

**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:** 202405726

**Date Issued:** February 27, 2025

**Name and Address of Facility Investigated:**

**Disposition:** Inconclusive

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

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

**License Number and Program Type:**

1070306-H\_CRS (Home and Community-Based Services-Community Residential Setting)  
1070299-HCBS (Home and Community-Based Services)

**Investigator(s):**

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**Suspected Maltreatment Reported:**

It was reported that there were multiple unexplained injuries to a vulnerable adult (VA).

There were also concerns about multiple unexplained injuries to another vulnerable adult who lived at the same facility during the same time period. Those allegations were investigated simultaneously and addressed in DHS report 202405861.

**Date of Incident(s):** June 30 to July 16, 2024

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

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

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

**Summary of Findings:**

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

The VA was diagnosed with profound intellectual disability, cerebral palsy with spastic quadriplegia, and a seizure disorder. The VA was not able to verbally communicate but was able to communicate with a "low tech" communication board.

*According to the VA's Coordinated Services and Support Plan (CSSP) Addendum and the VA's Self-Management Assessment:*

- Staff persons assisted the VA with "all activities of daily living" including dressing, grooming, bathing, eating, toileting, and all other personal cares.
- The VA had movement in his/her arms and was able to grasp objects, but had "limited" fine and gross motor skills.
- The VA used a wheelchair for mobility and relied on staff persons to propel his/her wheelchair. The VA's wheelchair was equipped with foot straps, a pommel (a raised cushion that sits between the upper legs to prevent sliding forward), and lap belts. For transfers, the VA used a ceiling lift or Hoyer lift with the assist of one staff person, and in the event no lift was available, needed the assist of two staff persons to transfer.
- The VA relied "completely" on staff persons to regulate his/her water temperature for hand washing and bathing.
- Staff persons scheduled all medical appointments, provided transportation to appointments, advocated

for the VA while at appointments, and ensured that health care professionals' recommendations were followed. G1 was notified of all medical appointments and made decisions regarding the VA's medical care. The VA was not able to articulate when s/he was ill or injured, so staff persons observed for signs that indicated the VA was ill or injured and sought medical attention "as needed." Staff persons contacted G1 when 9-1-1 was necessary.

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

- The VA was unable to identify potentially dangerous situations; lacked community orientation skills; had inappropriate interactions with other persons; and was unable to defend him/herself from verbally/physically aggressive persons. The VA had a history of bruising and/or scratch marks "of unknown origin due to uncontrolled spasticity."
- The VA extended his/her legs and arms due to "uncontrolled spasticity" and might inadvertently scratch, hit, or kick other persons. This put the VA at risk for aggression from others. To reduce this risk, staff persons ensured that the VA's wheelchair ankle straps were securely fastened or positioned the VA in a place with "ample" space to extend his/her legs and arms.
- Staff persons visually checked the VA at bath time and during dressing and changing for any signs or symptoms of injury. Any unusual scratches or bruises other than mentioned above were reported "promptly."

According to notes from a June 21, 2024, staff meeting, at shift change, staff persons conducted "full body skin checks" from head to toe. The two staff persons completed the skin checks together for "prompt and accurate identification of skin integrity and/or injuries." If any injury was noticed, staff persons monitored for pain and made sure that the injury was "promptly" documented and reported to a supervisory staff person, RN1, or RN2.

Facility documentation showed that staff persons, including the SP, were trained on the VA's plans; the staff meeting notes from June 21, 2024; and the Reporting of Maltreatment of Vulnerable Adults Act prior to the incidents.

*Regarding bruising on the VA's head:*

The VA's medical records provided the following information:

- On July 2, 2024, at 3:25 p.m., the VA was seen at urgent care for a "bump" on his/her face. P6 told the doctor that on June 30, 2024, the VA hit him/herself in the face, causing a bruise. On the morning of July 2, 2024, staff persons noticed the bruise spreading and brought the VA in for an evaluation.
- While at the appointment, P6 called RN1 who was "unaware" that the VA was at the clinic. RN1 was aware of the injury on the VA and that a "neuro screen" check had been completed at the facility.
- The doctor took photos and noted a greenish bruise from the right lateral third of the VA's forehead to below the right eye and down to the side of the VA's chin and neck. There was also a "Battle sign" with purple bruising behind the VA's right ear.

