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: 202408278

Date Issued: March 5, 2025

Name and Address of Facility Investigated:

Heartland Homes of Duluth LLC
3051 Morris Thomas Road
Duluth, MN 55811

Heartland Homes of Duluth LLC
1086 88th Street W
Duluth, MN 55808

Disposition: Substantiated as to neglect of a vulnerable adult by SP1 and SP2.

License Number and Program Type:

1073502-H_CRS (Home and Community-Based Services-Community Residential Setting)
1073498-HCBS (Home and Community-Based Services)

Investigator(s):

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Licensing Division
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Suspected Maltreatment Reported:

It was reported that a staff person (SP1) smoked marijuana with a vulnerable adult (VA) and gave the VA a "weed pen" that contained marijuana. During the course of this investigation, it was also reported that that another staff person (SP2) gave the VA marijuana.

Date of Incident(s): September 21 or 22, 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 17, paragraph (a):

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 October 9, 2024; from documentation at the facility; and through eight interviews conducted with two supervisory staff persons (P1 and P2), a facility staff person (P3), the VA's guardian (G), two clients (C1 and C2), the VA, and SP2. Attempts to reach SP1 via telephone and United States mail to request an interview were unsuccessful. SP1 no longer worked at the facility.

The VA was diagnosed with major depression, a seizure disorder, schizoaffective disorder, anxiety, and an intellectual disability. The VA enjoyed going to the movies, going to the library, going shopping, and spending time with family. The VA lived at the facility which was a three-level house with two other clients. The VA had a hard time saying, "No," to people, according to the VA's plans. In the Spring of 2024, the VA was going to attend a substance-use disorder (SUD) treatment program for the use of marijuana but when the VA's transportation to the SUD program arrived, the VA refused to go. The VA was of legal age to use marijuana.

The facility's *Alcohol and Drug Use* policy stated that it was not permissible for staff persons to be "on duty when under the influence of alcohol or illegal drugs or impaired by any chemicals or prescription/legal drugs." Additionally, the facility's *Employee Handbook* stated that smoking, including e-cigarettes was prohibited in the facilities, offices, and vehicles.

The VA provided the following information regarding SP1 smoking marijuana with the VA:

- A few weeks prior to this interview, SP1 gave the VA a red "weed pen" without anyone else knowing. It was "almost empty" when SP1 gave it to the VA, but it was empty now because the VA used it. SP1 did not like when the VA would stay upstairs in his/her bedroom, not wanting to be downstairs. When the VA smoked marijuana, s/he was "more active and talkative" and SP1 wanted the VA to "hang out with staff" more.

- The VA stated that SP1 did not smoke marijuana or a tetrahydrocannabinol (THC) "pen" with the VA while SP1 was working. SP1 "vaped" nicotine inside the facility and also allowed clients to do so. The VA could tell the difference between a nicotine "vape" and a THC pen because THC pens were "longer and skinnier."

- Several weeks prior to the interview, the VA had a friend over to hang out on the facility porch, never going inside the facility. The VA had a "homemade bong," and the friend was going to have another friend drop off some "weed," but the friend never did, so they did not smoke anything. The VA's friend did not "stay long" because one of the other clients did not "feel safe" so SP1 told the VA that the friend needed to leave. SP2 was also working that day and went out to the porch to "nicely" tell the VA's friend that another client was having a "panic attack" and that the friend needed to go so the VA's friend left.

- The VA bought his/her own marijuana from a smoke shop while on a 30-minute walk from the facility and stated that P1 said that residents could smoke as long as it was away from the facility but P1 changed his/her mind because s/he thought the VA's physician should be the one to approve that.

- The VA heard that SP1 no longer worked at the facility because s/he was "always laying" on the couch the "whole time," sometimes "playing" on his/her phone, and "not really doing anything" around the facility. When declining to take clients to their scheduled activities, SP1's "excuses" were that s/he was "too tired to drive" or that s/he did not "want to do that."

