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: 202407464

Date Issued: June 27, 2025

Name and Address of Facility Investigated:

Disposition: Inconclusive

Dungarvin Centerville
3488 Centerville Rd
Vadnais Heights, MN 55127

Dungarvin Minnesota LLC
1440 Northland Drive Ste 100
Mendota Heights, MN 55120

License Number and Program Type:

1070893-H_CRS (Home and Community-Based Services-Community Residential Setting)
1070806-HCBS (Home and Community-Based Services)

Investigator(s):

Christine Cavanaugh
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
christine.cavanaugh@state.mn.us
651-431-3444

Suspected Maltreatment Reported:

It was reported that a staff person (SP) slapped and pushed a vulnerable adult (VA), and the VA was heard on camera footage yelling, "Ow," multiple times.

Date of Incident(s): August 26, 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 subdivision2, paragraph (b), clause (1):

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.

Summary of Findings:

Pertinent information was obtained during a site visit conducted on September 10, 2024; from documentation at the facility and law enforcement records; and through seven interviews conducted with two staff persons (P1-P2), two supervisory staff persons (P3-P4), the VA's guardian (G), and the SP. The VA started his/her interview, but requested to end it before information regarding the incident was obtained.

The VA enjoyed playing basketball, going for walks, and car rides. The VA also liked to go swimming, bowling, shopping, and spend time with family. The VA was diagnosed with moderate intellectual disability, autism, attention deficit hyperactivity disorder, impulse control disorder, and unspecified pervasive developmental disorder. The VA had a history of physical aggression and self-injurious behaviors. Staff persons helped the VA learn healthy coping skills and prompted the VA to verbally inform them of how s/he was feeling rather than demonstrate target/maladaptive behaviors. If the VA showed signs of agitation, staff persons provided opportunities for the VA to talk about how s/he was feeling and offer different items or activities. Staff persons were to redirect the VA if s/he displayed maladaptive behaviors. If the VA demonstrated physical aggression, staff persons attempted to remain out of the VA's reach. If the VA was close, staff persons were to block the VA's attempts to hit/kick/bite. If the VA continued to be aggressive and staff were not in imminent harm, staff continued to minimize verbal cues and only give simple infrequent redirection to use his/her coping skills. Continued discussion at that time could escalate the behavior further. Staff persons were not to engage in a "power struggle" during any aggressive situation.

The facility was a single-family home with an attached garage. The VA's bedroom was in the basement/lower level. A camera was located in the dining room area that captured a full view of the dining room, and front entry way and a partial view of the front entry way, kitchen, living room, and stairway going down to the lower level.

The *Investigation Report and Summary* provided the following information:

- On August 27, 2024, in the morning, P2 arrived for his/her shift and the VA told P2 s/he "got into a fight" with the SP the previous evening in the garage. The VA said s/he "punched" and "kicked" the SP and that during the incident, the SP "scratched" the VA. The VA showed the scratch to P2, who then took photos of the injury. P2 saw a "red scratch" on the VA's hand and cuts on his/her fingers as well as bruising on his/her arm. None of the injuries were "severe" and did not require first aid. The VA previously applied ointment to the scratches. The bruising appeared to be "a few days old." P2 asked the VA how s/he got the bruises, but the VA did not recall any incidents that would have caused them. P2 documented the information and sent the pictures to P3.

- The VA said that when s/he and the SP were outside in the garage, the SP "hurt [the VA] pretty badly" and "made [the VA] bleed." The SP "scratched" the VA's middle finger, pinched him/her "really hard," and kicked him/her "pretty hard." The VA said the bruises and scratches were from the SP while they were in the garage. The VA stated s/he had no injuries from being kicked by the SP.