- The VA was diagnosed with a traumatic head injury “with Battle sign” and the medical records noted that the VA’s bruising was “not consistent” with the VA hitting him/herself on the head. The doctor could not rule out a skull fracture and advised taking the VA to the emergency room for advanced imaging.
- On July 2, 2024, at 4:47 p.m., the VA was seen in an emergency room for a “head injury.” The VA “reportedly” hit him/herself in the face “multiple times” and had bruising to the right side of his/her head and eye, with a “positive Battle sign.” According to the facility staff person at the hospital, the VA “struck” him/herself in the face three days prior. The VA was seen at an urgent care clinic earlier that day and was referred to the emergency room for evaluation.
- Photos taken while in the emergency room showed the VA had bruising on the right side of his/her forehead, down along his/her temple and right cheek, behind his/her right ear, and along his/her neck. The VA had a black eye on the right side.
- The emergency room did a computed tomography (CT) scan of the VA’s head and facial bones which was “unremarkable for acute traumatic pathology.”

According to The National Institute for Health’s National Library of Medicine, a Battle sign was bruising over the mastoid process (bone behind the ear) and was “typically” the result of head trauma.

According to the VA’s progress notes, the SP documented on June 30, 2024, at 1:30 p.m., while the SP changed the VA, the VA “was stretching [his/her] arms and legs strongly.” The VA then “hit [him/herself] face with [his/her] arm just beside [his/her] right eye.” The SP noticed a “small discoloration” and informed RN1 and P1 about the injury. An entry completed by the SP later on June 30, 2024, said there was a “black sign” behind the VA’s right ear and that the SP notified RN1 and P1.

The G provided the following information:

- On July 2, 2024, at 10:30 a.m., the G received a text message from P2 saying that the day prior (July 1, 2024), when staff persons changed the VA’s clothing, the VA hit him/herself with his/her arm on the face next to his/her right eye. The G went to the facility to see the VA and “the entire right side of [the VA’s] face and neck had bruises.” The bruising on the VA’s neck was yellow but the one near his/her eye was black and looked “newer.” There was also a “large red/purple” bruise and a “large red welt” behind the VA’s right ear. P2 was not able to tell the G how the VA received the additional bruises.
- The G requested that the facility bring the VA to urgent care for the bruising. Urgent care diagnosed the VA with a “Battle sign,” there were concerns that the VA had a skull fracture, and the VA was referred to an emergency room. An emergency room nurse told the G that s/he had “bad feeling” and did not think the VA caused the injuries from hitting him/herself.
- The VA was not able to hit him/herself in the face or head and was unable to grip objects.
- The G was concerned because there had been an increase in injuries to the VA in recent months that were not similar to the VA’s self-induced injuries caused by his/her spasticity. Typically, the VA’s self-induced injuries were to his/her forearms or hands when the VA moved them around with excitement.

RN1, RN2, P6, and the VA's progress notes provided the following information:

- On June 30, 2024, RN1 received a phone call from the SP that the VA hit him/herself on the face causing "some discoloration" around the VA's right eye. The discoloration was "fading" and the VA did not appear to be in pain. RN1 requested a picture of the injury and reminded the SP to follow up with documentation. RN1 also instructed the SP to put ice on the affected area, monitor for changes, and notify RN1 of any changes.
- Later that night, P6 informed RN1 that there was another bruise behind the VA's right ear. P6 reviewed the SP's progress notes about the bruising and P6 said the bruise s/he saw appeared related to what the SP documented. RN1 had P6 implement a neuro check (neurological assessment) and P6 said everything appeared "okay" so RN1 was not concerned as the injury seemed consistent with what the SP told RN1 about the VA hitting him/herself. P6 said that the VA did not appear to be in pain so RN1 advised P6 to monitor the VA and if there were any changes to bring the VA to a doctor for evaluation.
- On July 2, 2024, RN1 was not working but spoke to an unknown staff person at 1 p.m. about a picture that was sent to RN1 of the VA's bruising. The staff person said the VA did not appear to be in pain and there were no behavioral changes. RN1 asked if the G had been notified and the staff person did not respond. RN1 then texted the staff person and P1 that the VA should be seen since the new picture was not consistent with the SP's explanation and was "much worse in appearance" than was previously discussed. RN1 contacted RN2 who said that the new appearance of the bruising might be a progression of the preexisting bruise and the facility should continue monitoring the VA at the facility unless the G requested that the VA receive medical attention. RN1 then notified the facility and P1 to continue monitoring the VA and did not receive a response from either.
- Later that day, RN1 spoke to P1 and the staff person working and discussed that a neuro check needed to be completed and if there were concerns or if the G requested, then the VA needed medical attention.
- RN1 was not updated until later that day, when RN1 received a phone call from P6 who was at urgent care with the VA. The urgent care doctor explained to RN1 the appearance of the bruises and that they were "concerning" because the injuries were consistent with a "trauma, such as a fall" and not with the VA hitting him/herself. The doctor explained that the VA needed to go to the emergency room so RN1 explained this information to P6.
- RN1 then called the G who said earlier that day, the G was at the facility and had concerns about the VA's injuries and "care in general." While they were talking, the G said that urgent care was calling and ended the call with RN1. RN1 and P6 texted updates about the VA while in the emergency room, including that the doctor said that the VA's bruising was likely due to trauma.
- On July 3, 2024, RN1 entered the urgent care and emergency room doctor's notes, diagnosis, and follow up from the VA's visits into the facility's computer system.
- Later on July 3, 2024, RN2 documented the VA's bruises and the SP's information about how they occurred. RN2 noted that the VA's bruising was "consistent with the initial bruising dispensing due to gravity." RN2 said that internal bleeding could have "pooled" when the VA was laying down. Aside from

the appearance of the bruises, the VA's condition appeared to remain at baseline, including no information that s/he was in pain or behavioral changes.

- RN2 stated that the VA had a history of bringing his/her hands near his/her face. However, RN2 had not previously seen the VA hit him/herself on the face and head. When the VA became "excited" s/he flung him/herself around in his/her wheelchair.
- On July 5, 2024, RN1 saw the VA's bruising and noted it was "much improved" in appearance.

P1 and P2 provided the following information:

- The VA enjoyed when persons sang to him/her when providing cares. If the VA was "quiet" and did not move around, staff persons knew "right away" that something was wrong and that prompted staff persons to pay more attention to the VA and monitor the VA closely. If there was a concern, staff persons contacted the G who determined if the VA needed medical attention.
- The VA was "spastic," especially when s/he was excited about something, and moved his/her arms and hands around. P1 and P2 each stated that during spastic movements, the VA had previously hit him/herself in the face and had hit his/her hands on his/her wheelchair.
- P1 and P2 each stated that whenever transferring the VA, two staff persons assisted.
- P2, P3, P5, P7, and the SP were the main staff persons who worked with the VA, and there were also occasional float staff persons who rarely worked at that location.
- On June 30, 2024, at 1 p.m., P1 received a phone call from the SP saying that the VA kept moving his/her hands when the SP was changing the VA and the VA hit him/herself near his/her eye. The SP sent P1 a picture of the VA that showed a "tiny spot" above the VA's eye and "a little black" inside the VA's eye. P1 told the SP to contact RN1 and to notify the G "as soon as possible" so s/he was aware. The SP asked P1 if it was "okay" to hold the VA's hands while changing the VA and P1 told the SP s/he was not allowed to restrain the VA.
- P1 did not go to the facility until July 2, 2024, and saw the VA's bruise had spread behind his/her ear. P1 contacted RN1 who said that s/he instructed staff persons to put an ice pack on the bruise and that was how it possibly spread. P1 asked P6 if the bruise had previously been "this bad" and P6 responded it had been but RN1 told him/her to continue monitoring. P1 then notified the G of what P1 saw.
- P1 and P2 were at the facility during weekdays and did not have concerns about staff persons' interactions with the VA. P1 thought the bruising possibly spread because of the ice pack or pooling from the VA lying down in bed. P1 did not think the bruise was the result of physical abuse because s/he was often at the facility but never had concerns about staff persons' interactions with the VA.