- SP1 never missed giving the VA's medications due to laying or sleeping on the couch and did not know if SP1 had missed giving any other clients medications due to sleeping on the couch.

SP2 provided the following information:

- On September 21, 2024, at about 2:15 p.m., the VA had a guest visiting the facility and they were sitting on the deck so SP2 sent a text message to P2 asking if the VA was allowed to have guests. The guest brought a "weed bong" but no one had any marijuana at the time. P2 told SP2 that it was "definitely a no" for the VA to have guests if there was "weed." SP1 asked SP2 to address the fact that the VA had a guest because SP1 did not want the VA "to not trust" SP1 after SP1 "worked so hard" to get the VA to trust SP1. SP2 told the VA's guest that s/he would call 9-1-1 if s/he had marijuana and was smoking it on the facility property.

- During the conversation between SP1 and SP2, SP1 told SP2 that SP1 and the VA smoked "pot together all the time" and SP2 relayed this information to P2 via text messages. SP2 also said that SP1 admitted to smoking "weed" with the VA "once." SP1 clarified to SP2 that they had smoked "weed carts [cartridges]" not the marijuana plant.

- SP2 did not think that SP1 smoked "weed" with any of the other clients, but SP1 would also sleep during shifts on the facility couch and smoke a nicotine vape pen inside the house. SP2 took videos of SP1 sleeping and laying on the couch and sent them to P2. In one of the videos, SP1 could be heard "snoring." SP2 knew the difference between the smell of a nicotine vape pen versus a "weed pen" because of the "burning oil" odor of the marijuana versus the "fruity" smell of the nicotine pen. Also, the shapes of the two types of pens differed. SP1 and the VA "shared everything" from food to sharing the "vape pen."

- SP2 did not see SP1 smoking the "weed" pen with the VA on September 22, 2024. P2 relieved SP1 of the remainder of his/her shift on September 22, 2024.

P2 provided information consistent with SP2's account regarding the text messages and added the following information:

- On September 21, 2024, the VA had a guest over in the afternoon that brought a marijuana "bong" and P2 told SP2 to have the guest leave or 9-1-1 would be called. Additionally, SP2 told P2 that SP1 had admitted to smoking marijuana with the VA "once."

- On September 22, 2024, P2 relieved SP1 of his/her shift at about 4:30 p.m. and spoke with SP1. P2 asked SP1 about sleeping on shift, not helping at the facility, and smoking marijuana with clients. SP1 looked "shocked," and denied smoking marijuana with clients while working but did not deny sleeping. P2 told SP1 that s/he could leave and that P2 would finish the shift. P2 then reported the information to his/her supervisor.

- The facility's policy stated that smoking anything inside the facility was not allowed and there was "no tolerance" for showing up to work "inebriated" or to be using substances while working.

- The VA denied smoking marijuana with SP1, denied seeing SP1 smoke inside the facility, but said that SP1 would "lay down a lot."

- The VA sometimes had a "hard time" admitting "the truth" but would end up "admitting to things.".

P1 provided information consistent with P2 and SP2 and added the following:

- SP1 and SP2 were scheduled to work from 9 a.m. to 9 p.m. at the facility on September 21 and 22, 2024.

- The VA stated that they did not have marijuana when his/her friend was over, but that they were "looking for some." The VA and SP2 told "the same story" to P1.

- After initially denying where it came from, the VA told P1 that s/he got a "weed pen" from SP1. SP1 denied giving the VA a "weed pen" to P1 but according to SP2, SP1 said that s/he gave the VA a "weed pen."

- P1 saw the videos that SP2 sent to P1 which showed SP1 laying and sleeping on the couch both September 21 and 22, 2024. P1 thought that SP1 "missed" giving another client noon medications due to "sleeping" through the 11 a.m. to 1 p.m. medication window but did not know for sure and P1 was unable to provide documentation that showed any medications were missed.

- The VA was "not always accurate," and would sometimes hide information. The VA did not want to get SP1 "in trouble." Once the VA began to talk about details, s/he was usually "pretty accurate." The VA admitted to smoking "weed" and had recently been "respectful" and smoked marijuana off the facility property since marijuana had become legal and the VA was of legal age to use it.