- On August 26, 2024, P1 and the SP worked the evening shift. P1 said that about an hour after they ate dinner, the VA requested more food. P1 "explained" to the VA that s/he had just eaten dinner and did

not need to eat again "so soon." The VA then started "banging around the kitchen," "slamming doors," and walked into the garage. The SP was in the garage already, so P1 did not follow the VA. While they were in the garage, the VA and SP got into an "altercation" which continued after they came back inside. While the VA and the SP were in the kitchen, the VA pushed the SP and pulled on his/her shirt. The SP attempted to block the VA's "attacks" and to get the VA to let go of his/her shirt. P1 intervened a "few times" asking the VA to "stop," and eventually the VA stopped. P1 then made some food for the VA. The VA told P1 that s/he was scratched by the SP and showed P1 the scratch s/he sustained on his/her fingers. P1 stated the scratches were "mild" and did not require first aid. P1 did not see the SP hit the VA at any point during the incident and the only physical contact s/he saw was when the VA was grabbing onto the SP's shirt and the SP grabbed onto the VA's hands to release the SP's shirt. P1 did not know anything about the bruises later found on the VA, but stated the VA had a prior fall in the bathroom. (Note: There was no additional information of a date/time the fall occurred.) The VA had a history of hitting his/her head and hands on the wall and biting him/herself on the wrist.

- P3 was aware of the incident and received pictures from P1 of the scratches and bruises. P1 stated the bruises were "greenish" and "looked like someone tried to grab [the VA]." P3 watched video footage of the incident with P4 and saw the SP and VA in the kitchen and on the stairs leading to the lower level where the VA's bedroom was. During the incident, the SP and VA went into the garage, where there were no cameras.

- P3 talked to the SP, who denied hitting the VA or doing anything to cause the VA harm. P3 asked the SP about the incident and scratches the VA sustained. The SP said that the VA hit him/her and also attempted to kick and punch the SP. The SP was "trying to defend" him/herself by "walking around" and "avoiding" the VA and at some point, the VA was scratched during that time. The SP did not document the incident. P3 talked to P1 about the incident and P1 said that the VA and SP were "arguing" and at some point, went in the garage so P1 did not know what happened during that time. P3 talked to the VA about the incident and the VA said that s/he was "kicking and fighting" the SP because s/he wanted to go outside. The VA did not state s/he was bruised by the SP, only scratched.

- P4 was told about the incident from P3 and watched video footage of the incident with P3. P4 stated that the video footage showed the VA enter the garage followed by the SP. About one minute later, the VA came back inside and went downstairs again followed by the SP. P4 saw the SP grab something from the VA (later identified as the keys for the facility van). While the VA and SP were on the stairs, the SP "slapped" the VA and the VA said, "Ow." The SP and VA then walked upstairs and entered the kitchen. The VA was kicking and hitting the SP, and the SP appeared to "push" the VA away from him/her before walking into the garage. At some point, P1 attempted to intervene. P4 did not know what caused the bruises.

- The SP said s/he started his/her shift around 4 p.m. and at that time, the VA had already "completed" his/her "gas station outing" for the day. Later that evening, the VA wanted a sandwich, but P1 reminded the VA that s/he had just eaten dinner. However, the SP told P1 to make the VA a sandwich, so P1 was in the kitchen while the SP and the VA were outside. At one point, the VA returned inside the house while the SP stayed in the garage. Then the SP went inside and upstairs to the staff office. When the SP returned downstairs, P1 told the SP that the VA took the facility's van keys and went back outside. The SP went into the garage and saw the VA "banging" his/her hands on the van, expressing s/he wanted to go to the gas station. The SP "encouraged" the VA to return the keys, but instead of doing so, the VA walked around the van and inside the house. The VA started walking down the stairs towards his/her bedroom

with the keys. As the two of them stood on the landing of the stairs, the VA gave the SP the keys and the SP turned and walked upstairs towards the kitchen followed by the VA. As the SP walked up the stairs towards the kitchen, the VA started hitting the SP and the SP tried to "block" the VA's hits and "redirect" the VA to calm. The SP stated s/he was usually able to redirect the VA and help him/her to calm, by talking to the VA, but this time s/he was unsuccessful. At that point, P1 finished making the VA's sandwich and told the VA it was ready. The VA was not responsive and continued to "attack" the SP. The SP then moved from the kitchen to the garage to "get away" from the VA and "give [the VA] some space." The VA followed the SP into the garage continuing to hit the SP. While in the garage, the SP told the VA that P1 made him/her a sandwich. The VA then stopped hitting the SP and walked back inside. The VA brought his/her sandwich downstairs to his/her bedroom and stayed there for a period of time.