P3 thought that other staff persons did not "deliberately" injure the VA but were not careful when providing cares. The VA was spastic but was not able to reach his/her face. The VA's bruises had recently increased and P3 was unable to explain why. P3 thought P5, P6, and the SP needed additional training because they worked most

often with the VA and were “rougher” with things such as using the lift. P3 previously told P1 about his/her concerns about staff persons being properly trained.

P6 stated on an unknown date, when s/he arrived at the facility, s/he saw bruising on the VA’s face so s/he called RN1 and P6 drove the VA to the hospital. P6 did not remember what the doctor said about the bruising. The VA had previously hit him/herself on the face when moving his/her hands. P6 denied causing the bruising on the VA’s head and face and denied any concerns about other staff persons’ interactions with the VA.

P4 stated that the VA had a history of putting his/her hand in front of his/her eyes. The VA was “very spastic” and it was possible that the VA hit him/herself on the forehead. P4 did not have concerns about staff persons interactions with the VA.

P5 stated that the VA moved his/her hands around “a lot” and it was possible that caused the bruises. P5 was not working at the facility around the time of the bruising and did not have concerns about other staff persons’ interactions with the VA.

The SP stated that on multiple previous occasions, the VA hit him/herself while the SP changed the VA’s clothing or when the VA was “agitated.” The SP did not recall specifics about this incident but denied doing anything to cause bruises to the VA.

**Conclusion regarding bruising on the VA’s head:**

The VA needed assistance from staff persons for mobility and “all activities of daily living,” and his/her plans stated that s/he had a history of bruising and/or scratch marks caused by his/her “uncontrolled spasticity.”

Consistent information was provided that on June 30, 2024, the VA sustained a bruise on the right side of his/her face. The VA’s medical records from July 2, 2024, showed the VA had a Battle sign, which was “typically” the result of head trauma, and the VA was diagnosed with traumatic head injury.

The SP documented in the VA’s progress notes that the bruise was a result of the VA hitting him/herself in the face while changing on June 30, 2024. Although P1, P2, P6 and the SP each said that the VA had previously hit him/herself in the face during spastic movements, the G and P3 each said the VA was incapable of hitting him/herself in the face or head, and the VA’s medical records noted that his/her injuries were “not consistent” with the VA hitting him/herself on the head.

Although the VA’s injury was concerning, given that the SP denied doing anything to cause the bruises, P1-P6 did not have concerns about other staff persons’ interactions with the VA, and there was no other information provided on how the VA sustained the injury, there was not a preponderance of the evidence as to the cause of the bruise.

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

to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult and which is not the result of an accident or therapeutic conduct).

Regarding blisters on the VA's hand:

The VA's medical records provided the following information:

- On July 16, 2024, at 8:33 p.m.:
  - The VA was seen at an emergency room for a "hand injury." The G told the doctor that earlier that morning, a staff person called the G and said that the VA had "hit" his/her hand on a chair and his/her hand was swollen but s/he was able to move it. The VA developed blisters throughout the day on his/her right hand.
  - The G said that the VA had a bath that morning and right after the bath, the VA started hitting his/her hand. Otherwise, the VA was "isolated" inside his/her bedroom. The G said that the VA was left hand dominant and did not "commonly open [his/her] right hand." The VA was recently exposed to COVID but the G said s/he had a negative rapid test.
  - The doctor noted that the blisters were only on the VA's right hand, and photos taken at the emergency room showed there were red or blistered areas on the VA's right wrist, lower right palm, and along the lateral side of the VA's right hand. Although the VA recently started an antibiotic for an unrelated issue, the appearance was "dissimilar" to any drug rash and was limited to a single location.
  - Given the development of the VA's blisters throughout the day, a possible hot water injury "appear[ed] the most likely [cause]" at the time. Another doctor "briefly" examined the VA's hand and concurred that the appearance was similar to a "scalding injury." It was not consistent with a with a forced immersion because of the scattered lesions across the VA's hand.
  - The VA was diagnosed with deep partial thickness burn of his/her right hand and superficial burn of multiple sites of right hand. The VA was given pain medication and referred to a burn specialist.
  
