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:** 202501001

**Date Issued:** June 18, 2025

**Name and Address of Facility Investigated:**

Residential Services of NE MN Inc
552 Anderson Road
Duluth, MN 55811

Residential Services of Northeastern MN, Inc.
2900 Piedmont Avenue
Duluth, MN 55811

**Disposition:** Substantiated as to neglect of a vulnerable adult by a staff person.

**License Number and Program Type:**

1070764-H_CRS (Home and Community-Based Services-Community Residential Setting)
1070738-HCBS (Home and Community-Based Services)

**Investigator(s):**

Emily Kearns/Heidi Murphy
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
Emily.Kearns.2@state.mn.us
651-431-6513

**Suspected Maltreatment Reported:**

It was reported that a vulnerable adult (VA) obtained and swallowed a pen which needed to be surgically removed. A staff person (SP) failed to provide supervision and follow policies regarding the VA's access to the pen.

**Date of Incident(s):** February 2, 2025

**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 March 3, 2025; from documentation at the facility and medical records; and through nine interviews conducted with the VA, the SP, a facility supervisory staff person (P1), facility staff persons (P2, P3, P4, P5, and P6), and the VA's guardian (G).

The facility was a single-family, one-story residence with a basement in a residential neighborhood that was staffed 24 hours per day. The VA's bedroom was on the main floor off the dining room area, which was open to the living room area.

The VA had a diagnosis of a mild intellectual disability, diffuse traumatic brain injury, post-traumatic stress disorder, borderline personality disorder, and fetal alcohol syndrome. The VA had a history of ingesting and inserting foreign objects. The VA enjoyed being outside, throwing a football around, grilling, and making food.

The VA's plans stated, "Staff will sign out approved items from the staff office before allowing anything into [the VA's] living space. This is to assist with preventing SIB [self-injurious behavior] and keeping track of said items." "[The VA] requires line of sight supervision with anything being brought into [his/her] living space." "[The VA] has two staff working with [him/her] during awake hours (7:00 a.m.-10:00 p.m.). [The VA] has at least 1 staff within line of sight during these hours". The VA was not able to use the restroom independently and was not allowed to have privacy while in the bathroom. The facility had a *Log for items [the VA] has to turn back in* sign in/out sheet. The sheet documented the date, time the item was signed out, staff initials, name of item, and time the item was returned. Restricted items included crayons, markers, cell phone, Xbox controller, camera, and sunglasses. "There may be other items temporarily locked up at any given time due to attempts of self-harm."

The VA's Rights Restrictions included protection-related right to personal privacy and access to personal possessions at any time. The VA had an open bedroom doorway with no door and required the bathroom door to be partially open.

The VA provided the following information:

- On an unknown date in February 2025, P2 was in the kitchen making dinner and the VA and the SP were in the living room. The VA asked the SP for a pen to write in his/her journal. The SP got a pen out of the office for the VA. The SP watched television in the living room and the VA snuck the pen into his/her pocket when the SP was not looking.

- The VA stated s/he was upset that the SP was "not doing their jobs correctly" and s/he wanted to kill him/herself.

- P2 told the SP and the VA that they needed to go to the store to get items for dinner. The VA asked to use

the bathroom prior to leaving. The SP was outside the door while the VA used the bathroom. The bathroom had a sliding pocket door that remained half open while the VA was in there. The SP watched television and did not keep eyes on the VA. The VA went to the sink, leaned over and "shoved the pen down my throat."

- The VA estimated s/he swallowed the pen at approximately 1:50 p.m. The three went to a neighborhood convenience store. P2 went into the store while the SP and the VA stayed in the van. The VA was in the backseat and the SP was in the front passenger seat and P2 drove. The VA stayed in the van with the SP while P2 went into the store.

- After driving back from the store, the three got back to the house and were going to play a card game. The VA asked the SP where the pen was the SP gave the VA. The VA lied to the SP and P2 and said s/he forgot where s/he put it. The SP went into the office and came out with a different pen and said, "I found it". The VA said, "No, you didn't. I swallowed the pen." The pen was described as a common all black Bic pen with a cap, however, the cap had been removed prior to being handed to the VA by the SP.

- The SP and P2 took the VA to the hospital, where an endoscopy was performed to remove the pen. The VA was discharged after the procedure that evening. When the VA walked outside to meet the SP and P2 to go back to the facility, the VA walked out in front of the van in an attempt to get hit. P2 stopped the van in time and did not hit the VA. The VA was brought back into the hospital and was admitted for a psychiatric evaluation for the evening and held overnight.

- The VA stated all staff persons spend time on their phones, which was a violation of his/her supervision policy. The VA believed staff persons are supposed to leave their phones in their "drawers." The VA did not feel s/he could report that issue to anyone and stated s/he feared getting in trouble.