- The SP denied hitting, grabbing, or slapping the VA and stated that his/her actions were attempts to redirect the VA's hands and block the VA's hits. At the time, the SP was unaware the VA was injured and the VA never said anything to the SP about being hurt. The SP also said s/he did not believe the VA told P1 about his/her injuries since P1 did not mention anything to the SP about it. The SP could not recall that any of his/her actions would have injured the VA. When the VA was banging on the van, s/he used the van keys and the keyring bent. It was possible that the bent keyring could have scratched the VA. The SP could not recall any interactions that would have resulted in bruises on the VA, but the VA had a history of self-injurious behavior, including biting him/herself, hitting his head and arms on walls, kicking things, and scratching his/her skin until it bled. The SP did not know or hear of any situations or incidents where the VA could have been injured.

- Four photos of the VA's injuries showed the following:

    - A photo showed a red scratch about one half inch long on the VA's right wrist.

    - A photo showed a wound on the middle finger on the VA's right hand. The wound was red (approximately the size of a dime) with a "crescent-shaped" indent in the middle.

    - A photo showed a light brown bruise on the VA's right inner forearm, "slightly larger" than a "golf ball."

    - A photo showed a "small scattering" of "greenish-yellow" bruising on his/her right upper arm, spanning an area of a "few inches."

  [Note: This investigator viewed the four pictures of the VA's injuries which were consistent with the *Investigation Report and Summary*'s description.]

- Reports were reviewed and there the facility determined there was no information/documentation of any injury or behavioral event occurring to explain the origin of the VA's bruises.

A camera was located in the corner of the dining room. On the right side was a door to the garage. The camera also showed the stairwell going down to the VA's room and portions of the kitchen and living room. The video showed the following:

- Around 6:50:04 p.m. the VA entered the house from the garage holding a plastic lidded cup. The VA walked into the dining room and then went into the kitchen and was off camera. At 6:50:25 p.m. the

door to the garage opened and shortly after the VA came back into view and started opening cupboards and the refrigerator.

- At 6:50:42 p.m., the SP entered the facility from the garage and shut the door. The VA talked about wanting a peanut butter and jelly sandwich, and off camera P1 told the VA that s/he just had dinner. The VA said, "I just want a snack," some jelly on my bread. During this time, the SP walked around the kitchen appearing to move dishes from the counters to the sink and then walked out of the kitchen and into the living room out of view of the camera, while the VA continued to prepare his/her jelly bread. P1 again reminded the VA s/he just had dinner. The VA continued to repeat that s/he was still hungry and just wanted some bread.

- At 6:51:43 p.m. the VA carried the jelly and a cutting board off camera to a drawer. The VA opened the drawer and took out what appeared to be a set of car keys and then shut the drawer. The VA the turned out of view of the camera and quickly turned around walking away from the kitchen with only the keys in his/her hands. At 6:51:59 p.m., the VA opened the garage door and walked into the garage closing the door.

- At 6:52:12 p.m., the SP walked into view of the camera from the living room to the garage door, opened it and went out closing it behind him/her nine seconds later. At 6:52:47 p.m. the garage door opened and the VA returned inside and went downstairs immediately followed by the SP. As the garage door closed, the SP turned on the stairwell light. At that point, the SP and the VA were at the landing of the stairs with the SP's back towards the camera and the VA partially visible. The SP was saying something about the keys while the VA said, "I wanna go for a ride," while the SP's left hand held onto the VA's right arm/wrist and used his/her right hand appearing to try to get the keys from the VA's hand.

- At 6:53:04 p.m., the SP appeared to get the keys from the VA and turned to walk back up the stairs when the VA grabbed the SP's arm. The SP pulled his/her arm out of the VA's grip and walked back upstairs pointing at the VA and saying something that was not clearly audible. The SP then turned to walk back up the stairs. As the SP walked up the stairs, the SP turned back towards the VA and "quickly swiped downward" with his/her right arm, slapping the VA's left forearm. The VA said, "Ow," and the SP continued walking up the stairs with the VA following close behind.