During the course of this investigation, information was provided that SP2 gave marijuana to the VA. The VA did not want to be interviewed again regarding this. However, the VA provided the following information to P1:

- P3 told P1 that after the interview with this investigator, the VA was "agitated" and told P3 that on the weekend that SP1 gave the VA "weed," that SP2 took a 30 minute smoke break in his/her car where SP2 smoked marijuana, then gave the VA marijuana and said, "You cannot tell anyone about this."

- The VA "knew the outcome" of letting staff persons know about this and did not want to talk to this investigator about this incident.

P3 provided the following information:

- After the VA met with this investigator and went back to the facility, something was "bothering" the VA for the rest of the day. The VA was "upset" and told P3 that s/he felt it was "not fair" that SP1 was getting "in trouble" when what SP2 did was "much worse." The VA said that one day, SP2 "cued" the VA to SP2's car while C1 and SP1 were inside the facility. SP2 then gave the VA two marijuana "buds" and told the VA not to tell anyone. That same day, SP2 took a 30-minute break in his/her car and "smoked" marijuana in his/her car. C1 and the VA told P3 they saw this happen, but that C1 was not around to see SP2 give the VA the "buds."

- P3 thought that "maybe" the VA and C1 knew it to be marijuana versus cigarettes because the driveway was "extremely close" to the facility and that they possibly smelled the odor.

- P3 took the VA to visit C2 (who had moved out of the facility during the course of this investigation) and was talking about the incident. C2 said that it was "not fair" and that SP2 also offered C2 marijuana once. P3 told C2 and the VA that they should not be discussing an open investigation.

C1 provided the following information:

- Sometime in early September 2024, C1 saw SP2 on a 30-minute break, smoking marijuana in SP2's vehicle. C1 knew that SP2 was smoking marijuana because it "smelled very strongly" of it. Sometime in the afternoon or evening after this investigator interviewed the VA, the VA told C1 that SP2 gave the VA "two buds" of marijuana on a prior occasion.

- C1 smelled the odor of marijuana on SP2 another time, on a weekend, when SP2's significant other stopped by to drop something off. SP2 and the significant other were by and inside SP2's vehicle and SP2 "came out smelling like weed." C1 did not think any other staff persons or clients saw this that day.

C2 provided the following information:

- C2 moved to a different facility on September 24, 2024. Sometime when C2 was still living at the facility, s/he saw a staff person, whose description matched SP2, but the name could not be recalled, smoking marijuana in the front seat of his/her vehicle. C2 knew it was marijuana because of the "smell that was on" SP2. SP2 went out "every hour" to smoke marijuana.

- This was the only instance in which C2 had observed a staff person smoking marijuana. C2 did not see SP2 or any other staff person give any clients in the facility any marijuana, but was told by the VA that SP2 gave some to the VA and smoked it with the VA on the porch.

SP2 denied ever smoking marijuana with or giving marijuana to the VA. SP2 denied smoking marijuana in his/her car while working and stated that s/he did not smoke marijuana or cigarettes at all. SP2 stated that his/her vehicle smelled like marijuana because SP2's significant other smoked marijuana while using SP2's vehicle.

The G provided the following information:

- The VA was "quiet," "independent," and was "very social." The G was told that the VA was given marijuana by SP1 over the weekend prior to September 23, 2024, and had also been asking to use marijuana but that it was not allowed in group settings. The G was not sure why SP1 would give the VA marijuana as that was "not okay."

- The VA told the G that "a staff person" had "okayed" the VA inviting a friend over, that staff persons knew that a friend was coming, and that no one indicated there was a problem that the friend would be there.

- The VA was very "truthful" and would often "tattle on" him/herself.

- The VA had been told by staff persons that s/he could smoke marijuana during his/her 30-minute walks away from the facility. The G was "fine" with this as long as the VA's physician gave the approval which at the time of this investigator had not been given.