P2 provided the following information:

- On an unknown Sunday in early February 2025, P2 was working with the SP at the facility. P2 prepared items for dinner and realized an ingredient was missing. P2 told the VA and the SP that they needed to go to a convenience store to get the missing item. All three needed to go because the VA had a 2:1 staff ratio. At approximately 1:30 p.m., P2 went and cleared snow off the van and went back into the facility. The VA asked to use the bathroom and the SP went with him/her. The three then went to the store at approximately 1:45 p.m. P2 went in the store and the SP and the VA stayed in the van.

- The three returned to the facility at approximately 2 p.m. and were about to play a game. The VA complained about his/her stomach hurting. The VA asked to use the bathroom and the SP took him/her. The SP typed a message on his/her phone and showed it to P2 at 2:53 p.m. and asked, "Did [the VA] give you a pen." P2 did not know what the SP referred to and stated the SP tried to be discreet. P2 said, "No," and asked, "What pen?" P2 then asked the VA if s/he had a pen. The VA answered s/he had one but did not know what s/he did with it.

- P2 started looking all over for the pen. The VA lifted a remote control and looked under it, which tipped

off P2 when s/he realized a pen would not fit under a remote. P2 knew the VA knew where the pen was and s/he was not telling them.

- The SP went to the office and grabbed a "random pen" and said s/he found it. The VA stated that was not the pen because s/he had "swallowed it." P2 notified P3, P5, and P6 and then transported the VA to the hospital, along with the SP. P2 notified the G and the CM.

- The VA was discharged from the hospital at approximately 9 p.m. P2 went to get the van and as s/he was driving toward the SP and the VA, the VA ran out in front of the van and P2 slammed on the brakes to avoid hitting the VA. The VA was readmitted to the hospital for evaluation for being suicidal.

- P2 stated the VA had swallowed the pen before they left for the convenience store, when s/he had used the bathroom. The bathroom supervision policy was that the VA needed to be kept in sight the whole time while using the bathroom. The sliding pocket door was closed halfway. There was a chair about 15 feet from the bathroom for staff persons to sit in and watch the VA. The SP had mentioned that day that s/he did not like watching the VA in the bathroom. The VA stared at staff persons and would make them uncomfortable. The VA told P2 that the SP was not facing him/her and was facing the opposite direction and was on his/her phone when the VA swallowed the pen.

- P2 was unaware the VA had a pen. The SP did not follow protocol for when the VA used pens, pencils, markers and other items. Items were kept in a locked office and were signed out on a sign-out sheet. Other staff persons were notified when the VA had an item signed out. Staff persons kept eyes on the VA the entire time s/he had possession of a signed-out item. The SP did not follow any of those procedures.

- P2 typically signed items out for the VA and took him/her to the bathroom as the SP was a "couch potato" and was "couch locked." The SP was not willing to get up and take the VA to the bathroom most times.

P1 provided the following information:

- On February 2, 2025, P1 was contacted by P4 and was told the VA swallowed a pen and went to a hospital. The pen needed to be surgically removed.

- The VA had rights restrictions in place and items were kept locked in the office. There was a sign out procedure. Staff persons signed out the item, watched the VA the entire time s/he had the item and then signed the items back in on the log and put the item back in the office and locked the office. Staff persons were supposed to tell their coworker an item had been signed out. All staff persons were trained on that policy. The SP did not sign out the pen and did not notify P2 the VA had a pen.

- P2 told the SP and the VA they needed to go to the store to get an item for dinner. The three drove to the store and P2 went in, while the VA and the SP stayed in the van. When they returned to the facility, the VA asked the SP if s/he had given the pen back. The VA told the SP and P2 that s/he had swallowed the pen. The VA was taken to the hospital and had the pen removed.

- The VA swallowed the pen when s/he used the bathroom. The SP was supposed to watch the VA in the

bathroom, but did not keep the VA in visual contact the entire time.

- The SP stated s/he had forgotten about the pen.

- When the VA had been discharged and was waiting for P2 to drive the van around, the VA "jumped" in front of the van and tried to get hit. The VA was readmitted for psychiatric evaluation.

- The SP had issues with staying awake on previous shifts. The SP fell asleep during his/her shift on December 23, 2024, and was given a "first and final," which meant if s/he was caught sleeping again, s/he would be terminated.

- The VA has "set [staff] up to get them in trouble" when s/he saw them not following the supervision policy of eyes on him/her at all times.

- The VA stated s/he had an opportunity and "took it". The VA had been an accurate at providing information but had also "twists things around and stretches the truth."

- The SP was trained on the VA's plans. However, the training records were kept in the SP's "drawer" and the SP took all items out of the drawer. The training records could not be located. P1 contacted the SP and asked if s/he had the training records. The SP stated s/he did not know what P1 was talking about and stated s/he was never trained.