- At 6:53:17 p.m., the VA and the SP were each up the stairs and in the dining room. The VA reached towards the SP's chest appearing to try hit the SP but the VA and the SP each step back. P1 was still off camera but said, "Stop." The SP said something along the lines of "watch yourself" or "get onto yourself." The VA then kicked his/her left leg at the SP as the SP backed up. Then as the VA moved towards the SP, the VA "slapped" the SP on the right wrist. The VA attempted to hit the SP's wrist a second time but, the SP blocked the VA's hand, grabbed it, and pushed it away. The VA again tried to hit the SP, but the SP blocked it hitting the VA in the left arm. The VA looked at his/her left arm and said, "Ow." At this point (6:53:28 p.m.) the SP was backed into the corner of the kitchen and out of the camera's view while the VA remained in view. For the next minute, until 6:53:37 pm., the VA continued to hit and kick the SP as the SP continued to block and/or push the VA back. At times, one or both were in and out of view, the SP was heard talking to the VA but it was not audible, and P1 was heard saying, "Stop. [The VA] stop." The VA also said, "Stop," several times as s/he continued to hit the SP.

- At 6:54:37 p.m., the SP walked away from the kitchen corner, through the living room towards the garage door. The VA was in the kitchen and as the SP reached the stairwell, s/he turned around to face the VA

who was walking from the kitchen toward the SP. The VA continued trying to hit the SP as the SP blocked the VA's hits and backed away from the SP

- A 6:54:58 p.m., P1 entered the kitchen verbally redirecting the VA to stop and the VA walked away from the SP and turned toward the kitchen. The SP opened the garage door and went into the garage. The VA was in the kitchen with P1 repeating for the VA to stop and leave the SP alone, but the VA walked past P1 and at 6:55:09 p.m. the VA opened the garage door and went into the garage as P1 walked back into the living room and off camera.

- At 6:57:41 p.m., P1 entered the garage and returned at 6:58:38 p.m. entering the kitchen. [Note: The video ended at 7:00:15 p.m. prior to the VA or the SP returning inside. However, the *Investigation Report and Summary* stated that at 7:00 p.m., the VA entered the house and walked downstairs. P1 asked the VA if s/he was "ready" for his/her sandwich and the VA said s/he was while standing on the landing of the stairs. The VA looked at his/her fingers and sated, "[the SP] made me bleed." P1 then said, "You were attacking [the SP]." The VA did not respond and walked downstairs off camera. At 7:04 p.m., the SP entered the facility from the garage and no more interactions were seen.]

P1 provided information in his/her interview that was consistent with the information s/he provided in the *Investigation Report and Summary* regarding the incident. Additionally, P1 said that when s/he saw the "fresh" scratches on the VA, s/he thought maybe the SP's nail scratched the VA's fingers. The VA had a history of biting his/her hand and hitting his hands on a wall, but P1 never saw the VA scratch him/herself. When the VA displayed maladaptive behaviors, staff persons were to "give [the VA] space." If the VA became aggressive, staff persons may need to "block" the VA. The VA was able to "tell the truth," but "sometimes lied." For example, the VA might say a staff person hit him/her when they did not. P1 had no concerns with the SP's interactions with clients and said the clients "loved" him/her.

P2 provided information in his/her interview that was consistent with the information s/he provided in the *Investigation Report and Summary*. Additionally, P2 stated that s/he worked the day before the incident and did not see any bruises on the VA. P2 was not sure where the bruises came from; however, the day before when P2 worked, the VA had maladaptive behaviors and was punching on walls. The VA had a history of self-injurious behavior including scratching him/herself on his/her hands and picking his/her fingernails. If the VA had a wound, s/he scratched that as well. P2 did not look at the VA's hands prior to the incident to know if s/he had the scratches. P2 stated that when the VA was aggressive, staff persons were to redirect him/her and give the VA "space." The VA had a history of falsifying information such as saying staff hit him/her when they did not, but the VA was able to report accurate information and was usually truthful if s/he said something repeatedly and consistently to multiple persons. As far as P2 knew, the VA did not change his story regarding the incident. P2 had no concerns with the SP's interactions with clients.

