested the VA drink some water or eat grapes while they watched the draft. The VA said, "I can't do this, I'm so frustrated, I'm so hungry," and went upstairs. The VA often left an area when s/he was upset and went somewhere else to calm.

- About "a minute or two later," R1 also went upstairs to get water and then came back down. R1 said that the VA was making more food so the SP and R1 went upstairs. The VA stood in front of the microwave that was cooking food. The SP stopped the microwave, took out the food, and stood by the sink. The SP asked what the VA was doing, and told the VA that the VA had a full meal and could not overeat. The VA said s/he was "frustrated" and "hungry".

- The SP told the VA that the VA already ate "exactly what you wanted for dinner, no more food." The SP reminded the VA to not "overfill" his/her stomach before bed to avoid feeling sick. The SP suggested the VA eat some grapes or carrots and drink water to help his/her "stomach settle."

- At that point, the VA "clap[ped]" him/herself in the face with both hands, "slap[ped]" his/her own face and said how hungry s/he was. The VA's palms landed on his/her eyes and his/her fingertips landed on the VA's forehead. The SP tried to get the VA to talk about the situation, but the VA said, "I am just

frustrated, I can't do this anymore, I just hungry." The VA started to walk towards the patio sliding door, opened it, and started to move to the deck.

- The SP told the DHS investigator s/he moved behind the VA and put his/her right arm underneath the VA's armpit between the VA's body and his/her right arm. The SP lifted his/her arm straight up to "carry [the VA's] weight" so the SP's bicep went into the VA's armpit. The SP hoped to prevent the VA from dropping to floor and getting hurt, which the VA had done in the past. The SP did not lift the VA's feet off the floor. The SP reached his/her left arm between the VA's body and left arm. The SP grabbed the VA's left wrist and pulled it into the VA's body. The SP tried to keep the VA in a "ball" to prevent him/her from "flail[ing] it out" and getting injured on the way back into the house. The VA told the SP, "Let me go, I am hungry, I need to get chicken."

- The SP started to turn the VA around towards the kitchen area and positioned him/herself between the VA and the patio door. The SP denied yanking or pulling on the VA. As the VA tried to pull away from the SP, the VA's feet "got intertangled," crossed, or possibly tripped on the sliding door rail frame. The VA fell to the floor, and the SP was pulled down with the VA. The SP tried to move him/herself away to avoid falling on top of the VA. The SP did not know where R1 was while this occurred, but heard R1 attempt to "talk [the VA] down."

- The SP was not certain how the VA landed on the floor. The VA then hit him/herself on the face, "quickly spun" onto his/her buttocks, sat crossed legged and faced the SP. The SP sat up between the VA and the patio door. The VA took off his/her outer shirt, threw it, and hit him/herself in the chest. The SP told the VA they were not going to get food and to "please stop." At that point, the VA's nose was bleeding and the SP offered to help the VA with it. The VA said s/he was "fine" and "just hungry." The SP asked if they could talk about the situation while s/he helped to clean the VA's bloody nose. The VA said, "Don't touch me."

- Later the SP asked the VA if s/he would be willing to take a shower to clean up. The VA paced in the hallway for a while then calmed, asked for a towel, and took a shower. After the VA showered s/he appeared to be "better" and said s/he was "sorry" for what happened. The rest of the night was "fine."

- The SP documented in the VA's progress notes the VA "tried to run off and was stopped with physical redirection. All info is noted in the incident report."

- On April 26, 2024, the SP saw that under the VA's eye there was a "black and blue mark." Since the VA did not complain about his/her eye, no medical attention was sought. The rest of the day the VA appeared to be able to move around "fine" and was outside and dribbled a basketball. The VA was "fine" the rest of the weekend.

- The SP physically intervened with the VA during the incident because the SP was concerned about the risk to the VA if s/he left the facility without supervision that night as it was "really dark out" and the backyard was "full of mud." The SP was concerned the VA might open the fence gate and there was pond nearby with high water due to recent rainfall.

- The SP was trained to perform emergency use of manual restraints (EUMR) two years prior to the incident. The SP did not recall if the method s/he used to redirect the VA during the incident was a part of the training. The SP was not aware that the VA's wrist hurt, and thought if it was injured that the injury might have occurred when the VA fell on the floor. The SP denied pulling or yanking on the VA's wrist and denied slapping, shoving, or throwing the VA at any time. The SP said it was possible the VA believed s/he was shoved when s/he fell to the floor.

- The SP provided inconsistent information to LE and for the facility's internal review regarding the physical interaction between s/he and the VA near the sliding door:

  - The SP told LE s/he was behind the VA and "hooked" his/her arms under the VA's armpit area temporarily restraining the VA, and at some point, grabbed the VA's wrist.

  - The SP provided information for the facility's internal review that s/he grabbed the VA's wrist to stop him/her from leaving and the VA pulled away and dropped to the ground.

There were no criminal charges related to the incident.

G1 and G2 provided the following information:

- G1 and G2 had no concerns about the supports the VA got at the facility. If the VA had an issue at the facility s/he would have let G1 or G2 know. The VA might get "worked up" and "stuck" on items. The VA fixated on things like food, which might lead to him/her leaving the facility without supervision. If staff persons were not able to find the VA, they contacted LE.

- On April 27, 2024, the P texted and emailed G1 and G2 about the April 25, 2024, incident.