P3 provided the following information:

- On February 2, 2025, P3 learned the VA swallowed a pen from a group message sent out by P2. The message informed the group that the VA went to the hospital to have the pen removed and then s/he attempted to get hit by the van when they were leaving the hospital.

- When the VA knew staff persons were not watching, s/he would engage in self-injurious behaviors (SIBs). The VA would tell staff persons when s/he ingests or insert foreign objects.

- The VA's supervision policy stated that the VA had a 2:1 staff ratio during the day and 1:1 at night, with 15-minute checks. There was an alarm on the VA's bedroom doorway that sounded when the VA got up to use the bathroom (the door to the VA's bedroom had been removed.) Staff persons were to have the VA in direct line of sight. When the VA used the bathroom, the supervision policy stated staff persons had to keep eyes on the VA, no privacy was allowed.

- There was a sign out procedure for items the VA wanted to use. Items were to be signed out, staff persons were to keep the VA in constant sight while the items were used, and then the items were signed back in. When an item was signed out, the staff person was to notify any other staff persons at the facility that the item had been signed out. All items that were a hazard to the VA were locked in the office.

- P3 stated a previous staff person had trained the SP. When that staff person left, P3 took over training the

SP. The SP trained for six weekends total. The SP continually forgot passwords and lost training and test paperwork and would have to start over. P3 confirmed that the SP had shadowed other staff persons as part of his/her training, was certain the SP was trained on the VA's plans and knew the VA's supervision policy and procedure for signing out items for the VA to use. New staff persons had to review the VA's plans, shadow other staff persons and sign off on policies before they were allowed to "work the floor."

P4 provided the following formation to the DHS investigator:

- On February 2, 2025, P4 was notified by P6 via text message, that the VA was going to the hospital. The VA had a long history of SIBs, primarily ingestion of foreign objects.

- P4 stated there were times when certain staff persons were "lackadaisical." Staff persons were supposed to sign items out for the VA, keep visual contact on the VA while s/he was using the item, and sign the item back in. Staff persons had to rely on each other to "do what they were supposed to do."

P5 was the on-call supervisor on February 2, 2025, and received a call around 3 p.m. from an unknown staff person who stated a client had swallowed a pen and was being evaluated at the hospital. P5 did not know which staff person or client it was. P5 received a second call around 7 p.m. saying they were still at the hospital.

P6 was the on-call nurse on February 2, 2025, and was contacted by P2 around 3 p.m. and told the VA had swallowed a pen and was going to the hospital. P6 contacted P4 and notified him/her of the situation. P6 received a second call around 7 p.m. that the VA was still in the ER.

The G provided the following information:

- The G was notified the VA swallowed a pen from the hospital on February 3, 2025. The G did not receive notification from the facility until February 10, 2025.

- Staff persons were supposed to watch the VA constantly. The VA did not have any unsupervised time. There was an alarm on the VA's bedroom door that would alert staff persons if the VA left his/her room.

- The G had concerns that the VA could not speak to the G in private. Staff persons were always within audible range and the G felt the VA was hesitant to speak on certain topics.

The SP provided the following information:

- On or around February 2, 2025, the SP worked a double shift from 7 a.m. to 9:30 p.m. The SP also worked a 15 hour shift the previous day and had to return to work less than eight hours later.

- At approximately 1:30-1:40 p.m., the VA asked the SP for a pen to use. The SP went into the locked office, where restricted items were kept and gave a pen to the VA. P2 told the VA and the SP that they all needed to go to the store to get items for dinner. The SP "got distracted and forgot about the pen." The three went to the store and returned to the facility around 2 p.m.

- The VA asked the SP about the pen. The SP asked P2 if the VA had given the pen to him/her. P2 acted like

s/he "didn't know what I was talking about." The SP searched for the pen and went into the office and looked for it. The SP did not realize there was another pen just like the missing pen and found one on the floor. The SP showed the VA the pen and asked if s/he was sure s/he did not give it back. The VA denied that s/he gave it back and then stated s/he had swallowed it.