- On July 19, 2024, the VA was admitted to a hospital for "ongoing right-hand swelling, blisters/skin lesions, as well as concerns of abuse" at the facility. According to a dermatologist, the VA had flaccid fluid filled lesions on his/her right palm, knuckle, third finger, and right lateral hand. The VA also had bruising on his/her right wrist and forearm. Biopsy of the lesions were "most consistent with a reaction to prior trauma."

The G stated on July 16, 2024, at approximately 11:30 a.m., P2 called the G and said that the VA's right hand was "swollen" and the VA had been "banging" his/her hand on his/her wheelchair. At approximately 5:30 p.m., P2 called the G again and said that the VA had blisters on his/her hand. The G told P2 to bring the VA to the emergency room. The G met the VA at the emergency room and the doctor said that the VA had burns consistent with splash or splatter burn. The G texted P2 and told him/her that the VA was burned and P2 did not understand how the VA could have sustained burns. On September 14, 2024, the G found a lighter in the VA's bedroom behind furniture. The G did not provide information linking the lighter to the burn on the VA's hand.

RN1, RN2, P1, P2, P4, and the VA's progress notes provided the following information:

- RN1 stated that between July 9 and 11, 2024, the VA was seen by a doctor and diagnosed with an ear infection and had a fever. On July 15, 2024, the VA had a seizure and later that day tested positive for COVID.
- On July 16, 2024, P2 saw that the VA's right hand was swollen and called the on-call registered nurse and the G. P2 sent the on-call nurse a picture of the VA's right hand and the VA's hand was "slightly puffy" with "slight discoloration on his/her last three knuckles." The on-call nurse noted it was possibly bruising and it was unknown how the VA received these injuries since the VA had COVID and was isolated in his/her bedroom. The on-call nurse noted that the VA was "very spastic" and hit his/her hand "frequently" on the wheelchair. The on-call nurse told P2 to give the VA acetaminophen and apply a cold pack for the swelling. P2 later notified the on-call nurse that the VA's skin turned "black" from the cold pack.
- P2 also notified P1 who looked at the VA's hand and thought that the VA possibly injured it by hitting his/her hand on the wheelchair. P1 called the G and RN1 who asked that staff persons continue to monitor the VA for changes.
- P4 spoke to the G about the VA's wheelchair. They discussed the hard molded armrest pad and P4 explained that the pad was intended to keep the VA from putting his/her hand behind the insert, getting his/her hand stuck, and possibly injured. They agreed to keep the armrests how they were and not change them.
- Around 5 p.m. on July 16, 2024, P2 noticed that there were blisters on the VA's hand and called the on-call nurse again and said that the VA had blisters on his/her hand and sent the on-call nurse another picture. The on-call nurse noted that the blisters were "concerning." P2 notified the G who requested that the VA be seen at the emergency room so a staff person brought the VA in.
- Later that day, the G called P1 and told him/her that the doctor said the VA had "burns" on his/her hand and it occurred between 5 p.m. on July 16 and 5 a.m. July 15, 2024.
- P1 was unsure how the VA got the burns on his/her hand. The VA was isolated in his/her bedroom because s/he had COVID and staff persons did not bring any hot beverages or other hot items into the VA's bedroom. P1 worked until 9 p.m. the prior evening and did not see any staff persons go into the VA's room with hot liquids or do anything concerning to the VA. P5 and another staff person (P8) worked the overnight shift and P1 did not have concerns about either of their interactions with the VA.
- RN1 did not know what caused the blisters. RN1 asked P2 to check the facility's water temperature and it was within normal limits. RN1 asked if the VA had prolonged sun exposure and was told the VA had not been outside. RN1 researched online about the VA's antibiotics or seizure medications but did not find anything that would explain the blisters.
- On July 19, 2024, RN1 created a late entry dated July 18, 2024, that said P2 called RN1 in the morning because the VA's left hand was "red" and swollen. RN1 told P2 to contact the G about the concerns.

Later that day, RN1 showed up to the facility and looked at the VA's left hand and did not see any new concerns.