- When LE talked with the VA, the VA said the SP "hit" him/her when the SP was "helping" the VA. When G1 had lunch with the VA soon after the incident and the VA said, "[The SP] grabbed me and I got a bloody nose."

The CM had no concerns about the supports the VA received at the facility. The CM was not aware of any recent times the VA left the facility without supervision, nor any history of the VA self-injuring. If the VA had a concern about the facility s/he would tell "anyone that will listen." The CM was emailed a copy of the incident report. The CM did not talk with the VA about what happened.

The Facility's *Emergency Use of Manual Restraint (EUMR) Not Allowed Policy* stated:

- Positive support strategies and techniques must be used to attempt to de-escalate a person's behavior before it poses an imminent risk of physical harm to self or others.

- Physical contact or instructional techniques must use the least restrictive alternative possible to meet the needs of the person and may be used to... block or redirect a person's limbs or body without holding the person or limiting the person's movement to interrupt the person's behavior that may result in injury to self or others, with less than 60 seconds of physical contact by staff or to redirect a person's behavior

when the behavior does not pose a serious threat to the person or others and the behavior is effectively redirected with less than 60 seconds of physical contact by staff.

- Restraint may be used as an intervention procedure to… assist in the safe evacuation or redirection of a person in the event of an emergency and the person is at imminent risk of harm.

- The facility did not allow the emergency use of manual restraint.

Facility documentation showed that the P and SP received training on the VA's plans, "EUMR Holds," and the Reporting of Maltreatment of Vulnerable Adults Act.

Minnesota Statutes, section 245D.04, subdivision 3, paragraph (a), clause (15) states that a person's protection-related rights include the right to engage in chosen activities.

Conclusion:

On the evening of April 25, 2024, the VA finished eating food that was ordered for him/her and wanted food that was being saved for R2. The SP told the VA that s/he just ate a meal and not to eat the saved food. The VA got upset and went upstairs to the kitchen and began to microwave more food. R1 and the SP followed the VA upstairs. The SP told the VA s/he could not have more food, stopped the microwave, and removed the food. The VA became upset, wanted to leave the facility, and opened the patio door. At that point, the SP and the VA had a physical altercation. The VA sustained bruises and a bloody nose during the incident, after the incident the VA said his/her wrist hurt, and the following day CP2 said the VA was "almost in tears" and CP5 said the VA appeared "distraught" about the incident.

The VA provided inconsistent accounts to various persons regarding the specifics of the physical interaction with the SP, including that the SP hit the VA, threw the VA, grabbed the VA by the shirt and "tossed" the VA, and/or "beat [the VA] up." R1 said the SP grabbed the VA's wrist, pulled the VA away from the door, and the VA fell on the floor, then the VA hit his/her own face, causing a bloody nose. The SP also provided inconsistent information regarding the specifics of the physical interaction with the VA. The SP provided information for the facility's internal investigation that s/he pulled the VA's wrist to keep him/her from leaving the facility. However, the SP told the DHS investigator that s/he physically redirected the VA away from the doorway by approaching the VA from behind, placing one arm between the VA's torso and arm and lifting up, and using his/her other arm to take hold of the VA's wrist, pulling it toward the VA's body. The SP then guided the VA away from the door, during which the VA and the SP fell to the floor where the VA slapped him/herself in the face several times, then his/her nose began to bleed.

Regarding physical abuse:

Given the inconsistencies in the VA's accounts of what happened, that the VA had a history of hitting him/herself, and that the SP and R1's version of events were consistent that the VA's injuries were self-inflicted, there was not a preponderance of the evidence as to whether the SP engaged in conduct that was not an accident or therapeutic conduct that produced or could reasonably be expected to produce physical pain or injury.

It was not determined whether 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 neglect:

The VA did not have any tights restrictions. The SP's refusal to permit the VA access to food, and interference with the VA's food preparation, was contrary to both the VA's plans and the facility's policies and procedures, which each required that staff persons attempt to de-escalate the VA's behavior using positive support strategies; and was also a violation of Minnesota Statutes, section 245D.04, subdivision 3, paragraph (a), clause (15).

The facility's policies and the VA's support plans did allow for physical redirection and body guidance for less than 60 seconds as a "last resort" when the VA was at imminent risk of harm. However, the VA was not at imminent risk of harm when s/he was attempting to leave the facility on the evening of April 24, 2024. In addition, the SP did not position him/herself between the VA and the door to block the exit as stated in the VA's plan. Rather, the SP used a physical intervention that involved holding the VA from behind and/or pulling on the VA's wrist, and in using physical intervention to turn the VA away from the exit, the two fell and ended up on the floor.

While the SP limited the VA's freedom of movement by hooking him/her under the arm, grabbing the VA's wrist, and turning the VA away from the door when there was not an imminent risk of harm, there was not a preponderance of evidence that the physical interaction exceed the 60 second timeframe of a physical redirection, nor that the act itself harmed the VA as opposed to the VA dropping to the floor and self-injuring. Therefore, there was not a preponderance of the evidence as to whether the SP failed to supply the VA with care and services which were both reasonable and necessary to maintain the VA's physical and mental health and safety.

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

Action Taken by Facility:

P1 completed an *Internal Review* which stated that policies and procedures were adequate and followed by the SP. The facility planned to complete a refresher course on EUMRs for all staff persons. The VA's *Care Plan* was changed to state staff persons were to "block [the VA] or the exit… redirect, and help guide [his/her] body back in."

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

On February 21, 2025, the facility was issued a Correction Order for the licensing violation outlined above.