- The SP stated when the VA wanted an item, it is supposed to be signed out. P2 "came around and I got distracted." The VA "usually has a pen for two seconds and gives it back to you."
- The SP did not sign the pen out and stated s/he did not always sign items out. "We are told that we are supposed to but we don't do it all the time."
- The VA's supervision policy was 2:1, eyes on, in line sight at all times. The SP stated when the VA used the bathroom, a staff person was supposed to sit right outside the bathroom and keep eyes on the VA. The SP had talked to P3 and stated s/he was uncomfortable "doing that" and "would have other staff do it." The VA used the bathroom prior to leaving for the store. The SP supervised him/her in the bathroom and stated the VA "was in my line of sight. I never saw [the VA] go near [his/her] mouth." The SP stated, "I'm not gonna stare at [him/her] but [s/he] have to see [him/her] out of my peripheral and see that [s/he] wasn't doing nothing, s/he was just sitting there and pretty much just staring at me the entire time. That's where the uncomfortability comes in. I don't like [him/her] sitting there using the bathroom staring at me."
- The SP believed the VA swallowed the pen when they were at the store in the van. The VA was seated in the backseat and the SP was in the front passenger seat. The SP stated s/he watched the VA in the mirror while they were in the van. The SP did not see anything "out of the ordinary."
- The SP stated s/he was never trained on the VA's plans. "I walked in, got the job, they had me skip through some books, then put me on the floor. They never taught me anything, never coached me through the stuff with [the VA]." The SP did know the protocol for when the VA swallowed an item, which was to call the supervisor, the on-call nurse, the case worker, and the guardian. The SP said s/he was not trained in reporting maltreatment of vulnerable adults; however, s/he knew to report it, had heard of a "MAARC" report but stated s/he was not trained how to do it, and admitted s/he read something about it but did not remember what.

Medical records showed the VA was seen at a hospital emergency department on February 2, 2025 at 3:30 p.m. for ingestion of a foreign body. The foreign body (ballpoint pen) was removed with the assistance of anesthesia and general endotracheal intubation. The VA was discharged at 9:13 p.m.

Facility training records showed all staff persons that were interviewed had received training on the Reporting of Maltreatment of Vulnerable Adults Act and P2 and P3 had been trained on the VA's plans prior to the incident. The facility provided the SP's certificate of completion for Maltreatment of Vulnerable Adults and Prohibited Procedures, dated July 24, 2040. The facility could not locate any other training records for the SP and believed the SP took the records from the facility when s/he cleaned out his/her drawer.

*Relevant Rules and or Statutes*

Minnesota Statutes, section 245A.041, subdivision 3, paragraph (a), clause (2), stated the license holder must maintain and store records in a manner that will allow for review, personnel records must be maintained for a minimum of five years following termination of employment.

**Conclusion:**

A. Maltreatment:

Information showed that on February 2, 2025, the SP provided the VA with a pen and did not follow the VA's plans to sign the pen out. The VA put the pen into his/her pocket and asked to use the bathroom. The SP supervised the VA in the bathroom but did not keep eyes on the VA the entire time. The VA swallowed the pen when the SP was not watching him/her in the bathroom. The VA, the SP, and P2 went to a store to get items for dinner. When they returned, the VA asked the SP where the pen was at. The SP produced a pen and stated s/he had "found it." The VA stated that was not the pen and told the SP and P2 that s/he swallowed it. The SP stated s/he had been "distracted and forgot about the pen." The SP stated s/he knew of the policy to sign items out and that sign out procedure was not done. The SP knew of the VA's supervision plan and stated s/he was "uncomfortable" watching the VA in the bathroom. The SP stated s/he did not stare at the VA while s/he used the bathroom but kept him/her in his/her peripheral vision. The SP did not see the VA swallow the pen and thought the VA might have swallowed the pen in the van. The VA was taken to a hospital to have the pen surgically removed.

The VA's plans stated, "Staff will sign out approved items from the staff office before allowing anything into [the VA's] living space. This is to assist with preventing SIB [self-injurious behavior] and keeping track of said items," and "[The VA] has two staff working with [him/her] during awake hours (7:00 a.m.-10:00 p.m.). [The VA] has at least one staff within line of sight during these hours."

Given that the SP stated that s/he gave the VA the pen without signing it out and did not supervise the VA when s/he had the pen so subsequently the VA swallowed the pen without the SP or P2 knowing, there was a preponderance of the evidence that the SP failed to supply the VA with reasonable and necessary care or services, including supervision.

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.

The SP did not follow sign out procedures for the pen and stated that s/he was aware of the procedure to do so. In addition, the SP did not follow the VA's supervision requirements while the VA was in the bathroom. Although the SP stated s/he was not trained, and the facility did not have training documentation which was a violation of Minnesota Statutes, section 245A.041, subdivision 3, paragraph (a), clause (2), given that P3 stated s/he trained the SP and that the SP knew the procedures for the VA's supervision and signing out items, it was likely the SP was trained therefore the SP 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 neglect for which the SP was responsible was not recurring maltreatment because it was a single incident but was determined to be serious maltreatment because the VA required care of a physician.

**Action Taken by Facility:**

The facility completed an internal review and determined related policies and procedures were adequate and were not followed, there was a need for further staff training and staff persons were retrained on the procedures that need to be followed. The reported incident was similar to past events, as the VA had an extensive history of looking for opportunities when staff persons were not watching or following procedures and harmed him/herself. The facility took corrective action and the SP weas no longer working at the facility.

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

The SP was 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 the SP was responsible for maltreatment and the disqualification of the SP are each subject to appeal.

On June 18, 2025, the facility was issued a Correction Order for the violation outlined in this report.