- On July 18, 2024, RN2 spoke to the G on the phone who wanted the VA brought to the emergency room for "new swelling." RN2 asked the G about the "new swelling" and the G said s/he received a video earlier that morning "that was not help to [him/her]." RN2 looked at the VA's left hand and told the G that there was no visual sign of injury; including no swelling, redness, or discoloration to the left hand. RN2 saw that the VA's ring and index fingers were "larger" than the rest of his/her fingers but that was baseline for the VA. The G agreed not to have the VA transported to the emergency room until the following day. RN2 asked the G to discuss with the doctor the potential that the blistering on the VA's hand was from COVID as there were reports of COVID causing blisters and skin lesions. RN2 had no information that the VA was exposed to anything hot that could cause a splatter burn and the VA was isolated in his/her bedroom when the injury was thought to have taken place.
- Later on July 18, 2024, RN1 contacted the VA's blood doctor and left a voicemail to discuss possible cutaneous porphyria (buildup of chemicals in the body) but had not received a call back. RN1 emailed the G to ask the doctors about this as a possible explanation for the blisters on the VA's right hand. The G responded that cutaneous porphyria, COVID, and medications were all ruled out as possible causes by the doctors. The G also wrote that the blisters were being biopsied and that the VA was admitted to the hospital.
- RN1 and P2 each said it was also possible that the blisters were friction burns caused by his/her hands rubbing on his/her wheelchair. RN1 "felt strongly" that this was the case.
- RN1 and RN2 did not think staff persons caused the injuries to the VA and thought that what staff persons said happened to the VA was consistent with his/her injuries. When RN1 was at the facility, s/he did not see staff persons doing anything "harmful" or "negligent." RN2 thought staff persons were "hyperaware" of any marks or injuries to the VA because they were "so scared" of the G. When RN2 saw staff persons working with the VA, s/he saw "a lot of care and positive interactions" and did not have concerns about staff persons' interactions with the VA. When the VA received an injury, the facility took steps to correct and make sure the VA was not injured the same way again.
- P1 and P2 were at the facility during the weekdays and did not have concerns about staff persons' interactions with the VA.

P4 stated that the VA had a history of putting his/her hand near the wheels of his/her wheelchair. It was possible that the VA's hand was caught in the wheelchair and/or s/he rubbed it on his/her wheelchair without staff persons' knowledge. P4 did not know of any other way the VA possibly received the blisters on his/her hands and P4 did not have concerns about staff persons' interactions with the VA.

P5 originally thought that the VA's blisters were caused by a bug bite because s/he was outside a few days prior to staff persons noticing them. P5 denied doing anything to cause the blisters and did not have concerns about other staff persons' interactions with the VA.

P6 did not work around the time that the VA received the blisters on his/her hands but on an unknown date when P6 returned to work, another staff person told P6 that the VA was in the hospital with blisters on his/her hands.

The SP did not work at the facility around the time of the VA's blisters. The SP "could not imagine" how the VA sustained the blisters. The SP did not have concerns about other staff persons interactions with the VA.

**Conclusion regarding blisters on the VA's hand:**

Consistent information was provided that on July 16, 2024, the VA's right hand was swollen and later developed blisters. The VA was diagnosed with deep partial thickness burn and multiple superficial burns on his/her right hand, and medical records stated that hot water appeared to be the most likely cause of the burns. However, there was no information provided that the VA's right hand had contact with hot liquids on July 16, 2024. Although the VA might have washed his/her hands on this date, RN1 provided information that the facility's water temperature was within normal limits. In addition, RN1 and P1 each thought the VA's blisters could have been caused by friction when the VA rubbed his/her hands against his/her wheelchair. Although the VA's burns were concerning, given that P1-P6 and the SP did not have concerns about other staff persons' interactions with the VA; and there was no other information provided that explained how the VA sustained the injury, there was not a preponderance of the evidence as to how the VA sustained the burns.

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

**Action Taken by Facility:**

The facility completed an internal review and determined that policies and procedures were adequate but not followed. The G and the CM were not notified timely of the VA's bruise because of a failed text message. P1 notified the G and the CM as soon as s/he realized the error. Because of the increase in injuries, staff persons were reminded to "use care" when assisting the VA.

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

No further action taken at this time.