P3 provided information in his/her interview that was consistent with the information s/he provided in the *Investigation Report and Summary* regarding the incident. P3 also stated that s/he watched the camera footage of the incident and it looked like the SP stretched his/her arm at the VA and made physical contact. The SP told P3 that s/he was "defending" him/herself while "getting away" from the VA. The VA had a history of scratching his/her arms and hands; however, the scratches that occurred during the incident timeframe were more "significant." The VA did not always tell the truth regarding incidents with staff persons, but it also depended on how the person phrased the questions. If someone asked the VA if a staff person hit him/her, the VA would say that they did. Staff persons were trained to redirect the VA when s/he had maladaptive behaviors. Staff persons

were also trained on personal safety training for all clients. P3 worked at the facility for about a year and had no concerns with the SP's interactions with clients.

P4 provided information in his/her interview that was consistent with the information s/he provided in the *Investigation Report and Summary* regarding the incident. P4 also stated that on August 27, 2024, s/he reviewed the facility camera footage and provided information that was consistent with the video. P4 said that the bruises on the VA's arm were not in the same location as the video footage showed physical contact by the SP, so P4 thought they were from a "separate situation." The VA told P4 that while s/he and the SP were in the garage, the VA hit and kicked the SP but never stated that the SP hit him/her. The VA was "not the most accurate reporter," but it depended on the situation. The VA had the ability to report accurate information, but did not always do so. The VA was known to say a staff person hit him/her when it did not happen. P4 had no concerns with the SP's interactions with clients prior to the incident and said that the incident "took [P4] by surprise." The SP was "considered such a great staff."
The G said that the VA's reporting of information was "hard to decipher" at times. Sometimes the VA exaggerated and told lies, but other times s/he was very "black and white" and "very honest"—it was "kind of a fine line." However, if "someone did something to [him/her]," the G thought s/he would "tell the truth," but persons had to "figure it out" to see if the information was truthful. The G saw the VA after the incident and the VA showed the G scratches and bruises. The VA told the G that the SP "got mad," "grabbed" the VA's hand and scratched it, and gave the VA a bruise. The G met the SP prior to the incident and had no prior concerns.

The SP provided the following information in his/her interview:

- On August 26, 2024, sometime after dinner, the VA was in the garage with the facility's van keys hitting on the van with them. At some point later, the VA went inside and down the stairs to the lower level while holding the keys. The SP followed the VA to retrieve the keys. While on the landing of the stairs, the SP got the keys from the VA and when the SP started to walk back upstairs, the VA followed and tried to hit the SP, so the SP "blocked" the VA's hits. Once they were both upstairs in the kitchen, the VA continued trying to hit the SP. The SP "redirected" the VA's hands and told the VA that his/her sandwich was ready and not to hurt him/herself. The VA was "being persistent" so the SP went to the garage to give the VA "space." However, the VA followed and continued trying to hit the SP. The SP told the VA again that his/her sandwich was ready and eventually the VA went inside, got the sandwich, and went to his/her bedroom.

- The day after the incident, the SP received a call from P1 who said that the VA told P1 that s/he "fought" with the SP and sustained a scratch. The SP told this investigator that d s/he used his/her hand to redirect and block the VA's hand, but did not know what could have caused the injury. The SP stated that when the VA had the van keys there was a "bent" piece on the ring holder so maybe the scratch came from that, or it could have been from another incident.

- The SP stated the only physical contact s/he made with the VA was to block the VA from hitting him/her. The SP denied hitting the VA.

Law enforcement investigated this report, and it was not submitted for charges.

P1-P4 and the SP were trained on the Reporting of Maltreatment of Vulnerable Adults Act and the VA's plans.