All staff persons interviewed for this investigation were trained on the Reporting of Maltreatment of Vulnerable Adults Act, the facility's *Alcohol and Drug Use* policy, and the VA's plans.

Conclusion:

A. Maltreatment:

Regarding SP1:

Information was consistent that the VA said SP1 gave the VA an "almost empty weed pen" containing marijuana that the VA then used the rest of. The VA had a history of using marijuana and had been planning along with his/her team to enter a substance use disorder program for using marijuana and then refused to go.

SP2 stated that SP1 told SP2 that s/he and the VA had smoked "pot together all the time." SP2 later said that SP1 admitted to smoking marijuana with the VA "once." SP1 clarified to SP2 that they had smoked "weed carts [cartridges]" not the marijuana plant.

The VA stated that SP1 never smoked marijuana or THC pens with the VA, and the VA never witnessed SP1 smoke marijuana while working. C1 and C2 did not witness SP1 smoking with the VA.

SP1 denied giving the VA a "weed pen" or smoking marijuana with the VA.

Although SP1 denied giving the VA the pen and denied smoking marijuana with the VA, given that SP1 had reason to minimize his/her actions for fear of consequences, that the VA provided consistent information to different people, that SP2 stated SP1 told SP2 that SP1 and the VA smoked marijuana together, and that the VA and his/her team had a goal of the VA attending substance use disorder treatment for marijuana use, there was a preponderance of the evidence that SP1 failed to provide the VA with reasonable and necessary care and services.

It was determined that 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).

Regarding SP2:

Information was consistent that the VA said that SP2 smoked marijuana in his/her car and also gave the VA two marijuana "buds" that the VA then used. The VA had a history of using marijuana and had been planning along with his/her team to enter a substance use disorder program for using marijuana and then refused to go.

Information from P1, P3, and the VA showed that after the VA met with this investigator, s/he became "agitated" and "upset" because according to the VA, s/he did not think it was "fair" that SP1 was getting "in trouble" when SP2 also gave the VA two marijuana "buds." According to the VA, C1, and C2, SP2 would smoke marijuana in his/her vehicle during work breaks and came back smelling like the "odor" of marijuana. C2 stated that SP2 would do this "every hour" when s/he worked at the facility. C1 and C2 did not witness, but heard from the VA that SP2 gave the VA two marijuana buds.

SP2 denied ever smoking marijuana with or giving marijuana to the VA. SP2 also denied smoking marijuana in his/her car while working and stated that his/her vehicle smelled like marijuana because SP2's significant other smoked marijuana while using SP2's vehicle.

Although SP2 denied giving the VA marijuana, given that SP2 had reason to minimize his/her actions for fear of consequences, that the VA provided consistent information to different people, that C1 and C2 provided information consistent with the VA's information even though they did not see the marijuana "buds," and that the VA and his/her team had a goal of the VA attending substance use disorder treatment for marijuana use, there was a preponderance of the evidence that SP2 failed to provide the VA with reasonable and necessary care and services.

It was determined that 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).

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 and SP2 were each trained on the VA's plans and the facility's *Alcohol and Drug Use* policy. SP1 and SP2 were each 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 neglect for which SP1 and SP2 were responsible did not meet statutory criteria to be determined as recurring or serious because each was a single incident, and the VA was not injured.

Action Taken by Facility:

According to the facility's *Internal Review,* policies and procedures were adequate but were not followed for both allegations. There was a need for staff person training. There was not a need for corrective action by the facility because SP1 no longer worked at the facility and SP2 was being moved to a different facility location.

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

SP1 was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, SP1 was notified by the Office of Inspector General that any further substantiated act of maltreatment, whether or not the act meets the criteria for "serious," will automatically meet the criteria for "recurring" and will result in disqualification. The determination that SP1 was responsible for maltreatment is subject to appeal.

SP2 was not disqualified from providing direct care services as a result of the maltreatment determination in this report. The determination that SP2 was responsible for maltreatment is subject to appeal.