Relevant Rules and Statutes:

Minnesota Statutes, section 245D.06, subdivision 7, paragraph (b), clause (b), item (4), states that permitted actions and procedures include being able to block and 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.

Minnesota Statutes, section 245D.04, subdivision 3, paragraph (b), clause (6), states that a person has freedom and support to access food and potable water at any time.

Conclusion:

Information obtained showed that on August 26, 2024, around 6:50 p.m., the VA requested multiple times that s/he wanted more food, but P1 told the VA that s/he had just eaten dinner and did not need to eat again that soon. The VA eventually received more food. Not allowing the VA to have more food upon request was a violation of Minnesota Statutes, section 245D.04, subdivision 3, paragraph (b), clause (6).

Video footage during that time also showed that after the VA was denied food, s/he obtained the facility car keys and then there were several interactions between the VA and the SP. While the VA and SP were on the stairway landing to the lower level, the SP's left hand held onto the VA's right arm/wrist and the SP used his/her right hand appearing to try to get a set of keys from the VA's hand. Once the SP appeared to get the keys from the VA and walk up the stairs, the VA grabbed the SP's arm and the SP pulled his/her arm out of the VA's grip and walked back upstairs pointing at the VA and saying something that was not clearly audible. The SP then turned to walk back up the stairs and as s/he was doing so, the SP turned back towards the VA and "quickly swiped downward" with his/her right arm, slapping the VA's left forearm. The VA said, "Ow," and the SP continued walking up the stairs with the VA following close behind. Although the SP hit the VA, the VA had just grabbed at the SP prior to the SP walking up the stairs, and based on the view of the camera, it was not able to be determined if the SP hit the VA purposefully or was trying to redirect the VA's arm/hand away from the SP as the SP continued to walk up the stairs. Then when the VA and the SP were upstairs in the dining room/kitchen, there were several interactions between them where for approximately the next two minutes, the VA hit and kicked the SP and the SP blocked and/or pushed the VA attempting to prevent the VA from doing so. Then the SP and the VA went into the garage and the video ended prior to their return inside.

Information obtained was consistent that after the incident, the VA had scratches and bruises and it was believed the scratches were a result of the incident but it was unknown how the VA sustained the bruises. According to the Investigation Report and Summary around 7 p.m., P1 asked the VA if s/he was "ready" for his/her sandwich and the VA said s/he was while standing on the landing of the stairs. The VA looked at his/her fingers and sated, "[the SP] made me bleed." P1 then said, "You were attacking [the SP]." The VA did not respond and walked downstairs off camera.

On August 27, 2024, the VA told P2 s/he "got into a fight" with the SP the previous evening. The VA said s/he "punched" and "kicked" the SP and that during the incident, the SP "scratched" the VA. Photos of the VA's injuries showed a red scratch on the VA's right wrist, a wound on the VA's right hand middle finger, a light brown bruise on the VA's right inner forearm, and some green/yellow bruising on the VA's right upper arm.

The SP said s/he used his/her hand to redirect and block the VA's hand, but did not know what could have caused the injuries. The SP stated that when the VA had the van keys there was a "bent" piece on the ring holder so

maybe the scratch came from that, or it could have been from another incident. The SP said the only physical contact s/he made with the VA was to block the VA from hitting him/her. The SP denied hitting the VA.

Given that the VA was hitting and kicking at the SP, it was reasonable for the SP to take some action to prevent/redirect the VA and the SP's actions at the time of the incident were consistent with Minnesota Statutes, section 245D.06, subdivision 7, paragraph (b), clause (b), item (4). Although the VA had scratches and bruises on his/her hands/forearm, there was not a preponderance of the evidence whether all of the SP's actions were therapeutic conduct or whether the VA sustained the injuries by any means other than accidental.

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).

Action Taken by Facility:

The facility completed an internal review and stated their policies and procedures were adequate, but not followed by the SP. All staff persons were retrained on the VA's support plan, how to avoid getting into "power struggles" with the VA, and on prohibited procedures to avoid when working with the VA. The SP no longer worked at the facility.

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

Given that the facility took immediate corrective action, a Correction Order was not issued for the violation outlined above.